

"NO FIVE FINGERS ARE ALIKE"

**WHAT EXILED KURDISH WOMEN
IN THERAPY TOLD ME**



BY NORA AHLBERG



**THE INTERNATIONAL SERIES OF PSYCHOSOCIAL PERSPECTIVES ON
TRAUMA, DISPLACED PEOPLE, AND POLITICAL VIOLENCE**

Series Editor: Renos K. Papadopoulos

“NO FIVE FINGERS ARE ALIKE”



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*What Exiled Kurdish Women
in Therapy told me*

NORA AHLBERG

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To my husband and our children Mildrid and Ernst Hugo



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ACKNOWLEDGEMENTS

People and Subjects

This work is based on the analysis of refugee narratives related to me – the therapist – by traumatised kurdisch clients in exile who have given their permission for these accounts to be published. To my knowledge, no similar material has been gathered before. What little research there has been on Kurdistan has either been philological or based on ethnographic fieldwork in the area, while Amnesty reports restrict themselves to describing human rights violations. In addition, clinical works in which kurds might be involved, if ethnically differentiated at all, give cultural and religious identity secondary importance.

I am grateful for the professional support of professor in psychiatry Nils Johan Lavik, former head of the Psychosocial Centre for Refugees (PSCR), University of Oslo, professor Fredrik Barth, the founder of the study of social anthropology as well as the study of Kurdistan in Norway, and my teacher in comparative religion professor Juha Pentikäinen, University of Helsinki, whose work on the world view of a karelian refugee woman (1978) was my first introduction to the subject. Dr Barbara Harrell-Bond, anthropologist and at the time Director of The Refugee Studies Programme at the University of Oxford, has a share in the fact that this book has come about. I have repeatedly been able to draw on the courtesy and expertise of this unit, where I was a Visiting Fellow in the autumn of 1994.

I also want to acknowledge my gratitude to professor of kurdology Joyce Blau at the Sorbonne, professor of medical anthropology Benedicte Ingstad, professor of clinical psychology and member of the Board of Directors (PSCR) Anni von der Lippe, professor of developmental psychology Karsten Hundeide, professor of cultural studies Saphinaz Naguib, and professor of south asian history Pamela Price, all at the University of Oslo. My indebtedness extends to an interdisciplinary inspiring milieu at The Norwegian University of Science and Technology and, especially, previous dean of the Faculty of Arts Håkon With Andersen and his successor Petter Aaslestad. The appreciation shown by practitioners and students of many diverse subjects have been an additional inspiration for me while paving the way for

an interest in the area of cultural psychology and comparative religio-cultural analysis.

Moreover, I want to mention professor of social psychology Karmela Liebkind, University of Helsinki, whose keen intellect and refined quantitative analysis constitutes a continuing challenge for my own work, and the host of Finnish colleagues, particularly folklorists, who have put various themes of tragic or violent culture such as Siberian shamanistic healing practices, female wailing, blood feuding and extraordinary death on the international research agenda. In Norway, not least as a result of the seminal work on migration and mental health carried out by Ørnulf Ødegaard and Leo Eitinger, disaster psychiatry under the leadership of professor Lars Weisæth, University of Oslo, has attained an international reputation. The obviously important links between these fields, however, has not yet been fully explored, and much work remains to be done.

The present work has been financed mainly by the Norwegian Research Council, especially through the programmes of International Migration and Ethnic Relations, and Mental Health. The Norwegian Academy of Science has contributed by funding a preliminary study, as has the Finnish Academy of Science by funding an inter-nordic follow-up study within the framework of its programme on Cultural Traditions and Internalisation Development. Dr. Mette Rudvin, University of Bologna, has greatly improved my language, while Ernst Hugo Bjerke has proof read the manuscript. Besides the administrative support from which I profited at the Psychosocial Centre for Refugees, University of Oslo, I have, since its foundation in 1986 on the initiative of Dr.med. Edvard Hauff among others, here also profited from a milieu of warm collegiality. I would especially like to mention psychoanalyst Dr. Carl Ivar Dahl for his supervision regarding the therapeutic aspects of my work whenever I needed him, as well as Dr. Sverre Varvin, director of the Psychoanalytic Institute in Oslo, Dr. med. Sol Dahl, Dr. psychol. Ellinor Major and Dr. Øivind Solberg, head of the outpatients' unit, because of our common academic interests. Fellow Nora Sveaass, Department of Psychology, has repeatedly joined me in teaching psychology students on issues discussed in this book. There are, of course, many more who remain unmentioned to whom I extend my gratitude.

Apart from time spent with the clients, most of my time collecting material was spent with one particular interpreter, Zarin Pettersen,

who loyally supported me all the way. Together we have pondered the many relational difficulties encountered during the course of our work together, and their possible personal, professional, ethical and even political ramifications, and have in the process created a mutually satisfying working relationship. However, I alone bear responsibility for the views put forward in this publication, as Zarin does for any opinions pertaining to the matter that she will hopefully come to pursue in her own professional work.

Last, but not least, I would like to thank the clients themselves for their willingness to share with me and the readers such painful experiences and memories. Since those of them who appear in this study are marked by an oral tradition, it is difficult to render justice to the richness of their communication, especially while working with an interpreter at a distance of two or even three languages. But their narratives, told from a subjective point of view, are nevertheless all-important in expanding our understanding of what it is like, mentally, to cross borders and, perhaps, prepare us to respond more adequately to the challenges involved.

This study will hopefully add to our professional knowledge of traumatisation generally, and its relationship to the adjacent cross-cultural problems developing in the wake of exile in particular.

While my themes covers widely and 'holistically' both from within the fields of psychology and psychiatry (i.e. as related to its clinical aspects) as well as from comparative and, especially, anthropology of religion when it comes to cultural understanding; however, the empirical material is based on a few indepth cases of clients whose therapeutic contacts with me, the resercher, extends over years of weekly or, at times, other-weekly, sessions. It has taken some time to prepare the text for publication because – in addition to the ordinary difficulties of balancing between family life and a university career – the personal nature of its content reckoned such a delay advantageous from the point of view of ethical considerations. However, I am rather confident that its subject matter remains relevant for an interdisciplinary interested readership, though it is of course ultimately for the informed reader to judge.

SERIES EDITOR'S FOREWORD

This remarkable book is the second in the International Series of Psychosocial Perspectives on Trauma, Displaced People and Political Violence and it continues with what the first one offered – a unique opportunity to the English speaking readers to familiarise themselves with important European contributions in this field that usually are not accessible to them.

Nora Ahlberg allows us to get a privileged close look at her practice and to listen to the voices of her refugee clients. But her book is much more than a reproduction of their tumultuous experiences. It manages to achieve a most sensitive balance between providing authentic testimonies of suffering and endurance, and articulating an authoritative and scholarly methodology for treating this delicate material. I am not aware of any other book that addresses so ably both of these facets of the refugee experience.

Moreover, this is (to my knowledge) the only book of its kind that focuses exclusively on refugee women, and one of the few that limit their scope only to one group of refugees – the Kurds, in this case. Although the book is about Kurdish women in Norway, nevertheless, its appeal and contents are of universal value and applicability. Also, although it was first published in Norway in 2000, by no means is it dated.

The general reader will get an unparalleled insight into a therapeutic way of working with refugees and the specialist reader will have a vast range of themes to feast on. These include theoretical considerations of ideas about collective trauma, narrative life stories, working cross-culturally, mental health perspectives on refugees, the formation of meaning, to mention but a few.

Professor Nora Ahlberg is an eminent academic and clinician, immensely experienced in working with refugees. She is head of the Norwegian Centre for Minority Health Research and professor of psychology at the Medical

Faculty at the University of Oslo as well as associate professor at the University of Helsinki. Before taking up her present position she was professor and head of the Psychosocial Centre for Refugees at the University of Oslo and the Department of Religious Studies at the University of Trondheim. By combining the academic disciplines of psychology, religious and psychosocial studies with clinical sensitivity, Professor Ahlberg succeeds in producing an outstanding book that can become an invaluable resource for everybody working in this field.

Renos K. Papadopoulos
Series Editor

ABOUT THE AUTHOR

Dr Nora Ahlberg (b. 1952) has a background as full professor – alternately of psychology and comparative religion – at three out of four Norwegian universities, in addition to the Oslo University College, and as associate professor at the University of Helsinki. She is presently head of the Norwegian Centre for Minority Health Research and professor of transcultural psychology at the Medical Faculty at the University of Oslo. Before taking up this position she was professor and head of both the Psychosocial Centre for Refugees at the University of Oslo and the Department of Religious Studies at the University of Trondheim.

Her interdisciplinary background covers clinical psychology and comparative religion, in particular anthropology. Her main fields of research are minorities, issues of world view and migration, especially refugees and the Muslim diaspora. Through her attachments to the faculties of arts, social Sciences and medicine, she has gained genuine interdisciplinary experience from counselling, teaching and evaluation within the fields of psychology, the history of religion, anthropology and psychiatry. She has lectured at several foreign universities; and outside of the university her competence has been utilised by various clinical or political bodies and NGOs as well as by the media. Her doctoral thesis was made use of for making a television documentary.

AUTHOR'S FOREWORD TO THE PRESENT EDITION

Many things have changed since the therapies described in this book were conducted. Wars, terror and polarised debates about negative sides of cultural traditions complicate attempts to speak cross-culturally. Although issues of health are not 'hot' in the same sense, there is more to them than meets the eye. So what lessons have we learnt?

Personally I would still stress a need for acknowledging the cumulative aspects of trauma within "the extended refugee scenery". Forced migration and a subsequent resettlement as a member of a minority group in a new sociocultural setting, increase the risk for somatic and mental health problems. Different illness profiles in the countries of origin and exile, painful events before and during relocation, as well as problems of integration, all influence the situation. But while cumulative traumas go together, our more specific therapeutic tools may fall short of acknowledging this reality. An example could be a circumcised girl, who is also a distressed refugee, and suffers from retraumatisation while giving birth, involving several of these aspects.

We must to a much larger extent consider an extra-therapeutic framework or the existence of many-sided problems, which are not easily resolved within the consultational space alone.

Also, the fact that the therapeutic alliance is under such extraordinary challenge, actualizes issues of professional closeness and distance. Due to mutual avoidance behaviour, migrants tend to be in a poorer condition when they arrive for treatment, a fact that might lead to more drastic measures, such as enforced committal or heavy medication. Working in a cross-cultural context increases the risk of inappropriate reactions of over- and under involvement. We may avoid treating Third World migrants altogether, or give them different services, frequently of lesser quality, such as medication in the absence of a more demanding and time-consuming "talking cure". Also, the use of an interpreter increases the time for consultation at least two-fold; while introducing a triadic

constellation that may activate competition about who is in charge, or, alternatively, who is to take the blame when things go wrong.

Cross-cultural migrants are particularly vulnerable in relation to health care because it frequently involves the most personal, intimate or private sphere meeting interventions located in a public space. The problems may not be exclusive to migrants, but there are few instances in which they are as obvious as in a cross-cultural setting. Such is the case, for example, with regard to existing tensions between the protection of citizens in times of ill health or misfortune versus forced intervention in their lives, even when these are seen as part of preventive measures. Between public and private or even transnational micro-space important ethical challenges, which affect our professional work, are thus rendered visible. It may therefore be wise to try to unpack our interpretational frames in order to reflect on the conceptions of clinical reality that we have created.

Nora Ahlberg
October 2007

INTRODUCTION

Towards Interdisciplinary Theory and Understanding

NOTES ON A WARTIME PICTURE

One of the clients brought me a six hour long video tape filled with human tragedy, raids and killings of adults and children alike. Though it was simply overwhelming to view, her point was a different one; that these were the only remaining pictures of her dear *Home*. It seemed like a compulsive backward glance at a happy childhood through the spectacles of organised social violence; while being, moreover, cast away on foreign soil.

While many minority studies have been written by, and implicitly concerned with men, this one focuses on woman brought up in a traditional setting dominated by gender segregation¹. At the same time, however, it is a work about displaced persons whose stories remind us not only of the atrocities of wars fought in their homelands, but of the extent to which wars continue to be waged on the psychocultural level even after its victims have reached what they believe to be a safe haven in a cross-cultural exile.

As for the subject matter, I have tried to present the clients' truths as I have understood them as a therapist/researcher invited to hear and feel their tragedies and separation from their loved ones. The narratives on which I base my analysis are thus in themselves the products of a cross-cultural encounter involving three people including the interpreter. I feel fairly safe in alleging that it has been an experience of mutual challenge and confidence building. Writing on the life history approach in general, Catani (1981, 212) aptly describes it as "a two way seduction, a love story that recounts the development of an intense affective relationship whose exchange exists on a purely oral basis". To ignore this fact in favour of an exclusively documentary approach would be to renounce the fundamental importance of interpersonal communication generally, and therapeutic relationships in particular.

It goes without saying that the mental hospitality of these women, reflecting a more general kurdish attitude of sharing with your guests, has made a deep impression on me. The same applies for their pride

despite feelings of desperation and ‘shame’ that have been brought about by traumatic experiences in their old as well as in their new lives. I also want to point out that the pure duration of these treatments, extending over many years, allows for a unique material as compared to what therapeutic experience we have hitherto had from cross-cultural settings involving tradition-oriented third world clients and their western-educated therapists.

An extended focus, comprising also the field of cultural study, makes this study somewhat different from those of my psychologist/psychiatrist colleagues working within the field of traumatology, despite the fact that it is based on the same empirical foundation. While I hope I have avoided oversimplification, I am afraid, however, that my emphasis on issues, which I find worthy of criticism from a human rights perspective within the fundamentalist islamic tradition, may be held against me. I therefore wish to point out that transgressions of this kind are in no way restricted to one particular – religious or secular – ideology. Moreover, recent developments in Iran have lessened the negative focus on that country in order that my findings may be judged more unrestrained by high-level political connotations.

There is no shortage of bad prognoses concerning the coping of tradition-oriented refugee clients in exile, or of the threats to their familiar way of life. The present work is, symptomatically, in many ways, a reflection of an integration or a mourning process, and, therefore, has some affinities with the assimilation analysis used by Varvin (1998; 1999). Because of the additional factor of severe trauma, many have reached a breaking point, generally diagnosed as post traumatic stress disorder (PTSD), when entering treatment. New conditions, such as the fact of receiving therapy, bring about new ways of viewing problems where the old ways brought no relief. I have tried to avoid overemphasising the clients’ cultural past by simultaneously relating it, with due respect, to their present exile conditions. Because this past is less known or present in other clinical works, it might, therefore, seem accentuated here.

Though third world refugees are generally associated with the drama of international politics, their presence among us presents a range of profound, although less obvious, issues. For example, as migrants from muslim tribal areas they meet opposition in areas of family law and custom, where their religious custom involves diverse

forms of marriage practices, as well as those related to the custody of children and the elderly, practices which are rooted in deeply felt humanitarian considerations. Seen from this perspective, their exiled predicament is a far cry from the ideals of unambiguous acceptance of the rights of individual citizens in the West without regard to gender or culture, who may freely choose with whom or how they prefer to pursue their lives. My material shows that traumatised refugees who harbour tradition-oriented norms and values that are perceived as alien by the majority, are especially vulnerable, sometimes resulting from pure misunderstanding, but also due to the more or less conscious use of institutionalised violence.

Working within a therapeutic setting, one is, from time to time, privileged in being able to venture beyond the boundaries of one's own professional realm when faced with wider ethical or cultural perspectives in the clients' accounts. What is likely to begin as a case of post traumatic stress might end in a tale from inside a life story marked by culturally alien and psychosocially extreme circumstances. And, in the midst of all the despair and failure, also one of basic human trust and coping. It is at this point in a therapeutic relationship that the diagnostic estimates and their carefully assessed causes will start to appear as being meaningful. This, of course, happens in any fieldwork setting, but here with the added obligation required by medical ethics to do what is in your power in order to ease the victims' burden. From this point of view – and the fact that the treatment has been free of charge for the clients – the setting is more characterised by 'a give and take' than the case is in ordinary fieldwork.

The ethnography of the clinical context can never be regarded purely as an issue of acquiring the greatest possible amount of correct information. For such a venture, the manner of relating problems is all too sensitive. To be allowed to live together with one's kinsmen, to keep one's secrets in peace or to protect one's dead, such issues all present complications that result from specific belief systems and which add to other psychosocial problems. These are complications that we cannot avoid dealing with if we are to acquire an accurate picture of the situation of traumatised refugees cast in the role of patients on foreign soil, and consequently of our own role as psychotherapists working in a cross-cultural context.



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PART ONE:
A CULTURAL STUDY OF
CLINICAL CONTEXT



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THE INTERDISCIPLINARY CHALLENGE

The Extended Use of Clinical Data

This work is a study of trauma, not from the narrow perspective of psychiatric pathogenesis, but from a wider, interdisciplinary viewpoint, that is, including a comparative psychocultural analysis. It takes as its theme two rather problematic concepts – namely *trauma* and *culture*. Both of these concepts are highly relevant to the research on forced migration from the developing countries and so called ‘traditional settings’ to the urban western context. My ultimate aim is to reconsider the impact of trauma and culture on victims of forced migrants in order to further our theoretical insights in this area. However, the themes of this study also carry other implications for the analysis of cross-cultural treatment and the psychological consequences of cultural change and migration more generally.

Because of the fact that illness and suffering always originate within a particular psychosocial environment any investigation of its patterns must also relate to the cross-cultural aspects of this fact. In view of the traditional religious settings from which the migrants at issue here come, it becomes particularly obvious how illness and suffering are intertwined with moral problems, and how recovery and further coping are therefore not only dependent on modern medicine, but ontological validity as well.¹ It is my firm conviction that any successful psychotherapy is dependent on getting things right from the patients’ point of view, i.e. the *emic* perspective of the insider, which the medical anthropologist Arthur Kleinman (1980; 1988 a) calls illness. And which he saw as distinct from the external *etic* concept of disease that denotes the theoretical interpretations of pathology as used by professional helpers.

In the anamnestic efforts to understand, a psychotherapist is, however, largely dependent on the patients’ retrospective reconstruction, because he or she seldom meets them outside the office in the way the fieldworker does. This fact acquires added importance in therapeutic work with victims of organised social violence because the emerging trauma story, in directing attention to the atrocities committed, may

in retrospect also function as a sort of political condemnation of the perpetrators of the violence. It was for this reason that the therapeutic method of *Testimonio* (witness story) was introduced in Chile in the 1970s as a means of re-establishing the personal and political ties severed as a result of extensive political repression².

These and similar concerns have led me to engage in the present research, the material of which was collected in a clinical setting, with all the limitations that this entails. A wide range of interdisciplinary variables influence any cross-cultural therapy with traumatised refugees. Besides the psychological factors involved in victimology, there are social factors reflecting the marginalisation of third world migrant patients, and somatic factors following hardships during combat or in prison. Legal and spiritual problems should also be added to the list as they reflect the various sociocultural discourses at hand. Furthermore, all these different variables affecting the individual clients will, in the long run, promote the accumulation of collective memory and traditional lore.

The qualitative approach used in this study is based on an effort at increasing understanding of what psychoculturally meaningful connections occur within such diverse conceptual frames. In this aspect, then, its scholarly aims coincide with psychodynamically oriented forms of therapy. According to Varvin's report on the 1991 Standing Conference on Psychoanalytic Research by the International Psychoanalytic Association, psychoanalysis can be defined as 'a search', while *re*-search is simply a systematic revision of the material by 'seeking again'. In other words, the process through which results is construed into ideas or concepts. Gagnon (1981, 52) similarly defines data collected by the life history approach in the following way: "Each account expresses a critical reading of a situation; a reading determined by a project, and constructed with the help of signification acquired through biographical experience." This statement is likewise relevant for understanding the therapeutic process when it is viewed as a means of fostering the progressive unfolding of a meaningful life project. As a therapist, I see my task as coming to terms with this continuous process without 'premature closure', and as a researcher, as describing it at length from the point of view of certain multidisciplinary conceptual frameworks.

Working with refugee clients' trauma stories, the therapist/researcher can in a clinical setting benefit by borrowing skills from biographers and historians, particularly from the life history or his-

tory of mentality approach³. As I have not personally collected other documents than the client's verbal reports themselves, *focused life story* is, for my purposes, a more accurate term than life history, and a somewhat broader concept than that of illness or trauma story used by the medical professions. There is, according to Bertaux (1981, 7), a certain terminological confusion within the field owing to the use of overlapping concepts such as autobiography, personal document, life record, case history and so on. My own approach covers only partial life histories. It is topically restricted, on the one hand by what the clients spontaneously brought to the therapy sessions, and on the other by the therapist/researcher's interest in the field of comparative cultural analysis and knowledge of the field of traumatology.

Related life course research being carried out in the social sciences tends to focus on patterns of deviation or divergence. Studies are frequently made of juvenile delinquents, drug addicts or the mentally ill, more recently extended to include third world migrants.⁴ What is common to these categories of people is that they have been denied the right to belong to a given community as full social subjects. A recent extension of such scholarly interests deals with victims of social violence, such as women subjected to sexual assault, children exposed to incest or refugees who are victims of torture.⁵ Besides the after-effects of interpersonal violence, the larger focus of the study of trauma encompasses the effects of other stressful events, such as those resulting from natural disasters or serious accidents. In clinical studies the ensuing disturbances in 'belonging' are then analysed as they appear in therapeutic sessions through verbal material and behaviour, as well as by generating emotional climates. A micro traumatic situation is often found to have been provoked in the helper as well.

A more recent trend, however, is that of extending the focus from merely researching misery towards protective and rehabilitative factors and the patients' ability to cope with stress and unhealth. This accords with a shift in the World Health Organisation's focus from merely curing disease towards preventing it, and the promotion of health. In a similar way, in the field of psychology, the concept of learned resourcefulness has been launched in contrast to what could be described as learned helplessness⁶. The refugee situation represents a rare opportunity for understanding not only the pathogenic effects of trauma, but also mechanisms that explain the ability to 'not let oneself down' – i.e. resilience – or to cope in the face of massive

trauma⁷. Within the field of cultural studies, the ensuing criticism of conceptualising the world view of the individual as a sort of static prison which hinders development has brought a parallel search for approaches in which the subjects are seen as active rather than passive agents in their own lives.

Likewise, ethnographic monographs tend to focus, if not on deviant, then certainly on exceptional people, such as leading shamans or tradition-bearers. The same is largely true of the history of religion, of literature or of philosophy, in that they unfailingly emphasise great and exceptional men and the systematically developed beliefs of such men – and more lately women, assuming that they are generally shared.⁸ In my opinion, however, the extent to which beliefs are uniform or elaborated varies depending on a number of factors. Besides, the aforementioned scholarly approaches tend to obscure the beliefs of ordinary people such as the subjects of this publication. Despite the fact that they have been struck by extraordinary circumstances in their region of origin they still represent quite ordinary kurdish women whose knowledge of the world outside of their own restricted female sphere and folk beliefs is fairly limited, i.e. prior to their exile.

While systematised belief systems or ‘grand theories’ may be a practical necessity, according to the finnish philosopher Kurten (1990), theoretical issues do not necessarily concern most humans. A prevalent life story is therefore primarily a way through which the individual expresses those aspects of the past, which are relevant to the present in terms of his or her future-oriented – and quite practical – intentions. From the perspective of Berger and Luckmann’s world view analysis⁹ it could, moreover, be said to be part and parcel of the external and objective impact ‘out there’, but simultaneously internalised by the individual. This is why the subjects at issue here can be considered both products and producers of a history, which can, therefore, be studied from *within* and *below*. Because the refugees are actors in a specific psycho-socio-cultural context, their narratives will contain both collectively and individually, subjectively, construed meaning.

Despite the fact that intrapsychic and interpsychic meanings cannot be equated, one should nevertheless try to find ways to conceptualise and explore their connections without reducing the one to the other. Through a heuristic movement back and forth between individual and collective levels, the analysis of the separately emerging

narrative accounts of this study, not only focuses on understanding individual particularities, but becomes, rather, a method by which one can identify elements contained in them that might lead to analytical generalisation (i.e. *not* statistical generalisation). The specific themes that have emerged from my study, during therapy sessions with the participants, have subsequently been analysed on the collective level across cultures, as well as in terms of individual relationships and private solutions. The material ensuing from a micro level analysis might, but does not necessarily, coincide with the collective one, for example, where clients – like mine – are undergoing change as a result of alien majority pressure; or it may include mere fragments of the collective patterns involved¹⁰.

Indeed, the need for a general shift in research focus towards the interface between a number of ideologically divergent and distinct cohort groups becomes evident in this study. Such a shift is particularly important when analysing the multicultural identities of second and subsequent generations of acculturating migrants groups. But the adaptational choices of other groups, such as the more conservative pakistani foreign workers of Norway, are increasingly present also in the views of the first generation kurdish subjects of this study. Their reference in this respect is thus not only to the majority ‘Norwegian culture’ as understood by them.

With only a few cases at hand, I have followed a ‘replication logic’ rather than a ‘sampling logic’ in agreement with the multiple case study design presented by Yin (1991, 52ff). The analysis of the research propositions have been conducted separately for each case by relating its data to the particular individual context, that is without pooling across data. Each individual case consists of a separate study in which convergent evidence is sought regarding the facts interpreted on the single case level. The findings pertaining to each individual case are then considered the information needing replication in the results of other individual cases. In other words, the patterns of explanation given for each single case are cross-checked or compared across cases in order to reach cross-case conclusions, following the replication model of multiple cases. The theoretical propositions are thus tried out in a variety of contextual circumstances, and alternative patterns are pursued in order to reach an interdisciplinary, differentiated understanding.

In our scholarly efforts to build on systematised beliefs that serve the

organisational needs of scientific constructions or ‘grand theories’ some things may go unnoticed. For example, one should bear in mind the extent to which a coherent world view or identity psychologically may constitute an extraordinary achievement, even under unicultural conditions. Compared to what holistic knowledge we may have constructed about particular cultures from a number of mostly written sources, in most people, identity remains a partial, fragmentary and somewhat irrational unit. Man, according to such a view, is no more a purely calculating rational being than an emotionally reacting one, who carries conflicting and irrational elements in his basic assumptions and identity. The impossibility of uncovering such personalised elements under ordinary fieldwork circumstances is apparent, and a clinical setting, such as the one used in this study, therefore seems to be more profitable.

A more particular aim of mine has been to analyse the emerging refugee narratives in the light of the deep-seated normative ruptures encountered by the clients at home as well as in exile, whose sources are often twofold; traumatic events in the countries of origin and cross-cultural migration. Following the humanities approach, my primary objective has not been to produce ‘progressive’ or applicable results, but to acknowledge what forms of interdependence there exists between our long term goals and certain issues of ultimate importance which require renewed treatment by each successive research cohort. In so doing I also hope to avoid the saturation of knowledge resulting from a mere quantitative analysis; an issue to which I will return in chapter 14 on methodological choice and the study of sensitive issues.

ADVANTAGES OF THE APPROACH:

— Since very little concerning the lives of tradition-oriented kurdish women has been written down, and since many of the subjects at issue here are illiterate, their stories have to be recorded at source. Hence, the advantage of an oral – i.e. face to face – approach;

— In a therapeutic setting, informants themselves choose to come to me (the therapist/researcher), and, presumably, I may provide some relief to their problems;

— The therapeutic setting offers opportunities for the researcher of attaining a certain amount of cross-cultural intimacy or looking

‘behind the scenes’ while ideally remaining an outsider, in no way a matter of course for a participant observer in the field;

— It may offer the clients the chance to reflect on the norms of their own culture as well as those of the alien culture;

— Transference relations and emotional climates are made explicit as a variable of the research;

— During the course of the therapy the knowledge gained by both therapist and clients may become all the more profound and thus objective, as it is increasingly subjectively felt during the course of year-long treatment processes;

DISADVANTAGES OF THE APPROACH:

— Loss of context-specific observational and source-critical data. This is all the more important when considering the desire migrants might have to break with their former patterns. Their point of view as expressed in the therapeutic setting might not necessarily coincide with those that are dominant in their own milieu, but, might, rather be considered marginal in the eyes of their own people;

— Although the client is free to stop coming at any time, the explicit/greater power in the relationship still lies in the hands of the therapist. One related problem is the ability to draw a neutral line between the assumptions of caregiver and care-receiver as further discussed in Part two of this publications.

Inside-Outside the Therapeutic Room and Migrant *Problem Families*

By emphasising the relationship between treatment variables and belief systems, it is likely that elements which are relevant to the analysis of the expanding health care system in general and the mental health care sector in particular, elements that may otherwise go unnoticed, will emerge. Mental health workers must, from time to time, unpack their well interpretative schemes and rethink the versions of clinical reality that they themselves have created. Such pursuits are, perhaps, nowhere more promising and potentially profitable than in the cross-cultural setting. Indeed, the interdisciplinary lesson is derived from

this incorporation of certain intervening socioculturally determined variables into our psychological models and vice versa.

The methodological disparities of researching a unicultural psychotherapeutic setting and a cross-cultural one cluster around various points on the axis of particularism/universalism. Moreover, while subjects are actively sought by the fieldworker, participants in a therapeutic context generally – and ideally – seek treatment themselves; and differences of this nature will clearly affect the asymmetrical balance of the subject-object relationship. However, this distinction seems to diminish in importance for cross-cultural migrant-clients in that they are frequently referred to specialists – like psychotherapists – for treatment by various authorities. Besides, they tend to arrive in therapy expecting treatment that is different from what is on offer, and consequently must learn how to make use of the help received. For example, the therapist frequently encounters a request for treatment of a somatic complaint or advice on problems concerning the social welfare system.

Referring to the concept of *parsities* ('persian syndrome'), a term used by frustrated health care professionals in describing their ethnic minority patients, Pliskin analyses an encounter between jewish-iranian patients and their israeli doctors. She concludes, somewhat bombastically, that

Failure to comprehend the sociocultural factors involved in illness expression, exacerbated when patients and practitioners come from two different cultural backgrounds, contributes to faulty labelling, unsuccessful treatment, frustrated practitioners, unhappy patients, and the failure of therapy (1987, 238).

Recognising the need to pay special attention to the way in which health services are provided for minorities is not a matter of course, but ignorance of the customary practices and beliefs of such patients on the part of health care professionals is only one aspect of this issue. Problems presented by ethnic minority clients often have causes, which lie outside the control of the help providing system. This may, furthermore have an adverse affect on the helpers themselves as they often eventually become 'burnt out' by continuously having to share in their patients' misfortune over sustained periods of time (cp. the concept of secondary traumatisation¹¹).

While many customary practices have no bearing upon health, a few are nonetheless crucial to the provision of culturally appropriate and sensitive health care. In the field of psychotherapy, we have no choice but to take these issues seriously. The high level of anxiety found in the refugee population has alerted their minority representatives, and especially their clinically educated compatriots, to the danger of misdiagnosis that results from overlooking the psychosocial and cultural context. And the growing awareness of the ethnocentrism inherent in our scientific concepts has brought an increasing concern for overcoming such tendencies also within the field of psychology¹². One reaction that has resulted from such efforts has been that of emphasising the primary importance of cross-cultural studies and therapy carried out by insiders as a priority, thereby counterbalancing the tendency by western scholars to monopolise the presentation, also the history of the others. This has particularly been commonplace where outsiders have not taken into account the ‘colonial stranglehold’ or accompanying racism, so acutely felt by many minorities.

There are, however, good reasons to scrutinise this position from the point of view of the desirability of creating scientific or therapeutic ‘ghettos’. It might lead to the exclusion of researchers belonging in a minority group from free choice of the subject of their study in a neoimperialistic manner. Such endeavours are, in my view, better served by a model in which the minority is free to scrutinise the majority, and vice versa. The ensuing debate has led to further disagreement as to whether or not refugees are in need of psychological help at a more general level (e.g. “Forced migration is not mental illness”). From this point of view, the rehabilitation centres for refugees which have largely been established in the West are even accused of creating de facto psychological quarantines where dangerous migrants (read terrorists) accustomed to resorting to violent opposition and fighting are ‘disempowered’ so that they no longer constitute a threat¹³.

Culture, of course, is just another term for the psychosocial heritage or prism through which, and the prison from which, we view the world. Therefore, it must not be forgotten that this concept is equally applicable to the therapists as well as their clients, even though cultural understanding has never been central to psychiatric nosologies. It is also true, however, that the conflict between sensibility to cultural context and various human rights issues can at times become difficult to handle. However, post traumatic stress in combination

with the additional stress of a cross-cultural migration often creates difficulties in the exile situation without the parties being aware of its causes. Furthermore, families belonging in ethnic minorities' that are perceived as 'problematic' by their helpers share certain characteristics which render them particularly vulnerable from the point of view of popular western notions about psychological well being. Among such characteristics we find a background in a traditional, often muslim, community, as well as severe traumatisation.

A typical case is the following:

The parents are more often than not illiterate¹⁴, the husband worn down by prolonged torture or warfare as the wife seeks help for social or somatic problems while carrying secret traumas of her own. Frequently, there is also an excessive recourse to medical examinations without this having, to any appreciable degree, lessened the high level of anxiety. There are four or more children who will in time be exposed to the scrutiny of a professional system of helpers. The apparent unity of the family and problems of interpretation has, however, left outsiders without much knowledge about real problems. Nevertheless, many a suspicion has been raised about family violence, mismanagement of the children, incest and the like.

After a couple of years as a *problem family* 'in orbit', a cumulative crisis may occur, and desperate professional caregivers often feel that the ensuing despair is directed against themselves. This is the point at which the expertise of a centre such as the Psychosocial Centre for Refugees is frequently called on. The child welfare authorities or the police might already have become involved in the case, or the parties may have been separated, but, from the point of view of the largely medical staff, we find that:

- the reasons for referral seem vague;
- the opportunity to work undisturbed for the therapist is limited by distracting external conditions related to problems of housing, language or even residence permits;
- the only thing that is fairly certain is the accumulation of psychosocial and cultural stress factors; albeit often not explicitly manifested.

From an outsider's point of view, the subjects of this study are refugees recognised as such by the United Nations High Commissioner for

Refugees, and, moreover, here in the role of patients. They are all adult muslim females; married, and members of what has been perceived by their helpers as such multiproblem families mentioned above. Three of them are disability pensioned for psychological reasons, just as their husbands were before them, and the others are sustained by other types of refugee or unemployment aid. In all but one case, several family members have also received treatment. All of them, without exception, have a history of problems with professional helpers such as the child welfare authorities, social workers, the police, or the primary health care system.

Despite the lack of any active research done outside of the therapeutic space on my part – to be further discussed below – some background material throwing light on that sort of strained relationships and the general pressures/expectations from various authorities directed at the therapeutic staff of the centre, has reached me.

*All ex. 1: TIME AND MANNER OF REFERRAL

1. *Aisha*; referred to the centre about a year after her arrival in the country via an interpreter, for failure to perform her housekeeping duties. She arrived at the centre, accompanied by her husband, complaining of somatic pain and continuing problems with the Social Services. She was to remain with us for six years, including a one year intermittent break.
2. *Nasreen*; referred about two years after her arrival in the country following an ‘unsuccessful’ treatment period at another psychiatric outpatients’ department. Her husband was already receiving treatment. Complaints about ‘nerves’, somatic pain as well as disobedient children. She stayed in therapy for four years.
3. *Fatima*; referred about one and a half year after her arrival in the country via her solicitor because of an acute conflict with the immigration authorities who refused to allow her husband to be reunited with her. There turned out to be some confusion regarding her legal status due to contradictory evidence allegedly produced in police interrogations. She was to stay in my therapy for four and a half years.
4. *Layla*; referred about a year after her arrival via an interpreter who had worked with the family in an outpatients’ setting. She arrived at the centre accompanied by her husband, determined to move away from the area against the will of the local authorities. Complained