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Traditional ways of coping with consequences of traumatic stress in Acholiland

Northern Ugandan ethnography from a Western psychological perspective

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Dissertation zur Erlangung der Doktorwürde an der Philosophischen Fakultät der Universität Freiburg (Schweiz). Genehmigt von der Philosophischen Fakultät auf Antrag der Professoren
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Freiburg, den 9.10.2009
Pof. Dr. Thomas Austenfeld, Dekan

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FOREWORD AND ACKNOWLEDGEMENTS

Since July 2006, the Ugandan Government and the Lord's Resistance Army (LRA) are engaged in peace talks. There is hope that negotiations will end one of Africa's most brutal wars, which has devastated the Acholi sub-region and neighboring districts in Northern Uganda. The 23-year-old war has displaced 95% of the Acholi people, who had to endure in provisional camps for internally displaced people (IDP[1] camps) over many years. The past three years of relative peace have seen the decongestion of several IDP camps, with people moving towards their homes by putting up in new sites. Many have meanwhile managed to get back and cultivate their ancestral land. When writing about the dehumanizing conditions in the IDP camps, the pervading military insecurity, continued abductions, and other appalling features of the war, I was arguing with myself whether to write in the present or the past tense. Some of the descriptions given in CHAPTER 2 are still true and could have been put in the present tense. Other conditions have meanwhile changed for the better. Finally, I decided to write everything in the past tense. I did so for the sake of consistency, and even more so to express my desire that one day all the horrors of war may belong to the past.

From January 2002 to August 2006, I lived in the war-ravaged area, working as a psychological consultant to a local organization (Caritas Gulu Archdiocese[2]). My task was

[1] Internally displaced persons (IDPs) are, similar to refugees, people who have been forced to leave their homes for reasons such as religious or political persecution, war or natural disaster. Unlike refugees, they have not crossed an international border and have no specifically defined legal status (http://www.reliefweb.int/library/documents/2002/idp-module1-2002.pdf).

[2] Gulu Archdiocese consists of the three districts of Gulu, Kitgum and Pader in Northern Uganda. These three districts are often called the 'Acholi' districts or 'Acholiland', as they are mainly

to help the Psychosocial Support Program of Caritas Gulu develop and implement projects to alleviate the psychosocial suffering caused by war.

While working and living in Northern Uganda, I learned a lot from my local colleagues. This was indispensable, as the challenges we encountered during a volatile civil war were immense and different from the problems I had 'in my previous life' seen in Europe. CHAPTER 1 of this thesis describes the most important features and consequences of this dreadful war. Here it should suffice to mention that they went far beyond the scope of what is captured in theories of Western Clinical Psychology.

As a licensed psychotherapist, I would have been interested in doing work that was more closely related to my specialization. However, living in the middle of the disaster, I fast perceived the complexity of situation. It was obvious that, at the given time, we had to attend to countless issues more basic and more pressing than psychotherapy. Further, I knew that in order to engage in psychotherapy and train people in this field, I first had to be acquainted with the local language and culture. Of specific importance was to learn more about how Acholi people have traditionally understood and coped with traumas resulting from war and other calamities.

To my surprise, it was not only I who felt knowing too little about Acholi traditions. Although the local social workers, being Acholis themselves, obviously knew more on 'traditional' culture than I did at the beginning of my stay, they also appeared to have only limited knowledge on the traditions of their people. Due to strong influences of Christianity, 'Western culture' and the destructive socio-cultural effects of the war, much of the knowledge on traditions, including 'traditional ways of coping', had been lost. Most of it had remained familiar only to few people of the older generation.

During discussions and consultations with both local social workers and community members, we realized that it was crucial to gain a better understanding of the provisions of the local culture and traditions. Many traditional rituals and procedures had the potential of fostering healing among the war torn communities. Yet despite the relevance of the topic, there was no easily accessible literature on it.

As my local colleagues were similarly interested in discovering more on the potentials of local traditions for healing from war, we decided to set up a research project with the aim of documenting and promoting the potentially applicable traditional healing practices in Acholi. During three years of fieldwork in Northern Uganda, we managed to collect substantial ethnographic data, which show the potential that lies in Acholi traditions.

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inhabited by people of the Acholi ethnic group. The population of Gulu, Kitgum and Pader, counting about one million people altogether, has at the same time been worst affected by the civil war.

Getting to know and learning to appreciate a new and quite different culture was personally very enriching for me. I would like to thank all who have accompanied and supported me in this process, though it is impossible to mention them all by name.

First and foremost I would like express my deep gratitude to Peter Wilhelm, who supported the project in different ways over many years and provided helpful comments on earlier drafts of the manuscript.

I also thank the members of our local research team. Caroline Aloyo, who coordinated the Psychosocial Support Program (PSSP) of Caritas Gulu Archdiocese, has been supportive of our research project from the beginning to its conclusion. Francis Xavier Okot has carried out most of the data collection. His interest in Acholi traditions and excellent abilities in building up trustful relationships with elders, healers and other community members enabled us to describe details of concepts, rituals, and case studies that would have otherwise remained undiscovered. Scholastica Amono and Josef Ogaba merit thanks for supporting him in his efforts. Thanks also go to other staff of the PSSP, especially to Gabriel Onen, Grace Arac, Mark Okot and Paul Rubangakene who supported our research as desk officers and social workers. Community Resource Persons of the PSSP of Gulu Archdiocese have also facilitated and contributed to this study in many ways. Special thanks go to Marcellino Opio, Vincent Otim and Andrew Angelo Banya. Furthermore, I would like to thank all the elders, chiefs, traditional healers, ritual performers and other members of the community who willingly availed their time and knowledge to answer our questions and allowed us to participate in their rituals.

I also send my gratitude to Joseph Okumu for inspiring discussions on Acholi traditions and for availing me important literature. For pointing me to further literature on the Acholi I also thank Tim Allen, Ronald Atkinson and Sverker Finnsröm. For their support in searching literature on cross-cultural psychology my thanks go to André Birbaum and Jenny Kehl as well as to Lynne Cripe, Andrea Horn and Stuart Lustig. Paul Bolton, Gerhard Mayer and Phuong Pham provided valuable hints on ethnographic and qualitative methodology.

This research would not have been possible without the financial support given by the Ministry of Development Cooperation of the German Government via Arbeitsgemeinschaft Entwicklungshilfe (AGEH). I'm grateful to Ludger Reining and Stefan Willmutz from AGEH for their support during my stay in Northern Uganda.

Last but not least I want to express my gratitude towards Professor Meinrad Perrez for supervising the study.

OVERVIEW OF CONTENT

This study describes how Acholi communities perceive, explain, and cope with the consequences of traumatic stress according to their traditional culture. Additionally, comparisons of the ethnographic descriptions with the concept of posttraumatic stress disorder (PTSD) and related therapeutic approaches provide information for judging the applicability of Western clinical concepts and therapies in the Acholi cultural context. The exploratory study applies ethnographic methods for data collection, such as key informant interviews and participant observation. The analysis of data mainly employs qualitative procedures.

The INTRODUCTION sketches the current debate on the cross-cultural applicability of the PTSD concept and specifies the research questions. PART ONE depicts the background to this thesis, with CHAPTER 1 portraying the psychosocial consequences of the civil war that has been culminating in a complex emergency with widespread psychological traumatization. CHAPTER 2 describes the history of the Acholi ethnic group, including the development of an Acholi identity and socio-political organization. It also delineates the traditional cosmology of the Acholi and respective changes during the colonial and post-colonial era. PART TWO gives an outline of the clinical knowledge on disorders of posttraumatic stress and related interventions. PART THREE discusses cross-cultural issues on mental health and posttraumatic stress. This includes an outline on methodological concerns, as well as a review of literature on the cross-cultural epidemiology of PTSD and respective interventions. After describing the methodology of the study, PART FOUR presents the empirical core of this thesis, the ethnography. CHAPTER 11 gives a systematic outline of Acholi traditional ways of coping with psychosocial adversities, with a focus on concepts and healing ceremonies dealing with the consequences of traumatic stress. CHAPTER 12 presents case studies illustrating how the before-described concepts and rituals are implemented in contemporary Acholi society. In both ethnographic chapters, specific attention is paid to *kwero merok*, a cleansing ritual for returning warriors, as it shows interesting parrallels to Western trauma therapy.

PART FIVE interprets and discusses the ethnographic data from the perspective of Western clinical psychology, which has been defined in PART TWO and THREE. The comparison of local (Acholi) concepts and symptom descriptions with the PTSD concept reveal both substantial similarities and differences. With regard to cross-cultural diagnostics, the study concludes that although the concept of PTSD might be biased towards the experience of populations from Western industrialized countries, it is a good starting point for investigating posttraumatic stress reactions among the Acholi. Two points merit further investigation. (a) The high threshold on criterion (C) in the DSM-IV definition of PTSD might not match the culturally shaped patterns of posttraumatic stress reactions among the Acholi. (b) Considering local idioms of distress (especially dissociative immobilization reactions) when assessing (or screening for) posttraumatic reactions among the Acholi might ease detecting those who suffer from severe posttraumatic stress syndromes.

The analysis of descriptions of Acholi rituals provides evidence suggesting that exposure to past traumatic events and ritualized expressions of social support are central elements of the ritual *kwero merok*. Hints on the effectiveness of traditional rituals in our ethnography are evaluated. The study concludes that Acholi rituals have the potential to contribute to healing in a war-torn society, mainly by improving social cohesion and integration among communities. However, the existence of traditional ways of coping should not categorically preclude the application of so-called Western approaches to trauma therapy, particularly as traditional rituals are accepted by and accessible to only part of the Acholi population. The study closes with an outline on issues that should be considered when implementing ‘modern’ approaches to trauma therapy in low-income countries.

INTRODUCTION

The past century has seen a rise in the number of wars worldwide. In any year during the 1950s, the world stated an average of nine active wars. The number rose to 11 per year in the 1960s, to 14 in the 1970 and to 50 in the 1990s (Summerfield, 1998). At the same time, the character of wars has changed. Most of the wars are nowadays internal wars, in which the civil population has become the main target. Accordingly, the history of 'modern war' saw a steady rise in civilian casualties. In the First World War, only 5 percent of the victims were civilians. In the Second World War, the proportion of civilian victims had risen to 50 percent. By the end of the last century, the approximate share of civilian victims in wars was about 80 percent (Dubrow, Liwski, Palacios, & Gardinier, 1995). The deliberate targeting of civilians in most 'modern wars' entails widespread psychological traumatization among the general population (De Jong, Komproe, van Ommeren, El Masri, Araya, Khaled, et al, 2005). This is no different in the war-torn Acholi region of Northern Uganda (Annan & Blattman, 2006 b; Bayer, 2006; Pfeiffer, 2006), where the present study has been conducted.

Use of the PTSD concept in complex emergencies across cultures

In 1980, the diagnosis of posttraumatic stress disorder (PTSD) was introduced in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1980). The new diagnosis inspired much research, including studies on epidemiology and therapeutic approaches to disorders of traumatic stress. Within a few years, PTSD had become one of the most popular areas of inquiry, fascinating to clinicians, scientists, and mass media alike.

The attractiveness of the concept also swiftly led to the spread of its use in most parts of the world, namely in responses of humanitarian organizations to complex emergencies. While up to the mid-eighties the international community had responded to war, genocide and natural disasters mainly with relief programs providing food, shelter and physical health care for the affected populations, agencies now increasingly included 'trauma programs' as part of their emergency responses. The first peak of this development was reached in the mid-nineties, when almost simultaneous crises in former Yugoslavia and Rwanda prompted respective 'trauma' - interventions by various international organizations. Since then, however, the predominant use of Western psychological approaches in emergencies in Non-Western societies has been much criticized.

In an important analysis, Summerfield (1999; 1998; 1997; 2001) has pointed out that the impact of 'modern' war is broad and pervasive. It does not only 'traumatize' individuals, but also stresses the social fabric of communities. Most importantly, it targets and destroys ways of life, including crucial social, cultural and material resources that are essential for recovery. Summerfield (1999) has advocated that humanitarian efforts should therefore respond to these social complexities rather than narrowly focus on interventions suggested by a limited construct, such as PTSD.

Evidence from disaster research supports the relevance of Summerfield's arguments. Norris (2002) considers 'community functioning' a vital component in postdisaster dynamics and notes that in disaster research "community destruction explained significant variance in postdisaster psychological, physical, and social functioning" (Norris, 2002, p. 2). Similarly, Norris, Friedman & Watson (2002) highlight that social and material resources play an important role in protecting the mental health of

people in times of disaster. At the same time, these resources are often stressed or destroyed by calamities (Green, 1996).

Many practitioners and researchers concerned with interventions in complex emergencies consequently advocate the implementation of so-called 'psychosocial programs'[3] to support disaster-stricken communities in restoring the most basic material and social resources that are known to be crucial for recovery. Psychosocial programs typically apply community-wide intervention strategies that focus on strengthening protective factors and have a declared emphasis on sustainability through capacity building of local communities. Further priorities are on supporting the concerned population in reestablishing a sense of safety, normalcy, and control over the situation (Dubrow et al., 1995; Klingman, 2002). Psychosocial interventions typically promote community engagement and support communities in mobilizing internal resources to address their needs (Bala, 1996; Boothby, 1996; McCallin, 1998).

In many Non-Western countries, indigenous forms of healing may be vital resources within communities, which might play an important role in social and individual recovery processes after war. Honwana (1998; 2001), Green and Honwana (1999) and Efraime (1996) have described the benefits of traditional ritual in the aftermath of 15 years of war in Mozambique. Wessels and Monteiro (2000) and Honwana (1998b) highlighted the importance of traditions in healing the wounds of war in Angola. From a different perspective, but still relevant to the topic, Kirmayer, Simpson and Cargo (2003) have pointed out that a history of cultural oppression and marginalization might have contributed to the high levels of mental health problems found in Aboriginal communities of Canada today.

In a similar vein, Marsella and Christopher (2004) have argued that humanitarian aid should match the cultural context and cautioned that interventions from external agents do risk undermining existing local avenues of coping. They have underlined that disasters are cultural encounters of local people and external agents. The dynamics of such encounters have the potential to influence cultural developments, especially in situations of war and other calamities that persist over many years. In complex emergencies, international aid agencies with their expatriate 'experts' usually hold the

[3] Commendable overviews on concepts and guidelines on psychosocial programming are provided by Loughry and Ager (2001), Loughry and Eyber (2003) and the 'Psychosocial Working Group' (2003). In the Ugandan context, such psychosocial programs have been described (Williams, Aloyo & Annan, 2001), and respective guidelines have been developed (Uganda National Psychosocial Core Team, 2004).

power to define the problem and respective interventions, which bears the risk of marginalizing local priorities and knowledge (Summerfield, 1999). Marsella and Christopher (2004, p. 524) note:

> "The emergent disaster culture can become a resource of cultural preservation and support, or it can become a source of stress that undermines the very humanitarian efforts that are being exerted by service providers"

In the context of complex emergencies across cultures, the above arguments put the potential implementation of trauma-focused psychotherapeutic interventions, as suggested by the PTSD concept, into perspective. It is obvious that responses to war and disaster that solely focus on addressing individual traumatization would be far too narrow if conceptualized as a stand-alone intervention (Reichenberg & Friedman, 1995). There is widespread consensus that the *exclusive* reliance on a specific diagnostic concept in determining interventions would be inappropriate, as it might lead to analyses that miss out crucial dimensions of disasters.

However, some researchers and practitioners go further to reject the PTSD construct categorically, condemning it as harmful and cross-culturally invalid. Becker (1997) has argued that in order to grasp the meaning of traumatization, a proper understanding of the socio-political conditions under which it occurs is crucial. According to him, the PTSD concept has remained too vague in defining the traumatic event. He has claimed the diagnosis pathologizes victims of oppressive regimes and inadequately individualizes socio-political problems (Becker, 1997; Becker 2001). According to Bracken (1998), the PTSD concept is based on seventeenth century European philosophy of enlightenment, as well as on an egocentric notion of self and society. He therefore argues that the PTSD concept is not valid in collectivist societies. Bracken asserts that Western psychiatry is itself an ethnopsychiatry and points out that: "just because we can identify a particular symptom in different cultures does not indicate that it has the same meaning in these different cultures" (1998, p.41).

Despite such fundamental criticism, other researchers and practitioners concerned with psychosocial and mental health programs in complex emergencies still emphasize the potential benefits of the PTSD construct when applying it within a wider framework and at its proper place (see, for example, Kaz de Jong, 2001, on the 'use and abuse' of the PTSD concept).

Leaving the specific discussion on the use of the PTSD construct in complex emergencies, we now have a look at general literature on its use across cultures. In their landmark edition on *Ethnocultural Aspects of Posttraumatic Stress Disorder*, Marsella, Friedman, Gerrity & Scurfield (1996b) concluded the following:

> In our opinion, PTSD is a clinically meaningful diagnosis because of universals in human experience in response to trauma. Any individual who meets the diagnostic criteria is a person who has been unable to recover from the traumatic experience(s) to which s/he was exposed. Such continuous psychological involvement with the relentless recycling of traumatic material through reexperiencing, avoidant, numbing, and arousal symptoms is often a major source of subjective, interpersonal, social and functional distress. (p. 531)

Friedman and Marsella (1996) have argued that various PTSD symptoms are linked to universals in the human stress response and have noted that "no other psychiatric syndrome has been conceptualized in terms of classic learning theory as well as PTSD" (p. 17; see also Debiec & LeDoux, 2004). Stamm & Friedman (2000) have further highlighted that the ability to cope with danger and stressful events has been a crucial theme in evolution and symptoms of PTSD can be understood within this evolutionary frame. On the base of such considerations, it has been hypothesized that universal neurobiological processes strongly shape symptoms of reexperiencing and hyperarousal (Criteria B and D in the DSM-IV), while symptoms of avoidance and numbing (Criterion C in the DSM) are comparably more determined by cultural influences (Friedman & Marsella, 1996; Stamm & Friedman, 2000; Friedman & Jaranson, 1994). Widely acknowledged universals notwithstanding, Jenkins (1996) stressed the importance of local idioms of distress in human responses to traumatic experiences and criticized that reactions of immobilization (freezing) are not considered in the DSM-IV. In a review article on cultural diversity in the appraisal and expression of trauma, Stamm and Friedman (2000, p.70) summarize:

> The important question is not whether PTSD can be detected among trauma survivors from traditional ethnocultural backgrounds. Indeed, PTSD has been found among Southeast Asians, Latin Americans, Middle Easterners, American Indians, and other trauma survivors from non-Western cultures … Rather, the important question is whether PTSD or some other idiom of distress reflects the best conceptualization of the impact of traumatic stress on survivors from certain ethnocultural groups.

While recognizing the usefulness of the PTSD concept as such, Marsella, Friedman, Gerrity et al. (1996b) emphasize that symptoms must be understood in their proper ethnocultural context. At the same time, they question the frequent uncritical use of the

PTSD concept across cultures. Friedman & Marsella (1996) point out that by far most of the research validating the PTSD concept has been carried out in Western industrialized countries and criticize methodological weaknesses of research on PTSD among people from non-Western backgrounds.

Yet instead of abandoning the PTSD concept as a whole, they propose engaging in more cross-culturally sensitive research (Draguns, 1996; Marsella, Friedman, Gerrity & Scurfield, 1996b). Marsella, Friedman, Gerrity et al. (1996b) recommend the use of qualitative and ethnographic methods in studies of PTSD to account for indigenous perspectives and avoid ethnocentric bias. Draguns (1996) has proposed the study of indigenous healing practices, lamenting the dearth of information in this area of research. Most experts in cross-cultural psychology have stressed the value of ethnography in approaching cross-cultural aspects of mental disorders, including posttraumatic stress (Lopez & Guarnaccia 2000; Marsella, Friedman and Spain, 1996; Marsella, Friedman, Gerrity et al., 1996b). Such approaches are deemed more appropriate to detect and understand ethno-cultural variations in the etiology, expression, course and treatment of posttraumatic stress disorders than mainstream quantitative research.

Research questions

Taking up the arguments of the above-sketched discussion and review of literature, this study explores local descriptions and explanations of phenomena of traumatic stress, as well as respective ways of coping among an ethnic group of Northern Uganda (the Acholi). By applying ethnographic research methods, it shall give answers to the following research questions:

1 a) How have Acholi people traditionally understood phenomena of traumatic stress and their (psychological) consequences?

b) How have the Acholi people traditionally coped with the sequelae of traumatic stress?

The systematic outline of traditional concepts as well as rituals and healing procedures that relate to traumatic stress, are considered the empirical core of the here presented thesis.

In a second step, the ethnographic data will be explored from a Western clinical perspective by highlighting similarities as well as differences between the described 'traditional' Acholi and Western clinical approaches to healing. The central research questions guiding this comparative analysis can be summarized as follows:

2 a) How do 'traditional' Acholi concepts relate to the concept of PTSD? (Which similarities do exist? Which differences do exist?)

b) How do 'traditional' Acholi healing procedures relate to Western therapeutic procedures? (Which similarities do exist? Which differences do exist?)

The analyses shall, from the perspective of an ethnographic study, shed light on the following questions:

3) Does applying concepts and interventions that have mainly been developed in Western industrialized countries, such as PTSD and exposure therapy, likely make sense in the Acholi region?

4) If yes, what needs to be considered, when applying such concepts and procedures among the Acholi?

This research is meant to complement research that has used a quantitative approach to studying PTSD in Acholi (Bayer, 2006; Pfeiffer, 2006). At the same time, we describe a perspective on cross-cultural psychology of traumatic stress, which has so far rarely been explored, thus rendering a unique contribution to the international evidence on the cross-cultural applicability of PTSD. This is the first study giving a systematic outline and analysis of Acholi concepts and rituals of psychosocial relevance. The findings of this exploratory research might also provide the base for studies that are more focused on specific topics. The ethnographic descriptions should be of interst to international staff of aid agencies working in the Acholi region, regardless of whether they apply the PTSD concept and related interventions or not.

PART ONE: LOCAL BACKGROUND

Uganda, an East African country with a population of about 30 millions (World Bank, 2006), neighbors Kenya to the east, Rwanda to the south, Democratic Republic of Congo to the West, and Sudan to the North. The formation of the Ugandan state was not the result of a gradual process of national integration. Instead, its existence and borders were almost entirely determined by colonial powers by the end of the 19th and early in the 20th century (Leggett, 2006; Odhiambo, Ouso & Williams, 2003). Within one state, Uganda harbors numerous ethnic groups speaking more than 33 distinguishable languages (Nzita & Mbaga-Niwampa, 1997). The Acholi, an ethnic group of about one million people living in Northern Uganda, belong to the Luo, a subgroup of the Nilotic peoples (Finnström, 1999).

In average, Ugandan indicators of human development have considerably improved in the past decade. Between 1992 and 2005, the average life expectancy has risen from 42.6 to 49.7 years, and the adult literacy rate increased from 50.5 to 66.8 percent (United Nations Development Program, 1994; 2007). However, the war torn Acholi districts have not profited from the general improvement in living conditions reflected in these figures. On the contrary, mortality rates during 2004 had risen to 2.8 deaths/10.000 people per day, which well is beyond the benchmark of an 'emergency out of control' (Médecins Sans Frontières, 2004). Most health units and schools had closed down or been displaced due to military insecurity. Killings and abduction of people had become common in the countryside.

This thesis documents and analyzes 'Traditional ways of coping with traumatic stress in Acholiland'. CHAPTER 1 focuses on describing the psychosocial consequences of the Northern Ugandan War, including the widespread traumatization among the population. CHAPTER 2 delineates the general history and traditions of the Acholi people, which have shaped their ways of coping to a great extend. This outline should help the reader understand the general cultural background, in which the more specific 'traditional ways of coping with traumatic stress' (described in CHAPTERS 11 and 12) are embedded.

1 The Northern Ugandan War

During the 20 years of war, the conflict in Northern Uganda has become a most painful illustration of ‘modern warfare’. It almost perfectly matches the following description of ‘modern wars’ by Bracken and Petty (1998, p 3):

> In these conflicts civilians are no longer ‘incidental’ casualties, but the direct target of violence. Mass terror becomes a deliberate strategy. Destruction of schools, houses, religious buildings, fields and crops as well as torture, rape and internment become commonplace. Modern warfare is concerned not only to destroy life, but also ways of life. It targets social and cultural institutions and deliberately aims to undermine the means whereby people endure and recover from the suffering of war.

This chapter describes the psychosocial impact of the war on the general population and the widespread psychological traumatization in the area. We will close the chapter by describing a project that attempts fostering recovery from the devastating psychosocial effects of the Northern Ugandan war. However, before we come to this, we give a brief outline on the history of the conflict. Detailed descriptions of the history and impact of the war are provided by Behrend (1999), Finnström (2003) and Dolan (2005).

1.1 Brief outline on the history of the conflict

The war began in 1986, when troops of the new National Resistance Movement (NRM) government under Yoweri Museveni moved north following their capture of Kampala and overthrow of the previous regime. Soldiers of the previous government, many of them of the Acholi ethnic group, had fled north to their home areas after the fall of Kampala. Most discarded their weapons, and tried to merge into the population at large. Some, however, regrouped to fight against the new government. In the course of a few months to years, various rebel groups rose and gave up their struggle. Then Joseph Kony, whose military force later came to be known as the ‘Lord’s resistance arme’ (LRA), appeared on the scene.

In the first years of his fight against the government, Kony had received at least moderate if not significant support from the Acholi population, though it had been less than the popular support rendered to former rebel forces. This changed dramatically during the conflict. The more the population stayed behind the expectations of the LRA in moral and practical support to the movement, the more the guerrilla army turned to violence against the populace for which it claimed to be fighting. And, the more relentless the terror from the side of the LRA, the more the popular support dwindled. Thus, the Lord's Resistance Army more and more alienated itself from the population. It turned to abductions of young people and even children as a means of refilling their ranks and spreading terror among the population.

The army of the Ugandan government, on the other side, seemed unable or unwilling to protect the population from the increasing LRA terror (Civil Society Organization for Peace in Northern Uganda, 2004). Seemingly in response to LRA attacks, it added pressure on the local population. This was done by applying brutal 'counter-insurgency' measures, which included detaining and torturing of innocent civilians, as well as massive displacement of the population into Internally Displaced People's Camps (IDP camps). Thus, the civil population was caught between the enemy lines, taken hostage, abused and manipulated by both sides.

1.2 The impact of war on the population

The conditions of displacement and the pervasive impact of this war on Acholi society and culture cannot be summarized in a few pages. Chris Dolan (2005) has challenged the generally accepted description of the situation as primarily a war between the LRA and the Ugandan government. Instead, he argues, the situation is more adequately described as mass torture, which he terms "Social Torture". The UN Under-Secretary-General for Humanitarian Affairs, Jan Egeland, had previously termed the situation in the war torn districts of Northern Uganda as "one of the world's worst humanitarian crisis" that had nevertheless received little international attention (UN-OCHA Integrated Regional Information Networks, 2003).

The war has had the most disastrous impact in the three Acholi districts of Gulu, Kitgum, and Pader. There, by 2005, more than 90% of the population had been driven from their homes into internally displaced people (IDP) camps. The conditions in these cramped and

insecure camps were dominated by destitute poverty. People living there were cut off from their fields and dependent on insufficient supplies by the World Food Program. Those who ventured out to dig their ancestral land risked being killed by the LRA or by government soldiers. Apart from hunger and malnutrition, the severe shortage of clean water and adequate sanitation facilities in IDP camps caused severe health problems. The crude mortality rate rose beyond the benchmark of an 'emergency out of control'[4] (Médecins Sans Frontières, 2004).

The features of camp life most obvious to the eyes of a visitor were the densely packed huts and the crushing material poverty. Yet, the psychosocial consequences of camp life might have been even more severe and far-reaching. Dependence on external aid was humiliating for many, and the resulting idleness had a wide range of destructive and debilitating effects on the entire population. Feelings of uselessness due to the inability to provide for their families led many men to abuse alcohol. Such conditions presented a fertile breeding ground for domestic violence and other conflicts within families (Harlacher & Okot, 2005). Furthermore, destitute poverty and alcoholism promoted delinquency and violence within the larger community. The general cultural decay also disrupted the supportive system of the extended families and clans. While neighbors in traditional rural settings had typically supported each other, indifference and mistrust prevailed in the camps. In addition, the possibilities for carrying out cultural activities were extremely limited in the camp setting. This severely limited the passing on of cultural knowledge from the older to the younger generation (Baines, 2005). The war thus did not only impose extreme stressors on the entire population, but also harshly hampered traditional ways of coping with it.

Moreover, the supposedly temporary IDP camps that had at times been named "protected villages" by the Ugandan Government, proved to be neither temporary nor protected. Many had to live under the appalling conditions of such camps for more than a decade (Acholi Religious Leaders Peace Initiative & Justice and Peace Comission, 2001). They were subjected to murder, mutilation, rape, looting, the mass burning of houses, and mass abductions by the LRA, and further predations by government soldiers and common criminals (Civil Society Organization for Peace in Northern Uganda; 2004), with almost no effective security provided by the government until 2005.

[4] In 2004, Médecins Sans Frontières reported a crude mortality rate (CMR) of 2.8 deaths/10.000 people per day, noting that according to internationally agreed benchmarks, a rate of more than 2 per 10.000 a day is classified as an 'emergency out of control'.

1.3 Widespread psychological traumatization

To provide a sense on the scope of traumatic experiences the general population was exposed to, we now summarize the results of some survey studies carried out in the affected area. Pham et al. (2005) has reported exposure to traumatic events in the general population in camps of several northern districts affected by the war. In a random sample drawn in Gulu district, 47% had witnessed a family member being killed, 39% had seen a friend or neighbor killed and 48% had been forced to carry loads for the LRA (Pham et al, 2005). Annan and Blattman (2006 b) report similar results: Among a sub-sample of people who had never been abducted, 41% had witnessed killings and 33% had seen a battle or attack. Thirty percent of the people interviewed had a parent who had died a violent dead and 28% had witnessed the setting of houses on fire with people inside them.

The people most severely affected by the Northern Ugandan war were those who had been abducted by the LRA. Recent estimates suggest that 66.000 youth between the age of 13 and 30 have been abducted (Annan & Blattman, 2006 a). Their experiences are often especially horrific (Human Rights Watch, 1997; Amnesty International, 1997; Dolan, 2005). They regularly had to carry heavy loads and walk long distances with inadequate food, water, or footwear. They were routinely beaten, and forced to beat or even kill fellow abductees. They were also forced to attack their own community and sometimes even to kill their own relatives and family members. Abducted girls were forced into sexual slavery as commanders' "wives," and were otherwise subjected to rape, unwanted pregnancies, and the risk of sexually transmitted diseases.

A brutal system of severe punishments for disobedience as well as rewards for carrying out the orders of commanders most likely had a brainwashing effect on the young people. They often internalized the attitudes of their torturers over time and become "willing" actors and perpetrators of atrocities. For physical and psychological survival, most abductees likely had no other choice but to become part of the terror system, at least for a certain time and to a certain extent.

Existent quantitative studies on abducted children and youth also report extremely high exposure to violence for abductees. Annan and Blattman (2006 b) have found striking exposure in a sample of male formerly abducted youth in a population based survey. According to their data, 91% of the abductees had witnessed beatings or torture of other people, 63% had received severe beatings themselves, 78% witnessed at least one

killing, 20% were forced to kill a civilian and 8% were forced to kill a family member or friend. Derluyn et al. (2004) reported that 77% of their sample of former abductees saw somebody being killed, while 39% were themselves forced to kill another person. 64% of the respondents were forced into military training and consequently had to fight in combat. Among abductees who had been taken to Sudan, 27% drank their own urine for the sake of survival. Among the abducted girls, 35% were forced into sexual slavery (given to commanders as 'wives') and 18% gave birth to one or more children in captivity. Pfeiffer (2006) and Bayer (2006) report similarly shocking results.

While some of the abductees managed to escape during the first days after abduction or were released by the LRA, others stayed with the rebels over many years. When they arrived at "Reception Centers" after having escaped, been captured by government forces, or released by the LRA, they were often weak or even malnourished. They also suffered from numerous physical injuries such as sore feet or bullet wounds, and were frequently haunted by nightmares. Many other escapees returned to their communities without passing through a Reception Center. In either case, return to the community after months or years of captivity was hard-hitting. In addition to the physical and psychological distress the returnees suffered from, they were perceived by parts of the community to be the ones who had committed atrocities against their own people. Many believed they were haunted by *cen*, the vengeful spirits of those they had killed. Such vengeful spirits were in turn feared by the community (Finnström, 2003), thus adding another stressor to both the returnee and receiving community.

To support communities and returnees in coping with the extreme stressful situation, Caritas Gulu Archdiocese established a Psychosocial Support Program (PSSP). The research to the present thesis was carried out within the structures and with substantial support of the Psychosocial Support Program of Caritas Gulu, while the author of this thesis has worked as a consultuant to the program. Thus, the Program forms an important part of the background to the study, and will be described below.

1.4 Attempts to foster healing: The Psychosocial Support Program of Gulu Archdiocese

The Psychosocial Support Program (PSSP) of Caritas Gulu Archdiocese was initiated in 1999. The PSSP aims at strengthening community resilience and promoting the reintegration of formerly abducted people by extending 'psychosocial support' to war affected communities and individuals.

In July 2002, the PSSP started running a Reception and Rehabilitation Center for formerly abducted people in Pajule, Pader District. Many of the people abducted by the LRA escaped with severe health problems. Therefore, providing basic medical care was of prominent importance. Further, clean drinking water, regular meals and proper shelter had to be organized. The 'psychosocial' ingredients of the program in the Reception Center included education (for example on the amnesty law, hygiene, HIV), basic 'counseling' and physical exercises. Psychotherapy directly addressing the traumatic experiences and their effects were far beyond the capacity of the Pajule Reception Centre. Instead, the concept had to be solution-oriented, by attending to immediate and most pressing needs (Harlacher & Aloyo, 2004). During the clients' stay in the reception center, social workers, in cooperation with branch offices and community resource persons, had to trace the whereabouts of the family as swiftly as possible. This was an enormous challenge in times of military insecurity. After a few weeks or months in the center, returnees could usually be reunited with their parents (if these were still alive) or with other relatives.

Nevertheless, the 'rehabilitation' of returnees was not completed with the act of reunification. On the contrary, the most difficult part of their rehabilitation was then still ahead (Aloyo, 2001). Most of them had to return into the harsh and hostile environment of IDP camps, which offered almost no opportunities, but continued exposure to existential insecurity and deprivation (Women's Commission for Refugee Women and Children, 2001).

The research on traditional ways of coping was set up with the intention to explore cultural resources within the local communities, which could be mobilized and supported to foster reintegration and healing of a war-torn society. While the results of this study will be outlined in CHAPTERS 11 and 12, we summarize the history and general traditions of the Acholi, as described in the existing literature, in the following CHAPTER.

2 History and General Traditions of the Acholi[5]

Histories and traditions are always a matter of reconstructing the past through its traces left in the present. Thus, neither history nor traditions can ever be fully comprehensive or accurate in the sense of reflecting the past as it "really" was, leaving room for different perspectives and interpretations. This chapter focuses on the Acholi past, but with the major aim of facilitating an understanding of cultural elements that are relevant today, especially with respect to the topic of "traditional ways of coping and healing" that is the primary focus of this work.

The chapter is divided into four major sections. The first delineates the development of an Acholi identity; the next three in turn provide brief discussions of socio-political organization, patterns of daily life and cosmology. Each section begins with a description of pre-colonial developments and the "traditional" social order and than provides a summary of pertinent changes during and after colonial rule. We have used the past tense in our discussion for the sake of consistency, although many of the structures and practices persist (even if altered over time) and remain relevant to this day.

[5] Sections 1 to 4 of this Chapter have already been published in Harlacher, Okot, Aloyo, Balthazard and Atkinson (2006, pp. 15-52). They have been only slightly edited for the purpose of this thesis. The edits were on introductions to sections, as well as on references to chapters, bibliography, transcripts and annexes.

2.1 Acholi Identity from an Historical Perspective

2.1.1 The pre-colonial era

The history of the "Acholi" people can be traced over several hundred years, mainly on the basis of oral traditions and historical linguistic research (Atkinson, 1999). Although many parts of the Acholi past remain murky or simply unknown, it is certainly not the history of a people – or an area – that developed in seclusion. Acholi history is instead a history of numerous groups who migrated, interacted, and mixed with others, exchanging and assimilating parts of each other's culture and language in the process. It is also part of a broader historical narrative of the origins and spread of Luo-speaking peoples, which emphasizes long-distance migrations and epic splits leading to the founding of Luo-speaking groups that are today called "Acholi," "Alur," "Jopadhola" and the Kenya "Luo". Through a common connection to or descent from the legendary kingdom of Bunyoro-Kitara, links can be established to many other peoples of Uganda as well, including the Banyoro, Batoro and Banyankole people (Odhiambo *et al*., 2003).

Actually, the available historical evidence strongly indicates that less than two hundred years ago, "the Acholi" were neither known nor recognized by name as one distinct people or group. However, by the end of the 18th century, there were people living in the area of Central Northern Uganda who spoke a similar Luo language and had developed a common socio-political order that distinguished them from other people living around them. And these features had begun to define the people who would eventually be called "Acholi" (Atkinson, 1999).

2.1.1.1 Migration

In the grand narrative of Luo migrations, the origins of the Acholi are typically located along the banks of the river Nile in what is now Southern Sudanese territory. There, early Luo speakers were likely to have been pastoralists and fishermen. About A.D. 1200-1300, some of these early Luo seem to have started migrating southwards towards present-day Uganda (Odhiambo *et al.*, 2003).

Sometime around 1500, an important group among these migrants moved south across the Nile. When they arrived in the new land, they found a mysterious ruling group called

"Bacwezi" who had established a far-flung kingdom among the Bantu-speaking people there, called "Bunyoro-Kitara." After having stayed at the margin of the kingdom for some time, part of the incoming Luo group took over power from the Bacwezi and started the famous "Babito" dynasty of the Bunyoro-Kitara kingdom.[6] Other Luo-speaking groups remained in the northernmost part of the kingdom, organizing themselves as chiefdoms under the suzerainty of the Babito kings.

During this same period, across the Nile to the north, the area now called Acholiland was populated by people who were organized in lineages or clans of agnatic kin without the overlay of chieftainship (the term "clans" will be used throughout this study as it is the English term for these groups typically used in Acholi today). They were speaking languages quite different from Luo.[7]

By the beginning of the 19th century, however, people in this area were predominantly speaking a Luo language (Acholi) and were organized in chiefdoms. And according to a thorough analysis of available evidence, this dramatic change took place primarily through peaceful, not violent, means. Drawing from Atkinson (1999), the following section summarizes how these important changes likely transpired.

2.1.1.2 The introduction of chiefdoms in Central Northern Uganda

During the late 17th and early 18th centuries, many Luo-speaking groups living in or just to the north of the kingdom of "Bunyoro-Kitara" moved into the area of Central Northern Uganda.

As they had already adapted – and skillfully adjusted – to ideas of royalty, most of these groups were headed by a chief (*rwot*; plural, *rwodi*) who claimed *royal descent* and possessed royal regalia, most importantly royal drums.

Oral traditions of many Acholi chiefdoms claim that when these new groups with their chiefs and royal drums appeared, the local people encountered were extremely impressed and therefore swiftly agreed to become subjects. Historically, however, the process was almost certainly more complex and many factors likely played a significant role in the integration of clans into chiefdoms. While it is possible, even likely, that the claim of royal

[6] The way this take-over in power took place is not clear, but the available evidence suggests that it was likely through peaceful means.

[7] The languages spoken were mainly Central Sudanic and Eastern Nilotic languages, while Luo is considered a Western Nilotic language (Atkinson, 1999)

descent accompanied by royal regalia would have made a strong impression on local peoples without chiefs, the system of tribute must have been at least equally important. As groups claiming chiefly status moved into new territory, their subjects continued to be able to hunt. And according to the system of tribute, the chief was given a part of each animal killed. It is likely that this availability of meat at the chief's disposal was one factor that allowed him to show a level of "generosity" towards the local population that demonstrated he was a leader of quite different qualities than existing clan leaders – that he was indeed "royal" and endowed with special powers. Furthermore, the chiefs with their royal lineages must have applied other suitable strategies and good negotiation skills in order to integrate "commoner" clans (*lubong*). The outcome of such negotiations can be deduced from the setup of the later chiefdoms.

After having accepted the chief as ruler, the "commoner" clans continued to be in charge of their own affairs. Most importantly, they continued with their clan-based forms of production (agriculture, cattle keeping and hunting), and their particular clan-based religious beliefs and practices were respected. Clan heads, along with clan elders, continued to lead their clans and settle internal disputes.

In addition, heads of incorporated clans were given important roles in the chiefdom. They became senior councilors of the chief and spokesmen representing the interests of their clan within the chiefdom as a whole. They also played major roles in chiefdom-wide rituals. In all these ways they were allowed to participate actively and have major voices in the chiefly order. The new chiefdom-related functions of these clan heads were often accompanied by material benefits.

However, the clan heads and elders agreed that their agnates would pay regular tribute to the chief. The tribute was paid in both kind and service. Mainly, subjects had to give a defined part of any large animal killed in the hunt and also provided tribute service, most importantly joining hands to work in the fields of the chief's wives. This system of tribute, together with the ideas of "royalty", played important roles in stabilizing the newly established associations.

After several clans had joined a chiefdom, the new entity had surely acquired major advantages in comparison to those still organized in single clans. The larger political unit provided more powerful military assistance and protection in times of clashes with neighboring groups. They also gave a higher level of food security when drought and famine struck, which always lurked as a dreaded possibility.

The establishing of a new chiefly order in Central Northern Uganda did not happen quickly. It was a process that stretched over more than a century, with hesitant beginnings and then a marked acceleration over the last three quarters of the 18th century. By 1800 almost 70 chiefdoms had been established, comprised of more than 300 and perhaps 350 or more clans (Atkinson, 1999, p. 261). The process had been hastened by two major 18th century droughts, which increased both physical and food insecurity. Over time, and especially during times of particular stress such as drought, clans living on their own must have felt too vulnerable and exposed to potential attacks by neighbors who were militarily more powerful, driving them to join bigger political units.

Over the same period, the majority of the people living in this area came to speak the more prestigious Luo language, the language that was linked to the new socio-political "royal" order.

2.1.1.3 Naming of the group as a result of interaction with outsiders

Even though by 1800 A.D., people were speaking the same or at least a similar Luo language and had developed similar customs and socio-political organization, they were not yet recognized as one distinct people. Although a number of different versions exist to explain how the name "Acholi" came about, it seems most likely that Arabic-speaking slave and ivory traders in the 19th century played a major role in this process. According to Crazzolara (1938) these traders had had previous contact with the Collo (Shilluk) in what is now Southern Sudan and started calling the people they met in Central Northern Uganda Shuuli, as they heard them speaking a similar Luo language. With time, this label was molded into Acholi. Whatever process actually led to the naming, it seems to be clear that the concept took some time in being generally recognized. According to Atkinson (1999), the entrenchment of the term can be analyzed in the writings of European travelers such as J. H. Speke and Samuel Baker. While Baker in the 1860s still used the term "Madi"[8] to refer to the people of Central Northern Uganda, he started widely using the term "Shooli" and "Shooli country" in the 1870s (Atkinson, 1999, pp. 270-72). "Shooli" eventually became "Acholi." But the introduction and general use of a label by outsiders was only one more in a long series of developments leading to an ever evolving

[8] He even used the term "Madi language" to refer to a Luo word list, which he had compiled in Acholi. (Atkinson, 1999).

Acholi identity. Historical events during the colonial and post-colonial eras have continued to shape and re-shape that identity in fundamental ways.

2.1.2 The colonial and post-colonial eras

2.1.2.1 Entrenchment of an "Acholi" identity

In the early years of the 20th century, when the Acholi area became one of the three districts in the Nile Province of the Uganda protectorate, British administrators decided to set up a council of chiefs with a "paramount" chief at the top. Such a council and the office of a paramount chief had not existed in the area before, and the institution was clearly intended to promote the administrative interests of the colonial rulers. Yet with time, such structures also fostered the further development of a collective identity among the people who were by now called "Acholi," including the sense of a more clearly marked distinctness with respect to other "tribes."

Apart from devising administrative structures that created or reinforced distinctions and divisions between what were considered discrete "tribes," colonial rule also produced, or at least deepened, another important cleavage among Ugandan people: the north-south divide. When the British came to Uganda, they saw Buganda as a well-organized monarchy, with political structures that they could recognize as similar to what they knew from home. The north, in contrast, was seen not only as geographically remote, but also less promising in terms of profits. This perception led to major investments being concentrated in the Buganda region while the North was mainly seen as a reservoir of cheap labor.

For the Acholi, the implications of this divide were even more specific. In the colonial economy, they were not only assigned two roles common to the North: to produce cotton as a cash crop and to provide cheap migrant labor to the more "developed" south. In addition, colonial stereotypes identified the Acholi as an especially martial people, and Acholi young men were disproportionably recruited into the colonial army and police forces.

By the outbreak of the Second World War, more Acholi men were serving in the army than any other ethnic group in Uganda. As migrant labor and cotton production were not very

profitable, even more tried to join the Kings African Rifles, many of them successfully. In 1945, by the end of World War II, 5600 Acholi were serving in the army. This represented twenty percent of their poll-tax paying population (Girling, 1960, p.179).

Atkinson summarizes the effects of the colonial intervention on "tribal" identity at this time:

> Meanwhile, the line drawn on colonial maps and images in people's heads demarcating Acholi from neighboring tribes were increasingly operationalized, reinforced, and reified, in a pattern common to much of colonial Africa …. Politics was to be strictly limited and exclusively tribal. Individuals and social and political groups among the Acholi competed for power and influence within the context of their tribe, and the Acholi as a collective entity competed with other tribes for scarce social and economic investments and opportunities. All of this served the interests of those in power …. In this context, the Acholi and their neighbors increasingly saw themselves as different and distinct from each other, and acted as if this were so (1999, p. 7).

The preference of the colonial power for recruiting soldiers from Acholi and the other colonial dynamics that heightened and politicized ethnicity not only created and reinforced tribal stereotypes during the colonial era, but also left an extremely difficult heritage in post-colonial times.

At the end of the colonial rule, the Acholi were the most strongly represented ethnic group in the Ugandan national army, and their prominence grew during the first administration of Milton Obote. The high number of Acholi soldiers in Obote's army proved to be a deadly legacy when in 1971 his regime was ousted by Idi Amin in a military coup. While Amin is well known for having terrorized and killed thousands of Ugandans over the 1970s, the Acholi as an ethnic group surely bore more of the burden than most. This pattern would be repeated, in an even more extreme way, from 1986 to the present, as a vicious war has ravaged Acholi in myriad ways, including an unprecedented exposure to violence meted out by government and rebel combatants alike. At the same time, Acholi fighters—in various government and rebel forces, and some only children—have also wreaked violence, both in Acholi and elsewhere. Atkinson has expressed the effects of such cycles of violence on the development of an "Acholi" identity very clearly:

> "Especially since 1971, then, little has mattered more to Acholi, individually and collectively, than ethnic identity. For many thousands of men, women and children, being identified as Acholi has literally meant, depending on chronology and circumstance, life or death (1999, p. 11)."

Ethnic identity and the north-south divide have clear bearings on the still-ongoing war in northern Uganda and the reconciliation processes that will surely someday follow. It remains to be seen how the Acholi and the Ugandan people as a whole will be able to transform the heavy legacy just outlined into a positive national identity, accommodating many peoples with rich cultures but also troublesome histories.

2.2 Socio-political Organization

2.2.1 The pre-colonial era

As noted above, by about 1800, the people of Central Northern Uganda were organized in chiefdoms. During colonial rule, these chiefdoms lost most of their formal socio-political functions, but remained important culturally. Most Acholi today continue to self-identify as members of precolonial chiefdoms.

Each of the numerous chiefdoms that made up pre-colonial Acholiland consisted of several clans. Each such clan made up the core of a separate village. The clan members living in each village lived together in smaller groups, forming distinct hamlets. Every hamlet was in turn comprised of several households. Following the lead of F.K. Girling, the anthropologist who first provided a systematic description of Acholi socio-political organization, this section will first discuss the smallest social units, households and hamlets, before proceeding to larger entities of clans and chiefdoms (Girling, 1960; Okumu, 2005).

2.2.1.1 Households and hamlets

A household was regarded as the smallest social unit, typically a husband, wife (or wives), and children. As soon as the children grew up and were properly married, they set up a new household. While a man normally settled in the hamlet of his family of origin, a woman most often left her family and settled with her husband's clan.

A hamlet consisted of a few households typically grouped together in a circle around a common compound (*dye-kal*). The people living in a hamlet shared the same fire place

(*wang oo*) and cooperated closely in all aspects of daily life. Most or sometimes all of the male members of a hamlet were very closely related kin.

2.2.1.2 Clans

Hamlets were part of a larger entity – a village – made up primarily of agnates and their wives. From the point of view of kinship, a village corresponded to the notion of a "clan settlement" and was in the olden days fenced by brushwood or euphorbia for protection against enemies (Girling, 1960, p. 8). As with a hamlet, a clan ("*kaka")* or village ("*gang")* was characterized by a high level of social cohesion and socio-economic cooperation. Many hunts and agricultural activities were organized at the clan or village level. When cultivating the village fields, the members of a hamlet typically formed one work party (*"awak"*) combining forces with others of the clan or village.

Each village was under the authority of a clan head (*"ladit kaka"*) who was regarded as the living representative of the ancestors of that clan. A village or clan could, for example, be called "Pa-Amot" ("of Amot") or "Jo-Pamot" ("the people of Amot"), after the name of the remembered ancestor or progenitor from whom the clan traced its descent. Typically, clan identification was appended to the name of the chiefdom of which the clan was a member. To continue with this example, The Pamot (or Jo-Pamot) was part of the Padibe ("Pa-Adibe" or "Jo-Padibe") chiefdom, so Pamot clan members would usually identify themselves as "Padibe Pamot," at least to those outside Padibe. People were proud of their ancestors and were typically able to rehearse the names of their clan heads many generations back. Clan heads, and elders more generally, were highly respected and had important functions in resolving conflicts.

Clans were never static entities. They had a natural (but not inevitable) tendency to grow. After reaching a size considered large enough to sustain itself on its own, hamlets sometimes moved and settled as a separate village, typically in a different chiefdom. In such instances, they became an increasingly distinct sub-unit of the parent clan. But they still knew they were related and maintained special relationships, even over distances. In addition, most villages contained people who were not members of the village's core clan (or were not married into it), but were outsiders of various categories - close friends, male kinsmen of women married into the clan, refugees, war captives, and others. Over time, some of these outsiders - or their descendants - were incorporated into the core clan.

2.2.1.3 Chiefdoms

A chiefdom was comprised of several "clans" or villages under the rule of one chief (*"rwot";* plural, *rwodi*). Mostly, chiefdoms were made up of at least one royal or aristocratic village and several commoner villages.

A chief governed through a council of elders (*"ludito kaka"*; in their function as councilors also sometimes called *"lukwena"*), who were the representatives of the different villages or clans. The primacy and power of the chief was limited, as he had no standing army to enforce his decisions. Each village of the chiefdom continued to enjoy a high level of autonomy and the role of the chief was essentially to rule by consent rather than by domination and coercive power.

Taking these circumstances into consideration, it was crucial for a chiefdom to have a ruler with distinct abilities. Chieftainship was hereditary, with the culturally preferred successor being the previous chief's youngest son born to his "chiefly wife" (*"dak ker"*). But this succession pattern was only a preference, and another son could easily be chosen if he was perceived as having better leadership qualities. Such qualities included generosity, intelligence, good listening skills, the ability to speak persuasively and, perhaps most importantly, an excellent sense of judgment and the ability to mediate and arbitrate inter-clan conflicts within the chiefdom.

Apart from depending on the leadership qualities of the ruler, the cohesion of the chiefdom was fostered through other means and mechanisms as well. Chiefdom-wide rituals were performed regularly, with all the clans participating. For example, a sowing ceremony involving all the chiefdom's clans was carried out before sowing the fields, usually accompanied by ritual procedures to encourage rain (chiefs were believed to have special powers as "rainmakers"). Other ceremonies and rituals were carried out for harvesting. Most often, the clan longest settled in an area where a chiefdom was established was responsible for rituals concerning the spirit (*jok*) of that area. This spirit then typically became the *jok* of the chiefdom. Other clans were given responsibility for the ancestral shrine (*abila*) of the chief. The various clans of the chiefdom also played specific, important roles in the installation ceremonies of a new chief (Girling, 1960; Atkinson, 1999). Certain productive activities were also organized chiefdom-wide, most importantly, big dry-season hunts. Furthermore, the chief usually deepened ties with clans in his chiefdom by marrying women from these clans. All of this – together with the system of tribute - promoted social cohesion and collective identity within a chiefdom.

2.2.1.4 "Acholiland"

Towards the end of the 19th century, the area today called "Acholiland" was the home of around 70 independent chiefdoms. Relationships between these chiefdoms ranged from friendly to hostile, and alliances for defense or attack changed over time. According to Atkinson (1999), the chiefdoms of Acholiland can be clustered into eight zones (see ANNEX 2), based on the frequency and quality of relationships between them. Chiefdoms within a zone had far more regular and (mostly) friendly interactions. Contacts between chiefdoms from different zones were less frequent and more likely to be hostile. Prior to the 19th century, and especially before the intrusion of outside ivory and slave traders and the introduction of firearms beginning in the 1850s, large-scale warfare in Acholi seems to have been rare. When such conflict did occur, it typically took the form of several chiefdoms – usually from within the same cluster or zone – uniting against a common enemy, either within Acholiland or outside. The most common causes for hostilities in the area were clashes surrounding the rights to hunting and grazing grounds, or raids on cattle (Girling, 1960).

2.2.2 The colonial and post-colonial eras

The following paragraphs focus on changes to (or the creation of) "traditional" offices that are currently most relevant, particularly the offices of the "chief of the hoe" (*rwot kweri*), the "*atekere*," and the "chief" (*rwot*).

2.2.2.1 The de facto abolition of traditional leadership by the colonial government

The relatively decentralized socio-political order that characterized precolonial Acholi was not convenient for the colonial authorities. For administrative purposes, they much preferred a more hierarchical and neatly structured system. Therefore, even if the general strategy of the British was to administer their African colonies through a policy called "Indirect Rule," which supposedly relied on "traditional" African authorities, the pre-existing political organization in Acholi was completely undermined and changed. The magnitude of these changes, however, was deceptively masked by maintaining the titles of precolonial authority figures for newly created – or fundamentally changed – offices.

Girling, who did his research in the 1950s, explains:

> It should be noted that these groupings [of clans and chiefdoms] although still known to the people, are not accorded official recognition by the [colonial] administration. A hierarchy of chiefs has been established, the area has been divided up into Counties, and the County Chief is known officially as a *Rwot*. But although the title is the same, this has nothing to do with the original indigenous organization [of clans into chiefdoms] (1960, p. 9).

Instead of using the demarcations of clans and chiefdoms as administrative units, the colonial administration divided Acholi District into six "counties," each headed by a county chief or *rwot*, as they were called. The counties in turn were divided into "divisions" (corresponding to what are nowadays called sub-counties), each headed by a *jago.* Again a traditional term was used as a title for an administrator appointed by the colonial government[9]. Further, the divisions were divided into parishes and the parishes into villages. While the boundaries of these colonial governmental units were drawn with administrative purposes uppermost in mind, in a number of instances they did reflect (at least to some degree) pre-colonial chiefdoms in some instances and clans in others.

To improve "administrative efficiency," most traditional rulers who were initially appointed as colonial chiefs were replaced over time by non-hereditary chiefs selected by the colonial administration. The new "chiefs" were chosen on political and educational criteria, to suite the requirements of the new administrative tasks. These were mainly collecting hut tax and inducing people to work on roads and rest camps, as well as to grow cotton.

To distinguish between the new and the traditional chiefs, local people referred to the modern county chiefs as *"rwodi kalam"* ("pen-chiefs") while the "traditional chiefs" were called "*rwodi macon*" ("the "old chiefs") or "*rwodi me Acholi"* ("chiefs according to Acholi customs"). Thus the heirs of precolonial chiefs were still informally recognized and continued to carry out some of their cultural and social functions, especially in the area of conflict resolution. Yet, as to be expected, with time the old system became increasingly more eroded and marginalized.

[9] The term *jago* was used in some areas of precolonial Acholi to denote the role of certain clan leaders in a chiefdom as senior councilors to the chief.

While the patterns of settlement according to clans and chiefdoms in some areas had already been disrupted by the influence of slave and ivory traders *(muni kutoria* and *muni jadiya*) in late pre-colonial times, more displacement and resettlement ensued during the colonial area. Aside from the fact that the opportunities created by external influences triggered much voluntary movement, people were also forced to move closer to the roads that had been built throughout the district (Atkinson, 1999). Girling comments on this topic:

> Today, in many areas the traditional kin groups have scattered over a wide area, and strangers (i.e. non-kin) are often the closest neighbors. Typical of these areas are the people living round the townships of Gulu and Kitgum, those living in Anaka, which was resettled in 1936 (1960, p. 193).

The heightened mobility and intermixing of people – in addition to weakening customary Acholi offices – must be considered a major driving factor for the emergence of "new traditional" offices.

2.2.2.2 The emergence of the Rwodi Kweri and the Atekere

The wide-scale resettlement and increased mobility of people in colonial Acholi triggered the formation of new productive groups. These groups were based on neighborhoods, rather than on both neighborhood and kinship ties as had been the case in former times. Again Girling describes this, from the perspective of the 1950s:

> [These groups] were organized spontaneously and without either the knowledge of the British Administrative Officers or the encouragement of the local Chiefs .... In each of these areas the local people have appointed what are known as *Rwodi* and *Jagi Kweri*, Chiefs of the hoe .... It is their duty to organize the rotation of the *Awak* on the fields of the local group. Those who fail to obey the orders of the *Rwot* and his officials are fined a chicken, or those who persistently neglect to take part in the work parties on the fields of others are omitted from the benefits of the group … (Girling, 1960, p. 193).

The "traditional office" of the *rwot kweri* (chief of the hoe), though created during the colonial era, continues to be relevant today and functions in roughly the same way. As in the past, *rwodi kweri* are usually charged with the responsibility of organizing communal digging and resolving conflicts that arise in this context. Additionally, they are often called upon to settle land disputes.

However, cases that require traditional rituals to be carried out are usually referred to the *atekere*, another office created during the colonial era. Apart from presiding over sacrificial ceremonies, the *atekere* is often asked to settle disputes within the community, especially if they have ritual implications.

Both *rwodi kweri* and *atekere* still render important services to the community, especially in terms of conflict prevention and resolution. Still, it is important to note that over the last twenty years their role has been substantially marginalized in most parts of Acholi, while the current, post-1986 Local Council (LC) system, the police and the courts have become more important.

Yet it is still striking that the offices of *rwodi kweri* and *atekere* have retained what influence and importance that they have, while nearly all the other "new traditional" offices introduced by the colonial administration have more or less vanished from the scene. This is most likely related to the fact that neither *rwodi kweri* nor *atekere* have ever been on the payroll of either the colonial or post-colonial governments and have thus been seen as being closer to the people. This might have given space for the evolution of these offices over time to meet peoples' ever changing needs.

2.2.2.3 The (re)installation of "traditional" chiefs

The offices of the major traditional leaders throughout Uganda were abolished by then-President Milton Obote in 1966. President Yoweri Museveni opened the way for the comeback of traditional leaders in Uganda's 1995 constitution. During the late 1990s, on the basis of the new constitution, assisted by an influential report by Dennis Pain (1997), strong efforts were made to bring back some form of official recognition to the traditional leadership in Acholiland. With major funding from the Belgian Government, civil society organizations initiated a process of consultation with different clans and communities in order to determine who could be rightfully recognized and installed as traditional chiefs (*rwodi*). In the following years many such *rwodi* were (re)instated, with the vision of enabling them to take a lead in future efforts to attain peace and reconciliation within and between communities in Acholi and Uganda as a whole.

Currently, the reinstated traditional leaders have set up an Executive Council of Acholi Traditional Leaders (*"Ker Kwaro Acholi"*), with Paramount Chief David Onen Acana II at the apex of the structure. Just beneath the Paramount Chief are two chiefs representing the Gulu and Kitgum/Pader areas respectively. Consisting of about 20 members including

chiefs, elders, and a few women and youth representatives, the Council's main charge is to represent traditional Acholi leaders and play an important role in cultural affairs.

Ker Kwaro Acholi as an institution has strong positive potential. At the same time it also has major challenges to overcome.[10] One important strength of this new institution lies in its potential to foster reconciliation at local and regional levels.

2.3 Patterns of Daily Life

2.3.1 The pre-colonial era

The pattern of daily life in pre-colonial Acholi was shaped to a considerable degree by the conditions and opportunities offered by the natural environment. The climate in Central Northern Uganda is harsh, with a long dry season from November to March and often late or unreliable rainfall.

Given sufficient rain, however – which falls mainly from April to October – the area's mostly fertile soil is highly productive. During the rainy season people were generally busy with agricultural activities. In addition, high grass and raised water levels in the streams made travel and communication were more difficult and thus also tended to keep people close to home (Girling, 1960). In the dry season, however, the work load was lighter and movement easier. This was the time to organize large hunts, visit relatives and friends farther away, and organize funeral rites, courtship dances and marriages.

2.3.1.1 Gaining a livelihood

The people of pre-colonial Acholi built their livelihoods on a mixture of agriculture, hunting and animal rearing.

The heaviest agricultural work such as clearing, planting and harvesting were mostly organized communally, within clans. Day-to-day activities such as weeding were carried

[10] See Baines (2005, p. 30-33) for a more elaborate discussion on some of these the potentials and challenges.

out mainly by individual families – a man, his wife (or wives), and their children. Both men and women contributed substantially, and roughly equally, to the considerable labor demands of hand-tool farming. The most important of these tools was the iron hoe, either made locally or obtained as a trade item from nearby peoples. Staple foods planted included different varieties of millet and sorghum, greens, pulses, sesame and sweet potatoes. After harvesting, much of the food was preserved and kept in granaries (*dero*).

Hunting was another important activity, both economically and socially. A wide range of hunting methods were utilized by individuals, small groups and huge hunting parties. The weapons used in hunting were mostly bow and arrow or spears, while techniques included the use of traps (strings, nets, concealed pits, and others) and the skillful encircling of animals.

Apart from agricultural activities and hunting, people raised domestic animals, mainly chicken, goats, sheep, and (particularly in northern and eastern Acholi) cattle. The resulting diet was generally rich in calories as well as both vegetable and animal protein, and was further supplemented by collecting a variety of wild fruits, mushrooms, honey and, in certain areas, by fishing. Yet despite all this, food security could never be taken for granted. Oral traditions recount several severe famines due to major droughts over the 18th and 19th centuries.

2.3.1.2 Pleasures of life

Life in pre-colonial Acholi was certainly not idyllic or easy. There was much hard work to do and many hardships and dangers to face. But there were also rewards and pleasures. Two major activities that were certainly a source of joy and pride to the community were those centered around the *"wang oo"* (central fireplace) and a variety of dances (*"myel"*). Both of these prominent features of Acholi life surely also contributed to people's resilience in times of difficulties.

2.3.1.2.1 Wang oo

Wang oo is often mentioned with great nostalgia in present-day Acholi. The term denotes both to the central fireplace where people gathered and the activities that took place on such occasions. Many today consider *wang oo* one of the most important "institutions" of Acholi culture and regard it as the "informal school of the Acholi" (Associazione Volontari per il Servizio Internazionale, 2002). Indeed, it must have been at the *wang oo* where vital elements of the cultural heritage of Acholi were passed on from generation to generation.

Frequently, before food was ready, people of a hamlet began sitting together and narrating folk stories (*"ododo"*).[11] Such stories were good entertainment and often used to "deceive the hunger" while waiting for the evening meal. But apart from the aspect of amusement and distraction, they often conveyed moral lessons and other important elements of cultural knowledge. While the more complex contributions were surely expected from adults, younger people were also supposed to add in their stories, thus training their verbal competence and ability to speak in front of an audience. Proverbs ("*carolok*")[12] and riddles (*"koc"*) had a similarly dual function of entertainment and education (Okumu, 2000).

When food was ready, the people of the hamlet ate together, with all the households of the hamlet contributing food. Such communal eating facilitated the care of orphans and other disadvantaged people.

The occasion of "*wang oo*" was also used by elders to teach younger ones about the history of the clan and chiefdom. Even a young person was expected to know the names of clan heads, and *rwodi* many generations back. The elders would praise the successes and achievements of their chiefdoms and clans, and would explain past hardships such as wars and famines. They would teach the young people about their kinship relations both within and outside the village to make sure that they would not engage sexually with relatives (incest was strictly taboo and the rule of exogamy was carefully followed).

Information on taboos, rituals and expected behavior was passed on at the fireplace in many different ways. Often, elders used the time to correct misbehaviors of members of the hamlet indirectly by relating proverbs and folk tales. It was then up to the listeners to pick up the message and adjust accordingly. At other times, when conflicts had already overtly erupted, they were openly discussed and resolved at the *wang oo*. Such sessions were practical lessons in conflict resolution as both sides had the opportunity to explain the causes and course of the conflict from their perspective. After elders had come to a conclusion in the case, people would then discuss how similar conflicts could be prevented in the future. And if during a quarrel a taboo ("*kir*") had been violated and a

[11] Many *ododo* are documented and published (see Odonga, 1999; Odonga, 2000; Justice and Peace Commission, Gulu Archdiocese, 2003).

[12] "Carolok" have been extensively collected and thoroughly explained by Banya (1994; see also Odonga, 1999).

sacrificial ceremony ("*tum*") was required for purification, the elders would immediately start organizing for it at the *wang oo*.

Any kind of news could be announced and work to be done the following day could be discussed and assigned at the fireplace. Finally, while some people engaged in light manual work, others sometimes sang songs accompanied by music instruments such as the thumb organ (*"lukeme"*) or harp (*"andungu" and "nanga"*). *Wang oo* could, and often did, continue late into the night.

2.3.1.2.2 Traditional dances

Another much cherished activity with deep roots in the past has certainly been dancing. A variety of dances were performed on different occasions and by different groups (Associazione Volontari per il Servizio Internazionale, 2002; Bere, 1934). The "royal dance" (*"bwola"*) was typically danced in honor of the chief or when other important people visited a chief.

"Laraka-raka", a courtship dance, was mainly performed by youth, and "funeral dances" ("*myel awal wilyel*") took place during funeral rites (Okumu, 2000). The different dances ranged across an array of important social functions and facilitated the expression of a variety of emotions. The importance of dance in general in coping with different forms of distress can hardly be overestimated. And a number of Acholi dances were strongly linked to cosmology and religious practices, a topic dealt with both later in this chapter and in CHAPTER 11.

2.3.1.3 Concepts of wealth and gender roles

Being rich for a man in pre-colonial Acholi meant primarily having many cattle as well as many wives and children (although having many wives and cattle was a consequence as well as a sign of wealth). Prestige for both men and women depended very much on having many children. Without having "produced" one could certainly not be a respected person in the community.

This was especially true for women. And in addition to bearing and raising children, women had to work hard and for long hours to make the household run. It was considered their work to fetch water, collect firewood and cook every day, while simultaneously looking after children and smaller domestic animals. Collecting wild fruits and mushrooms was also regarded as women's work. As noted above, agricultural work

was fairly equally shared between men and women, with men also responsible for looking after cattle, hunting, physical protection, and warfare.

Women had to show high respect towards men. For example, they were expected to kneel down when greeting their husbands and visitors, and usually had to wait until the men had finished with their meal before they ate.

2.3.2 The colonial and post-colonial eras

The patterns of daily life certainly changed during the colonial era, although for most, who continued to be rural mixed-farmers, the changes were usually not dramatic. The same cannot be said of the last twenty years. The long war that has marked these years has resulted in exposure to extreme levels of violence and trauma, and the vast majority (over 90%) of Acholi have been displaced off their land into squalid, disease-ridden camps (called Internally Displaced Persons Camps), where they are largely dependent on humanitarian aid for survival. Many have been in the camps for more than a decade.

In the camps, opportunities to engage in "traditional" cultural activities are extremely limited. The important *wang oo* cannot take place for security and other practical reasons. Thus the passing on of the cultural heritage has been practically severed, with the result that young people especially have only very limited knowledge of their history and culture. Additionally, due to destitute poverty and security concerns, the possibilities for carrying out traditional rituals and ceremonies are very restricted (Baines, 2005). Many people abuse alcohol owing to the miserable circumstances of camp life; domestic violence is rife; and respect towards elders has diminished significantly. The devastating impact of displacement on the social fabric of the communities can hardly be overestimated. A society once characterized by a high level of social cohesion and mutual support within overlapping communal networks (homestead, hamlet, clan, chiefdom) is drifting towards a harsh individualism. Tensions between young and old, male and female, and people in general, as well as physical violence in all its forms, have been steadily increasing.

2.4 Cosmology: Safeguarding the Rules of Social Life and Dealing with Evil

Much of our understanding of the traditional religion of the Acholi is owed to Okot p' Bitek (esp. 1971). He was both a son of the soil and a trained anthropologist, and has rendered the most thorough descriptions and critical analysis on this topic.

2.4.1 The pre-colonial era

According to Okot p' Bitek (1971), the Central Luo (including the Acholi) did not believe in an omnipresent "high god" with absolute powers, nor was their religion concerned with the ultimate origin of man or eternal life after death. Rather, it was geared towards grasping the causes of misfortune and finding ways to deal with it. The belief in various spiritual forces – all of them powerful in their respective areas – provided explanations for the many hardships of life and offered avenues to cope with them. The traditional cosmology was also instrumental in fostering unity and mutual support within a clan or chiefdom, and could also help mobilize against external threats. Religion was thus neither separate from politics nor from practical affairs more generally, but penetrated the society in all its dimensions.

The main "spiritual forces" in Acholi cosmology can be categorized as the *ancestors*, clan and chiefdom *jogg*i and "free" *jogg*i.

2.4.1.1 Reverence to the ancestors

In the traditional religion of the Acholi, the ancestors (*kwari*) played a central role. It is important to note, however, that the ancestors who were revered and approached were not just anyone who had died, but rather the significant and highly respected people of a clan. In prayers and litanies, ancestors were mostly addressed by their names and taken to have "human" attributes. Thus they could feel thirsty, cold or satisfied, and when a

spirit medium (*ajwaka*[13]) "called them", they could speak through the mouth of the *ajwaka* in a way that their voices were recognizable to elders who had known them in the past (Okot p' Bitek, 1971). The ancestors were clan members who had died, but who still cared for and were able to help (or harm) the people of their clan.

In a sense, the respect enjoyed by elders in traditional society was related to reverence for ancestors, as the elders were considered closest to them. The curses of elders were feared for the same reason. Elders were also the most knowledgeable about clan (and chiefdom) history and knew best how their forefathers had dealt with past situations. When conflicts arose or hardships were encountered, the important question that typically first came up was "How did our forefathers deal with such?" Precedents and rules about how to deal with issues of importance or concern *(ongon)* were passed on from generation to generation. Elders were regarded as the experts on such matters, but the ancestors were considered to be the spiritual guardians watching over them.

An important related concept is the notion of taboo (*kir)*. Committing *kir* not only meant violating important social rules, but also offending the ancestors who were safeguarding those "rules". The ancestors were believed to have a special interest in seeing their clan united, and they could send illnesses or other misfortunes as punishment when people were quarreling with each other. Thus the common belief in the spiritual powers of the ancestors, along with related taboos and ceremonies, increased clan cohesion and often helped correct errant behavior by clan members. Such beliefs were especially important in limiting and settling disputes within a clan.

In pre-colonial times, an ancestral shrine (*abila* or *kac*) was found in almost every homestead. An *abila* could have various forms, such as a miniature shelter made of wood and grass, or a small structure made of stone.

At the *abila*, people offered sacrifices and prayed to their ancestors on various occasions. Prior to any important undertaking, people gathered at the shrine to ask for the blessings of the ancestors. They also thanked them for success in a hunt or battle, the birth of children, a good harvest, and other good fortune. When disease or other misfortune struck the community, people would typically turn to their ancestors for assistance. They

[13] Beginning in the colonial period and continuing up to today, the term "ajwaka" (plural, "ajwaki") has mostly been translated as "witch doctor." As this is both a derogative and misleading label, we prefer to use the vernacular terms "ajwaka" and "ajwaki" in this study.

would ask for forgiveness and give sacrifices in case clan members had somehow offended their forefathers.

2.4.1.2 Clan and chiefdom joggi

Another important and distinct category of spiritual forces was embodied in the concept of a clan *jok (jok kaka)* or chiefdom *jok. Jok* (plural, *joggi*) is a general term that can be translated as "spirit force," "spirit power" or "god" A clan or chiefdom *jok,* however, was a spirit that belonged to a particular clan or chiefdom, and was typically tied to a particular place. Thus the spiritual power of such *joggi* was not general but specific and limited (Okot p'Bitek, 1963).

Clan and chiefdom *joggi* were all named, and their abodes were usually places that human beings were not supposed to frequent, such as steep mountains, deep forests or specific sites at a river. The chiefdom *joggi* of *Patiko,* for example, were *Baka* and his "wife" *Alela*. They reside on two neighboring hills and had been "given" to the *Patiko chiefdom* by the commoner clan (the Pangang) settled in the area when the first chief of Patiko, *Rwot* Atiko, arrived with his followers.

The area around the abode of a *jok* was believed to be sacred ground, and certain rules needed to be followed when there. For example, it was typically forbidden to urinate or defecate there and none was supposed to drive a spear into the soil (Okot p' Bitek, 1971, p. 64). Any infringements could provoke the anger of the *jok*, who might then send misfortune and illness to the offender and his or her relatives.

Many clans settled in Central Northern Uganda before the introduction of chiefdoms had clan *joggi*. When a chief and his followers came to stay in an area, the *jok* of the oldest commoner clan present was often accepted to as the chiefdom *jok.* The head of that clan was usually acknowledged as a special spiritual leader, was accorded the title of *"won ngom*,*"* ("father of the soil"), and continued to be in charge of the *jok*. Many chiefdoms had only one chiefdom *jok*, but others would add additional ones, especially if they moved to distant areas and incorporated new clans there.

Typically, once a year the people went to offer sacrifices to the *jok* and prayed for its protection and assistance. Such feasts (*"tedo jok"* or *"tero jok"*) were usually organized chiefdom wide. Members of the different clans attended and the chief sent his representatives. However, the *won ngom* and his assistants (*"luted jok"*) were in charge

of the ceremony. After having sacrificed to the *jok*, people were welcomed at the home of the chief, where he addressed his subjects. Joyful celebration typically followed.

Importantly, people attending the feast were required to be of "clean heart." Murderers, thieves, and people with unsettled disputes were not allowed to participate in the ceremony. This motivated individuals and groups to settle their disputes before the day of the sacrifice. Otherwise they had to expect to be punished by the *jok* and their prayers would not be heard (Okot p'Bitek, 1971, pp. 82-84). Thus, in a manner similar to reverence to ancestors, the chiefdom *joggi* played an important role in sustaining moral order in society. In addition, the presence and importance of chiefdom *jogi* helped sustain and reinforce chiefdom-wide membership and solidarity that embraced all the clans in the chiefdom. As with the ancestors, the chiefdom *jok* was believed to have an interest in the well-being of the people and was not expected to send unjustified punishment. Therefore, more serious and "unexplainable" illnesses and other misfortunes were most often attributed to other spirits, including "free" *joggi*.

2.4.1.3 "Free" joggi

Spirit forces that were not limited to certain territories or groups of people can be categorized as "free" *jogg*i (Okot p' Bitek, 1971; Behrend, 1999a). They were spirits "free" to move over large distances, and could even be at different places at the same time. Unlike clan or chiefdom *joggi,* they were prone to possess people and could be used not only to heal but also to cause harm. An *ajwaka* could utilize the powers of a free *jok* to divine and heal. But she could also employ such spirits to hurt and even kill. Many free *joggi* could be utilized for witchcraft and sorcery.

The concept of free *joggi* played an important role in explaining diseases, and also provided ways of coping with them. According to Okot p' Bitek (1971), some free *joggi* "specialized" in causing specific illnesses or symptoms, For example, *Jok* Orongo was believed to cause aches and shivering, while *Jok* Olila caused stomach disorders, *Jok* Odude was said to cause headaches, and *Jok* Kulu was feared to cause miscarriages. Okot p' Bitek elaborates:

> The significance of these spirits to the Central Luo was first and foremost medical; it was believed these *jok* caused diseases, the cure for which lay in dealing with the spirits in the methods described. It may be said that it was the diseases which were spiritualized, in the same way as other illnesses were

> seen in terms of the anger of the ancestral spirits, or the curse of the living parents.
>
> But if it was stomach ache, headache, miscarriage and other diseases that the Central Luo spiritualized, the technique of treatment dealt not only with the physical aspects; the patient was given herb to drink or rub on the affected part, but at the same time received full psychological treatment as well. It is important to note that most of the complaints dealt with in spirit possession were cases in which anxiety played a large part. The striking difference between the diseases attributed to the free *jok*, and those caused by ancestral spirits is that with the latter, guilt was a dominant factor. The ancestor's were angry because they had been neglected, because somebody among the living had not done his or her duty. With the free *jok*, on the other hand, there was no apparent cause for their attack (1971, p. 114).

Another type of spirit that can be classified as free *joggi* is *"cen." Cen* has been translated as "vengeance ghost," the spirit of dead people that could befall the living to cause serious trouble. As *cen* is of particular importance to the main topic of this study, it will be dealt with in more detail in CHAPTER 11 below.

2.4.2 The colonial and post-colonial eras

Although traditional cosmology still pervades Acholi society to a considerable extent, significant changes have occurred over the last century. The most striking of these changes are the weakening of the influence of the clan and chiefdom *joggi*, the proliferation of free *joggi*, and the introduction of Christianity.

2.4.2.1 The weakening of the clan and chiefdom joggi and the proliferation of free joggi

The feasts of sacrificing to the clan and chiefdom *joggi* (*"tedo jok"*), briefly described above, supposedly stopped entirely during the colonial area. This must have been a gradual process characterized by the weakening of traditional offices, and the arrival of new ideas and opportunities. Yet some elders interviewed in 2005 insisted that these *joggi* should again be given sacrifices – and apologies – once the current war has ended, as many of their locations have been trespassed upon or even bombed (Transcript 10). All in all, however, the reverence towards clan and chiefdom *joggi* seems to have almost died out.

With the general weakening of traditional offices and beliefs, the reverence to ancestors has certainly been weakened as well, although to a lesser extent. Ancestors are still addressed regularly in various rituals, as will be described in more detail below in CHAPTER 11 and CHAPTER 12.

The so-called "free" *joggi*, on the other hand, increased strongly in number and influence during and after the colonial area (Behrend, 1999a). Their numbers appear to have been very limited in pre-colonial times (and they may have only been introduced into Acholi, from Bunyoro-Kitara to the south, in the 19th century). During the colonial period, however, a proliferation of free *joggi* occurred and such spirits became almost unlimited in number. Many of these appeared and then soon faded from the scene. Others, however, survived to join the repertoire of free *joggi* known to people up to today. Examples of such long-lived and widely known free *joggi* dating from the colonial era according to Okot p' Bitek (1971) include *Jok* Rumba (supposedly derived from the Latin American "rumba" dance), *Jok* Omarari (likely a corruption of the English "marine"), and *Jok* Muno (spirit of a white person). LRA leader Joseph Kony has been said to be possessed by various spirits, hailing from different parts of the world, including "Silver Koni" from the Congo, "King Bruce" from the USA, and "Ing Chu" from Asia (Behrend, 1999b).

The tremendous proliferation of free *joggi* in Acholi, both during the colonial period and more recently during the twenty-year northern Uganda war, has often been interpreted as being fuelled by the perception of new threats coming from outside and increasing tensions within (Behrend, 1999a). The related individual and collective anxiety might well have found their expression in the appearance of new and foreign spirits that offer explanations for new forms of suffering and means to defend against them (Behrend, 1999a).

Practices and suspicions of sorcery and witchcraft also increased during the colonial era, and have spiked again over the last two decades. Currently, such suspicions and accusations of "spiritual attacks" have been leading to extremely harmful dynamics throughout Acholi. The typical pattern proceeds as follows: When someone believes that he or she has been bewitched, the person usually consults an *ajwaka*. After confirming the suspicion of the client, the *ajwaka* then often offers "healing" by counter-bewitching the suspected aggressor. Such processes can bring about recurring cycles of "bewitchment," fueling increased communal and individual stress and tensions rather than alleviating anxiety or resolving outstanding issues. Many *ajwaki* have unfortunately taken advantage

of what they see as a lucrative business opportunity in such dynamics and play a very negative role in this respect up to today.

Heike Behrend (1999a) argues that witchcraft had probably been successfully controlled by chiefs and clan leaders within the pre-colonial religious system. With the decline of their offices, the related control mechanisms were also weakened. This has appeared to open the door for many charlatans. Social control over the *ajwaki* was further weakened by the successive marginalization of their position and their healing practices, following the introduction of Christianity.

2.4.2.2 The introduction of Christianity

An excellent discussion of this topic can be found in Heike Behrend (1999a, pp. 113-127), which provides the basis for summary treatment that follows.

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Alongside all the other changes that accompanied colonial rule, the introduction of Christianity triggered complex processes of accommodations and adjustments in Acholi cosmology. Today, most people in Acholi are baptized Christians, but traditional beliefs and values still permeate and shape the interpretation of Christian teachings, as has been true from the earliest spread of Christianity. As Behrend aptly writes:

> "In the course of this process [of evangelization], not only was the Acholi religion 'Christianized', the Christian teaching was also 'Acholi-ized". (1999a, p. 116).

Even though the missionaries brought their teachings with the dual claims of exclusivity and universality, Acholi tended to accept them as teachings that could co-exist with traditional concepts. Thus Christian teachings were incorporated into the indigenous cosmology and vice versa. Indeed, when trying to study and understand concepts of traditional Acholi cosmology today, one is inevitably confronted with limits of understanding that arise from the long period of interaction and mutual influence of traditional and Christian beliefs. The consequences of such complex interactive processes make any attempt to reconstruct "traditional" (pre-colonial) cosmology necessarily partial and tentative.[14]

[14] Unfortunately, the available documentation of pre-colonial religious concepts is controversial and insufficient. It derives primarily from sources written by European missionaries, travelers and administrators (Okot p'Bitek, 1963).

The adaptation of Acholi religious beliefs started right from the beginning of evangelization (Okot p' Bitek, 1973b). This can be interpreted as an expression of the original Acholi attitude towards religion, which reflects a high level of flexibility and ability to incorporate and tolerate. Similar traits can be found in most African religions.

Missionaries on the other hand made concerted efforts to emphasize the exclusiveness of their teachings. In an attempt to find a proper Luo translation for "God" in the Christian sense, they chose "Rubanga"[15] and declared all other spirits to be satanic spirits. Accordingly, they regarded the activities of traditional healers or spirit mediums (*ajwaki*), as well as the reverence for ancestors, as evil, thus neglecting the healing potential of these traditional institutions. For Catholic Christians, the Second Vatican Council in the 1960s could have offered a theoretical opening towards more respect to local practices. However, on the ground in Acholi, the old missionary habit of seeing Christianity and local practices as opposed to each other continued to spread, prevailing over a more tolerant understanding of different religious expressions.

While Christian teachings at the beginning of the 20th century were clearly located at the periphery of the religious order in Acholi, they steadily moved towards the center. Today, earlier, pre-colonial religious elements such as traditional rituals that include reverence to ancestors and, even more, the consultation of spirit mediums, are clearly marginalized. Going to church is typically done openly and with pride, while visits to the *ajwaka* are arranged in secret. Such sentiments and behavior might well be contributing to the spread of harmful practices and charlatanism among the *ajwaki*. Yet they continue to be influential, as many people continue to consult the spirits while being practicing Christians at the same time. Simultaneously, the influence of cults of spirit possession, as well as other elements of traditional religion, can be seen within the Christian Churches, most strikingly in the frequent practice of exorcism (the driving out of evil spirits) which is especially popular in, but not limited to, Pentecostal Churches.

[15] In the traditional belief system, however, Jok Rubanga was (and is) a spirit believed to cause hunchbacks (tuberculosis of the spine).

2.5 Literature on traditional ways of coping and healing in Acholi

The literature published on the Acholi is extensive. Most of the books and articles focus on the history of the Acholi, in the sense of providing chronologies of different clans and accounts of historical events (Adimola, 1954; Anywar, 1948; Atkinson, 1999; Crazzolara, 1950; 1951; 1954; Gray, 1951; 1952; Onyango-Ku-Odongo & Webster, 1976). Other publications focus on the socio-political organization of the Acholi (Girling, 1960) as well as on traditional religious ideas (Okot p'Bitek, 1971) and their continued impact in postcolonial times (Behrend, 1999a). Moreover, the prolonged war in Acholi has prompted substantial publications that discuss factors maintaining and ways to solving the conflict (Dolan, 2005; Finnström, 2003; International Crisis Group, 2004). In the same context, Acholi traditional approaches to justice have received attention in several books and reports (Allen, 2006; Baines, 2005; Finnström, 2003; Pain, 1997).

While mostly treating historical and political topics, the above-mentioned publications do also contain descriptions of traditional concepts and portrayals of healing rituals. However, from a present perspective, they carry various inherent limitations. (a) It remains unclear, which of the ceremonies described in early publications are still practiced. Many of them might have meanwhile died out, have changed or lost relevance. (b) Descriptions mostly rely on the accounts of single key informants, who at times witnessed the ritual many years before the interview (e.g. Girling, 1960) or do not specify the provenience of the accounts (e.g. Wright, 1936). (c) The rituals were usually described with a specific purpose in mind (e.g. showing the importance of chiefdom-wide rituals for the stability of larger political units, as in Atkinson, 1999). Naturally, such descriptions give sufficient details to illustrate the point made by the author, but leave out other details that are of importance for analyses from a general psychosocial perspective and from a psychological perspective on traumatic stress. Overall, descriptions of the rituals in the extant literature are often of questionable reliability and rudimentary with respect to contents of psychological relevance.

Nevertheless, some of the available documentation merits consideration in a contemporary psychosocial context. Okumu (2005) describes the welcome and cleansing ceremony *nyono tonggweno* (stepping on the egg) and the reconciliation ceremony *mato oput*. Brief descriptions of *mato oput* are also provided by Girling (1969, pp. 66-67) and

Baines (2005, pp. 57-61). Without going into details, Baines (2005, pp. 26-30) provides short definitions of various Acholi terms. These also include rituals like *nyono tonggweno* (stepping on the egg), *lwoko pik wang* (washing away the tears), *tumu kir* (cleansing for a taboo committed), *gomo tong* (bending the spears), *moyo piny* (cleansing a specific area), *ryemo gemo* (chasing spirits from a wide area), *kwero merok (*cleansing someone who has killed in war) and *ryemo jok* (chasing out of spirits). Girling (1960, pp. 103-104) and Wright (1936, p. 186) describe the ritual *kwero merok*. Okot p'Bitek (1971) provides detailed accounts on *ryemo jok.* Behrend (1999a, p.42) depicts a ritual for returning warriors that match elements of *nyono tonggweno* (stepping on the egg), followed by *kwero merok,* without giving the procedure a name (cf. ANNEX 5 for an overview of 'external sources' considered in our ethnographic descriptions).

Despite existent documentation on some rituals, a systematic outline and analysis of rituals that might be helpful in addressing the psychosocial impact of the Northern Ugandan War has so far not been available. Even more striking is the dearth of research on concepts and rituals of specific relevance to coping with traumatic stress, which is the topic of this thesis.

PART TWO: WESTERN CLINICAL PERSPECTIVE ON TRAUMATIC STRESS

In CHAPTER 1, we have outlined the impact of the Northern Ugandan War on the general population and on abducted people. The striking exposure to most severe traumatic events is, according to Western clinical psychology, expected to cause significant posttraumatic distress and high rates of posttraumatic stress disorder.

In the following chapters, we delineate a Western perspective on traumatic stress, including the concept of posttraumatic stress disorder (CHAPTER 3), as well as other disorders related to traumatic stress (CHAPTER 4). We will also discuss early interventions after exposure to traumatic stress (CHAPTER 5) and the most prominent psychological treatment options for disorders of traumatic stress (CHAPTER 6).

3 Posttraumatic Stress Disorder (PTSD)

Exposure to life threatening and horrific events has been part of human experience throughout history. It is therefore not surprising that accounts on the debilitating effects of extreme stressors are found in literary and historical documents that are centuries old. They can be found, for example, in Homer's Iliad (Shay, 1991) and in Shakespeare's Henry IV (Maercker, 2003b). But is was not until 1980, when a specific related syndrome that went beyond describing acute stress reactions first appeared in an official diagnostic manual. By then, Posttraumatic Stress Disorder (PTSD) made its first appearance in the Diagnostic and Statistical Manual of the American Psychiatric Association (1980). This new diagnostic category according to most researchers and clinicians has provided an important and useful conceptualization of the potential long-term impact of traumatic exposure on mental health and has promoted the development of effective treatment approaches.

This Chapter gives an overview of the concept, including diagnostic criteria, epidemiology and etiological models.

3.1 Diagnostic criteria

In this thesis, we mainly refer to the diagnostic criteria of the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association in its current version, the DSM-IV TR (American Psychiatric Association, 2000, as cited in Keane & Kaloupek, 2002). In comparison to the criteria spelled out in the International Classification of Diseases (ICD-10) of the World Health Organization (Weltgesundheitsorganisation, 1994) the DSM criteria provide a higher degree of operationalization and have up to now been most widely used by researchers. Therefore, the DSM-IV criteria shall be spelled out in more detail in this chapter. The most important revisions that occurred in the transition from DSM-III to DSM-IV will also be outlined, to exemplify some of the discussions that have emerged around the concept. We will refer to the criteria defined in the ICD by outlining the major differences to the DSM definition.

3.1.1 Diagnostic criteria according to DSM-IV

The DSM-IV TR (American Psychiatric Association, 2000) specifies six criteria for the diagnosis of PTSD. The (A) criterion characterizes the causing stressor; criteria (B) to (D) depict the three symptom clusters of re-experiencing, avoidance / numbing and hyperarousal, while criterion (E) defines the required duration of the described symptoms. Criterion (F) obliges the clinician to check whether the symptoms cause significant distress or impairment to the concerned person. To diagnose PTSD, a clinician must confirm all six criteria (A-F). In the below outlined diagnostic criteria we omit the notes on child-specific symptoms for the sake of brevity.

The (A) criterion defines the traumatic event, which is assumed the cause of the symptoms specified in criteria (B) to (D). It is divided into two parts and requires that

1) A person has experienced, witnessed, or been confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
2) The person's response involved intense fear, helplessness, or horror.

This *stressor* criterion defines the etiologic event and has always been one of the most controversial among the six criteria. It has also seen the most noteworthy changes since the introduction of the diagnosis in the DSM-III. While the DSM-III (APA, 1980) had defined a traumatic event as being outside of common human experience, the emphasis in the DSM-IV is on threatened death or serious injury. This change reflects an increased understanding about the frequency and impact of traumatic events. It considers that disastrous events are more frequent than previously thought. Further, it expands the definition to include subjective responses of the concerned person, thus de-emphasizing the objective features of the stressors. This is significant, as it makes the definition of traumatic events more sensitive to factors that mediate individual responses to stressful events, such as psychological, socio-historical and ethnocultural variables.
Furthermore, the list of events has been explicitly widened in the DSM-IV. In addition to the core events mentioned in the DSM-III (military combat, rape, criminal violence, natural disasters and accidents), it includes the death of a loved one from any cause, as long as it was sudden and unexpected. It also includes the event of being diagnosed with a life threatening illness. This expansion has led to a marked increase in lifetime prevalence of exposure to traumatic events in studies using DSM-IV criteria (Breslau, 2002).

The second (B) criterion reflects symptoms of re-experiencing. These are by concerned individuals often perceived as the most disturbing and debilitating symptoms of PTSD. To

clinicians they are the most distinctive symptoms in relation to other disorders. They include:

1) Recurrent and intrusive distressing recollections of the traumatic event, including images, thoughts and perceptions,
2) Recurrent distressing dreams of the event
3) Acting and feeling as if the traumatic event were recurring, (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur at awakening or when intoxicated).
4) Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
5) Physiological reactivity on exposure to internal or external cues that resemble an aspect of the traumatic event

The DSM-IV stipulates that at least one out of the five above-described forms of re-experiencing must be confirmed to meet diagnostic criteria.

Criterion (C) in the DSM encompasses symptoms of avoidance and numbing. They comprise symptoms of active phobic avoidance, as well as more 'passive' symptoms that are associated with a more general pattern of emotional numbing:

1) Efforts to avoid thoughts, feelings and conversations associated with the trauma
2) Efforts to avoid activities, places or people that arouse recollections of the trauma
3) Inability to recall an important aspect of the trauma
4) Markedly diminished interest or participation in significant activities
5) Feeling of detachment or estrangement from others
6) Restricted range of affect (e.g., unable to have loving feelings)
7) Sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

To meet the requirements for the diagnosis, at least three of the above symptoms must be confirmed. It is worthy to note that by requiring three symptoms of the avoidance/numbing cluster to be affirmative, the DSM sets a relatively high threshold. Many people who suffer from intrusive recollections and several other typical PTSD symptoms fail to qualify for the diagnosis of PTSD because they do not meet the criterion (C). Because of the high threshold set by the (C) critierion in the DSM, the lowering the number of required symptoms and the introduction of the concept of partial PTSD in the DSM have been discussed (Schützwohl & Maercker, 1999). Moreover, the (C) criterion amalgamates symptoms of 'avoidance' and 'numbing' in one cluster, although most of the factor-analyses on the structure of PTSD symptoms suggest a solution separating the two groups of symptoms would provide a better fit (King, King & Orazem, 2006; Maercker,

2003b). It remains to be seen if, as a response to more recent empirical findings, the (C) criterion will be changed in the impending DSM-V.

Criterion (D), the last cluster of symptoms, describes a state of hyperarousal that partly overlaps with other anxiety disorders (e.g., insomnia and irritability) but also contains symptoms more specific to PTSD (e.g., the startle reaction and hypervigilance):

1) difficulty in falling or staying asleep
2) irritability or outbursts of anger
3) difficulty concentrating
4) hypervigilance
5) exaggerated startle response

The DSM demands two or more of the hyperarousal symptoms to be confirmed in order to meet the diagnostic criteria. Overall, the three clusters of symptom criteria, (B) to (D), have not been significantly changed in the transition from DSM-III to DSM-IV.

Criterion (E) requires the duration of the established symptoms to be more than one month. This takes into consideration that some of people who have developed symptoms after exposure to a traumatic event do seem to recover within the first weeks. In case the traumatic event happened less than one month before assessment, the clinician would check the criteria for an Acute Stress Disorder, which is described further below.

Lastly, criterion F (which was still absent in the DSM-III) spells out that a diagnosis will only be given if the disturbance causes ‘clinically significant distress’ or impairment in important areas of functioning (e.g., social relations, profession, or others). According to estimates by Breslau (2002), the added (F) criterion accounts for a reduction of identified cases by 25% in epidemiological studies. This illustrates that, while symptoms of PTSD can cause significant psychological distress and severe impairment in daily life, it is important to recognize that some people might experience only insignificant distress and impairment. They would therefore not be in need of treatment.

Despite including the (F) criterion, the changes from the DSM-III to DSM-IV have, all in all, led to higher estimates of PTSD prevalence, which is mainly due to the enlarged stressor criterion (Breslau, 2002).

3.1.2 Diagnostic criteria in the ICD-10

The diagnostic criteria stipulated in the ICD-10 widely overlap with those in the DSM-IV. Yet there are also noteworthy differences.

First, criterion (A), which defines the traumatic event, does not consider the emotional response of the potentially traumatized individual (Maercker & Karl, 2005a). Especially in in cross-cultural diagnoistics, this is might be a shortcoming as it disregards subjective processes that mediate the impact of the event on the individual. On the other hand, the formulation in the DSM can be criticized in the light of existing evidence that some individuals who do not report having experienced strong emotions during exposure – as required by the DSM – can nevertheless develop severe symptoms (see Halligan & Yehuda, 2000; Ozer, Best, Lipsey & Weiss, 2003 on peritraumatic dissociation). From this perspective, the definition in the ICD is more inclusive as it gives the assessing clinician space to consider a wider range of qualifying individual responses.

The second important difference between the definitions in the DSM and ICD concern the (C) criterion (Maercker & Karl, 2005a). Here, the ICD does not include numbing symptoms spelled out in the DSM avoidance / numbing cluster. Further, the ICD requires only one form of avoidance to meet the (C) criterion, whereas the DSM demands three symptoms of this cluster to be confirmed. Overall, the ICD sets a markedly lower threshold for diagnosis, and therefore studies using ICD-criteria in the assessment usually suggest a higher prevalence of PTSD than those using DSM-criteria.

3.2 Epidemiology

The following summary on the epidemiology of PTSD mainly reflects studies carried out in Western industrialized countries, mostly in Northern America and Europe. Studies that yield information on the prevalence of PTSD in non-Western countries will be discussed in the CHAPTER 9.2.

3.2.1 Prevalence of exposure to traumatic events

As stated above, the DSM-III had defined a traumatic event as being outside the range of normal human experience. Later, studies on the frequency of traumatic events have led to

the revision of the idea that traumatic events are rare occurrences. The US-American National Comorbidity Study (NCS) found a lifetime prevalence of exposure to traumatic events of 60% (Kessler et al., 1995). Studies that are more recent tend to find even higher figures approaching 90% (Breslau, 2002). Although the prevalence of exposure to traumatic events obviously varies according to region, population characteristics and methodology applied int the study, the evidence clearly shows that traumatic events are by no means as rare as previously assumed.

3.2.2 Conditional risk and prevalence of PTSD

With the high prevalence of exposure as summarized above, it has also become clear that most people who have been exposed to a traumatic event do not develop PTSD. While Kessler et al. (1995) report a lifetime prevalence of 60% for traumatic exposure, the related lifetime prevalence of PTSD was about 8%. According to a review by Breslau (2002), the conditional risk of developing PTSD after having been exposed to a traumatic event ranges from 9 to 14%. Although a single traumatic incidence is generally unlikely to cause PTSD, some traumatic events do have a relatively high likelihood to do so. The likelihood to develop PTSD after rape is estimated between 30 - 50% (Maercker & Karl, 2005). Similarly high is the estimate for PTSD as a consequence of direct exposure to war (Keane et al., 2000; Maercker & Karl, 2005b). In contrast, even serious traffic accidents lead to PTSD in only 5% of the cases (Maercker & Karl, 2005). Green, Lindy, Grace and Leonard (1992) point out that certain disasters also have the potential to induce PTSD at high rates. Among the survivors of the dam collapse in Buffalo Creek they found a lifetime prevalence of 59% and a striking 25% point prevalence 14 years after the flooding.

Most epidemiological studies have found gender differences in the prevalence of PTSD and conditional risk. According to the above-quoted National Comorbidity Survey (Kessler et al., 1995), male were slightly more likely to be exposed to traumatic events than females. However, among women the lifetime prevalence of PTSD was markedly higher (12%) than among men (6%). This result can partly be attributed to the fact that women are more often exposed to most severe stressors (especially rape). It might at the same time be linked to biological (Southwick et al., 2003), as well as psycho-social gender differences (Andrews, Brewin & Rose, 2003).

Overall, studies conducted in the USA seem to yield a lifetime prevalence of PTSD of about 5 to 9%. The prevalence of PTSD in Europe seems to be noticeably lower. A study reflecting data from six European countries reported a 1.9% lifetime prevalence of PTSD (The ESEMeD/MHEDEA 2000 Investigators, 2004). Perkonigg, Kessler, Storz and

Wittchen (2000) report a life time prevalence among a young sample in Germany (aged 14-24 years) of 1% for male and 2.2% for female. Twentysix percent of the male and 17.7% of the female sample had experienced at least one traumatic event. While exposure and resulting PTSD are markedly lower in European studies compared to US studies, the conditional risk is similar (Perkonigg et al., 2000).

3.2.3 Risk and protective factors

As aforementioned, the definition of the stressor criterion in the DSM-III in a way reflected the then assumed primacy of the traumatic event *per se* as the etiologic agent causing PTSD. Empirical findings on the relatively low conditional risk for developing PTSD therefore prompted intensive research with the aim of identifying potential risk factors associated with the onset and maintenance of PTSD.

Factors before exposure

Several factors signal a higher risk before exposure. Among them are female sex, young age (under 25), low level of education and intellectual functioning, prior exposure to trauma and childhood adversity, prior psychiatric disorders and a family history of psychiatric disorders (Friedman, 2001; Halligan & Yehuda, 2000). Some neurobiological risk and protective factors for PTSD have also been identified. Gilbertson, Shenton, Ciszewski, Kasai, Lasko, Orr & Pitman (2002) identified a smaller hippocampal volume as a risk factor. In contrast, a sympathetic nervous system with a pattern of relatively low baseline noradrenaline and spikes that swiftly return to baseline after challenging situations has been proposed as an important protective factor (Southwick et al., 2003).

Factors associated with the traumatic event

Important risk factors associated with the traumatic event are the ‘nature of the traumatic event’ and the ‘severity’ or ‘dose’ of exposure. Further, the immediate reaction of individuals to traumatic events, especially peritraumatic dissociation, has been identified as a risk factor.

With regard to the nature of the traumatic event, the following types are distinguished (Maercker, 2003b): interpersonal violence (e.g. rape, physical assault and war) is considered more likely to produce PTSD than impersonal trauma (e.g. natural disasters). Generally, Type II traumas (repeated or long lasting) are deemed more pernicious than Type I traumas (circumscribed brief and single incidents). Participation in atrocities is also regarded a risk factor (Friedman, 2001). Generally, suddenness,

unexpectedness and perceived uncontrollability of traumatic events are also considered to increase their harmful impact on individuals.

Concerning the 'severity' or 'dose' of exposure, an intuitively plausible assumption is that the more severe the traumatic exposure, the higher the likelihood that the individual will succumb to PTSD. Despite its plausibility, many studies in Western industrialized countries could not confirm this pattern or display severe methodological shortcomings (McNally, 2003). Moreover, dose of exposure generally explained surprisingly little variance of PTSD severity (Maercker, Beauducel & Schützwohl, 2000). While it it is well conceivable that other factors (e.g. initial reactions at exposure) explain comparably more variance in later posttraumatic stress symptoms, these results might also be related to the limited statistical variance of the 'dose of exposure' in the samples of the studies in question. Studies with combat veterans (Cozza, 2005) and with refugees in non-Western countries (Mollica, 1998; Neuner, 2003) suggest specifying the dose-response model in the sense that it is likely more the cumulative effect of multiple traumas rather than the severity of single traumatic events that overstrains the resiliency of individuals. In a sample of refugees examined by Neuner (2003), among respondents who had experienced more than 27 different types of traumatic events, all had developed full PTSD. Neuner interprets these findings to indicate that there might not be such a thing as the ultimate hardiness against PTSD. While people can be more or less vulnerable to develop PTSD, a psychobiological limit to resilience against traumatic stress likely exists for any individual (see also Kolassa & Elbert, 2007, who support the same conclusion from a neurobiological perspective).

Another important risk factor concerns the immediate reaction of the individual to the traumatic event. In a meta-analysis, Ozer, Best, Lipsey & Weiss (2003) found that peritraumatic dissociation had the highest effect-size among all the predictors of PTSD. The discussion on the relationship between dissociation and subsequent PTSD is however complicated by questions concerning the definition of the term and possible mediators connecting dissociation to PTSD (DePrince, et al., 2006). Nevertheless, there is strong evidence that peritraumatic psychological processes and immediate reactions to the trauma are strong predictors of PTSD (Maercker & Karl, 2005b).

Factors after exposure

Among the risk factors after exposure, the factor 'social support' yielded the highest effect size in the meta-analysis by Brewin, Andrews & Valentine (2000). Approaching the topic from a cognitive perspective, but consistent with Brewin's findings, Dummore, Clark and Ehlers (1999) found that differences between 'no PTSD' and 'PTSD' groups were highly significant for the factor 'negative perception of other's responses'. Overall, studies

revealed more consistent positive effects for ‘perceived social support’, while the data on ‘received social support’ are inconsistent (Kaniasty, 2005). Still within the discussion on the impact of ‘social support’, it has plausibly been argued that negative interactions and attitudes have a stronger impact on symptom development than the lack of positive ones (e.g. Andrews et al, 2003). A study by Müller, Mörgeli & Maercker (2008) identified disapproval from both family and social environment as strong predictors of severe PTSD symptoms, thus confirming the importance of negatively perceived interactions.

Social welcome and recognition might be another important protective factor. It has been speculated that the comparably high prevalence of PTSD among Vietnam Veterans might be related to the negative and partly hostile reception they encountered upon their return form the war. While so far most studies have used general measures of social support, Maercker has proposed a new and more trauma-specific construct of social acknowledgement (Maercker & Müller, 2004). In comparison to social support, social acknowledgement considers a wider societal context (including public opinion, pressure groups, etc.). Moreover, the items of the self-report scale specifically refer to reactions of society in appreciation of the victim’s unique state and difficult situation after the traumatic event. Maercker and Müller (2004) could show that their more specific concept of social acknowledgement explained a higher proportion of PTSD symptom variance than a conventional measure of social support. Their studies show that victims of crime and political prisoners with PTSD diagnosis report significantly less social acknowledgement than those without diagnosis (Maercker & Karl, 2005b).

Overall, studies give strong evidence on the link between measures of social support and PTSD. However, the causal relation between the two variables might be complex and is not yet clear. While the hypothesis of social support influencing PTSD severity is plausible, the causal linkage might not be unidirectional. It is well possible that social support declines with time because of elevated posttraumatic stress and related troubles in social relations. The relevance of this hypothesis of a ‘reversed’ order of cause and effect is illustrated by Keane, Scott, Chavoya, Lamparski & Fairbank (1985). They collected retrospective data on ‘social support’ of Vietnam veterans (1) before entering military service, (2) following discharge from service, and (3) data on present social support at the time of the study. For the period prior to their service, PTSD and non-PTSD veterans reported similar levels of social support, measured on various dimensions. In contrast to the well-adjusted veterans, however, the level of social support for the veterans diagnosed with PTSD had significantly declined over time. Kaniasty and Norris (2008) have carried out a longitudinal study with disaster victims, with assessments conducted across four points in time (6, 12, 18 and 24 months after disaster). According to their analysis, (low) social support largely explained posttraumatic distress in the earlier

postdisaster phase (first year after the impact). As time elapsed, social selection increasingly accounted for the support-to-distress relationship, suggesting that persons with PTSD related distress might experience a decline in their social support over time.

Disclosure of important aspects of the traumatic event towards family and friends has also been considered having an influence on the development of posttraumatic stress disorder. Analogue studies with students suggest talking or writing about significant and distressing events in one's life has a positive impact on mental and physical health (Mehl & Pennebaker, 1999). Based on such results it was proposed that people who openly talk about past traumatic events might have a lower risk of developing PTSD. However, such proposition has been questioned in clinical studies, which showed a much more complex picture (Maercker & Karl, 2005b). There is evidence that specific disclosure attitudes, such as a strong urge to talk about the trauma and (at times simultaneously) reluctance to talk about the trauma, as well as strong emotional reactions while disclosing are related to higher PTSD symptom severity (Müller, Mörgeli & Maercker, 2008). Overall, the data so far available suggest that people who are moderately affected by traumatic events might indeed profit from talking about the trauma to friends and family, while those most severely affected might not.

Most of the literature on risk factors for PTSD focuses on adult trauma survivors, while children have received comparably little attention. Although most of the above-outlined factors will also be relevant for children, the parents' or caretakers' reactions to the trauma (incl. their emotional stability and emotional availability to their children) is deemed most important in determining the outcome of traumatic exposure in children. An interesting review on studies illuminating such relational factors in early childhood is given in Scheeringa and Zeannah (2001).

3.2.4 Phenomenology and longitudinal course

The phenomenology of PTSD is multifaceted. While the symptoms described in CHAPTER 3.1 can vary from mild to very severe, different types of trauma contribute differently to the shaping of symptoms. Single traumatic incidences (Type I trauma) are most closely related to the clinical picture of PTSD as described in CHAPTER 3.1. Prolonged and repeated traumatizations (Type II trauma), however, typically lead to a more complex clinical picture, often referred to as 'complex PTSD' (Hermann, 1992; cf. CHAPTER 4.2). Moreover, PTSD is related to various comorbid disorders (cf. CHAPTER 4.3.), which

contribute to causing psychological distress, and functional impairment in the life of the concerned people (Maercker, 2003b).

The severity of PTSD may vary over time and take a different course for different individuals. During the first few hours and days after a traumatic incident, the picture of an acute stress disorder with associated symptoms of dissociation is often prominent (see CHAPTER 4.1 on acute stress disorder). While symptoms of PTSD do often feature in the first days and weeks, these are usually regarded as a normal reaction to an abnormal event. As explained above, the diagnosis of PTSD will only be given if the symptoms persist after the first month following the trauma and all diagnostic criteria are met (American Psychiatric Association, 1994). Symptoms of PTSD might well remit without treatment, especially during the first months after the traumatic event. However, the more time elapses with symptoms persisting, the lower the chances for spontaneous remission to occur (Maercker, 2003). The results of the National Comorbidity Study (Kessler et al, 1995) allow rough estimates on the frequency of spontaneous remissions. For about one third of the relevant sample, the symptoms remitted within the first year, while about half of the sample took 4 years to recover. Another third of the sample, however, remained severely disturbed even ten years after the incident and beyond. These data are aggregated over a sample representing different types of trauma. Thus, they do not tell much about courses related to specific traumata (e.g. rape or car accidents). It is generally assumed that the more severe the symptoms are at the beginning, the higher the likelihood of chronic PTSD (Ehlers, 1999). Furthermore, clinical observations suggest that the majority of people who have ever developed severe PTSD might be in a state of remission with occasional relapses for most of their life. Such relapses are often triggered when clients are confronted with situations or major life events that relate to the original trauma in a significant way (Friedman, 2001). A late onset of PTSD beyond six months after the traumatic incident is relatively rare, with an estimated probability of 11% (Ehlers, 1999).

3.2.5 PTSD and functioning

Posttraumatic stress disorder with its comorbidities is known to interfere with everyday functioning. This is already plausible on the ground of the detrimental and impairing impact of its most frequent comorbid disorders (e.g. alcohol abuse and depression). More specifically, symptoms of PTSD themselves can interfere with daily tasks in many ways. Difficulties to concentrate can severely hamper performance at work or at school;

permanent symptoms of re-experiencing can impede the ability to engage in important social relationships, including with one's spouse and children. This is just to mention a few concrete examples. Moreover, PTSD is often associated with significant interpersonal problems. These include difficulties in expressing affection and sexual intimacy, social withdrawal, and, most noticeably, anger and aggression (Beckham, Feldman, Kirby, Hertzberg & Moore, 1997; Chemtob, Hamada, Roitblat & Muraoka, 1994; Novaco & Chemtob, 2002; Thorp & Stein, 2005).

There is evidence that anger and aggression is especially closely related to combat-related PTSD (Novaco & Chemtob, 2002), but not limited to it (Feeny, Zoellner & Foa, 2000; Schützwohl & Maercker, 2000). Heightened readiness for violent behavior in turn can strongly interfere with employment and marriage, as well as with other intimate relationships (Frueh et al, 1997). In studies conducted by Beckham et al (1997), combat veterans with PTSD reported a remarkable 110 times higher occurrence of violent behaviors during the past year versus combat veterans without PTSD (22 versus 0.2 acts).

Furthermore, the National Vietnam Veterans Readjustment Study (NVVRS) revealed that veterans with PTSD were markedly less likely to be married, and those married had significantly higher rates of marital problems and divorce compared to veterans without PTSD. Most strikingly, one half of male veterans diagnosed with PTSD had been arrested or jailed more than once and 35% were homeless or vagrant (Kulka et al, 1990, as cited in Thorp & Stein, 2005).

3.3 Etiological models

Various biological, psychological and social factors are considered in explaining the development and maintenance of PTSD symptoms. Complementing the outline on risk factors in CHAPTER 3.2.3, we start this section by delineating etiological models that provide explanations on symptoms of hyperarousal and active avoidance. Next, we proceed to the more complex issue of understanding traumatic memories and mechanisms underlying the specific features of flashbacks. Then we summarize cognitive and integrative models on the etiology of PTSD. At the end of this section, we recap the major conclusions for understanding spontaneous recovery and treatment.

3.3.1 Understanding symptoms of hyperarousal and active avoidance

3.3.1.1 Acute and chronic stress reaction

Symptoms of hyperarousal are overall considered a consequence of an acute and chronic general stress reaction ('fight or flight response' and 'general adaptation syndrome'), which are generally characterized by an increased physiological arousal.

Both, 'fight or flight reaction' and 'general adaptation syndrome' (Selye, 1950), are biological mechanisms that promote coping with a variety of stressors. The 'fight or flight reaction' involves increased activity of the sympathetic nervous system (SNS). The release of neurotransmitters (most importantly adrenaline and noradrenaline) leads to a general activation of the organism. Accelerated heart rate, increased blood pressure, increased muscle tonus and other sympathetic responses prepare the organism for increased performance in the face of immediate threat. A second major system, the hypothalamic-pituitary-adrenocortical-axis (HPA-axis) relates to the 'general adaptation syndrome', which is considered a longer lasting reaction to a stressful environment.

Several biological alterations that correspond to the above outlined systems have been found to distinguish patients with PTSD from controls. These abnormalities include a more active sympathetic nervous system, as well as distinctly altered HPA and serotonergic systems (Friedman, 2001a; Friedman, 2001b; Yehuda, 2001; Flatten, Hofman, Galley and Liebermann, 2001). Furthermore, the sensitivity of the stress system to trauma associated stimuli has been shown to be distinctly heightened in individuals with PTSD (Flatten, Schiepek, Hansch, Perlitz & Petzold, 2003; Vasterling, 2007).

3.3.1.2 Application of learning theories

Symptoms of active avoidance are mostly explained in terms of the basic behaviorist paradigms of classical and operant conditioning. According to learning theories, the explanation goes as follows: through classical conditioning, once neutral stimuli that were perceived shortly before or during the traumatic event, acquire a highly aversive quality to the traumatized person. In the language of this model, they become conditioned stimuli (CS) with the capacity to evoke reactions similar to the real threat (US). In the case of a rape, for example, the look and smell of the rapist, as well as associated light conditions and noises etc., would all become stimuli that can trigger intense fear in the victim. In the following second phase of avoidance conditioning, the traumatized person learns to

reduce fear and unpleasant arousal by avoiding stimuli that are related to the traumatic events. This might include avoiding certain places, activities and even thoughts. While early learning theories hypothesize that the 'reduction of fear' reinforces and thus maintains avoidance behavior, later learning theories place more emphasis on the operation of expectations in explaining avoidance behavior (Margraf, 1996a).

3.3.2 Understanding flashbacks and traumatic memory

The paradigms of classical and operant conditioning, together with later cognitive learning theories, provide reasonable explanations for most symptoms of avoidance (except symptoms of passive avoidance, which are better explained by cognitive theories outlined further below). They are also instrumental in elucidating the etiology of most symptoms of re-experiencing. The symptoms most difficult to explain, however, are flashbacks and specifics of traumatic memory. Several models have been developed to address these puzzles. Below, we delineate the ones that are most relevant to the subject of this thesis.

3.3.2.1 'Hot/cool system view' and biological correlates

The theory of 'hot' versus 'cool' memory systems (Metcalfe & Jacobs, 1996) provides a plausible model explaining the occurrence and quality of flashbacks. It focuses on two cerebral subsystems considered crucial for memory and learning: the hippocampus (cool system) and the amygdala (hot system). The hippocampus is thought responsible for the encoding of events in a well-elaborated spatial and temporal context. Its corresponding 'cool' memory system is regarded as being complex, emotionally neutral, well organized and subject to control processes. As a result, cool-system memories can be retrieved willingly. In contrast, the 'hot' system related to the amygdala is deemed responsible for storing emotional and sensory memories. It is regarded as quick, highly emotional, fragmentary and stimulus driven. Consequently, hot-system memories are involuntarily triggered by external or internal cues (Metcalfe & Jacobs, 1996).

A crucial point for understanding traumatic memories according to the 'hot/cool system view' is that hippocampus and amygdala respond differently to increasing levels of stress. While the amygdala raises its activity with increasing stress in a rather linear way, the hippocampus appears to raise and then reduce its activity similarly to the curve of the Yerkes-Dodson Law (Metcalfe & Jacobs, 1996; Brewin, 2001a; Brewin, 2001b). This

implies that at levels of traumatic stress the hippocampus is largely dysfunctional while the amygdala is extremely active (see figure 1).

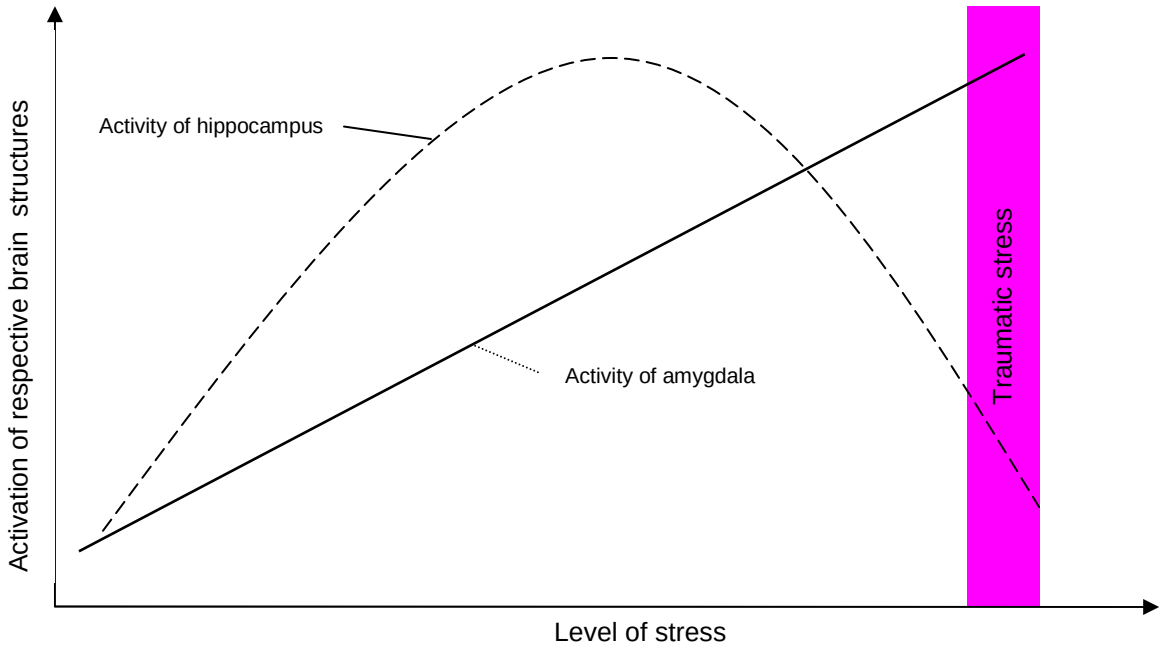

Figure 1: Activity of Hippocampus and Amygdala at Different Levels of Stress

The assumption of an extreme activation of the amygdala and a corresponding low activity of the hippocampus during traumatic exposure renders some frequent and puzzling posttraumatic symptoms plausible and understandable. Table 1 summarizes the most important of them:

Table 1: Qualities of 'Cold' and 'Hot' Memories and Posttraumatic Symptoms

Cold system memories (hippocampus)	Hot system memories (amygdala)	Posttraumatic symptoms explained
Unemotional	Highly emotional and sensory	Symptoms of re-experiencing are usually accompanied by strong emotions and sensory perceptions
Well elaborated	Fragmentary	Clients with PTSD are often confused about the sequence of the event and frequently can't recall parts of the incident
No specific focus on emotionally relevant stimuli, but rather comprehensive storage of events	Focus on emotionally relevant stimuli, especially those that indicate danger ('weapon focusing')	Clients with PTSD vividly recall stimuli that have special emotional relevance (hot spots); at the same time they are often amnestic for other important details of the traumatic situation
Embedded in the context of time and space	Not embedded in the context of time and space	"Here and now quality" of flashbacks
Retrievable at will	Triggered involuntarily by internal and external stimuli associated with cues perceived in the traumatic situation	High occurrence of symptoms of re-experiencing; emotions can change drastically without 'understandable' reason, as clients are often not aware of the triggers.
Controlled and comparably slow	Uncontrolled and quick	Triggering of sudden and strong emotional and behavioral responses, especially in clients with severe PTSD

The hot/cool system view is backed by extensive neurobiological research (LeDoux, 2002; Debiec & LeDoux, 2004) and further buttressed by the plausible assumption that such dual system provides a survival benefit for the species. As biological and evolutionary arguments are especially relevant to understanding the intercultural applicability of the PTSD construct, it is worth examining these issues further.

3.3.2.2 An evolutionary perspective on fear learning and PTSD

From an evolutionary viewpoint, the device of two memory systems (hot/cool) provides a 'learning program' that is able to condition and store immediate responses to new survival threats in one single go, thus complementing Seligman's well-known specific 'preparedness' to develop fear responses towards certain natural threats, like snakes and spiders (Davey, 1995). This perspective elucidates the crucial value of the hot memory system, which in situations of everyday life (in a peaceful environment) often causes seemingly useless or even detrimental overreactions.

Interestingly, the early stages of research that finally lead to the above-outlined understanding of two distinct but interacting memory systems, involved extensive studies on fear conditioning with rats. In many years of research, LeDoux and colleagues have not only identified brain structures that are most relevant to the involved processes, like

the amygdala and the hippocampus. They have also discovered neuronal pathways that explain quick responses occurring without or with little cortical involvement. In this context, they distinguish a slow 'cortical pathway' from a fast 'thalamic pathway' (LeDoux, 2002, Debiec and LeDoux, 2004). The slow cortical pathway leads from the sensory organs via the thalamus to cortical regions and then to the amygdala. It thus conveys a rather complex representation of the situation based on cortical computations before a reaction is initiated. The fast thalamic pathway, in contrast, provides a shortcut that communicates rather imprecise but fast information from the senses to thalamus and then directly to the amygdala, excluding cortical processing. This 'fast connection' from thalamus to amygdala explains very sudden, strong and 'unintended' emotional responses. The value of the fast, but imprecise thalamic pathway, must be seen in its survival benefit: when confronted with a potential lethal threat, milliseconds can decide over life and death.

Debiec and LeDoux (2004) argue that basic principles of learning, such as fear conditioning, are relevant to PTSD. The most important aspects of fear learning as outlined by Debiec and LeDoux (2004, esp. p. 809) can be summarized as follows: (1) Fear conditioning occurs quickly. A single CS-US pairing is often enough to establish a memory. (2) Once acquired, the emotional memory remains accessible throughout lifetime. (3) Responses to stimuli previously associated with physical harm usually weaken after further learning experiences that indicate the stimulus is no longer associated with threat. However, even if this change at times appears to be an 'extinction' of memory, evidence suggests that a weakened response to these stimuli is the result of the brain controlling the fear rather than an elimination of memory (LeDoux, 2002). The learned US – CR association can be reactivated by further stressful events, even years after it has seemingly vanished.

The above three points - even if primarily meant to describe fear conditioning in animals – have considerable explanatory value for the longitudinal course of PTSD. In particular, they elucidate the often-observed new occurrence of symptoms, even years after successful treatment or spontaneous remission.

3.3.3 Integrative models

Brewin, Dalgleish and Joseph (1996, as cited in Brewin, 2001b) have brought forward a conceptualization similar to the above-outlined 'hot/cool system view'. In their 'dual representation theory of posttraumatic stress disorder', they have presented a cognitive neuroscience account of PTSD and have postulated two distinct types of memory: a

‘verbally accessible memory’ (VAM) system, which is well integrated into other autobiographical memories and can be deliberately retrieved as required; and a ‘situationally accessible memory’ (SAM) system, which is ever involuntarily triggered by situational reminders of the trauma and therefore held responsible for flashbacks (Brewin, 2001a; Brewin, 2001b).

Foa and Kozak (1986) explain flashbacks as a result of trauma induced changes in memory structures. Consistent with the above-outlined theories, their cognitive model postulates a fear structure containing information on stimuli, emotional meaning, and physiological responses. Stimuli in such fear structure are typically cues that were perceived by the traumatized person shortly before or during the traumatic event (e.g. acoustic, visual, olfactory perceptions and proprioception). Emotional meaning characteristically includes some sense of threat, but can also incorporate a range of other emotions like guilt, shame, and anger. Physiological responses commonly comprise of signs of a general physiological activation (fast heartbeat and accelerated breath, sweat, etc.). According to this model, the triggering of any of the elements can cause the activation of the entire fear structure.

In their ‘cognitive action theory of PTSD’, Chemtob, Roitblatt, Hamada, Carlson and Twentyman (1988) have conceptualized PTSD symptoms as a context-inappropriate activation of ‘survival-mode’ functioning. Based on extensive research and clinical experience with Vietnam combat veterans, they suggest that many of the typical features of PTSD (e.g. increased physiological arousal, narrow focusing of attention on signs of danger, confirmation bias) were adaptive in combat situations, although they are often highly dysfunctional in civilian life. Conceptualizing this idea in propositional networks, they postulate that a PTSD network is characterized by a threat-arousal node with a markedly lowered threshold of activation. The activation of the threat-arousal node would in turn inhibit alternative modes of information processing, with characteristic cognitive, emotional and behavioral consequences.

Ehlers and Clark (2000) presented another elaborate cognitive model of posttraumatic stress disorder, in which they suggest that PTSD becomes persistent in individuals who process the traumatic event in a way that leads to a sense of serious, current threat. This sense of continued threat is, according to Ehlers and Clark, a consequence of (1) excessive negative appraisals of the trauma and its consequences and (2) a disturbance of autobiographical memory characterized by poor elaboration, contextualization, as well as strong associative memory and perceptual priming.

Examples for negative appraisals on the event itself would be “I attract disaster” or “bad things always happen to me”. Negative appraisals of the sequelae include the appraisals of PTSD symptoms (e.g. “I’m going mad”), of social support from family and friend (“they don’t care”) or emotional responses (e.g. “It was my fault” leading to feelings of guilt). Regarding the memory of the traumatic event, Ehlers and Clark integrate Brewin’s (1996) concept of dual representation. Furthermore, in keeping with Foa and Kozak (1986), they propose that in persistent PTSD, S-S and S-R associations are particularly strong for traumatic material. Strong perceptual priming for stimuli that were temporally associated with the traumatic event, including a reduced perceptual threshold for these stimuli and poor stimulus discrimination are further factors held responsible for the frequent triggering of reexperiencing symptoms.

Ehlers and Clark (2000) suggest that PTSD symptoms are often maintained by dysfunctional cognitive and behavioral strategies that prevent changes in negative appraisals and trauma memory. Examples for such strategies are thought suppression, safety behaviors and avoiding reminders of the trauma.

Apart from the above outlined models that have meanwhile been subjected to substantial empirical research, other ideas on factors maintaining or preventing posttraumatic stress disorder do exist. Victor Frankl (1963) has early introduced the idea that finding meaning in horrible experiences might support recovery from the adverse sequelae. Despite the appealing character of theories that attempt accounting for the human desire to understand and make sense of experiences, there are so far only few rigorous empirical studies in this field (Updegraff, Silver & Holman, 2008). Antonovsky (1979, as cited in Bengel, Strittmatter & Willmann, 2000) asserts that a sense of coherence, including its three facets (comprehensibility, manageability, meaningfulness), plays a crucial role in maintaining mental health in the face of traumatic adversity. Although the empirical underpinning of Antonovsky’s model so far appears weak, this does not necessarily devalidate its assumptions (Bengel et al, 2000; Maercker, 2003b). Janoff-Bulman (1992) argues that considerable distress in the aftermath of trauma is caused through dramatic changes in basic assumptions of traumatized persons about the world. While according to Janoff-Bulman people usually believe that the world is benevolent, predictable, and meaningful and that self is worthy, such positive assumptions are often shattered after trauma.

3.3.4 Implications for recovery and treatment

The above-delineated etiological models do not only make sense of the phenomenology of posttraumatic stress disorder, but also provide a framework for understanding spontaneous recovery. Further, they suggest general strategies for treatment.

Mostly, initial symptoms of posttraumatic stress after a traumatic event can be understood as a normal reaction to an abnormal event. Commonly, when safety resumes, posttraumatic stress reactions remit with time, often within days. With regard to this process, Brewin (2001a; 2001b) postulates, that intrusive recollections operate to transfer information from the 'situationally accessible memory' (SAM) system to the 'verbally accessible memory' (VAM) system. This process strengthens voluntary routes of retrieval and impedes involuntary triggering of memories with 'here and now' qualities.

Foa and Riggs (1995) suggest that emotional processing with consequent changes in the fear-structure is the key to symptomatic improvement. For favorable changes to occur, they hypothesize that two conditions must be met: First, the fear structure must be fully activated (including emotional responses), and second, new information that is incompatible with the fear structure must be introduced. Foa and Riggs (1995) underline that repeated activation of the fear structure and simultaneous introduction of new information is needed for effective changes to occur. This can happen spontaneously or in psychotherapy. Foa, Zoellner & Alvares (1999) highlight, that in the process of therapy symptoms of PTSD reduce when the narrative on the traumatic event becomes more coherent and organized.

Ehlers and Clark propose two major conditions for symptomatic improvement. First, "the trauma memory needs to be elaborated and integrated into the individual's preceding and subsequent experience in order to reduce intrusive reexperiencing." (Ehlers and Clark, 2000, p. 335). Second, problematic appraisals of the trauma and its sequelae need to be changed.

Overall, the various etiological models outlined above suggest similar processes underlying spontaneous recovery: The traumatic memories are processed emotionally and cognitively in a way that they are integrated into autobiographical memory, including its spatial and temporal context. Symptoms of avoidance, including passive symptoms like numbing and dissociation are suspected to hinder such processing and prevent spontaneous recovery. Further, problematic interpretations of the trauma and its consequences are thought to increase avoidance and exacerbate symptoms. Hence, any treatment of PTSD should tackle at least two major issues: (1) facilitate the elaboration

and integration of traumatic memories and (2) address the dimension of meaning by correcting problematic interpretations of the traumatic event and its sequelae.

4 Other disorders related to traumatic stress

Above we have delineated the concept of PTSD, including its epidemiology and posited etiology. Although the PTSD concept has clearly triggered most research on traumatic stress and has stimulated much of the development of effective treatment approaches, there are still other diagnostic concepts that reflect the potential impact of trauma and merit consideration. To complement the above descriptions, we below look at the diagnosis of acute stress disorder, the concept of complex PTSD, and disorders frequently comorbid with PTSD.

4.1 Acute stress disorder

The diagnosis of an acute stress disorder (ASD) was (re-) introduced in the DSM-IV to capture the immediate sequelae of trauma (Friedman, 2001a). According to DSM IV, ASD can only be diagnosed after a set of symptoms has lasted for at least two days and maximally four weeks; after this period, the diagnosis of PTSD can be considered. The symptoms of ASD largely overlap with those of PTSD. However, ASD has a markedly stronger emphasis on dissociative symptoms, while requiring only one symptom of the classical PTSD symptom clusters (re-experiencing, avoidance/numbing and hyperarousal) respectively to be met. The diagnosis of ASD requires at least three of the following dissociative symptoms:

1) A subjective sense of numbing, detachment, or absence of emotional reaction
2) A reduction of awareness of his or her reactions (e.g. “being in a daze”)
3) Derealization
4) Depersonalization

5) Dissociative amnesia (i.e., inability to recall an important aspect of the trauma)

The diagnosis has been included in the DSM to promote early recognition and treatment of severe and impairing stress reactions in the first month after traumatic exposure, assuming that ASD diagnosis would predict subsequent PTSD. Yet its empirical underpinning, especially the supposed predictive value of the dissociative symptoms for the later development of PTSD has been questioned (McNally, Bryant & Ehlers, 2003; Zoellner, Jaycox, Watlington & Foa, 2003).

4.2 Complex PTSD

For more than a decade, clinicians have voiced the need for a diagnostic concept reflecting the aftermath of trauma beyond the notion of a 'simple' PTSD. One of the most outstanding proponents of a wider diagnostic concept capturing the consequences of trauma is Judith Herman.

Building on the distinction between Type I and Type II traumata (Terr, 1991), Herman (1992) argues that the diagnostic criteria of PTSD are mainly derived from research on survivors of circumscribed single traumatic events (Type I trauma). Findings from research on the effects of traffic accidents, short-term disasters, rape, and combat would however fail to capture the more complex consequences of protracted abuse and trauma, like long-term sexual and physical abuse in childhood and repeated torture during political imprisonment (Type II trauma). To fill this void Herman (1992, p. 119) put forward the notion of a "complex posttraumatic stress disorder". She thus suggested a new diagnostic category meant to reflect the effects of prolonged and repeated trauma.

The proposed new diagnosis was considered for inclusion in the current (fourth) edition of the DSM under the label of "disorder of extreme stress not otherwise classified" (DESNOS). The notion of 'DESNOS' or 'complex PTSD' includes the following criteria (van der Kolk, 2002, p.135):

1. Impairment of affect regulation
2. Chronic destructive behavior (self-mutilation, eating disorders, drug abuse, etc.
3. Amnesia and dissociation
4. Somatization

5. Alterations in relationship to self
6. Distorted relations with others
7. Loss of sustaining beliefs

Although DESNOS was finally not approved as an official diagnostic category for inclusion in the DSM-IV, there is still quite some discussion on whether or not the diagnosis of PTSD is sufficient to meet clinical needs. After all, the proponents of an additional category bring forth arguments invoking significant treatment implications for disorders of extreme stress. Van der Kolk (2002) argues that – while patients with 'simple' PTSD might in fact respond well to exposure treatment – patients with DESNOS often do not and may even be harmed by it. If the proposed new category has such important implications for treatment, so the argument, it is well worth to be considered.

The official position of the American Psychiatric Association (APA), reflected in the DSM IV, also bears some logic. It is argued that the differential validity of DESNOS has so far been found insufficient in field trials. 92% of the persons who met the criteria for DESNOS also met the criteria for PTSD (Marsella et al, 1996b). It would therefore be more appropriate to establish the diagnosis of PTSD first and then check for frequent comorbid disorders and other problems that are often associated with posttraumatic stress disorder. Thus, all relevant information could be considered in setting up a treatment plan.

Going into further details of this discussion is beyond the scope of this thesis. For our sake, it should suffice to state that the concept of PTSD is still being vigorously discussed and challenged; and that this is already the case when it comes to its application in Western industrialized countries. Further, it is interesting to note that concepts putting more emphasis on symptoms of dissociation, somatization and on the impact of trauma on social relationships (like 'complex PTSD' or DESNOS) play a major role in the debate.

4.3 Disorders frequently comorbid with PTSD

People with chronic PTSD are likely to suffer from other psychological disorders at the same time. In the National Comorbidity Study (Kessler, et al, 1995), 80% of persons who had ever suffered from PTSD met the criteria for at least one other diagnosis. The most frequent coexisting disorders included drug abuse or dependence (including alcohol), major depression and dysthymia, anxiety disorders (social phobia, simple phobia,

generalized anxiety disorder, agoraphobia, and panic disorder) and conduct disorders. While men had a stronger tendency to develop dependencies on drugs and conduct disorders, the prevalence of comorbid anxiety disorders was higher among women.

Other authors add somatoform and dissociative disorders to the list of diagnoses comorbid with PTSD, pointing out that up to 80% of women with somatization disorders report a history of sexual abuse (Siol, Flatten & Wöller, 2001). Dissociation and borderline personality disorder are related to sexual and physical abuse, especially during childhood (Fiedler, 1995). Finally, people with PTSD are more vulnerable to somatic illnesses, especially disorders affecting cardiovascular, gastrointestinal and endocrinological systems (Schurr, 1996; Friedman, 2001a).

A closer look at the criteria for different disorders in the DSM and the ICD show that the high co-morbidity rates of PTSD (especially with anxiety disorders and depression) can partly be explained as an artifact based on overlapping diagnostic criteria. Nevertheless, there is ample evidence that PTSD, while certainly the most common disorder following traumatic exposure, is rarely the only consequence of extreme stress. The potential psychological sequelae of trauma have been shown to be wide and can be fully captured neither by a single diagnosis nor by any combination of them. However, it is important to consider that the purpose of diagnostic categories is not to be all-inclusive. Instead, diagnoses should serve practical purposes, such as helping clients to access effective treatment or promoting research that eventually works towards achieving the same end of relieving suffering.

Closing this chapter, we note that exposure to traumatic stress is not only related to disorders and dysfunction, but has also been related to positive changes summarized under the term of posttraumatic growth (Tedeschi & Calhoun, 2004; Turner de & Cox, 2004). However, as Maercker and Zöllner (2004) conceptzualize in their Janus-face model, posttraumatic growth includes both a constructive and an illusory, self-deceptive side. This ambiguous nature of the concept might explain the so far inconsistent empirical findings on the releationship between posttraumatic growth and posttraumatic adjustment (Wagner, Forstmeier & Maercker, 2007). While persons who have experienced more severe trauma tend to perceive more positive posttraumatic changes than persons exposed to less severe traumatic events, such perception might not reduce the psychopathological late sequelae (Maercker & Herrle, 2003; Zöllner, Rabe, Karl & Maercker, 2008).

5 Early intervention

The topic of early psychological intervention after trauma has gained much attention during the last decade, not only in professional circles but also in the media. This heightened interest went with social dynamics following the inclusion of PTSD in the DSM, which also included popular 'victim' movements demanding more support to concerned individuals and groups in the aftermath of trauma (Raphael & Dobson, 2001). The widespread coverage and dissemination of knowledge on the psychological sequelae of trauma and claims that effective interventions are available to reduce the suffering of survivors has brought about a "change of culture" (Raphael & Dobson, 2001, p. 139). While previous lay views typically held that "such matters should not be talked about, that it would be better to put what happened 'behind you' and to try 'forget about it'" (Raphael & Dobson, 2001, p. 139), the opinion that 'debriefing' or 'trauma counseling' should be made available to survivors increasingly gained public support. Unfortunately, whether and when talking about the trauma is beneficial to survivors is not yet as clear as early enthusiastic reports on debriefing and other psychological interventions have suggested.

In the following, we provide an overview on the main approaches to early intervention after trauma: Frontline treatment, psychological debriefing, psychological first aid and and early interventions with cognitive behavioral approaches. Common to them is the aim of reducing psychological suffering in the early aftermath of trauma and preventing debilitating long-term sequelae.

5.1 Frontline treatment

Early intervention for survivors of traumatic events has a comparably long history in the military. As acute combat stress reactions were often threatening unit strength and military functioning, principles for early treatment or prevention of further dysfunction among

soldiers were already introduced during the First World War (Cozza, 2005). The PIE-model has since then played an important role in frontline treatment. The acronym PIE, standing for **p**roximity, **i**mmediacy and **e**xpectation, summarizes the approach.

Procedure

Soldiers were supposed to be treated as close to the frontline as possible, however being in a safe place. The principle of immediacy proposed prompt intervention after combat or the showing up of an acute combat stress reaction, without allowing much time to pass. Expectancy denotes that the soldier had to expect to soon return to combat, since the stress reaction was framed as a 'normal condition' of 'combat exhaustion' that would soon remit. The content of PIE treatments can vary from most simple interventions known as 'chicken soup' treatment to treatment that is more sophisticated (Shalev, 2002). Yet an emphasis is commonly placed on relatively basic interventions (shelter, food, drinks, rest, peer support, positive regard, and the opportunity to ventilate emotions).

Empirical support

Solomon and Benbenishty (1986) reported positive effects of PIE interventions with Israeli soldiers in the Lebanon War. According to their interpretation of data, frontline treatment resulted in a higher rate of return to the military unit after treatment and lower rates of PTSD. A reexamination of available studies on PIE, however, suggests that its effectiveness might have been overstated and methodological concerns have been raised. Some authors utter suspicion that PIE might serve the interest of the military rather than the needs of the individual soldiers (Jones and Wessely, 2003; Cozza, 2005). Overall, it can be stated that the effectiveness of PIE practice has not yet been convincingly proved, although it is still valued and used in the military (cf. Wothe & Siepmann, 2003).

5.2 Psychological debriefing

The supposedly successful use of the PIE model in the military encouraged the use of similar interventions with civilians. Mitchell (1983) pioneered in this field by developing Critical Incident Stress Debriefing (CISD) to mitigate stress reactions among firefighters, police officers and emergency medical staff. Mitchell's approach has later on been taken up and slightly modified by Dyregrov (1989). In practice, various interventions described as debriefing are offered to trauma survivors in different fields, locations and times after

the trauma (Perren-Klingler, 2000). Sometimes, interventions share only some elements with CISD or psychological debriefing in its original form (van Emmerik et al, 2002).

Procedure

Psychological debriefing is mostly conducted in groups between two and ten days after a critical incident (McNally et al, 2003). Meta-analysis and reviews on psychological debriefing have usually considered interventions that were carried out in the first month (Emmerik, 2002). To illustrate the procedure, we give a brief description of psychological debriefing (PD) according to Dyregrov (1989). Psychological debriefing, like the 'Mitchell model', consists of seven distinct phases (Mitchell, 1983; Dyregrov, 1989; Bisson, et al, 2000,):

In the first phase, the debriefer(s) introduces the purpose and procedure of the exercise, which is mainly seen in reviewing the reactions of participants to the trauma and discuss methods of dealing with them in order to prevent future problems. The second phase focuses on expectations before the event and collecting the facts on what happened during the incident. Participants are prompted to think about whether they had expected what happened. They are then facilitated in gathering the very facts of what occurred during the incident. Each participant is encouraged (but not forced) to describe the incident from his or her perspective. Third, after having described the factual event, thoughts and sensory impressions (e.g. what had been seen, heard, smelled, etc.) during the incident are elicited. This leads to the fourth phase, in which emotional reactions are the focus of attention. At this stage, the debriefer encourages the participants to express and release their emotions. This is done by prompting with questions concerning frequent distressing emotions such as fear, helplessness and frustration or by asking for the 'worst part' of the event. Emotions that some participants might have experienced since the traumatic event had passed, such as anxiety, anger, guilt and depression are also elicited, as well as emotions during the debriefing itself. In the fifth phase, the debriefer 'normalizes' the previously expressed reactions by stating that they are 'normal' responses to an 'abnormal' event. Some frequent posttraumatic reactions which might occur in future, such as some typical symptoms of PTSD are also discussed. The sixth phase addresses issues of future planning and coping. The beneficial effect of discussing feelings with friends and family is emphasized along with other coping strategies. In a final phase, the debriefer summarizes what has been covered during the session and distributes printed material on normal human responses to traumatic events, which suggest that symptoms usually remit within weeks. Participants are encouraged to seek professional assistance if this does not occur in their specific case.

Empirical support

Although the above procedure would appear reasonable and promising to most clinicians, its efficacy has not been proven so far (Gray, Litz & Maguen, 2004). While most participants of group or individual debriefings subjectively perceive it as helpful in overcoming their traumatic experiences, randomized controlled trials on the effects of debriefing do not support the same conclusion. Overall, meta-analysis and reviews suggest that debriefing has no efficacy in reducing or preventing symptoms of posttraumatic stress disorder and other trauma-related symptoms (Bisson et al, 2000; Lewis, 2003; McNally et al, 2003; Ruzek, 2001; Shalev, 2002; van Emmerik, 2002). Some of the methodologically strongest studies have even found adverse effects of debriefing. Mayou, Ehlers & Hobbs (2000) conducted a randomized controlled trial (RCT) with survivors of traffic accidents. In this study, the debriefed group had a significantly worse outcome 3 years after the intervention evidenced on several measures, like general psychiatric symptoms, travel anxiety, pain, physical problems, and overall measures of functioning. The authors of the sudy concluded that psychological debriefing has adverse long-term effects.

However, the International Society for Traumatic Stress Studies (ISTTS) considers it premature “to conclude that psychological debriefing should be discontinued as a possible intervention following trauma” (Bisson et al, 2000, p.55). Bisson et al (2000) further specultate that there might be benefits of aspects of psychological debriefing (PD), especially when employed as part of a comprehensive stress management program, in contrast to one-shot interventions that have been evaluated. The ISTTS recommends that

> “ … if PD or any similar intervention is to be employed, it should be provided by experienced, well-trained practitioners, should not be mandatory, and potential participants should be properly clinically assessed. If employed, the intervention should be accompanied by clear and objective evaluation procedures to ensure meeting the objectives set for it.” (Bisson et al, 2000, p.55).

Following the empirical evidence that psychological debriefing has the potential to do harm, several possible explanations have been brought forward. Generally, psychological debriefing is suspected to interfere with natural processes of healing (McNally et al, 2003; Van Emmerik, 2002). More specifically, one hypothesis refers to studies according to which heightened autonomic arousal in the first days following the traumatic event was associated with a greater likelihood for developing long-term posttraumatic symptoms. Psychological debriefing, so the suggestion, might interfere with the decrease of autonomic arousal after the event (Ruzek, 2001). In line with this argument, it has also been speculated that the intense exposure caused by PD might be re-traumatizing for

certain individuals, not allowing sufficient time to habituate (Bisson et al, 2000). In a more recent review, Gray and Litz (2005) conclude that taken together, empirical evidence neither supports assertions that critical incident stress debriefing or psychological debriefing promote posttraumatic adjustment, nor that they are generally harmful.

5.3 Psychological first aid

As a reaction to the disappointing results of early interventions related to psychological debriefing, experts have increasingly recommended responding to survivors' needs in the aftermath of trauma with more flexible and less specific interventions. Psychological first aid, in line with this recommendation, aims at meeting the needs and priorities of survivors, rather than pretending to know what exactly is best for them. Furthermore, it builds on empirical knowledge of risk factors for PTSD and therefore recommends providing practical help as well as promoting social support (Gray, Litz & Maguen, 2004).

Procedure

The National Center for PTSD and National Child Traumatic Stress Network (2006) have published a field operations guide on psychological first aid that describes the following core actions: The first core action, *contact and engagement,* aims at establishing contact to survivors in a non-intrusive and helpful manner. The second, *safety and comfort,* is meant to enhance safety and provide physical and emotional comfort. Apart from ensuring immediate physical safety as much as possible in a given situation, emphasis is placed on increasing a sense of predictability, comfort and safety. This is done by providing relevant information to survivors and promoting physical comfort and social engagement by practical means. Most importantly, separated families and social units are to be helped to come together as early as possible. Special attention should be given to children who are separated from their parents. Further, survivors should be protected from unnecessary exposure to additional traumatic experiences and trauma reminders. The third core action, *stabilization,* aims at calming and orienting emotionally overwhelmed and disoriented survivors, if needed. Here, the manual spells out helpful and detailed instructions on how to identify and assist people who are likely most in need of psychological support and stabilization. The fourth core action concerns the *gathering of information* to tailor later psychological first aid interventions. The manual offers several points on which the active seeking of information from survivors might be important to identify immediate needs. It

also recognizes, however, that survivors' needs and priorities might at the same time limit information gathering. The fifth core action, *practical assistance*, is seen as a central component of psychological first aid. It tries to address above identified needs and help in problem-solving. *Connection with social support* has already played a major role in increasing safety and comfort. Nevertheless, the sixth core action spells out more in detail, how social support can be enhanced in an emergency setting. Giving *information on coping*, as well as making *linkage with collaborative services* are other core actions spelled out in the manual.

Empirical support

Although the manual details reasonable suggestions on the ground of current empirical knowledge, empirical evidence that psychological first aid is helpful in the aftermath of disasters is still outstanding. Core issues to be considered when evaluating the new approach, such as specifying interventions and outcomes, are discussed by Ruzek, Brymer, Jacobs, Layne, Vernberg & Watson (2007).

5.4 Early intervention with cognitive behavioral approaches

In contrast to psychological debriefing and psychological first aid, cognitive behavioral therapy (CBT) has mostly focused on individual treatment. Further, CBT was usually not implemented as a single-time intervention. Instead, it commonly comprised of approximately four sessions, often addressing clinical symptoms of ASD or acute PTSD.

Procedure

Treatments included typical cognitive-behavioral interventions, such as education about trauma symptoms, training in relaxation skills, exposure to the traumatic event *in sensu*, *in vivo* exposure to avoided situations associated with the trauma and cognitive restructuring. All these are typical interventions for treating PTSD, which will be described in more detail further below.

Empirical support

McNally, Bryant and Ehlers (2003) provide a good review of the relevant studies on the efficacy of cognitive behavioral interventions in the acute posttraumatic phase. Similarly to

psychological debriefing, some early attempts to apply CBT in the first weeks following trauma failed to prove its superiority over natural recovery. Although more recent studies suggest that CBT may be effective, even in the first month, the evidence remains mixed. Clearer evidence for the efficacy of CBT in reducing posttraumatic symptoms has been found for interventions starting from one to three months after trauma. For this span of intervention, CBT has been found superior to controls in several randomized controlled studies. Raphael and Dobson (2001) come to a similar conclusion in their review on acute posttraumatic interventions. They recognize cognitive behavioral therapy as "a basis for an acute posttrauma intervention provided in the early weeks *but not* immediately posttrauma" (Raphael & Dobson, 2001, p. 148). Ruzek (2001) also endorses the efficacy of cognitive behavioral interventions in the early aftermath of trauma, but cautions that they might not be appropriate for everyone.

> "In cases where exposure methods may be contraindicated (i.e. those experiencing extreme anxiety, suicide risk, marked ongoing stressors, or acute bereavement), other techniques, including anxiety management, supportive therapy, or pharmacological intervention may be used." (Ruzek, 2001, p.2)

All in all, our empirical knowledge on effective early interventions to prevent trauma related disorders is still limited and does not allow for clear and final conclusions on the important questions of when, with whom and how to intervene. There is however some indication that very early interventions that contain elements of exposure can be problematic.

On this ground, McNally, Bryant and Ehlers (2003, p.66) reason:

> "… Contrary to the widely held belief, pushing people to talk about their feelings and thoughts soon after the trauma may not be beneficial. Perhaps systematic exposure to trauma memories should be reserved for people who fail to recover on their own."

6 Treatment of PTSD

In contrast to early interventions after traumatic events, there is already is huge body of evidence on effective treatments for posttraumatic stress disorder. Among the various approaches, cognitive-behavioral therapies have received most research attention. The term ‘cognitive-behavioral therapy’ is often used to denote various approaches, such as exposure, systematic desensitization, stress inoculation training, cognitive processing therapy, cognitive therapy, assertiveness training and relaxation training (cf. Rothbaum et al, 2000). The various cognitive-behavioral approaches in turn often include several modules as will be seen in the descriptions further below. Their common feature is a relatively close linkage to psychological learning theories. Other approaches that have gained substantial empirical support are eye movement desensitization and reprocessing, usually referred to as EMDR (Chembtob et al, 2000), psychodynamic therapy (Kudler et al, 2000; Flatten, Wöller and Hofmann, 2001) and pharmacotherapy (Friedman et al, 2000). Various other approaches have so far received comparably little research attention. Among them are hypnosis (Cardeňa, Maldonado, van der Hart & Spiegel, 2000), resource oriented imaginary (Reddemann, 2001), marital and family therapy (Riggs, 2000a; 2000b), group therapy (Foy et al., 2000) and creative therapies (Johnson, 2000).

The following gives an outline on the most relevant treatment approaches. Before describing treatments that have received most substantial empirical support for their efficacy, we discuss general treatment issues that cut across different approaches. Subsequently, we describe exposure therapies, cognitive therapies, eye movement desensitization and reprocessing (EMDR) and anxiety management. Finally, some contentious issues and limits to our current knowledge will be highlighted.

6.1 General treatment issues

Several issues cut across different approaches. One of the most fundamental points is the establishing of a good treatment relationship. An atmosphere of trust and safety within the therapy is considered the base for any further specific intervention. This is especially true for the emotionally most demanding elements of treatment, such as exposure to past traumatic material. In line with this argument, most clinicians agree that PTSD therapy includes three (or at least two) subsequent stages (cf. Herman, 1992; Friedman, 2001a; Flatten, Wöller & Hofmann, 2001):

In the first stage, the primary aim is to establish a safe and trustful treatment relationship and help the client gain increased control over their emotional reactions. Considering that man-made traumata have a high potential to disrupt a person's capacity to engage in trustful relationships, this can already pose a therapeutic challenge. Stabilizing interventions that support clients in their efforts to cope and solve problems concerning their present lives are paramount in this stage. Such interventions include psycho-education on PTSD and related symptoms, client-centered responses conveying empathy, positive regard and emotional support, resource-oriented interventions, relaxation training, anxiety management and stabilizing imaginary (cf. Reddemann, 2001).

The second stage of therapy aims at 'working through' the past trauma. This 'working through' or 'exposure' is demanding for clients (and therapists) and therefore requires good abilities of the client to regulate intense emotions, apart from a stable and trusting relationship to the therapist. Further, the physical safety of the client is of principal importance. A woman, for example, who is still living with a physically abusive partner, first needs to get to a safe place to stay before exposure treatment can be initiated. A history of psychosis considered a contraindication for exposure (Ehlers, 1999). Strong tendencies to dissociate, auto-aggressive behavior, suicidal ideation, explosive anger, as well as drug abuse and other comorbid disorders need to be considered in the treatment plan and adequately addressed before commencing exposure treatment (McFarlane, Golier & Yehuda, 2002; Shalev, Friedman, Foa & Keane, 2000).

In the third stage, the stage of 'integration', the emphasis is again on finding a practical ways forward in daily life, rather than on intrapersonal processes. This can mean looking at new perspectives concerning profession, family life, friends and society. (As shall be described further below, cognitive behavioral therapies typically don't distinguish stages two and three, but address the included contents simultaneously.)

It is widely acknowledged that exposure or 'working through' is a key ingredient in trauma therapy. On the other hand, it is also important to be aware that "trauma-focused treatment is not necessarily the treatment of choice for everyone" (Shalev, Friedman, Foa & Keane, 2000, p.377). According to experts in the field,

> "… PTSD treatments that deliberately avoid traumatic material to promote problem solving and adaptive coping in a here-and-now context may not only be beneficial, but may actually be the treatment of choice for some with PTSD." (Friedman, 2001a).

6.2 Exposure

Exposure has been successfully used in treating various anxiety disorders long before PTSD was introduced in the DSM (Rothbaum & Foa, 1999). Specific procedures differ in intensity of exposure and corresponding arousal, as well as in duration. Concerning the intensity of exposure, the two extremes of high and low levels of aroused anxiety are marked by systematic desensitization and 'intensive exposure' (flooding, implosion). Furthermore, exposure can be carried out *in sensu* (narrating and imagining the traumatic event) or *in vivo* (confronting the feared stimuli in real-life situations).

Rationale

The rational of exposure has been derived from learning theories, according to which fears are acquired through classical conditioning and maintained through operant reinforcement of avoidance behavior (see CHAPTER 3.2). Hence, exposure is employed to counter such avoidance by systematically confronting phobic clients with the feared stimuli. Habituation, a physiological process of gradual decreasing of autonomous activation and corresponding anxiety in the face of the feared stimulus, is deemed key to therapeutic improvement in exposure therapies for anxiety disorders (Deacon & Abramowitz, 2004). The same mechanism has been posited for the treatment of posttraumatic stress disorder.

For posttraumatic stress disorder, however, additional and more specific mechanisms have been suggested. Edna Foa, a major theorist in the field of PTSD, has posited a pathological fear structure underlying PTSD symptoms (Foa & Riggs, 1995). In her emotional processing theory, she suggests that successful treatment involves correcting the pathological elements of the fear structure. This correction is possible

according to the theory, when the fear structure is activated and new information is introduced (e.g. during the reliving of the traumatic event in therapy). Several specific mechanisms involved in producing successful treatment outcomes are proposed. Rothbaum and Foa, (1999, p. 3) outline the most important mechanisms as follows:

> First, repeated imaginal reliving of the trauma is thought to promote habituation and thus reduce anxiety previously associated with the trauma memory, and correct the erroneous idea that anxiety stays forever unless avoidance or escape is realized. Second, the process of deliberately confronting the feared memory blocks negative reinforcement connected with the fear reduction following cognitive avoidance of trauma related thoughts and feelings. Third, repeated reliving of the trauma in a therapeutic, supportive setting incorporates safety information into the trauma memory, thereby helping the patient to realize that remembering the trauma is not dangerous. Fourth, focusing on the trauma memory for a prolonged period helps the patient to differentiate the trauma event from other non-traumatic events. Thus, it helps the client to view the trauma as a specific occurrence rather than as a representation of a dangerous world and of an incompetent self. Fifth, the process of reliving helps changing the meaning of PTSD symptoms from a sign of personal incompetence to a sign of mastery and courage. Sixth, prolonged, repeated reliving of the traumatic event affords the opportunity for focusing on details central to negative evaluations of themselves and modify those evaluations. The mechanisms most salient during *in vivo* exposure are the correction of erroneous probability estimates of danger and habituation of fearful responses to trauma relevant stimuli.

This authoritative description of the exposure rational shows that – apart from the physiological process of habituation - cognitive changes are seen as being crucial to successful treatment of PTSD. In practice, therefore, exposure treatment is often combined with explicit cognitive interventions.

Procedures

Systematic desensitization, on the low end of levels of aroused anxiety, combines a process of gradually increased exposure with relaxation (Rothbaum et al, 2000). The ‘screen technique’ is another method that can help clients moderating their emotional response to the rehearsed trauma. Here, the course of the trauma is viewed by the client on an imaginary screen. In imagination, various qualities of the presentation can be altered. The sound can be put off, the colors put black and white; the ‘film’ can be accelerated and viewed from a distance, while the client imagines him or herself being in a safe place (Perren-Klingler, 2000b). According to clinical experience, techniques that

help clients reduce anxiety can be helpful for those who experience high levels of anxiety before exposure or get easily overwhelmed by anxiety during the exposure. In contrast, for clients who do not engage sufficiently during the exposure, techniques aiming at intensifying the emotional engagement might be beneficial. Here, the client would be instructed to close the eyes and narrate the traumatic event in the present tense while vividly imagining what is happening. The therapist might prompt to focus on emotionally distressing details (hot spots) to increase emotional processing. Intense exposure techniques, such as flooding and implosion aim at a maximum arousal to promote habituation. As these examples show, exposure therapy can be carried out in many variations.

In a widely applied procedure, clients are encouraged to describe the relevant traumatic event aloud or go through it in imagination guided by the therapist. At the same time, attention is paid to the thoughts and feelings that occurred during the event and occur during the reliving (Jaycox, Zoellner & Foa, 2002). The procedure is typically repeated several times in one single session, until anxiety decreases. Usually, the narrative of the trauma or the whole therapy session is tape-recorded and the patient given the tape to listen to it between the sessions (self-exposure in *sensu*). Such therapeutic exposure *in sensu* is commonly complemented by exposure *in vivo*, as the therapist encourages the client to confront situations, places and activities that are associated with the trauma and have therefore been avoided since the traumatization. (Of course, exposure *in vivo* only tackles situations in which safety is warranted.)

Empirical support

The empirical evidence for the efficacy of exposure in the treatment of posttraumaic stress disorder is extensive (Najavits, 2007). Moreover, there is broad consensus that exposure is generally effective in treating most anxiety disorders, including PTSD (Newman & Stiles, 2006). The International Society of Traumatic Stress Studies (ISTSS) (Rothbaum, Meadows, Resick & Foy, 2000, p. 64 and p. 324), recommend exposure as “the first line of treatment unless reasons exist for ruling it out”. They subsume under exposure “flooding / imaginal / *in vivo* / prolonged / directed” exposure and conclude that exposure therapy (EX) is effective:

> In summary, the evidence is very compelling from many well controlled-trials with a mixed variety of trauma survivors that EX [exposure therapy] is effective. In fact, no other treatment modality has such strong evidence for its efficacy. (Rothbaum et al, 2000, p. 321).

However, it is discussed that exposure may not be equally effective for everybody (Solomon & Johnson, 2002). Rothbaum et al, (2000, p. 324) state:

> There is some preliminary evidence that EX is not effective for patients who were perpetrators of harm, especially when guilt is the primary emotion. There is also evidence that individuals whose primary emotional response is anger may not profit as much from EX as individuals whose primary emotional response is anxiety.

Although a more recent study (Stapleton, Taylor & Asmundson, 2006) suggests that anger and guilt need not be obstacles to effective exposure treatment, the above expressed reservations might still be valid to some extend.

Little is known about differences in efficacy between certain exposure techniques. Systematic desensitization, however, has proven less effective than the above-summarized exposure techniques. Outcome studies suggest that longer sessions of exposure are more effective than shorter ones and that the use of relaxation in exposure does not increase its effectiveness (Rothbaum et al, 2000). Rather new exposure techniques, such as the screen technique have not yet received sufficient research attention. Controlled studies in this field are still missing (Maercker, 2005).

6.3 Cognitive therapies

Not unlike exposure therapy, cognitive therapies have also been employed in the treatment of other disorders before they have been applied in the treatment of PTSD, especially in treating depression (Beck, Rush, Shaw & Emery, 1979; Hautzinger, 1997), anxiety disorders (Beck, 1976) and substance abuse (Beck, Wright, Newman & Liese, 1993).

Rationale

Cognitive therapies are based on the idea that the way people think about the world, other people and themselves has an important impact on their emotions and well-being. They assume that it is not the events themselves which lead to particular emotional responses, but rather subjective and at times erroneous (or at least unhelpful) interpretations of events. This postulate goes back to ancient Greek and Roman philosophy of the Stoics (Hoellen, 1992) and has been most prominently employed and further developed as ‘rational-emotive therapy’ by Albert Ellis (1982). According to cognitive theory, anxiety results from an interpretation of the world as being dangerous and threatening; anger results from and interpretation of others being unfair, etc. Cognitive theories commonly posit particular cognitive distortions underlying specific disorders. Concerning PTSD,

cognitive therapy aims at identifying trauma-related irrational or dysfunctional beliefs and thoughts in order to challenge and modify them in the course of treatment.

Consistent with a general cognitive approach, Ehlers & Clark (2000) have suggested that excessive negative appraisals of the traumatic event and its sequelae are fundamental to the development and maintenance of PTSD. At the same time, they acknowledge that the specific characteristics of the trauma memory are important. Consequently, they have developed a therapeutic procedure that includes exposure, but has an explicit focus on cognitive interventions. In this respect, the approach of Ehlers & Clark is not an exception, but instead an example of a general tendency of PTSD – treatment approaches to combine several distinguishable modules (cf. Jaycox et al, 2002; Maercker, 2005). Therefore, the distinction of 'exposure therapy', 'cognitive therapy' and 'anxiety management' is to a certain extend artificial and might, in practice, just reflect specific foci rather than 'purity' of approaches.

Procedures

In cognitive therapy of PTSD (Ehlers & Clark, 2000), a cognitive focus is followed in the assessment at the beginning of and throughout the therapy. In the course of treatment, a wide range of potentially problematic appraisals is identified and worked on. Predominant emotions, such as anger, shame, guilt and fear, are seen as important hints to cognitive themes.

Importantly, the therapeutic rationale needs to be well understood and accepted by the client before further steps can be taken in therapy. General topics of this rationale are "PTSD as a common reaction to an abnormal event", the need to elaborate the trauma memory, and dysfunctional implications of avoidance behaviors and overly negative interpretations of the trauma and it sequelae. Similar to the above-explained 'exposure', clients are encouraged to "reclaim" their lives by gradually confronting situations that have been avoided since the trauma (*in vivo* exposure). The exposure *in sensu* (reliving) is in cognitive therapy followed by the identification and discussion of problematic thoughts and beliefs associated with the trauma. Here techniques commonly used for cognitive restructuring are used (e.g. Socratic dialogue, see Ehlers, 1999 for a more detailed description). According to Ehrlers and Clark (2000), patients who are likely to require particularly extensive cognitive restructuring, "are those who (1) experience anger, guilt or shame, (2) interpret their behavior or emotions during the event as showing something negative about themselves … (3) experienced violence over a prolonged period of time" (Ehlers and Clark, 2000, p. 339). Ehlers reasons that with clients who mainly report feelings of guilt, shame or anger, repeated reliving might not be helpful. In such cases, exposure should be used to identify dysfunctional interpretations to be worked upon with

cognitive interventions (Ehlers 1999, p. 41). Another important content of treatment is identifying triggers of intrusions and flashbacks, which is achieved by educating clients in self-monitoring techniques and discussing the results of respective 'homework' in therapy. This intervention is thought to promote a better discrimination between stimuli that occurred during the trauma and those encountered in daily life. *In vivo* exposure is seen as another important method to promote stimulus discrimination. Ehlers and Clark write (2000, p. 340):

> "In vivo exposure to avoided reminders of the trauma (e.g. the site, similar situations, activities, feelings, smells and sounds) is a powerful way of helping patients to emotionally accept that the traumatic event is in the past. When revisiting the site of the event, discussion of similarities and differences between what the scene looked like during the trauma and what it looks like now helps the client in establishing a time perspective and helps discriminating the harmless stimuli that happened to coincide with the trauma from dangerous stimuli encountered during the traumatic event."

Ehlers and Clark (2000) also use imagery techniques similar to those applied in hypnotherapy (Perren-Klingler, 2000b) in order to facilitate cognitive restructuring. The cognitive-behavioral treatment proposed by Ehlers (1999) involves about 12 (weekly) therapy sessions and three (monthly) booster sessions.

Resick & Schnicke (1992) have developed another cognitive approach to the treatment of PTSD. In their 'cognitive processing therapy' they essentially address fundamental beliefs commonly affected by traumatic experiences. Drawing on McCann and Pearlman's (1990; as cited in Solomon & Johnson, 2002) work on self-schemas altered by trauma, the five dimensions of safety, trust, power, esteem and intimacy are given special attention in cognitive processing therapy. Further, the topic of responsibility for the traumatic event and its consequences is explored. Cognitive processing therapy uses common cognitive restructuring methods that have also been applied in cognitive therapies of other disorders, including the ABC-model that goes back to Albert Ellis (1982). In contrast to most other therapists, Resick and Schnicke have their clients write an account on the traumatic event and read it in therapy. This can be seen as a markedly different way of realizing 'exposure' to the traumatic event.

Empirical support

Cognitive therapy including Cognitive Processing Therapy have received substantial empirical support for their efficacy (Najavits, 2007; Solomon & Johnson, 2002). Contrary to clinical intuition, however, the combination of exposure and cognitive therapy did not

yield better results than either of the two treatments alone (Friedman, 2001a; Najavits, 2007).

6.4 Eye movement desensitization and reprocessing (EMDR)

Eye movement desensitization and reprocessing (EMDR) goes back to a personal experience of F. Shapiro who, during a walk, noticed that specific movements of her eyes helped her to reduce distress related to aversive thoughts (Shapiro, 1995; Chemtob et al, 2000). Following this experience, Shapiro developed and conceptualized the EMDR procedure. Proponents assert that EMDR is an integrative treatment informed by a wide range of current PTSD theories. Indeed, EMDR includes exposure as well as cognitive interventions, and it can be linked to various widely accepted theories on PTSD. While drawing on different theoretical models, Shapiro proposed an "accelerated information processing" model, with the core assumption that eye movements in the context of EMDR activate self-healing mechanisms.

Procedure

The procedure of EMDR is described as follows (Chemtob et al, 2000): Like in other treatments of PTSD, the first step is about getting information on the trauma, establishing an appropriate treatment relationship, giving general information about traumatization and educating the client on the treatment rationale. After identifying a 'target memory', the therapist asks the client for a negative cognition that goes with this specific part of traumatic memory (e.g. "I am shameful"). Then client and therapist look for an alternative positive cognition (e.g. "I am honorable") and its present validity is rated by the client on a 7-point scale. Further, negative emotions associated with the traumatic memory are attended to and subjective units of disturbance (SUD) rated. Trauma-related physical sensations are also identified. All these activities are part of the assessment and carried out before the actual therapeutic procedure begins.

In the process of *desensitization and reprocessing*, the client is asked to hold in mind and pay attention to the disturbing image, the negative cognition and the physical sensations associated with the traumatic memory. At the same time, the clinician moves her fingers back and forth in front of the client's eyes, which the client is supposed to track by making lateral eye movements. After about 20 back-and-forth eye movements, the

procedure is stopped; the client is allowed to take a deep breath and gives feedback on any changes of the image, thoughts, emotions and bodily sensations during the exercise. This information can be used by the therapist to instruct the client for the next sequence. The process is repeated until the SUD ratings have considerably decreased towards zero. Then the positive cognition that has been identified in the assessment phase is (re-)introduced and its validity rated by the client. The client is then instructed to hold the target image and follow the therapist's fingers movements while now covertly rehearsing the positive cognition. This procedure is repeated until the positive cognition is rated as being (satisfactorily) valid by the client. Subsequently, the client is asked to scan the body for any sign of discomfort and tension. In case there are any left, such signs are then attended to in another sequence of repeated eye movements. Techniques of relaxation and imagination can be used to help the client reach a closure of the session.

Empirical support

Although EMDR has received substantial empirical support for its efficacy (Najavits, 2007), is has also been subject of a major controversial debate. The controversy was nourished initially by exaggerated claims of extraordinary treatment successes with EMDR, in combination with the assertion that saccadic eye movements would be crucial to the astonishingly fast and often overly comprehensive therapeutic improvement (McNally, 1999). Dismantling studies however indicate that eye movements might not be critical to the effects of EMDR. Meanwhile it is widely accepted that other stimulation, such as tone or taps, is equally efficient (Chemtob et al, 2000).

6.5 Anxiety management and stress inoculation training

As in posttraumatic stress reactions anxiety usually plays a major role, anxiety management techniques have been part of most treatments for PTSD, at least in clinical practice. Clinical experience shows that simple stress reduction methods (e.g. breathing retraining, Jaycox et al, 2002) are well appreciated by clients at the onset of treatment (c.f. Foa & Rothbaum, 1996) and thus help establishing a good treatment relationship. This in turn is the base of all psychotherapy and can open the door for successful application of further treatment modules, such as exposure. As a stand-alone treatment, however, most

approaches to anxiety management (e.g. biofeedback, relaxation training) do not render positive long-term effects (Rothbaum et al, 2000).

A more complex approach to anxiety management is taken in the stress inoculation Training (Meichenbaum, 1985; 1991), which has been adapted by Veronen & Kilpatrick (1983, quoted in Hembree & Foa, 2003) for the treatment of rape victim's.

Rationale

The rationale of SIT is based on social-cognitive learning theories. It further rests on the assumption that stress cannot be attributed to either environment or person, but is always the result of the interaction between environment and person. Stress, in this view, results when an individual appraises environmental demands as straining available coping resources. Therefore, developing and improving intra- and interpersonal stress management skills is given paramount importance in SIT.

Procedures

Like stress inoculation training (SIT) in its original form, Veronen and Kilpatrick's adaptation contains typical cognitive-behavioral approaches to stress management, like relaxation training, cognitive restructuring, guided self-dialogue, role playing, covert modeling, assertiveness training and thought stopping. But there are also modules specific to the application of SIT with trauma survivors. The training on (self-) monitoring and recognizing conditioned stimuli (associated with the traumatic situation) is meant to help clients identify anxiety responses at an early stage and control them before they become overwhelming. Clients are supported and encouraged to use their newly acquired coping skills when confronting trauma related stimuli. Thus, SIT must be considered as containing elements of exposure. Education about trauma and PTSD is also specific to SIT in the adaptation for the treatment of posttraumatic stress.

Empirical support

In contrast to other anxiety management interventions, SIT has proven positive long-term effects with female assault victims (Rothbaum et al, 2000). Although Rothbaum et al (2000) caution that relaxation training included in SIT might incur the risk of relaxation-induced anxiety, the effectiveness of SIT as a treatment package has meanwhile been well established (Najavits, 2007). Thought – stopping, however, might actually have a negative impact and should better be left out (Najavits, 2007).

6.6 Contentious issues and limitations of current knowledge

It is not the purpose of this thesis to try disentangling the complexity of outcome research. Some issues, however, are worth of note, such as the optimal level of fear activation during exposure, differential effects of exposure on different groups of patients and acceptance of exposure among patients. Another important point is to demarcate the limits of the current knowledge on treatments of PTSD. Below, we will address both issues in turn.

6.6.1 Contentious issues

The level of optimal fear activation or arousal during exposure has been subject of much debate. Advocates of exposure therapy usually hold that a high level of fear activation is important for success of treatment (Jaycox et al, 2002; Foa et al, 1995; Rauch et al, 2004). Others argue that very high levels of fear activation bear the risk of re-traumatization (e.g. Flatten, Wöller & Hofman, 2001). Proponents of exposure point out that high levels of fear activation are related to positive treatment outcome in several studies and are further supported by theoretical considerations, such as the paradigm of habituation. However, according to Metcalfe & Jacobs (1996) extremely high levels of stress might impede therapeutic improvements by rendering the hippocampus dysfunctional while the amygdala is highly active. Indeed, empirical evidence on this point is not conclusive. Van Minnen and Hagenaars (2002) have found that non-improved patients had significantly higher ratings of anxiety at the start of the first exposure session. Thus, high ratings of anxiety were predictive of worse treatment outcomes, contradicting the above-quoted findings by Jaycox et al (2002).

In a review that differs in tone and conclusions from the above-summarized ISTTS-recommendations (Foa, Keane & Friedman, 2000), Solomon and Johnson (2002) highlight possible complications of exposure therapies. As an example, they report adverse effects suffered by Lebanon War veterans in an exposure based treatment program (Solomon, Bleich, Shoham, Nardi & Kotler, 1992; Solomon, Shalev, Spiro, Dolev, Bleich, Waysman & Cooper, 1992). Solomon and Johnson (2002, p. 950) caution:

> "Despite the demonstrated effectiveness of flooding, it should be noted that cases of severe complications have been reported in the use of flooding for

> PTSD, including exacerbation of depression, relapse of alcoholism, and precipitation of panic disorder. …The efficacy of both life and imaginal exposure appears to depend on providing the patient with both control over the level of exposure and strong therapeutic support".

Despite differences in opinions, most clinicians might easily agree that an 'adequately high' level of fear activation is optimal for therapeutic improvement.

Another controversial issue regards client's acceptance of exposure therapy. Critics argue that a significant proportion of patients do not consent engaging in exposure therapy and relate exposure to increased dropout rates (McFarlane & Yehuda, 2000). In a retort to such criticism, Hembree et al (2003) presented an analysis of 25 controlled studies of cognitive-behavioral treatment that included data on dropout. The treatment approaches comprised of exposure therapy, cognitive therapy, stress inoculation training and EMDR. Further, studies often included control conditions, such as relaxation, supportive counseling and waiting list controls. The analysis concluded that no difference in dropout rates could be detected between treatments that included exposure versus treatments that did not.

We can be sure that the debate on the above topics will continue. While some clinicians and theorists claim that at least a portion of patients with PTSD do not accept, do not respond or even respond negatively to exposure treatment, others defend the efficacy of exposure treatments with further empirical data. If critics do have a point in their argument, however, it would be interesting to know which patients do not accept or not respond positively to exposure therapy. Ehlers, Clark, Dumore, Jaycox, Meadows & Foa (1998) have presented an interesting study suggesting that survivors whose trauma memories reflected 'mental defeat' and showed an absence of mental planning were significantly less responsive to exposure treatment. The results of a study by Foa, Riggs, Massie & Yarczower (1995) indicates that clients with high levels of anger might benefit less from exposure treatment than clients whose predominant feeling is fear. However, a study by Stapleton et al (2006) suggests that anger need not be an obstacle to effective exposure treatment.

6.6.2 Limits of current knowledge

The inclusion of posttraumatic stress disorder into the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM) has triggered much research. This has meanwhile led to developing and evaluating various effective treatment approaches, as

outlined above. Nonetheless, many questions and clinical challenges remain unresolved, waiting to be tackled by further studies.

In their monograph on effective treatments for PTSD (Foa, Keane & Friedman, 2000), the task force of the International Society of Traumatic Stress Studies (ISTSS) recognizes that the treatment of PTSD with comorbid disorders has not yet been sufficiently addressed. Foa, Keane & Friedman (2000, p. 4) remark:

> It is customary, for example, in studies of PTSD treatment to exclude patients with active substance dependence, acute suicidal ideation, neuropsychological deficits, retardation and cardiovascular disease. Generalization of the findings, and the resulting guidelines, to these populations would not be appropriate,

The task force also recognizes the limitations of the PTSD concept itself and the potential limitations of treatment approaches that have been developed within this line of research (Foa, Keane & Friedman, 2000, p. 2):

> It is also recognized that the PTSD diagnostic framework is inherently limiting and these limitations may be particularly salient for survivors of early childhood sexual and physical abuse. Sometimes referred to as DESNOS, people with these histories display a wide range of relational and interpersonal problems that contribute to distressed lives and disability. Yet relatively little is known about the successful treatment of patients with these trauma histories. There is a growing clinical consensus, with a degree of empirical support, that some patients with these histories require multimodal interventions applied consistently over a longer time period.

Moreover, little is known about other specific issues, such as the treatment of children and adolescents (Chemtob and Taylor, 2002; Cohen et al, 2000; Cohen, 2008; Landolt & Hensel, 2008), and various modalities of inpatient treatment (Courtois and Bloom, 2000). Further research is still needed to improve our understanding of matching different treatment choices with survivors of trauma (Foa & Shawn, 2002).

From an ethnocultural perspective, it is important to consider that most of the research on the concept of PTSD and respective treatment approaches has been carried out in Western industrialized countries. The task force of the ISTSS explicitly recognizes the cultural limitations of the present knowledge (Foa, Keane & Friedman, 2000, p. 2), when they write:

> Little is known about the treatment of PTSD in non-industrialized countries. Research and scholarly treaties on the topic come largely from the Western industrialized nations. The task force acknowledges this cultural limitation explicitly. There is growing recognition that PTSD is a universal response to exposure to traumatic events that is observed in many different cultures and societies. Yet there is a need for systematic research to determine the extent to which the treatments, both psychological and psychopharmacological, that have proven efficacy in Western societies are effective in non-Western cultures.

Although eight years have passed since the publishing of the above-quoted ISTSS-guidelines, the above-said is still valid.

PART THREE: CROSS-CULTURAL CONSIDERATIONS ON MENTAL HEALTH AND POSTTRAUMATIC STRESS

In PART TWO, we have summarized concepts and treatment approaches on disorders of posttraumatic stress. In doing so, we have almost exclusively referred to studies that have been carried out in Western industrialized countries. The applicability of these approaches in non-Western and less industrialized societies is still disputed. In PART THREE, we have a look at publications that address cross-cultural aspects of mental health and posttraumatic stress. The relevant literature is huge and scattered across a wide range of publications in clinical psychology, cross-cultural psychology, cultural anthropology and other disciplines. Therefore, the presented overview of literature cannot claim to be comprehensive, but will rather attempt to delineate the major lines of argument.

In CHAPTER 7, we outline some general theoretical considerations on the topic. CHAPTER 8 presents evidence on the influence of culture on mental disorders. CHAPTER 9 will deal with the central question of the applicability of the PTSD concept across cultures.

7 General theoretical and methodological considerations

It is generally acknowledged that culture does have the potential to influence the expression of psychological distress and mental disorders. However, little consensus exists on the extent of such cultural influence and the specific mechanisms involved. Instead, opposing camps hold fundamentally different views on how culture interacts with psychopathology. These are often referred to as the 'universalist' versus 'relativist' positions. The 'absolutist' position, which claims that mental disorders are the same in any culture, is widely seen as indefensible. It does therefore not play a significant role in the debate (Ryder, Yang & Heine, 2002).

In the following, we start by briefly describing the universalist and relativist position. Then we have a look at definitions of culture and postulated pathways of cultural influence on mental disorders. Next, we highlight some cross-cultural issues in the assessment of mental disorders, such as ethnocentricity and cultural equivalence. Cultural diversity within ethnic groups and the notion of ethnocultural identity shall also be discussed. Finally, we summarize how culture is considered in current diagnostic manuals.

7.1 Universalism versus Relativism

The universalist interpretation assumes universal processes and patterns underlying mental disorders. It emphasizes evolutionary themes and biological substrates as a base of emotions and disorders. Nevertheless, the universalist position acknowledges that that culture has the potential to influence how underlying universals are expressed. For example, fear might have its universal biological roots in the limbic system, but culture

might bring about variations in defining specific situations that elicit fear and in the ways fear is expressed. Culture might also influence interpersonal responses to fear, as well as coping responses (Marsella, Dubanoski, Hamada & Morse, 2000). However, in the universalist view, culture is seen as 'just' one among many other factors shaping the features of mental disorders.

The relativist position, in contrast, argues that culture has a fundamental and pervasive influence on mental disorders and underlines the mutual embeddedness of culture and disorder (Sam & Moreira, 2002). It strongly argues that basic processes, such as the construction of reality and emotions are bound to culture. Therefore, relativists argue that the influence of culture goes far beyond the effect of an independent variable. In line with this argument, Lutz (1985, p. 65) holds that:

> "Culturally provided knowledge systems constitute the structures of existence in a fundamental way; they determine how people experience themselves and each other. In this scheme, cultural knowledge is not merely a tool used by a thinking person; it is rather both the form and substances of consciousness."

According to the relativist view, all mental disorders described in the DSM or ICD must be considered culture-bound syndromes (CBS), which are seen as limited to the dominant culture of Western industrialized countries (Ryder, Yang & Heine, 2002).

The notions of universalism versus relativism also relate to 'etic' versus 'emic' approaches to mental disorders and illness. While the etic stand argues for the universality of mental disorders, the emic approach proposes generating illness categories from within cultures (Queckelberghe, 2005a).

The relativist-universalist controversy has in the past decades stimulated heated debates, which might have been fueled by the fact that the two 'paradigms' are associated with different academic disciplines (anthropology vs. psychology) and methodological preferences (qualitative vs. quantitative approaches). Up to now, neither of the camps has provided evidence that would warrant their sole acceptance (Kleinman & Good, 1985; Marsella, Dubanoski, Hamada & Morse, 2000). Much to the contrary, the evidence base, though relatively broad, is fraught with methodological problems. It seems that the opposing paradigms have eventually fostered efforts to affirm positions, instead of stimulating thorough research and arguments based on solid evidence.

An important starting point for research should therefore be openness to detecting and weighing both culture-specific and general or 'universal' processes and phenomena.

Looking at most research that has so far contributed to our knowledge in psychopathology, one must recognize that the risk of overlooking culture-specific phenomena has been inherent in most quantitative research designs. On the other hand, by merely focusing on culture-specific phenomena, one might well be overlooking generalities (Lopez & Guarnaccia, 2000).

We will now look into some theoretical and methodological issues that are fundamental to cultural aspects of mental health. One of the most basic issues is the very definition of the term ‘culture’.

7.2 Definitions of culture

The definition of ‘culture’ is crucial to the study of cultural psychopathology. Already in the 1950s, Kluckhohn & Kroeber (1952, quoted in Marsella, 1987) reviewed more than 150 definitions of culture, pointing out the difficulties in defining the concept.

Marsella, Dubanoski, Hamada & Morse (2000, p.50) proposed defining culture as:

> “shared acquired patterns of behavior and meanings that are constructed and transmitted within social-life contexts for the purposes of promoting individual and group survival, adaptation, and adjustment. These shared acquired patterns are dynamic in nature (i.e. continuously subject to change and revision) and can become dysfunctional. The shared acquired patterns are represented externally in artifacts, roles, activity contexts, and institutions, and they are represented internally in worldviews; identities; meanings; values; attitudes; epistemologies; consciousness patterns; cognitive, somatic, and affective processes; and concepts of self and personhood.”

Readers familiar with other definitions might realize that the above description already responds to several issues that have been raised in response to earlier conceptualizations (cf. Marsella, 1987, p.381; Marsella, Friedman & Spain, 1996, p. 117).

As many of the available studies and arguments on cultural psychopathology still reflect the influence of such older definitions of culture, we below summarize the major criticisms that have been launched in this regard.

In a thoughtful review, Lopez and Guarnaccia (2000) identify several points: First, culture has often been defined as values, beliefs and practices pertaining to specific ethnocultural groups. Following such definitions, many studies have linked expressions of culture (e.g. idioms of distress) to ethnicity or race. Such generalization does however not account for the heterogeneity that exists within ethnic groups. Therefore, it is proposed to relate idioms of distress to specific value or belief orientations, rather than indiscriminately linking them to ethnocultural groups. Second, most definitions have implicitly depicted culture as a static phenomenon. Consistent with the above quoted definition by Marsella et al (2000), Lopez and Guarnaccia make clear that

> "culture is as much a process as an entity … Attempts to freeze culture into a set of generalized value orientations or behaviors will continually misrepresent what culture is." (Lopez & Guarnaccia, 2000, p. 574).

Third, most definitions have portrayed people as mere recipients of culture. Such understanding might underestimate the individuals' active role in negotiating their cultural worlds. While recognizing the importance of cultural inheritance and general social values, recent anthropological works pay more attention to the surfacing of culture as a product of life histories and innovations that emerge from individuals and small groups. Further, the influence of values and belief systems (e.g. individualism-collectivism) on social practices in different ethnocultural groups might have been overly stressed. While correlations between cultural beliefs and practices remain undisputed, Lopez and Guarnaccia (2000) further add that environmental conditions might importantly contribute to shape social practices. For example, challenges posed by particular environments might pressure extended families and larger social units to cooperate closely in order to cope with misfortunes. This latter aspect has up-to-date received little attention in concepts and discussions on culture.

7.3 Postulated pathways of cultural influence on mental disorders

Clinical psychologists early recognized that culture does have the potential to influence psychopathology (Tanaka-Matsumi & Chang, 2002). Yet it has taken long until concrete models of cultural influence have been presented. Marsella (1987, p. 383) lists the following possibilities:

1. Culture co-determines physical and psychosocial stressors
2. Culture co-determines coping mechanisms and resources used to mediate stressors
3. Culture determines basic personality patterns, including self structure, self-concept, and need/motivational systems
4. Culture determines the language system and thus influences perception, classification, and organization of responses to reality
5. Culture co-determines standards of normality, deviance, and health of an individual and society, as well as attitudes and treatment orientations.
6. Culture determines classification patterns for various disorders and diseases.
7. Culture determines the patterns of experience and expression of psychopathology, including its onset, manifestation, course, and outcome.

Despite the plausibility of the above-listed mechanisms, one must critically note that – to our knowledge – they have not yet been empirically tested. Nevertheless, this long list convincingly suggests a pervasive influence of culture on psychopathology, and Marsella (1987) rightly urges researchers and professionals to consider the range of cultural factors influencing mental disorders. Similar mechanisms of cultural influence on mental disorders have been proposed by Queckelberghe (2005a), referring to Tseng (2001; quoted in Queckelberghe, 2005a).

7.4 Cross-cultural issues in assessing mental disorders

Given the pervasive impact of culture on psychopathology, several issues need to be considered when assessing mental disorders across cultures.

7.4.1 Ethnocentricity

By far most of research in clinical psychology and psychiatry has been carried out in Western industrialized countries. As almost all major concepts are based on data stemming from studies on Western samples, a serious risk of ethnocentric bias arises

when applying existent concepts and diagnostic categories to members of non-Western cultures (Marsella, 1987).

Marsella, Dubanoski, Hamada & Morse (2000) lament two distinguishable but related deficiencies in cross-cultural research, which they call the *error of omission* and the *error of commission*. The *error of omission* refers to the failure to conduct enough cross-cultural studies. Thus, on the base of little knowledge, inadequate generalizations about human behavior and psychopathology are made. The *error of commission* refers to the relatively few studies that have been carried out in non-Western societies, and is seen in the ethnocentric approach of most of such research. Marsella (2003) criticizes that most of cross-cultural studies are insensitive to the experience of the ethnocultural groups under study. He further notes that psychopathology is frequently discussed without consideration of the life context in which it is shaped, experienced and communicated. Marsella (2003, p.2) further elaborates:

> This is a serious problem, because decontextualization permits the researcher/clinician to assign their ethnocentric meanings and interpretations to the problems independent of the context in which they emerge and are sustained. There may be little consideration for situation stressors as well as normative personality configurations that may differ from those of the researcher/clinician.

The *error of commission* is further characterized by the use of assessment methods that might not be culturally appropriate and instruments that are not equivalent for the population under study. Marsella (1987, p.385) insists that “cross-cultural studies require methods designed to limit ethnocentric bias”. In this respect, the notion of cultural equivalence is crucial. Marsella, Friedman and Spain (1996, p. 118) point out that: “If measures are not equivalent, validity is questionable.”

7.4.2 Cultural equivalence

Marsella (1996; Marsella et al, 2000) distinguish four types of equivalency, including linguistic, conceptual, scale, and normative equivalence.

Linguistic equivalence refers to the adequacy of language used in an assessment instrument (Marsella et al, 2000). It also acknowledges that instruments should be administered in the language preferred by the subjects under study. To achieve linguistic equivalence, the method of “back translation” is recommended for cross-cultural studies. In this procedure, the text (e.g. an assessment form in English) is first translated into the

locally preferred language by a person (or group) skilled in both languages. The result of the translation is then translated back into the original language by another person (or group) equally skilled in both languages, and is then compared with the original text. Thus, weaknesses in the first translation become evident, even to researchers without any knowledge of the local language. Consequently, shortcomings can be discussed and the process can be repeated several times until the outcome is satisfactory.

By cutting out at least crude errors, the procedure of back-translation delivers results that are clearly superior to one-way-translations. However, it is also evident that many words and concepts do not have equivalents with both the same denotative and connotative meanings in two languages. This is especially true for languages from different cultural backgrounds. The intricacies of translation are often further compounded when dealing with abstract terms reflecting emotions and inner experiences. In addition, it is important to consider that an accurate translation of in instrument does not warrant its validity. Here, still other forms of equivalence come into play.

Establishing ***conceptual equivalence*** might be one of the most challenging tasks in cross-cultural research. *Conceptual equivalence* refers to the similarity in the nature and meaning of a concept (Marsella et al, 2000). For example, the word dependency in Euro-American cultures is usually associated with immaturity and other negative attributes. In contrast, in Japanese culture, *amae,* which is the closest equivalent to the English term 'dependency', is highly valued and encouraged; a dissimilarity that obviously relates to differences between individualist and collectivist cultures (Marsella et al, 2000). A researcher who would naively apply Western personality inventories to Japanese samples could – because of ignored cultural difference - infer the whole group under study lacks maturity. This obviously would be a terrible plunder and typical product of ethnocentric bias.

As a systematic way of exploring different concepts of foreign cultures (and subcultures), **ethnosemantic methods** have been developed and are used in anthropology and cross-cultural psychology (Lutz, 1985; McCurdy, Spradley & Shandy, 2005; Peltzer, 2006; Spradley, 1979). Ethnosemantics include a set of techniques for studying concepts and world views. The procedure attempts to focus on the subjective experience of the respondents, rather than the assumptions of the researcher. Therefore, ethnosemantic interviewing starts with basic and rather general questions (e.g. 'grand tour' and 'mini tour' questions: McCurdy et al, 2005). In order to detect concepts that specifically reflect the culture under study, special attention is given to discovering *folk terms*. Usually, a researcher would focus on one domain of functioning (e.g. illness, emotions, etc). For example, a folk term for 'emotion', if such a term exists in the given

local language, could be chosen as a domain (cf. Lutz, 1985). In a first step, the domain universe would be elicited by asking the informant to name all 'emotions' (using the folk term) that are known among the local people. In the next step, the taxonomic structure of a selected domain is extracted. To examine the organization of a domain, specific questions can be asked (e.g. "what kind of …?" in order to elicit further subcategories). Semantic relationships can be graphically portrayed through relational statements ("kinds of", "steps in", "parts of", "way to") or by making taxonomic boxes (McCurdy et al, 2005). Sorting, ranking and scaling can also be part of clarifying the organizational structure of a domain (Marsella, 1987; Marsella et al, 2000). Then, the meaning of subcategories can be thoroughly investigated by eliciting attributes, word associations, or using triadic contrasts, semantic differentials, pile sorts and other procedures. Furthermore, questions referring to overt behavior can be applied, e.g. informants would be asked if a person who feels a certain emotion would behave in one or another way. Behavior observation can also be used to study subjective experiences (Marsella, 1987).

McCurdy et al (2005) refer to 'discovering of folk terms', 'eliciting taxonomic structure' and 'sorting for attributional meaning' as the 'core tasks' of ethnosemantic ethnography. Furthermore, they instruct the ethnographer to 'consciously stay naïve'. It is seen essential for the researcher to regard the informant as a 'teacher' who remains the authority on her culture throughout the process of investigation. This attitude should help generate results basing in the cultural concepts and shared meanings of the informants' cultural group while avoiding distortions through the researcher's cultural frame as much as possible. Nevertheless, it is the researcher guiding the interviews by asking questions and it is the researcher taking the decisions on which contents and aspects of culture to focus.

Apart from linguistic and conceptual equivalence, ***scale equivalence*** must be considered. In self-report questionnaires as well as in clinical interviews, Likert scales, Thurstone scales, true-false ratings and other means of quantifying responses are widespread. It seems that most if not virtually all of the respondents in Western societies have been exposed to such scales more or less frequently. In cross-cultural studies, however, an equivalent understanding of such scales cannot be taken for granted. For example, in many cultures, people might feel uncomfortable with true-false ratings, because the statements usually do not take into account situational factors that would co-determine the response. Others might be more preoccupied with not giving a 'wrong' answer, rather than reporting their own experience or opinion (Marsella, 1987; Marsella et al, 2000).

With only few exceptions, virtually all the clinical standard instruments that are also in frequent use in cross-cultural research have been constructed and systematically tested in Western industrialized countries only. Hence, respective norms are not available for 'non-Western societies'. However, ***normative equivalence*** requires that norms on the group under study be available and used. Marsella et al (2000, p. 52) remark:

> If you use Western standards of normality to define adjustment and deviancy among non-Western populations without any sensitivity to the possibility of bias, you may end up labeling an entire population disturbed, deviant or maladjusted.

Keane, Kaloupek & Weathers (1996) add ***content equivalence*** to the above-outlined types of equivalency. To illustrate their case, they argue that two different societies might also differently respond to certain types of events, such as rape. A scale measuring such responses should reflect the items of such domain accordingly. If an instrument is to be applied in two different societies, the scale should include both items that reflect responses that are common to both societies, as well as items that are specific to the societies under investigation. Keane et al (1996) suggest that using the same instrument for two cultures would only be acceptable if content equivalence is sufficiently high. If it is low for the too cultures involved, separate instruments would be required.

7.5 Intra-group cultural diversity and ethnocultural identity

In the above descriptions on cross-cultural issues in assessing mental disorders, we have often referred to dichotomies, such as 'Western' versus 'non-Western' or 'industrialized' versus 'non-industrialized' countries. Indeed, these terms and respective generalizations are frequent in literature on cultural psychopathology. Undisputedly, they do have some validity and can be useful as a first orientation in general discussions.

Nevertheless, it is evident that neither people from Western nor from non-Western countries can be considered a reasonably homogeneous group. Even if we consider data from a single 'non-Western' country, we must be aware that usually data from many different ethnic groups and cultural backgrounds are cumulated. Moreover, even one ethnic group is not necessarily a homogenous cultural entity. Bhui & Sing (2004) lament

that differences within ethnic groups have been long ignored and sharply criticize the "crude categorization of 'ethnicity' as a euphemism for race" (p. 125).
Marsella, Friedman and Spain (1996, p. 117) add:

> Among ethnocultural minorities, the variations in behavior within a given ethnocultural group are dramatic and profound, and any effort to group people together for research on the basis of the largest possible ethnocultural dimension (e.g., Arab, Asian, Black, Hispanic) contributes excessive error variance to the design.

As one major step forward in disentangling the complexity, Marsella recommends considering 'ethnocultural identity' in cross-cultural research. According to Marsella (2003, p.4), "Ethnocultural identity refers to the extent to which an individual endorses and manifests the cultural traditions and practices of a particular group".
Marsella (1987, p.393) states:

> A critical and long overlooked issue in cross-cultural research is ethnic identity. Most cross-cultural research is in fact a comparison of national groups or racial subtypes rather than cultural groups. This is the case because studies do not examine ethnic identity levels of their subjects. Rather, they sample members of different ethnic groups without any awareness of their attachment or affiliation to a particular cultural tradition.

7.6 Co-variation of culture with other independent variables

Potential co-variations of culture with other independent variables have so far been widely neglected in research on cultural psychopathology. Although some studies have addressed the issue with sophisticated statistical procedures, such as multiple regression analyses, most studies of the past decades have uncritically suggested 'cultural' differences when discussing outcomes that have differed between ethnic or racial groups. It is obvious that such conclusions are premature and the matter is far more complex, as culture is not the only determinant of outcomes. In a study on cultural beliefs and health behavior among Latinas in USA, Chavez, McMullin, Mishra and Hubbell (2001) confirmed the value of cultural beliefs in explaning health behavior. However, structural factors, such as medical insurance, education, and language acculturation were even more important in determing the use of health services. Marsella, Friedman, and Spain (1996) remarked the

following with respect to research on PTSD, but the point is relevant for cross-cultural research on psychopathology in general:

> What does it mean, for example, when Whites, African Americans, American Indians, and Hispanics are found to differ in rates of PTSD if the samples studied also differ in educational level, social class, exposure to trauma …, urban-rural residence, and so forth? Using broad categories of ethnocultural group membership as the basis for research studies may, in fact, create more problems than it resolves. It is essential that clinical studies attributing differences in PTSD rates, expression, and treatment responsivity to ethnocultural variables control for, or at least account for, these and other possible sources of variance." (Marsella, Friedman and Spain, 1996, p. 106)

Lopez and Guarnaccia (2000, p. 590) write:

> Cultural psychopathology research requires a framework that incorporates culture in multifaceted ways. Accordingly, it is important that cultural research not obscure the importance of other social forces such as class, poverty, and marginality that work in conjunction with culture to shape people's everyday lives. The examination of both social and cultural processes is one way to help guard against superficial cultural analysis that ignore or minimize the powerful political economic inequalities that coexist with culture.

Closing this section, we quote Bhui & Singh (2004), who suggest that major improvements on the discussed matter are already on the way:

> … There is a move away from using simplistic ethnic groupings or 'race' based research variables to more sophisticated categories including identity and coherent cultural groups which are distinct but not distinguished in studies recruiting ethnic groups. Socio-economic and ethnic variables are now assessed both at an individual level and at a community level such that processes that contribute to inequalities … are discernable across ethnic groups. (p. 126)

7.7 Cultural considerations in the ICD-10 and DSM-IV

Both ICD and DSM hold a universalist view of mental disorders (Thakker, Ward & Strongman, 1999). While the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM) has meanwhile made considerable progress in including

culture as a topic (Lopez & Guarnaccia, 2000), the International Classification of Diseases (ICD) has up to now made less visible efforts to address the issue. The term ‘culture’ is lacking in the index of the ICD-10 (Weltgesundheitsorganisation, 1993; World Health Organization, 1992). Although it lists some culture-bound syndromes (for example Latah, Koro, Dhat-syndrome), these are subsumed under other existing psychiatric disorders without much comment.

In contrast to the ICD-10, the DSM-IV attends to cultural issues by including:

a) Statements on how culture can influence the expression, assessment, and prevalence of specific disorders;
b) Guidelines on a cultural formulation of clinical diagnosis to complement the multi-axial assessment; and
c) A glossary of culture-bound syndromes.

Ad a): The descriptions of various disorders in the DSM now include hints on potential cultural influences. For example, for the diagnosis of a Major Depression Episode, the DSM-IV (APA, 1994) states:

> Culture can influence the experience and communication of symptoms of depression. Underdiagnosis or misdiagnosis can be reduced by being alert to ethnic and cultural specificity in the presenting complaints of a Major Depression Episode. For example, in some cultures, depression may be experienced largely in somatic terms rather than with sadness or guilt. Complaints of nerves and headaches (in Latino and Mediterranean cultures), of weakness, tiredness, or imbalance (in Chinese and Asian cultures), of problems of the "heart" (in Middle Eastern cultures), or of being "heartbroken" (among the Hopi) may express the depressive experience (1994, p. 324).

Ad b): In the appendix, the DSM-IV provides guidelines for the evaluation of potential cultural influences on assessment and treatment. Here, the clinician is instructed to consider and evaluate a range of factors, such as the cultural identity of a client, culture specific explanatory models, culture specific expressions of distress, cultural factors in the psychosocial environment of the client and culture as an aspect that might influence the relationship between clinician and client.
Ad c): the appendix also provides short descriptions of 25 culture-bound syndromes (CBS). We shall discuss the issue of culture-bound syndromes in a later section.

The efforts to address the issue of culture in the current edition of the DSM have been acknowledged as a great improvement in comparison to the DSM-III (Lopez &

Guarnaccia, 2000; Smart & Smart, 1997). On the other hand, the DSM-IV has also been criticized for its remaining flaws (Kirmayer, 1998; Marsella, 2003). It has been widely disapproved that important parts of the recommendations of the 'culture and diagnosis task force' (which had developed cultural materials for incorporation into the DSM-IV) were left out in the final edition. Lopez & Guarnaccia (2000) comment that the limited attention given to cultural issues and placing culture-bound syndromes in the appendix exoticize the role of culture. The DSM deals with culture as 'just one other issue' that is potentially affecting the diagnostic assessment of certain cultural groups. In contrast,

> "cultural researchers view culture as infusing the presentation of all disorders of all people" (Lopez & Guarnaccia, 2000, pp. 576-77).

8 Evidence on the influence of culture on mental disorders

There is a vast and diverse, but often contradictory body of evidence on the influence of culture on mental disorders. It spans from anthropological studies using qualitative methodology to epidemiological surveys using standardized questionnaires. Given the magnitude of the topic, it would be inadequate to try providing a comprehensive outline on the available literature within this thesis. Instead, we sketch some key points of discussion by describing the main lines of argument on exemplary topics.

We start by providing an outline on key features of explanatory models and treatment of mental illness in Sub-Saharan Africa (SSA), thus giving the reader an idea on how illness has been understood and treated in SSA. Then we describe some culture-bound syndromes as another illustration of the influence of culture on mental illness. Finally, we review some major findings of cross-cultural research on depression.

8.1 Explanatory models and treatment of mental illness in Sub-Saharan Africa

Assumptions that clients hold on causes of their psychological troubles are considered a crucial determinant for the utilization and efficacy of health services (Patel, 1995). They often determine whether a person seeks help for a malady and from whom, and co-determine expectations on the efficacy of therapeutic procedures, as well as clients' motivation and ability to engage in them. In clinical psychology, such idiosyncratic or lay theories on health have mostly been discussed under the term 'Health-Beliefs-Model' (Kanfer, Reinecker & Schmelzer, 1991). In cross-cultural research, the term Explanatory

Models (EMs) stands for clients' assumptions on potential causes of health and illness (Patel, 1995; Eisenbruch, 1990).

According to Kanfer et al (1991), achieving a sufficient match between the etiological models of client and therapist is a precondition for successful psychotherapy. With the argument that 'Western' and 'non-Western' explanatory models on psychopathology are markedly different or even incompatible, anthropologists and cross-cultural psychologists have often suggested that Western psychotherapy is not applicable in non-Western societies. No matter which conclusions we draw from qualitative descriptions and comparison of health beliefs and therapeutic procedures in different societies; they do merit consideration. Adequate knowledge and consideration of peoples' beliefs on mental illness is also crucial in any assessment of mental health. It provides researchers with valuable cues on the limitations of their instruments and helps develop culturally sensitive assessment methods for cross-cultural epidemiological studies.

In the following, we give an outline on some often-found communality in explanatory models of mental illness across Sub-Saharan Africa. Admittedly, Sub-Saharan Africa (SSA) is a vast area with diverse cultures, and some discomfort must naturally arise when making generalized statements on such a huge continent. On the other hand, significant similarities in beliefs about traditional religion and mental health are reported over different SSA countries (Janzen & Green, 2003; Mukene, 1983; Patel, 1995; Panu-Mbendele, 2004). We therefore first describe some common threads that go through the diversity of explanatory models of mental illness in SSA. Then we give an outline on common treatment procedures.

8.1.1 Explanatory models

In a review of studies on explanatory models in Sub-Saharan Africa (SSA), Patel (1995, p.1293) points out three fundamental ideas about causality:

> First, all things which exist or which happen have a cause …; secondly, occurrences which seriously effect human beings, such as birth, puberty, drought, and so on, are also intentionally caused; and third, the cause of any occurrence can be ascertained by divination, memory, reason and empirical judgment.

When it comes to classifying illness, Patel (1995, p. 1296) argues that they foot on both aetiological and phenomenological grounds:

> First, though there is a common assumption that classification is often solely on aetiological grounds, there is evidence that phenomenological classifications are also important. Thus, the type and severity of behavioral disturbance is often used to classify broad categories of mental illness; it is *within* these categories that aetiological models are used for further classification. Secondly, the classifications are used flexible and patient-dependent; thus, even though phenomenology may be used by a healer to understand the nature of the illness, an aetiological model is almost always provided since it gives the illness experience meaning for the patient. Thirdly, there is a general classification of illness into the two categories of 'normal' and 'abnormal' illness …

The mentioned distinction of 'normal' versus 'abnormal' illness is an important common feature of SSA explanatory models. The terms also correspond to other often-used dichotomies, such as Murdock's (1978, as cited in Eisenbruch, 1990) distinction between 'natural' vs. 'supernatural' illnesses and Foster's (1976) categorization of 'naturalistic' vs. 'personalistic' causation and treatment (cf. Janzen & Green, 2003; Peltzer, 2007). The rigid dichotomy of such classification has, however, also been criticized. Patel (1995) rightly highlights that attributions are rarely one-dimensional. On the contrary, supernatural explanations of illness often have biomedical ('natural') reason alongside them, especially when it comes to physical symptoms. As Janzen and Green (2003, pp. 8-9) put it:

> A community may know very well that the spirochete transmitted by the bite of an anopheles mosquito causes malaria in the blood of a human. But the diviner may shed light on the question of why some people are infected and not others, or why some died when all others were infected.

Western medicine usually describes mechanisms that explain *how* certain diseases come about, but does not provide answers to questions like "Why did it happen to me?" and potentially "Who caused it?". Explanatory models in SSA are more concerned with answers to "Why?" - questions, without, however, entirely neglecting the physical or physiological dimension. Although explanations on the two dimensions are seen as complimentary rather then mutually exclusive, they differently relate to the use of health services: While, according to local beliefs, the 'normal' dimension can be addressed by Western biomedicine, the 'abnormal' or 'supernatural' dimension requires 'supernatural' cures, usually provided within the traditional system.

Supernatural explanations can play an important role for any illness, but are most dominant for mental illness (Mukene, 1983; Okot p'Bitek, 1971; Panu-Mbendele, 2004). Whether an illness is considered 'natural' or 'supernatural' is decided by the healer, usually through divination. Nevertheless, symptoms and course of the illness give important clues that are interpreted by the community at large (Okot p'Bitek, 1971; Panu-Mbendele, 2004).

In supernatural illnesses, 'spirits' are regarded the main causes. There are spirits of different types, such as ancestors, alien or evil spirits, and the spirits of people who have died an unnatural death (Patel, 1995). Ancestors are believed to play a protective role for their living descendants and help keeping good health. Nevertheless, they can also cause illness in case they are offended by the living, for example, when people violate taboos (Mukene, 1983). The active role of the ancestors is closely related to the idea of continuity between the living and the dead. People who have passed away still play a significant role in the affairs of the living and usually uphold their prior personal characteristics, such as social status, character and preferences (Okot p'Bitek, 1971; Mukene, 1983). Evil and alien spirits, in contrast, are deemed causing illness unrelated to the behavior of the concerned person, as the intervention by evil spirits is based on malicious intentions. Similarly, witchcraft is a widely held belief, according to which living persons with supernatural powers and evil character can cause illness and misfortune. Mental illness caused by bewitchment is believed to be far more serious than illness caused by ancestors (Patel, 1995).

Patel (1995, p. 1294) lists some frequent explanations for mental illness in SSA, including:

> Failure to propitiate the ancestors with the necessary sacrifices or rituals; non-observance of taboos and consequent ancestral displeasure; bewitchment; intrusion of evil spirits sent by sorcerers; and excessive worry over matters 'which have been kept to himself'.

Even though hereditary mental illness is recognized, the transmission is often placed in a spiritual context. While the prominent role of spirits in explaining mental illness remains undisputed, there is also evidence that "biomedical concepts were incorporated, including drug abuse, old age, AIDS, poverty, unemployment and marital discord" (Patel, 1995, p. 1294). Patel quotes further studies according to which views about illness are in a process of change and that the importance of spiritual causal models might be dwindling. (See also Peltzer, 2007, on changing explanations for physical diseases through Western influences in non-industrialized countries).

Before closing this section, we should note another important particularity in SSA culture: Certain psychotic symptoms like hallucinations do often have status value and are therefore rarely interpreted or recognized as pathology (Patel, 1995). Thus, behavioral disturbances are the core features defining psychotic states in SSA, while in Western cultures cognitive and perceptual symptoms (for example hallucinations) have more diagnostic value. This difference relates to the outstanding positive function that is attributed to 'spirit possession' in SSA cultures (Behrend & Luig, 1999). It has traditionally been central for treating mental illness and the welfare of the community in general.

8.1.2 Divination and treatment

Traditional ways of treating mental disorders are still widespread in SSA (Panu-Mbendele, 2004). This is related to the salience of supernatural causes in SSA explanatory models and to the lack of modern mental health services in most SSA countries.

Traditional treatment approaches in SSA are diverse and eclectic in nature (Panu-Mbemdele, 2004). Similar treatments are at times applied for somatic and mental illness. It is considered of utmost importance to find out the cause of the illness. In case the illness is attributed to supernatural forces, which is most often the case with mental illness, this cause must be addressed. At the same time healers usually apply further remedies (for example herbs) to calm the symptoms.

Healers can be classified according to their main approaches to treatment (Panu-Mbendele, 2004; Kelly, 1998). The major categories are herbalists, herbalist ritualists, ritualist herbalists and spiritualists (Kayombo, 1998; Panu-Mbendele, 2004). Most of the healers use divination and ritualistic treatments as a major tool, except pure herbalists, who treat by application of herbs and other natural substances only. The treatment setting can include the healer and patient only, but often demands the active participation of the family and wider community of the patient. Location and modality of treatment also vary (Panu-Mbemdele, 2004). Consultations are usually carried out on the healer's compound. At times, however, the healing intervention must be carried out in the patient's home or in a third place (for example the wilderness). In case a disease calls for more intensive treatment and care, the patient usually stays on the healer's compound for the time needed. This can be for days, weeks and even months.

A typical treatment can be described as follows (Panu-Mbendele, 2004): In the early phase of a consultation, the healer finds out about the complaints of the client through

thorough examination. This assessment can include the systematic interrogation of the client, visual examination, and palpitation. Usually, divination comes into play early in the procedure. In this case, the healer or spirit medium might find out the symptoms through divination. In another variant, the healer appears as the medium through which ancestral or other spirits are interrogating the patient (Dech, 1995). Regardless of the concrete procedure, attention is not only given to symptoms and complaints of the patient. When it comes to the causes of the illness, healers mostly concentrate on finding out about potentially disturbed relationships in the social environment of the client (Kutalek, 1998). This environment does not only include relationships to the living, but also to the dead.

The process of divination and applied techniques vary according to location and healer (Heidenreich, 2003). Often, carved figurines or natural objects, such as seashells and animal bones are shaken out and thrown onto a mat in front of the healer and the client (Janzen & Green, 2003). The diviner then interprets the constellation of objects. Healers often use states of trance or spirit possession to harness the powers of the spirit world. The spirits reveal the causes of the illness and tell what needs to be done to address it. The assistance of spiritual agents in a state of spirit possession or trance can also enable healers to divine without the use of specific objects. Dancing, drumming or taking specific drinks might also be used to get into trance (Panu-Mbendele, 1995). Apart from states of trance and spirit possession, dreams and spontaneous visions also play an important role in divination (Kayombo, 1998).

The treatment usually follows the divination in addressing the identified causes. If, for example, the healer divines that the illness is a consequence of ancestral displeasure for a broken taboo or missed sacrifices, sacrificial rituals might be suggested. If the healer discovers that evil spirits are causing the illness, these spirits must be driven out. Often protecting measures such as wearing a charm might be prescribed to prevent future ills. Consistent with a multi-causal explanatory model, such prescriptions often go with the additional application of herbs, massages, incisions and behavioral instructions (Schneider & Gruber, 1998). If the symptoms soon improve and finally subside, the treatment has been successful. If not, patients might consult another healer in search of the cure.

In SSA, illness can also indicate the vocation to become a healer, which is the case when the spirit causing the illness wants the patient to become a healer (Kayombo, 1998; Mukene, 1998). Then, the therapy mainly consists in introducing the patient into the healing profession. Such introduction can take several years during which the patient goes through specific rituals that successively initiate her into the new role of a healer.

During this time, she is also taught to divine and treat different ills (Mukene, 1983; Panu-Mbendele, 1995; Kayombo, 1998).

Concluding this sub-section, we note that the general population and traditional healers alike usually view 'modern medicine' and 'traditional healing' as complementary rather then competing with each other (cf. Dech, 1995). Certain diseases are deemed to be best treated by modern health services, others by traditional healers. People who can afford the expenses often seek modern and traditional health services at the same time or in sequence. Conversely, a strong sense of competition does exist between traditional healers and protagonists of new (often Pentecostal) churches that offer healing services (Panu-Mbendele, 2004). It has been noted that Christian healers use similar techniques and specialize on similar kinds of ills, but at the same time contrast with traditional healers through different explanatory models or belief systems.

8.2 Culture-bound syndromes

Culture-bound syndromes (CBS) are often quoted as evidence for the significant influence of culture on psychopathology (cf. Queckelberghe, 2005 a). At the same time, the matter is subject of a controversial body of literature. For some, culture-bound syndromes are clear evidence that "cultural factors are not merely an overlay of variance upon uniform patterns of psychopathology" (Thakker, et al, 1999) and thus confirm a relativist perspective on cultural psychopathology. Others view them as 'folk illnesses' and as 'local ways of explaining any of a wide assortment of misfortunes' rather than as specific syndromes (Simons, 2001). Kirmayer (1996, p.147) notes:

> Study of culture related syndromes makes it clear that they are a heterogeneous group of problems spanning syndromes, folk illnesses, idioms of distress, and simple attributions.

Debate also exists on which syndromes to consider 'culture-bound'. While inclusionists argue that any defined disorder is a culture-bound syndrome, exclusionists accept only few syndromes that mainly occur in non-Western populations (Queckelberghe, 2005a, 2007).

The DSM-IV (APA, 1994) includes a glossary of 25 culture-bound syndromes. Its list is obviously not exhaustive, but rather intended to reflect the better-researched syndromes

most relevant to North - American clinical practice. It defines culture-bound syndromes as follows (p. 844):

> The term *culture-bound syndrome* denotes recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category. Many of these patterns are indigenously considered to be “illnesses,” or at least afflictions, and most have local names ... culture-bound syndromes are generally limited to specific societies or culture areas and are localized, folk, diagnostic categories that frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations.

As examples of culture-bound syndromes that occur in Sub-Saharan Africa, we will briefly discuss *zar* and *koro*.

Zar is most prevalent in areas of North Africa (e.g. Ethiopia, Somalia and Sudan) and the Middle East. It is a common expression for the experience of spirit possession. A person perceived to be possessed by a spirit can experience dissociative episodes that may include shouting, laughing, hitting the head against the wall, singing or weeping (American Psychiatric Association, 1994; Bahire Tibeb, 1998). As spirit possession is common all over SSA, similar syndromes do likely also occur (under various terms) in most other parts of Africa.

Koro is of Malayan origin and is mostly reported in South- and East Asia (American Psychiatric Association, 1994). It is characterized by episodes of sudden and intense fear of penis loss (in women often loss of the clitoris or nipples). The DSM also mentions that various names exist to denote this syndrome in different parts of Asia. There is evidence that similar syndromes do also exist in Sub-Saharan Africa. Prinz (1998) provides a case study on ‘*kasa basoslo*’, a culture-bound syndrome occurring among the Azande in Northeast Congo. In his case report, he describes a young women suffering from intense fear. Consistent with a local folk believe, she was convinced that her clitoris had been magically stolen by a hunter who wanted to use it as a lucky charm during his hunting expeditions. The woman feared that her death was likely imminent. Although a medical examination showed that her clitoris was still intact, she could not be reassured by the Western medical doctor. Dzokoto and Adams (2005) analyze reports of a small-scale epidemic of genital shrinking in West Africa, pointing out huge overlap, but also differences between features of koro in Asia and koro-like distress in West African countries.

Simons (2001) highlights the difficulties that arise in describing and classifying culture-bound syndromes. Especially, the decision on when to subsume descriptively similar patterns of behavior and experience into one category is a tricky matter, which makes it hard or even impossible to produce satisfying classifications and descriptions of culture-bound syndromes (Simons, 2001; Simons & Hughes, 1986). Moreover, for many culture-bound syndromes, reliable empirical data are widely lacking. Kirmayer (1996) notes that the prevalence and pathological significance of many culture-bound syndromes, even for some of those included in the DSM, has never been adequately established.

Despite shortfalls in research, some culture-bound syndromes have already received significant attention. 'Attaques de nervios', common among Latin American communities, is an example for a well researched CBS. Guarnaccia and Rogler (1999) have outlined a consistent research agenda that suggests a systematic procedure for exploring culture-bound syndromes. Much of it they have carried out on 'attaques de nervios'.

Overall, the existence of culture-bound syndromes illustrates the potential influence of culture on mental illness. For many culture-bound syndromes, minor physiological dysfunctions aggravated by cognitive misattributions likely play an important etiological role. Interpersonal causes and systemic functions of symptoms as well as cultural notions about legitimate forms of illness are other factors to be considered (cf. Kirmayer, 1996). Further, elevated levels of anxiety and depression might play a prominent role in precipitating some culture-bound syndromes (e.g. attaques de nervios, cf. Guarnaccia and Rogler, 1999).

Moreover, it is obvious that culture also impinges on the manifestation of disorders that are not explicitly considered 'culture-bound' in the DSM (Queckelberghe, 2007). For example, a common expression of panic disorder in North America and Europe implies fear of a heart attack, and chronic fatigue syndromes are increasingly attributed to environmental toxins or viruses (Kirmayer, 1996). Bulimia and anorexia are still other examples for disorders strongly shaped by culture (Soh, Surgenor, Touyz & Walter, 2007).

8.3 Depression and somatization

The research and debate on culture and depression is another emblematic example for the controversy between relativist and universalist positions that still mark the field of cultural psychopathology. Although most experts would agree with the simple and general statement that some depressive symptoms occur universally, while others vary across cultures, there is room for disagreement on a range of issues. Indeed, finding out what the universal features and what the cultural varieties of depressive experience are, is a difficult task bedeviled with methodological complications.

8.3.1 General findings and controversial issues

In 1985, Kleinman & Good launched the by now classic volume *Culture and Depression*, bringing together contributions by anthropologists, psychologists and psychiatrists. Many authors of the volume focus on debunking major methodological pitfalls in cross-cultural research, such as ethnocentrism and anthropological naïveté. Most of them explain their insights and views by outlining their own research efforts in the field and stressing a relativist view on mental disorders (Lutz, 1985; Schieffelin, 1985; Obeyesekere, 1985). In the same volume, Beiser (1985) proposes that - despite all methodological problems and cross-cultural variety - there is good evidence suggesting that the concept of depression is valid across cultures. He attributes differences found in symptom expressions to communicative context, legitimacy of symptom expression in specific cultural contexts and culturally shaped help-seeking behavior rather than on differences in the underlying experience. Thus, this early and groundbreaking book already contains the major relativist and universalist arguments that are still exchanged without settlement up to today. Most arguments apply to cultural psychopathology in general and are not specific to depression. They have therefore already been outlined above, in the discussion on concepts and methodological issues in cross-cultural research.

For depression, two major points of intercultural variation are most widely discussed and accepted in the literature. The first concerns feelings of guilt and low self-esteem. These often go with depression in Western societies, and are part of the DSM and ICD definition, but are deemed less frequent in non-Western societies (Kleinman and Good, 1985; Marsella, 2003; Queckelberghe, 2005). The second point regards the tendency of somatization, on which Thakker et al (1999, p. 853) remark: “Undoubtedly the most

striking and consistent finding of the relationship between culture and depression is the variation in somatization." Although Thakker et al (1999) are right when they state that empirical findings on somatization are most striking and consistent in comparison to other results in cultural psychopathology, this does not mean there would be no room for dispute. In order to depict some areas of disagreement and the corresponding arguments in some detail, we shall below focus on 'depression and somatization'.

Important cues on potential intercultural differences in psychopathology of depression come from epidemiological studies. These revealed remarkably low rates of depression in China and Taiwan, with lifetime prevalences of 1.5% and below (Cheng, 2001). Such figures mark a stark contrast to results from other countries. There, lifetime prevalences of more than 5.2% in the United States and up to 19% other countries are common (Ryder et al, 2002; Cheng, 2001; Smith & Weissman 1992, quoted in Cheng, 2001).

Further, rich empirical evidence shows that symptoms of somatization are more often found in Chinese samples, in comparison to data collected among nationals of other countries (Kim, Li & Kim, 1999). It has also been argued that depression in China is organized in different clusters from the ones defined in the ICD or DSM. People might experience symptoms that cut across various disorders defined in the ICD or DSM without, however, suffering from or reporting enough symptoms to qualify for a single Western diagnosis (Ryder, et al, 2002).

The clear disparities in epidemiological data across countries with strikingly low rates of clinical depression and high levels of somatization in Chinese and Taiwanese samples are consistent enough to be generally accepted as an indication of cultural differences.

However, discrepancy exists in the details of interpretation. While some interpret survey results as evidence of **different depressive *experiences*** across cultures (Thakker, 1999; Marsella, 2003), others argue that differences might merely reflect **culture specific *illness behavior*** (Mumford, 1993; Cheng, 2001).

The most frequent argument suggesting *different experiences* refers to cultural differences in mind-body distinction (Ryder, Yang & Heine, 2002). People from non-Western cultures, so the argument, experience emotions in ways that merge mind and body. Conversely, people from the Western world experience the mind as central to the self and pay little attention to the body and therefore experience and report more

psychological and less somatic symptoms[16]. Other authors explain different prevalence rates with culture specific *illness behavior*. Cheng (2001) suggests that mental illness is particularly stigmatized in Chinese societies, and the overt expression of emotions is culturally discouraged. Therefore, people would underreport psychological symptoms.

It is obvious that the given explanations of different depressive experiences and different illness behavior are not mutually exclusive, but might both contribute to differences in the prevalence of depression. Moreover, somatization is not exclusive to non-Western societies, but is also widespread in Western societies. Further, somatic discomfort and complaints are known to accompany depression regularly, even in the West (Kirmayer, Robbins, Dworkind & Yaffe, 1993; Lipsanen et al, 2004; Portegijs et al, 1996). Kirmayer (1996, p. 140) states:

> The intrinsic phenomenology of affective and anxiety disorders includes a prominent somatic aspect so that pain and other somatic symptoms related to muscle tension and autonomic disturbance are present in almost all depressed patients …

To get an impression on differences and overlap between depression in Western and non-Western societies, a look into the Chinese Classification of Mental Disease is of interest. The Chinese Classification of Mental Diseases, 2nd Edition – Revised (Chinese Medical Association & Nanjing Medical University, 1995, quoted in Ryder et al, 2002) contains a diagnostic category of neurasthenia, or *shenjing shuairuo,* which is described in five symptom clusters:

1. Emotional disturbance manifested as troubled vexation or being easily aroused;
2. Easily excited by activities, accompanied by many uncontrollable thought associations;

[16] Ryder et al (2002) propose testing the hypothesis of low mind-body-distinction being causal for high levels of somatization empirically by operationalizing and measuring both constructs at an individual and societal level. A significant negative correlation between measures of the two constructs (within and across cultures) would support the explanation. The same procedure could be applied put other frequent ad hoc explanations to empirical scrutiny, such as 'interdependent self'. This suggested shift to empirical investigation is promising. So far, debates on cross-cultural psychopathology have often focused on hypothetical ad hoc explanations, without subjecting them empirical scrutiny.

3. Mental excitement or work leads to easy fatigue, including poor memory and concentration, ineffective thinking, inconsequential thoughts lingering in the mind, or head feeling unclear;
4. Nervous pain associated with muscle tension, head feeling tight or swollen, pressure in the brain, or bodily pain; and
5. Sleep disturbances.

A comparison of the above criteria with diagnostic criteria of depression in the DSM and ICD reveals overlap as well as differences. Concerning the differences, the second Criterion clearly strikes as the symptom most specific to Chinese culture. However, significant overlap of symptoms for the rest of the criteria is also evident.

Ryder et al (2002) quote studies, according to which as many as 80% of psychiatric outpatients in China were diagnosed as neurasthenic, often seeking treatment for self-diagnosed neurasthenia. The high rates of neurasthenia in combination with the low rates of depression in China led researchers to explore the relationship between neurasthenia and depression.

In a combined clinical and anthropological field study, Kleinman (1982) assessed 100 psychiatric outpatients with neurasthenia in the Hunan province of China, using DSM-III diagnostic criteria. According to his assessment, 87 % of these neurasthenic patients met the criteria of a Major Depressive Disorder. Anxiety disorders and chronic pain syndromes were also frequent among neurasthenic patients. Although the patients presented with mainly somatic complaints, such as insomnia, dizziness and various pains, depressive symptoms were revealed when properly probed. Depressed mood was given as a chief complaint in only 9% of the cases. These results suggest that illness behavior importantly contributes to the variations in rates of depression across cultures.

However, this does not mean that depression is the same all over the globe and culture could be neglected in the therapy of depression. Kleinman (1982) noted that in the same study, therapy with antidepressants improved some depressive symptoms, but was less effective in reducing social impairment that accompanied the illness. This suggests that, even if depression is diagnosable according to DSM, effective therapy should also address socio-cultural factors potentially underlying or upholding the illness behavior.

We summarize that so far the empirical evidence on culture and depression is not conclusive. While anthropological descriptions usually reveal notable differences in psychopathology across cultures, quantitative epidemiological studies often suggest that depression occurs with similar core features in most countries and cultures.

8.3.2 Research on depression in Subsahran Africa

Before we close this section, we outline some of the research on the validity of depression as a diagnostic category in SSA, especially in Rwanda and Uganda. We focus on studies carried out by Paul Bolton and colleagues, which excel through the skilled application of ethnographic methods and comparisons to categories defined in official diagnostic manuals. Paul Bolton has chiefly employed qualitative and ethnographic procedures, complimented by quantitative analysis of data. He carried out a series of studies in Rwanda and Uganda, which makes his research even more relevant to the present thesis.

In a study on the local perceptions of the mental health effects of the Rwandan genocide, Bolton (2001b) used mainly ethnographic methods. In a first round of data collection, he applied the method of free listing to have communities describe the main problems caused by the genocide in 1994. Interestingly, the commonly listed mental or emotional problems included many of the DSM-IV criteria for depression. In addition, free lists contained local idioms of distress. In the same interviews, community members were asked to name community consultants for mental and emotional problems, such as traditional healers and local leaders. In a second round of exploration, these local experts were then interviewed for more detailed descriptions of local idioms of distress that had been identified in the free listing exercise (especially on *guhahamuka*, *agahinda* and *akababaro*). Bolton (2001b) found out, that “Between them, *guhahamuka*, *agahinda* include all symptom categories required for DSM-based diagnoses of depression ...” Bolton (2001b) inferred the results of the study support the content validity of the syndrome in the given local population. Interviews and pile sorts also revealed other symptoms that potentially constitute local expressions of depression. Such symptoms, e.g. ‘feeling that there is a cloud within oneself’, ‘instability of the mind’ and others, were later considered in local depression assessments.

Bolton (2001a) describes a procedure for testing the validity and reliability of standard psychiatric assessment instruments without using a ‘gold standard’. This procedure was applied to validate the Hopkins Symptom Checklist (HSCL) for the Rwandan population in question, and can be summarized as follows: Persons who had been identified by local informants as suffering from a local syndrome (*agahinda gakabije*) were interviewed using the depression section of the (DHSCL). Diagnoses by local cultural experts were related to depression diagnoses using the DHSCL. Bolton (2001a) found a similar relationship between depression and *agahinda gakabije* as has been found between depression and grief in Western countries, which was interpreted as supporting criterion validity.

Furthermore, both construct validity, assessed using factor analysis, and internal reliability (Cronbach's alpha = 0.87) turned out to be satisfying.

In a later study (Bolton, Neugebauer & Ndogoni, 2002), which built on the above outlined research, a locally adjusted version of the Hopkins Symptom Checklist was used to estimate the prevalence of depression five years after the 1994 genocide. At the same time, functional impairment was assessed, using a culturally sensitive approach to function assessment. The approach stipulates the local creation of function assessment instruments in a well-defined and feasible process that identifies locally relevant tasks and dimensions of impairment (see Bolton & Tang, 2002, for details). Thus, the study collected data on 'symptom depression' using a culturally adjusted and validated questionnaire, and data on 'impairment', using an assessment instrument that had been developed in the local cultural context. The community-based survey of Rwandan adults was conducted using well-devised sampling and interview procedures (Bolton, Neugebauer & Ndogoni, 2002). To estimate the prevalence of major depressive disorder, the items of the locally adjusted HSCL were related to DSM symptoms (A-criterion). Similar to the variable 'symptom depression', 'impairment' was converted into a dichotomous variable by defining a cut-off score. The study revealed a point prevalence of 'symptom depression' of 17.9%. Considering 'impairment' as an additional diagnostic criterion, the point prevalence was only slightly reduced to 15.5%. This result demonstrates that in the given sample, symptoms of depression were substantially and significantly associated with overall impairment, supporting (criterion) validity of the depression concept in the local population.

Results similar to the above have also been found in respective studies in Uganda. Wilk & Bolton (2002) conducted a study on local perceptions of the mental health effects of the Uganda AIDS epidemic. Using ethnographic methods as described above, two local syndromes could be identified (yo'kwekyawa and okwekubaziga). Again, between them, they included all of the nine major DSM-IV symptom criteria for major depressive disorder (Wilk & Bolton, 2002). Again, impairment was strongly related to symptom depression (Bolton & Wilk, 2004). The point prevalence of depression was as high as 21%, with traditional healers often expressing inability to treat the syndromes (Verdeli et al, 2003).

The above research has meanwhile led to a controlled clinical trial in which an adjusted version of Interpersonal Psychotherapy (IPT) in a group format was applied (Verdeli et al, 2003). The results of this trial immediately after intervention were encouraging (Bolton et al, 2003). Even more importantly, in a follow-up assessment, the rate of depression in the intervention group (11.7%) was still significantly lower than in the control group (54.9%).

Functional impairment was also significantly reduced (Bass et al, 2006). Such successful implementation of interventions basing on the diagnosis of depression also points to its validity in the local context.

Patel, Araya & Bolton (2004) quote similar controlled trials that have recently been carried out with mixed, though encouraging results in Chile and India. Patel et al (2004, p.540) summarize:

> … it is worth trying interventions found to be effective in other cultures, but … their effectiveness needs to be tested when applied to new populations. The studies also demonstrate that scientific evaluation of interventions, in the form of adequately powered randomized-controlled trials … are feasible in developing countries both from a practical and ethical viewpoint. …. Above all, it is time to use the new evidence to actively combat the skepticism of policy makers that there is nothing to be done against depression in developing countries.

9 Cross-cultural applicability of the PTSD concept

In PART TWO of this thesis, we have given an outline on the concept of PTSD, related diagnoses and treatment approaches. In doing so, we focused on studies that have been carried out in Western industrialized countries among predominantly Western populations, reserving the more specific discussion on cross-cultural research on PTSD for PART THREE.

This chapter starts with some considerations on the cross-cultural assessment of PTSD. Next, we review literature on the epidemiology of PTSD across cultures, followed by an outline of studies that aim at identifying cross-cultural variations in reactions to traumatic stress. Last, we turn to cross-cultural interventions based on the PTSD construct.

9.1 Cross-cultural assessment of PTSD

Despite theoretical arguments pointing to universals in human responses to trauma (Friedman & Jaranson, 1994; Friedman & Marsella, 1996; Stamm & Friedman, 2000), assessing such across cultures is anything else but straightforward. Keane, Kaloupek & Weathers (1996) give an outline on ethnocultural considerations in assessing PTSD. They recommend multidimensional assessment procedures, which include checking for symptomatology and adjustment. Further, they underline that issues of cultural equivalency and psychometric properties of the instruments (such as reliability and validity) must be taken into account. Concluding their article, Keane et al (1996) give some examples of racially and culturally sensitive assessment instruments, that have been shown to validly assess trauma-related psychopathology in non-Western cultures, such as the Harvard Trauma Questionnaire (HTQ), the Indochinese PTSD Screening

Scale, the Vietnamese Depression Scale, the Clinician-Administered PTSD Scale (CAPS) and the PTSD Checklist (PCL). Other instruments that are generally regarded to be valid across cultures have been described in Hollifield et al (2002) and Renner, Salem & Ottomeyer (2006).

The validation of instruments in different cultures and societies must be regarded an important step in research on cultural psychopathology. However, it is questionable how far the validation of any instrument is generalizable across cultures. Can an instrument that has been validated using a clinical sample of Southeast Asian patients be assumed to be valid across all non-Western cultures? This is certainly not the case. Can it be assumed to be valid in an Asian community sample? Even this must be doubted. Hollifield et al (2002) have given an excellent review on cross-cultural measures of trauma and discussed the related methodological difficulties. Their review has also illustrated that the question on how an instrument can be soundly validated is still open to debate. While clinical interviews carried out by culturally competent clinicians have often been regarded as the gold standard against which new instruments should be validated (Keane et al, 1996), such approach has also been questioned. Hollifield et al (2002) have proposed that validated measures of impairment might be better standards to be used in the validation of mental health measures.

Apart from considerations on potential developments in assessment instruments and procedures, most of the research conducted in the field still leaves ample space for improvement by using available instruments and applying procedures recommended for cross-cultural research. In their review, Hollified et al (2002) point out that in the 183 reviewed studies, 125 different instruments were used. Only 20 instruments among them were culturally adjusted or developed for cross-cultural research. Half of the studies reported quantitative data without giving information on statistical properties of the instrument or associations with other criteria. Generally, Hollifield et al (2002) lament the lack of attention paid to sound measurement principles. Although their critical article reviews studies in refugee research specifically, their arguments might be valid for cross-cultural research in general.

On the other hand, one must also recognize that validation studies have been carried out and are still under way. Ahmad, Sundelin-Wahlsten, Sofi, Qahar & von Knorring (2000) tested a semi-structured, culturally adjusted interview for the diagnosis of PTSD and other posttraumatic symptoms in children (Posttraumatic Stress Symptoms in Children, PTSS-C). They compared results of psychometric properties among Kurdistanian and Swedish children and applied cross-validation procedures with other instruments (Diagnostic

Interview for Children and Adolescents, DICA; Child Posttraumatic Stress Disorder Reaction Index, CPTSD-RI). According to the authors, the results revealed excellent cross-cultural validity.

Smith, Perrin, Dyregrov & Yule (2003) applied principal components analysis to validate Horowitz' Impact of Event Scale that had been administered to almost three thousand 9-14 year old children from Bosnia. According to the authors, factor analysis showed "an identical underlying factor structure as when it was used with British children who experienced a single-incident trauma" (Smith, Perrin, Dyregrov & Yule, 2003, p. 315). However, differences also showed up and the authors concede, "Hypervigilance is likely to change its meaning when measured in a situation of ongoing threat" (Smith et al, 2003, p. 320). Overall, they conclude that their study "shows how children from Bosnia react in ways that are more similar than different to children from other cultures".

Most other studies on the cross-cultural validity of PTSD instruments also revealed strong communalities of posttraumatic reactions across cultures; but also found differences (Chen, Lin, Tang, Shen & Lu, 2001; Asukai et al, 2002; Renner et al, 2004). However, relatively small differences of results between samples are usually difficult to interpret, as they might be attributed to a wide range of variables other than cultural factors. Vague phrases like 'reactions are more similar than different' are therefore frequent when results of validation exercises across cultures are interpreted. While final conclusions cannot be drawn from such studies, the general outcome of such studies rather points to the validity of the PTSD construct across cultures.

In an interesting study related to the topic, de Jong, Komproe, Spinazzola, van der Kolk & van Ommeren (2005) examined the cross cultural validity of the Structured Interview for Disorders of Extreme Stress, SIDES. Comparing data from survivors of mass violence in Algeria, Ethiopia and Gaza, they found that the factor structure was not stable across the three different samples. Further research is needed to examine and improve the cross-cultural validity of the DESNOS construct and related assessment instruments.

9.2 Epidemiology of PTSD across cultures

Despite the relative scarcity of research carried out in non-Western developing countries (Girolamo & McFarlane, 1996), there is a considerable body of research providing valuable information on the epidemiology of PTSD across cultures. Most of this research,

though carried out in the United States or Europe, examines responses of ethnic minorities to traumatic events, such as disasters and war. Allen (1996) gives a good outline of literature on PTSD among African Americans, highlighting how lack of economic resources, institutional racism and prejudice can heighten vulnerability to trauma. Manson, Beals et al (1996) review and discuss research on PTSD and related disorders among American Indians. Robin, Chester & Goldman (1996) specifically discuss the effects of cumulative trauma on mental health of American Indian communities. Abueg and Chun (1996) give an outline on PTSD among Asians and Asian-Americans. Hough, Canino, Abueg & Gusman (1996) review literature on PTSD among Hispanics. They lament that most studies are largely descriptive, rather than comparative. Hence, they call for studies that are truly comparative and at the same time culturally sensitive. Indeed, to address issues of comparability and cultural sensitivity at the same time might be one of the biggest challenges in cross-cultural research. Usually, cultural sensitivity is traded for comparability and vice versa.

In the following sections, we give a selective overview of reviews and studies that have been carried out in disaster research and research on military veterans, as well as of research on refugees and victims of war. For methodological reasons, the studies outlined below are prone to reveal evidence on the communalities across cultures rather than on cultural specifics. Studies designed to teeth out cultural specifics will be described further below.

9.2.1 Disaster research

In a commendable review on cross-national and ethnocultural issues in disaster research, Green (1996) summarizes that from the existing literature no conclusions can be drawn about the impact of cultural factors on human responses to disasters. This is not surprising, given the huge methodological problems of disaster research that already complicate comparisons between studies within one culture. Here, differences in the timing of the assessment, different procedures in sampling and assessment (e.g. of exposure and its effects), and variables that potentially mediate responses to disasters play an important role (Norris, 2006). Following Green's (1996) analysis, factors that predict resiliency and quick recovery from the aftermath of disaster are the same across cultures. They melt down to the extent of available social and material support. Importantly, data do not only show that poor resources contribute to aversive outcomes

and protracted consequences of trauma after disasters, but also that such processes are especially marked and severe in low-income countries (Green, 1996)[17].

In an extensive review and analysis of disaster literature, Norris, Friedman, Watson, Byrne, Diaz & Kaniasty (2002) reported several risk factors that were identified consistently across studies and ethnic groups. These include female gender, low socio-economic status, high level of secondary stressors (life events, chronic stress), pre-disaster mental disorders, low social embeddedness, low perceived social support and high levels of resource loss. Moreover, higher impairment was generally found in samples of developing countries and in those who experienced man-made mass violence (e.g. shooting sprees, terrorism as compared to natural or technological disasters). Further, disasters that led to substantial community destruction were associated with more severe mental health problems (see also Davidson & McFarlane, 2006). Results on other potential risk or protective factors were inconsistent, including effects of ethnicity (Norris, Friedman, Watson, Byrne, et al, 2002).

Another noteworthy result is that disaster does indeed have the potential to cause severe short- and long-term distress and impairment among the stricken population (Norris, Friedman & Watson, 2002). Again, this result is consistent across cultures. However, gender effects were found to be mediated by culture, with greater gender differences in Mexican samples, and comparably smaller differences among African Americans (Norris, Friedman, Watson, Byrne et al, 2002; Norris, Weisshaar et al, 2001).

9.2.2 Research on military veterans from different ethnic backgrounds

Along with the many studies conducted on military veterans, the National Vietnam Veterans Readjustment Study (NVVRS) is among the few that considered ethnocultural variables in a sophisticated research design. It is at the same time likely the largest study on war veterans and therefore the most revealing about potential differences in posttraumatic responses among ethnic groups. The following outline of the NVVRS is mainly based on the authoritative review by Schlenger and Fairbank (1996). The study

[17] Factors mediating responses to trauma are often not controlled in cross-cultural studies. Therefore, these finding also suggests that differences in outcome (or PTSD measures) that are at times attributed to race or culture, might also be explained by mediating factors distributed unequally among ethnic groups (Green, 1996).

included a representative sample (N=3016) of theater veterans, era veterans and matched civilian counterparts. With the objective of enabling the reliable investigation of the potentially differential impact of war on African American and Hispanic minorities, members of this group were systematically over-sampled. An extensive multi-measure assessment that included self-report scales as well as structured clinical interviews rendered detailed data on pre-exposure characteristics and war zone stress of the subjects. Findings of the NVVRS indicated striking differences in the prevalence of PTSD among African American (20.6%), Hispanic (27.9%) and White (13.7%) male theater veterans.

Various conceivable explanations were proposed to account for the increased PTSD rates in non-White veterans, including institutional racism and bicultural identity (Allen, 1996; Marsella, Friedman & Spain, 1996). Later analyses of the data, however, revealed that after considering the impact of predisposing factors and traumatic exposure, the difference between African American and White veterans was reduced to insignificance. The difference between Hispanics and Whites was reduced, but remained statistically significant (Schlenger & Fairbank, 1996). It must be added that the mentioned adjustments on the base of multiple regression analyses did not include post-exposure experiences, such as social support after homecoming, which are also known to influence symptomatology and recovery. Therefore, final conclusions cannot be drawn, and there is still room for further speculation.

Other results are more consistent across ethnic groups and easier to interpret. The most striking among them is that combat experience has a high potential to cause PTSD. For instance, the prevalence in the African American sample was 20.6% for theater veterans, 4.4% for era veterans and 1.3% for the civilian counterparts (Schlenger & Fairbank, 1996). A similar pattern, decreasing from theater veterans to civilian counterparts has been found for Hispanics and Whites.

Further, the NVVRS showed that veterans with PTSD were much more likely to suffer from adjustment problems in comparison to veterans who did not meet the diagnostic criteria for PTSD. They had more marital problems, lower educational and occupational achievements, and higher crime rates (cf. CHAPTER 3.2.5 on PTSD and functioning). Even if this was true across different ethnic groups, adjustment problems were especially marked in African American veterans (Schlenger & Fairbank, 1996).

Above we have summarized the results concerning Hispanic, African American and White Vietnam veterans. Other minorities in the Vietnam War have been fewer in numbers and have not been over-sampled. Data of the NVVRS are therefore less telling in this respect. Generally, studies on PTSD in American Indian and Asian American Vietnam Veterans

are much scarcer, but do exist (cf. Abueg & Chun, 1996; Loo, 1994). Yet, because of much smaller sample sizes and other methodological constraints, they are less conclusive than NVVRS analyses.

9.2.3 Research on refugees and victims of organized violence

9.2.3.1 Studies on refugees

Research on refugees is another important source of data on intercultural communalities and variations in responses to trauma. Meanwhile, a substantial body of literature on the mental health of refugees and victims of organized violence from all over the world has been accumulated. It provides data on the effects of trauma in various populations coming from South-Eastern Europe (Smith, Perrin, Yule, Hacam & Stuvland, 2002; Mollica et al, 1999), the Middle East (Dyregrov, Gjestad & Raundalen, 2002; Ahmad, Sofi, Sundelin-Wahlsten & von Knorring, 2000; Lopes Cardozo et al, 2004), Asia (Mills et al, 2005; Marshall et al, 2005), Latin America (Hondius et al, 2000; Eisenman et al, 2003) and Africa (Dyregrov, Gupta, et al, 2000;. Karunakara et al, 2004; Schaal & Elbert, 2006). A review on migration and mental health in Europe (Carta, Bernal, Hardoy & Haro-Abad, 2005) states that posttraumatic stress disorder is by far the most common mental health problem among refugees and asylum seekers. Apart from PTSD, depression and anxiety disorders (other than PTSD) are believed to be widespread. Estimations of the prevalence of PTSD among refugees usually range from 3% to 86% and of rates of depression from 3% to 80% (Fazel, Wheeler & Danesh, 2005). Obviously, differences in sampling and assessment procedures, as well as differences in experiences of the people under study and a host of mediating factors might account for part of the inconsistencies found across studies. Exclusive reliance on self-report data and systematic biases in sampling are among the most frequent weaknesses in refugee research (Hollifield, 2002).

Fazel, Wheeler & Danesh (2005) conducted a review of interview-based psychiatric surveys of unselected refugee populations. Studies in which diagnoses were made on the base of self-report questionnaires and studies with selected populations (e.g. clinical samples) were excluded. The review analyses data on refugee mental health stemming from 20 surveys that sampled 7000 refugees in total. Subjects came from four continents (mainly from Southeast Asia, former Yugoslavia, Middle East and Central America). They

were resettled in seven Western high-income countries. On the methodology of assessment, Fazel et al (2005, p.1310) report that "[in] a few studies, diagnoses were made solely on the bases of clinical interview, but in most studies trained interviewers made diagnoses using validated diagnostic methods, mainly with semi-structured interviews." In order to limit potential biases associated with smaller studies (non-optimum features of design, publication bias), Fazel et al (2005) based their combined estimates of prevalence on a sub-sample of studies with more than 200 participants each. Following the described method, they conclude that about 7-17% of the subjects met the criteria for posttraumatic stress disorder, while only about 5% were diagnosed with major depression. Among the subjects diagnosed with PTSD, high levels of comorbidity were observed.
It is noteworthy that Fazel et al (2005) did not elaborate on the crucial issue of cross-cultural validity of assessment procedures in their discussion of the results. Instead, the review has triggered debate on how sampling and general assessment methods[18] might have biased outcome of research in this field (Hollifield, 2005; Miller, Elbert & Rockstroh, 2005). This might reflect the confidence (of authors and readers of the journal alike) that, given the applied inclusion criteria, the review had considered only well-designed studies using culturally adequate assessment procedures.

9.2.3.2 Studies carried out in Sub-Saharan Africa

Above we have reviewed studies on refugees. The smaller portion of the summarized data has been collected in developing countries, and the dearth of published research is even most striking for Sub-Saharan Africa. Nevertheless, some interesting studies have been published.

Karunakara, Neuner, Schauer, Singh, Hill, Elbert, & Burnham (2004) report on a population based survey carried out among three population groups in Southern Sudan and Northern Uganda (West Nile region). The random sample consisted of more than 3000 adults who were interviewed using the Posttraumatic Diagnostic Scale[19] (PDS) to assess traumatic events and posttraumatic symptoms. An extensive demographic questionnaire was administered to obtain detailed information on other variables

[18] Sampling procedures that resulted in different outcomes were: random vs. complete samples; Relevant dimensions in assessment were: clinical assessment vs. semi-structured interview; subjects assessed through an interpreter or by an interviewer who speaks their language.

[19] For a description of the PDS, see Keane, Weathers & Foa, 2000, or Foa, Cashman, Jaycox and Perry, 1997, quoted in Keane, Weathers & Foa, 2000.

potentially related to traumatic stress. The prevalence of PTSD in the described population was estimated to be between 48% for Sudanese stayees, 46% for Sudanese refugees who had migrated into the Ugandan West Nile region and 18% for Ugandan nationals staying in the West Nile. Regression analyses showed that the number of violent events witnessed in the past year and the number of violent events witnessed ever were significantly associated with PTSD symptoms. Further, low socio-economic status was predictive of higher symptom levels.

While the before described study has been carried out in the neighboring West Nile region, we will below outline two studies that have been carried out in the area of the Northern Ugandan conflict. Both studies assess people who had been abducted by the Lord's Resistance Army.

Bayer (2006) interviewed 58 formerly abducted children who at the time of assessment stayed in one of the reception centers in Gulu town. When they were abducted, the children were between 5 and 18 years old. When they were assessed, they had spent an average of almost three years with the LRA rebels. Using the Childhood PTSD Reaction Index (CPTS-RI) to assess symptoms of PTSD and the Depression Self-Rating Scale for Children (DSRSC) to assess depression, Bayer estimated a point-prevalence of 42% for PTSD and 33% for depression. Bayer's data also reveal a high rate of comorbidity between the two syndromes: 26% of the subjects were estimated to suffer from PTSD and depression at the same time. Further, Bayer assessed the 'will for reconciliation'. His data suggest, that children suffering from PTSD are less willing to reconcile with their offenders in comparison to children who don't. This finding is consistent with findings from Pham, Weinstein & Longman (2004) who found a negative correlation between severity of traumatization and openness to reconciliation in victims of the 1994 genocide in Rwanda.

Pfeiffer (2006) assessed 72 formerly abducted people who were recruited in Gulu reception centers and IDP camps. The average age of the participants when assessed was 24 years. The average duration of time they spent with the rebels was almost 8 years for the reception center sample and 4 years for the IDP camp sample. Using the Posttraumatic Stress Diagnostic Scale (PDS) to assess PTSD and the Hopkins Symptom Checklist (HSCL-25) to assess depression and anxiety, Pfeiffer (2006) found that 49% of the overall sample met DSM-IV criteria for PTSD. According to the HSCL's cut-off for clinical relevance, an estimated 60% would meet the criteria for an anxiety disorder and 71% for depression. In addition, data revealed strikingly high levels of comorbidity. Ninety-four percent of the subjects who met the criteria of PTSD also met the cut-off for depression, and 77% met criteria for anxiety disorder according to the HSCL-25. In a

multiple regression analysis, the number of trauma-types experienced proved to be the most prominent predictor of the PTSD sum score (r=0.45). This result is consistent with the dose-response model (described in section 4.3.3). Analyses at item level showed that symptoms of passive avoidance (inability to remember parts of the event, loss of interest, feeling isolated, emotional numbing) were remarkably rare. Symptoms of active avoidance (avoiding thoughts and feelings, avoiding activities and persons) were prominent in the sample. This finding in line with the general hypothesis that symptoms of avoidance (here specifically symptoms of passive avoidance) are to a higher extend shaped by culture (cf. Friedman & Marsella, 1996, Stamm & Friedman, 2000). Noteworthy among Pfeiffer's results was that the frequency of the HSCL-symptoms 'feelings of guilt and self-blame' was extraordinarily high. About 80% of the sample reported suffering from extreme feelings of guilt.

Overall, the summarized research provides strong evidence on substantial communalities in posttraumatic reactions across ethnic groups. PTSD has been diagnosed consistently across different cultures. Patterns of comorbidity and other epidemiological features overall match those found in Western studies.

On the other hand, it has been argued that the application of standardized assessment instruments bears relatively little potential of detecting cross-cultural variations. The documented communalities do therefore not exclude that significant cross-cultural differences might exist. To identify cultural differences in responses to disasters, a qualitative approach is more promising. To complement the picture sketched by epidemiological research, we below outline reviews and studies that have focused on identifying cultural variations.

9.3 Ethnocultural variations in posttraumatic stress

The edited volume *Ethnocultural Aspects of Posttraumatic Stress Disorder* by Marsella, Friedman, Gerrity and Scurfield (1996) is up to now the most comprehensive publication on this topic. We have already quoted many chapters of this excellent book, which is in weight and quality equivalent to Kleinman and Good's (1985) classic on *Culture and Depression*.

Below we start by recapping some points made by Jenkins (1996) and Kirmayer (1996) in the same book. Then we outline an outstanding study by Norris, Weisshaar et al

(2001) in some detail. To give further examples on studies designed to explore cultural specifics in posttraumatic stress, we will sketch two further studies carried out on Asian refugees.

Jenkins (1996) has reported on research among Salvadoran women refugees who were suffering from serious problems of *nervios*, a culture specific syndrome described in the annex of the DSM-IV. Additionally, feelings of heat (*calor*) were prominent in the sample, pointing to another culture specific idiom of distress. According to Jenkins (1996), symptoms of avoidance and numbing were not marked in the sample. This finding resonates with results reported by Pfeiffer (2006) who stated that symptoms of passive avoidance were remarkably rare among an Acholi sample (as described in the section above). An analysis of qualitative symptom descriptions from the Acholi region by Birbaum (2006) also concluded that avoidance symptoms were rarely reported.

Symptoms of re-experiencing and hyperarousal symptoms on the other hand were common. This is in line with the assumption that symptoms of avoidance are strongly shaped by cultural influences, while symptoms of reexperiencing and hyperarousal relate to universals in human responses to stress. Jenkins (1996) criticizes that reactions of immobilization (freezing) and the notion of collective trauma are not considered in the DSM-IV.

In a thoughtful review on ethnocultural variations in somatoform and dissociative disorders and potential implications for PTSD, Kirmayer (1996) underlines that culture specific idioms of distress may make certain somatic symptoms or attributions especially outstanding, while de-emphasizing others. Social norms and stigmatization of mental illness might inhibit the expression of psychological symptoms. Most importantly, dissociation is socially more accepted in traditional cultures, which might lead to a higher inclination to dissociate as a reaction to traumatic stress (Kirmayer, 1996). The content and interpretation of such dissociative experiences is usually strongly shaped by culture (Odenwald, van Duijtl & Schmitt, 2007).

In a study on Mexican victims of disaster, Norris, Weisshaar et al (2001) used qualitative methods to elicit emic perspectives and symptom descriptions following exposure to traumatic stress. They conducted 24 unstructured interviews, with the major and central question being: “It [the disaster] must have been awful, how did the disaster affect you and others who lived here?” (Norris, Weisshaar et al., 2001, p. 743). Interviewers were instructed to avoid any prompting for specific symptoms. The interviews, lasting between 45 minutes and two hours each, were recorded on audiocassettes and yielded several

hundred pages of transcripts. These transcripts were then coded with references to the 17 symptoms of PTSD specified in the Diagnostic and Statistical Manual of the APA. Symptoms were coded affirmative only, when coders agreed that the symptom had been specifically described by the interviewee without having been specifically prompted by the interviewer.

Descriptions of symptoms that could not be classified as one of the DSM criterion symptoms were each written on a card. The cards were then sorted into conceptually coherent groups by nine adult Mexican volunteers. Cluster analysis of the pile sorts revealed five clusters of posttraumatic symptoms that do not feature in the PTSD diagnosis of the DSM and might be culture specific. These included 'ataques de nervios', depression, lasting trauma, pain and illness, weakness and weight loss. The analysis revealed that, apart from potentially culture specific symptoms, DSM criterion symptoms were also often mentioned. Norris, Weisshaar et al. (2001, p. 750) summarize: "… we believe the evidence from this study solidly supports the relevance of PTSD for Mexican survivors of disaster." They however recommend that any comprehensive assessment of well-being among Mexican disaster survivors should also include ataques de nervios, depression and physical health, apart from PTSD. The importance of including culturally sanctioned and specific responses in disaster research had also been emphasized by Green (1996). He pointed out that, contrary to popular belief, people experiencing *ataques de nervios* do regularly meet criteria for mental disorders (see also Guarnaccia & Rogler, 1999).

Terheggen, Stroebe & Kleber (2001) conducted a study among Tibetan refugees in India with the aim of identifying cross-cultural differences in traumatic experiences and traumatic stress reactions. They put forward that the destruction of temples and other religious signs and buildings as well as the prohibition to live according to one's own religion and culture are traumatic experiences in Tibetan culture. Although the study did not include any standard PTSD assessment, an applied intrusion-avoidance measure suggested that a PTSD-like syndrome is diagnosable among Tibetans. Further, intrusion-avoidance was significantly related to anxiety, depression and somatic complaints. Terheggen, Stroebe & Kleber (2001, p.402) infer that "western conceptualizations of trauma and distress provide a useful basis for starting investigations in nonwestern cultures".

Matkin, Nickles, Demos & Demos (1996) report on another study that examined cultural effects on symptom expression among Cambodian and Vietnamese refugees. They interpret the results as supporting the cross-cultural validity of the PTSD construct among

Cambodians. For the Vietnamese group the data were less conclusive. Noteworthy was a higher proportion of somatic complaints reported by Vietnamese patients in comparison to Cambodians. This result is consistent with findings of research on depression which documents stronger tendencies to somatization in Chinese and closely related cultures[20].

9.4 Intervention

Assessing PTSD in the cross-cultural context should of course not be an end in itself. The described research efforts are mainly justified by the hope that the concept might be helpful in identifying and relieving suffering related to traumatic experiences across cultures. The controversy on the application of the PTSD concept in complex emergencies has already been outlined in the INTRODUCTION to this thesis.

In the following, we give a brief outline on literature that provides general guidelines for treating PTSD in the cross-cultural context. Then we describe Narrative Exposure Therapy, a specific approach to treating PTSD across cultures.

9.4.1 General principles for treating PTSD across cultures

Globalization and increasing cultural diversity in all parts the world increasingly confronts mental health systems with the need to develop approaches for mental health care that take this diversity into account. While the existing literature on ethnocultural considerations in treating PTSD mainly refers the North American and European context, there is increasing consent that psychotherapy with ethnic minorities requires the consideration of their specific cultural background (Boehnlein, 1987; Kirmayer, Simpson & Cargo, 2003; Marsella, 2003).

Generally, experts tend to agree that people from non-Western countries who meet the diagnostic criteria for PTSD show a similar response to treatment as do Westerners (Friedman & Jaranson, 1994). Nevertheless, it is deemed important to adjust general

[20] The people of Vietnam supposedly have their origins in southern China, whereas Cambodians are said to be of Malay-Indonesian origin (Matkin et al, 1996)

treatment strategies to the cultural background of the client. Marsella et al (1996b, p. 536) write:

> … it appears that non-Western traumatized individuals with PTSD can benefit greatly from a trauma-oriented treatment approach. Within the context of PTSD-focused treatment, there is plenty of room for therapeutic strategies that are culturally sensitive and that incorporate specific treatments for individuals from specific ethnocultural backgrounds.

Various models and guidelines on cross-cultural psychotherapy have been published. Kinzie (2001) has presented clinical guidelines for the cross-cultural treatment of PTSD, including structure and staffing issues for practical programs. Peltzer (1996) gives detailed outlines on how to set up counseling and psychotherapy services for victims of organized violence in different socio-cultural contexts, including Malawi, Uganda and Germany. Gusman et al (1996) propose a multicultural developmental approach for the treatment of trauma. Lustig (2003) provides a procedural manual of 'testimonial psychotherapy' and presents a series of case descriptions on its application with adolescent Sudanese refugees in the United States (Lustig, Weine, Saxe & Beardslee, 2004). Straker (1994) has published a case study on integrating African and Western healing practices in South Africa. Kirmayer, Groleau, Guzder, Blake & Jarvis (2003) describe a service model of 'cultural consultation'.

The quoted literature on treating PTSD across cultures offers valuable guidelines for clinical practice. It suggests that clinicians who intend to work with clients from different cultural backgrounds should receive formal training in cross-cultural psychotherapy and attain a good level of familiarity with clients' cultures through literature study and travel (Marsella, 2003). Before planning and engaging in interventions, a clinician should assess the patient's ethnocultural identity, cultural explanatory models, as well as culture-related stressors and ways of coping. In the diagnostic and therapeutic process, the clinician should also consider principles of cultural equivalency and be aware of cultural expressions of distress (Boehnlein, 1987). Psychotherapy in the intercultural context does not only require a high level of cultural knowledge and skills, but also much flexibility and open-mindedness from the side of the clinician. Often, the help of interpreters and culture brokers must be sought to bridge language or cultural gaps and add valuable cultural knowledge to clinical expertise (Kirmayer, 2003). Importantly, the treatment should be open to integrating healing practices specific to the client's culture. This can be done by collaborating with traditional healers (Stamm & Friedman, 2000). Manson et al (1996) underline the importance of traditional ceremonies for healing among American Indians.

Although past traumatic experiences must be considered in refugee mental health care, Lustig, Kia-Keating et al. (2003) underline that approaches to assessing and treating refugees should avoid narrowly viewing them as victims of traumatization. Rather, post-flight stressors and potentially protective factors need to be given adequate attention. Their recommendations are supported by empirical evidence, which shows that unspecific stress can significantly influence the course of posttraumatic stress disorders (Porter & Haslam, 2005; Steel, Silove, Bird, McGorry & Mohan, 1999).

The aforementioned guidelines and suggestions represent the valuable knowledge of experts with extensive clinical and research experience in the cross-cultural field, though their potential impact on cross-cultural treatments has not yet been evaluated in controlled empirical studies. They are meant to improve assessment and treatment across different therapeutic techniques, without being specific to defined treatment approaches.

9.4.2 Narrative Exposure Therapy

A treatment for PTSD that has already been manualized and subjected to empirical scrutiny across cultures is Narrative Exposure Therapy (Schauer, Neuner & Elbert, 2005). This therapy has been developed on the base of positive experiences reported with Testimony Therapy, a therapeutic approach used to treat survivors of the Pinochet Regime in Chile (Cienfuegos and Monelli, 1983, quoted in Neuner, Schauer & Ehlers, 2001). Below, we briefly summarize the procedure of Narrative Exposure Therapy (NET), following the treatment manual by Schauer, Neuner & Elbert (2005).

Rationale

NET has much in common with and borrows the main treatment principles of cognitive behavior therapy, with specific emphasis on exposure to past traumatic events and on integrating the hot traumatic memories into cool autobiographic memories.
However, these principles are adapted to suit specific needs often encountered in low-income countries. Systematically developing a narrative over the whole life span addresses the needs of people who have gone through a long history of multiple traumatic events. (Such histories are often found with refugees and victims of wars in low-income countries.) Further, its brevity makes it apt for application in settings with extremely limited resources.

Procedure

After thorough clinical assessment (including traumatic events and posttraumatic symptoms) the therapist explains the treatment rationale. During the treatment that consists of about 4-6 sessions of approximately two hours, the clinician supports the client in constructing a narrative of his life, which includes both the most positive and the traumatic events. The therapist pays attention to allow for habituation when the client describes traumatic events and to foster the integration of traumatic memories into 'cold' autobiographic memory. In the course of the therapy, a document containing the narrative of the client's traumatic history is written and signed by both client and therapist.

Empirical support

The efficacy of NET has been tested in a randomized controlled trial in the Ugandan West Nile region (Neuner, Schauer, Kaschlik, Karunakara & Elbert, 2004; Neuner, 2003). Sudanese refugees diagnosed as suffering from PTSD (N=43) were randomly assigned to 4 sessions of NET, 4 sessions of supportive counseling, or one session of psycho-education. Expert assessments using the PTSD section of the Composite International Diagnostic Interview (CIDI) in a follow-up revealed that one year after treatment only 29% of the NET group met the criteria for PTSD. In comparison, 79% of the clients who had received supportive counseling and 80% of the psycho-education group were still diagnosed as suffering from PTSD (Neuner, Schauer, Kaschlik, Karunakara & Elbert, 2004).

Another controlled study has been carried out with refugees living in Germany (Schauer et al, 2006). It compared NET as defined in the manual (Schauer et al 2005) with 'treatment as usual' (TU). 'Treatment as usual' included therapeutic interventions commonly applied with traumatized refugees in Germany, such as stabilization, activation of resources, relaxation and medication. Results revealed an effect size of 1.6 for the NET group and 0.4 for the TU group on reducing PTSD symptoms. Moreover, the success of NET could be demonstrated in parameters of neuromagnetic brain activity (Schauer et al, 2006).

Further uncontrolled trials and case studies suggest that NET is a promising treatment for traumatized refugees and victims of war across cultures. Onyut et al (2005) and Schauer et al (2004) present case reports and a pilot study on Somali children treated with a child-friendly version of NET. Neuner et al (2002) provide a case report on the use of NET in a refugee camp in Macedonia.

The presented results need to be interpreted with caution, as so far only few studies with small sample sizes do exist. However, they do warrant and even call for further investigating the approach.

PART FOUR: A 'TRADITIONAL' PERSPECTIVE ON COPING WITH TRAUMATIC STRESS

So far, we have depicted the background to this study by portraying the psychosocial consequences of the civil war in Northern Uganda and delineating the history and general tradtions of the Acholi people in PART ONE of this thesis. In PART TWO we have given an outline on the clinical knowledge on disorders of posttraumatic stress and related interventions, thereby depicting a Western clinical perspective on phenomena of traumatic stress. In PART THREE we have discussed cross-cultural issues on mental health and posttraumatic stress, including an outline on methodological concerns, as well as a review of literature on the cross-cultural epidemiology of PTSD and respective interventions.

In the following empirical part of the thesis, we approach the topic of traumatic stress from an emic perspective by providing an ethnography that focuses on 'traditional ways of coping with traumatic stress in Acholi'. CHAPTER 11 gives a systematic outline on general concepts and healing rituals in Acholi. CHAPTER 12 offers case studies, which illustrate how some of the rituals are applied in the contemporary social context. Before we come to this, we describe the methodology of the study.

10 Methodology of the study

In consideration of the specific research questions and research context outlined in the INTRODUCTION, the study mainly applies a qualitative approach. Different ethnographic methods, such as key informant interviews, participant observation, and case studies were adapted and combined to produce a coherent research design.
The anthropologist James P. Spradley (1979, p.3) defines 'ethnography' as follows:

> Ethnography is the work of describing a culture. The essential core of this activity is to understand another way of life from the native point of view.

The above definition is still valid today, although ethnographic research has undergone significant changes over the last decades. First, in the mid of the past century the interest most typically focused on 'exotic' people in remote corners of Africa, Asia and Latin America. Meanwhile, the attention of ethnographers has shifted to describing subcultures next door in their home countries (McCurdy, Spradley & Shandy, 2005). Second, ethnography in its early days typically tried to cover every important aspect of social life. Modern ethnographies usually concentrate on specific themes to investigate them more in depth (Valsiner, 2002). The ethnography presented in this thesis might appear old-fashioned for having chosen to describe 'traditions' of an African ethnic group. It is 'modern' for its limited focus on a specific topic.

In the following, we describe the research process and applied methods. We start by defining the terms and scope of the study. The second section gives an outline on the study design and general research process. Subsequently, we describe the procedures of data collection, including sampling, descriptions of samples, and the methods of data collection (key informant interviews and participant observation). The final section explains the procedures of data preparation and analysis, including transcription, translation and organizing data according to themes, as well as different forms of triangulation to check for consistency of data and validity of findings.

10.1 Definition of terms

The title *Traditional Ways of Coping with Traumatic Stress in Acholiland* contains three key terms that need clarification: 'Traditional', 'coping', and 'traumatic stress'.

Traditional: For the sake of the present investigation, we define the terms 'traditional' and 'traditions' pragmatically. 'Tradition' in this study is not a theoretically defined construct, but reflects the meaning given to it by our key informants. The Acholi have a consistent understanding of the words 'traditional' and 'traditions', and the Acholi language already provides important information in this respect. The words 'traditional' and 'traditions' are usually translated with phrases like "kit ma Acholi macon gitimo" (the way the Acholi did it in the old days), "kit ma Acholi macon giniang" (the way Acholi understood it in the old days), "tic Acholi" (Acholi rituals) or "cik Acholi" (Acholi customary law). These phrases show that people understand traditions as being closely related to their ethnic identity. The word "macon", which could be translated with 'in the old days', or 'in earlier times', however, does not refer to a concluded past, but to a past that is still living in the present days. It is still living in the memories of the people, in culturally shaped interpretations of the world and in ways of coping with misfortunes.

Coping: The term coping according to Lazarus & Folkman (1984) refers to a reiterative process that implies cognitive and behavioral efforts to manage situational demands (both external and internal) that have been appraised as taxing or exceeding the resources of the person. The conceptualization of coping as a "key concept for theory and research on adaptation and health" (Lazarus, 1993, p.234) has stimulated much research and the development of various refined concepts and taxonomies (Perrez, Laireiter & Baumann, 2005). Building on and extending Lazarus' work, Perrez & Reicherts (1992a) have conceptualized coping as personal responses to situations characterized by specific demands. The concept has also been applied to diverse clinical areas (Christensen & Kessing, 2005; Galvin & Godfrey, 2001; Perrez, 1992; Perrez & Reicherts, 1992b) and comparing different cultures (Farley, Galves, Dickinson & Perez, 2005; Mitschke, 2009).

With regard to the research questions outlined in the INTRODUCTION (especially questions 2 to 4), the term coping in our study does not imply the application of the sophisticated framework developed in the ample research on coping, as sketched above. Instead, we use the phrase 'coping' with traumatic stress in a colloquial sense, with the meaning of 'managing', or 'dealing with' traumatic stress.

Traumatic stress: We understand 'traumatic stress' as a psychobiological reaction to a traumatic experience. A traumatic experience implies exposure to an event that is perceived as threatening to one's own or a close associate's life or physical integrity (cf.

criterion A1 in the DSM IV definition of PTSD). To leave our cross-cultural investigation open to encompass potentially culture-specific responses, we deliberately leave the response of the concerned individual undefined. In this aspect, we keep with the event definition provided by the ICD 10 (in contrast to the DSM definition, which specifies the emotional response in criterion A2; cf. CHAPTER 3.1.1).

Putting the above definitions together, we define the topic of this thesis, 'traditional ways of coping with consequences of traumatic stress', to include Acholi concepts and procedures that are applied to manage perceived (bio-) psychosocial threats arising in the aftermath of traumatic experiences, particularly in response to events that include a threat to one's life or physical integrity (e.g. war, killings, and hunting incidents).

10.2 Design of the study and general research process

The following section describes the principal investigator's access to the field and his cooperation within a team of local researchers. Further, it outlines the general features of the research process.

10.2.1 Access to the field and cooperation in the team

In ethnographic research, access to the field is a major topic (Delamont, 2004). Usually, it means the investigator, after a thorough study of literature, goes out to the field to make observations and locate cultural informants who are willing to talk about the researcher's topics of interest (Spradley, 1979; McCurdy, Spradley & Shandy, 2005).

The access to the field for this study was different. When data collection for the research project started, the principal investigator had already been working in Northern Uganda for more than two years, as a consultant to a Psychosocial Support Program. This had allowed him to be acquainted with the local 'culture' and the local vernacular (Acholi language). Additionally, the close cooperation with local colleagues in his daily work had helped to build up trust and mutual respect, another important precondition for successful teamwork and team research (Mitteness & Barker, 2004). With time, it had also turned out that members of the Psychosocial Support Program were interested in exploring the traditions of their own people. This constellation opened an 'access to the

field' that would have otherwise been barely open to 'outsiders' of the local culture. The 'psychosocial team' provided complementary skills and expertise that were essential for the research project. The local colleagues had a far better understanding of the local culture to begin with, excellent skills in the local language and the membership of the ethnic group under investigation. The principal investigator had a better understanding of methodological issues and was in a better position to keep the necessary distance to the topic, which is equally important in social research (Delamont, 2004).

The complementary composite of the team formed the basis of our 'collaborative research' and led to define different foci of responsibilities of local researchers and the principal investigator. The decisions, which topics to choose for investigation were taken together as a team, while the principal investigator was advising the team on methodological matters. The local researchers carried out the data collection, which included key informant interviews and participant observation. They were also in charge of writing selective transcripts of the tape-recorded key informant interviews and of writing summaries of their participant observations. These tasks implied some data analysis and interpretation, as will be discussed in more detail further below. Editing transcripts and summaries was done in a collaborative work by the principal investigator and the local researchers. The final analysis of the data and the writing of the ethnography was then again the responsibility of the principal investigator, while local researchers were continuously consulted on specific questions. Figure 2 gives an overview of the responsibilities and tasks carried out by the principal investigator and local researchers.

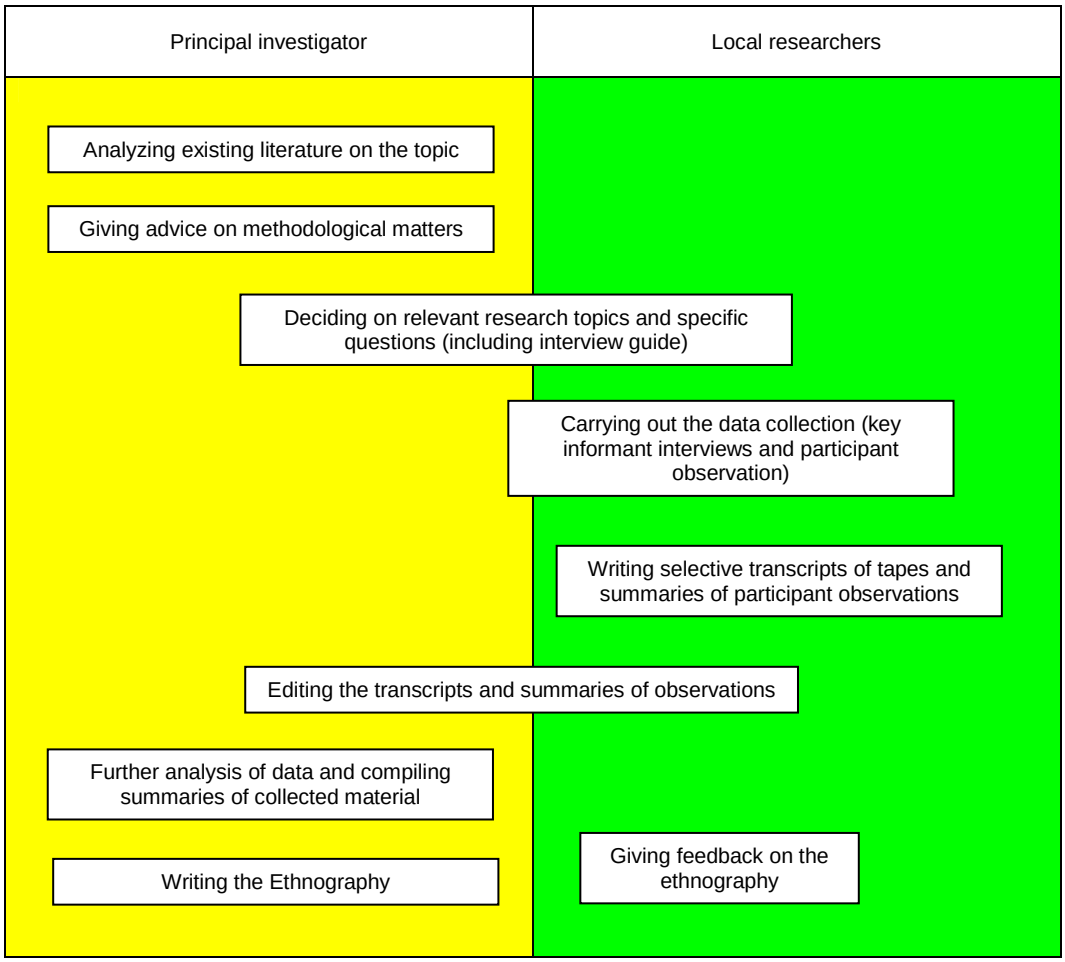

Figure 2: Responsibilities and Tasks of Principal Investigator and Local Researchers

10.2.2 Research process

Following research questions 1 and 2 outlined in the introduction, we started by mapping out specific research topics. Based on these topics, we drew up a first set of specific questions, which made up the first semi-structured interview guide. Equipped with such guide, the local researchers went out to identify key informants and carry out the first round of data collection. An important methodological consideration was to pose the same set of questions to several key informants to allow getting a sense of the consistency and variations of the responses. Based on the analysis of the data collected in the first round, we identified new and usually more specific areas of inquiry and worked out respective questions for further interview guides. This reiterative process of collecting data and working out specific questions for further interviews was repeated continuously to cover more of the proposed topics and provide richer material on the issues of interest. Figure 3 gives an overview of the research process.

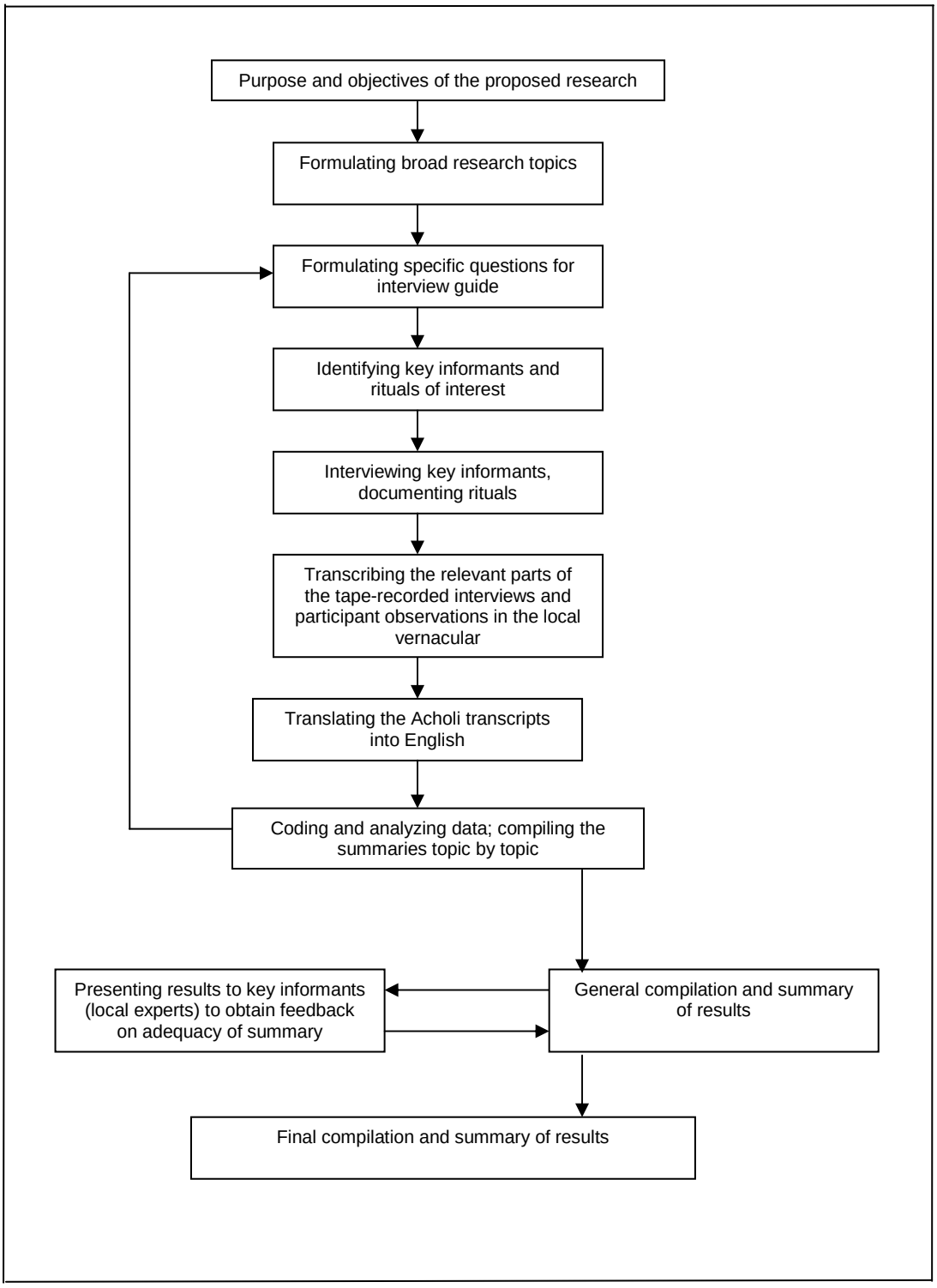

Figure 3: Overview of Research Process

Another crucial ingredient to the research design was combining different methods of data collection to allow examining the consistency and validity of the data (for example, by comparing data from key informant interviews with data from participant observation). The details of these triangulations will be described in CHAPTER 10.4.

10.3 Data collection

Data collection for this study was carried out in a particularly violent phase of the Northern Ugandan Conflict, between February 2004 and July 2006. During this time, military threats restrained movement and it was generally dangerous to stay in areas remote from towns. Despite these challenges, we managed to collect data from various Acholi areas (see below). This was mainly achieved by utilizing the structure and network of the Psychosocial Support Program (PSSP) of Caritas Gulu that employs social workers in all three Acholi districts (Gulu, Kitgum and Pader). Employees of the PSSP often provided us information on cultural informants and local traditional activities, which enabled the researchers to collect data effectively when in the field. Thus, dangerous journeys to rural areas could be limited.

In the first year of research, expert interviews (e.g. with traditional healers and elders) were the main method of data collection. Such interviews were most adequate to get a general picture on the relevant concepts and traditional procedures. After we had clarified on the most crucial concepts and identified the most important rituals, the focus shifted towards participant observation of specific rituals and case studies. This shift pursued the aim of documenting specific traditional procedures in detail and collecting illustrative material on how they are applied in the contemporary social context.

Although data collection was the prior responsibility of the local researchers, the principal investigator in several occasions accompanied them for interviews and participant observation of traditional rituals. This allowed him to confirm that the interviewers followed the agreed methodological guidelines for interviewing and participant observation and produced faithful records of interviews and observed rituals.

10.3.1 Sampling procedures

The selection of key informants and rituals to be described mainly followed the rationale of 'purposeful sampling' (Patton, 2002), or 'theoretical sampling' (Glaser and Strauss, 1967), as is typical in anthropological research (Bernard, 1995; Spradley, 1979). Cultural experts were selected for their superior knowledge on specific aspects of the local culture. This sampling rationale follows the dominant view in anthropology that the cultural competence of key informants (not representativeness of the sample) is crucial for the quality of an ethnographic study (Bernard, 1995; Spradley, 1979; See Gobo, 2004, on arguments justifying the use of non-probability samples in qualitative research). To account for the possibility of varying 'traditions' among the Acholi, we sampled informants hailing from different geographical areas. We collected data from all three Acholi districts (Gulu, Kitgum and Pader) and further analyzed data according to eight geographical areas, which Atkinson (1999) describes as different 'zones' within the Acholi territory (see description of the samples below). The selection of key informants was also co-determined by the accessibility of the area in which key informants lived and their willingness to contribute to the research without being paid.

Sampling for individual expert interviews: When sampling for individual expert interviews, we realized another stratified element by selecting informants representing various traditional roles in the community (see description of the samples below). To identify cultural experts for individual interviews, we asked community members and social workers familiar with local communities, who among them are most competent in a specific cultural domain (as typical in ethnographic studies, c.f. Bolton, 2001b).

Sampling for focus groups: The sampling for focus groups was similar to the above-described procedure for individual interviews. However, for focus groups we did not maintain the stratified selection with respect to 'community roles' of the participants. Here, the selection of participants captured a more homogeneous sample, almost exclusively consisting of elders and chiefs (see description of the sample below). The more homogeneous composition was deemed culturally more appropriate to allow for discussions on concepts and procedures that elders are most familiar with.

The sampling for participant observation of rituals and for case studies followed the information given by our key informants and the purpose of the study (see Patton, 2002, and Glaser & Strauss, 1967, on 'theoretical' or 'purposeful sampling'). Participant observations pursued the objective of depicting rituals, which our cultural experts had described, in more detail and allow checking for consistency of data. Case studies were to illustrate how traditional ways of coping are practiced in the contemporary social context. They were often reconstructed retrospectively through interviews with informants who had

been involved in the performance of a traditional ritual in different roles. When the researchers heard about such cases *before* the ritual was carried out (mostly through social workers of the Caritas Psychosocial Support Program), they asked the concerned community if they were allowed to witness the ritual. If the community agreed and other practical reasons (military insecurity, time schedules) did not impede attendance, the researchers traveled to the spot well before the specified date to document the procedures through participant observation.

10.3.2 Description of the samples

Overall, the study reflects data from 29 individual expert interviews, 11 focus groups, 11 participant observations of rituals and 40 (non-expert) interviews with community members who were involved in traditional healing procedures. The latter 40 interviews were carried out in the context of case studies. Below, we describe our samples of key informants on four variables: 'cultural zone', 'traditional role in the community', gender and age.

'Zones' reflect clusters of Acholi clans and chiefdoms that have in the past maintained most frequent friendly interactions and thus supposedly show the lowest variance in traditions (for details see Atkinson, 1999; Harlacher et al., 2006). Atkinson (1999) gives estimates on the population of zones (ANNEX 2, table A), which enable us describing our sample with regard to the relative population size in 1900. (Better figures are not available, as 'pertinence to former chiefdoms' or 'zones' is not part of official census data.)

Individual expert interviews

Table 2 shows the dispersion of the 29 individual expert interviews over the different zones.

Table 2: Individual Expert Interviews According to Acholi Cultural Zones

	Zones								
	Zone 1 South-Eastern Zone	**Zone 2** Central Zone	**Zone 3** North - Central Zone	**Zone 4** East-central Zone	**Zone 5** Western Zone	**Zone 6** South-Central Zone	**Zone 7** North - Eastern Zone	**Zone 8** North-Western Zone	**Totals**
Estimated population by 1900	32.150	25.500	24.800	16.800	14.000	5.500	3.400	3.000	125.150
Estimated percentage of population	25,7	20,4	19,8	13,4	11,2	4,4	2,7	2,4	100,0
No. of experts interviewed	**5**	**5**	**7**	**8**	**3**	**1**	**0**	**0**	**29**
Percentage of the sample	16,7	16,7	23,3	26,7	10,0	3,3	0,0	0,0	100,0

Note. The table shows the relative population sizes according to zones as estimated by Atkinson (1999), as well as numbers and percentages of expert interviews carried out in these zones.

The sample represents 6 out of 8 zones. The two remotest zones, which during the period of data collection were inaccessible due to military insecurity, are not represented in the sample. Following Atkinson's (1999) estimates, the population of the unrepresented lineages of zones 7 and 8 makes up about 5% of the Acholi people. Zones 1, 2, 5, and 6 are slightly underrepresented, while zones 3 and 4 are somewhat overrepresented, with the achieved percentages of the perfect quota[21] ranging from 65 to 199 percent.

Table 3 shows the numbers of individually interviewed cultural experts according to 'traditional role' and 'gender'.

Table 3: Individual Expert Interviews According to Gender and Traditional Role in the Community

Community role of informants	Men	Women	Total
Chiefs	2	0	**2**
Elders without specific duties	8	2	**10**
Atekere[a]	3	0	**3**
Rwodi Kweri[b]	1	0	**1**
Ritual performers[c]	5	0	**5**
Ajwaki[d]	0	7	**7**
Herbalists[e]	0	1	**1**
Total number	**19**	**10**	**29**
Percentage	**65,5**	**34,5**	**100**

[a]Atekere: elders with specific duties in the general performance of rituals. [b]Rwodi Kweri: elders with specific duties in conflict resolution. [c]Ritual performers: elders in charge of performing specific rituals, e.g. kwero

[21] Achieved pecentage of perfect quota = percentage of sample / percentage of population * 100%

merok. [d]Ajwaki: traditional Acholi healers who use spirits, herbs and other means to heal. [e]Herbalists: healers who use only herbs to heal.

The sample includes chiefs and 'common' elders, elders with specific duties in the general performance of rituals (atekere) and in conflict resolution (rwodi kweri), and elders entitled to perform specific rituals because of their specific experience (ritual performers). It also includes spirit media (ajwaki) and healers healing through herbs only (herbalists). (For further explanations of the offices of elders and healers, see CHAPTER 1, especially 1.2.2 and CHAPTER 11, especially 11.1.2.) The composition of the sample with regard to the roles of the informants in the community is not intended to be representative of Acholi society, but to reflect the different perspectives of 'experts on traditions' with their specific core competences.

With regard to the general population, the sample is unbalanced for gender (about two-thirds of the informants are male). Further, it is unbalanced for age, with older people being overrepresented (see ANNEX 3, table B). The average age in this sample was 57 years. Given an average life expectation of about 50 years in Uganda (World Bank, 2006) and strikingly high mortality rates in war-torn Acholi districts (Médecins Sans Frontières, 2004) further lowering the average life expectation, we have certainly captured an extreme segment of the society with regard to age. On gender and age, the composite of the sample reflects the dominant position of elder men in a traditionally patriarchic society. The 'List of cultural experts – individual interviews' in ANNEX 3 (table B) gives further details on this sample.

Focus groups

We carried out 11 focus groups with 135 respondents in total. Table 4 shows the dispersion of the focus groups over the different zones.

Table 4: Focus Groups According to Zones

	Zones								
	Zone 1	**Zone 2**	**Zone 3**	**Zone 4**	**Zone 5**	**Zone 6**	**Zone 7**	**Zone 8**	**Total**
Estimated percentage of population	25,7	20,4	19,8	13,4	11,2	4,4	2,7	2,4	100,0
Number of experts interviewed	**1**	**3**	**3**	**3**	**1**	**0**	**0**	**0**	**11**
Percentage of the sample	9,1	27,3	27,3	27,3	9,1	0,0	0,0	0,0	100

The sample represents 5 out of 8 zones. The three unrepresented zones (6, 7, and 8) correspond to 9.5% of the total Acholi population (according to estimates by Atkinson, 1999). Zones 1 and 5 are underrepresented, while zones 2, 3 and 4 are overrepresented, with the achieved percentages of the perfect quota ranging from 35 to 204 percent.

As in individual expert interviews, men of older age are overrepresented in the sample of focus groups (see ANNEX 3, table C). With regard to community roles, it represents only the roles of elders and chiefs. Table C in ANNEX 3 lists further details on this sample.

Community members interviewed in the context of case studies

Table 5 shows the dispersion of the 40 interviews with community members carried out in the context of case studies over the different zones. The sample represents 6 out of 8 zones. As for the individual expert interviews, the population of the unrepresented lineages of zones 7 and 8 makes up about 5% of the Acholi people, following Atkinson's (1999) estimates. Zones 1 and 6 are slightly underrepresented, while zones 2, 3, 4, and 5 are moderately overrepresented, with the achieved percentages of the perfect quota ranging from 70 to 325 percent. Zone 3 (North-Central Zone) is strongly overrepresented due to case studies on a specific ritual that we deemed especially interesting on healing from traumatic stress (kwero merok). We were able to localize this ritual in northern zones only.

Table 5: Community Members Interviewed for Case Studies According to Zones

	Zones								
	Zone 1	**Zone 2**	**Zone 3**	**Zone 4**	**Zone 5**	**Zone 6**	**Zone 7**	**Zone 8**	**Total**
Estimated percentage of population	25,7	20,4	19,8	13,4	11,2	4,4	2,7	2,4	100,0
Number of experts interviewed	**5**	**8**	**18**	**4**	**4**	**1**	**0**	**0**	**40**
Percentage of the sample	17,9	28,6	64,3	14,3	14,3	3,6	0,0	0,0	100,0

Table 6 shows the numbers of community members interviewed in the context of case studies according to 'traditional role' and 'gender'. The composition of the sample is to reflect the perspective of the 'non-expert' community involved in traditional practices.

The sample includes people who were involved in rituals either as persons who had a ritual carried out on them, or as ritual performers, or as concerned community

members (relatives and friends) or social workers. We mostly interviewed persons who were subject to traditional healing rituals and their close family members, but also interviewed other community members, especially elders and social workers.

With 55% male and 45% female respondents, the sample is rather balanced for gender (see table 6). With an average age 41 years, the community sample is markedly younger than the sample of experts interviewed individually.

Table 6: Community Members Interviewed for Case Studies According to Gender and Traditional Role in the Community

Community role of informants	Men	Women	Total
Persons subject to traditional rituals	9	3	**12**
Members of close family	6	7	**13**
Elders	4	1	**5**
Social workers	1	5	**6**
Other community members	2	2	**4**
Total number	**22**	**18**	**40**
Percentage	**55**	**45**	**100**

Further details on community members interviewed for case studies are listed in ANNEX 3, table D. Table F in ANNEX 3 gives a synopsis of individual expert interviews and community interviews according to gender and role in the community.

Participant observations of rituals

Table 7 shows the dispersion of participant observations of rituals over the different zones. The sample represents 4 out of 8 zones. The four unrepresented zones (1, 6, 7, and 8) correspond to 35.2% of the total Acholi population (according to estimates by Atkinson, 1999). Zone 4 is somewhat underrepresented, while zones 2, 3 and 5 are overrepresented, with the achieved percentages of the perfect quota ranging from 68 to 223 percent.

Table 7: Participant Observations of Rituals and of Divination by an Ajwaka According to Zones

	Zones								
	Zone 1	**Zone 2**	**Zone 3**	**Zone 4**	**Zone 5**	**Zone 6**	**Zone 7**	**Zone 8**	**Total**
Estimated percentage of population	25,7	20,4	19,8	13,4	11,2	4,4	2,7	2,4	100,0
Number of experts interviewed	**0**	**4**	**3**	**1**	**2**	**0**	**0**	**0**	**10**
Percentage of the sample	0,0	45,5	27,3	9,1	18,2	0,0	0,0	0,0	100,0

The fact that the sample of participant observations leaves 4 zones unrepresented, has practical reasons: Carrying out participant observations of rituals was the most demanding task, as it usually required the team getting informed of an impending ritual weeks or at least days before it was actually performed. The team then had to assess whether the security situation and logistics (e.g. transport) permitted the journey and stay in the locality where the ritual was to take place. As even then the actual date of the ritual was usually vague, depending on dynamics in the community, researchers often had to travel days before the ritual began and stay in the field for several days. Because of these practical reasons, four participant observations were carried out in zone 2 (Central Zone), where the head office of Caritas Gulu was situated (see table 7). Further details on participant observations are listed in ANNEX 3, table E. A synopsis of interviews and participant observations according to zones is given in table G, ANNEX 3.

10.3.3 Semi-structured key informant interviews

Semi-structured interviewing was, apart from participant observation, the method of choice for collecting our data. It combines two qualities crucial for our study: On the one hand, it allowed the local researchers enough flexibility to engage in a ‘natural’ dialogue with key informants while respecting cultural conventions. On the other hand, it warranted collecting comparable qualitative data in a systematic process.

10.3.3.1 General procedures

The general methodological considerations to semi-structured ethnographic interviewing were informed by anthropological writings, such as Spradley (1979) and Bernard (1995).

Book chapters and articles selected by the principal investigator were made available to the local researchers and relevant issues discussed in the team. On the base of such discussions, the team agreed on methods and strategies. The main purpose of the applied methods in interviewing was to help informants remember and express their cultural knowledge, and enable the researchers carry out the documentation in a systematic and transparent process. Key strategies in this sense were the researchers' staying 'consciously naïve' during ethnographic interviewing and posing open-ended questions without inadequately influencing the informants' answers.

As is common practice in ethnographic research (Spradley, 1979), we tape-recorded the interviews. The audio records were the base for transcriptions and detailed analyses of the contributions. In the introduction to the interviews, the interviewers explained that a tape recorder would be used and sought the consent of the informants. In practice, informants willingly agreed without exception.

The local researchers conducted interviews individually and the discussions in focus groups. By combining the two approaches, we wanted to make use of the strengths of both methods. Individual interviews were expected to be easier to direct and allow discussing specific topics more in depths. Focus groups were likely to involve richer dynamics that were considered instrumental for our research (for example triggering complementary contributions through statements of participants; comparison of opinions; developing consent or dissent on specific topics). The facilitation of the focus groups was guided by general considerations on ethnographic interviewing (Bernard, 1995; Spradley, 1979), by principles on guiding focus groups (Macnaghten & Myers, 2004) as well as by the cultural competence of the local researchers and the interview guide.

10.3.3.2 Construction of the interview guides

To carry out semi-structured interviews, a first interview guide to direct the initial round of data collection had to be constructed. Following the research questions outlined in the introduction to the thesis, we started with the investigation of traditional concepts related to (what in Western psychology is termed) 'traumatic stress' and ways of coping with it (research questions 1 and 2). In line with our definition of tramatic stress (see CHAPTER 10.1), the first interview guide started by describing hypothetical situations that meet the A1 criterion of the PTSD definition in the DSM-IV (cf. CHAPTER 3.1). Key informants were then asked to explain or speculate on likely responses (immediate, short-term and long-term) of people exposed to such events. (When constructing the interview guides, we formulated the questions in the local vernacular (Acholi), the language in which almost all of the interviews were held. This facilitated the formulation of questions that

were meaningful in the local culture and were easily understood by key informants. The questions below reflect the English translations of the Acholi interview guide.)

Examples for items describing hypothetical situations that meet the A1 criterion were:

> *When people go through horrible experiences that are threatening to their life during hunting: what do they do and how do they feel?*
>
> *When people go through horrible experiences that are threatening to their life during war/ fighting: what do they do and how do they feel?*

Other questions were referring to 'committing atrocities', 'being raped' or 'being struck by disasters' such as Ebola. However, while questions on hunting (*dwar*) and war/fighting (*lweny*) prompted elaborate descriptions by key informants, other questions (on atrocities, rape, disaster) were much less successful in eliciting responses.

The second part of the interview aimed at clarifying local concepts, explanations and attributions:

> *The things that you have told us like [mention what key informant has already said] … How do Acholi people understand them?*

The third part aimed at exploring ways of coping:

> *„How can a person who has gone through [mention what key informant has already said] and suffers from [mention what key informant has already said] be helped?"*

Another question aimed specifically at informing the Psychosocial Program on traditional ways of improving the reintegration of returnees from LRA in the current circumstances:

> *"What can be done to help the children / people who come back from LRA captivity?"*

The first interview already led to the discovery of an important local concept (*ajiji*) that bears similarity with the concept of 'traumatic stress'. This prompted us to include further questions in the following interviews:

> *"What is 'ajiji'?"*
>
> *"What are possible causes of 'ajiji'?"*
>
> *"What are the signs of ajiji"?*

ANNEX 4 contains the full range of questions used in the first round of data collection. Five individual interviews were carried out using these questions as the prior guide. The questions of the first interview guide that were successful in eliciting responses were maintained to guide the first round of focus groups. Questions that were not successful in

eliciting responses were dropped (e.g. questions on reactions to rape and disasters). After the first round of individual interviews and focus groups, we had identified the relevant concepts and traditional practices. Further interviews then aimed at clarifying remaining questions on these topics and covering additional topics. One of these topics focused on traditional procedures that could help resolve conflicts within and among communities. Other questions explored traditional activities and structures that were potentially instrumental in fostering resilience. Furthermore, we had early started identifying persons who had gone through traditional rituals. To document the procedures and get a sense of the effects of such rituals, we developed further interview guides. For the cases of returnees who engaged in a ritual of *kwero merok*, the interview guide instructed the interviewers to explore on the following topics: Which were the most distressing experiences in captivity? What were the psycho-social difficulties and troubles the returnee met when back in the community? How did the decision to perform a *merok* ritual come about? Were there changes in (posttraumatic) symptoms and psychosocial adjustment after the ritual? If yes, which changes occurred on the level of symptoms and individual wellbeing? Which changes occurred with regard to the adjustment in the community? The interview guides that have directed later key informant interviews are provided in the COMPANION VOLUME to this thesis.

Since key informant interviews were instrumental in mapping the general ground (including relevant traditional concepts and procedures), we used them as the main strategy of data collection in the first year of fieldwork. To document already identified procedures more in detail and get illustrations of their application in the contemporary social context, we increasingly applied participant observation in later stages of data collection.

10.3.4 Participant observation

Participant observation is *the* strategic method of data collection associated with cultural anthropology (Delamont, 2004). Its specific strength is often seen in its validity, as it observes phenomena in their ‘natural’ setting and attenuates the problem of reactivity that usually accompanies the collection of observational data (Bernard, 2000). In anthropology, the terms ‘participant observation’, ‘ethnography’ and ‘fieldwork’ are frequently used interchangeably, as Delamont (2004, p.218) explains:

> Participant observation, ethnography and fieldwork … can all mean spending long periods watching people coupled with talking to them about what they are doing, thinking and saying, designed to see how they understand their world.

In anthropological fieldwork (or participant observation), the 'spending time with people' is typically accompanied by taking field notes. Such field notes, which are usually *not* part of a 'public record', characteristically form the base of an ethnography (Bernard, 2000).

The approach taken in our study was different from the procedure explained above. Thus, we use the term 'participant observation' in a slightly different way. 'Participant observation' in our study refers to the documentation of specific traditional rituals, which we had previously identified as relevant to our topic. To document such rituals in detail, local researchers (usually two people) went to follow the ritual while taking notes. In addition, a tape recorder was used to record crucial parts of the rituals (for example, when the elders made their pleas to the ancestors). To complement the observational and audio data, we interviewed key persons to the ritual to seek their views and clarify questions on the procedure and context of the ritual. Interviewees included traditional 'experts' (e.g. ritual performers) and 'common' community members. Summaries of the observations (including the interviews) were thereafter transcribed, translated and edited to form part of the (public) database (see COMPANION VOLUME) on which of the ethnography (presented in CHAPTER 11 and 12) is grounded.

In contrast to traditional anthropological methodology, field notes taken outside the context of specific rituals were not central to our approach of data collection. Occasional observations of interest to our research were usually discussed in the team and then often led to the formulation of new questions to be clarified in key informant interviews. Nevertheless, the 'immersion into the field' over several years by the principal investigator, and over a lifetime by the local researchers, provided a continuous flow of instructive observations. These provided an important part of the background knowledge that helped organizing, interpreting and in some occasions complementing the contents of the transcripts.

10.4 Data preparation and analysis

For analyses of qualitative data, a wide range of procedures has been proposed (for overviews, see Bernard, 2000; Fahrenberg, 2002; Faltermaier, 1996; Patton, 2002). The

analysis of data, as described below, generally followed procedures explained by Patton (2002), and was inspired by Mayring's (1989; 2002; 2003) outlines on basic processes of interpretation in qualitative data analysis, namely summarization, explication and organization. The following section outlines the details of the applied procedures.

10.4.1 Transcribing and organizing data according to themes

In order to make the audio data and field notes accessible to careful analysis, we had to computerize them. The tape-recoded key informant interviews were therefore transcribed using MS Word. The field notes and selective audio records taken during participant observation of rituals, as well as tape-recorded interviews with participants were transcribed using the same word processing program.

10.4.1.1 Transcribing tape-recorded interviews and field notes

Regarding the transcription of tape-recorded interviews, a variety of choices does exist. These range from literal transcripts that contain extra information on the details of speech and context (pauses, accentuation, intonation, volume, etc.), to selective transcripts or summaries of content (Mayring, 2002). Given the purpose of our study and the need to economize workload, we considered selective transcripts the most adequate strategy (see Macnaghten & Myers, 2004 for arguments and criteria justifying selective transcripts). When transcribing the audio records, we primarily selected those passages for transcription that contained answers to the before-formulated research questions. This procedure relates to the distinction between "interview-data-as-resource" and "interview-data-as-topic" (cf. Rapley, 2004): we had clearly opted to consider our data as 'resource'.

The concrete procedure for transcribing informant interviews went as follows: As soon after the interview as possible, local researchers listened to the tapes and identified passages that contained information on the topics of our research. They then transcribed them in Acholi language.

With regard to participant observation of rituals, local researchers transcribed field notes, selective audio records, and the recorded interviews with participants. The transcription of interviews carried out in the context of participant observation followed the principles of transcribing interviews described above. The field notes taken during the rituals aimed at describing the witnessed procedures in a comprehensive and conceivable way, focusing on details of psychosocial relevance.

10.4.1.2 Translating the transcripts

After transcription, the local researchers and the principal investigator translated the Acholi text into English in a joint effort. Local researchers did the first translation. To achieve translations understandable to readers foreign to Acholi culture and language, the principal investigator then edited the first English version in close cooperation with the local researchers. Practically, he went through the English text (comparing it to the Acholi) and marked passages that were not sufficiently clear or comprehensible to readers without specific cultural knowledge. In case he clearly understood the Acholi version, he proposed alternative formulations or the insertion of explicating footnotes. If he did not understand the Acholi text either, he highlighted the respective paragraph or sentence. After having gone through the whole text, he sat together with the local researcher who had done the interview and transcription and went through the changes to verify whether the edited passages adequately reflect the meaning intended by the Acholi original. For passages, which the principal investigator had not understood in the Acholi text, the local researchers gave additional explanations. Then they strived together to find an English translation that adequately reflects the meaning of the Acholi version.

At times, words and phrases were difficult to translate. The difficulties in translation were largely due to the huge differences between the two languages and related cultures in question (Acholi and English): Unlike in translations between European languages, problems in finding translations with equivalent meanings were common, as the translation of words often implied the translation (and explication) of cultural meanings (cf. CHAPTER 7.4.2 on cultural equivalence). In such cases, we often opted to use the original Acholi term, while explaining it in footnotes. Nevertheless, we had to limit the use of Acholi terms to produce transcripts clear to readers without knowledge of the Acholi language and to advance towards preparing a readable ethnography in English. Despite the efforts we put into providing a precise translation of the Acholi version, information does inevitably get lost in the process of translation. Therefore, we kept the Acholi text (paragraph by paragraph) in the transcripts. For further data analyses, it was of great value to the principal investigator to be able to refer to the English and Acholi transcriptions simultaneously.

10.4.1.3 Organizing data according to themes

To facilitate the comparison and analysis of the data collected from different key informants and participant observations, we organized the transcripts according to themes that reflected the predefined topics of the study. At the lowest level, we mainly used

indigenous terms as labels (e.g. *ajiji*; *mato oput* and *kwero merok*). At higher levels, we introduced analyst-constructed categories that organized the transcripts into larger coherent sections (e.g. coping with killings; coping with incidents related to hunting, etc.). We formatted all these categories as 'headings' in MS Word documents, including the emic concepts at lower levels. Thus, we could use the word processing program to create tables of content, which reflected the important topics covered in each transcript. Apart from easing the comparison of specific contents of the different transcripts, the described process turned the transcripts into readable and conceivable documents, which make up the COMPANION VOLUME to this thesis.

The headings of the ethnography (see CHAPTER 11) reflect the combined use of emic and analyst-constructed categories as described above. The principal investigator organized the chapter into 'explanations of concepts' and 'descriptions of rituals', which are again sub-divided in different sections, such as 'traditional concepts of disease' and 'traditional healers'. Though local researchers and elders agreed that such organization of the topic does make sense from an emic perspective, there would have been other ways to organize the chapter. The most important point, however, is that the concrete descriptions faithfully reflect emic concepts, such as *cen* and *ajiji* or specific rituals such as *nyono tonggweno* or *lwoko pik wang*. At this concrete level, we were most strongly committed to remain as close as possible to the descriptions given by our key informants.

The above description expounds that transcribing audio records and computerizing field notes already included major steps of data analysis and interpretation. In this process, local researchers have taken important decisions, such as selecting relevant passages for transcription. Translating the transcripts included further acts of interpretation, carried out in a joint effort by local researchers and principal investigator. The principal investigator did the further analyses of the material, such as organizing them into themes, but in the process consulted the local researchers for clarification in cases of remaining doubts on the meaning of certain passages.

So far, we have described the process that led to the compilation of the COMPANION VOLUME to this thesis, which contains the transcripts providing the base for all further analyses of data, including those leading to the ethnography outlined in CHAPTER 11, the case studies in CHAPTER 12 and the interpretations in CHAPTER 13. In these analyses, the concept of triangulation played a major role. The following section describes in which way we have applied the approach in the present study.

10.4.2 Triangulation

Triangulation is a term used in trigonometry, where it defines a process of calculating the coordinates or distance to a point, when the hypotenuse and angles of a triangle are given (or measurable). In qualitative research, the term denotes an array of strategies to control for systematic bias or distortion of results. According to the rationale of triangulation, the accuracy of data and interpretations can be checked by looking at the same data (or phenomenon) from two different perspectives, and comparing the results obtained from these perspectives. Patton (2002) distinguishes between triangulating methods, sources, analysts and theories or perspectives.

The data of the present study permit the comparison of information from key informant interviews and participant observations, from individual interviews and focus groups, and from different key informants interviewed on the same topics (triangulation of sources and methods of data collection). We also compared our data with descriptions of rituals and concepts found in published and grey literature, as well as papers given to us by key informants and community members, although sources of this kind were only few (see table H, Annex 5). As most of the research and data analysis was done in a team, triangulating analysts and theoretical perspectives has also played a major role throughout the process. The ways in which we applied these triangulations differed for the various analyses.

10.4.2.1.1 Triangulation in compiling the transcripts

The above-described process of transcribing key informant interviews and field notes in a joint effort of local researchers and principal investigator already implied the triangulation of multiple analysts with different theoretical perspectives. The analysis included at any time at least two analysts (one local researcher and the principal investigator) who looked at the data from different theoretical perspectives. The local researchers looked at the data from a perspective that was close to an ‘emic perspective’ of culture brokers, moderated by their academic training (bachelor degree) in developmental sciences, philosophy, or social administration. The principal investigator was looking at matters from a perspective largely determined by his training as a clinical psychologist, including methodological considerations and his interest in cross-cultural trauma psychology. When editing the transcripts, questions or proposals by the principal investigator were frequent, but disagreements were rare and easily resolved at any time. In case of disagreements on details, we discussed the issue until there was a resolution (principle of consensus).

10.4.2.1.2 Triangulation in compiling the ethnography (Chapter 11)

Much methodological effort went into the compilation of the ethnographic chapter that provides a systematic outline of concepts and rituals. Here, we applied various forms of triangulation to check the consistency of data and corroborate the validity of findings.

Triangulation of methods and sources

When compiling the ethnography (CHAPTER 11), we compared data collected from different sources and with different methods topic by topic. Table 8 gives an overview of the evidence on the described rituals. (Detailed information on the sources is given in ANNEX 5.) It shows that we have collected data most extensively on elaborate rituals with a high relevance to our topic (e.g. *kwero merok*). In contrast, undemanding and brief rituals like 'stepping on the egg' (nyono tonggweno) or 'chasing away spirits from a wide area' (ryemo gemo) required less documenting efforts to reach an adequate 'theoretical saturation' (Glaser & Strauss, 1967) and consistency of data, especially as these rituals have still been widely practiced and were generally known by local people.

Table 8: Overview of Sources of Ritual Descriptions

Rituals	External sources	Individual expert interviews	Focus groups	Case studies with participant observation[a]	Case studies without participant observation	Total no. of Sources
Nyono tong gweno	3	1	5	0	0	**9**
Lwoko pik wang	1	1	4	0	0	**6**
Moyo tipu	0	2	2	0	0	**4**
Tumu kir	2	0	6	2	2	**12**
Mato Oput	5	4	4	2	1	**16**
Gomo tong	3	1	2	0	0	**6**
Moyo piny	1	0	4	2	0	**7**
Ryemo gemo	1	1	0	0	0	**2**
Moyo Kom	1	0	4	2	2	**9**
Kwero Merok	4	7	3	1	3	**18**
Ryemo Jok	1	2	0	0	1	**4**

[a] The participant observations in this column do not include the documentation of a divination by an ajwaka, as this was not counted as a ritual.

We did not find substantial inconsistencies between data collected with different methods, although the descriptions of rituals obtained through participant observation were more comprehensive than descriptions retrieved through interviews or focus groups. Similarly, we could not detect constant and substantial inconsistencies between data from focus groups and individual expert interviews, although all respondents provided more elaborate descriptions on topics they were more familiar with (e.g. elders provided more details on rituals performed by elders and *ajwaki* on procedures carried out by *ajwaki*). Likewise, we did not detect substantial inconsistencies between external sources and our data, though our data were more detailed in describing concepts and processes of psychosocial relevance. Clear inconsistencies appeared when comparing single contributions with each other. If there was a clear dissent among key informants on a specific topic (e.g. on the applicability of a specific ritual in the contemporary social context), we usually depicted both views in the ethnography. If the inconsistency was on a detail of a specific ritual, we usually treated it as an illustration of a variant of the same ritual. Generally, we compiled the ethnography on topics on which we had collected enough and sufficiently consistent data.

The strength of evidence on which our ethnographic descriptions are based does not only differ between rituals (as illustrated in table 8), but also with respect to specific elements of the portrayed rituals. Table 9 gives an overview of evidence on the most important elements of the ritual *kwero merok,* showing that ‘spearing the goat’, ‘roasting the meat’, and ‘stepping off the fire’ were mentioned in thirteen sources, while ‘eating the lunyare herb’ was mentioned in only three sources.

Table 9: Strength of Evidence on Different Elements of the Merok Ritual

Ritual Action	Transcripts no.														External sources			Total of sources
	1	2	3	5	6	8	9	10	11	12	15	16	18	21	1[a]	2[b]	3[c]	
Invoking the ancestors	0	1	0	0	0	0	0	0	1	0	0	0	1	1	1	0	0	**5**
Adorning the warrior	0	0	0	0	0	1	1	0	0	1	0	1	1	1	1	0	0	**7**
Singing praise songs for killer or the spirit	0	0	1	0	1	0	0	0	1	1	1	1	1	0	1	0	1	**9**
Men holding spears	0	0	0	0	0	0	0	0	0	0	0	1	1	1	1	0	0	**4**
Women or virgin girl shrieking in triumph	0	0	0	1	0	0	0	1	1	1	0	0	1	0	1	0	0	**6**
Spearing the goat	1	0	0	1	1	1	1	1	1	1	1	1	1	0	1	0	1	**13**
Roasting the meat	1	1	1	1	1	1		1	1	1		1	1	0	1	0	1	**13**
Performing mock fights	0	1	0	0	0	0	0	1	0	0	1	1	1	0	0	0	0	**5**
Competing for 'Labana' meat	0	0	0	0	0	0	0	1	0	0	0	1	1	1	0	0	0	**4**
Stepping off the fire	1	1	1	1	1	1	0	1	1	1	1	1	1	0	0	0	1	**13**
Cleansing at the termite hill	0	1	1	0	0	0	0	0	1	0	0	1	1	0	0	0	1	**6**
Eating from the lunyare herb	0	0	0	0	0	0	0	0	0	0	0	1	1	1	0	0	0	**3**
Giving a '*moi* name'	0	0	0	1	0	0	0	1	1	1	1	1	1	0	1	1	1	**10**

Note: If in any given source, the ritual action was mentioned, the respective cell of the table was coded with 1; if the ritual action was not mentioned, the coding 0 was given. External sources were [a]Wright, 1936, p. 186; [b]Girling, 1960, p. 103-104; [c]Behrend, 1999a, p.42.

Triangulation of multiple analysts and different theoretical perspectives

Usually, *triangulating analysts* means that two or more people analyze the same qualitative data independently and compare their findings (Patton, 2002). At times, inter-rater reliability for the coding is calculated. This is possible when the analysis is about sorting statements into distinct categories. In the process of writing the ethnography, such categorization (e.g. which ritual or element of a ritual does the informant describe in a specific section?) was only a preliminary and uncomplicated step taken when compiling the transcripts. The crucial step was compiling readable summaries on topics (e.g. of specific rituals) that adequately reflected the different descriptions by key informants and other sources. Coding such process quantitatively would have been neither helpful nor easily feasible and was therefore not done. Consequently, calculating inter-rater reliability was not possible at this point. Instead, we applied the principle of consensus when

agreeing on the final version of the summaries (see also Norris, 2001, who applied a similar procedure). As already described above, the principal investigator gave his summaries to the local researchers, asking them for comments and corrections. If there was any disagreement, we would discuss the issue until there was a resolution. Disagreements were rare and easily resolved.

Review by inquiry participants

Qualitative research often uses the review of results by the people under study to validate findings (see Whitley & Crawford, 2005 on 'respondent validation'). German language textbooks term this procedure 'Kommunikative Validierung' (see Mayring, 2002; Flick, 2000; Fahrenberg, 2002) and deem it especially relevant for validating findings of studies that aim at describing emic or 'insider' perspectives. Therefore, after the principal investigator had finished the first draft of the ethnography (CHAPTERS 1 and 11 of this thesis), we gave it to three elders (local experts) hailing from the districts of Gulu, Kitgum and Pader for their comments. The feedback was positive and confirmed the accuracy of the descriptions.

Review by and cooperation with an academic expert on Acholi traditions

Besides consulting elders, we sent the draft to Ronald Atkinson for his comments. Atkinson is a renowned Africa historian who has specialized on Acholi traditions. The outline on the history and general traditions of the Acholi (CHAPTER 1) has been based on Atkinson's (1999) work to a great extend. Moreover, it was evident that a historian who had spent most of his academic life studying the traditions of the Acholi would also be an excellent reviewer of our descriptions on 'traditional ways of coping in Acholi'. Ronald Atkinson confirmed the plausibility of the descriptions from the academic perspective of a Historian. Furthermore, he offered his help by editing the draft with much care. In doing so, he significantly contributed to the quality of our ethnography, and became a co-author of the then published book (Harlacher, Okot, Aloyo, Balthazard & Atkinson, 2006).

10.4.2.1.3 Triangulation in compiling Chapters 12 and 13

The case studies presented in CHAPTER 12 refer to transcripts that have been written and edited in teamwork and thus imply the triangulation of multiple analysts. Since case studies per definition refer to one case, they do not claim generalizability but are mainly to illustrate general cultural patterns outlined in CHAPTER 12. In this light, we deemed the above-described procedure in compiling the transcripts sufficient to bolster the credibility and confirmability of the given accounts. Moreover, almost all case studies in this thesis reflect a small number of one to three referenced transcripts, which allows readers easily

verify the consistency between case studies (CHAPTER 12) and transcripts (COMPANION VOLUME) for themselves.

CHAPTER 13 contains various analyses and interpretations, which imply triangulations of sources and methods of data collection. To keep the description of procedures close to the pertinent interpretation, they will be explained in CHAPTER 13.

11 Traditional ways of coping and healing in Acholi[22]

This chapter builds on a general knowledge of Acholi traditions, including cosmology and socio-political organization, which has been delineated in CHAPTER 2. It focuses on describing traditional concepts and Acholi ritual practices that imply considerable community involvement and are mostly carried out by elders. It begins with a description of general concepts and patterns of healing, including traditional concepts of diseases and the most important offices of traditional healers. It goes on explaining some traditional concepts related to the consequences of war, such as the supernatural implications of killings. The second half of this chapter provides detailed outlines on various specific healing ceremonies. Although not all of the described concepts and rituals are closely related to coping with traumatic stress, they provide important context information for understanding traditional ways of coping in Acholi.

11.1 General concepts of coping and healing

As already noted in CHAPTER 2, culturally based (or "traditional") ways of coping in Acholi are characterized by, and based upon, high levels of mutual support in closely knit social units. This feature of Acholi culture goes hand-in-hand with another, as the major challenges of life – from economic activities such as agriculture and hunting to conflicts and death – have traditionally been met with a high level of communal involvement rather than being left to the individual alone. Finally, traditional ways of coping with such

[22] This Chapter has already been published in Harlacher, Okot, Aloyo, Balthazard and Atkinson (2006, pp. 53-112). It has been only slightly edited for the purpose of this thesis. The edits were on introductions to different sections, as well as on references to chapters, bibliography, transcripts and annexes.

challenges regularly extends beyond the world of the living to require consultation and reconciliation with the spirit world.

Before continuing, it is important to note that while the following discussion focuses on "traditional" patterns of coping and healing, any "traditional" procedure carried out today is done so within the context of a society ravaged by war and displacement, alongside and often in competition with newer cultural patterns. Moreover, different individuals and segments of Acholi society hold different beliefs on the appropriateness of traditional procedures and beliefs.

11.1.1 Traditional concepts of disease

In order to explain traditional ways of healing, it is helpful to distinguish between "normal diseases" and "spirit related diseases". "Normal" diseases are believed to have their causes in the "natural" world, while "spirit-related" diseases are attributed to the "supernatural." In actual practice, causal attributions can be pluralistic, but to clarify distinctions they will be outlined separately.

11.1.1.1 "Normal" diseases

It can safely be assumed that people have always acknowledged that certain diseases can be caused by physical or physiological agents (for example, dust, heat, cold, too young or old age) and have treated them with herbs and other natural medicines whenever possible. Today, a wide range of diseases are familiar to the population (including malaria and a variety of bacterial, viral and fungal infections). Such well known illnesses[23] are usually taken as "normal" diseases and, when they can, people typically seek treatment at a health unit or hospital. As soon as the symptoms respond to treatment and the patient perceives improvement and then healing, the cure would be achieved and life would continue as before. However, in cases where the disease does not respond positively to medical treatment or symptoms return time and again, many people begin to suspect that there might be a supernatural cause behind it.

[23] "Illness" in this study is used to reflect the common understanding of the word (synonymous with disease) and does not necessarily refer to a more specific meaning of culturally constructed ideas held by the patient (as is common in medical anthropology).

11.1.1.2 "Spirit-related" diseases

"Spirit related" diseases are believed to be caused by spiritual agents such as ancestral spirits, clan or chiefdom *joggi*, or free *joggi* (see Chapter 2.4 for an explanation of the terms). Ancestors and clan or chiefdom *joggi* are expected usually to send relatively mild illnesses as a response to the misconduct of family or clan members. Free *joggi*, including *cen*, are mostly held responsible for more severe illnesses. Moreover, free *joggi* do not need a specific reason for their action but can attack people out of sheer malice.

Generally, unknown sicknesses that occur suddenly and with strong symptoms that do not respond to medical treatment make people suspect an "attack" by a free *jok* (case study no. 5 in CHAPTER 12 provides a typical example). Conversely, milder but persistent symptoms, or misfortunes that effect many members of a wider family, are more likely believed to be caused by ancestral spirits, especially if people are aware that a member had broken some taboo or otherwise misbehaved (for an example, see CHAPTER 12, case study no. 1.)

Apart from such distinctions based on the course of the disease, the quality of symptoms, and the social context in which they appear (all operative today), certain diseases in the past were categorically attributed to the action of certain spirits. Measles (*"two anyo"*), for example, was identified as such a disease. In such cases, even if the belief had no scientific basis, it led to sound preventive behavior by limiting close contact with the sick person, as the spirit causing the illness was believed to be contagious. With epilepsy (*"two cimo"*), on the other hand, the belief in a spiritual cause typically led to highly unsupportive attitudes and behaviors. People suffering from epilepsy were prone to being avoided socially, and even if they fell into water or fire, none would dare to rescue them out of fear of contracting the spirit when touching the "possessed."

Severe psychiatric disorders have also been typically seen as caused by spirits. Within the context and aftermath of war, *cen* – the vengeful ghosts of those who had died a violent death – is surely the most widespread interpretation of mental illness (discussed further below).

11.1.2 Traditional healers

In Acholi society, the main categories of healers are elders and *ajwaki* (spirit mediums). Some pure herbalists also exist, but they seem to play a minor role. This is most likely because the treatment of "natural" diseases has been widely taken over by Western medicine, and herbs for treating minor ills are also widely used by family members and

elders. *Ajwaki* also use herbs fairly frequently, but such herbs are often related to "spirit power" and thus transcend the typical meaning of the term *herb* as a chemically active natural substance.

11.1.2.1 Elders and ritual performers

Elders in Acholi are respected for their good character and knowledge of traditional culture. It is believed that their mature age and other positive attributes bring them especially close to the ancestors and they are thus considered to be in the best position to mediate between the living and the dead in matters concerning the clan and its "children". As such, elders are looked upon to discuss possible causes of misfortune and diseases and to find proper responses. They are especially responsible for healing diseases and misfortune that are believed to be sent by ancestors or clan *joggi* as a response to misbehavior by clan members. Most typically, conflicts within a clan are resolved on the initiative of elders. Subsequently, the ancestors are addressed and given sacrifices in order to appease them and to ensure their future assistance and protection. As discussed in CHAPTER 1.2.2.2, in present-day Acholi the *atekere* has an especially important position among the elders and is often put in charge of carrying out rituals.

Elders are entitled to perform a wide variety of rituals by right of their status as elders. Some rituals, however, need to be performed by special "ritual performers" with more specific qualities. The ritual of *"kwero merok*," for example, has to be performed by a person who has already been cleansed and healed in that specific ceremony. In other instances, the ability to perform a specific ritual can be inherited from a parent and is thus passed on from generation to generation.

Overall, elders and more specialized ritual performers play important roles in the prevention and treatment of supernatural or "spirit-related" diseases. However, in the case of certain kinds of diseases, or if the intercessions of elders or interventions of ritual performers are not successful and disturbances persist, an *ajwaka* might be consulted to discover the cause.

11.1.2.2 Ajwaki

In Acholi culture, an *ajwaka* is a person (typically a woman) who is believed to be possessed by a spirit who empowers her to divine and to heal.

Typically, illness and insanity are the first signs indicating that a person might become an *ajwaka*. While spirits that cause illnesses are usually chased out in order to

heal, this is not normally done if the spirit "declares" that it wants the possessed person to become a healer. In such cases, the patient is then initiated into the healing profession and becomes an *ajwaka*. The power of the spirit (or in certain cases several spirits) that once brought the disturbances would thereafter be used to divine and to heal (see CHAPTER 12, case study no. 6, for a typical account of how someone becomes an *ajwaka*).

Treatment by an *ajwaka* almost always begins with the act of divination. *Ajwaki* typically emphasize that they do not need to be told of a patient's symptoms. Often, cowry shells are used to divine what is causing the disturbance and what needs to be done. Other *ajwaki* utilize water to divine the past and the future, or they call upon the spirit or spirits responsible for disturbing the patient and ask him or her to speak. All this is done with the help of the *ajwaka's* spirit (or spirits). It is important to note that it is always her spirit (*jok ma megge*) – the spirit that initially possessed her – that gives her spiritual power and access to the spirit world. The spirits of the *ajwaka* are not only used to communicate with the spirits disturbing the patient, but their authority is also harnessed to finally chase them out and "heal". If the disturbing spirit(s) are stronger than the *ajwaka's* spirit(s), the patient would need the assistance of a "more powerful" *ajwaka* to be healed.

Typically, an *ajwaka* explains most diseases and symptoms in the idiom of "spirit possession." She then divines that one of the many free *joggi* (for example, the spirit of a dead person, *"cen"*) is disturbing the patient. Often she claims that persons with evil intentions sent bad spirits to disturb the patient or, conversely, has taken the patient's spirit away through bewitchment and sorcery (*koro tipu*).

Unlike the spiritual powers of ancestors and clan or chiefdom *joggi*, who are interested in the well being of their people, the powers of free *joggi* that possess an *ajwaka* are often morally ambivalent. Thus an *ajwaka* can use her spiritual powers for good or for bad, to heal as well as to "bewitch." Thus *ajwaki* are often suspected to be the cause of misfortune, diseases and even death.

11.1.3 War and the supernatural implications of killings

One of the most painful aspects of war in general is the killing of many people, both combatants and innocent civilians. It is no different for the Acholi. Many who have been killed during the twenty-year northern Uganda war have not been accorded a proper burial. In addition, many of the perpetrators – both willing and unwilling – of these killings

have been returning to the community. In Acholi cosmology, these issues pose immense psychological and social challenges for the affected individuals and their communities. In order to comprehend these challenges and responses to them, it is necessary to understand traditional perceptions and concepts of killing and war.

11.1.3.1 "Cen" and other concepts related to killings

According to traditional Acholi beliefs, a person who has killed (or has merely come upon a dead body) must, at the earliest occasion, inform the community at home about the incident. This enables the community (typically the person's clan) to arrange for proper cleansing rituals to ward off spirit-related consequences. It is believed that *cen* – the vengeful spirit of a dead person – would usually haunt the killer to take revenge, and that such revenge would not necessarily be limited to the killer but could affect his entire family and clan.

In cases where someone has killed an enemy or a foreigner in a war, the cleansing would typically take place in the form of *"kwero merok,"* an elaborate ritual for "cleansing the enemy." If a person has killed someone from a friendly clan, the cleansing would be performed in a *"mato oput"* ritual. The latter is intended to reconcile the two clans that have been separated by the killings, but also to appease the spirit of the dead in order to prevent negative spirit-related consequences.

Being haunted by *cen*, however, is not restricted only to people who have killed or have kinship relations to the killer. *Cen* can also be contracted just by finding a person who has died a violent death or passing through an area where killings have taken place. The spirits of the people killed would be expected to linger in the area with the desire to revenge their violent death. Therefore, when finding a dead person, people would typically take precautions to prevent the spirit from attacking. As elders explain:

> In case you have found a dead body, you should pick a leave and throw it on the corpse while making a plea saying "I am not the one who killed you, I have just found you!" Such pleas are made to convince *cen* to spare innocent by-passers and rather follow the killer. (Transcript 7, p.50)

If a corpse or corpses are found in an area or close to a path that people need to frequent, inhabitants would arrange for the deceased to get a proper burial and the area would be cleansed in order to prevent the spirits of the dead from disturbing the living (for a concrete example, see CHAPTER 12, case study no. 3; the *moyo piny* cleansing ritual itself is described just below).

The activities indicated above can be carried out by elders or ritual performers. When, however, a person shows severe signs of being haunted by cen (and has not yet told the people at home about the killing), an ajwaka would typically be consulted. If the results of her divination indicate that the person is besieged by cen, she would either put herself in charge of chasing out the spirit or refer the person back to elders for cleansing.

Elders emphasize that nobody is ever forced to be cleansed in a traditional ritual. At the same time, the community always maintains a keen eye on those who show signs of being "possessed" or disturbed by a spirit. And in cases where *cen* is suspected, the disturbed person is generally motivated to engage in a traditional process as a result of the ongoing and unabated suffering attributed to *cen*.
An elder from Lamogi explains:

> Sometimes these returnees do not say it but the spirit of the deceased keeps haunting them. The bad spirit comes in nightmares or causes the person to behave like insane and others pick up tools of killing. When this happens, elders would ask the person whether he had killed people. If he accepts having killed, then he should be cleansed but if he refuses, then he is not forced to be cleansed. The bad spirit is the one to force the person to accept the guilt (Transcript 15, p.93).

11.1.3.2 Signs of having killed

Traditionally, people in Acholi seem to have relatively clear and convergent concepts about behaviors that a person who has killed is expected to show, and they would easily suspect persons who show "signs of having killed" of being haunted by *cen*.
Here is a brief explanation by a traditional healer from Bwobo:

> If a person has killed someone and has not told his people at home, people would begin to know it through his bad deeds for he would be filled with the heart of doing harm… Especially when *cen* has taken control of him, like when he is drunk, he would be filled with the heart of doing bad things and even kill. (Transcript 3, p. 15)

An *ajwaka* from Acholi Labwor gives more details:

> If someone kills another person, the spirit of the murdered person would catch the murderer. This would disturb him every now and then through bad dreams. The spirit would come to fight the murderer and this makes him shout, the body shakes, startles and speaks anyhow. When all this is happening, the person will

> suffer from madness and he would be seeing what happened before time and again. (Transcript 5, p.28)

In order to protect themselves, people would often avoid close social contact with a person who is believed to have *cen* (or "*ojebu*"[24]). Such avoidance is usually motivated by a mixture of fear of being effected by the bad spirit and the disturbing behavior of the person who is believed to be possessed. As an elder from Alokolum explains:

> Acholi fear the killer, for they say his hands are sullied with blood, his hands are full of *'ojebu'.* (Transcript 1, p.3)

This is affirmed by the experience of a returnee from the Palabek before he went through a cleansing ritual:

> What was so painful in my life was that the boys with whom I was putting up had all left me because of the nightmares that were disturbing me at night. People didn't want to share meals with me and many times I was insulted. Other boys also abandoned me, talking badly about me. (Transcript 30, p.222)

11.1.3.3 The concept of "ajiji"

The signs of having killed are closely related to the Acholi concept of *"ajiji,"* which is broadly conceived to include both short-term and long-term reactions to threats to life and confrontation with death. An elder from Alokolum explains:

> What happens to a person who is being attacked by *ajiji* is that *"kome nure"*[25], he loses strength, cannot think straight, the body shakes and *"kome bedo dibidibi"*.[26] It can cause madness (*"apoya"*). (Transcript 1, p.2)

A traditional healer from the Bwobo elaborates further:

> If people go for hunting and they see a wild animal, or a man is being threatened, he would tremble and the knees get paralyzed. … On his return home, it can bring nightmares for he would keep on seeing the animal that had threatened him. He could even shout and tremble. This trembling does not

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[24] *"Ojebu"* can be translated as "dirt" or "spiritual impurity" and is believed to bring bad luck or to have negative consequences for people.

[25] *"Kome nure"* refers to different elements of experience – the body feels heavy, weak; lack of energy; knees are too weak to hold the body; being inactive.

[26] *"Kome bedo dibidibi"* refers to inactivity, not feeling like doing anything, impairment in social and professional functioning.

> require any treatment because the Acholi perceive it as being only a very strong fear. If it has caused madness, then the person is taken to an *ajwaka* for cleansing (Transcript 3, p.16).

As the above quote illustrates, the meaning of *ajiji* is not limited to the short-term reaction to immediate danger to one's life. Elders know that if somebody's life has been threatened, that person is likely to show related symptoms in the following days. Such symptoms (for example, nightmares, shouting, trembling) are usually interpreted as strong fear. Elders and healers expect such symptoms to remit without treatment as time passes, but they also recognize that *ajiji* can lead to "madness". The descriptions of "madness" (*apoya* or *bal pa wic*) encompass a wide variety of disturbances, including severe nightmares, "visions" during which people vividly see what has happened in the past, overly aggressive behavior, excessive shouting, talking about things that are not related to what is currently happening in the person's surroundings, moving around in long and aimless walks, collecting rubbish and many more.

An *ajwaka* from the Acholi Labwor explains:

> Madness comes in connection with killing that someone has committed. If the person has killed a mad person, it is very difficult to cleanse. In such a case compensation must be paid. Madness also comes when you meet an image of a person; you have seen someone being killed. All this comes as a result of *"cen."* *"Cen"* does not stay on a person all the time, but rather comes at the time it wants to. For the formerly abducted persons, in most cases it comes when they see a place that resembles the place where the murder took place, or when they are speaking words or doing things, which are similar to those when the murder took place. *"Cen"* also likes disturbing these people at night when there is nothing that could stop them, and also when spirits are moving around (Transcript 6, p.41).

In cases of such "madness," people would not expect a spontaneous remission, but see the necessity for treatment. According to Acholi traditional beliefs, people would typically assume that the person is now besieged by a bad spirit, most often *cen*. A wide range of healing ceremonies exists to address this and other forms of spiritual impurity. The next section describes several healing ceremonies that are applied in different circumstances and for different purposes.

11.2 Specific healing ceremonies

Despite the deplorable living situation for the majority of people in the camps, where most cultural activities are severely restricted, many healing ceremonies are still practiced. A number of them have already proved to be instrumental in helping to reintegrate returnees coming back from the LRA.

The word "healing" in this study is used in a broad sense to denote both individual and collective healing. Some of the rituals described below have an emphasis on healing individuals from psychological distress; others focus on the healing of communities that have been divided by conflict. Yet in each of them, aspects of both individual and communal healing are intertwined and addressed in one way or another.

The n*yono tonggweno* ("stepping on the egg") and *lwoko pik wang* ("washing away the tears") rituals have been especially important in the welcoming and initial cleansing of people who have returned to the community from the LRA war. Cultural provisions for dealing with a situation where a person has died in the "wilderness" or "bush," and whose spirit is therefore considered to be restless, are explained in the section on *moyo tipu*. The three rituals of *tumu kir, mato oput* and *gomo tong* have important implications for the prevention and resolution of conflicts. There are also several procedures for cleansing an area of bad spirits (*moyo piny*). Finally, a number of ceremonies such as *kwero merok*, *ryemo jok*, and *moyo kom* are conducted to heal individuals with the support of the community.

11.2.1 Receiving someone who has stayed a long time away from home

Several rituals or ritual acts can be applied to receive back into the community those who have been away from home for a long time. These rituals include "stepping on the egg" (*nyono tonggweno*), "washing away the tears" (*lwoko pik wang*), and often also *moyo kom* (a general procedure to cleanse the body of bad spirits). N*yono tonggweno* is the briefest of these rituals and has been utilized more often than any other in recent years. If the returnee has already been mourned by the family, this ritual is usually combined with *lwoko pik wang*. Although these two ceremonies often flow into one another, they are

described separately here for the sake of clarity. The two rituals together are often referred to as *moyo kom*, even though in other contexts the term *moyo kom* can be used to denote a separate cleansing ceremony (described below) as well.

11.2.1.1 Nyono tonggweno – stepping on the egg

The ritual of *nyono tonggweno* is usually performed at the family or clan level, but has also on occasion been organized on a larger scale by the Acholi cultural leadership (*Ker Kwaro Acholi*). Such "collective stepping on the egg" (*nyono tonggweno lumuku*) has at times received considerable media attention, especially when these ceremonies have involved top LRA commanders.

11.2.1.1.1 Purpose

Traditionally, when someone had been away from home (outside clan territory) and then returned, a cleansing ritual had to be performed at the entrance of the clan settlement. This is related to the belief that outside home, people could contract spirits that – if not cleansed – would bring misfortune to the whole community. The necessity for a general cleansing also applies to people who come back from abduction by the LRA.

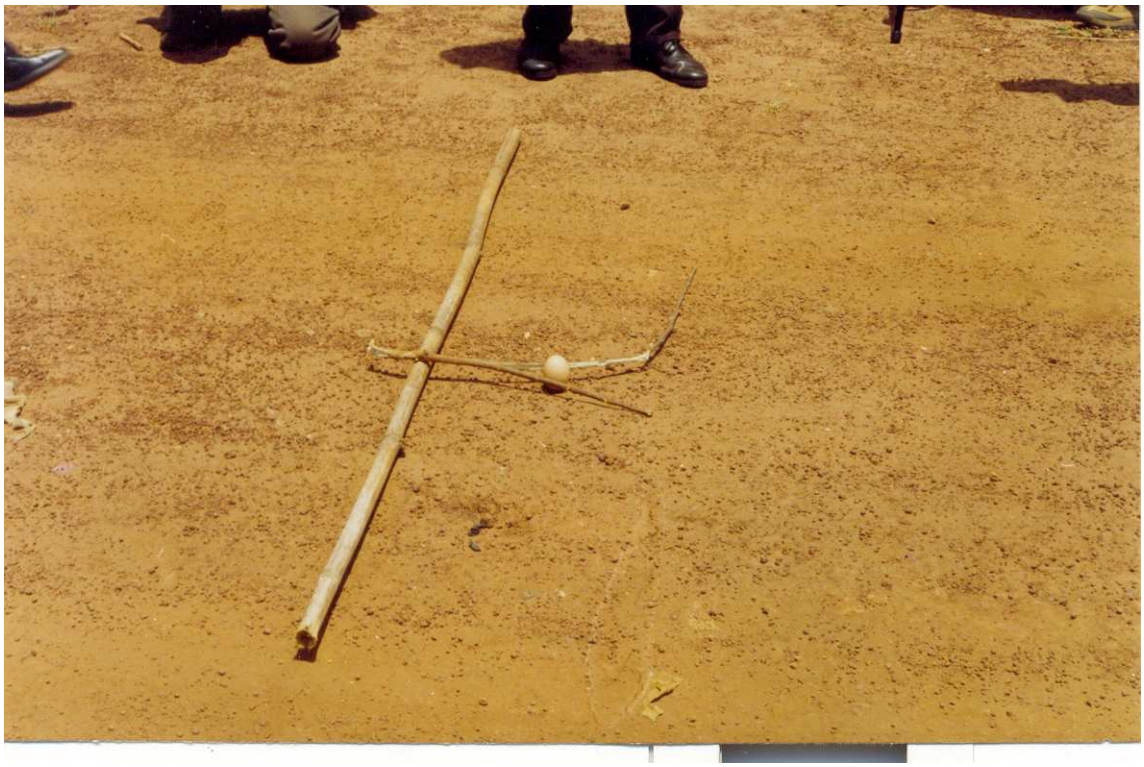
But the purpose of "stepping on the egg" goes beyond that of a mere cleansing ceremony. When someone has left the clan after a quarrel or disagreement with people at home – and might at times have even sworn never to return – *nyono tonggweno* can be performed as a gesture of welcome and commitment on the part of both the community and the returnee to begin living together in harmony again.

With regards to its cleansing function, however, it should be emphasized that stepping on the egg would usually not be expected to cleanse the returnee from *cen* that has been contracted as a result of killing. To cleanse a person from such an aggressive spirit, a more elaborate ritual would usually be considered necessary, such as *moyo kom*, *ryemo jok* or *kwero merok* (as outlined below).

11.2.1.1.2 Procedure

Nyono tonggweno belongs in the category of brief and relatively undemanding rituals. Although variations in procedures can be observed across different clans, an egg, a twig from an *opobo tree,* and the *layibi* (a long stick used for opening the granary) are mostly used.

When practiced at a household-level, typically an egg is put on the path leading to the homestead, placed in between a split *opobo* twig. The *layibi* lies behind it (see picture).



Picture 1: Arrangement for the 'stepping on the egg' ceremony

On his way to the homestead, the returnee steps on the egg and passes over the *layibi*. With this brief act, the "stepping on the egg" ceremony in its narrowest sense is completed.

In a focus group involving chiefs and elders from the various clans and areas, the meaning of the items used in the ritual was explained as follows:

> An *opobo* twig is slippery and is used to wash away dirt[27] that these children have passed through so that they are left clean. The *layibi* was used by elders to feed people with food stored in the granary. *Layibi* is used to show that these children should be kept properly, and that keeping them is not the responsibility of one family but each member of the clan. An egg is used because it is

[27] *Opobo* wood or twigs were traditionally used to make a soap-like substance that was in turn used for washing hair (especially to get rid of lice) and clothes. "Dirt" in this context, however, clearly refers to a spiritual dimension.

> innocent and does not even have a mouth. Thus these returnee children should stay without sin that could have come as a result of their stay in captivity, for they were innocent when they were captured. (Transcript 7, p. 45)

Elders from Labuje (Kitgum district) describe another ritual act that can be carried out as a part of "stepping on the egg" – the passing of a glowing spear grass over the leg:

> When people took long time outside home … they should be made to step on an egg before they enter the home and a glowing spear grass would be passed on their leg. Burning their leg symbolizes burning any bad deed the person might have committed while staying out. If somebody had been staying away from home for a certain problem [quarrel, bad attitudes] then the problem should get out of him. If the person had vowed[28] not to come back home ever, then a glowing spear grass is passed on the leg so that he/she may become healthy. This is like a sacrifice for the vow or bad action that made him to stay out. (Transcript 10, p. 71)

11.2.1.1.3 Applicability

As noted above, *nyono tonggweno* is currently used with much frequency. This might be due to the easy availability of the basic requirements for the ritual (egg, *opobo* twig, and granary stick) that even poor households can afford. The large-scale, collective "stepping on the egg" rituals organized by *Ker Kwaro Acholi* have sometimes welcomed more than a hundred returnees in a single ceremony. In addition to demonstrating a positive sign of welcome to the returnees on behalf of the Acholi community, these events have also been important in promoting traditional rituals and values.

Elders however emphasize that even if such a ritual is carried out in a collective ceremony, it should again be performed when the returnee enters the family's homestead. As noted above, the collective rituals organized by *Ker Kwaro* have at times been misinterpreted as the paramount chief conducting collective *mato oput*, and many elders, especially in rural areas, have viewed them with considerable skepticism. But misunderstandings have not been limited to this point alone. A group of elders from Atanga, for example, interpreted it as *moyo kom* and commented critically:

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[28] The Acholi Luo term is *"kwong,"* meaning to vow something, evoking the ancestors to be witnesses.

> Cleansing of the children is done only once. However, it is very important … that each child passes through the process of cleansing at their parent's place where he would stay after the cleansing ritual. All children should be cleansed at their homestead. Mass cleansing ceremonies, the way they are performed at the [paramount] chief's compound, are not desirable. What could be done is to welcome them but not to cleanse them in a group at the chief's compound. (Transcript 16, p. 109)

Chiefs and elders from *Ker Kwaro* on the other hand stress that what they did was indeed welcoming the children, and even if "stepping on the egg" had been performed collectively at the paramount chief's compound or any other place, it should be repeated at the household level, and other elements of cleansing should be added:

> The chiefs of each clan [actually, each pre-colonial chiefdom] and the chiefs as a whole know that these children were abducted to live bad lives, and on their return they should be welcomed. The chiefdom has the obligation to welcome these children, and they use three things: an *opobo* twig, a *layibi* and an egg …
>
> After welcoming the returnee children at the chief's compound, they are sent home to their parents. The parents should welcome their children again with an *opobo* twig, an egg and the *layibi*, which are put at the entrance of the homestead … . The parents would then slaughter a goat and a ritual is performed to cleanse the child for he/she had already been mourned. (Transcript 7, p. 44-45)

Here the representative of the *Ker Kwaro* alludes to the ritual of *lwoko pik wang*, described in the next section. The combination of *nyono tonggweno* and *lwoko pik wang* is indeed often called *moyo kom*, especially when the slaughtering of a goat is involved.

11.2.1.2 Lwoko pik wang – washing away the tears

11.2.1.2.1 Purpose

The "washing away the tears" ceremony is seen to be important when the returnee has been mourned because people thought that he or she had already died. If the shed tears are not washed away in a proper ritual, they are believed to bring misfortune. Elders from Lira Paluo explain:

> Washing away the tears is done for someone who has already been mourned as dead but then reappeared . . . . Washing away the tears would also be done for someone who had stayed outside home for long and people did not know whether he was still alive or not. For a person who had been feared to be dead and for people who were worried about and mourned, when they come back home, washing of the tears is done . . . .
>
> If washing of the tears for someone who has been mourned is not performed, the person would stay as if mad and not healthy. He would stay like a dead person . . . . The ritual helps in washing away the bitterness of the people who mourned the person so that this bitterness does not bring problems such as sickness that doesn't cure. (Transcript 26, p. 190 and p.191)

11.2.1.2.2 Procedure

Specific procedures differ from place to place, but would everywhere include the "washing away the tears" by literally washing the returnee's face with blessed water. If resources are available, the parents or relatives would often slaughter a goat. The goat would be eaten and the water that was used for washing the hands before and after the meal would then be used for several ritual acts. First, it would be sprinkled on the child as a blessing (*goyo pii*). Then it would usually be used to cleanse the child by pouring it on the grass-thatched roof of the hut when the child enters and again when the child comes out (*kiro pii*). The same water would again be used by family members and relatives to "wash away the tears" (*lwoko pik wang*). This gesture not only washes away the tears shed for the child, but also washes away the attendant bad omen.

Elders from Amida describe a variation of the proceedings that link "washing away the tears" with "stepping on the egg" in a ceremony involving multiple old chiefdoms:

> *Rwodi* thus welcome the children all together on their return from captivity. However, the family of each child should repeat welcoming the child by passing over *layibi* and *opobo* and stepping on an egg. A celebration feast for the return of the child would be held and a goat is slaughtered for people to eat. The water used for washing the hands is sprinkled on the child as a blessing so that he may stay healthy. The same water is also poured on the thatched roof above the door to drip on him as he enters and comes out of the hut (Transcript 11, p. 79).

Often, when people cannot afford a goat due to the destitute poverty prevailing in Acholi, the above rituals are adapted so that "ordinary water" is used for blessing, cleansing, and washing away the tears, leaving out the slaughtering of the animal. Elders from the Lira Paluo elaborate on such a procedure, with no goat included.

> The father of the child would call close relatives who had mourned the child like the uncles, aunts . . . . When these people come, the father of the child would pour water in the calabash for the people to wash their face. The water which was used for washing the face is sprinkled on the chest of the child so that he might stay healthy. As each person sprinkles the water on the child, he or she would make the *agat* by saying: "We had already wept for you; we thought that you were dead. May our sorrow that made us weep for you not bring any problem to you. Today we have washed away our tears so that you may stay healthy."
>
> All this would happen from home in front of the door. . . . The remaining water is then poured on the grass thatched roof of the hut so that it drips on the person as he would enter and come out of the hut. Afterward, people would sit down and the father of the child would give them food. (Transcript 26, p.190-191)

Elders emphasize that *lwoko pik wang* should usually be combined with other rituals. Most often it would be preceded by "stepping on the egg" and followed by the ritual of *moyo kom*, in which a goat would be stabbed.

11.2.1.2.3 Applicability

According to our observations, *lwoko pik wang* ceremonies that include the slaughtering of a goat are not currently in common use, almost certainly because many households cannot afford the animal for this purpose. However, ritual acts that are often described in the context of "washing away the tears," such as *goyo pii* and *kiro pii* are still often enacted.

11.2.1.3 Moyo tipu – cleansing the spirit

The procedures described above can all be applied in the fortunate case that a person who has been abducted returns to the community alive. Yet many people once abducted never return to the community because they are killed or die of disease or other reasons in the bush. For many reasons, this causes significant distress to the concerned families

and the community as a whole. One point specific to Acholi traditional culture is that the spirits of people who have died in the bush, and therefore have not received a proper burial, are believed to be wandering about as vengeful spirits (*cen*), potentially causing trouble to relatives and the surrounding community. Elders from Lira Paluo explain:

> When unknown death has occurred, sickness would disturb the bereaved family ... the father would go to find out the cause of the sickness from the *ajwaka*, who would reveal that the unknown death is causing the sickness. They would then ask [the spirit of] the deceased for the cause of the death and it would narrate it. The deceased would also explain what should be done to stop the sickness. The deceased always do this [causing sickness] to make people aware that they have already died. (Transcript 26, p. 197)

The proposals of the spirit of the deceased about what should be done to help him or her rest and abandon disturbing activities would usually revolve around certain culturally-determined patterns. Typically, people would be advised to spear a goat in the bush where the relatives of the deceased would be given twigs of the *olwedo* plant by elders. The twigs would be brought home and placed on the depiction of a grave. After this ceremony, the way to last funeral rites for the deceased would be open. An *ajwaka* from Acholi Labwor elaborates:

> When your child has been killed in such a war, you spear a goat quietly without cleansing the killer. Then fire is generated the traditional way and a goat is roasted. Everything including the head is eaten in the bush; nothing is to be brought back home. The parents of the deceased are given the leaves of the o*lwedo* plant in the bush, and the twigs would be brought home – no happiness, but sadness only. This is done to show to the spirit of the child that it had been cared for and cleansed. After that, the last funeral rites can be done. (Transcript 5, p. 32)

Last funeral rites (*guru lyel*) are extremely important in Acholi culture, as they are seen as the final act of setting the spirit of the deceased to rest in the other world. Normally they should be preceded by the burial of the corpse (*yik*) and the first funeral rites (*pwuru lyel*). Elders from Lira Paluo elaborate on the topic of last funeral rites, noting that an *ajwaka* would often be involved to approach the spirit of the deceased before the rites are concluded.

> The last funeral rite of someone who had died in the bush and the body was not found … can be done. An *ajwaka* would be invited before the last funeral rite is done. The *ajwaka* would go along the path holding *olwedo* leaves and would call the spirit of the dead person. The *ajwaka* would call the spirit to come into the hut … (Transcript 26, p.196)

11.2.2 Rituals with a focus on conflict resolution

11.2.2.1 Tumu kir - cleansing for a taboo committed

Tumu kir is a ritual ceremony that has important implications for the reduction and resolution of smaller-scale, more local conflicts in Acholi society. The word *tum* refers to a "cleansing" and "sacrificial" act, while *kir* refers to defined "taboos". Elders in some areas give the term *kir* a more specific meaning by arguing that all abominations tantamount to *kir* would be acts committed with anger or even hatred, and would therefore displease the ancestors. Other clans define the term more widely to include incidences such as falling into a grave. Despite such differences in the use of the term, many of the behaviors that constitute *kir* across clans are those that might kindle or accompany already-existing conflicts. Examples are quarreling over land, at the water source or for firewood, burning somebody's hut, uttering curses, sexual activities in the bush or with relatives, and various forms of violence (including fighting between husband and wife or father and son, and even throwing food at another person). Other behaviors and attitudes widely regarded as *kir* are those prone to hinder the resolution of a conflict, such as not accepting or admitting wrongdoing or an unwillingness to talk.

11.2.2.1.1 Purpose

In order to avoid misfortune, *tumu kir* is performed through cleansing and offering sacrifice for an abomination that has occurred in the community. It is traditionally believed that actions or events which are considered *kir* displease or even insult the ancestors and clan or chiefdom *joggi.* As a result, misfortunes of many kinds (from disease or accidents to unfertile fields) are expected to strike the offender and the entire clan. The only way to avoid such misfortune - after *kir* has already occurred – is to perform a proper ceremony, including a sacrifice to propitiate the ancestors and ask for their further protection.

With this background of beliefs, Acholi have a strong motivation to avoid actions that are considered taboo. If someone nevertheless commits such a serious offense, a public

ceremony and sacrifice is performed. This reinforces for the community the importance of respecting culturally stipulated bylaws and taboos. Moreover, the ceremonies are resplendent with symbolic acts that can be understood as supporting the credibility and salience of the stipulated taboos, thereby emphasizing social norms and values that are likely to help prevent and solve conflicts within the community.

11.2.2.1.2 Procedure

Process leading to the ceremony

Whenever *kir* has occurred, the responsible elder or elders from the affected homestead or hamlet are informed. The elders then summon those involved in the offending behavior (either as parties or witnesses) to examine the cause and to understand the sort of offence that has been committed. Traditionally, such discussions would be held at the central fireplace (*wang oo*) and thus involve members of the extended family living together in a hamlet. In such settings, people would also talk about possible ways of preventing such offences or conflicts in the future. The family elder would then give a report to the *atekere* who would come to re-examine the offense and its implications. After confirming that *kir* had indeed been committed, he would then decide on the actual procedure for the cleansing ceremony and request that the offender(s) arrange to obtain the necessary sacrificial animal.

According to customs, two basic types of purification rituals are distinguished: those that require a goat to be slaughtered and those that require a sheep. Purification rituals that require a goat are used to cleanse *kir* that result from such offenses as quarreling over land, fighting at water sources, wrestling with a father, or uttering curses. Rituals that require a sheep include abominations related to fire, ashes, or feces, such as setting someone's hut on fire or throwing food at another person. In Acholi traditional beliefs, the blood of a sheep is said to be "cold" and is therefore used to cool down a tense situation.

The ceremony itself

The actual procedures of *tumu kir* differ according to the particular offenses committed and vary from area to area across Acholi. A specific description of a *tumu kir* ceremony using a goat is offered by elders from Alokolum:

> During the purification ritual, when the *ateker* is sacrificing the goat for the crime, the offender is holding the head of the goat and the offended is holding the legs. The offender is holding the head to show acceptance and repentance

> for the crime that has brought uncleanness [dirt] into the family. During the purification, the *ateker* slaughters the goat while making pleas: *"You goat, your blood is to take away the dirt [-y action] that occurred at home. Today we are not killing you without a cause; let your blood wash away this sin so that people stay in good health."*
>
> He then cuts the goat open, takes the content of the lower intestine (*wee*) and puts them on the feet and the position of the heart *(pal cwiny)* of the victims of the offence [here meaning both the offended and the offender]. He also sprinkles it on the houses to make sure that the offence gets off the offender, offended, and the whole family. After the purification, the two persons who were involved in the quarrel are publicly warned not to repeat such a mistake. This at the same time serves as a warning for the entire community. (Transcript CR 2, p. 278)

Procedures using a sheep can be very similar and usually such ceremonies include the communal eating of the slaughtered animal in the compound. The water used for washing the hands can be either used for blessing (*goyo pii*) and cleansing (*kiro pii*), or poured away in the direction of the setting sun in order to send the abomination away forever.

In another type of *tum*, the sheep is dragged away from the homestead and members of the concerned family should not eat it. Elders from Alokolum give some details:

> A sheep that is dragged away … is applied to offences related to ashes and fire like the setting on fire of houses. For this, a herbalist who has the herbs for *kir* is called by the *ateker* . . . . The herbalist would come and drag the sheep round the burnt house, pierce the stomach and take the content of the lower intestines [*wee*] and throw them on the house. Afterwards she weaves grasses to make a rope and drag the sheep [away from the homestead] using the rope. They go and divide the sheep from outside the homestead; the meat should not be brought to that home and the family members do not eat it. This is to drag the ashes that could attack people through *kir* in order to make it leave the home. (Transcript CR 2, p. 279)

11.2.2.1.3 Applicability

According to observations in the field, *tumu kir* is still practiced and demanded by the people. There are indications that failing to carry out such cleansing rituals due to the lack of livestock or other requirements for the ceremony (which is not uncommon in current conditions) leads to considerable tensions and psychosocial distress, especially among

the older generation. Still, the symbolic power of such rituals to serve as a public admonition to adhere to positive and widely accepted social norms has the potential to contribute considerably to a more peaceful living environment in local communities throughout Acholi.

11.2.2.2 Mato oput - reconciliation ceremony after a killing

"Mato oput" literally means "drinking *oput*". *Oput* is a tree common in Acholi, and its smashed roots are used to prepare a bitter drink that is shared at the peak of the ceremony. *"Mato oput"* is widely known as a key element of Acholi culture beyond Acholi's borders. Often, however, *mato oput* has been misunderstood and romanticized as a kind of magic bullet to solve virtually any type of conflict. Further, the notion of *mato oput* has also been used metaphorically to refer to nearly every reconciliation process taking place in Acholi today, thus bringing confusion to the scope and nature of *mato oput* as properly understood.

In this section, *mato oput is* defined as a concrete ritual marking the peak of a process of conflict resolution, specifically referring to a killing that has occurred in the community. Or, as an elder from Payira puts it: "*Mato oput* is the final act which concludes the process of reconciliation that follows a … killing" (Transcript CR 1, p.272).

It is important to note that both the crucial processes that precede the ritual as well as the ritual itself are integral to the procedure. Thus, it is not the ritual itself that 'does the trick', but the ritual in combination with all of the essential and down-to-earth procedures necessary to pave the way to a successful ritual conclusion.

11.2.2.2.1 Purpose

Mato oput aims at re-establishing relationships that have been suspended between two clans as a response to either a premeditated or accidental killing.

The ritual of *mato oput* was traditionally not applied for killings that happened in war, but rather to those occurring between clans that had up to that point maintained friendly relationships with each other. In pre-colonial days, the chances that people could successfully engage in such a reconciliatory process were greatest when the concerned clans belonged to the same chiefdom, and the odds were still favorable if those involved belonged to the same "zone" or cluster of chiefdoms (as indicated in CHAPTER 1.2.1.4).

Given the current sense of a common Acholi identity extending across all of Acholiland, the procedure is most likely applicable between any of the Acholi clans.

It is important to understand, however, that the ritual of *mato oput* is normally only carried out after a typically long process of mediation between the two involved parties. Thus the actual ritual marks the peak, and successful conclusion, of a reconciliation process between two clans in the aftermath of a killing. The *mato oput* ritual would not be carried out or would be absolutely meaningless if the preliminary stages of mediation and negotiation had not been successful. The willingness of the offender's clan (not the offender as a single person) to assume responsibility for the act committed, as well as its readiness and ability to pay compensation, are essential for a successful process leading to the ceremony. In earlier times, a young girl from the offender's clan was given as compensation for deliberately committed murder; this has been replaced by a system in which cattle or money are the most common forms of compensation.

Beyond facilitating a process of conflict resolution between two parties, the ritual of *mato oput* also addresses a crucial spiritual concern. As long as the ceremony is not concluded, the *cen* of the killed person would be expected to haunt the killer and cause diseases in his (or less often, her) family or clan. This traditional belief has often been a strong motivation for someone who has killed to initiate and support the process leading to the ritual. This is especially the case if the killer has been haunted by nightmares or disturbed by diseases that could be interpreted as spirit related. Whether or not the killer believes in the traditional interpretation of *cen*, escaping the social consequences of this still widely held belief is often difficult, as he might easily be accused of being the cause of diseases and misfortune befalling the family. A young man from Pabo who wanted the ritual of *mato oput* performed for a killing he had committed, affirmed this when he talked about his motivation:

> I want that everything ends well [alluding to the spiritual and social dimension of *mato oput*] so that in future, if malaria comes [to befall my children], people would not have a pretext to accuse me. I also hope that when the ceremony is concluded, good relationships will again exist. (Transcript 22, p. 161)

11.2.2.2.2 Procedure

Process leading to the ceremony

Immediately after a killing, relationships between the two clans involved are suspended. In practical terms, this means that the two concerned clans would cease all social and

economic interactions, they would not eat each other's food or buy each other's goods, nor would they engage in any joint leisure activities. Most often, they would not even greet each other. This avoidance of interaction between members of the two hostile clans is an important measure to prevent the escalation of conflict. In the spiritual realm, moreover, the spirit of the person killed would want to see that the living relatives show some level of solidarity. Should relatives continue life as usual despite the killing, *cen* could easily bring diseases to members of the deceased's own clan.

These days, a killing is generally reported to the police followed by the usual legal process. In accordance with traditional procedures – and complementary to the modern legal process – the local representative of the *rwot moo* (anointed chief; acknowledged successor of the rulers of a pre-colonial chiefdom) would also be informed. This could be done by either the relatives of the killed or the relatives of the offender. The mediating elders (representing the chief) – who would in most favorable conditions hail from a clan considered neutral in the conflict by both parties – would then sit together with representatives of the two clans to examine the circumstances of the killing. If the emotions involved are so intense so that they do not allow for productive discussions, the mediating elder(s) might decide to let some time pass before bringing the two groups together, while continuing to see each separately in what was essentially a form of shuttle diplomacy. Such mediation efforts can involve periods of higher and lower intensity and take many years. The first aim of the involved elders would typically be to prevent an escalation of the conflict (most importantly, revenge killings or destruction of property), knowing that with time, when emotions have cooled, the settlement of the conflict will likely be easier.

If and when the offender's clan is ready to assume responsibility, and the involved parties can agree on the amount of compensation to be paid, two huge steps forward have already been taken. According to currently held notions of "traditional" compensation, roughly 10 cattle and 3 goats are required for a premeditated killing, although this varies somewhat from area to area across Acholi. In contemporary monetary terms, one head of cattle is reckoned as equivalent to 50,000 Uganda shillings, while a goat is considered to be worth 20,000 Uganda shillings.

Once a specific compensation has been agreed upon, the cultural ideal is that the offender and responsible elders then consult other clan members to see how much each can contribute. In principle, every household would be required to contribute something, as the effects of the killing impinge on the entire clan. However, in the current

circumstances of extreme poverty and the many forces undermining clan cohesion and collective sentiment, this ideal is not always possible to implement. Thus, the process of collecting compensation itself can take many years.

But once the agreed-upon compensation has been raised and the elders verify that the completed sum is indeed ready to be handed over, the representative of the *rwot moo* would consult the two parties and agree on a date for the ceremony.

The day of the reconciliation ceremony

The ceremony of Mato Oput is extremely rich in details and symbolic acts. A rough outline of a prototypical procedure follows, although specific particulars – but not the general form or intent of the ritual –can vary considerably in different parts of Acholi.

On the day of the reconciliation ceremony, the mediating elders meet with the two parties at an agreed-upon neutral site for the ritual, outside of not only the villages of the two groups involved, but any village at all. The relatives of the slain person and those of the killer gather apart from each other close to the site. Then, on instruction by the ritual performers, selected representatives of the two parties approach each other armed with sticks to stage a mock fight, with the elders using a *layibi* (a long stick used to open a granary) to separate them.

The two groups involved in the mock fight hit the *layibi* (instead of each other), hurling insults back and forth as the women of the bereaved clan wail to express their grief and mourning. Eventually, the people of the offender's clan give in, saying: "We accept that we have committed a wrong, let us now pay for it."

Then the elders ask if the offending group has the money for compensation ready. After this is confirmed, the mediators tell the victim's clan to hold back, because the other side has accepted to pay the compensation. Then the parties are separated while saying: "Nothing bad should exist any longer; such bad heart should stop now!"

The procedure of mock-fighting, acceptance of guilt, separation, and appeasement is repeated three times if the deceased was a male, four times if the deceased was female (this gendered distinction in the pattern of repetition is common in Acholi rituals in general).

Next, the performing elders tell people to bring a sheep in order to proceed towards final reconciliation and re-unification by sharing food. The killer's clan brings a sheep and cuts it across the stomach into two halves. The blood is collected in a bowl. The front half of the sheep is then given to the bereaved clan. The bereaved clan in turn produces a goat, cuts it in the same way and gives the front part to the killer's clan.

Similarly, the livers of both animals are cut into two halves and exchanged between the clans. The blood of the two animals is mixed together in a bowl, and mixed with unfiltered local beer and the smashed root of the *oput* plant to form a bitter potion.

After all of these preparations have been concluded, the highly symbolic act that has given the name to the ceremony occurs: the drinking of the bitter concoction that has been prepared (*mato oput*). In this ritual, two people from each side – from the offender's and the offended community – kneel down with their hands folded behind their back and sip the juice from a bowl, their heads touching in the process.

Picture 2: Mato oput: Drinking from the bitter roots

People from each side then continue to drink in pairs until all the representatives of both communities have participated in this central symbolic act of reconciliation.

In the meantime, the livers of the animals have been roasted. The performing elders then cut the liver into pieces and put them on a flat winnowing basket (*"odero"*); the pieces from the sheep and goat are intermixed. This is followed by another significant ritual act, the ritual feeding of the liver. Typically, female ritual performers pick up pieces of liver using *lacaa* thorns. Three times they then take the liver right up to the mouths of people, pretending to feed it to them, before finally allowing them actually to take the liver from the tips of the thorns. Again, all representatives of the two clans are made to eat pieces of the liver in this ritual manner.

As this ritual is being conducted, the meat of the sheep and goat are being cooked together. While this meat is still on the fire, elders of the victim's clan accept and verify the compensation (today mostly paid in money) which is usually purified using a hen.

Then two further rounds of "ritual eating" by representatives of the two clans ensue: the eating of the head of the animals and the eating of a certain type of green vegetable called *boo*. After that, all other people in the vicinity join in eating the prepared meat of the slaughtered animals. Up to this point, all the cooking and sharing of the food has been done on the path, outside the village.

After all of this, representatives of each clan take the process to another level by commencing to share meals in a hut. As the ritual is performed at a neutral site, outside of the villages of either clan, they use huts that have been assigned to either side for the specific purpose. They eat a specific dish (*odeyo*) and offer each other drinks. In this way, each clan is host to the other. The offering and sharing of food and drink in a "home" is regarded as a sign of deep fellowship in Acholi culture and marks a high level of intimacy and trust.

After this last and most intimate ritual eating has taken place, the ceremony of *mato oput* is considered to have concluded well, and all the people around begin to eat and drink, continuing to share food informally. The relationship between the two clans is now regarded as restored, and even inter-marriage between the two clans is again possible.

At this stage, the elders caution those present to leave the "bad heart" behind and live with each other as brothers and sisters. The two groups are warned never to do any wrong to one another in regards to the issue that had been resolved that day. The spirit of the deceased had been appeased and is happy to see that compensation has been paid for his killing and the ceremony has been carried out properly. It is believed that from that moment on, neither the spirit nor the ancestors would sanction any revenge related to the killing. If anyone afterwards engaged in such acts of revenge, he would suffer serious spirit-related consequences.

Bringing the process to a close

Although the relationships between the two parties at this point are considered to be fully restored, some elders would argue that the process of Mato Oput has not come to a close until a new life is born from the use of the compensation. The process traditionally goes as follows:

When the message has been delivered that the compensation (money or cattle) has been realized and the ritual of *Mato Oput* is imminent, elders of the bereaved clan would consult an *ajwaka* to find out which family (*doggola*) should receive the compensation. Traditionally the received money would be used to pay the pride price for a son of the clan to get married to a woman. The woman would be expected give birth to a child that would then be seen as the continuation of the killed person. The child would often bear the name of the deceased. The *ajwaka* would call the spirit of the deceased who would tell which family should receive the money or cattle for it to live on within the clan.
Elders from Palabek explain:

> When the money has already been given, the *ajwaka* is called to purify the house in which the money will be used. The spirit would then say: "You have put my money in good hands and thus, the first born should be called with my name." (Transcript CR 4, p. 287)

11.2.2.2.3 Applicability

Despite the extent to which the ceremony of *mato oput* has become known both in and outside Uganda, its performance is relatively rare in contemporary Acholi, especially in the reintegration of former LRA combatants. The destitute poverty that has been rampant in Acholi for many years might be one reason for the relatively low occurrence of the ritual. Related to and in addition to this consideration it is necessary to be aware that the whole process of reconciliation begins with the offender's community accepting the responsibility for the murder committed, including their readiness (and ability!) to pay the compensation. Without the repentance and the payment of the compensation, *Mato Oput* cannot take place and might not have any meaning in Acholi culture.

Traditional beliefs in the spirit world certainly have also been weakened in the course of time, thus further contributing to the decline of the ritual. The persecution of murder under the national law is surely another factor contributing to the decline of the customary practice. While the usual detention of the murderer might relieve some of the tension for the community during the time of imprisonment, elders emphasize that it makes the struggle in collecting the indemnity even harder.

Yet to say that the ritual of Mato Oput has been considerably weakened certainly does not mean that it has completely lost its importance. It is essential to consider that there *are* strong values of forgiveness and reconciliation in the Acholi culture and for many Acholi

this spirit of forgiveness and beginning anew is associated with the term and ritual of *mato oput*. Furthermore the symbolic acts in the ceremony have a strong power and meaning in the local culture that could still be used to assist reconciliation in and among communities. On the other hand, the concrete application of the process described above to people coming back from LRA or to a more general process of reconciliation among the Acholi and even other people at a national or international level is certainly not straightforward. Nevertheless, in discussions with elders it was noted that they are considering how the procedure of *mato oput* could be used in one or another way to support reconciliation processes within the Acholi community, especially after the ending of the present civil war.

Elders from the North Central Zone reflect:

> As we know, the ceremony *mato oput* is conducted as a response to killings when the two people (killer and killed) are known. In the current war it is very difficult to establish who killed who. It is the rwodi that should take oput [reconcile] on behalf of the people. (Transcript 10, p. 68)

11.2.2.3 Gomo tong – bending the spears

11.2.2.3.1 Purpose

Gomo tong ("bending of spears") was performed in former times as a symbolic ceremony to mark the end of a war or bloody conflict between different Acholi clans or chiefdoms, or between Acholi and neighboring ethnic groups. The ritual implied a vow by both sides evoking 'the living dead' and promising that such killings would not be repeated. If one side did again lift a spear against the other without a very good – and new – cause, the tip of the spear would turn back against the aggressor. According to a number of elders from different parts of Acholi, *gomo tong* could be carried out with or without the ceremony of *mato oput*.

11.2.2.3.2 Procedures

Bending of spears with mato oput

Gomo tong with *mato oput* was likely to be organized after a bloody conflict had occurred between two Acholi clans or chiefdoms. For example, if a man killed a member of another clan/chiefdom in Acholi and the issue could not quickly be addressed by *mato oput*, the possibility was strong that revenge killings would occur, leading to a cycle of violence affecting both sides. In such cases a chief and his representatives who were acceptable

to both sides came in to mediate. The side that committed the first killing was usually required to pay compensation. After a successful mediation, the day of *mato oput* and *gomo tong* would be determined.

On that day, *mato oput* would first be performed, addressing the initial killing. The 'bending of spears' would then follow the same day, with both sides vowing not to lift their spears against each other again.

Bending the spears without mato oput

When conflicts occurred between Acholi and neighboring ethnic groups, *gomo tong* was performed without the ritual of *mato oput*. Nevertheless, elders of the two groups would sit down to discuss the reasons that triggered and perpetuated the conflict. After agreeing to end the fighting, chiefs and elders of both sides would warn their people to stop the killing. On the day of bending the spears the elders and chiefs would also discuss how to limit any possibilities of future conflicts and killings. The *gomo tong* ceremony would then be performed by either breaking the spears apart or literally bending the tips of the spears. Then the two sides would slaughter a bull for the elders to eat and then disperse.

11.2.2.3.3 Applicability in the current situation

The most recent "bending of the spears" was performed in a dramatic ceremony in 1984 between the Acholi and their Madi neighbors to address and stop the cycle of violence between the two ethnic groups that spiked after the 1979 fall of Idi Amin (Finnström, 2003). This example indicates that symbolic acts of reconciliation and peace building rooted deep in the past can still have relevance in the present, even if the preferred weapons of war had changed.

In several focus groups, elders discussed if and how bending of the spears could possibly be applied to mark symbolically an end to the current conflict and to promote peace and reconciliation. Most of them seem to agree that the ceremony could not only have applicability in fostering processes of reconciliation within Acholi, but also with neighboring ethnic groups and perhaps even the current government.

11.2.3 Cleansing areas

The most important ritual, intended to cleanse discrete areas is called *moyo piny.* A procedure for chasing away bad spirits from a wider area is *ryemo gemo*. In this section, *moyo piny* is described in some detail and *ryemo gemo* only briefly.

11.2.3.1 Moyo piny – cleansing a specific area

When elders and other key informants described the rituals above, their depictions and interpretations, while not entirely uniform, were fairly consistent across different areas of Acholi. In the case of the *moyo piny* ritual, however, variety almost prevailed over consistence. Still, it is possible to delineate the main patterns of *moyo piny* without totally neglecting the reported differences in purpose, procedures and even naming.

Moyo piny is also sometimes called *tumu tura* and can be translated as "cleansing an area." Often the term *moyo* is used in conjunction with a term specifying the area to be cleansed, for example, *moyo kulu* (cleansing a small stream or brook) or *moyo got* (cleansing a mountain). At times, the naming as well as the purpose and procedure overlaps with *tum* and even *tumu kir*. The reason for this is that if a taboo (*kir*) is broken in a certain location, it is not only the person or persons involved who need to be cleansed, but also the place itself.

11.2.3.1.1 Purpose

Moyo piny or *moyo tura* is generally performed to cleanse an area from any bad spirits or other negative influences from the spirit world. Such ceremonies are seen as necessary when misfortunate incidences have stricken a community in a specific location over and over again. Elders from Pajule explain:

> *Moyo piny* is a cleansing ceremony used to purify any kind of problems that repeatedly occur in a certain place. If injuries or death occur frequently in a certain place, elders would sit down to discuss why such things are happening and what should be done. It is also elders who would do the purification. The area to be purified could be a bad hill, a water source that kills people time and again, or in a valley that kills people. (Transcript 27, p. 200)

Elders from Ayom:

> *Moyo tura* [note the variation in name] is done at a place where people had been killed or where dead bodies have been found. The concerned area should be cleansed in order to avoid any future problems there. According to traditional beliefs, killings can cause failure to rain in the concerned area or people to contract serious injuries or even to die at that very place. (Transcript 24, p.175)

Moyo piny ceremonies can also be done as a preventive measure, before killing or other negative events have happened. This is made clear by elders from Lira Paluo

> *Moyo piny* is done to prevent spirit related diseases and to prevent spirits from disturbing people in a certain area. *Moyo piny* can also be done to prevent strong winds, rain and hailstorms which would spoil crops. It is also done to prevent strong sunshine which would be spoiling crops. Cleansing of the area can also be done by the chief in order to prevent sickness, injuries and accidents. (Transcript 26, p.194)

Finally, elders say that *moyo piny* or *moyo tura* can also be performed to bring about success in hunting. In such cases, it is understood as a sacrificial ceremony to propitiate spirits that might otherwise spoil a successful hunt.

11.2.3.1.2 Procedure

In most cases, the *moyo piny* ritual requires a sheep or a he-goat, although because of the rampant poverty that characterized current Acholi, a chicken can at times suffice as a substitute. In any case, it is the elders who sit and determine if and how the ritual is to be carried out. An example of a stream cleansing is provided by elders from the Pajule:

> When elders want to cleanse an area, for example a stream, they look for a he-goat and take it to the stream side. Elders do the *agat* by saying:
>
> *"You the stream, there you are, today we have brought the goat for you because we surely know that a goat washes all the impurity from the body of human beings. And if you are the one brining problems to us, then today we are bringing you blood; now we do the cleansing. The eye of the setting sun should take [away all bad things]. It has taken them! Take them far!"*
>
> The invocation is done three times and when it is finished, the mouth of the goat is held shut tightly to prevent it from crying. Then the stomach is pierced with a knife. The *wee* [contents of the lower intestines of an animal; used very

> frequently in Acholi rituals] of the goat is then removed and thrown on the bank of the stream. Two elders are selected to bring the *wee* to the stream. At the bank of the watercourse, they would again do the *agat* and throw the *wee* on the water. Afterwards, they come back … to skin the goat and get it cooked . . . . Then the elders pick some pieces of the [cooked] goat's meat and "sow" [throw] it towards the direction of the stream before they start eating. After they have finished eating, all of them go back home. (Transcript 27, p.201)

Another example of *moyo piny* is described by elders from Lira Paluo:

> On the eve of cleansing the area, the chief would beat the drum to inform the people on what would happen. The chief's messenger would also move among all the villages to inform people about the upcoming event. The following day, people would not go to the garden nor fetch water because the spirits being chased would be moving. If one did so, the person could be caught by the spirits. People would collect all the ashes from their fires and all water that had remained in the pot from the previous day would be poured away.
>
> The chief would kill a goat and throw pieces of meat from all parts (*ajata*) towards the east, north, south and west. As he would be throwing the pieces, he would say his *agat* so that his area remains well, nothing bad should happen and crops should yield well. A brew from sorghum would be given to people to take. On that day the chief would also admonish people on how they should live [together in harmony]. Later, people would sit down to eat and drink. *Bwola* and *Acut* dances would be danced. (Transcript 26, p.194-195)

11.2.3.1.3 Applicability in the current situation

Elders emphasize that *moyo piny* is still important and applicable in the current situation. At the same time they lament that the ritual is not carried out as often as it should be, in large part because people are frequently unable to afford the requirements for carrying out the ritual, especially a goat or a sheep. Another reason for the rare application of the ritual lies in the religiously motivated disapproval of traditional rituals. As expressed by elders from Lira Paluo:

> Cleansing the area is important in Acholi tradition and can still be applied up to today. Although the chiefs are not performing many rituals of *moyo piny*, the *atekere* are performing the ritual at lower levels, which is helpful. Chiefs should

> perform *moyo piny* at this particular time because brutal killings and atrocities have been committed. If not cleansed, this can cause spirits and bad diseases to kill many people.
>
> Currently, the ritual of *moyo piny* has become very rare because people cannot afford the requirements. Secondly, the chiefs are not able to gather their people around them because people are scattered in different places. *Moyo piny* is still difficult because the rebels can still commit more atrocities after the area has been cleansed. This would render the cleansing useless. Balokole [evangelical, "saved" Christians] regard traditional rituals as the work of Satan. This is another reason why *moyo piny* is so rare and even few people know about it. (Transcript 26, p. 195)

11.2.3.2 Ryemo gemo – chasing spirits from a wide area

Moyo piny is not to be confused with *ryemo gemo*, the general chasing away of bad spirits from a wider area by making a lot of noise. Traditionally, *ryemo gemo* has been performed regularly across wide areas, most often in a preventive effort to chase away all bad spirits that might be lingering about before they harm people. The drumming and beating of calabashes – and nowadays also the beating of tins and cooking utensils – would run through the whole area, in a proceeding that might remind Europeans of the Carnival at home.[29]

11.2.4 Rituals with a focus on individual healing

11.2.4.1 Moyo kom – a general cleansing ritual

Moyo kom is often used as a very general phrase to denote the cleansing from negative influences of spirit forces. As mentioned above, it sometimes refers to the combination of *nyono tonggweno* (stepping on the egg) and *lwoko pik wang* (washing away the tears). But it can also be used to refer to a separate ritual.

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[29] Carnival in Europe actually goes back to pre-Christian rituals that were aimed at chasing away bad spirits by making loud noises, although they have experienced significant metamorphosis throughout the years. It is worth pointing out in this context that such "pagan influences" have thus survived centuries of Christianity in Europe and yet are still considered an important part of the culture.

Data collected on the ritual of *moyo kom* showed considerable variation from place to place. This is partly due to the general nature of the phrase, but also to differences in specific ritual practices among clans. What follows is a description of the purposes and ritual acts that are typically associated with *moyo kom*.

11.2.4.1.1 Purpose

The purpose of *moyo kom* is to cleanse the concerned person from spiritual impurity in order to prevent misfortune and ill health. The ritual can be seen as necessary for someone who has been involved in killings, has violated a taboo, or has in other ways provoked agents of the spirit world. According to examples given by elders, the ritual should "bring good health," "remove bitterness from the heart," "take away bad utterances," and "deter *cen*," among other benefits.

11.2.4.1.2 Procedure

Typically, the *moyo kom* ritual begins with elders invoking the ancestors, after which a goat is slaughtered in a ritual way and cut open. The *wee* is then removed from the intestines and put on the chest (*pal cwiny*) of the person to be cleansed, while elders make pleas and give their blessings.

In order to illustrate the ritual in more detail, an extract of records on a *moyo kom* ritual witnessed in Central Zone are presented. The ritual was performed to cleanse an adolescent couple, because the young man had made love with his girl friend in the hut of his future mother-in-law.

> After the pleas [to the ancestors], the *atekere* held the mouth of the goat while the uncle (*nero*) of the girl held the legs. The *atekere* then cut the throat of the goat just in front of the offenders. The goat was taken to be skinned as people sat down waiting . . . . Then the *wee* was given to the *atekere* to be placed on the chest of the offenders.
>
> The a*tekere* called the young man and the girl to stand in front of the house and placed the *wee* while saying: "Today I place my *wee*, let these children stay healthy. No more problems to exist, their future should be clean."
>
> He began by putting the *wee* on the woman and then did the same on the man, repeating the invocation. Thereafter, he threw the remaining *wee* in the direction of the setting sun while saying: "Anything bad coming should be taken by the setting sun! The setting sun should take it far, and should take it forever!"

> Some portion of the meat [of the goat] was first fried and given to elders to eat. The water used for washing hands was kept in a calabash. Then the *atekere* warned the offenders not to repeat the same mistake in future or otherwise they would fall into more serious problems . . . . In the discussion, the mother-in-law was asked not to stay with a bitter heart about what had happened because it had already been cleansed. She was told to remove all ill feelings concerning the son-in-law and begin a new life, because if she could not forgive, the blessings would not be affirmed by the ancestors . . . .
>
> The male offender was then asked to produce a goat for the mother-in-law and alcohol for the elders who had gathered there. (Transcript 35, p. 240-241)

In addition to using the *wee* in the manner described and admonishing the various participants in the ceremony, other ritual acts such as *kiro pii* and *goyo pii* (described above), are often incorporated as well. The sharing of food by elders and all the others present is another important part of the ritual, which normally concludes with the common *agat*: "*Anything bad should be taken away by the setting sun. It has taken it! Take it far*!"

11.2.4.1.3 Applicability

According to elders, *moyo kom* has a wide range of applications still today. Elders unanimously emphasize that children who are coming back from rebel captivity should be cleansed in a ritual of *moyo kom*. They also stress that people suffering from *ajiji* (adverse short- and long-term reactions to severe danger and confrontation with death – discussed above) often need the cleansing provided by *moyo kom* ritual.

11.2.4.2 Kwero merok – cleansing someone who has killed in war

Kwero merok is one of the most elaborate ritual ceremonies in Acholi culture. It lasts for three or four days, depending on whether the person undergoing the ritual has killed a man or a woman. Although traditionally not applied to someone who had killed members of his or her own family or clan, it is currently performed at times on returnees who have done so and who suffer from extremely severe psychological distress (corresponding to generally recognized "signs of killing").

11.2.4.2.1 Purpose

Traditionally, when men who had killed enemies came back from war, they were considered impure and required to go through an elaborate ritual with the purpose of cleansing them from the spirit of the killed enemy. This was seen as necessary in order to

prevent diseases that would be expected to befall the killer and his clan as the result of *cen*. This important part of Acholi cosmology would seem to also apply to the people who come back from LRA having killed. Rituals such as "stepping on the egg" (described above) would from this perspective be seen as important but preliminary rituals of welcome and initial cleansing. Returnees more severely affected by *cen* – for example, as a result of involvement in killings at close range – would be seen in need of additional cleansing in a more powerful ritual such as *kwero merok*.

11.2.4.2.2 Procedure

Process leading to the ceremony

According to elders, soldiers who come back from war – most commonly and importantly in the current context, those coming back from the LRA – are expected to tell their family about what happened "in the bush," especially about killings they might have committed. The family members are then to report the matter to elders, who again listen to the story of the returnee. On the basis of the information obtained, they might decide that a *kwero merok* ritual needs to be performed (although as discussed just below, the applicability of *kwero merok* is often not clear-cut). Sometimes, elders might consult an *ajwaka*, who would then invite the spirit of the killed to talk. The killed then recounts the killing and tells what needs to be done for him to leave the killer. In case prior investigations point to the ritual of *kwero merok*, people would arrange for it.

Procedure for cleansing somebody who has killed a man

The ritual typically starts with the cleansing of the ancestral shrine (*abila*), where elders invoke the ancestors for their assistance in the ceremony. People displaced in the camps sometimes make a temporary shrine for the sake of the ritual (see picture).

Picture 3: Elder purifying the ancestral shrine using a white chicken

From that point on, throughout the coming days of the ceremony, the killer will be supported not only by the ancestors, clan elders and the extended family, but even more visibly by four specific persons who remain close to him throughout. The first is the ritual performer, *lakwe*, who must be a man who has killed before and has already been cleansed in the same ritual of *merok*. The second is the lakwe's helper (*lanwojo*), who is selected for his courage and fearlessness and will be the second person to spear the goat in the grazing ground when that part of the ceremony takes place. Third is the person in charge of singing the *wayo* songs (the *lawayo*), who not only remains close to the killer during the day but even sleeps in the same hut with him for the coming nights. Finally, a virgin girl also remains near the killer for the whole duration of the ritual, day and night. During this time, the killer is adorned with ostrich feathers and beads, symbolizing pride and victory.

To mark the beginning of the ceremony, the bark of the *ogali* tree is tied to the killer (see picture).

Picture 4: Tying the *ogali* to mark the beginning of the ceremony

This shows that he is in the process of being cleansed in a *merok* ritual. *Merok* songs – songs about the killed enemy – are sung, and people dance and perform mock fights, using spears or sticks. The killer blows his horn, while the virgin girl ululates as an expression of joy and praise.

Throughout the ceremony, specific songs are sung, often accompanied by vigorous dances and mock fights. The *merok* and *wayo* songs elaborate on topics surrounding the dead body of the person killed, praise the victor as well as the deceased, and rebuke the spirit of the deceased to leave and let the killer remain healthy.

After finishing the first round of songs, the ancestors are again addressed by elders, pleading that *"our child should remain healthy and whoever speaks ill, the setting sun should take it away"* (Transcript 18, p. 127).

For the next two days, *wayo* songs are sung regularly and people even get up in the middle of the night to sing the songs.

On the day of the ceremony's climax, people leave the homestead for the grazing ground, where the killer spears a goat in a ritual manner, followed by the *lanwojo*.

Picture 5: The killer spears the goat in a ritual manner

The meat of the goat is then roasted and courageous men compete for the meat in a ritually prescribed way, showing their ability and urge to fight.

Picture 6: Brave men compete for the labana meat

The fire that was used to roast the goat's meat is put out by stepping on it with bare feet, after it has been covered with fresh leaves. This "dancing" on the fire is believed to deter the spirit of the killed.

Picture 7: Dancing on the fire

Another important ritual act follows: cleansing at the termite (*aribu*) mound. The killer is dragged through the termite mound three times in order to make the termites bite him (see picture).

Picture 8: Cleansing at the termite hill

The worker termites are believed to bite the bad spirit that is disturbing the killer, thus prompting it to leave. The virgin girl, the helper (*lanwojo*), and the ritual performer (*lakwe*) are then subjected to the same procedure, all in an effort to deter bad spirits that are believed to linger among the people during the ritual.

Following this, people go back to the homestead, where elders give their blessings and the ancestors are again addressed. Next, the killer and other brave men who had been competing for the goat meat in the grazing ground are given the herb *lunyare* to chew. The taste of *lunyare* is very bitter, and chewing it is considered an important vow in Acholi culture. A man who has licked or chewed the herb should not run away, even if a wild beast should threaten or war come. It is believed that if someone who has participated in this ritual turns his back when threatened, he will die since he has failed to fulfill the promise he made in the presence of his ancestors.

Traditionally, a specific *moi* (or "killer") name would be given to the killer at this juncture, signifying that he has killed an enemy.

The ritual is concluded with a final litany (*agat*) to chase the *cen* out of the killer. Elders point spears that have been blessed in front of the *abila* at the eyes of the killer, threatening and commanding the bad spirit to leave: *"You, today we do our agat on you; you should get out because we have already cleansed you! The setting sun today should take it, and has taken it, away!"*

The people gathered would answer: *"And has taken it away!"*

The above litany is repeated several times, led by elders and echoed affirmatively by all those present. Relaxed sharing of food and drinks then follows.

Procedure for cleansing somebody who has killed a woman

The procedure for cleansing someone who has killed a woman differs in a number of ways. First, the ritual lasts four days instead of three. Second, the killer is required to perform all the work a woman is expected to do in society. In a *kwero merok* ritual observed and documented in detail, the killer was required to carry out women's duties on the second, third and fourth day of the ritual. Elders from Atanga explained:

> Cleansing the killing of woman is … difficult … because you have to do all those things that a woman does: you have to wear an apron like a woman, fetch water, grind corn, look for food, fetch firewood, wash dishes, and do all the petty works that a woman does in a homestead. (Transcript 16, p.108)

An *ajwaka* confirms:

> Traditionally, purifying someone who has killed a woman was difficult, for he has to carry a pot of drinking water, bowls, has to split firewood, cook and do all kinds of work that a woman does and the way it should be done. For this reason, the women were respected and were not killed anyhow. (Transcript 5, p.28)

Even if the content and sequencing of specific ritual acts in cleansing the killer of a woman as opposed to one who had killed a man is different (in many ways, dramatically so), the other main elements constituting the ceremony, and overarching purpose and themes are essentially the same.

11.2.4.2.3 Applicability

Although key informants were fairly consistent when describing the major elements and ritual acts that make up *kwero merok*, they are less unanimous when it comes to judging whether this ritual should be utilized with returnees coming back from the LRA. The basic objection has been summarized by elders as follows:

> Cleansing for this current war is very difficult because the war is between brothers only. What could be done is to reconcile in the ceremony of *mato oput*, because cleansing with the ceremony of *kwero merok* is not done after a killing between brothers in Acholi tradition. (Transcript 16, p.108)

Yet at least in parts of Acholiland *kwero merok* is being performed with returnees from LRA captivity. A ritual performer from Kitgum district looks at the application of the ritual from a pragmatic view, even alluding that the Christian God would be supportive of such rituals and would assist in bringing about the positive results:

> These things are rightly important because it has been culturally very much respected by the old Acholi people and when it was done, God [Rubanga in the original transcript] would hear their prayers and would bring good health to the person who had killed. It is done to bring good health to the person who has killed … so that his mind is as clear as when he was born. (Transcript 12, p. 83)

Finally, with respect to *kwero* merok, an elder from Gulu reasons in the following manner:

> Nowadays one cannot say that whoever kills another person with a gun should be cleansed, especially if the killing had been committed without seeing the person killed. But all the killings done face to face where the people saw each other should be cleansed through the ritual of *kwero merok*. In the case of our children coming back from captivity, when they tell us that they have killed face to face, for instance flogging someone to death or cutting the person with a machete, or beating with sticks, they should also be cleansed. (Transcript 15. p.93)

11.2.4.3 Ryemo jok – chasing out a "free" jok

As noted above, the chasing out of a "free" *jok* is closely related to the notion of spirit possession. The category of free *joggi* includes *cen*, the vengeful spirit of a person who has died a violent death, but also other spirits, all of which are believed to disturb the living. *Ryemo jok*, the chasing out of a free *jok,* is done by an *ajwaka* using the power of her own spirits.

11.2.4.3.1 Purpose

According to traditional Acholi beliefs, virtually any problem can potentially be caused by spirits. Such problems might include a wide variety of medical and psychological complaints, but also relationship problems and more generally, virtually any perceived misfortune. Psychological distress often seems to play a major role when people consult an *ajwaka;* Okot p' Bitek (1971) suggests anxiety in particular.

The purpose of chasing out the bad spirit, then, is to cleanse the person and thereby re-establish overall mental, physical, social and spiritual health. An *ajwaka* explains the basic rationale:

> When someone … comes to an *ajwaka*, the *ajwaka* pours the cowry shells and sees what has happened. After having established that it is the spirit … who is causing problems …, she will advise the people that the spirit should be removed from the person. (Transcript 4, p. 21)

11.2.4.3.2 Procedure

The procedures applied by an *ajwaka* vary from case to case, especially as it is the possessing spirit itself that is consulted to determine what is necessary for it to go away and leave the patient healthy. Nonetheless, certain frequent culturally shaped patterns can be discerned.

The consultation characteristically begins with the process of divination, using cowry shells, water, leather (*laa*), or any other procedure preferred by the individual *ajwaka*. During this process, she will see that the patient is disturbed by a spirit and subsequently invites the spirit to communicate. At times the spirit talks through the *ajwaka* or the patient, but often it talks from another location (for example, 'from the earth' as in case study no. 7 in CHAPTER 12). The type of spirit that is revealed in this process, and the content of its communication, determine the course of the treatment. An *ajwaka* explains:

> If it [the spirit] says that it is a spirit of war, then a symbol of a gun is made out of wood and put (pressed) across the person's chest and a song would be sung for him. He would hold the wooden-made gun and pretend to shoot while rolling on the ground as if he is in a battlefield. This spirit would lead him to the bush. When he reaches the bush, the *ajwaka* invokes the spirit which would then come and talk: "I am so and so, why have you killed me?" The bad spirit would then tell where it comes from and how it was killed. All these things the spirit would say speaking through the patient as he/she becomes possessed. It would then tell the people that it is leaving. The possessed patient then goes and picks the sheep provided and runs with it further into the bush, falls down and breaks the neck of the sheep. If the spirit has commanded that no one should eat the sheep, then it is left for the vultures to eat. (Transcript 5, p. 29)

The same ajwaka explains another procedure:

> When the ritual *wero jok* is performed, the *ajwaka* makes the patient to sit on a stool. Then a drum is beaten and the shaker is shaken, as people would begin to sing. The patient, getting possessed by the bad spirit will then get up and start dancing. In the course of the possession, he will then pick a goat/sheep, run with it to the bush where he/she will fall and cut off the head of the goat/sheep. When he/she has fallen down, the *ajwaka* shakes the shaker and transfers the spirit from the person to the head of the goat/sheep, which should not be eaten. The *ajwaka* would shake the shakers on the head and on the position of the heart to remove the evil spirit. The patient would then be cleansed – free from the evil spirit, which has been transferred to the goat/sheep. (Transcript 5, p.30)

Another *ajwaka* offers a variant, but essentially similar account:

> The *ajwaka* then calls the spirit of the murdered person to talk. The spirit would ask for blood of a sheep or goat to be offered for it to go. The sheep/goat would then be placed right on the back of the killer and is then speared while still on the back of the killer. The blood of the sheep/goat flows down and the elders then say "all bad things that our child has done or has been forced to do should be cleansed today." Then the *wee* [content of the lower intestines] of the goat and the goat itself is pulled from the back of the killer over his head, placing it in front of him. The *wee* of the goat is smeared on the person. Having done this they would have given food to the spirit. Then herbs are given to the killer to take, others will be burnt where he sleeps and others are to be put in the water which he will use to bathe. Still others are taken while making pleas. (Transcript 4, p.21-22)

These examples allude to both the variation and the similarities of procedures. Mostly, the killing of a goat or sheep is involved when chasing out a spirit, although less demanding spirits might at times be satisfied with a chicken. Then, in most cases, the disturbing spirit is either sent away with the gift of, or transferred onto the animal, which is left in the wilderness. After *ryemo jok*, the *ajwaka* might still treat the client, applying herbs and other procedures.

11.2.4.3.3 Applicability

As most of the returnees who come back from the LRA are considered, at least by parts of the community, to be contaminated with *cen*, the procedure of *ryemo jok* is one option of treatment according to local cosmology. Arguing that *ryemo cen* should be applied to returnees who suffer from *cen*, rather than the ritual of *kwero merok,* an *ajwaka* says:

> This [*kwero merok*] was done at the time when people fought their enemies. This fighting was different from the war we are facing now, where people are killing anybody be it a brother, father or an enemy. Therefore, for the killing in the current war, we don't cleanse with the ritual *kwero merok*, but people are taken to an *ajwaka* to purify them and remove the evil spirits. (Transcript 5, p.30)

Finally, another argument that traditional healers give in opposing the suitability of *kwero merok* in the current context is that in the "olden days" (pre-colonial Acholi), the cleansing of the warriors in the *kwero merok* ritual took place immediately upon returning from war. Given this, the procedure would therefore not apply to returnees who have returned to the community some time ago, and who already manifest the signs of "madness" (*bal pa wic*). The treatment of *bal pa wic*, they argue, requires the assistance of the *ajwaka*.

12 Case studies on ‘traditional’ ways of healing

In the previous chapter, we have outlined traditional ways of healing in Acholi by describing respective concepts, as well as healing offices and rituals. When depicting the rituals, we aimed at providing prototypical descriptions rather than illustrating its actual application.

In the following, we offer some case studies to show how the above-described traditional concepts and rituals are applied in the context of contemporary Acholi society. The first part of this chapter offers case studies on the general practice of traditional healing. The second section provides case studies on the ritual k*wero merok;* a ritual that is of specific interest to our topic, as it shows interesting parallels to Western trauma therapy (cf. CHAPTER 13.2.3). To protect the identity of the persons described in the case studies, we have altered their names.

12.1 Case studies on the general practice of traditional healing

The following case studies cover different aspects of Acholi healing. Two cases studies are on rituals to that address the consequences of broken taboos; another one is on a ritual for cleansing an area from *cen.* Further two case studies illustrate the interaction between traditional, Christian, and modern approaches to healing. The section closes with two case studies describing the initiation of and a treatment by an *ajwaka*.

12.1.1 Case study no. 1: Miscarriage because of a broken taboo and cleansing at the well[30]

It was in 2004, when Aber and Aling quarreled on a path near the well. Later in the day, they met again at the water source and fought for a second time. However, the issue did not come to the attention of the elders.

A year after these disputes, Aling eloped with a man. She became pregnant twice, but had two miscarriages. To understand the cause of the miscarriages, her in-laws consulted an *ajwaka.* The diviner found out that the spirit of the river was angered because Aling and Aber had fought in front of it and nothing was done to cleanse the water source. The *ajwaka* told them that, to prevent any further problems, they should sacrifice a black he-goat. She also detailed the procedures of the proposed ritual. When Aling was again pregnant in early 2006, *tum* (the sacrificial ritual) was hurried to prevent another miscarriage.

In preparation for the sacrifice, the *rwot kweri* and elders convened a hearing. Everybody present consented to the *tum,* and both parties agreed to contribute some money to buy a black he-goat.

At the day of *tum,* the family of Aber brought the goat. The family of Aling was also present. The *rwot kweri* and the representative of the *atekere* left for the place where the fighting had taken place. On arriving there, the representative asked Aber and Aling to hold the legs of the goat. The representative held the mouth of the goat shut as he cut the throat and was making the following pleas:

> You the water source, these children quarreled in your presence, but we did not know that you were angered. Today we offer our sacrifice, we ask you to allow our child, Aling to stay well and give birth safely. For Aber, who is not yet married, let her be without any problem at the time she will be giving birth. Today the blood of the goat is poured to wash all sin, nothing bad should exist anymore.

After skinning the goat, the *wee* [content of the lower intestines] of the goat was given to the representative of the *atekere*. He called Aling and Aber, while standing on the spot where the goat had been slaughtered. Then he placed the *wee* on their chest, saying:

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[30] This case study is based on transcript 34 (see COMPANION VOLUME). Data collection included participant observation of the ritual and informal interviews, carried out by Francis Okot in May 2006. The same case study has been published in Harlacher et al, 2006, and has been only slightly edited for this thesis.

> Today I place the *wee* so that your heart shall be cool and nothing bad shall remain. No quarreling should ever happen again and you shall remain healthy.

The *wee* was first put on Aling and later on Aber. Afterwards, they were told to go home without talking to anybody. They were also instructed not to look behind until they had entered their mothers' huts. Meanwhile, the people who were skinning the goat had given some meat to the representative of the *atekere*. The meat was to be roasted. After roasting, the representative threw the pieces of meat to (the spirits of) Tochi river, pleading:

> You Tochi, we ask you to allow the child to be healthy. Nothing wrong should happen. The unborn child should live. No similar problem should occur again.

Later, he also threw some pieces of meat to the tributaries of river Tochi. The remaining meat, he threw westward while making the *agat*:

> Today we have made sacrifice for the water source. [Speaking to the spirits:] You who are in the direction of the setting sun, anything wrong coming should be taken with the setting sun, the setting sun should take it far, nothing wrong should remain.

The rest of the meat was roasted and people ate. After sharing food and informal conversations, people dispersed. The knife, which had been used for cutting the throat of the goat, was given to the *atekere*.

12.1.2 Case study no. 2: Illness because of a broken taboo and the cleansing of a woman[31]

Akena aborted "Odoch", and although she stayed well for a while, she later fell sick and was taken to the hospital. But the doctors could not detect any disease. When the sickness persisted, she sought advice from elders. They decided to consult an *ajwaka,* who discovered that the abortion of the child was the cause of the strange sickness. The spirit of the aborted child demanded that compensation be paid for having him killed. Following the demand of the spirit, the clan collected money to be used to marry a woman to a son of the clan. The woman was then to give birth to a child who would be considered the continuation of the life of the aborted child. When elders of the clan had made their

[31] This case study is based on transcript 23 (see COMPANION VOLUME). Data collection included participant observation of the ritual and informal interviews, carried out by Francis Okot in November 2005. The same case study has been published in Harlacher et al, 2006, and has been only slightly edited for this thesis.

contributions, it was agreed that the family of Oculo should use the money to get a proper woman for their son. But it was necessary to perform a cleansing ceremony before the couple could stay together as husband and wife. Otherwise, so the elders feared, the future wife would not be able to stay well in the family.[32]

In November 2005, elders gathered to perform the cleansing ceremony for Anyomo, the woman married with the compensation money. Anyomo came and stopped on the path leading to the home where the elders were waiting for her. At the entrance to the homestead, an elder was holding a sheep tied with a rope. He began his invocation, saying:

> "Now you, our ancestors, you Okuc, I am not the one who has put this rule, but I am following today what you began long time ago. Today I have brought a woman home to help us, to cook for people of this home. This is my saliva [referring to his blessing] so that she helps people in the family."

Then another elder came and invoked his blessings:

> "Here I also invoke my saliva [blessings], you Poromoi, Labanya, Okuc, all of you [referring to the list of ancestors]. We ask you for your blessings on this day when we purify this young woman. We have corrected what had gone wrong by paying compensation. Allow this young woman to give water, give birth, be healthy and lead a good life. You our child [referring to Odoch, the child that had been aborted], you should be happy because we have done everything you have demanded for. We want this young woman to give birth so that your name shall stay on earth[33]."

Other elders were following with similar invocations, asking for good health, fertility and well-being.

Then the sheep was slaughtered by cutting the throat and the blood flew on the path. The young woman stepped on the blood passing towards the house of her mother in-law. Then the *wee* (contents of the lower intestines) was removed from the sheep and placed on Anyomo's chest, welcoming her in the home. While placing the *wee*, elders again invoked their blessings, saying:

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[32] The pattern described in this first part of the case study follows the 'spiritual logic' of the *mato oput* process (CHAPTER 11.2.2.2): A killing requires the payment of compensation. The compensation must be cleansed. The money is used to pay the bride price for a woman, and the child born from the marriage is considered the continuation of the person who had been killed.

[33] This is referring to the aborted child who according to Acholi traditional beliefs shall continue to live in the child to be born by the woman.

"You [referring to the ancestors]! Today we are pleading as we place our wee, so that this young woman should stay in good health, bear children and feed the home. All problems must pass from afar, child bearing and good health is what we want."

Four other elders did the placing of the *wee* and each of them invoked their blessings. Most of these invocations were again made to ask for good health, childbirth, food and good relationships. All this was done while Anyomo and the elders were standing in front of her mother in-law's door.

Finally, the last elder invoked his blessings to chase away any bad spirits [*gato agat*], repeating the following litany several times:

"If anything bad comes, the [setting] sun must take it away."

And the congregation always responded:

"And has taken it away"

Then the elder threw the remaining *wee* in the direction of the setting sun.

Meanwhile, young men had been cooking the meat of the sheep in the yard. When the food was ready, it was served to the different groups: the children, boys, girls, young women, elderly women and elderly men. The water used for washing the hands before and after eating was not poured, but was collected in a calabash. Elders would use it afterwards for blessing Anyomo and her husband: In this process, each elder invoked the ancestors while putting drops of the collected water on the chest of both the wife and the husband. This was repeated three times by each elder. When they had finished giving their blessings, the remaining water was poured on the ground. The ritual ended with informal conversations among all participants, while sharing food and drinks.

12.1.3 Case study no. 3: Preventing misfortune by cleansing an area[34]

In May 2004, the rebels killed two women in a place called Dyang Bii, in Palabek Gem sub-county. The women were not known to the locals, as they had been abducted from another area and were killed when passing through Dyang Bii. Nevertheless, elders of the area considered it necessary to give the women a decent burial. This was to prevent the

[34] This case study is based on transcript 14 (see COMPANION VOLUME). Data collection included participant observation of the ritual and informal interviews with the *atekere* of the concerned area, carried out by Francis Okot and Gabriel Onen in May 2006. The same case study has been published in Harlacher et al, 2006, and has been only slightly edited for this thesis.

consequences which the bloodshed could bring to the area and to cleanse the family in whose abandoned homestead the women had been murdered. According to the elders, without a proper burial the spirits of the dead could start haunting the family members, the area could become a spot of incessant bloodshed, and the blood of the murdered women could cause the crops not to yield.

When the researchers came to the scene at the day of the burial, people were plucking grasses, spitting saliva on it and throwing them on the skeletons.[35] Then the head of the concerned homestead narrated what had happened and expressed his intention to bury the women.

After the head of the family had talked, the *atekere* explained the steps that would be taken: the digging of the grave, the stabbing of the sheep and the sprinkling of the *wee* in the grave and on the skeletons, followed by the burial of the human remains and the eating of the sheep. He also explained that the blood of the sheep would cool down the blood of the women killed and thus prevent problems.

When the grave was dug, the *atekere* made his pleas as he stabbed the sheep:

> "Today we bury you. We wish you do not do any harm to us people here, for we don't know the people who killed you. As we sprinkle the grave, where you will take your rest, we ask you to follow those who have killed you. Let our area stay in peace. No more bloodshed should occur here again."

Then he cut the sheep open, took out the *wee* and sprinkled it on the grave, the skeletons and the area around so that the crops would grow well.

Next, another elder made pleas saying:

> "Today we have buried you. You should not look at us with bad eyes but rather look at the people who had done wrong to you. I then throw these guts on the area where your blood had been shed. Today we cleanse the whole of this area using this sheep. We have thought of you as of any other person who should not rot without proper burial, thus we are giving you a burial. Don't look at us but rather at the people who killed you."

Afterwards, the skeletons of the murdered women were carefully placed in the grave that had been dug just next to where they were lying. This was done by an elder with a hoe, cautiously scratching the human remains together with adjacent soil and then covering them with earth. An elder was the one to bury the women, emphasizing the importance of the event.

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[35] This was a gesture of sympathy and respect. According to traditional beliefs, the spirits of the women were lingering around the place *(*as *cen)* and anyone who did not pay them respect in the above way could contract them.

12.1.4 Case study no. 4: Attempts to healing between 'Christian', 'modern', and 'traditional'[36]

By the time of the interviews in June 2005, Awor was 20 years old. She had been abducted by the LRA when she was 15 and came back three years later. Awor had conceived a child in captivity and gave birth when back in the community.

Distressing experiences

When with the LRA, Awor was forced to pass over dead bodies while making pleas to the spirits of the dead: If she ever returned home, the spirits (*cen*) should haunt her. She saw the killing of many people and was forced to smear the blood of the killed on her chest.

The aftermath

After her escape, Awor passed some time in a reception center, and was later reunited with her family. Once home, Awor felt that "kome nure"[37]. She had no strength to do anything. Bad dreams, in which she re-experienced the brutal killings witnessed in captivity, kept reoccurring. In her dreams, she was hearing people pleading not to be killed. Awor preferred staying alone without talking and could cry without any apparent reason. She complained of permanent headaches. Something [a spirit force] could fall on her and could make her speak in a way people could not understand.

The decision to perform a ritual

Awor tried many things to stop the trouble she was facing. While at the reception center, she joined the Pentecostal Assembly of God (and became 'saved') so that she could be prayed on to release her from her problems. However, the prayers did not help. When she was at home, she tried communal digging, but to no avail. She tried both Western drugs (from the local health center) and Acholi traditional herbs, but neither helped. She also tried to stay alone for she thought that maybe the bad words she was hearing from people were causing her problems. When her sickness was increasing, her parents talked to her, proposing to accept a traditional ritual, but she refused. Nevertheless, as her health

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[36] This case study bases on transcript 20 (see COMPANION VOLUME). Data collection included interviews with Awor herself, her mother, her peers and her responsible social worker, carried out by Francis Okot in June 2005. The same case study has been published in Harlacher et al, 2006, and has been edited for this thesis.

[37] "Kom" is body; while "nure" refers to a general sensation of the body being weak and without strength. Especially the joints (knees and elbows) feel weak and the person is prone to joint aches.

deteriorated to the point where she could no longer care for her child, and after further discussions with her parents and elders from her clan, she agreed that a traditional ritual be performed on her.

The ritual

None of the people interviewed were able to describe the ritual procedure in detail. Awor and her mother stated that it was '*yubo kom*' (often used as synonym to *moyo kom*), which is a general term for 'cleansing the body from a bad spirit'. (Yet they were sure that it was not a *kwero merok* ritual.) Awor narrated that she was taken to the grazing ground, where she had to spear a goat. *Opobo* rids were broken and used to cane her. This was to chase out the bad spirit. After that, they went back home.

Changes after the ritual

After the ritual, Awor's nightmares stopped. Awor now associates with people and is rearing pigs, which helps her bringing up her child. Awor, her mother and her peers are convinced that the traditional cleansing was very helpful and stress that she now likes other people – unlike before the ritual.

12.1.5 Case study no. 5: A mysterious paralysis treated by an ajwaka and 'born again' Christians[38]

In late 2003, Ocen, a man in his mid-thirties, went hunting in the company of other young men. A few days after they had returned, Ocen's hands started shaking and he fell down. His right hand became paralyzed and the paralysis spread to his right leg. He could not speak, get up or even eat.

When Ocen was asked what happened when the sickness first attacked him, he said that he had not been seeing any thing nor had he been having any vision. It [a spirit force] just came, threw him down and then paralyzed him. Ocen noted that the right side of his body was paralyzed and he could feel it aching in the bones.

According to his sister Ajok, this was not the first time Ocen has suffered from this illness. After having retired from the army, he had already fallen sick. Then, an *ajwaka*

[38] This case study is based on transcript 13 (see COMPANION VOLUME). Data collection included interviews with Ocen himself, his mother, and his sister, carried out by Francis Okot in September 2004. The same case study has been published in Harlacher et al, 2006, and has been only slightly edited for this thesis.

established that he had passed over a body when he was a soldier. The spirit of the dead person was therefore haunting him and causing problems. After having taken the herbs prescribed by the *ajwaka*, his state improved and he stayed well for another two years up to this second attack.

Ocen's mother confirmed that he had been a soldier in the past. She added that he had gone through many experiences that could have caused this sickness. Apart from having killed, he had also stayed at the lake side (Lake Kyoga). It is believed that many evil spirits linger around the lake side, and people who live there use a lot of herbs[39]. Therefore, he might have stepped on a bad herb, or he could have been bewitched. The mother, who is a healer herself, stated that it was hard for her to tell the cause of this sickness. But it was impossible to do anything about the illness unless the cause of the symptoms was identified.

Ocen stayed in the state of paralysis for four months until he was taken to an *ajwaka* to ascertain the cause. According to the *ajwaka*, the symptoms were caused by the spirit of a dog that had replaced Ocen's spirit. In addition, she found out that still another bad spirit was besieging Ocen.

In order to cleanse him, the *ajwaka* called the spirit of the dog to come and eat meat that had been prepared for it. She then took the meat and her equipment for cleansing, passed them round Ocen's head and threw the meat westward. The *ajwaka* then called Ocen's spirit and reinstated it in his body. The ritual was performed at the *ajwaka*'s place and took three days. Apart from the above-described procedures, herbs were also used for treatment. Some of them were prescribed for use when back home. Although the *ajwaka* had found out that another bad spirit was besieging Ocen, it could not be chased out, because the family did not have enough money to pay for the ritual's requirements.

Nevertheless, Ocen noticed some improvement. But even though, he could not yet talk after the traditional treatment. Therefore, some Balokole[40] ('saved' or 'born again' Christians) came and prayed over him three times. Later, they took him to their church, where they again prayed over him. After a short while, Ocen began to talk and became more aware of himself and his surroundings.

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[39] According to local beliefs, herbs can be linked to spirits that haunt the people who step on them or trespass against the herbs' owners. The word 'herb' in this context implies such spiritual connotation.

[40] The Balokole ("the saved ones") form a fundamentalist Christian movement with theological origins in the English and American revival movement of the 18th and 19th centuries. Despite its origins, the Balokole developed into an indigenous African movement that sought to renew the Protestant churches in several East African countries (Behrend, 1999a)

Ocen still feels body ache at times. This, so people speculate, could be attributed to the fact that the *ajwaka* has not chased out the other bad spirit she had identified. As the treatment given to Ocen was both 'traditional' and 'Christian', people still wonder which healing procedure made Ocen talk and walk.

12.1.6 Case study no. 6: How Ajok became an ajwaka[41]

Some time ago, when Ajok's father was still a game ranger, he killed a hippopotamus at the river Nile. Her mother told her to go to the river to wash the intestines of the hippo. When Ajok arrived at the river at a place called 'wang mon' (the ladies' site), she found an old man dressed in a white cassock, with a long beard, seated on a stone in the water. Instead of showing respect to him, she just began to wash the intestines close to the old man. Suddenly a maelstrom appeared and what she was washing was taken away by the force. Ajok noticed that something very strange was happening and started running home. The old man ran after her, but was unable to catch her.

On arriving home, she was not able to narrate what had happened, but kept on seeing the image of the man at the riverside. She could not talk for a week and showed signs of insanity. In her mind, the old man reappeared repeatedly to tell her that she had not shown any respect towards him and that for having offended him, she would not give birth.

Days later, these visions started causing ill health and she was close to becoming completely mad. She was taken to an *ajwaka* from the Alur tribe. The *ajwaka* told the elders that the 'spirit of the river' (*jok nam*) had taken control of her and that she should be purified to prevent her from becoming insane.

The *ajwaka* took three days to bring her back to her senses. She mixed various herbs and smeared them on Ajok's body, while repeatedly invoking the spirit. This procedure finally helped Ajok to 'open her eyes'. She then began to narrate what had happened to her and was considered to be cured.

Some years later, however, after the family had returned to their original home, the very same man who had been at the River Nile, reappeared at the well where Ajok was fetching water. She ran home, her mouth again tied, and she was unable to speak.

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[41] This case study bases on transcript 4 (see COMPANION VOLUME). Data collection included interviews with Ajok herself, carried out by Francis Okot and Scholar Amono in March 2004. The same case study has been published in Harlacher et al, 2006, and has been only slightly edited for this thesis.

Her mother went to an *ajwaka* from Acholi who confirmed that Ajok had encountered the "spirit of the river" and that now the spirit wanted her to undergo a ritual to make her become an *ajwaka*, otherwise she would go mad. Finally, cowry shells were given to her so that she would become an *ajwaka*. Since then, the very *jok* that had been disturbing her has provided her with power to divine and to heal.

12.1.7 Case study no. 7: Treatment by an ajwaka[42]

Odong is about 40 years old. He had already been a soldier in Obote's army and fled home after Museveni had taken over power. In 1999, he was abducted by the LRA. When he came back from the LRA after five years, he joined the Local Defense Unit (LDU).

Distressing experiences

Odong reported that he was forced to kill a fellow captive while being with the LRA. He chopped the boy, who was pleading for mercy, into pieces. Odong was also forced to pass over dead bodies while vowing that he should be haunted if he ever goes back home.

The aftermath

The bad spirits started disturbing Odong when he had come back from rebel captivity and had joined the Local Defense Unit. The spirit attacks made him feel dizzy. *Kume nure* most of the time and he felt the spirits strangling him when he was sleeping. According to his social worker, Odong had terrible nightmares and flashbacks on how he killed the boy, who was pleading for mercy. When he was at home, he quarreled a lot for no reason. He stayed alone most of the time and was talking very little. He didn't like people and said that he would not trust them.

Often, Odong moved around aimlessly, neglecting his duties. At times, when he was on duty in the trench (*adaki*), he would see spirits coming and he would shoot. The commander of the local army detach confirmed that he could no longer leave Odong with

[42] This case study is based on transcript 25 and 41d (see COMPANION VOLUME). Data collection included interviews with Odong himself, the performing *ajwaka*, his aunt, his army detach commander and his responsible social worker, carried out by Francis Okot in in December 2005 and June 2006. The same case study has been published in Harlacher et al, 2006, and has been only slightly edited for this thesis.

a gun, because he would shoot at anybody, claiming to see rebels coming. Therefore, his superior sent him home to be cleansed.

Treatment

According to the ajwaka, Odong did not have to tell her about his problems when he came to her. The *ajwaka* threw down cowry shells and was able to see them. She found that Odong had once been abducted and taken to the bush where he killed people. He had also passed over dead bodies. The *ajwaka* saw that *aywaya* [spirit of the forest] was disturbing him. With the help of her spirit, the *ajwaka* was also able to divine the symptoms that Odong was suffering from: dizziness and leaping of the heart (*poto cwiny*[43]). She also saw that some bad spirits had befallen him and thrown him down, taking command over the movements of his body.

In order to cleanse him, the spirits required a brown male sheep, a black he-goat and a black chicken. When all items were obtained, the ritual was carried out at the homestead of Odong's aunt. Early in the morning, the *ajwaka* lead him around the stool[44] and made him sit on it. Then she rhythmically began shaking the rattling gourd (*ajaa*). Others joined in beating the drums and singing, thus helping to evoke the spirit to come and possess Odong. Soon, Odong started shaking heavily and he fell to the ground convulsing like a person at the point of dying. After having recovered, Odong took a sheep and a black chicken and ran with them into the bush.

On arriving there, Odong collapsed again. The *ajwaka* lifted him and made him to lean on her. Then she picked the rattling gourd to remove the bad spirit from Odong. She continued shaking the rattling gourd and moved it up and down again and again. The *ajwaka* began to talk to the bad spirits, saying: "Come down here, I don't want you to kill this child because he belongs to us! And also don't disturb him anymore! Get this thing [referring to the sheep] to eat and go with it!" A negotiation between the *ajwaka* and various spirits followed. In the course of the negotiation, the spirits agreed to leave the sick person after having received their gifts: "If you want me to go, then you should know that something is still missing". The *ajwaka* then asked the bad spirit to say what it wanted. The bad spirit listed the flour for bread, a knife, saucepan, water and locally distilled brew (*arege*).

[43] *Poto cwiny* denotes fast and strong heart beat which can be irregular and gives the concerned person a feeling of imminent danger.

[44] "Stool" here refers to the divine stool, which is often used for invoking the spirit (*yengo jok*).

After having concluded with the spirits, the *ajwaka* cut the throat of the sheep, pierced the stomach, took the *wee* [contents of the lower intestine] and put it on the feet and the chest (*pal cwiny*) of everybody present. Some of the *wee* was also sprinkled on the ground. Finally the congregation moved back to the homestead, where still other acts of cleansing where performed.

After having finished the cleansing ritual at the homestead of Odong's family, the *ajwaka* took him to her home to stay with her for some time. This was to monitor how Odong was doing. She asked Odong to remain close to her, just in case any bad spirit (*ajwani*) wanted to come back. In her home, she kept many herbs to prevent bad spirits (*ajwani*) from disturbing people.

Soon, the *ajwaka* found that Odong's spirit had left and she decided to take it back on him. While shaking the rattling gourd, the *ajwaka* began to call Odong's spirit from where it had hidden: "Come! Come!" The *ajwaka* asked the spirit where it had been as she saw it coming. The spirit answered that it had ran away out of fear. The spirit was seen black in color. It was not moving straight but moving "zigzag". As the spirit entered the rattling gourd, the *ajwaka* realized that the gourd was becoming heavy. Then she pressed it on the forehead of Odong, with the spirit inside.

When the spirit had been taken back on Odong, he fell down and became unconscious. This prompted the *ajwaka* to fan him for almost two hours. His body became very cold and so she covered him with a bed sheet. After some time, he came back to his senses. When he got up, the *ajwaka* tied a giraffe fur on his right hand to prevent his spirit from leaving. When a bad spirit is leaving [and entering] a person, it causes a lot of pain. So, the *ajwaka* also gave him herbs to ease his pains. This marked the end of the ajwaka's treatment. Odong had stayed at her place for five days and then went back to his home.

Changes after the ritual

After the ritual, the spirit attacks on Odong had stopped. Odong went back on duty in the army. According to the detach commander, Odong has been doing his work well since the ritual has been performed. At home, he is now less quarrelsome than before and helps with occasional works when he comes during his time off from duty. However, he still does not like staying with people.

At the time of the last follow-up in June 2006, Odong was sick with '*two akwota*'[45]. However, Odong does not think that this sickness caused by the spirits that had been cleansed by the *ajwaka*.

12.2 Case studies on a specific ritual - kwero merok

Already in 2004, we heard that in some rare cases communities performed *kwero merok* rituals on people who had returned from LRA captivity. The anecdotes indicated that the ritual was effective in reducing nightmares and other distressing experiences that are locally often attributed to *cen*, but might overlap with the criteria of posttraumatic stress disorder, as described in the DSM (see CHAPTER 13.1 for a detailed analysis). For this reason, we decided to follow up and document some cases more systematically, which enables us to provide the following four case studies.

12.2.1 Case study no. 8: Kwero merok on Owot[46]

By the time of the first interview, Owot was about 17 years old. He had been abducted by the LRA at the age of 12 and stayed with them for more than four years. 'In the bush', Owot had attained the rank of a sergeant. He was also an escort to a high-ranking commander.

Distressing experiences

While with the LRA, Owot was made to witness the killing of countless people. He was also forced to pass over dead bodies while making vows to their spirits: "If I ever return

[45] *Two akwota* is the local term used for almost any disease that makes parts of the body swell. Often, it is a form of cancer.

[46] The information reflected in this case study is based on interviews by Francis Okot with Owot himself, as well as with his mother and his social worker. The interviews were carried out in November 2004 (see COMPANION VOLUME, transcript 19a), June 2005 (transcript 19b) and June 2006 (transcript 41b).

home, your *cen* should catch me". In Sudan, where he received military training, he had to sleep surrounded by human skeletons.[47]

When back in Uganda, Owot was forced to kill many people. Among the most horrible experiences was the killing of students whom they had ambushed on the road. Together with fellow abductees, he had to kill them by cutting them into pieces, starting from the legs. The students wailed and pleaded, but the abductees had to continue chopping them to death. Before the students died, they were told to vow that their spirits would haunt the killers if they ever went back to school. To affirm these vows, alongside with other abductees, Owot was told to make pleas that if he ever went back to school, his studies shall be ruined like the studies of those students who had been hacked to pieces.

Owot's fighting unit was led by a very cruel commander. At times, when they were cooking, he ordered them to use human heads as cornerstones to support the cooking pots over the fire. The smell of the burning hair and the cracking of the skull due to overheating made a deep impression on Owot.

In a fierce battle with the government army, his commander was killed. During the same battle, Owot and other LRA fighters scattered and were pursued by government forces. After some time, Owot found a water source and decided to quench his thirst. To drink from the well, he put down his machine gun, which he forgot when he left in a hurry. After realizing that he was without his gun, Owot went back to get it. Meanwhile, a militia armed with bow and arrow had surrounded his weapon. They shot their arrows at him, as he fired at them with his pistol. He had to kill many of them, before he could retrieve his gun.

The aftermath

When Owot was back in the community, the above-described scenes kept coming back to his mind. Owot was continuously haunted by nightmares and visions in which the most horrifying moments he had experienced recurred again and again.

Time after time, something could come and fall on him[48], and he did not know what was happening. It made him lose his strength. Often, his eyes would "get covered"[49] and

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[47] Given the local belief in *cen*, the vengeful spirits of the dead, this was an extremely distressing experience. The commander explained to the abductees that this would teach them courage.

[48] In the original transcript, the Acholi expression is "*gin mo bino opoto ikome*". This literally means, "something has come and fallen on him". The 'something' here is clearly related to a spiritual force (*jok,* or more specifically *cen*) coming and befalling the person.

[49] "His eyes get covered" is a literal translation from the Acholi expression „*wange umme*". The term describes an experience during which the senses (not only the sight, but all the senses) go numb. In such a state, people do not perceive clearly what is happening around them, even if their

his body energy would reduce until he fell down[50]. There would be no way to stop this. Such things happened mostly when he was alone or at night, but it could also happen when he was at school. When a teacher gave exercises to write, he would write insults to the teacher. Sometimes he would write about what had happened in the bush [in captivity], but [according to him] without awareness of what he was doing. When he was with people, his body could start trembling and even his way of speech could change.[51]

He could say things that he did not even know or remember afterwards, but people would tell him later what he had been saying. Some of the things he was told to have said was that he wanted to go back to the bush. He was also told to have been imitating firing bullets [pretending to fire bullets with an invisible machine gun] and making utterances about killing.

After having returned from the LRA, Owot was still much afraid of government soldiers. One day, when Owot was at home, he saw soldiers and started running towards the bush while shouting "catch him alive, don't shoot". Another day, when soldiers were patroling through his family's homestead, Owot jumped on one of them. He took the soldier's gun and began firing in the air. A few seconds later, he left the gun behind and ran away into the bush.

Owot also acted aggressively towards community members for no apparent reason. The urge of doing harm kept coming into his mind every now and then. Whenever someone annoyed him, he felt like using any tool to fight, but most of the time people could stop him.

During the first interview in November 2004, Owot kept on looking around with uneasiness as if monitoring the surroundings. Especially when somebody passed by, he seemed to expect something bad to happen. He did not want people whom he didn't know to come up to him. It took time for him to open up to the local researcher.

The decision to perform the ritual

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eyes are open. The senses of touch and hearing are strongly diminished and the thinking is not clear. In the local culture, the experience is attributed to a spiritual force (*cen, jok*) attacking the person.

[50] The reduction of body energy is a translation of the Acholi expression "*kome dok ni nuk*", "his body became '*nuk*'". According to our local researchers, '*nuk*' cannot be translated. The described experience includes the reduction of energy in the body, the numbing of the senses and often the falling of the person. So "*kome dok ni nuk*" is seen as closely related or even as a reflection of "*wange umme*" and is also attributed to a spiritual force (*cen, jok*) attacking the person.

[51] Such trembling and change of speech is also a common sign of spirit possession in the local culture.

After his escape from the LRA, Owot passed through a Reception Center in Lira. There, he converted to the faith of the Balokole ('saved' or 'born again' Christians). When he was already in Kitgum, he continued praying with other Balokole whenever he was disturbed by his sickness[52]. However, there was no improvement.

Owot was given the opportunity to go back to school with the help of an NGO. Yet the studies did not go well. Because of his often strange behavior, the teachers thought he was either ill or fooling them. Therefore, they took him to a Reception Center for psychosocial rehabilitation, but to no avail. He was again taken to the "Balokole" so that he would be prayed over, but all this did not help. Eventually, he gave up schooling and went back to his relatives who were living in an IDP camp. After the above-described incident of Owot attacking a government soldier, he was again taken to a Reception Center for psychosocial rehabilitation. Again, he was sent home without major improvement.

Owot had become a burden to the community, who not only feared his incalculable behavior, but also his 'spirits'. Therefore, elders told him that he needed to be cleansed in a traditional ritual. Owot first objected to this suggestion, but on realizing that neither 'psychosocial rehabilitation' nor prayers were helping and that instead his condition was worsening, he consented to the performance of a traditional cleansing ritual.

The ritual

In March 2005, a kwero merok ritual was performed on Owot. For descriptions of this ritual, see above (CHAPTER 11.2.4.2) and transcript 18 in the COMPANION VOLUME.

Changes after the ritual

In the first follow-up interviews, about three months after the ritual in June 2005, Owot and his mother reported significant positive changes. The spirit attacks and related nightmares, as well as his often strange and aggressive behavior had stopped. Owot was now able to socialize well with peers and other community members and didn't quarrel as much as he had before. His urge of fighting (*miti me lweny*) had also ceased.

In a second follow-up interview in June 2006 (transcript 41b), Owot could not be interviewed, as he had taken up school again. His mother explained that he was performing well both at school and at home. He had not complained of nightmares or anything [a spirit force] coming to fall on him. When he was coming home from school

[52] The local community often referrs to the strange behavior and experiences of returnees with the term "*two".* This is literally translated with "sickness". Generally, "*two"* can include physical and mental disturbances.

during holidays, so his mother, he helped providing for their home. He was working with other family members in the field and respected them. He also enjoyed being with his friends.

12.2.2 Case study no. 9: Kwero merok on Oling[53]

By the time of the first interview in May 2005, Oling was about 30 years old. He had been abducted by the LRA for an unknown period of likely a few months.

Distressing experiences

During his time with the LRA, the leading commander gave Oling a civilian and ordered to kill the man by beating him to death. At other instances, Oling had to step people to death without using any tool.

The aftermath

When Oling was sleeping, he often saw the man (whom he had been forced to kill) coming to plead not to kill him. Even during daytime, Oling saw the man coming. This made him very sad and he often began to shed tears. Most of the time "kume nure"[54] and he was feeling like having little strength. The eyes turned red as if he had eye problems yet he didn't feel any pain[55]. In addition, the urge of fighting and killing kept coming into his heart all the time. He was even more aggressive when he was drunk. All the time, he was afraid of being re-abducted and this made him repeatedly look at all sides in a fearful manner. His heart kept leaping every now and then. According to the local community resource person, Oling used to stay alone most of the time, did not work, and often moved

[53] The information reflected in this case study is based on interviews by Josef Ogaba and Francis Okot with Oling himself, his mother, grandfather, a community volunteer, the ritual performer and the responsible social worker. The interviews were carried out in May 2005 (see COMPANION VOLUME, transcript 18), December 2005 (transcript 30), and June 2006 (transcript 41a).

[54] *Kome nure* refers to a complex experience: body feels heavy and weak; the person feels a lack of energy, weak knees and is generally inactive. *Kome nure* has been described as an immediate response to a threatening situation, reminding of a freezing response (transcript 1). However, as above, it has also been described as part of a syndrome that resembles a depressive reaction.

[55] Red eyes are considered a sign of spirit possession in the local culture.

around aimlessly. Oling was avoided and insulted by his peers. People avoided sharing food with him[56].

The decision to perform the ritual

Oling thought of trying a traditional ritual because he had seen and heard of many people who were helped by it.

The ritual

The *kwero merok* ritual was performed in May 2005.

Changes after the ritual

In the first follow-up interview, carried out in December 2005, Oling remarked the following changes: He was now generally feeling better, the nightmares had stopped, and he had regained his strength. He was now able to work effectively and to sleep well. He meanwhile felt the desire to marry and he had gained many friends. He did not quarrel anymore, even when drunk. Oling's mother reported the following improvement: the madness[57] that had given him a hard life had stopped and his friends had started liking him. They now liked staying with him, and shared food with him. They had also stopped teasing him. The head of Oling's family noted that Oling was now well and had begun to take proper care of the home.

By the time of the second follow-up interview in June 2006, Oling had left to Kampala to stay and work with his uncle in the capital. His mother interpreted this as a sign that Oling was doing well and his uncle had trust in his abilities. According to his mother, Oling had not been disturbed by nightmares or flashbacks anymore and was committed to his work in the garden before he left for the capital. The local community resource person confirmed that there were no complaints about Oling after the performance of the ritual.

[56] According to traditional local beliefs, Oling was possessed by a spirit. This spirit was feared by at least part of the community, who avoided closer contact with him, especially the sharing of food.

[57] The term used in the original Acholi transcript is *"two apoya".* As already mentioned, *"two"* can be translated as sickness or disease, *"apoya"* refers to a mental disease and is usually translated with "madness".

12.2.3 Case study no. 10: Kwero merok on Kinyera[58]

By the time of the interviews, Kinyera was about 16 years old. He had been abducted by the LRA and stayed with them for about two years. Both of his parents were killed after his abduction.

Distressing experiences

While with the LRA, Kinyera had to move over dead bodies and was forced to loot, beat, and kill people. Once, when they were looting a home, his commander ordered him to kill a young mother. He had to stab her with his bayonet, while she was pleading to him to leave her alive. Her small child was sitting at the entrance of the hut watching them.[59]

The aftermath

According to Kinyera, the experiences kept haunting him and caused nightmares. In dreams, he saw the woman whom he had been forced to kill coming to plead to him, as she was doing at the time of the murder. Kinyera was seeing the committed atrocities in nightmares and in daydreams. When people annoyed him, he often had the impulse of killing them. When in the Reception and Rehabilitation Center, Kinyera found it difficult to interact with his peers, because he was afraid that he could hurt them. This made him stay alone most of the time.

The decision to perform the ritual

During his stay at the Reception Center, Kinyera's social worker took him to a priest so that he could be prayed on. However, for the three times he went, the prayers seemed to worsen his nightmares rather then reducing them. Thus, Kinyera lost hope in finding the cure through prayers.

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[58] The information reflected in this case study bases on interviews (by Francis Okot) with Kinyera himself and the responsible social worker as well as on written information by the ritual performer. The interviews were carried out in June 2004 (see Companion Volume, transcripts 8 and 9). The ritual performer could not be interviewed, as traveling to his place of residence was too dangerous. Instead, he was sent a request asking him to describe the ritual he had performed on the returnee while giving information on the traditional background of the procedure. His written response is reflected in transcript 12.

[59] This scene is reflected in the documentary "Lost Children" by Ali Samadhi and Oliver Stolz. This recommendable film received several prizes including the UNICEF-Film-Award and the GERMAN ACADEMY AWARD 2006 for "Best Documentary". The DVD is available at Amazon.de.

Before he was abducted, Kinyera had seen people undergoing traditional rituals after their return from LRA captivity. Although he had not been thinking of such a traditional ritual before, his persisting problems prompted him to opt for it.

The ritual

The *merok* ritual for the killing of a woman, which was performed on Kinyera, differs from the procedure for cleansing the killing of a man. The major difference is that the killer has to perform the work of a woman (e.g. fetching water, collecting firewood and food, grinding corn and washing dishes) from the second to the fourth day of the ritual (cf. CHAPTER 11.2.4.2.). According to his social worker, this was to make the [spirit of the] killed woman see that Kinyera had accepted the burden he had caused by the act of killing.

Changes after the ritual

In the follow-up interview, carried out in June 2004 (some month after the ritual), Kinyera reported that the nightmares and the images he used to see at daytime had stopped after the ritual. His social worker and teacher noted that Kinyera began to associate with peers.

12.2.4 Case study no. 11: An unfinished ritual - Kwero merok on Okello[60]

Okello had been abducted by the LRA for an unknown period. After his return, he was complaining of nightmares and something [a spirit] coming to haunt him. In June 2005, a ritual of *kwero merok* was started. According to information documented in transcripts 32 and 41e, the bark of the *ogali* tree had been tied on Okello to mark the beginning of the ritual and *wayo* songs had been sung. Yet after the first day, the ritual was interrupted. The informants gave contradicting information on why the ritual had not been brought to a close.

However, the people interviewed were unanimous in their judgment that Okello was now fine. According to Okello, he had no nightmares anymore and alluded that any other spirit attacks had also stopped. His paternal uncle stated that Okello was now taking good care of his family and was dedicated to his work in the field. While Okello attributed

[60] The information reflected in this case study bases on interviews by Francis Okot with Okello himself, his neighbors, his wife, his paternal uncle and the ritual performer. The interviews were carried out after the partial ritual had been performed. The dates of the interviews were in December 2005 (see COMPANION VOLUME, transcript 32) and June 2006 (transcript 41e).

the positive changes to the tying of the *ogali* during the first day of the ritual and expressed plans to finish the traditional ceremony in the near future, his neighbors were not sure whether it was the partial ritual that brought about the change. The ritual performer seemed angry about the interruption of the ritual, explaining that the tying of the *ogali* might help for a short time, but make a future cleansing even more difficult in case the ‘sickness’ returns.

PART FIVE: INTERPRETATION AND DISCUSSION FROM A WESTERN CLINICAL PERSPECTIVE

The ethnography, presented in CHAPTER 11, has provided a systematic outline on Acholi traditional concepts of coping and healing, as well as on specific healing ceremonies. CHAPTER 12 complemented these general descriptions with several case studies illustrating the concrete application of traditional procedures in the contemporary social context. Our descriptions of Acholi healing are in line with (and base on the fundaments of) our general outline on Acholi traditions in CHAPTER 1. The accounts derived from our own data also reveal much communality with the depictions of Sub-Saharan healing based on general literature (CHAPTER 8.1). This corresponds to the widely accepted view of prevailing similarities between traditional healing systems[61], which are not limited to traditional healing in Africa, but seem to cut across continents (cf. Häußermann, 2006.) However, a general comparison and discussion of traditional beliefs in Sub-Saharan Africa is not the subject of this thesis. Central to our topic is a comparison of Acholi healing with Western approaches; and more concretely, a comparison of approaches to healing from traumatic stress.

Approaching this specific topic, CHAPTER 13 explores symptoms described in the ethnographic data to illustrate similarities and differences between local descriptions and the concept of PTSD. CHAPTER 14 highlights similarities and differences between Acholi therapeutic procedures and Western traumatherapy. CHAPTER 15 discusses general strengths and limitations of the study, while CHAPTER 16 delineates the major conclusions.

[61] Of course, differences and controversies do also exist, for example, on the existence of a Highest Good or Supreme Being in traditional religions of people in Sub-Saharan Africa (cf. Bere, 1939; Bocassino, 1939; Okot p'Bitek, 1963; Okot p'Bitek 1971 and 1973a; Panu-Mbendele, 2004; Tempels, 1956; Wright, 1939).

13 Interpretation and discussion of symptoms

This Chapter explores similarities (13.1) as well as differences (13.2) between our ethnographic descriptions on Acholi manifestations of distress and the concept of PTSD. In CHAPTER 13.3, we look at some methodological issues of the interpretation. CHAPTER 13.4 discusses the implications of our results for cross-cultural diagnostics.

13.1 Communalities between PTSD and local manifestations of distress

In this section, we examine communalities between local descriptions and the concept of PTSD. For this purpose, we analyze:

1. Descriptions of *ajiji*. *Ajiji* is a local concept, which describes symptoms emerging during and in the aftermath of threatening events.
2. Descriptions of symptoms from three case studies (no. 8, 9, and 10; see CHAPTER 12.2). All subjects to the case studies had been exposed to multiple traumatic events during rebel captivity and in the aftermath suffered from severe psychological distress.

To evaluate information on *ajiji* and the symptoms described in the case studies, the principal investigator has coded the relevant passages of the transcript with the help of NUD*IST, a program for qualitative data analysis (version N6, see www.qsrinternational.com).[62]

[62] To analyze information on *ajij*, we have coded the text appearing under headings related to 'ajiji' in our transcripts. (The transcript had already been organized according to themes, as described in CHAPTER 11.) *Ajiji* is treated in ten transcripts: no. 1, 2, 3, 4, 5, 7, 10, 11, 26, and 27 (see COMPANION VOLUME). On case studies, we coded the sections that depicted the disturbances of returnees in the pertinent transcripts. (Relevant heading: 'Disturbances before the ritual' in transcripts: no. 8, 9, 18, 19a, 19b, and 30, see COMPANION VOLUME.)

13.1.1 Communalities between Ajiji and PTSD

To map out similarities between *ajiji* and the concept of posttraumatic stress disorder, we will go along the diagnostic criteria for PTSD, as stipulated in the DSM-IV-TR. The exploration starts by comparing the A-criterion with statements by our key informants on the causes of *ajiji*. Afterward we compare symptoms defined in the DSM (criteria B to D) with symptoms mentioned as part of *ajiji*.

Communalities with criterion A

Criterion A in the DSM requires that a person felt intense fear, helplessness, or horror (A2) in response to an event that involved a threat to life or serious injury (A1) (cf. CHAPTER 3.1.1).

The following quotes illustrate similarities between the 'causes of *ajiji*' and the criterion A1 of the DSM-IV. They mention the experiencing or witnessing of serious injuries, killings and other threats considered dangerous to ones life or physical integrity.
Elders from Labuje camp explain:

> Ajiji attacks people like during wartime or after seeing a threatening thing, or if an enemy comes by surprise. When someone comes back from war, he can be attacked by ajiji for he would have seen bad things like killings or he might have killed himself. Ajiji can also attack someone if a wild animal has threatened him. (Transcript 10, p.64)

Elders from Lira Palwo:

> Ajiji is caused when a person has seen (or experienced) something bad like serious injuries or killings or when something bad happened suddenly ... These bad events or things could be wild animals, big snakes or the presence of rebels. (Transcript 26, p. 189)

Apart from the above quotes from transcripts no. 10 and 26, similar descriptions on threatening events as causes of *ajiji* can be found in transcripts no. 2, 3, 4, 7, 11, and 27 (see ANNEX 7.1.1.1 for selected quotes).

When asked how they understand *ajiji* or what its causes are, key informants often described *ajiji* as intense fear (*lworo matek*). Elders from Labuje camp:

> Ajiji is intense fear that brings trembling of the body and makes someone to become paralyzed. (Transcript 10, p. 64)

The descriptions of *ajiji* as *being brought about by fear* (transcript 7) or *being intense fear* (transcript 10) or *bringing intense fear* (transcript 11) corresponds to the criterion A2 that concretizes the person's subjective response to the described event. Transcripts 2, 3, and 27

provide further evidence demonstrating the close link between *ajiji* and fear (see ANNEX 7.1.1.1).

It is important to note that the attributions to threatening events or fear do not exclude spirit related attributions as outlined in the section on culture-specific understandings below. Rather, several explanations are seen as complementary to each other. For example, *ajiji* due to a threatening incident with wild animals is often attributed to the spirit of the animals (see transcript 5, p. 31 on *lurongo lee*). Still, *ajiji* is also understood as 'strong fear'.

Communalities with criterion B

In the following exploration, we give one or two examples for any symptom stipulated in the DSM-IV that has been mentioned by our key informants. All further quotes are compiled in ANNEX 7.1.1.2. Table 10 (further below) gives an overview of the symptoms of PTSD in descriptions of *ajiji*.

We found two instances that indicate recurrent distressing recollections of the event (criterion B1). Elders from Lira Palwo state:

> The person attacked by *ajiji* would loose strength and *would be very afraid of what he has passed through.* (Transcript 26, p.188)

'Recurrent distressing dreams of the event' (criterion B2) are mentioned most frequently. They appear in 8 out of 10 transcripts that treat *ajiji* as a topic. We cite elders from Kitgum:

> Ajiji can also come during sleep and brings nightmares as a result of things you underwent. (Transcript 11, p.74)

A traditional healer from Bwobo clan:

> On his return home, it can bring nightmares for he would be seeing the animal that had threatened him. He could even shout and tremble. (Transcript 3, p.16)

The transcripts on *ajiji* provide two examples of 'Acting and feeling as if the traumatic event were reoccurring' (criterion B3). An *ajwaka* from Acholi Labwor notes:

> Ajiji can be noticed, because the concerned person … at times runs as if the person he/she is seeing would want to catch him/her. (Transcript 5, p.27)

Symptoms that might match B4 and B5 of the DSM-IV definition of posttraumatic stress disorder are also mentioned twice. The following quote from elders from Kitgum likely reflects 'intense psychological distress at exposure to cues that resemble an aspect of the traumatic event' (B4):

> The person starts fearing people or a place ... (Transcript11, p. 74)

The same elders also mention fast heart beat as a sign of *ajiji*. This likely stands for physiological reactivity on exposure to cues that resemble an aspect of the traumatic event (B5):

> Ajiji also brings heart leaps and fast heartbeat for the bad thing one had seen … (Transcript 11, p. 74)

Communalities with criterion C

The DSM-IV places much emphasis on symptoms of avoidance (see CHAPTER 3.1). At least three out of seven symptoms are required to meet the diagnostic criteria. In contrast to DSM requirements, only one statement of our key informants hints to a symptom of cluster C. The following quote can be interpreted as avoiding activities, though it may be rather weak evidence:

> The person attacked by *ajiji* would loose strength … Courage also disappears from the person. (Transcript 26, p.188 - 189)

Other symptoms like avoiding thoughts and feelings (C1), inability to recall aspects of the trauma (C3), diminished interest (C4), estrangement from others (C5), restricted affect (C6), and a sense of foreshortened future (C7) were not mentioned.

Communalities with criterion D

Symptom D1 (difficulty in falling asleep) has not been mentioned by our key informants. The following quote from an *ajwaka* is likely evidence for irritability and outbursts of anger (D2):

> Ajiji can be noticed, because the concerned person is aggressive … (Transcript 5, p. 27)

While symptom D3 (difficulties in concentrating) has not been mentioned, symptoms of hypervigilance (D4) have been mentioned twice. The following quote is from an *ajwaka*:

> Ajiji … makes someone to do things that are different from what other people are doing, like … looking around in fear every now and then … (Transcript 4, p. 20)

Although in an area of volatile civil war, like the Acholi region at the time of the interviews, such behavior can be considered as 'normal' and 'functional', local people obviously do notice that people who suffer from *ajiji* monitor the surrounding more often than other people (see also quote from transcript 5, ANNEX 7.1.1.2).

Symptom D5 (exaggerated startle response) was mentioned twice by our key informants. An elder at the paramount chief's place elaborates:

> Ajiji has many signs … Ajiji that causes mental problems is when the body startles and evil spirits would have besieged you. (Transcript 7, p. 47)

Table 10: Symptoms of PTSD in Descriptions of Ajiji

	Reexperiencing					Avoidance							Hyperarousal				
Documents	B1	B2	B3	B4	B5	C1	C2	C3	C4	C5	C6	C7	D1	D2	D3	D4	D5
Ajiji Transcript 1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ajiji Transcript 2	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ajiji Transcript 3	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ajiji Transcript 4	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Ajiji Transcript 5	0	1	1	0	1	0	0	0	0	0	0	0	0	1	0	1	0
Ajiji Transcript 7	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Ajiji Transcript 10	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ajiji Transcript 11	0	1	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0
Ajiji Transcript 26	1	1	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0
Ajiji Transcript 27	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Total	2	8	2	2	2	**0**	1	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**2**	**2**

Note: If in any given transcript on ajiji, a symptom specified in the DSM was mentioned at least once, the respective cell of the table was coded with 1; if no such symptom was mentioned, the coding 0 was given.

As summarized in table 10, we observe a high frequency of re-experiencing symptoms, a moderate frequency of hyperarousal symptoms and a striking paucity of avoidance symptoms.

13.1.2 PTSD symptoms in our case studies

As we had asked our key informants rather general questions on the nature and symptoms of *ajiji*, the contents of the above quoted passages have often been rather abstract. They might have therefore been difficult to interpret for readers who do not have any field experience in the Acholi region. In contrast, our case studies on returnees who had experienced multiple traumatic events after abduction by the Lord's Resistance Army render concrete accounts, which include information on the context in which the symptoms occur. We have added them to the above analysis to provide more vivid and contextualized examples, but also to complement the examination of the transcripts on *ajiji*.

As in the above interpretation on *ajiji*, we give one or two examples on each symptom if represented in the transcripts. All further quotes on classified symptoms are compiled in ANNEX 7.1.2.

Symptoms cluster B

The following quote describes both recurrent distressing recollections of the traumatic event (B1) and recurrent nightmares (B2):

> What he had done while still in captivity kept haunting him and was bringing nightmares. In the nightmares, he saw the woman whom he was forced to kill coming to plead to him [to spare her life], as she was doing at the time of the murder. Kinyera was also seeing all the atrocities they committed like looting, beating people and more, which kept coming during nightmares and even during day dreams. (Transcript 8, p. 56)

The next quote is a typical example for 'acting and feeling as if the traumatic event were reoccurring' (B3):

> One day, when the soldiers were going for their patrol and passed through the home of Owot, he jumped on a soldier and took his gun. Then he began to fire in the air. Afterwards he left the gun behind and ran away to the bush. … Another day when Owot was at home, he saw soldiers and started running towards the bush while shouting: "Catch him alive, don't shoot!" (Transcript 19a, p. 138)

By first taking the soldier's gun and then leaving it behind to run into the bush, Owot put his life in severe danger without having been threatened by the soldier prior to his own attack. The most likely explanation for this irrational behavior in the given context is that the soldier's uniform or other features associated with previous traumatic events had triggered a flashback.

The following quote likely is an example of 'intense psychological distress at exposure to cues that resemble an aspect of the traumatic event' (B4):

> Oling said that when he was sleeping, he could see the man (who had been given to him to kill) come to plead that he should not kill him. *Even during day time Oling could see the man coming. That made him very sad and he could begin to shed tears.* (Transcript 18, p. 124)

The following example illustrates 'physiological reactivity on exposure to cues that resemble an aspect of the traumatic event' (B5):

> All the time he was afraid that he could be re-abducted and this made him look at all sides in a fearful manner time and again, and also *his heart kept leaping all the time.* (Transcript 18, p. 124)

Symptoms cluster C

From seven symptoms of avoidance stipulated in the DSM-IV, we found quotes for only three (C2, C4 and C5). Additionally, the hints on C4 and C5 are rather weak (compare ANNEX 7.1.2.2). The following quote, however, shows that symptoms of avoidance are not totally absent in Acholi culture.

> His mother narrated that after having returned from the bush, Owot did not want to see [was very much afraid of] government soldiers. (Transcript 19a, p. 138)

"Owot did not want to see government soldiers" is a literal translation of "Owot pe mito neno lumony pa gamente". In the given context, this Acholi phrase expresses strong fear and avoidance of government soldiers. That fact that his mother mentioned it as a distressing consequence of his experiences while with the rebels, shows that she considered this behavior and attitude to be markedly different from 'normal' prudence in the contact with soldiers in a war area.

Symptoms cluster D

Symptoms of hyperarousal were mentioned more often than symptoms of avoidance. While passages on *ajiji* in our transcripts did not contain any hint to 'difficulties in falling or staying asleep' (D1), the following passage gives indirect evidence that sleeping had been a problem for this returnee before the healing ritual. When asked about the changes after the ritual, he gave the following information:

> Oling said he is now feeling better … He is now able to work effectively; he sleeps very well … (Transcript 30, p. 222)

Hints on the occurrence of 'irritability or outbursts of anger' (D2) were more frequent and explicit. A returnee from Palabek Gem:

> The urge of doing harm kept coming into his mind every now and then. This made him having the heart of fighting with bad things [using bad tools] that always kept coming back. Whenever someone annoyed him, he felt like using brutal weapons to fight, but most of the time people stopped him. (Transcript 19b, p. 142)

Another young returnee:

> Kinyera also said that he could not do play therapy to relax his mind for he could have hurt [was afraid to hurt] his fellow children. If someone made him annoyed, he would think of killing the person. (Transcript 8, p. 56)

Violent behavior is a frequent complication of posttraumatic stress disorder (Silva et al, 2001) and seems markedly more pronounced in combat-related PTSD (Chemtob et al, 1994). In this light, symptoms as described above probably reflect widespread difficulties of people with combat experience and comparably severe traumatizations.

The following passage on the experience of a returnee from Palabek is an example of typical difficulties to concentrate (D3), likely because of recurrent dissociative episodes:

> After he had started schooling … the studies didn't go well because when he was at school something could come and fall on him that made him not to know what was going on. (Transcript 19a, p. 137)

In two transcripts, we found passages hinting to hypervigilance (D4), like the following:

> [Owot] kept on looking around with uneasiness as if monitoring the surroundings. Especially when somebody passed by, he seemed to expect something bad to happen. (Transcript 19a, p. 138 - 139)

In the transcripts on the selected case studies, we did not find any passage reflecting exaggerated startle responses (D5).

Table 11 summarizes the pattern on DSM-symptoms mentioned in our case studies. Similar to the result of the examination on symptoms of *ajiji*, we observe frequent descriptions of symptoms of reexperiencing and hyperarousal, while symptoms of avoidance are rarely mentioned.

Table 11: Symptoms of PTSD in Case Studies

	Reexperiencing					**Avoidance**							**Hyperarousal**				
Sources	B1	B2	B3	B4	B5	C1	C2	C3	C4	C5	C6	C7	D1	D2	D3	D4	D5
Case study no. 8 (Transcript 19a, 19b)	1	1	1	0	0	0	1	0	0	0	0	0	0	1	1	1	0
Case study no. 9 (Transcript 18, 30)	1	1	1	1	1	0	0	0	0	0	0	0	1	1	0	1	0
Case study no. 10 (Transcript 8, 9)	1	1	1	0	1	0	0	0	1	1	0	0	0	1	0	0	0
Totals	**3**	**3**	**3**	**1**	**2**	**0**	**1**	**0**	**1**	**1**	**0**	**0**	**1**	**3**	**1**	**2**	**0**

Note: If in any given case study, a symptom specified in the DSM was mentioned at least once, the respective cell of the table was coded with 1; if no such symptom was mentioned, the coding 0 was given.

Table 12 summarizes the results of our examination on *ajiji*, as well as on the selected case studies to an overall summary. Largely, it illustrates the similarity of patterns found in the analyses of *ajiji* and of symptoms described in the case studies.

Table 12: Totals of Symptoms of PTSD in Descriptions of Ajiji and in Case Studies

	Re-experiencing					**Avoidance**							**Hyperarousal**				
Sources	B1	B2	B3	B4	B5	C1	C2	C3	C4	C5	C6	C7	D1	D2	D3	D4	D5
Totals in Ajiji Transcripts (N=10)	2	8	2	2	2	0	1	0	0	0	0	0	0	1	0	2	2
Totals in Case Studies (N=3)	3	3	3	1	2	0	1	0	1	1	0	0	1	3	1	2	0
Total all	**5**	**11**	**5**	**3**	**4**	**0**	**2**	**0**	**1**	**1**	**0**	**0**	**1**	**4**	**1**	**4**	**2**

Note: If in any given transcript on ajiji (row 3) or case study (row 4), a symptom specified in the DSM was mentioned at least once, the respective cell of the table was coded with 1; if no such symptom was mentioned, the coding 0 was given.

The above analyses have so far mainly exemplified universal reactions to traumatic stress by illustrating similarities between local expressions of distress and PTSD criteria. Yet although we have not commented on it, the above quotes at the same time illustrate the influence of culture. We explore this topic more in depth in the next section.

13.2 Culturally specific attributions and reactions to traumatic stress

Attributions of symptoms to the spirit world are widespread not only in Acholi (cf. Chapter 11.1.1), but also in other countries of Sub-Saharan Africa (cf. Chapter 8.1). Even if such explanations are usually seen as complementary to and not excluding other attributions (e.g. to strong fear or threatening events), they mark a strong contrast to explanations contemporarily held in Western countries. The next section summarizes and illustrates the major patterns. Further below, we will explore reactions that do not match PTSD criterion symptoms.

13.2.1 Culturally specific explanations of symptoms

Among the culture-specific (or 'traditional') explanations of *ajiji*, two main lines of attribution are widespread. One puts forward that the spirit (*tipu*) leaves the person, as a traditional healer from Bwobo explains:

> When someone has been threatened with a gun or a spear, or things that put his life in danger, *his spirit leaves him*, his body startles again and again, and later it can bring nightmares. (Transcript 3, p. 17)

Descriptions of the spirit leaving as a response to threat are also found in transcripts no. 26 and 27 (see ANNEX 7.2.1 for quotes).

The second, more frequent explanation posits a foreign spirit (e.g. *cen* or *jok)* taking possession of the affected person. Elders from Lapul:

> Our children who have come back from the bush could experience *ajiji* because of what they have done while in the bush, like the killings they have witnessed and the corpses that they have passed over. Walking on localities that Acholi believe to be the territory of spirits could also bring *ajiji*. (Transcript 27, p. 204)

According to local beliefs outlined in the ethnographic parts of this thesis (CHAPTERS 1.4 and 11.1.3), killings and passing over corpses always bear the risk of contracting *cen*, the vengeful spirits of the deceased. Similarly, walking through areas where *joggi* reside, such as thick forests and high mountains, can also cause *ajiji* as the *jok* of the area would attack the person (see CHAPTER 1.4 for detailed explanations on the notion of *jok*). Examples of similar attributions to spirits are found in transcripts no. 1, 4, 5, 7, 26 and 27 (see ANNEX 7.2.1).
An *ajwaka* from Acholi Labwor expresses the idea of a spirit haunting a person most clearly, when asked about the 'signs of having killed':

> If someone kills another person, the spirit of the murdered person would catch the murderer. This will disturb him every now and then through bad dreams. The spirit would come to fight the murderer and this makes him shout, the body shakes, startles and speaks anyhow. (Transcript 5, p. 28)

13.2.2 Reactions that do not match PTSD criterion symptoms

The feature common to the following descriptions is that they do not match PTSD symptom criteria and / or according to our view illustrate strong cultural influences on the expression of symptoms. This section starts with descriptions of symptoms that we believe are strongly shaped by local culture and proceeds to expressions of distress that do relate to universal patterns to a higher degree but still portray cultural specifics.

The following quote on a young female returnee illustrates 'speaking meaninglessly' (*lok atata*).

> Before she was cleansed … something [a spirit force] could fall on her and could make her speak meaninglessly, in a way people could not understand. (Transcript 20, p.147)

'Speaking meaninglessly' is a typical sign of spirit possession in the traditional culture, and in Western clinical psychology might be classified as a dissociative symptom. The following quote is another illustration of typical signs of spirit possession in the local culture:

> When he was with people, his body could start trembling and even the way he spoke [including his voice] could change. (Transcript 19a, p. 137)

In Acholi culture, spirit possession is not always regarded as a sign of psychopathology. Instead, it has even status value when it is associated with having power over, and through the spirit. *Ajwaki* and LRA leader Joseph Kony (or 'their spirits') often speak in foreign tongues and draw their power from their relationship to spirits (Behrend & Luig, 1999). This specific cultural backdrop and the frequency of pertinent descriptions in our data suggest that

symptoms of changing voice and language are more frequent in Acholi than in Western societies. Nevertheless, with returnees who seem to be haunted by a spirit (rather than having command over it), signs of spirit possession are associated with low status and often lead to social marginalization, as the following quote shows:

> Oling said … the boys with whom he was putting up had all left him because of the nightmares which were disturbing him at night, there was no sharing of food with him, many times he was insulted, other boys also abandoned him, talking badly about him. (Transcript 30, p. 222)

On the backdrop of the concepts explained in CHAPTER 11.1.3.2, it is obvious that the peers of Oling had left him because they saw him possessed by *cen*. In traditional Acholi culture, avoiding to share meals with a person disturbed by *cen* is a typical precaution against getting haunted by the same spirit.

Still other symptoms that cannot be specifically categorized according to DSM-symptom criteria have been mentioned in our transcript with relative frequency, like: “Talking to oneself”, “laughing without reason” and “talking about anything that comes to their mind” (transcript 7, p. 47), as well as “moving naked … singing unknown and meaningless songs” (transcript 5, p. 27). All these symptoms have been mentioned as signs of *ajiji*. Locally, such behaviors are often interpreted as signs of spirit possession. They might indeed reflect culturally specific symptoms, or alternatively point to various disorders classified in the DSM (e.g. psychosis), or both. Some of them might have been mentioned more frequently because they are especially salient to the eyes of observers (e.g. psychotic symptoms).

In the following paragraphs, we present some descriptions that appear highly specific to the local culture, but at the same time might relate to universal defense reactions triggered in a flashback. The Acholi terms used in the below depictions are difficult to translate and might reflect local idioms of distress. This quote describes the experience of a young male returnee:

> After he had started schooling in Kitgum, the studies didn’t go well because, when he was at school, something could come and fall on him that made him not to know what was going on. It made him loose his strength and even fall down. When the thing began to happen, he always complained of having no strength to do anything. Often, his “eyes would get covered” and the “body energy would reduce” until he fell down. There was no way to stop this. It happened especially when he was alone or when he was thinking of something and also at night. (Transcript 19a, p. 137)

"Something could come and fall on him" ("*gin mo bino poto ikume"*) in this context clearly refers to a spirit force attacking the person. "His eyes would get covered" refers to the Acholi notion „wange umme". The term denotes a complex experience during which the senses (not only the sight, but also all other senses) would get numb. Although the eyes are still open, the person has no clear perception of what is happening around him or her. The senses of touch and hearing are strongly diminished and thinking is impaired. In the local culture, the experience is usually attributed to an attack by a spirit force (cen or jok). The phrase "the body energy would reduce" is an attempt to translate "kome dok ni nuk". Again, the term denotes a complex experience associated with the reduction of energy in the body, the numbing of the senses and often the falling of the person. So "kome dok ni nuk" is seen as closely related to or even being a reflection of "wange umme".

While the descriptions are highly specific to the local culture, and the described symptoms are not explicitly mentioned in the DSM-IV, the quote reveals both relativist and universal themes[63]. To Western clinicians familiar with PTSD, the above account might reflect a dissociative reaction during a flashback. While different interpretations of such reactions during flashbacks do exist, they all point to universal human (Bracha, 2004) or even pan-mammalian (Levine, 1997) defense reactions. Such immobilization responses have likely developed as a survival strategy to cope with situations of inescapable threat (Bracha, 2004; Bracha, Yoshioka et al, 2005; Bracha, Bracha et al, 2005).

Immobilization responses are at times coupled with seemingly uncoordinated movements, as the following description of an ajwaka illustrates:

> The problems that Betty [the *ajwaka*] divined were as follows: dizziness, leaping of the heart ("poto cwiny"[64]), some bad spirits that could befall him [a returnee called Nyeko], throw him down and take command over the movements of his body. This made his body move in an uncoordinated way and shake again and again. The thing [spirit] that was falling on Nyeko would attack him from behind and he would not see it. It was disturbing him so severely that it made him fall and contract injuries on the head, mouth and arms. (Transcript 25, p.181)

Uncoordinated movements that at times occur during a state of dissociation and (partial) immobilization have been interpreted in various ways[65]. Levine (1997) has described such

[63] Descriptions of dissociative disorders in the ICD 10, especially F44.4 and 44.6, come close to the above illustrative quote (Weltgesundheitsorganisation, 1994).

[64] Poto cwiny = fast and strong heart beat which can be irregular and gives the concerned person a feeling of imminent danger

[65] In the ICD, the diagnosis of dissociative seizures (F44.5) describes a picture similar to the uncoordinated movements described above.

reactions as part of the therapy of traumatized (Western) clients. He argues that they correspond to the uncoordinated movements of an animal coming out of a 'freezing state'. Bracha, Yoshioka et al (2005) interpret such movements as acute sociogenic pseudoneurological symptoms that provided survival advantages in the evolution of the human fear-circuitry during the Neolithic. Both views understand them as reactions that have appeared early in human or even mammalian evolution and do appear across cultures.

Another interesting Acholi term, which might or might not reflect a universal defense reaction, is 'kome nure':

> Before she was cleansed, Aciro [a returnee] felt that "kume nure" and she had no strength to do anything… Aciro preferred staying without talking and could cry without any reason. (Transcript 20, p. 147)

According to our local researchers, "kume nure" generally refers to a complex experience: the body feels heavy and weak; the concerned person feels a lack of energy and is inactive; at times, the syndrome also includes sensing that the knees are too weak to hold the body. The weakness of joints is especially emphasized when mentioned as a response to immediate threat. However, as with the female returnee above, "kome nure" can as well be part of a syndrome that lasts over a long time, in this context reminding of a depressive syndrome (see case study on Oling, transcript 18, for a similar use of the term).

The above quotes illustrate how culture interacts with universal bio-psychological mechanisms in shaping symptoms of posttraumatic stress. They also show that the locally used language and its specific expressions co-determine descriptions. And even more importantly, they demonstrate that local beliefs in spirits and spirit possession powerfully affect how people perceive, interpret and react to symptoms. Even if many of the above-described symptoms can be understood as dissociative symptoms that do also occur among severely traumatized Western populations, attributions and thus the illness experiences are probably markedly different between Western and Acholi clients.

With the above examples, we have by far not exhausted the material on potentially culture-specific descriptions reflected in our transcripts. Further examples of culture-specific descriptions are found in the ANNEX 7.2.2 and in the COMPANION VOLUME to this thesis.

13.3 Methodological considerations on the interpretation of symptoms

The above interpretation implies the categorization of symptom descriptions into those matching specific DSM-IV criteria and others that do not. Such approach entails methodological intricacies with regard to a reliable and valid classification of described symptoms.

When responding to the abstract question on the nature and symptoms of ajiji, our key informants naturally answered by giving abstract descriptions with little context information. Although accounts from case studies rendered more vivid and contextualized information, a reliable and valid categorization on the base of such descriptions is still difficult. In practice, clinicians prompt clients for specific information on quality, frequency and context (e.g. triggers) of symptoms to check whether diagnostic requirements are met. Such procedure was not part of our study. Instead, the principal investigator did the categorization by examining the transcripts on the background of his field experience in Acholi and his experience as a licensed clinical psychologist. As only a single rater has carried out the classification, no inter-rater reliability could be calculated. We are aware that this methodological shortcoming weakens the conclusiveness of the presented analysis. However, the accessible documentation of the descriptions in the ANNEX and in the COMPANION VOLUME render the process of categorization transparent to readers, thus allowing them to judge for themselves to which extend the categorizations and related conclusions are supported by the data.

Although the reliability of classifications of single symptom descriptions has not been tested, the resulting pattern of cumulated symptom frequencies across the three symptom clusters turned out to be similar for the analyses of symptoms in descriptions of *ajiji* and symptoms mentioned in the case studies. This might indicate that the pattern across the three symptom clusters (frequent mentioning of reexperiencing, moderate frequency of hyperarousal, and low frequency of avoidance symptoms) is rather robust and less affected by weaknesses concerning the reliability of classifications.

With respect to patterns of symptoms in our study, the validity of classifications is a more serious concern than reliability. As we have evaluated symptom descriptions given by our informants without specific prompting, the mentioning of symptoms might be strongly influenced by their salience. For example, it is conceivable that symptoms of reexperiencing, such as nightmares and flashbacks are more salient to the community than symptoms of

avoidance, which might at least partly explain the comparably rare mentioning of avoidance symptoms.

In order to interpret relative frequencies of reported symptoms in the cross-cultural context (e.g. in samples from Western industrialized vs. non-Western low-income countries), it would be necessary to compare data collected under similar conditions (e.g. without or with specific prompting for symptoms) from comparable samples. We are not aware of any study that has implemented a design, which includes a comparison of symptoms patterns retrieved without specific prompting. Already qualitative studies that systematically evaluate symptom descriptions given without specific prompting are rare. A commendable exception is a study by Norris, Weisshaar et al. (2001) who have examined posttraumatic stress reactions in Mexico (see CHAPTER 9.3). Similar to our study, the qualitative descriptions of symptoms were collected without specific prompting, although other conditions (e.g. sample characteristics) differed from our study. Despite differences, a comparison with the findings of this study might be helpful in interpreting our results.

In extensive interviews with 24 Mexican disaster victims, overall 14 out of the 17 PTSD symptoms defined in the DSM were mentioned, while our transcripts mentioned 13 of the 17 symptoms. Similar to the results of our study, symptoms of reexperincing were mentioned most frequently. Rarely or not mentioned symptoms pertained to the cluster of avoidance and hyperarousal. Overall, the results of the Mexican study roughly match the pattern found in our data of Acholi descriptions, with most notable differences in anger expression and dissociative symptoms. Symptoms of irritability and anger were mentioned frequently in the Acholi sample, but were missing in the Mexican sample. This disparity does not necessarily reflect cultural differences, but might be due to the different kinds of traumatic events the samples had been exposed to (exposure to combat in the Acholi sample versus explosion of a gas line in the Mexican sample; cf. Chemtob et al, 1994, on combat-related anger in PTSD). Among the non-criterion symptoms, dissociation was remarkably absent in the Mexican sample. Apart from cultural influences, the frequent mentioning of dissociative symptoms in the Acholi sample might be related to the frequency and severity of traumatic events people have been exposed to. Chronic dissociation has been shown to be positively related to trauma severity in Western samples (Maercker et al, 2000). Moreover, dissociative symptoms are generally more common after repeated and long lasting traumatizations (Type II trauma; cf. Herman, 1992; van der Kolk, 2002) than after circumscribed brief single traumatic events (Type I trauma).

13.4 Implications for cross-cultural diagnostics

Apart from providing informative illustrations of the interaction between universal bio-psychological mechanisms and culture, our analysis has exposed remarkable overlaps as well as differences between Acholi descriptions and PTSD. On overlaps, we found astonishing parallels with regard to the posited causes of symptoms (threatening events and fear as causes of *ajiji*). Moreover, the analyses of symptoms revealed substantial overlaps with regard to symptoms of reexperiencing and hyperarousal. Differences between local descriptions and PTSD were found on symptoms of avoidance, which were mentioned only rarely both in descriptions of *ajiji* and in the analyzed case studies. Further, culturally shaped dissociative symptoms - especially immobilization reactions - appeared prominently in our transcripts. The frequency of their mentioning, and the fact that the Acholi language has specific terms denoting such complex reactions, indicate that dissociative immobilization reactions might be common in Acholi.

The above-described findings are consistent with the literature reviewed in the INTRODUCTION and CHAPTER 9, which we briefly recapture as follows: Dissociation as a reaction to trauma is more widespread in traditional cultures (Kirmayer, 1996; Stamm & Friedman, 2000). Reactions of immobilization in the aftermath of trauma might be more marked in non-Western cultures (Jenkins, 1996). Avoidance symptoms might be more influenced by culture than symptoms of reexperiencing and hyperarousal (Friedman & Marsella, 1996; Stamm & Friedman, 2000; Marsella, Friedman, Gerrity & Scurfiled, 1996b). The analysis of qualitative data from an Acholi sample (retrieved without prompting for specific symptoms) by Birbaum (2006) revealed a markedly low frequency of avoidance symptoms. Still on Acholi data, this time retrieved with specific prompting, Pfeiffer (2006) found that symptoms of passive avoidance were rare, while symptoms of active avoidance were well represented.

Is the PTSD concept applicable in Acholi?

Despite methodological intricacies and limitations discussed in CHAPTER 13.3, we believe that the presented evidence on overlaps between local symptom descriptions and the concept of PTSD supports the relevance of the PTSD concept in the Acholi cultural context. Although the DSM-IV criteria in their current form might not be the best conceptualization of posttraumatic stress in the local context, they can be a useful starting point in the absence of better (and empirically tested) concepts.

What should be considered when applying the PTSD concept in Acholi?

Apart from asserting its general usefulness, our findings also suggest that adjustments may be necessary to improve the fit of the PTSD diagnosis in Acholi culture. Most need for such amendments might be on avoidance symptoms, as the high number of required symptoms might currently lead to underdiagnosing PTSD in the Acholi cultural context. Here, the lowering of the number of required symptoms and the use of the concept of partial PTSD might be considered (cf. Schützwohl & Maercker, 1999). The local salience of dissociative immobilization reactions might be attended to by considering local idioms of distress in the diagnostic process. While awaiting future research, the criteria stipulated in the DSM, in combination with some of the above-described culture-specific idioms, might already be useful in identifying individuals who suffer from severe levels of posttraumatic stress.

14 Interpretation and discussion of therapeutic procedures

In this section, we interpret Acholi healing procedures. We start with general considerations on the comparison of Acholi healing and Western psychotherapy. Then we highlight major principles that according to our view distinguish traditional healing in Acholi from Western psychotherapy by going through some rituals described in CHAPTER 11. We then explore and interpret the ritual *kwero merok* by pointing out what we consider communalities with Western trauma therapy with regard to the applied therapeutic principles. Next, we evaluate hints on the effectiveness of traditional rituals in our case studies. The section closes with reflections on the general acceptance and significance of traditional rituals in contemporary Acholi society.

14.1 General reflections on Acholi healing and Western psychotherapy

At first glance, Acholi healing and Western clinical approaches to addressing symptoms of posttraumatic stress seem to have little in common. The explanatory models and the applied therapeutic procedures appear fundamentally different. However, such seemingly fundamental differences are also portrayed in the descriptions of various schools of Western psychotherapy. For example, regarding the posited etiology of psychological disorders, psychoanalysis and behavior therapy seem to have little common ground (Kriz, 1991; Neukom, Grimmer & Merk, 2005; Reinecker & Lakatos-Witt, 2005). When it comes to therapeutic procedures, proponents of different psychotherapeutic schools often emphasize similarly profound differences, even if considerable overlaps might exist in the actual implementation (Ablon & Jones, 2002).

Despite differences between psychotherapeutic schools, various models have been presented that describe features common to psychotherapeutic processes. Among the most prominent ones is Prochaska, DiClemente and Norcross's outline on the 'stages of change' (DiClemente, 1991; Heidenreich & Hoyer, 1998). Further, Grawe, Donati & Bernauer (1994) have stipulated and described four major mechanisms of therapeutic change in psychotherapy. On a general level, theorists agree that processes of learning are the base for any therapeutic change (Morris, 2003; Perrez & Baumann, 2005b). In this sense, all psychotherapies provide opportunities for corrective learning experiences; a general feature which also applies to Acholi healing.

Frank and Frank (1991) have identified several communalities between Western psychotherapies and shamanistic healing. According to their model, both Western psychotherapies and traditional healing are characterized by:

a) A healing agent
b) A sufferer who seeks help from the healing agent
c) A healing relationship.

Importantly, the healing agent's role is sanctioned by at least part of the sufferer's society, thus raising expectations for cure. The healing relationship consists of more or less structured meetings between healer and patient, in which the healer tries to relief the patient's suffering, often with the support of a group.

Further, Frank and Frank (1991) proposed four common features of psychotherapies:

a) An emotionally charged, confiding relationship between a patient and a helping person (often supported by a group);
b) A healing setting;
c) A conceptual scheme or myth that provides a plausible explanation for the patient's symptoms and prescribes a procedure for resolving them; and
d) A procedure or ritual that is believed to restore the patient's health.

Building on Frank's work, Morris (2003) presents a meta-model of theories of psychotherapy, proposing that all are composed of a myth and an associated ritual.[66] This general structure of a 'myth' associated with a 'ritual' that addresses the causes specified in the 'myth' also applies to Acholi traditional healing.

[66] Morris (2003) deliberately has chosen the words 'myth' and 'ritual' to highlight the epistemologically shaky status of theories of psychotherapy. For an excellent outline on the philosophy of science that discusses major arguments relevant to this debate, see Chalmers (1999).

14.2 Culture-specific aspects of Acholi healing

Apart from structural similarities between Western psychotherapy and Acholi healing as outlined above, differences do also exist. One major difference lies in the stipulated causes: In theories of Western psychotherapy, the causes of disorders are mainly seen in hypothesized psychological processes and structures, such as unconscious conflicts (Neukom et al, 2005), processes of classical and operant conditioning (Reinecker et al, 2005), dysfunctional cognitive schemas (Beck et al, 1979), and so forth. In Acholi healing, the causes of suffering are mostly located in the spirit world. Accordingly, Acholi healing rituals address the spirit world (ancestors and joggi), while Western psychotherapy applies procedures to tackle the posited psychological causes.

In addition to these fundamental differences, the particulars of Acholi healing procedures lie in their wealth of culturally shaped expressions. It would therefore be difficult to list them all without just repeating or adding on details that have already been outlined in the ethnographic chapters of this thesis (see CHAPTERS 1, 11 and 12). In this section, we will therefore limit ourselves to pointing out two superordinate principles that penetrate and inspire Acholi healing much more than Western psychotherapy: (a) The broad involvement of the 'living community', and (b) the involvement of the 'spirit world' in the healing procedures. We will illustrate these principles by going through a number of rituals in which they are highlighted.

In the ritual of 'stepping on the egg' (nyono tonggweno), the returnee is cleansed from spirits which he might have contracted during his stay outside clan territory. As these spirits are feared to bring suffering to the returning individual and the entire community, a cleansing ceremony is conducted. Apart from the aspect of spiritual cleansing that is attributed to the ritual, nyono tonggweno is a culturally significant act of welcome and a pledge by both the community and the returning person to restart living together in harmony. The returnee receives the blessings of family members and elders and is welcomed in a culturally determined way. This aspect is especially important, if the returning person had left the family or community in anger, or if other circumstances have led to an alienation between returnee and community members. The procedures of the ritual and the meaning attributed to them are likely to enhance social cohesion and mutual support among the community and promote a positive beginning anew.

In case the returnee had already been mourned or feared to be dead, 'stepping on the egg' (*nyono tonggweno*) is often combined with the ritual act of 'washing away the tears' (*lwoko pik wang*). Again, the ritual is conducted to ward off potential spiritual threats, but also

highlights the importance of the returning individual to the community, thus promoting the process of reintegration.

The returnee's identity of being part of a wider community is further fostered by another cleansing procedure that can be applied in combination with the 'stepping on the egg' and 'washing away the tears': In the ritual *moyo kom*, an animal is slaughtered for the cleansing. The community comes together to invoke the ancestors on behalf of the returnee and the entire clan.

When somebody has died away from home and the body could not be retrieved, the community is in a difficult situation. The spirits of people who have died and have not received a proper burial are believed to wander about restlessly, causing trouble and sickness in their own community. The procedure of *moyo tipu* (cleansing the spirit), gives the extended family the opportunity to hear the narrative of their deceased member of the community through the mediation of an *ajwaka*. In the process, the spirit of the deceased would suggest what should be done to help him find peace in the spirit world and abandon its disturbing activities. The family in turn would voluntarily follow the instructions, which usually revolve around some specific culturally shaped themes. After the pronounced procedures have been carried out, the last funeral rites can be done. Such procedure might be effective in reducing distress in the bereaved community and in helping the family come to terms with their loss and grief.

It is a common pattern in Acholi traditional healing that healers communicate with spirits to find out which healing procedure is appropriate. In case a spirit is causing the illness, they negotiate with the spirit to find out what it needs to accept leaving the patient (or the community) in peace. In the procedure of *ryemo jok* or *ryemo cen*, the disturbing spirit is then chased out.

Other rituals, like *tumu kir* (cleansing for a committed taboo) and *mato oput* (reconciliation ceremony after a killing) harness beliefs in the spirit world to promote social coherence within and peaceful coexistence between clans. The ancestors, who are seen as guardians of traditional values, are regularly invoked in Acholi rituals. In *mato oput*, the idea that the deceased child will live on in the child of the wife married with the compensation money, has the potential to console the bereaved community.

14.3 The ritual kwero merok in the light of Western Clinical Psychology

This section analyzes the ritual *kwero merok* from the perspective of Western trauma psychology, arguing that although the concrete ritual acts refer to meanings and customs that are specific to Acholi traditions and history, universal learning principles are operational in the ritual. However, before we come to the actual interpretation, we introduce the background to our research on *kwero merok*.

14.3.1 Background to our research on kwero merok

Early in the process of our research, we heard about young people who had escaped from LRA captivity and had gone through a *merok* ritual. According to anecdotal information, the ritual was astonishingly effective in reducing symptoms like nightmares, flashbacks and other frequent consequences of traumatic stress.

We belief that the *kwero merok* ritual closely relates to Western trauma therapy for several reasons: The ritual has traditionally been performed at the return of warriors from war. In this context, it was carried out to cleanse them from *cen*, the spirits of the enemies whom they had killed. As has been explained in CHAPTER 11.1.3.1, *cen* is one of the most prominent local explanations for nightmares and other expressions of distress that form part of the PTSD construct. Moreover, across cultures, combat entails a high risk for developing PTSD (see CHAPTER 9.2.2). In this sense, the traditional application of the *merok* ritual could be understood as an early intervention to address or prevent symptoms that in Western notions form part of posttraumatic stress disorder. On this backdrop, we decided to document the ritual in detail through participant observation and key informant interviews.

14.3.2 Interpretation of the merok ritual

The following interpretation refers to the prototypical description of the ritual *kwero merok* given in CHAPTER 11.2.4.2. In addition, the detailed documentation of one specific merok ritual, which we documented through participant observation (see transcript 18, COMPANION VOLUME), will be quoted to provide richer and contextualized information for the interpretation. The quotes from the case study are italicized to set them apart from the prototypical descriptions of the ethnographic summary. The procedures of the ritual are

outlined in the left column of the following pages, the interpretation in the right column. The main frame of reference for the interpretation is provided by the specific theories on the etiology and treatment of PTSD outlined in PART TWO. By interpreting ethnographic data from an explicitly defined perspective, we follow Bohnsack's (1983; 1993) suggestions on 'Documenting Interpretation'.

Procedures of the ritual	Interpretation
Invoking the help of the ancestors The ritual typically starts with the cleansing of the ancestral shrine (abila), where elders invoke the ancestors for their assistance in the ceremony. … *At the time of cleansing the shrine, the head of the family was making pleas invoking all ancestors to come and help in overcoming the problems at home and witness what was going to happen so that their child would remain healthy.* (Transcript 18, p. 126)	By invoking the ancestors to assist in the ceremony, the elders express their concern and care for the killer, who is to be cleansed in the ritual (**social support**)**.** According to epidemiological studies, social support is one of the most important factors positively related to recovery from traumatic stress (Brewin et al, 2000; Kaniasty, 2005).
Specific offices of participants in the ritual From that point on, throughout the coming days of the ceremony, the killer will be supported not only by the ancestors, clan elders and the extended family, but even more visibly by four specific persons who remain close to him throughout. The first is the ritual performer, ***lakwe***, who must be a man who has killed before and has already been cleansed in the same ritual of *merok*. The second is the lakwe's helper (***lanwojo***), who is selected for his courage and fearlessness and will be the second person to spear the goat in the grazing ground when that part of the ceremony takes place. Third is the person in charge of singing the *wayo* songs (the ***lawayo***), who not only remains	Through their continuous physical closeness to the killer, the four persons holding the described offices establish the core of a **safe and supportive environment** (Herman, 1992) for the coming days of the ritual. The fact that the ritual performer had been successfully cleansed in the same ritual is apt to engender hope and **combat demoralization** (Frank & Frank, 1991) As foreshadowed in the initial passage of invoking the ancestors, expressions of social support play an important role throughout the ritual. The supportive community according to Acholi beliefs does not only include the living, but

Procedures of the ritual	Interpretation
close to the killer during the day but even sleeps in the same hut with him for the coming nights. Finally, a **virgin girl** also remains near the killer for the whole duration of the ritual, day and night. *Oling and the virgin girl were … expected to sit most of the time and stay closely together, with the girl staying on his left hand side. … The killer and the virgin girl were not supposed to do any other task, but to concentrate on the ritual. The person in charge of "wayo" and the head of the family were also to stay close to them.* (Transcript 18, pp. 127-128)	also touches a spiritual dimension by taking in the deceased ancestors. In clinical psychology, **spirituality** has also been discussed as a coping resource to be utilized in the treatment of PTSD (Drescher & Foy, 1995). Participants of the ritual are instructed to concentrate on the ritual, and to refrain from carrying out any other tasks. This supportive and undistracted environment is a favorable condition for the **elaboration of traumatic memories**, which will be specifically prompted by various means, as we will see below.
Adorning the warrior … the killer is adorned with ostrich feathers and beads, symbolizing pride and victory. … To mark the beginning of the ceremony, the bark of the ogali tree is tied to the killer. This shows that he is in the process of being cleansed in a merok ritual. *Then, the ritual performer was preparing the frame on which the feathers were to be fixed in order to be placed on the head of the killer and the virgin girl. Next, a white strip … was tied on the person for decoration. Thereafter, the killer and the virgin girl were made to sit in front of the shrine. … From there, [while already adorned with the feathers] they were also decorated with beads, cowry shells … signifying decoration and pride.* (Transcript 18, p. 126)	The adornments in Acholi symbolize and convey pride, praise and victory, thus vividly expressing **social acknowledgement** (Maercker & Müller, 2004) for the killer. Social acknowledgement has been identified as another important factor positively related to recovery from traumatic experiences (Maercker & Karl, 2005b) Moreover, the recognition of the clan gives the frightening and potentially traumatic experience of the killer a positive interpretation and frame, thus **working against interpretations that lead to a sense of current threat** (cf. Ehlers & Clark, 2000). According to Janoff-Bulman (1992) such recognition might **counteract the shattering of positive assumptions** on the world and instead strengthen assumptions suggesting benevolence and predictability of the people around him, as well as meaningfulness of (past and future) actions and self esteem.

Procedures of the ritual

Singing songs and holding spears

Merok songs … are sung, and people dance and perform mock fights, using spears or sticks.

After that, a spear and horn was given to the killer. Then "wayo" songs were sung three times while all the men present were holding spears and sticks, demonstrating courage and manhood. The killer on his side kept on blowing the horn to accompany the "wayo" songs while also holding his spear. Whenever the killer blew his horn, the girl followed making ululations. Then people began to move to the bush

… three "merok" songs were sung while everybody was holding a spear, a stick or any fighting tool. One of the songs was a "bird's song" which was about vultures eating the corpse of the killed person. As they were singing "merok" songs, they danced… to show competition and manhood. During the dance, the killer blew the horn and the girl ululated.

… the killer led the way to go back home. On the way, they kept on singing while moving. These songs were also about merok, the killed only. The songs sung while moving were less vigorous than the songs sung in front of the abila [ancestral shrine] or in the bush. (Transcript 18, p. 127)

Interpretation

The lyrics of songs people sing are on topics that prompt the **elaboration of the trauma memory,** a point we will look at further below.

In many occasions, the songs go with vigorous dances, through which the warrior is prompted to move in ways that resemble the movements carried out during the fights with spears in a traditional war. Moreover, visual stimuli remind the warrior of the traumatic event. The men around him (and the killer himself) hold spears - the most common weapon used in traditional fights at close range. Thus, the scene brings together a variety of elements that are expected to be part of the fear structure (Foa & Kozak, 1986) of a warrior after a deadly spear fight, and thus likely confronts the killer with memories of the past, potentially traumatic event (**exposure**).

We hypothesize the singing of songs and simultaneous competitive movements do not only reactivate traumatic memories, but also instill self-confidence, which might counteract excessive anxiety (cf. Grawe, 2004, p. 107). The singing and blowing the horn also regulates breathing, and might thus **attenuate excessive arousal** to keep it within a range at which the hippocampus is still in a propoer state of functioning (see CHAPTER 3.3.2.1 on the 'hot/cool system view' and CHAPTER 6.5 on the importance of breathing in anxiety management). Moreover, the high level of social support expressed throughout the ritual might contribute to **managing anxiety** and excessive arousal of the killer during exposure (cf. Uchino, Cacioppo & Kiecolt-Glaser, 1996).

Procedures of the ritual	Interpretation
Recurrently combing ululation, songs and mock fights The killer blows his horn, while the virgin girl ululates as an expression of joy and praise. Throughout the ceremony, specific songs are sung, often accompanied by vigorous dances and mock fights.	The virgin girl and other women express their joy and praise for the killer throughout the ceremony (social recognition and support). Simultaneously, the songs as well as the dances and mock fights constitute intriguing ways of prolonged and recurrent exposure *in sensu* and *in vivo*. Thus, the ritual skillfully orchestrates various forms of **social support and exposure interwoven with each other.**
Singing *merok* and *wayo* songs The *merok* and *wayo* songs elaborate on topics surrounding the dead body of the person killed, praise the victor as well as the deceased, and rebuke the spirit of the deceased to leave and let the killer remain healthy.	Throughout the ceremony, people sing songs that express the support and acknowledgement of the group for the killer by praising him and rebuking the spirit of the deceased. At the same time, the contents of the songs likely expose the patient to memories of the past killing. We argue that combining social support with exposure fosters the **elaboration of (hot) traumatic memories** and helps weaving them into (cool) autobiographic memories (cf. Metcalfe & Jacobs, 1996), including its spatial and temporal context. According to theory, this results in strengthening voluntary routes of retrieval and impeding involuntary triggering of memories with 'here and now' qualities (Brewin, 2001).
Invoking the ancestors After finishing the first round of songs, the ancestors are again addressed by elders, pleading that "our child should remain healthy and whoever speaks ill, the setting sun should take it [the ill-spoken phrase] away". (Transcript 18, p.127)	The pleas of the elders throughout the ritual convey social support and engender hope. Interestingly, the verbal structure of such pleas is consistent with the principles of **trance-speech** (Bongartz & Bongartz, 2000; Revenstorf & Peter, 2001). According to hypnotherapeutic theory, such suggestive

Procedures of the ritual	Interpretation
	formulations have the potential to engender hope and foster healing processes (Revenstorf & Peter, 2001).
Singing *wayo* songs for the next two days For the next two days, *wayo* songs are sung regularly and people even get up in the middle of the night to sing the songs. *The [wayo] songs were to frighten the bad spirit of the killed person in order to make it leave the killer.* (Transcript 18, p.128)	Again, the singing of wayo songs fosters the elaboration of the trauma memory, (see above). The interruption of sleep for singing the wayo songs in the night might reduce the likelihood of nightmares, which are more probable after some hours of undisturbed sleep. In case the killer cannot sleep well after intense exposure to traumatic memories during the day, he will at least feel accompanied and supported by the *lawayo* and the virgin girl, rather than left alone during the night.
Day of the climax: **Leaving for the grazing ground** On the day of the ceremony's climax, people leave the homestead for the grazing ground, where the killer spears a goat in a ritual manner, followed by the *lanwojo*. *… people gathered early in the morning for the day of the climax: the day when the actual cleansing was supposed to happen. The killer, the virgin girl and the helper … were all made to sit in front of the [ancestral] shrine. All of them were wearing feathers on their head. The killer and the helper were holding spears in their hands. … Next, the spears that had been placed in front of the shrine on the first day were distributed [to other men present] and three … songs were sung while people danced. Then a … goat was given to the killer and people left for the grazing ground with the killer leading the way … Everybody moved in one group and they were moving with much*	While the killer during the first days of the ritual has been almost continuously exposed to potentially traumatic memories, the ritual's climax still increases the level of exposure: When the group leaves for the grazing ground, most people are equipped with spears. People move fast and vigorously, expressing competition. This situation contains a range of stimuli that were likely present shortly before and during the traumatic event (exposure in vivo). In line with theory, we argue that such in vivo exposure promotes the **discrimination of stimuli** and helps the warrior realize that situations and activities associated with the traumatic event (e.g. performing a mock fight) are not dangerous. According to Foa and Kozak (1986), this leads to **incorporating safety information into the trauma memory**

Procedures of the ritual	Interpretation
vigor. The movement was fast and expressed competition. (Transcript 18, p.129)	and thus promotes a learning process successively leading the client from fear towards **regaining mastery and courage** (cf. Rothbaum & Foa, 1999).
Spearing the goat *… When they reached the grazing ground, the ritual performer … told people … to begin the wayo songs, which were sung three times. … After the songs, the killer was told to go and spear the goat. While he was approaching the goat, he was to perform a mock fight. He speared the goat under the right foreleg. Next, he began to blow the horn and shouted the clan slogan as the virgin girl next to him ululated. Other people also ululated and the helper speared the goat a second time. The person in charge of "wayo" then started the wayo songs and everybody joined in while women ululated. Many wayo songs were sung repeatedly and loudly at this instance.* (Transcript 18, pp.129-130)	In the grazing ground, the patient is to spear a goat in a specific traditional manner. This exposes him to fighting movements and the sight of blood, which likely once more reminds him of the past killing. According to LeDoux (2002), the strong perceptual priming and stimulus-reaction associations for stimuli that are temporally related to the traumatic event weaken after further learning experiences that indicate the stimuli are no longer associated with threat. We assume that symptoms of reexperiencing triggered through trauma related stimuli are reduced through this mechanism.
Roasting the meat and performing mock fights The meat of the goat is then roasted … *… While the meat was being roasted, people kept on singing "wayo" songs. The words of the songs elaborated on how different animals behaved when finding a dead body while even imitating their cries and sounds. While the wayo songs were sung, the killer, the helper and other elders were frequently getting up to perform mock fights. The virgin girl was following them while ululating and other women also joined. The ululation was meant to chase away the spirit of the killed person which was believed to be lingering around the place.* (Transcript 18, p.130)	The sequence of roasting the meat again illustrates, how exposure *in sensu* (wayo songs), exposure *in vivo* (mock fights) and social support, as well as social recognition are interwoven in the ritual. We believe that the repeated and prolonged exposure throughout the ritual promotes the **habituation** of autonomous activation and corresponding anxiety. Such habituation is by theorists considered crucial to therapeutic improvement in exposure therapies (Deacon & Abramowitz, 2004).

Procedures of the ritual	Interpretation
Competing for 'Labana' meat … and courageous men compete for the meat in a ritually prescribed way, showing their ability and urge to fight. *… When the labana meat was ready, it was taken and placed on the stump of a tree. The boys and adults with strength and motivation to compete were supposed to struggle to snatch it with their mouth from there. So these strong and competitive people ran and went to bite the labana meat from the stump. When one person had bitten it, the others came to scramble for it from his mouth. The meat was not to be taken with the hand but bitten with the mouth until it was finished. While scrambling for the labana meat, all the competitors were holding spears or sticks to show their urge of competition. At the same time the virgin girl was ululating. After that, wayo songs were sung three times, and then people went to sit down.* (Transcript 18, p.130)	The competition for the labana meat again creates a situation that resembles a fight, with competitors holding spears and sticks. From the perspective of Chemtob's (1988) cognitive action theory of PTSD, the competition for Labana meat creates a highly competitive situation, which is likely activating the threat arousal node (of the propositional network), even if the killer has meanwhile become used to the sight of spears and other stimuli associated with the traumatic event. It thus supports further crucial corrective learning processes, including the discrimination of complex situations containing threat cues and further promotes the incorporation of safety information into the propositional network.
Stepping on the fire The fire that was used to roast the goat's meat is put out by stepping on it with bare feet, after it has been covered with fresh leaves. This "dancing" on the fire is believed to deter the spirit of the killed. *After the meat had been eaten all … the people started stepping on the fire [covered by the leaves]. The killer and the helper were in the middle of the group. The killer was holding his seat, the horn and the spear. The bell was hanging from his chest. Three songs were sung while people were dancing on the fire until it was put off. Before people left the place, they made sure the fire was thoroughly*	In the view of a client who believes in traditional cosmology, the whole group engaging in the ritual faces hostile spirits in order to help him in his struggle against evil spirit forces. Already this is a strong demonstration of social support. With the 'dancing on the fire', the clan members once more powerfully demonstrate their solidarity. The local belief in *cen* not only heightens the perception of the killer that he is supported by his clan, but also reframes his own reactions of anxiety as foreign (spirit) influence that will be banned during the ritual through the collective efforts of the group

Procedures of the ritual	Interpretation
put off and no smoke was going up. Every person present was to step on the fire because according to traditional beliefs, the spirit of the killed would turn to people who don't step on the fire. (Transcript 18, pp.131-132)	(reframing). The strong social support gives this cognitive frame credibility. Moreover, the reframing of symptoms in terms of *cen* in the context of social support might engender optimistic expectations and thus trigger a positive placebo response (Frank & Frank, 1991). The ritual might also contribute to reducing stress and anxiety by addressing the highly stress-inducing causal attribution of being haunted by a spirit. A general reduction of stress might in turn lead to the reduction of symptoms.
Leaving the grazing ground … *After the fire was put off, the ritual performer instructed people not to look back while leaving the place. He explained that this was important because if one did turn back, the spirit of the killed that was still lingering around there would get him or her. … Before people finally left the place, the ritual performer smeared the killer with pala [colored soil] on the forehead, the shoulder and the chest. This was to adorn him. … He then told the people to sing "wayo" songs … and people started moving… accompanied by mock fights …* (Transcript 18, p.132)	This passage shows how local beliefs in *cen*, the spirit of the killed, are reinforced through instructions by the ritual performer. It again illustrates how this cognitive frame might increase the perception of social support by the killer, as it allows the group to demonstrate their eagerness to support him by taking high risks for themselves. Again, expressions of social acknowledgement and solidarity through adornments are combined with exposure in sensu (*wayo* songs) and exposure in vivo (mock fights).
Cleansing at the termite hill Another important ritual act follows: cleansing at the termite (*aribu*) mound. The killer is dragged through the termite mound three times in order to make the termites bite him. The worker termites are believed to bite the bad spirit that is disturbing the killer, thus prompting it to leave. The virgin girl, the helper (*lanwojo*), and the ritual performer (*lakwe*) are then subjected to	In the cleansing at the termite hill, not only the killer, but also the virgin girl, the lanwojo and the ritual performer engage in painful procedures. This again is a strong expression of social support. Kaniasty (2005) points out that a high level of **perceived social support** is consistently related to recovery from traumatic events, while the data on 'received social

Procedures of the ritual	Interpretation
the same procedure, all in an effort to deter bad spirits that are believed to linger among the people during the ritual.	support' are inconsistent. In the light of this finding, we interpret that the ritual provides a template for the community to express their support in ways that cannot remain unperceived by the killer and leave little space for misinterpretations.
Back to the homestead Following this, people go back to the homestead, where elders give their blessings and the ancestors are again addressed.	By giving their blessings and addressing the ancestors, the elders again express social support and engender hope through giving emphasis to the spiritual dimension of the ritual
Eating from the lunyare herb Next, the killer and other brave men who had been competing for the goat meat in the grazing ground are given the herb *lunyare* to chew. The taste of *lunyare* is very bitter, and chewing it is considered an important vow in Acholi culture. A man who has licked or chewed the herb should not run away, even if a wild beast should threaten or war come. It is believed that if someone who has participated in this ritual turns his back when threatened, he will die since he has failed to fulfill the promise he made in the presence of his ancestors.	The chewing of *lunyare* herb with its cultural interpretations is a creative way to **counter future tendencies of avoidance,** which often contribute to the maintenance of PTSD (Ehlers & Clark, 2000). Here again, the ritual skillfully harnesses local beliefs in the spirit world for therapeutic goals. Moreover, assigning the killer a special responsibility to defend his clan against external threats conveys social acknowledgement (Maercker & Müller, 2004), facilitates the **finding of meaning** and fosters a **sense of coherence** (Antonovsky, 1979). Updegraff et al (2008) provide evidence that the finding of meaning is associated with better adjustment and lower levels of posttraumatic stress.

Procedures of the ritual	Interpretation
Giving a '*moi* name' Traditionally, a specific *moi* (or "killer") name would be given to the killer at this juncture, signifying that he has killed an enemy.	The *moi* name assigns the warrior a prestigious position in the clan (social acknowledgement) and reinforces his responsibility to defend his clan against external threats (finding meaning, sense of coherence).
Concluding the ritual The ritual is concluded with a final litany (*agat*) to chase the *cen* out of the killer. Elders point spears that have been blessed in front of the *abila* at the eyes of the killer, threatening and commanding the bad spirit to leave: "You, today we do our *agat* on you; you should get out because we have already cleansed you! The setting sun today should take it, and has taken it, away!" The people gathered would answer: "And has taken it away!" The above litany is repeated several times, led by elders and echoed affirmatively by all those present. Relaxed sharing of food and drinks then follows.	The final chasing out of the spirit might imply the most intense exposure in vivo of all exercises during the ritual. Although according to local beliefs, the spears are to threaten the spirit of the enemy (*cen*), in observable reality, they expose the killer to a menacing weapon close to his eyes. It is the same weapon he probably faced in a traditional war before killing the enemy. Again, the local belief in *cen* reframes anxiety and fear of the killer as foreign (spirit) influence that might come up violently for the last time as it is finally chased out by the elders, with the support of the ancestors (reframing). According to hypnotherapeutic theory, the verbal structure of the litany (trance-speech) when chasing out the spirit is engendering hope and might thus facilitate further healing processes (Bongartz & Bongartz, 2000).

Above we have interpreted the ritual procedure for cleansing someone who has killed a man. The procedure for somebody who has killed a woman differs substantially from the above-described, although the major elements of the ceremony remain the same. The most important differences lie in the fact that the ritual lasts for four days instead of three, and that

the killer during three days of the ritual is required to perform a woman's work (fetching water and firewood, grinding corn, cooking, washing dishes, etc.). Acholi elders declare that a successful cleansing for the killing of a woman is difficult to accomplish and killings on women have been rare. We speculate that the difficulties in such cases might stem from the killer's negative appraisals about having killed a woman, which might increase feelings of guilt and shame. Ehlers (1999) reasons that with clients who mainly report feelings of guilt and shame, repeated reliving might not be helpful and instead extensive cognitive restructuring is indicated. Obliging the killer to perform a woman's work during the ritual might be a culturally specific way to respond to such needs. However, as our data on the details of the ritual for cleansing the killing of a woman are rather thin, any interpretation on these specifics must remain highly speculative. We therefore return to summarize and comment our interpretation on the procedure for cleansing the killing of a man.

In brief, we argue that the major therapeutic ingredient in ritual *kwero merok* is exposure to past traumatic events accompanied by skillfully orchestrated social support. While exposure makes sure that the fear structure is fully activated (cf. Foa & Kozak, 1986), social support contributes to keeping the arousal within a range at which the hippocampus is still in a state of proper functioning to encode new information (cf. Metcalfe & Jacobs, 1996; Uchino et al, 1996).

Reviewing our interpretation on exposure, we note that during the first preparatory days of the ritual, the warrior has been almost continuously exposed to (potentially traumatic) memories related to the killing of the enemy. These memories might have been already triggered by the mere fact that he was adorned to be cleansed in the ritual and instructed to concentrate on this undertaking. In addition, traumatic memories were specifically prompted through the contents of repeated songs, the recurrent performance of vigorous dances and mock fights, the stabbing of the goat, the scrambling for *labana* meat and the menacing spears in front of the killer's eyes when elders chased out the spirit of the killer towards the end of the ritual. As outlined above, we hold that the exposure fosters the elaboration of hot traumatic memories by incorporating safety information into the trauma memory and weaving it into cool autobiographic memories. Moreover, exposure increases the ability to discriminate stimuli and complex situations, thus promoting a learning process that leads the killer gradually from generalized fear towards regaining mastery and courage. As Ehlers and Clark (2000, p. 340) state: "In vivo exposure to avoided reminders of the trauma (e.g. the site, similar situations, activities, feelings, smells and sounds) is a powerful way of helping patients to emotionally accept that the traumatic event is in the past." It seems that the ritual *kwero merok* has been composed to achieve this aim.

An open question regards the range of traumatic events for which the ritual can be applied successfully. Theoretical reasoning suggests that its effectiveness might be limited to addressing symptoms that have arisen from traumatic events that sufficiently resemble the templates for exposure applied in the ritual (e.g. fights with spears at close range and similar events). Interestingly, a ritual performer mentioned that if a client had been forced to kill somebody using a stick or club, sticks or clubs should be used in the ritual instead of spears (transcript 21, p. 153). We believe the ritual performer's strategy reflects a useful adaptation of the ritual to changed circumstances.

Skillfully interwoven with the exposure throughout the ritual, social support is realized in various creative manners, including prestigious adornments, the continuous close accompaniment by four people who hold the described ritual offices, the periodic pleas of elders before the ancestors, repeated ululations by women and songs of praise by the whole community. Moreover, the belief in *cen* (a dangerous and hostile spirit) allows the whole community demonstrating its strong determination to support the killer. This determination is expressed throughout the ritual, and specifically highlighted in procedures such as the stepping on the fire and the cleansing at the termite hill, where the people holding ritual offices engage in painful procedures to ward off spirit related threats. Finally, the killer is given a prestigious *moi* name and is assigned special responsibility to defend the clan. We argue that the continuous expressions of social support during the ritual counteract the shattering of positive assumptions of the world as being basically safe and predictable (Janoff-Bulman, 1992) and thus work against interpretations of the trauma that might lead to the perception of a serious current threat (cf. Ehlers & Clark, 2000). Social support might also reduce excessive arousal and related fear to a level at which the hippocampus is still functional to encode of new information (cf. Uchino et al, 1996). Further, it encourages the killer to overcome cognitive as well as behavioral tendencies of avoidance and thus (in combination with exposure) contributes to the thorough elaboration of traumatic memories. The strong support of the clan gives the (re-) framing of fear reactions and other PTSD symptoms as foreign spirit influence that will be banned with the support of the clan credibility and counteracts demoralization (Frank & Frank, 1991). Importantly, the ritual touches a spiritual dimension by including the ancestors and thus helps the killer in finding meaning and maintaining a sense of coherence (Antonovsky, 1979). Assigning the killer a *moi* name and special responsibility in defending the clan against external threats contributes to the same aim and additionally works against potential future tendencies of avoidance. Finally, the positive engagement for the killer during the ritual is according to Festinger's (1957) 'theory of cognitive dissonance' expected to positively change community attitudes towards the killer and might thus have a lasting positive effect on social support towards him after the

ritual has ended. This might considerably foster the reintegration of the returnee into the community on the long term (cf. Panu-Mbendele, 2004)

The above analysis suggests that a stunning variation of exposure therapy might have existed in some Luo groups since centuries. We speculate that the described elaborate procedures of therapeutic exposure have been developed through trial and error when the struggle for survival in hostile environments produced exceedingly high rates of traumatization. Especially during war and hunting expeditions, traumatization through recurrent events must have been frequent in the traditional setting. In wars, fights with spears at close range were likely the most common traumatic event. In hunting, menacing wild animals that turned against their hunters were another recurrent incident. It is not surprising, that for killing a dangerous wild animal such as a buffalo, an elephant and a leopard, rituals similar to kwero merok were carried out (Wright, 1936; Girling, 1960).

14.3.3 Methodological considerations on the interpretation of the ritual

Despite the details provided in the description of the *merok* ritual, methodological doubts likely arise when researchers interpret qualitative data and find them fit their own theory. Such skepticism is justified, as the researchers' theoretical orientation strongly influences their interpretation of healing procedures. There are plenty of examples illustrating this assumption. Lévi-Strauss (1967) has interpreted shamanistic healing in terms of Freud's psychoanalysis. Hess (1995) has described communalities of shamanism and music therapy. Wild-Missong (1995) depicts Gendlin's (1982) focusing as 'modern shamanism'. Panu-Mbendele (2004) argues from a perspective of systemic psychotherapy holding that 'membership' and 'social integration' are the key to understanding African traditional therapies.

The question comes up, whether all these interpretations are defensible. Do they capture different (but 'real') aspects of 'shamanistic' or 'traditional' healing, while simply neglecting or ignoring others? Or, do researchers unduly impose their own ideas and theories on data that do not warrant such interpretations? Whatever might be the case, the degree to which the interpretations are backed by the actual healing procedures is difficult to determine (cf. Ablon & Jones, 2002).

One of the underlying problems is that therapeutic mechanisms are not accessible to immediate observation and thus invite to interpretations according to preconceived theories. This is at least one major reason for the contentious debates among adepts of different

schools of Western psychotherapy. Here as well, proponents of specific psychotherapeutic schools or techniques see the therapeutic mechanisms they believe in at work in other therapeutic approaches. The controversy on Eye Movement Desensitization and Reprocessing illustrates the matter (McNally, 1999; see also CHAPTER 6.4).

Another difficulty lies in biases when documenting the therapeutic procedures. The documentation usually reflects elements that fit the author's interests and theory while omitting those that do not. To avoid long-winded and irrelevant descriptions, researchers have to select and describe observations that are relevant to their specific topic and theory. The largely confirmatory nature of human information processing (Evans, 1990) compounds the biases in documentation and interpretation.

Of course, we are not able to present a satisfying solution to these fundamental problems of philosophy of science in this thesis. Instead, we have tried to address them by providing information that allows readers judge for themselves to which extend our interpretations are backed by the data, and where methodological constraints might weaken their conclusiveness. Apart from the descriptions of the ritual procedures given in the left column of the interpretation, the COMPANION VOLUME contains all documents on which our description of the *merok* ritual is based. (As summarized in table 9, CHAPTER 10.4, *kwero merok* is described in 14 transcripts and 4 external documents; the most detailed description is provided in transcript 18.) CHAPTER 10 gives important information for evaluating the data by offering a detailed outline of the methodology, including study design, data collection and data analyses.

Overall, we believe the presented data soundly support our interpretation on therapeutic principles, especially on the importance of exposure in the ritual. However, we concede that they are not exhaustive, and complementary interpretations would have been possible.

14.4 Considerations on the effectiveness of traditional rituals in reducing psychosocial distress

Assessments on the effectiveness of traditional rituals have not been central to our research to this thesis. Nevertheless, our transcripts do contain hints on the effectiveness of some of the described traditional rituals. As the issue of effectiveness is important to our discussion further below, we now summarize and interpret the major cues documented in our

transcripts. We first explore hints on the described Acholi rituals in general. In a second section, we discuss our data on the effectiveness of the ritual *kwero merok*.

14.4.1 General considerations and hints on the effectiveness of traditional rituals

Overall, our descriptions and case studies suggest that traditional rituals might generally be effective in reducing psychosocial distress by reaffirming positive cultural values, strengthening social support systems, and improving interpersonal relationships. Examples for rituals that emphasize social cohesion and reintegration are *nyono tonggweno* (stepping on the egg), *lwoko pik wang* (washing away the tears), *tumu kir* (cleansing for a taboo committed) and *mato oput* (reconciliation after a killing). We believe that the impact of these rituals on the social level entail positive effects on the individual level. Additionally, traditional rituals open an opportunity for communities and individuals to address stress-inducing causal attributions, such as being haunted by spirits. This function is particularly apparent in rituals like *moyo tipu* (cleansing the spirit), *moyo piny* (cleansing a specific area), *ryemo gemo* (chasing spirits from a wide area) and *ryemo jok* (chasing out a free *jok*). Moreover, specific psychological mechanisms might also play a role, as has been suggested in our interpretation of the *merok* ritual further above.

The so far outlined hints on the effectiveness of rituals in our documentation are rather indirect and based on theoretical reasoning. Cues that are more direct come from our case studies. (Here, we exclude case studies on *kwero merok*, as they will be discussed further below.) From seven case studies on the general practice of traditional procedures, two clearly suggest positive effects. A young woman who had been abducted by the Lord's Resistance Army reported her nightmares stopped and her ability to engage in social and professional activities improved after the ritual (case study no. 4). Similar improvements on symptoms and functioning are reported on a male returnee (case study no. 7). Another two case studies render weak hints on positive effects: A young man who had suffered from a mysterious paralysis and other symptoms became better after the treatment by an *ajwaka* and showed further improvement after 'born again' Christians had prayed over him (case study no. 5). The description on Ajok, who became an *ajwaka* after suffering from spirit attacks, also implies that at least the functional impairment was addressed, as she became a healer through the treatment (case study no. 6). Two further case studies do not contain any cues, because we have not collected data on the impact of the applied procedures.

14.4.2 Reports on the effectiveness of the ritual kwero merok

Our case studies on the effectiveness of the ritual *kwero merok* have the following features in common: All persons who were subject to these case studies had been abducted by the Lord's Resistance Army and reported severe traumatic experiences. All of them afterwards reported suffering from symptoms that in clinical psychology are described as symptoms of posttraumatic stress. All reported significant improvement after the ritual. In all cases, the descriptions were backed by numerous additional interviews with other community members and social workers.

The first case study on the *merok* ritual (see CHAPTER 12.2.1, case study no. 8) is impressive with regard to the extreme traumatic experiences the returnee had gone through and his severe posttraumatic symptoms that had developed after the traumatic events. Not less striking are the reports on remarkable improvements after the ritual. Similarly impressive is the second case study on the ritual (see CHAPTER 12.2.2, case study no. 9). For both case studies, we carried out interviews to attain qualitative descriptions on the state of returnees before and after the rituals. A third round of interviews (second follow-up) was carried out more than one year after the ritual had been completed, confirming the stability of improvements.

Case studies no. 10 and 11 describe positive changes after the ritual, although the evidence is considerably weaker. The descriptions of symptoms and changes here rely on retrospection, which might compromise the validity of these data. Morover, the follow-up periods were shorter.

14.4.3 Methodological considerations on the evaluation of effectiveness of the rituals

With regard to Acholi rituals in general, we note that our ethnography offers only hints on the effects, but does not provide conclusive evidence. When evaluating these hints, we have to be aware that our research focused on 'traditional ways of coping' that might be helpful in addressing the psychosocial impact of war. With this positive focus guiding our sampling of traditional procedures, we were unlikely to document doubtable rituals or potential negative effects, thus leading to a systematic bias in our data. Evidently, a thorough impact assessment would require a quite different methodology and should explicitly appraise potential positive as well as negative effects.

In contrast to descriptions on the effects of Acholi rituals in general, the accounts on the changes after the *merok* ritual are impressive. Nevertheless, they must be interpreted with caution, as case studies are burdened with a number of methodological flaws that compromise their conclusiveness. Below we examine possible consequences of methodological weaknesses on three areas: (1) issues of measurement (reliability and validity), (2) cause-effect relationships (internal validity), and (3) generalization of results (external validity).

As we have not used standardized instruments in assessing the state of returnees or changes after the rituals, we are not able to report psychometric properties on reliability or specific forms of validity of instruments used. (However, instruments validated in Acholi language and culture were not available.) The qualitative semi-structured assessments prompted informants to report perceived changes after the ritual on broad areas (symptoms, individual wellbeing and social adjustment), and thus tapped into molar processes. Using such crude measure might have left many changes undetected, as interviewees likely described the most salient changes only. Although regrettable, we believe that this does not subtract weight from the changes that have been reported.

According to our opinion, the most severe weakness when it comes to the validity of measurement might lie in the fact that our study focused on documenting traditional practices with a positive potential of fostering healing. The explicit focus on positive traditional practices might have increased key informants' willingness to report positive effects of the documented rituals (hypothesis guessing, cf. Trochim & Donnelly, 2007). This tendency might have been reinforced by the fact that key informants in this study mostly represented the 'traditional' segment of Acholi society, which during the last century has become more and more marginalized. In this context, evaluation apprehension (Rosenthal & Rosnow, 1991) might have further strengthened the emphasis on positive descriptions. Although this point must be taken serious, we state that descriptions of changes after other rituals have not been as positive as those after *kwero merok*, indicating the specific potential of this ritual. Further, our documentation of changes does not only rely on accounts from community members, but also takes first hand observations of social workers and researchers into account. Moreover, the described changes included hard facts that could be verified by researchers, such as a returnee having taken up schooling again after he had dropped out because of trauma related disturbances (case study no. 8). Overall, we acknowledge that the documentation might be biased towards describing positive changes after the ritual. However, we argue that despite weaknesses that might have biased results, the presented evidence points to substantial changes having occurred in the course of time.

If we acknowledge that changes have occurred, the question arises whether these changes have been caused by the *merok* ritual. Cause-effect relationships are best investigated in experimental designs, which control a wide range of threats to internal validity (Shadish, Cook & Campbell, 2002). In this regard, case studies in general display significant shortcomings (Bryman, 2004). Especially the absence of a control condition leaves various alternative explanations on potential causes of the reported changes open. In discussing the possibility of such confounds, we keep with Trochim and Donelly (2007) who specified three criteria for establishing causal relationships: (1) Cause precedes the effect, (2) cause and effect covary, and (3) plausible alternative explanations should be ruled out. Our case studies provide good evidence for the first two premises. All informants were consistent in their descriptions of persistent disturbances before the ritual and improvements after the ritual. The fact of the ritual being a clearly demarcated event of only three to four days might have eased the judgment of changes by the community and returnees. It has also limited the timeline, in which alternative causes could have come into play. In this context, the hypothesis that the changes over the four documented cases is caused by other events occurring concurrently with the rituals (history threat) is implausible, especially as the returnees had passed many months to years in the community without tangible changes occurring. Given the short time of a few days of the ritual, naturally occurring changes over time (maturation) as an explanation are similarly implausible. Selection and attrition as threats to internal validity (Shadish et al, 2007), do not apply to our case studies. Likewise, regression, testing and instrumentation, as described by Shadish et al (2007), do not provide plausible alternative explanations for the described results. We conclude that for the four cases that we have evaluated, the essential criteria for establishing a causal relationship between ritual and the documented changes are met, as alternative explanations can be plausibly ruled out.

We summarize that despite methodological flaws (low number of cases, no control condition, no standardized pre- and post assessment), the presented case studies realize important virtues of naturalistic studies by assessing rituals as they are performed in the field with persons (and communities) who have actively sought engaging in them. In this regard, they are akin to effectiveness studies of psychotherapy (cf. Seligman, 1995). Although well-controlled efficacy studies have been widely embraced by the scientific community as the state-of-the-art design for empirically validating treatments, they have also been criticized for their shortcomings. Kadzin (2008) voices concern that key conditions of efficacy studies depart markedly from those in clinical practice, which limits their external validity. Moreover, even well standardized and validated measures used in the assessment of clinical trials provide little information on the extent to which patients have been helped in mastering their

daily life (Ablon & Jones, 2002; Seligman, 1995). In contrast, the qualitative descriptions by the concerned clients and community members in our case studies document improvements that are considered substantial by the persons who have engaged in the ritual and the community around them.

How far can the results of the presented case studies on the effectiveness of the merok rituals be generalized? The low number of cases examined and the highly selective sampling procedure applied in this study does not provide a good foundation for generalizing the results to the population of the Acholi or other defined populations. In the absence of possibilities to generalize on the base of probability sampling and related statistical models, generalizations in qualitative research are commonly more tentative and grounded on theoretical reasoning (Bryman, 2004). The proximal similarity model for external validity (Trochim & Donelly, 2007) provides a frame for such generalizations to people, places, settings and times that are similar to those investigated in the study. Theoretical reasoning suggests that our results on the effectiveness of the *merok* ritual might be generalized to rituals carried out on Acholi persons who have chosen to engage in the ritual with the support of their family and clan. The results might thus be generalizable (with reservations) to the traditional segment of Acholi society only, but not to people who hold beliefs that impede their engagement in traditional procedures. This leads to the question of the acceptance and significance of traditional rituals in contemporary Acholi society. The following section ponders on the acceptance of Acholi rituals in general, and on the application of the *merok* ritual more specifically.

14.4.4 Acceptance and significance of traditional rituals in contemporary Acholi society

Our claim that traditional rituals might be effective in alleviating different forms of distress, including symptoms of posttraumatic stress disorder, raises the question to which degree they are accepted by and accessible to the general population. As we have mainly interviewed elders, ritual performers and traditional healers, their views and perceptions are systematically overrepresented in our ethnography. This is advantageous when aiming at accurate and detailed descriptions of traditional worldviews and procedures, which was the main purpose of our study. When it comes to estimating the acceptance of traditional rituals in the general population, the method of giving voice to the most ‘traditional’ segment of the society leads to a systematic bias.

Nevertheless, our case studies exemplify that people tried out different treatment options, including prayers and Western medicine in sequence or even simultaneously (cf. CHAPTER 12, case studies no. 5 and 10). Moreover, carrying out a traditional ritual was at times considered the last option to which returnees only agreed in a certain state of desperation, after prayers and other attempts to find relieve had failed (cf. CHAPTER 12, case studies no. 4 and 8). Considering that we have focused our investigation on the most traditional segment of Acholi society, these findings suggest that even people who most strongly adhere to traditional world views are at the same time open to utilize Christian and modern avenues of coping. These findings suggest that the cultural identity of the Acholi people today is shaped by three major influences, namely traditions, Christian or Moslem faiths, and modernity. To which degree each of these pillars of identity[67] contributes to shape the ways of coping with traumatic stress, differs from individual to individual. Following hints in our data and personal observations of the principal investigator, believers of different Christian denominations relate differently to various traditional practices. While the Balokole (evangelical, "saved" Christians) categorically reject traditional rituals as 'satanic' (see quote on the applicability of *moyo piny,* CHAPTER 11.2.3.1.3), most Catholic believers are more tolerant towards local traditions and accept many, but not all traditional practices. Further, the acceptance of traditions varies with age, with people of older age generally adhering to traditional beliefs and practices more than younger ones. Moreover, the ethnography in CHAPTER 11 describes considerable differences in the level of acceptance and preservation between different rituals. Our data indicate that brief rituals like the stepping on the egg are still relatively widespread. (See CHAPTER 11.2.1.1.3 on the applicability of 'stepping on the egg'.) In contrast, elaborate and extensive rituals, like *kwero merok*, are no more common (see CHAPTER 11.2.4.2.3).

Since the *merok* ritual was one major focus of our interpretation, its significance in contemporary Acholi merits further reflections. As there are only few direct hints on the acceptance of the *merok* ritual in our transcripts, we have to consider the circumstances of the data collection and sampling procedures to come to an adequate interpretation. Given the extensive links of the research team to communities all over Acholiland, we take the fact that we were not able to trace any *kwero merok* ritual in Gulu district (where Caritas headquarters are located) as an indication that it has likely died out in these areas. Moreover, while in our review of literature we have found three curtailed accounts on the ritual, their authors have all assumed that it died out all over Acholi time ago. Whereas

[67] On the example of post-conflict East Timor, Loch (2007) provides a detailed analysis on the complex interplay of 'traditional', 'Christian' and 'modern' influences on ways of coping with post-conflict challenges in a non-industrialized society. The idea of considering the influences of traditions, modernity and Christian (or Muslim) faith as the major pillars of identity stems from his doctoral thesis.

Wright (1936) and Girling (1960) both refer to the date 1918, when the most recent *merok* rituals might have been carried out, Behrend does not specify a date. In the light of other researchers having thought the ritual had died out early in the 20th century, it is surprising that we were still able to trace the ritual in the 21st century. However, to document it in detail through participant observation, we had to travel more than 130 kilometers towards the Sudanese border into remote and militarily insecure rural areas. Still, in the few cases we have documented by using a highly selective sampling procedure, there are hints indicating that the ritual even then was often not the first treatment choice (see case study no. 8, CHAPTER 12.2.1). Moreover, while the interviewed traditional healers and elders had at least some knowledge on the ritual, the general population is definitely less familiar with it. Even if people knew about it, a substantial proportion of the population would object to such ritual for religious reasons (cf. CHAPTERS 1.4.2.2 and 11.2.3.1.3). Further, the elders and traditional healers we have interviewed are not unanimous when it comes to the questions whether returnees from LRA should receive a *merok* ritual (cf. CHAPTER 11.2.4.2.3). From these cues and considerations, we can infer that the ritual *kwero merok* has been driven to the remote margins of Acholi society and is nowadays accessible to (and accepted by) only a small proportion of the Acholi population.

14.5 Implications for cross-cultural psychotherapy

Our interpretation of Acholi healing procedures from the perspective of Western clinical psychology has revealed communalities as well as differences between traditional Acholi and Western approaches. When comparing Acholi rituals with Western psychotherapy, the differences are evidently more eye-catching than similarities. In this line, we have pointed out that Acholi ceremonies are resplendent with symbolic acts and details that refer to Acholi cosmology and history. Unlike Western psychotherapy, traditional concepts mostly locate the causes of suffering in the world of ancestors and spirits, and the healing procedures consequently address these posited causes. Moreover, the active participation of the community in Acholi rituals marks a strong contrast to the usually dyadic setting in Western psychotherapy.

However, beyond these obvious differences, we have also exposed substantial communalities between Acholi healing and Western psychotherapy with regard to their general structure and applied therapeutic interventions. Analyzing the ritual *kwero merok* from the perspective of Western trauma psychology, we have argued that the ritual applies exposure, cognitive (re-) structuring, social support and other therapeutic principles that also

form the ingredients of modern trauma therapy. Our interpretation suggests that the reported amazing effects attributed to the ritual might be related to such cross-cultural therapeutic mechanisms.

Although it was not a central topic of our investigation, our case studies give impressive evidence that the ritual *kwero merok* might be highly effective in reducing symptoms of posttraumatic stress, even with returnees who had gone through multiple extreme traumatic events and had subsequently developed severe symptoms. Because of the low number of cases and other limitations discussed in CHAPTER 14.3.3, the presented evidence is definitely not conclusive, but calls for further investigation. Apart from the specific analysis of the *merok* ritual, our general interpretation of Acholi rituals suggests that most of them have the potential to strengthen social support systems and foster the reintegration of returnees from rebel captivity into society. It is reasonable to assume that they thus also contribute to the healing from traumatic stress. Even more importantly, however, engagement in traditional ways of coping might substantially contribute to restoring social and cultural resources that have been destroyed by war. According to evidence from disaster research, these resources might play a vital role in protecting the mental health and facilitating recovery of the wider population (cf. Norris, 2002; Norris, Friedman & Watson, 2002).

Are Western psychotherapeutic procedures applicable in Acholi?

Reports on the existence and effectiveness of traditional rituals in addressing psychosocial problems have at times been used to criticize the application of Western therapeutic procedures in what is often called a 'traditional' or 'collectivist' society (cf. Green et al., 1999; Honwana 1998; Wessells et al., 2000). Bracken (1998) strongly argues that neither the PTSD concept nor related therapeutic interventions are applicable in non-Western societies.

We believe that our data do not support such categorical claims. On the contrary, our ethnography (CHAPTERS 1, 11 and 12) shows that contemporary Acholi is a complex society that reflects not only traditional, but also Christian, Muslim and 'modern' worldviews. It also indicates that beliefs and ways of coping are in a continuous process of change. During the last century, traditions have been driven to the margins of society, while Christian and modern influences have moved towards the center (cf. CHAPTER 1.4.2). This does not mean that traditions have become meaningless in Acholi. However, the degree to which they are accepted and practiced varies widely among the population.

Based on the above analysis, we hold that the often alleged fundamental differences in culturally shaped health beliefs and ways of coping do not provide a sound base for categorically excluding the applicability of Western psychotherapeutic approaches. Instead, the question whether such approaches are applicable in non-Western countries should be

treated as an empirical subject. So far, only few controlled outcome studies on the matter do exist. Randomized controlled trials on Narrative Exposure Therapy and Interpersonal Psychotherapy carried out in Uganda in recent years suggest that adaptations of psychotherapeutic approaches developed in Western clinical psychology can be successfully applied even under the difficult circumstances of developing countries (Bass et al, 2006; Bolton et al, 2003; Bolton et al, 2007; Neuner, 2003; Neuner, Schauer, Klaschik, Karunakara & Elbert, 2004). However, more research is still needed.

What should be considered when applying Western therapeutic approaches in Acholi?

Outcome research on defined therapeutic approaches is one important way to learning more on the applicability and efficacy of Western therapeutic approaches in different cultural contexts. However, even if the effectiveness of a specific approach has been established in the intercultural context, general clinical guidelines for cross-cultural applications of psychotherapy (Kinzie, 2001; Peltzer, 1996) should be considered. Most importantly, the clinician should be familiar with the client's cultural background (Marsella, 2003). For clinical interventions in Acholi, we recommend more specifically that clinicians should assess clients' ethno-cultural identity and individual health beliefs, including culture-related stressors and ways of coping. Treatments should be open to integrating traditional healing procedures as well as other faith-based activities. Hence, active collaboration with traditional healers, but also with relevant faith-based groups might be of importance. Given the dynamic blend of traditional, Christian and modern influences in Acholi society, one can take neither the approval of 'traditional' nor 'Christian' beliefs, nor the acceptance of 'modern' ideas for granted. Therefore, applying Western therapeutic approaches in Acholi requires a high level of flexibility by the clinician to tailor therapeutic interventions to suit individual preferences and beliefs.

15 General strengths and limitations of the study

This section describes strengths and limitations of the study, as far as the research process leading to the ethnographic CHAPTERS 11 and 12 is concerned. Methodological considerations on specific analyses of the ethnographic data have already been outlined following the pertinent sections in CHAPTERS 13 and 14. The general description of strengths and limitations below mainly refers to the criteria for judging the quality of qualitative research published by Seale, Gobo, Gubrium & Silverman (2004a, see also ANNEX 1) and Fischer (2006).

15.1 Strengths of the study

Before the actual data collection for the study started in February 2004, the principal investigator had already been working in the Acholi region for more than two years as a consultant to a psychosocial project. This allowed him to be amply acquainted with the local language, culture, and psychosocial practices in the field, which also included elements of Acholi traditions.

The design of the study proposed a transparent process of data collection. Following this plan, research systematically proceeded from mapping out general cultural provisions for healing in the first stage, to gathering detailed descriptions of specific rituals in the second phase. At the same time, the design was flexible enough to allow researchers respond to issues that emerged during the research, which was achieved through a reiterative process of data collection and formulating new and more specific research questions. 'Openness to emergent issues' is seen as one important indicator of quality in qualitative research (Seale, 2004).

The possibility to closely cooperate with local researchers in documenting 'traditions' was used as an opportunity to bridge cultural gaps and reducing ethnocentric bias, all crucial

matters in cross-cultural research (Marsella, 1987; McCurdy et al, 2005). Collaborative forms of research have become increasingly important in qualitative and ethnographic research, and are deemed especially important when aiming at validly describing 'insider perspectives' (Patton, 2002).

Dividing tasks within a team and the close cooperation with structures of the Psychosocial Support Program of Caritas Gulu enabled us to collect a wide range of data by carrying out a considerable number of individual expert interviews, focus groups, interviews with community members involved in traditional rituals, and participant observations of rituals. Though, like in most other qualitative studies, our sampling procedure is best described as 'theoretical' or 'purposeful' sampling (Glaser & Strauss, 1967; Patton, 2002), it included elements of non-proportional quota sampling with regard to community roles of key informants and geographical areas ('zones' described by Atkinson, 1999). Considering zones in data collection addressed the possibility of variation in concepts and procedures across different Acholi areas. Interviewing different kinds of traditional experts (community roles) permitted describing concepts and procedures in much detail and tap different traditional perspectives. Collecting data in different 'zones' and considering different community roles contributed to the heterogeneity of the samples, thus strengthening the external validity of the study. The detailed descriptions of the samples (CHAPTER 10.3.2), have rendered important information for discussing the generalizability of the results. Given that in qualitative ethnographic research the use of small and 'opportunistic' samples is typical and can be justified (Bernard, 1995; Gobo, 2004; McCurdy et al, 2005; Spradley, 1979), the fact that we have systematically collected a wide range of data under the difficult circumstances of an ongoing conflict and military insecurity is remarkable.

Detailed descriptions of the methodology, including design, data collection and analyses (CHAPTER 10), render the research process transparent and facilitate replication. The broad presentation of evidence in the form of computerized transcripts (see COMPANION VOLUME) enables readers to check in detail to which degree specific descriptions and interpretations in the thesis are supported by the collected data.

The analyses of data implied various forms of triangulation to verify the consistency of data and validity of findings. Triangulations included diverse methods of data collection, such as individual interviews, focus groups, and participant observation. They also took account of diverse sources of data (key informants hailing from different zones and assuming various community roles), and diverse analysts (local researchers and principal investigator). At the end of the process, the ethnographic descriptions have been validated through respondent validation and the review of an academic expert on Acholi traditions (see CHAPTER 10.4.2).

In the analyses and write-up, we have kept the ethnography (CHAPTER 11) clearly separate from the (psychological) interpretations (CHAPTER 13). The ethnographic

descriptions in CHAPTER 11 took an emic perspective by strictly refraining from interpretations foreign to 'traditional' Acholi culture. The psychological interpretations in CHAPTER 13 applied the theoretical perspective of Western trauma psychology that had been explicitly defined in PARTS TWO and THREE of this thesis. By keeping evidence (ethnographic descriptions) on the one hand and (psychological) interpretations on the other hand clearly separate and by carrying out the interpretations from a theoretical perspective that has been made explicit to the reader, we followed Bohnsack's (1993) suggestions on 'documenting interpretation' (Dokumentarische Interpretation).

This study for the first time provides a systematic outline and analysis of Acholi concepts and rituals of contemporary psychosocial relevance. Thus, the ethnographic descriptions and respective interpretations substantially extend on the anthropological knowledge of Acholi traditions by exposing their positive potential with regard to psychosocial healing of Acholi society in general and recovery from traumatic stress more specifically. Moreover, the study thoroughly documents a ritual (kwero merok), which was believed died out early in the 19th century (Wright, 1936; Girling, 1960). Interestingly, this ritual shows intriguing parallels to Western trauma therapy.

15.2 Limitations of the study

The following circumstances might be interpreted as weaknesses, limitations or strengths, depending on the perspective.

We have conducted the study within the institutional framework of Caritas Gulu Archdiocese, a Catholic Church organization. Although this arrangement has greatly facilitated our contact to communities and access to data, the question arises, to which extend this path of access might have biased the results of the study. The local Catholic Church is – in comparison to local Protestant Churches – relatively tolerant towards traditional procedures carried out by elders and the general community. Stronger reservations exist towards the practices of spirit mediums, the *ajwaki*. Although the director of Caritas Gulu had invited us to explore any procedure we consider relevant, the general attitude of the Church might have inadvertently influenced our research. The distance of the Church to the practices of *ajwaki* might have contributed to our motivation to cover a wide range of general practices performed by elders and the general community, while the healing practices of *ajwaki* have received less attention. This focus on practices carried out by elders and the general community is not necessarily a weakness of the study. It might even be

regarded a strength, as it counterbalances the focus of other studies that mainly concentrate on describing practices of specialized healers (Heidenreich, 2003; Janzen & Green, 2003), while neglecting the role of elders and other community members in traditional healing. Nevertheless, it is important to note that a different focus would have been possible. Further, the selection of key informants was mostly done by local researchers, supported by social workers of Caritas Gulu Archdiocese. It cannot be excluded that the data are biased through the community perception (and fact) of a Catholic organization carrying out the research.

During data collection, failures to gain access to certain sources were not well documented. However, potential key informants who were unwilling to be interviewed when asked were few. At times, interviews could not be carried out as planned, because key informants had to attend to other duties, mostly field work. Usually, another date was then agreed upon and the interview finally held. In the few cases in which respondents demanded money in exchange for information (about three cases), the interview was dropped and other informants were identified.

Another limitation of the study lies in the fact that the samples we have drawn are not representative of the Acholi people. With respect to 'zones' in Acholi, we collected data from 6 out of 8 zones, while it would have been desirable to have all zones represented in the sample. However, due to military insecurity during the period of data collection, this was not possible. The unrepresented zones, according to estimates (see CHAPTER 10.3.2; Atkinson, 1999) correspond to about 5% of the Acholi people. Although given the consistency of descriptions across the other zones it is likely that people in the unrepresented zones have traditionally adhered to similar worldviews and procedures, we cannot exclude with certainty that traditions among the unrepresented zones differ substantially from those described for the clans represented in the sample.

With respect to community roles, we sampled different kinds of 'traditional experts', thus focusing on the traditional segment of society. Although this was a deliberate choice in line with the purpose of our study, it is important to note that the sample does not reflect the complexity of contemporary Acholi society. Hence, our data do not allow depicting Acholi society in its complexity, but only describing traditional concepts and procedures in detail. By leaving the complexity of Acholi society unaddressed, we might have sketched an image that can easily be misinterpreted. We stress that our descriptions need to be complemented and integrated into a bigger picture that also portrays other social forces, such as the influence of Churches and the modern sector.

The scope of our study has been further delimited by directing the attention to traditional practices that in our view have a positive potential to help people overcome their traumatic experiences of war. We have not explored traditional procedures that might be harmful or counterproductive.

While we assert that the systematic outline of traditional concepts and procedures presented in CHAPTER 11 rests on a wealth of well-documented data that have been carefully analyzed, many of the interpretations in CHAPTER 13 remain tentative. Moreover, the applied sampling procedure does not provide a base for generalizing the results of the ethnography to a defined population. (Instead, the ethnographic data might help attaining a better understanding of traditional worldviews and procedures that still permeate Acholi society to a considerable extent.) This limitation (and strength) is typical of qualitative ethnographic approaches, which tend to trade defined generalizability for detailed descriptions and contextual understanding (Bryman, 2004; Patton, 2002). Yet it does not categorically exclude generalizing from our descriptions. However, generalizations will be based on the proximal similarity model for external validity (Trochim & Donelly, 2007) and thus remain hypothetical.

16 Conclusions

In the INTRODUCTION, we have sketched the controversial debate on the use of the PTSD concept across cultures in general and in complex emergencies more specifically. From the analysis of data collected in Acholiland we expected hints on the applicability of the PTSD diagnosis and related interventions in the Acholi cultural context, including its potential limitations.

Overall, we interpret our data as evidence pointing to the relevance and applicability of Western approaches to trauma healing in Acholiland. This applies to the concept of PTSD as well as to respective therapeutic procedures, such as exposure therapy. Two major arguments bolster this judgment: First, our ethnographic data reveal substantial overlaps between Acholi traditional and Western clinical approaches to healing. Second, the complexity of Acholi society in our view calls for a range of services to respond to the various needs of different people.

On diagnostics, we conclude that although the concept of PTSD might be biased towards the experience of populations from Western industrialized countries, it is a good starting point for investigating posttraumatic stress reactions among the Acholi. However, two points should be considered. (a) The high threshold of diagnostic criteria on avoidance symptoms in the DSM-IV might not match the culturally shaped patterns of posttraumatic stress reactions among the Acholi. (b) Local idioms of distress (especially dissociative immobilization reactions) should be considered when assessing posttraumatic stress reactions among the Acholi. With regard to potential local idioms of distress (e.g. *ajiji, wange umme*), our explorative investigations should be deepened by more focused studies examining their phenomenology and prevalence. When examining the validity of the PTSD concept in Acholi culture, quantitative validation studies should complement qualitative ethnographic research.

On Interventions, we conclude that it makes sense to investigate on and support existing local capacities for healing. Further research is warranted to examine the effectiveness and therapeutic principles of the *merok* ritual. In case our interpretation on effectiveness and therapeutic principles can be verified by research that is more focused and

rigorous, the ritual might inspire the investigation of patterns and methods of exposure which in Western trauma therapy have up to now received little attention (e.g. the possibility of applying continuous exposure over several days). Despite existing local approaches to healing, the application of so-called Western approaches to trauma therapy should not be categorically excluded. Whether they can be effectively applied in different cultures under specific circumstances should be investigated empirically.

When we argue that Western therapeutic interventions are in principal applicable in Acholi culture, we have to note the limiting influence of two major factors, which put our conclusion into perspective: (a) the lack of resources and (b) the intricacies of complex emergencies.

The lack of financial resources and trained personnel generally poses serious obstacles to building up 'modern' systems for mental health care in most African countries (World Health Organization, 2001). As many low- and middle-income countries typically do not have even basic primary health care infrastructure and services (Janzen & Green, 2003), the inherent weaknesses of primary care systems must be addressed before mental health services can be integrated (Kleinman, 2003; World Health Organization & World Organization of Family Doctors, 2008). These limitations and strategic considerations make clear that traditional healing systems need to play significant roles in the present and future mental health care in Sub-Saharan Africa (Alumanah, 1998; Peltzer, 1998), which is no different for the Acholi region.

Further, when intervening during or after war, the priorities and dynamics of complex emergencies must be taken into account. In the first place, we have to consider the destructive impact of war and disasters on communities, including their social, cultural, and material resources (Norris, 2002; Summerfield, 1999; see INTRODUCTION). In order to help restore an environment that is conducive to recovery from the stressors of war, a focus on community-wide interventions, as proposed by psychosocial programs, might be appropriate (Bala, 1996; Klingman, 2002; McCallin, 1998). While clinical interventions are not indicated in the impact and immediate postimpact phase of complex emergencies, they might be of critical importance in the recovery and reconstruction phase, when persons who have been unable to recover from their traumatic experiences by other means are still in need of specialized treatment (Vernberg, 2002).

Although psychosocial and clinical interventions might have important complementary functions, there is still a lack of evidence on the effectiveness of both approaches in response to complex emergencies (Bolton & Betancourt, 2004; Duffield, Reid, Shoham & Walker, 2005). Dealing with limited resources, and in the absence of clear evidence, the field has resorted to defensive and polarizing discussions, pitting 'clinical' versus 'psychosocial'

positions. This has delayed agreements on reasonable standards and policies for social and psychological interventions in emergencies, with negative consequences for the populations in need of support (van Ommeren, Saxena & Saraceno, 2005). Though progress has been made in the past years (cf. World Health Organization, 2001; World Health Organization, 2003), we believe that more could have been achieved if discussions were geared towards finding consensus rather than defending positions.

From the results of our study and the above discussion, we deduce some general recommendations that might be relevant beyond the limits of Acholiland: First, as to date empirical evidence on the effectiveness of both psychosocial and clinical approaches is still widely lacking, sufficient resources should be allocated to rigorous outcome research. Second, the evaluation and (selective) promotion of traditional ways of coping should be considered as part of an overall strategy to cover the mental health needs of the population in low- and middle-income countries. Third, when introducing new interventions and services, special care should be taken not to undermine existing local resources. A good documentation and knowledge of local resources, including traditional ways of coping, is obligatory to avoid detrimental side effects. Fourth, different approaches to mental health care and trauma healing should be regarded as complementary rather than mutually exclusive. The planning of mental health services should take all potential resources into account and aim at encouraging effective coordination and cooperation. Only if traditional healing, psychosocial, and clinical approaches are well coordinated, negative effects of competition can be reduced and effects of synergy be optimized. The ethnography and its interpretation presented in this thesis provide information that can be used for this purpose.

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Annexes

Contents

1 Criteria for judging quality in qualitative research

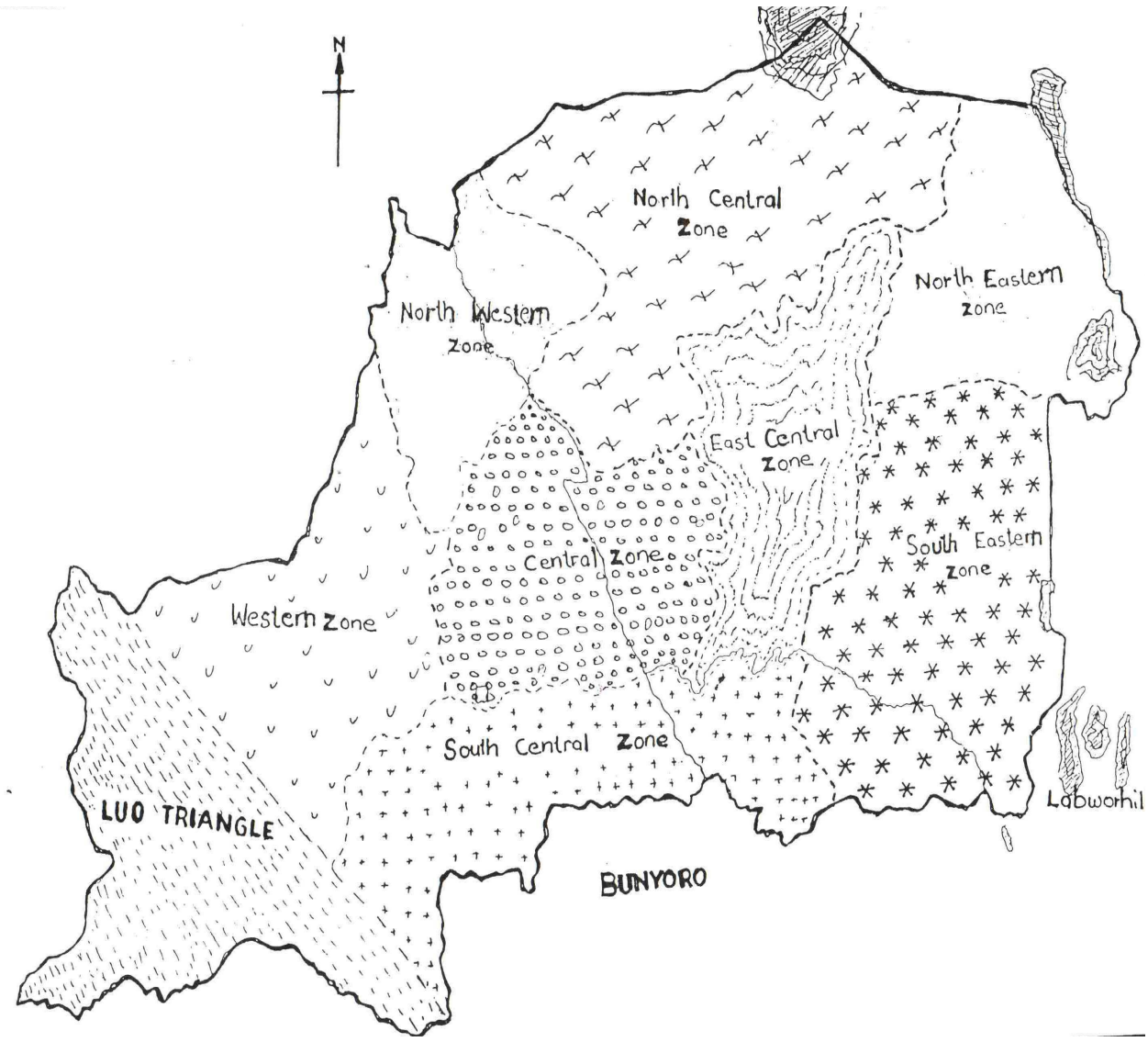
Finding consensus on criteria for judging quality in qualitative research has been difficult, as varieties of qualitative inquiry and divergent views do exist (Elliott, Fischer & Rennie, 1999; Fischer, 2006a; Patton, 2002; Seale, 2004). Moreover, defined criteria need take the local context of the particular research into consideration. Seale, Gobo, Gubrium & Silverman (2004a) have outlined criteria that in our opinion adequately fit the nature and context of our study. In our study, we have thriven to realize the features that 'good qualitative research' according to Seale et al. (2004a, p.8-9) is likely to show:

1. Its aim and purpose should be explained and set in the context (e.g. historical, political, disciplinary) in which these arose.
2. The rationale for the design of the inquiry should be explained.
3. The researcher should demonstrate openness to emergent issues.
4. The researcher should seek to be transparent and reflexive about conduct, theoretical perspective and values.
5. The study should provide understanding of context.
6. The study should re-present data or evidence faithfully.
7. A qualitative research study is likely to convey depth, diversity, subtlety and complexity.
8. Data or evidence should be actively and critically interrogated.
9. Claims should be supported by evidence for those claims.
10. Some (but not all) studies may be judged according to their utility or relevance for particular groups of people and particular power relations.
11. Some (but not all) studies may be judged according to whether they provide understanding of subjective meanings
12. The study should provide new insights.

2 Acholi cultural zones according to Atkinson

Table A: Zones in Acholiland with respective chiefdoms and numbers of lineages (clans).

Zone	Chiefdoms	No. of chief-doms	No. of lineages by 1900	Estimated population by 19000	Percentage of total population
Southeastern Zone	Paimol, Pukor, Umia Ayima, Umia Pacua, Pela, Wol, Parumo, Parabongo, Pacer, Pader, Pabal, Kwong, Pacabol, Koro, Ariya, Patongo, Ajali, Lira Paluo, Paicam, Adilang, Puranga and Kilak	22	113-138	32.150	25,7
Central Zone	Alero, Palaro, Payira, Paibona, Paico and Patiko	6	75 - 85	25.500	20,4
North - Central Zone	Padibe, Longorone, Popoka, Agoro, Lamogi, Palabek, Paluga, Lomura, Madi Opei and Madi Kiloc	10	56 - 62	24.800	19,8
East-central Zone	Lukwor, Koyo, Pugwenyi, Parwec, Lamogi, Pajule Paluo, Painata, Oryand, Ngekidi, Pageen, Lameet, Pajimo and Lukwor	13	55	16.800	13,4
Western Zone	Pabo, Paumu, Pagak, Lamogi, Papee and Pawel	6	30 - 36	14.000	11,2
South-Central Zone	Koc. Pokumu, Bolo and Bwobo	4	12	5.500	4,4
North - Eastern Zone	Namukora, Orom and Akara	3	11 - 19	3.400	2,7
North-Western Zone	Atyak	1	12	3.000	2,4
Total		**65**	**364 - 419**	**125.150**	100,0



Map 1: Geographical extension of Acholi cultural zones (drawing by Francis Opira).

3 Description of samples

Table B: List of cultural experts interviewed individually

Function	Gender	Age in years	Zone	Reflected in thesis as case study	Reflected in COMPANION VOLUME
Chief	m	65	East –central	No	Transcript 17
Chief	m	65	North-Central	No	Transcripts (17,) 28, (31)
Elder	m	54	Central	No	Transcript 1
Elder	f	58	Western	No	Transcript 2
Elder	m	68	Western	No	Transcript 15
Elder	f	53	Western	No	Transcript 38
Elder	m	50	East –central	No	Transcript 28
Elder	m	61	East –central	No	Transcript 28
Elder	m	70	East –central	No	Transcript 31
Elder	m	49	East –central	No	Transcript 31
Secretary of the paramount chief	m	55	Central	No	Transcript CR 1
Representative of the chief	m	59	East –central	No	Transcript 17
Atekere	m	65	North - Central	Case study no.3	Transcript 14
Atekere	m	58	Central	Case study no.2	Transcript 23
Atekere	m	73	Central	No	Transcript 35
Rwot Kweri	m	57	Central	Case study no.1	Transcript 34
Ritual performer	m	68	North - central	No	Transcript 21
Ritual performer	m	56	South -Eastern	Case study no.10	Transcript 12
Ritual performer	m	61	East –central	No	Transcript 17
Ritual performer	m	68	North – central	Case study no.9	Transcripts 18, 30, 41
Ritual performer	m	68	North – Central	Case study no.11	Transcript 32, 41
Ajwaka	f	52	South -Eastern	No	Transcript 4
Ajwaka	f	52	South -Eastern	Case study no.6	Transcript 4
Ajwaka	f	50	South -Eastern	No	Transcript 5
Ajwaka	f	50	South -Eastern	No	Transcript 6
Ajwaka	f	34	North – central	Case study no.7	Transcripts 25, 41
Ajwaka	f	28	East –central	No	Transcript 37
Ajwaka	f	34	North – central	No	Transcript 39
Herbalist	f	70	South -Central	No	Transcript 3

Note: Above list includes interviews which explored general concepts as well as interviews carried out in the context of case studies.

Table C: List of cultural experts interviewed in focus groups

Function	Gender	Age in years	Zone	Transcript no.
10 chiefs and 9 elders	1 woman, 18 men	45 - 80	Central, Western, Southesatern	7
17 elders	1 woman, 16 men	53 - 81	East -central	10
1 chief and 2 elders	3 men	69 - 83	East -central	11
1 chief and 9 elders	3 women, 7 men	54 - 85	Central	16
21 elders	3 women, 18 men	50 - 80	Central	24
1 chief and 9 elders	5 women, 5 men	51 - 88	South - eastern	26
10 elders	5 women, 5 men	45 - 79	East -central	27
1 chief, 18 elders	19 men	50 - 80	North - central	40
12 elders	12 men	50 - 75	Central	CR2
12 elders	Male	50 - 80	North - central	CR3
2 chiefs, 11 elders	Male	50 - 80	North - central	CR4

Table D: Interviews with community members for case studies

Function	Gender	Age in years	Zone	Reflected in thesis as case study	Reflected in COMPANION VOLUME
Person subject to traditional ritual	m	16	South -Eastern	Case study no.10	Transcript 8
Person subject to traditional ritual	m	36	North - central	Case study no.5	Transcript 13
Person subject to traditional ritual	m	35	East -central	No	Transcript 17
Person subject to traditional ritual	m	30	North - Central	Case study no.9	Transcript 18
Person subject to traditional ritual	m	17	North - central	Case study no.8	Transcript 19a
Person subject to traditional ritual	m	17	North - central	Case study no.8	Transcript 19b
Person subject to traditional ritual	f	20	North - central	Case study no.4	Transcript 20
Person subject to traditional ritual	m	32	Western	No	Transcript 22
Person subject to traditional ritual	f	37	South -Eastern	No	Transcript 29
Person subject to traditional ritual	m	30	North - central	Case study no.9	Transcript 30
Person subject to traditional ritual	m	19	Central	No	Transcript 35
Person subject to traditional ritual	f	17	Western	No	Transcript 35
Member of close family	f	32	Central	Case study no.5	Transcript 13
Member of close family	m	65	East -central	No	Transcript 17
Member of close family	m	68	East -central	No	Transcript 17
Member of close family	f	37	North - central	Case study no.8	Transcript 19a
Member of close family	f	37	North - central	Case study no.8	Transcript 19b
Member of close family	f	52	North - central	Case study no.4	Transcript 20
Member of close family	m	50	Western	No	Transcript 22
Member of close family	f	45	North - central	Case study no.7	Transcript 25
Member of close family	m	40	South -Eastern	No	Transcript 29
Member of close family	f	54	North - central	Case study no.9	Transcript 30
Member of close family	m	87	North - central	Case study no.9	Transcript 30

Function	Gender	Age in years	Zone	Reflected in thesis as case study	Reflected in COMPANION VOLUME
Member of close family	f	44	Central	Case study no.1	Transcript 34
Member of close family	m	55	East -central	No	Transcript 37
Elder	m	58	Central	Case study no.2	Transcript 23
Elder	m	62	Central	Case study no.1	Transcript 34
Elder	m	65	Central	No	Transcript 35
Elder	f	64	Central	No	Transcript 36
Elder	m	62	Western	No	Transcript 36
Social worker	f	26	South -Eastern	Case study no.10	Transcript 9
Social worker	f	24	North - central	Case study no.9	Transcript 18
Social worker	f	24	North - central	Case study no.8	Transcript 19a
Social worker	f	24	North - central	Case study no.8	Transcripts 19b, 41
Social worker	f	24	North - central	Case study no.4	Transcript 20
Social worker	m	44	South –Central	No	Transcript 29
Other community member	m	35	North - central	Case study no.7	Transcript 25
Other community member	f	36	South -Eastern	No	Transcript 29
Other community member	m	65	North - central	Case study no.11	Transcript 32
Other community member	f	53	Central	No	Transcript 35

Table E: Participant observations of rituals

Witnessed ritual	Place of ritual	Zone	Reflected in thesis as case study	Reflected in COMPANION VOLUME
Tumu kir – cleansing for a taboo committed	Alokolum	Central	Case study no.1	Transcript 34
Tumu kir – cleansing for a taboo committed	Alokolum	Central	No	Transcript 36
Mato Oput – reconciliation after a killing	Pajule	East -central	No	Transcript 17
Mato Oput – reconciliation after a killing	Pabo	Western	No	Transcript 22
Moyo piny - cleansing a specific area	Palabek Gem	North - Central	Case study no.3	Transcript 14
Moyo piny - cleansing a specific area	Kanyagoga	Central	No	Transcript 33
Moyo kom – a general cleansing ritual	Pece Division	Central	Case study no.2	Transcript 23
Moyo kom – a general cleansing ritual	Mican	Western	No	Transcript 35
Kwero Merok – cleansing someone who has killed in war	Palabek Gem	North - Central	Case study no.9	Transcript 18
Divination by an ajwaka	Palabek Kal	North - central	No	Transcript 39

Table F: Overview of individual interviews according to gender and role in the community

Community role of informant	Men	Women	Total
Individual expert interviews			
Chief	2	0	**2**
'Common' elder	8	2	**10**
Atekere	3	0	**3**
Rwot Kweri	1	0	**1**
Ritual performer	5	0	**5**
Ajwaka	0	7	**7**
Herbalist	0	1	**1**
Total number expert interviews	**19**	**10**	**29**
Percentage expert interviews	**65,5**	**34,5**	**100**
Community interviews			
Person subject to healing	9	3	**12**
Member of close family	6	7	**13**
Elder	4	1	**5**
Social worker	1	5	**6**
Other community member	2	2	**4**
Total number community interviews	**22**	**18**	**40**
Percentage community interviews	**55**	**45**	**100**

Table G: Overview of interviews and participant observations according to zones

	Zones								
	Zone 1 South-Eastern Zone	**Zone 2** Central Zone	**Zone 3** North - Central Zone	**Zone 4** East-central Zone	**Zone 5** Western Zone	**Zone 6** South-Central Zone	**Zone 7** North - Eastern Zone	**Zone 8** North-Western Zone	**Totals**
Estimated population by 1900	32.150	25.500	24.800	16.800	14.000	5.500	3.400	3.000	125.150
Estimated percentage of population by 1900	25,7	20,4	19,8	13,4	11,2	4,4	2,7	2,4	100,0
Individual expert interviews									
No. of interviews	**5**	**5**	**7**	**8**	**3**	**1**	**0**	**0**	**29**
Percentage of the sample	16,7	16,7	23,3	26,7	10,0	3,3	0,0	0,0	100,0
Group expert interviews									
No. of interviews	**1**	**3**	**3**	**3**	**1**	**0**	**0**	**0**	**11**
Percentage of the sample	9,1	27,3	27,3	27,3	9,1	0,0	0,0	0,0	100
Community interviews									
No. of interviews	**5**	**8**	**18**	**4**	**4**	**1**	**0**	**0**	**40**
Percentage of the sample	17,9	28,6	64,3	14,3	14,3	3,6	0,0	0,0	100,0
Participant observations									
No. of observations	**0**	**4**	**3**	**1**	**2**	**0**	**0**	**0**	**10**
Percentage of the sample	0,0	45,5	27,3	9,1	18,2	0,0	0,0	0,0	100,0

4 Guiding questions for first round of interviews

Exploring Symptoms

Explore short-term and long-term responses to traumatic events using the following questions:

Ka dano oneno jami malik tutwal ma bene romo buro kwogi I dwar, gitimo ngo onyo giwinyo ningning?
When people go through horrible experiences that were threatening to their life during hunting: what do they do and how do they feel?

Ka dano oneno jami malik tutwal i dog lweny gitimo ngo onyo giwinyo ningning?
When people go through horrible experiences that were threatening to their life during war / fighting: what do they do and how do they feel?

Ka dano gutimo jami malik tutwal calo neko dano, neko lee mager onyo tic aranyi mukene, gitimo onyo giwinyo ningning?
When people commit / have committed atrocities like killing people, killing a wild animal, what do they do and how do they feel?

Ka gibuyu onyo gimako dano tek tek me bedo kwede, gitimo ngo onyo giwinyo ningning?
If people have been raped: what do they do and how do they feel?

Ka peko madit opoto ikom lwak (calo Ebola, kec abango wang dako) gitimo onyo giwinyo ningning?
When a disaster has befallen people (like Ebola or famine): what do they do and how do they feel?

Exploring Explanations / Attributions

Explore explanations of short-term and long-term responses using the following question:

Ikom gin (lanyut) ma ititowa calo …. Acholi giniang dok gigonyo tyene ningo?
The things that you have told us like [mention what key informant has already said]: How do Acholi people understand them?

Exploring coping

Explore coping / treatment for short-term and long-term responses using the following question:
Ka ngat mo owoto / otimo … dok kombeti tye ki … giromo konyo dano kit man ningning?
How can a person who has gone through / done [mention what key informant has already said] and suffers from [mention what key informant has already said] be helped?

Special question to understand possible support for returnees:

Ngo ma giromo timone me konyo lutinowa ma gidwogo ki i lum?
What can be done to help the children / people who come back from LRA captivity?

Questions that were added after the first interview:

Ajiji obedo gin ango?
What is ‘ajiji’?

Ngo ma kelo ajiji?
What are possible causes for ‘ajiji’?

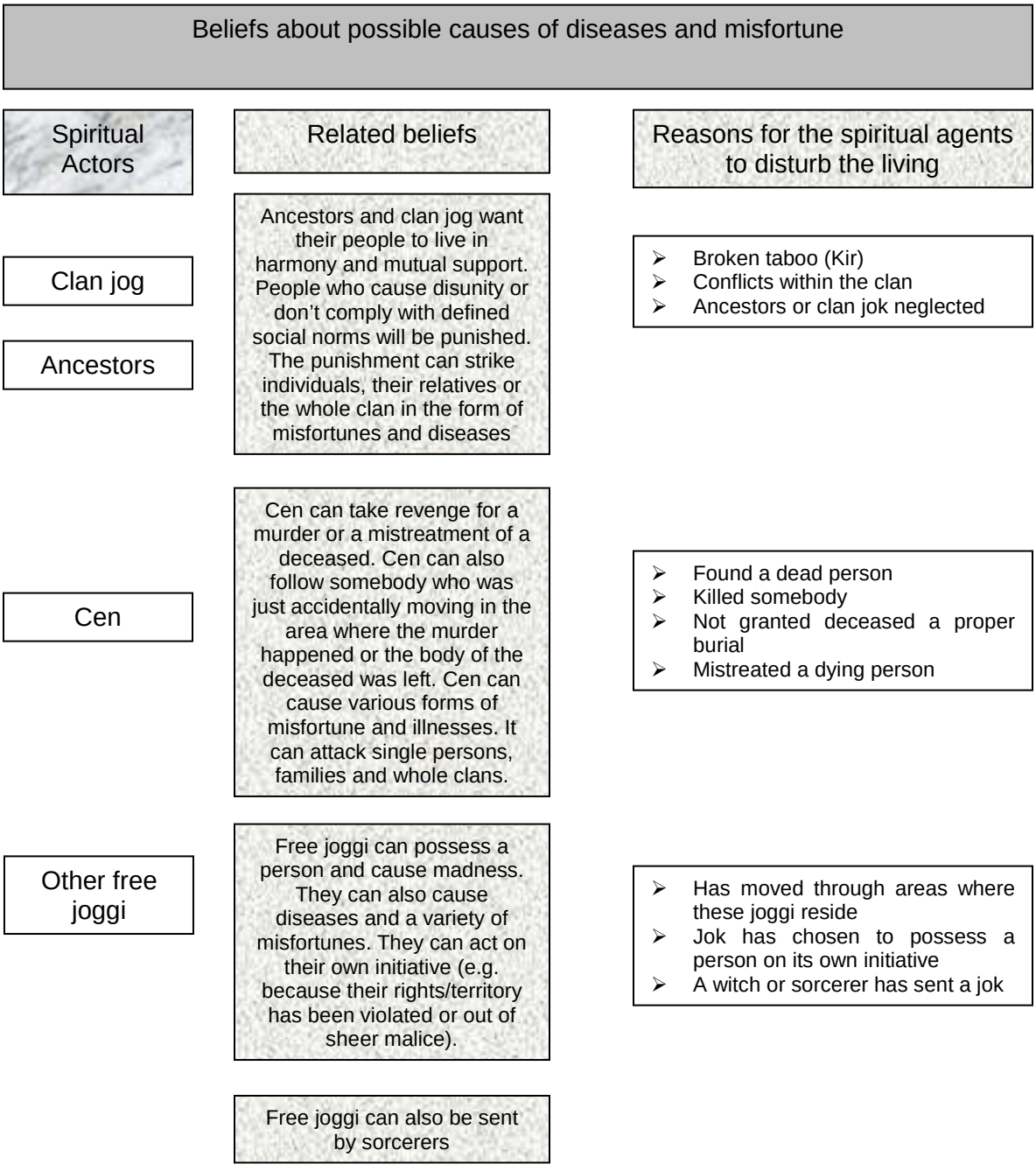
5 Overview of sources of ritual descriptions

Table H: Sources of ritual descriptions provided in CHAPTER 11

Described Ritual	External sources	Our data
Nyono tonggweno	Baines (2005, pp. 26-27) Beherend (1999, p. 42) Okumu (2005)	Transcript 6, p.8 (Individual interview) Transcript 7, p.4 ff (Focus group) Transcript 10, p. 10ff (Focus group) Transcript 11, p. 7ff (Focus group) Transcript 16, p. 16 (Focus group) Transcript 27, p.12 (Focus group)
Lwoko pik wang	Baines (2005, p. 28)	Transcript 15, p. 3-4 (Individual interview) Transcript 7, p.5 (Focus group) Transcript 11, p. 8 (Focus group) Transcript 26, p. 4ff (Focus group) Transcript 40, p. 5-6 (Focus group)
Moyo tipu	None	Transcript 5, p. 10 (Individual interview) Transcript 6, p. 3 (Individual interview) Transcript 16, p. 9 ff (Focus group) Transcript 26, p. 11 ff (Focus group)
Tumu kir	Atkinson (1999, p. 150) Baines (2005, p. 27; pp. 111-112)	Transcript CR 2, p. 4 ff (Focus group) Transcript CR 4, p. 3 (Focus group) Transcript CR 3, p. 2 (Focus group) Transcript 7, p. 6 (Focus group) Transcript 10, p.11 (Focus group) Transcript 24, p.7 (Focus group) Transcript 34 (case study no. 1, with participant observation) Transcript 36 (case study COMPANION VOLUME, with participant observation)
Mato Oput	Baines (2005, p.30; pp. 57-61) Girling (1960, pp. 66-67) Okumu (2005) CP1 – Unpublished paper written by community member (Marcellino Opio)	Transcript 1, p.3 ff (Individual interview) Transcript 2, p. 2 (Individual interview)ff Transcript 3, p. 2 ff (Individual interview) Transcript CR 1, p. 5 (Individual interview) Transcript 10, p. 6ff (Focus group) Transcript 11, p. 4ff (Focus group) Transcript CR 2, p. 7ff (Focus group) Transcript CR 4, p. 2 (Focus group) Transcript 17 (case study, COMPANION VOLUME, with participant observation) Transcript 22 (case study, COMPANION VOLUME, with participant observation) Transcript 28 (case study, COMPANION VOLUME, without participant observation)
Gomo tong	Baines (2005, p. 29-30) Finnström (2003) Pain (1997)	Transcript 38, p. 3-4 (Individual interview) Transcript 40, p. 3-5 (Focus group) Transcript CR 2, p. 7-8 (Focus group)
Moyo piny	Baines (2005, p. 28; p.107)	Transcript 10, p.11 (Focus group) Transcript 24, p. 6ff (Focus group) Transcript 26, p.9ff (Focus group) Transcript 27, p. 3ff (Focus group) Transcript 14 (case study no. 3, with participant observation) Transcript 33 (case study, COMPANION VOLUME, with participant observation)

Described Ritual	External sources	Our data
Ryemo gemo	Baines (2005, p. 27)	Transcript 1, p.5 (Individual interview)
Moyo Kom (and yubo kom)	Baines (2005, p. 28)	Transcript 7 (Focus group) Transcript 26, p. 4 and p. 8 (Focus group) Transcript 27, p.12 ff; p. 4ff (Focus group) Transcript 40, p. 6 (Focus group) Transcript 23 (case study no. 2, with participant observation) Transcript 35 (case study, COMPANION VOLUME, with participant observation) Transcript 20 (case study no. 4; yubo kom, without participant observation) Transcript 29 (case study, COMPANION VOLUME, without participant observation)
Kwero Merok	Baines (2005, p. 30) Behrend (1999a, p. 42) Girling (1960, pp.103-104) Wright (1936, p. 186)	Transcript 1, p. 5 (Individual interview) Transcript 2, p.4ff (Individual interview) Transcript 3, p. 3ff (Individual interview) Transcript 5, p. 7ff (Individual interview) Transcript 6, p. 2 (Individual interview) Transcript 15, p. 1 ff (Individual interview) Transcript 21 (Individual interview) Transcript 10, p. 4 ff (Focus group) Transcript 11, p. 3 ff (Focus group) Transcript 16, p. 11 ff (Focus group) Transcript 18 and 30 (case study no. 9, with participant observation) Transcript 8, 9 and 12 (case study no. 10, without participant observation) Transcript 19a and 19b (case study no. 8, without participant observation) Transcript 32 (case study no. 11, without participant observation)
Ryemo jok	Okot p'Bitek (1971, pp. 106-111) Baines (2005, p.28)	Transcript 4 (Individual interview) Transcript 5 (Individual interview) Transcript 25 (Case study no.7, without participant observation)

6 Beliefs about possible causes of diseases and misfortune



7 Universal and culture-specific attributions and reactions to traumatic stress

7.1 Communalities between PTSD and local manifestations of distress

Communalities between Ajiji and PTSD

A1: Threat

Transcript 2, p. 7
It is an intense fear that makes you being paralyzed especially *on seeing a wild animal or a person being killed.*

Transcript 3, p. 16
If people go for hunting and they see a wild animal, or a man is *being threatened/attacked,* he would tremble and the knees get paralyzed.

Transcript 3, p. 17
When someone has been *threatened* with a gun or a spear or things that put his *life in danger,* his spirit leaves him, his body startles again and again, and later it can bring nightmares.

Transcript 4, p. 20
"Ajiji" are bad events that a person has gone through in his/her life, things (events) that do not rhyme with normal life. These events could be *murder, seeing someone being killed, finding a dead body, seeing bad things done on someone.*

Transcript 7, p. 46
Ajiji is something in the human being that comes as a result of a bad event that had happened to someone. Ajiji is the shaking of the body that is brought about by fear of bad things that a person has passed through. *A wild animal like a lion or a beast* can also cause this ajiji. Ajiji is also something that frightens [poyo kom] people, brings *intense fear.*

Transcript 7, p. 47
… remembering *bad events* that the person has passed through. Ajiji thus comes due to what is happening in the present or if you are reminded of what had happened to you in the past.

Transcript 7, p. 47
Things that can cause ajiji are *bad things* that have happened to someone like: seeing a *brutal killing, killing somebody while being frightened of doing it, children who are sexually abused by adults,* moving in a thick and heavy forest where people are not supposed to go …

Transcript 10, p. 64

Ajiji is intense fear that brings trembling of the body and makes someone to become paralyzed (caught by ogiju). Ajiji attacks people like during wartime or *after seeing a threatening thing,* or *if an enemy comes by surprise.* If someone came back from war, he can be attacked by ajiji for he would *have seen bad things like killing or he might have killed.* Ajiji can also attack someone *if a wild animal had threatened him.*

Transcript 11, p. 74
Ajiji is *a bad thing* that had happened that brings fear for there is no peace at heart. Ajiji is also something that happens suddenly that can bring fear on the person (surprise attack). Ajiji can also come *when you see people being killed* or someone died at your present.

Transcript 26, p. 188
Ajiji in Lira Palwo is understood to mean "leaping of the heart" especially when one met any bad thing or saw *something that he perceived to threaten his life.*
...
Transcript 26, p. 188
For the children who had been abducted by the LRA, they had *witnessed many atrocities and others had been forced to kill.* These could have brought ajiji on these children which could haunt them for the rest of their lives unless they are helped.

Transcript 26, p. 189
Ajiji is caused when a person had seen something bad like *serious injuries or killings or when the bad thing happened suddenly.* Sometimes, the person might have moved in a spot where bad things are dwelling. These *bad things could be wild animal, big snakes or rebels* would be there. This could make the person startles and the spirit to go away. This could be at the place where people have been killed or bad things would soon befall you. This would cause fear to attack and you could feel the *threat to your life.*

Transcript 26, p. 189
What cause ajiji or madness on the children coming back from captivity is *brutal killings that they were forced to kill or to see.* Most of the things that our children passed through are bad that could bring ajiji on them.

Transcript 27, p. 204
One thing that can cause ajiji is when someone in the family has died, or when someone found a dead person along his way. Others could happen when somebody pointed a gun on you as if he wanted to shoot you or a spear is raised towards you as if he wanted to spear you. Other causes could be when all of a sudden some one heard a death announcement. *Seeing dangerous things* like big snakes and wild animals can cause ajiji. *Seeing something that threatens to kill the person* can also cause ajiji. On the other hand, if one sees a corpse, it could cause fear but ajiji would not be very strong.

A2: Intense fear

Transcript 2, p. 7
Lakaba kaba (=Ajiji) is an *intense fear* that shows itself with body trembling, and sometimes brings bad dreams …

Transcript 3, p. 16

This trembling does not require any treatment because the Acholi perceive it as being only a *very strong fear*.

Transcript 3, p. 16
But trembling in most cases vanishes by itself and does not need any treatment because it is said to be *intense fear*.

Transcript 7, p. 46
Ajiji is the shaking of the body that is *brought about by fear* of bad things that a person has passed through. A wild animal like a lion or a beast can also cause this ajiji. Ajiji is also something that frightens [poyo kom] people, *brings intense fear.* In short, ajiji can be *understood as fear.*

Transcript 10, p. 64
Ajiji is *intense fear* that brings trembling of the body and makes someone to become paralyzed.

Transcript 10, p. 64
Ajiji brings *intense fear,* trembling of the body and weakness at body joints.
...
Transcript 10, p. 64
As ajiji is *intense fear,* there is nothing that can be done on it, only that if your temper cools down then it will go away by it self.

Transcript 27, p. 204
Later when the spirit returns, the person would run with *a lot of fear in his heart.*

B1: Recurrent distressing recollections

Transcript 4, p. 20
Ajiji brings bad thoughts and bad life styles that are different from what a normal person does. It brings *thoughts on things that one has seen* or passed through.

Transcript 26, p. 188
Ajiji could bring strong and frequent headache. The person attacked by ajiji would loose strength and *would be very afraid of what he has passed through.* Ajiji could bring *many thoughts* that could come in nightmares

B2: Recurrent distressing dreams of the event

Transcript 2, p. 7
Lakaba kaba (=Ajiji) is an intense fear that shows itself with body trembling, and *sometimes brings bad dreams* …

Transcript 3, p. 16
On his return home, *it can bring nightmares for he would be seeing the animal that had threatened him.*

Transcript 4, p. 20

Ajiji brings nightmares, makes someone to do things that are different from what other people are doing …

Transcript 5, p. 27
Ajiji can be noticed, because the concerned person … *has dreams in which the person dreams/sees that someone is coming to fight him/her or dreams* of people who are dressed in an upsetting way coming to him/her …

Transcript 7, p. 48
Ajiji does not bring dreams, but *can come during dreams, as the person would be dreaming on what had happened to him.*

Transcript 10, p. 64
It can also come in nightmares.

Transcript 11, p. 74
Ajiji can also come during sleep and brings nightmares as a result of things you underwent.

Transcript 26, p. 188
Ajiji could bring many thoughts that could come in nightmares where the person could shout or get up from the bed.

B3: Acting and feeling as if the traumatic event were recurring

Transcript 3, p. 16
On his return home, it can bring nightmares for *he would be seeing the animal that had threatened him. He could even shout and tremble.*

Transcript 5, p. 27
Ajiji can be noticed, because the concerned person … *at times runs as if the person he/she is seeing would want to catch him/her.*

B4: Intense psychological distress at exposure to cues that resemble an aspect of the traumatic event

Transcript 11, p. 74
The person starts fearing people or places and this makes the person to live as though he does not have a spirit.

Transcript 26, p. 188
The person attacked by ajiji would loose strength and *would be very afraid of what he has passed through.*

B5: Physiological reactivity on exposure to cues that resemble an aspect of the traumatic event

Transcript 5, p. 27
Ajiji can be noticed, because the concerned person … *has strong and fast heart beat (poto cwiny) and body shaking (myel kom*), startling and abrupt getting up (putte /

mwomme), and at times runs as if the person he/she is seeing would want to catch him/her.

Transcript 11, p. 74
Ajiji also brings heart leaps and fast heart beat for the bad thing one had seen, reduction of the strength on seeing this bad thing, brings “shock” that can also kill the person, and can also bring madness.

C1: Efforts to avoid thoughts, feelings and conversations associated with the trauma

No Coding in this category

C2: Efforts to avoid activities, places or people that arouse recollections of the trauma

Transcript 26, p. 189
Courage also disappears from the person.

C3: Inability to recall an important aspect of the trauma

No Coding in this category

C4: Markedly diminished interest or participation in significant activities

No Coding in this category

C5: Feeling of detachment or estrangement from others

No Coding in this category

C6: Restricted range of affect (e.g., unable to have loving feelings)

No Coding in this category

C7: Sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

No Coding in this category

D1: Difficulty in falling or staying asleep

No Coding in this category

D2: Irritability or outbursts of anger

Transcript 5, p. 27
Ajiji can be noticed, because the concerned *person is aggressive,* …

D3: Difficulty concentrating

No Coding in this category

D4: Hypervigilance

Transcript 4, p. 20
Ajiji brings nightmares, makes someone to do things that are different from what other people are doing, like … *looking around in fear every now and then* ...

Transcript 5, p. 27

Ajiji can be noticed, because the concerned person … *likes monitoring the surrounding for any possible threat again and again* ...

D5: Exaggerated startle response

Transcript 7, p. 47
Ajiji has many signs: … *body startling …*Ajiji that cause mental problems is when *the body startles* and evil spirits would have besieged you.

Transcript 27, p. 204
Ajiji causes shaking of the body (myel kom), which leads to weakening of the body, *body startle [kome poo]* and his spirit disappears / runs away.

PTSD symptoms in case studies

B1: Recurrent distressing recollections of the traumatic event

Transcript 8, p. 56
Kinyera was also visioning all the atrocities they committed like looting, beating people and others, which kept coming during nightmares and even during day dreams.

Transcript 8, p.56
The images that he was seeing could come any time, be it day or nighttime. As a result of this, his life had become very difficult and he couldn't do anything about it.

Transcript 18, p. 124
Oling said that when he was sleeping, he could see the man (who had been given to him to kill) come to plead that he should not kill him. *Even during day time Oling could see the man coming.* That made him very sad and he could begin to shed tears.

Transcript 19a, p.137
When a teacher gave exercises to write, he would write in an abusive language insulting the teacher. *Sometimes he would write about what had happened in the bush [in captivity] but without knowing what he was doing.*

Transcript 19a, p. 138
After his return from captivity *various atrocities that he went through were coming back in his mind.* If this thing came over him, he could say many things that he did not even know. But people would tell him what he had been saying.

Transcript 19b, p. 142
Sometimes these visions came during day time and sometimes he felt like these things were happening again.

B2: Recurrent distressing dreams of the event

Transcript 8, p. 56
What he had done while still in captivity kept haunting him and was bringing nightmares. In the nightmares, he saw the woman who he was forced to kill, coming to plead to him,

as she was pleading at the time of the murder. Kinyera was also visioning all the *atrocities they committed* like looting, beating people and others, which *kept coming during nightmares* and even during day dreams.

Transcript 9, p. 61
He first narrated what had happened when he was still in captivity, and then later he told the counselor that *he was suffering from nightmares,* flashbacks and fast heartbeat.

Transcript 18, p.124
Oling said that when he was sleeping, he could see the man (who had been given to him to kill) come to plead that he should not kill him.

Transcript 19b, p. 142
Nightmares in which he dreamt of fighting and bad deeds that he passed through were also disturbing him.

Transcript 30, p. 222
Oling said, what was so painful in his life when he felt sick was: the boys with whom he was putting up had all left him because of the *nightmares which were disturbing him* at night, there was no sharing of food with him, many times he was insulted, other boys also abandoned him, talking badly about him.

B3: Acting and feeling as if the traumatic event were recurring

Transcript 9, p. 61
He first narrated what had happened when he was still in captivity, and then later he told the counselor that he was suffering from nightmares, *flashbacks* and fast heartbeat.

Transcript 18, p. 124
The eyes could turn red as if he had eye problems yet he didn't feel any pain. *Also the urge of fighting and killing kept coming into his heart all the time, more so even when he was drunk.*

Transcript 19a, p. 138
His mother narrated that after having returned from the bush, Owot did not want to see [was very much afraid of] government soldiers. *One day, when the soldiers were going for their patrol and passed through the home of Owot, he jumped on a soldier and took his gun. Then he began to fire in the air. Afterwards he left the gun behind and ran away to the bush.*

Transcript 19a, p. 138
Another day when Owot was at home, he saw soldiers and started running towards the bush while shouting "catch him alive, don't shoot".

Transcript 19a, p. 138
After his return from captivity various atrocities that he went through were coming back in his mind. *If this thing came over him, he could say many things that he did not even know. But people would tell him what he had been saying.* Some of the things that he was told to have said was that he wanted to go back to the bush. *He was also told to have been imitating firing bullets [pretending to fire bullets with an invisible machine gun] and making many utterances about killing.*

Transcript 19a, p. 138
When this thing [the memories that in the local culture are related to spirit attacks] began to disturb him, sometimes he would stiffen his muscles so that the thing could not over power his strength, but sometimes it did not go away until it had made him fall.

Transcript 19b, p. 142
Sometimes these visions came during day time and sometimes he felt like these things were happening again.

Transcript 19b, p. 143
Whatever he was doing he did not know that he was doing them but people were telling him that he had been shouting and abusing. When all these things were happening *he would be unaware and he would have no strength.*

B4: Intense psychological distress at exposure to cues that resemble an aspect of the traumatic event

Transcript 18, p. 124
Oling said that when he was sleeping, he could see the man (who had given to him to kill) come to plead that he should not kill him. *Even during day time Oling could see the man coming. That made him very sad and he could begin to shed tears.*

B5: Physiological reactivity on exposure to cues that resemble an aspect of the traumatic event

Transcript 9, p. 61
He first narrated what had happened when he was still in captivity, and then later he told the counselor that he was suffering from nightmares, flashbacks and *fast heartbeat.* He also said that he had been exposed to many atrocities: moving over dead bodies, being exposed to killings and even participating in killings.

Transcript 18, p. 124
All the time he was afraid that he could be reabducted and this made him look at all sides in a fearful manner time and again and also *his heart kept leaping all the time.*

C1: Thoughts, feeling, conversations

No Coding in this category

C2: Activities, places, people

Transcript 19a, p. 138
His mother narrated that *after having returned from the bush, Owot did not want to see [was very much afraid of] government soldiers.*

Transcript 19a, p. 139
He didn't want people whom he didn't know to come up to him. It took time for him to open up to the interviewer.

C3: Inability to recall an important aspect of the trauma

No Coding in this category

C4: Markedly diminished interest or participation in significant activities

Transcript 8, p. 56
Kinyera also said that *he could not do play therapy* to relax his mind for he could have hurt [was afraid to hurt] his fellow children. If someone made him annoyed, he would think of killing the person. This made him to *stay alone most of the time.* The images that he was seeing could come any time, be it day or nighttime.

C5: Feeling of detachment or estrangement from others

Transcript 9, p. 61
At the time of reception, *Kinyera was someone who stayed alone. Whatever he would do, he would do it alone.* He did not want noise, was easily provoked and felt like fighting anybody who annoyed him.

C6: Restricted affect

No Coding in this category

C7: Sense of foreshortened future

No Coding in this category

D1: Difficulty in falling or staying asleep

Transcript 30, p. 222
Oling said he is now feeling better because *the sickness which used to disturb him has ceased*. The nightmares have stopped and he has regained his strength. He is now able to work effectively, *he sleeps very well,* has the desire to marry, he has gained many friends; he does not quarrel, even if he is drunk.

D2: Irritability or outbursts of anger

Transcript 8, p. 56
Kinyera also said that he could not do play therapy to relax his mind for he could have hurt [was afraid to hurt] his fellow children. *If someone made him annoyed, he would think of killing the person.*

Transcript 9, p. 61
Whatever he would do, he would do it alone. *He* did not want noise, *was easily provoked and felt like fighting anybody who annoyed him.*

Transcript 18, p. 124
The eyes could turn red as if he had eye problems yet he didn't feel any pain. *Also the urge of fighting and killing kept coming into his heart all the time, more so even when he was drunk.*

Transcript 19b, p. 142
The urge of doing harm kept coming into his mind every now and then. This caused him having the heart of fighting with bad things [using bad tools] that always kept coming back. Whenever someone annoyed him he felt like using brutal weapons to fight, but most of the time people stopped him.

D3: Difficulty concentrating

Transcript 19a, p. 137
After he had started schooling in Kitgum public, the studies didn't go well because when he was at school something could come and fall on him that made him not to know what was going on.

D4: Hypervigilance

Transcript 18, p. 124
All the time he was afraid that he could be reabducted and this made him look at all sides in a fearful manner time and again and also his heart kept leaping all the time.

Transcript 19a, p. 138 - 139
When the interviewer (Francis Okot) was talking to Owot, he *[Owot] kept on looking around with uneasiness as if monitoring the surroundings. Especially when somebody passed by, he seemed to expect something bad to happen.* He didn't want people whom he didn't know to come up to him.

D5: Exaggerated startle response

No Coding in this category

7.2 Culturally specific attributions and reactions to traumatic stress

Culturally specific explanations of symptoms

The spirit leaves the person

Transcript 3, p. 17
When someone has been threatened with a gun or a spear or things that put his life in danger, *his spirit leaves him,* his body startles again and again, and later it can bring nightmares.

Transcript 11, p. 74
The person starts fearing people or a place and this *makes the person to live as though he does not have a spirit.*

Transcript 26, p. 188
For instance: *if someone met a ghost (resembling a human being), his spirit would disappear* and would have a severe attacked by Ajiji.

Transcript 26, p. 188 - 189
Fast heart beat and heart leap (“Poto cwiny”) is one way of knowing that ajiji is haunting somebody, as well as …. the *disappearance of the spirit of the person haunted by ajiji*.

Transcript 26, p. 189
This could make the person startles and *the spirit to go away. This could be at the place where people have been killed or bad things would soon befall you.*

Transcript 27, p. 204
Ajiji causes shaking of the body, which leads to weakening of the body, body startle [kome poo] and *his spirit disappears / runs away.* Sometimes *the person's spirit would have gone away* and the person could not run at the time when the incident had happened.

Another spirit takes possession of the person

Transcript 1, p. 2
The symptoms that can be seen with a person who has killed someone is that *the blood of the killed person catches the murderer* and makes him fall and he fails to run properly. Another thing that happens is that if this is not reported, the person becomes insane.

Transcript 1, p. 2
The Acholi interpret the symptoms of Ajiji of *someone who has killed another person, but has not told the people at home, that the symptoms are a message of death.*

Transcript 4, p. 21
The source of the problem can be seen from the cowry shells (gagi) when such person comes. *If it is found out that the person had killed, the spirit of the deceased is called to talk and later purification ritual is performed.*

Transcript 5, p. 27
Ajiji is a mental sickness of madness that affects the head. *Ajiji can be caused by the spirit of a dead person (cen)* …especially when someone has found a dead person, *when someone has stepped on the spirit of a dead person at the place he/she died* …when *a big spirit attacks a person and wants him/her to become an ajwaka, when somebody has looted or stolen something from a family that are possessed by a spirit (e.g. ajwaka) or have "bad herbs".*

Transcript 5, p. 27
If somebody shows these signs, he/she should be taken to an ajwaka for cleansing, because this cannot be cured in hospitals, only traditional herbs can cure it.

Transcript 7, p. 47
Ajiji is also understood in Acholi as something unclean ["cilo" = "dirts" - here referring to spirits] which has caught someone as a result of remembering bad events that the person has passed through.

Transcript 7, p. 47
Things that can cause ajiji are bad things that have happened to someone like: … *moving in a thick and heavy forest where people are not supposed to go, moving in between big and frightening mountains or under big trees where people are not supposed to go . Ajiji can also be caused by the killing of a mad person or someone with leprosy. Thus you would have dragged the bad spirits /*
that sickness into your clan.

Transcript 7, p. 47

Ajiji that causes mental problems is when the body startles and *evil spirits would have besieged you.*

Transcript 7, p. 48
Ajiji that comes during dreams are spirits that disturb the person.

Transcript 26, p. 189
If one is attacked by ajiji, *it can turn to be evil spirit that would require an ajwaka to cleanse it.* The person would then be taken to an ajwaka to chase the bad spirit causing ajiji.

Transcript 27, p. 204
Our children who have come back from the bush could experience ajiji because of what they had done while the bush like *killing they have witnessed and those that they have passed over. Walking on other areas which Acholi believe to be the territory of spirits and other bad spirits could also bring ajiji.*

Reactions to traumatic stress that do not match PTSD criterion symptoms

Transcript 1, p. 2
What happens to a person who is being attacked by "ajiji" is that "kome nure"[1], he/she looses strength, his/her rational thinking capacity lowers, the body shakes, "kome bedo dibidibi"[2], it can cause madness ("apoya"[3]) and his/her body and life are different from the normal ways.

Transcript 1, p. 2
Another thing that happens is that if this is not reported, the person becomes insane. Sometimes the person or his / her *child gets diarrhea.*

Transcript 4, p. 20
Ajiji brings nightmares… *talking something that is not the same with the topic of discussion, speaking to oneself, speaking meaninglessly and shouting.*

Transcript 5, p. 27
Ajiji can be noticed, because the concerned person is aggressive, does *not want to stay in the family steadily, likes moving around aimlessly, likes moving naked,* likes crying, *likes singing unknown and meaningless songs,* …

Transcript 7, p. 47
Ajiji has many signs: body shaking, madness, talking to oneself, *laughing*

[1] "Kom" is body; while "nure" refers to a general sensation of the body being weak and without strength. Especially the joints (knees and elbows) feel weak and the person is prone to joint aches. "Kome nure" refers to different elements of experience: body feels heavy, weak, lack of energy, knees are too weak to hold the body, being inactive.
[2] Kome bedo "dibidibi" refers to: inactivity, not feeling like doing anything, not functioning well.
[3] "Apoya" can be translated as madness or insanity: the head doesn't reason well and the body acts accordingly. There are different degrees of "apoya" or "bal pa wic".

without reason, endless and aimless movement at any time, body startling, *talking about anything that comes to their mind.* Ajiji that cause mental problems is when the body startles and evil *spirits would have besieged you*.

Transcript 18, p.124
Oling said that when he was sleeping, he could see the man (who had been given to him to kill) come to plead that he should not kill him. Even during day time Oling could see the man coming. That made him very sad and he could begin to shed tears. *Most of the time "kume nure"* and he has been feeling like having little strength. *The eyes could turn red as if he had eye problems yet he didn't feel any pain.*

Transcript 19a, p. 137
After he had started schooling in Kitgum, the studies didn't go well because when he was at school *something could come and fall on him that made him not to know what was going on. It made him to loose his strength and even to fall down. When the thing began to happen, he always complained of having no strength to do anything. Often, his eyes would "get covered" and the body energy would reduce until he fell down. There was be no way to stop this. It happened especially when he was alone or when he was thinking of something and also at night. When he was with people, his body could start trembling and even the way he spoke could change.*

Transcript 19a, p. 138
When this thing [the memories that in the local culture are related to spirit attacks] began to disturb him, sometimes he would stiffen his muscles so that the thing could not over power his strength, but sometimes it did not go away until it had made him fall.

Transcript 19b, p. 142
Something [spirit] could come always whenever he was sleeping and strangle him strongly. This caused his eyes felt as if they were pulled out and the thing [spirit] kept on saying move, move. The thing came like a human being that strangled him and wanted to take him to them, to a place he did not know.

Transcript 20, p.147
Before she was cleansed, *Awor felt that "kume nure" and she had no strength to do anything.* … She complained of constant headache all the time. *Something [a spirit force] could fall on her and could make her speak meaninglessly, in a way people could not understand.*

Transcript 25, p. 178
The bad spirits started disturbing Odong when he had come back from rebel captivity and had joined the Local Defense Unit. *The spirits caused severe illnesses as they would come and attack him. The attacks made him fell dizzy.* When he was in the trench (adaki) *he would see the spirits coming* and he would shoot anyhow. He often moved around aimlessly which made him neglect his duties at work. *"Kume nure" most of the time and he would say that he felt the spirits strangling him when he was sleeping / dreaming.*

Transcript 30, p. 222
… said, what was so painful in his life when he felt sick was: the *boys with whom he was putting up had all left him because of the nightmares which were disturbing him at night,*

there was no sharing of food with him, many times he was insulted, other boys also abandoned him, talking badly about him.