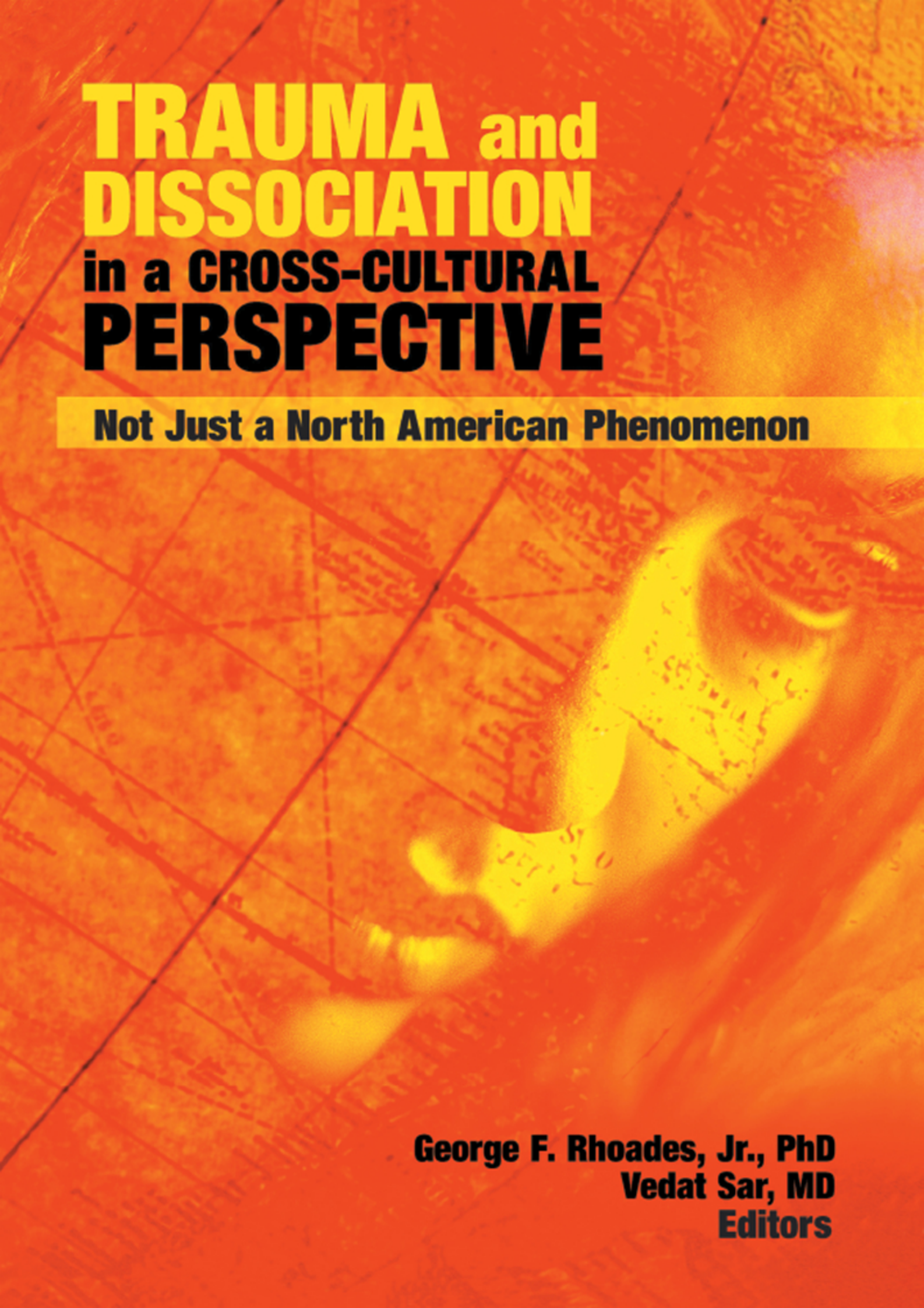
TRAUMA and DISSOCIATION in a CROSS-CULTURAL PERSPECTIVE

Not Just a North American Phenomenon



George F. Rhoades, Jr., PhD
Vedat Sar, MD
Editors

Trauma and Dissociation in a Cross-Cultural Perspective: Not Just a North American Phenomenon

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Trauma and Dissociation in a Cross-Cultural Perspective: Not Just a North American Phenomenon, edited by George F. Rhoades, Jr., PhD, and Vedat Sar, MD (Vol. 4, No. 1/2 and 3/4, 2005). *Examines the psychological, sociological, political, and cultural aspects of trauma and its consequences on people around the world.*

Prostitution, Trafficking, and Traumatic Stress, edited by Melissa Farley, PhD (Vol. 2, No. 3/4 2003). Prostitution, Trafficking, and Traumatic Stress *documents the violence that runs like a constant thread throughout all types of prostitution, including escort, brothel, trafficking, strip club, and street prostitution. The book presents clinical examples, analysis, and original research, counteracting common myths about the harmlessness of prostitution. It explores the connections between prostitution, incest, sexual harassment, rape, and battering; looks at peer support programs for women escaping prostitution; examines clinical symptoms common among prostitutes; and much more.*

Trauma Practice in the Wake of September 11, 2001, edited by Steven N. Gold, PhD, and Jan Faust, PhD (Vol. 1, No. 3/4, 2002). *"Extraordinarily timely and important. . . . It is now a different world that confronts mental health professionals. This book presents both broad theoretical perspectives and the personal accounts of some who have required care and those who provide it. It begins to help us understand the changes of the post 9/11 era–how domestic terrorism has affected the national psyche as well as individuals, inflicting new wounds and awakening old hurts." (James A. Chu, MD, Director, Trauma and Dissociative Disorders Program, McLean Hospital, Belmont, Massachusetts; Editor,* Journal of Trauma & Dissociation*)*

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ABOUT THE EDITORS

George F. Rhoades, Jr., PhD, practices and lives in Hawaii as a clinical psychologist. Hawaii is known as the "melting pot" of the Pacific wherein the application of cross-cultural principles of psychotherapy is both practical and necessary. Dr. Rhoades is both the Founder and Director of Ola Hou Clinic, Aiea, Hawaii and Adjunct Psychology Faculty at Wayland Baptist University. He was Chairman of the Psychology/Counseling Department at the International College and Graduate School from 1989 to 1997. He is an international author and speaker conducting workshops/trainings in Hawaii, USA, Canada, Europe, Asia, and the Middle East on anger management, trauma, dissociation, and Satanic Ritual Abuse. Dr. Rhoades worked in trauma counseling/workshops in Sri Lanka, Russia, Northern Ireland, and Iran. He was Consulting Editor for Corsini Dictionary of Psychology, radio host for four radio stations in Honolulu, Fellow with the International Society for Study of Dissociation (ISSD), Chair of ISSD World listserv, and Co-Chair of ISSD International Conference in Los Angeles.

Vedat Sar, MD, is a psychiatrist and Clinical Professor in Istanbul University Istanbul Medical School. He is founder and director of the Clinical Psychotherapy Section and Dissociative Disorders Program in the Department of Psychiatry at the Istanbul University Medical Faculty Hospital. A fellow member and former International Director of the International Society for the Study of Dissociation (ISSD), Dr. Sar has served as Co-Chair of the DSM-V Research Planning Conference sponsored by the ISSD. He is a fellow member of the International Society for the Study of Dissociation (ISSD) and has been honored by the ISSD with the David Caul Memorial Award in 1995 and 1999, the Morton Prince Scientific Achievement Award in 2001, and the Cornelia Wilbur Award in 2004. Dr. Sar has published more than 100 papers in peer-reveiewed journals, book chapters, and special journal issues in Turkish and English. He sits on the editorial board of the *Journal of Trauma & Dissociation*.

Trauma and Dissociation in a Cross-Cultural Perspective: Not Just a North American Phenomenon

CONTENTS

Foreword: Is Affect Dysregulation a Factor That Corresponds Across Cultures with the Presence of Dissociative Processes?

How does a mind work? What genetic and environmental factors contribute to the "happening" of a thought or feeling? How does a mind deal with adversity or stress that's so great that it alters how that mind functions for a moment or for as long as a person lives? What are the modes of experience that spice the particular cultural broth in which a mind grows and then influence the flavor of human relatedness? What does culture have to do with how a mind hides from itself? How are dissociative processes related to these kinds of conscious and unconscious experiences?

I am far from being convinced that we will answer these questions completely in my lifetime. Nevertheless, I am reassured that we are in an age where these questions are being addressed relentlessly and with a sense of urgency that takes offense at the outrage of attributing the "nervous" conditions of the survivors of domestic, military, and natural disasters/violence to inadequacies in the people who have been wounded by life (as our German colleagues point out in their essay in this book).

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In this age of automated violence, there are few questions more pressing than how to help a person heal from traumatic experience. There is no person reading this who cannot be impressed by the wide diversity of both natural and un-natural disasters that afflict the people of this world. What better work is there than to attempt to heal the wounded, and by doing so, interrupt the intergenerational cycles of violence that threaten us all?

In this collection of articles by a guest list of serious clinicians who have managed to pursue their interests in human traumatic experience and the dissociative disorders I have a sense of being a witness to these authors having all had an experience of standing in the middle of a crowded society and shouting out to the people gathered around them: "Hey, don't you get it?! They've been hurt, wounded! It's not some weakness of their minds. They're hurt! We can help them. Just pay attention to the wound, please. Can't you see it? It's there, right there. What's wrong? Why can't you see it? Look. Look where I'm pointing!" Why are these clinicians pointing and shouting? What are they looking at that others find so hard to see or even acknowledge might be there?

As you read these words, are you not familiar with a longing to not read more about violence, tragedy, and suffering? Have you not ever dreaded a return to your work after a good enough vacation? Remember, we clinicians are the ones with our eyes already open! What of those who learned to close their eyes as children? How eager would they be as adults to understand or even notice the wounds in the people who surround them?

Seeking an understanding of cross-cultural similarities and differences in the human response to severe adverse experience is a fine tool to use in the service of discovering basic human responses to emotional and physical trauma. It can remove the cultural packaging of individual and group behaviors and teach us all about the basics of being human. Basic assumptions of a given culture hide the rationales for cultural events that seem to elude a culture's members. Of course, there is a tax to be levied on any person who persists in opening their eyes: you get to see the world as it is: wonderful and terrible. Both conditions, wonderful and terrible, exist, simultaneously, sequentially, and inescapably. It is a sad reality. Yes, it has more or less always been this way for us humans. We are adaptable. BUT, the breadth and depth of the violent outcomes for human life that are arrayed before us in the beginning of the 21st Century are truly breathtaking. Let's consider a short list:

1. Global warming that will make the oceans rise, at some point and cover land occupied at this moment by 100 million people
2. Climatic changes from global warming that threaten everyone with more violent weather patterns even while temperatures rise minimally, on the average
3. Terrorist threats that randomly destroy human lives in both highly civilized and less civilized nations
4. Nuclear holocaust potentials
5. AIDS/HIV and the threat of the loss of whole populations of young and middle aged adults in some nations.
6. Predictions of an Avian flu pandemic
7. Pollution of the sky, water, and land to the extent that heavy metal and toxic chemical accumulations will gradually poison sources of human food and make them unfit for consumption without the risk of illness

If I am going to maintain my sense of well-being I have to find ways to escape consciousness for these world-wide disasters in progress (not in the making). Are you uncomfortable yet? I am. And I'm hoping you are too because then maybe you, like me, will try to figure out how to deal with some of these problems and apply yourself toward some solutions. And in this little list of some of the world's problems I have not addressed any of the interpersonal issues that have a well documented cumulative negative effect on psychological and physical health (Felitti, 1998). We must find ways of better understanding how to grow healthy minds, and how to help heal and repair those minds

The seventeen articles in this book provide you with two kinds of information that are not available elsewhere. First, in some of these articles, you will hear about the particular shape of psychological syndromes that have some of the hallmarks of dissociative processes such as dissociative amnesia, disremembered behaviors, possession beliefs, and spontaneous trance, amongst others. Second, you will learn about the state of the art in dissociative disorders studies and the struggles that exist in different societies as consciousness for the dissociative disorders tries to make its way into the thinking of mental health professionals throughout the world. There is no other comprehensive source for this information. It is a remarkable collection of efforts by many individuals and organizations. Equally important is that only fifteen years ago, just a handful of these authors were nearing professional recognition as experts in their field. Dissociative Disorders Studies are maturing and spreading throughout the world. This collection of papers is

well worth your time in taking the pulse and learning the rhythms of views of dissociative processes across many cultures.

WHAT ARE SOME UNDERLYING COMMON THEMES ASSOCIATED WITH DISSOCIATIVE PROCESSES ACROSS CULTURES?

As a psychoanalytically attuned psychiatrist, who is also trained in techniques such as hypnosis, eye movement densensitization reprocessing, and short-term dynamic psychotherapy, I have found it useful to try and identify common thematic elements of all these treatments. I suppose this is an aftereffect of my ten years of practicing medicine in a rural Virginia community, a town of two hundred people, in a county of ten-thousand, nestled against the east side of the Blue Ridge Mountains. I say this because I was born and raised in New York City, went to medical school in Richmond, Virginia, and did a residency in family practice in rural Blackstone, Virginia. It's been necessary, for this clinician, to look beyond the cultural differences between a cosmopolitan New York upbringing, the "southern charm" of Richmond, Virginia, the capital city of the Confederate States of America, and the provincialism of a rural, Baptist, Blue Ridge, farming community. In all these communities I met and befriended a number of wonderful people. In order to provide good medical care, I had to be aware of the individual beliefs that ran in families, as well as the local practices of different religious groups. For example, the risk of venereal disease was a part of the accepted risk taking behaviors of young adults in the era preceding AIDS/HIV in Richmond. However, the same infection was more often a major crisis in the life of a young adult in rural Virginia. Likewise, a diagnosis of cancer was very often felt to be a personal failing and a sign of un-cleanliness in the person who fell ill. Illness was thus associated with tremendous shame, despair, and secondary depression. The presence of a psychiatric disorder and a visit to a psychiatrist was much better tolerated in a large city than in a small town in rural Virginia. Thus, the function of a family physician was often similar to that of the head of a local place of worship; doctors and ministers were counselors as much as anything else they did. The shame of mental illness was too often viewed as a weakness of the soul, or culturally disowned as the work of "the devil." In other words, the feelings that people had about being ill more often than not determined the extent to which they could

engage in their treatment, and succeed in proper management or cure of their illness. This is doubly true about psychiatric problems.

What then can a clinician discern about psychiatric illness through the lens of dissociation as we scan across many cultures? I believe that what shows up inevitably is the role of affect, and affect dysregulation at the root of disturbances for all the individual cases described. Is affect dysregulation a factor which is present as a problem across cultures when mental illness is present, and especially when there is dissociative process? The authors in this book don't go out of their way to make this point, but if we look between the lines, and not even all that hard, I think this becomes obvious.

Let's look at a few examples. One of the more consistent cultural themes is the notion of demon possession, or simply possession by an outside entity. What are the properties and characteristics of these possession states? Thoughts, feelings, and motivations of the demons are anathema to the culture involved. Violent feelings and wishes to perpetrate violence, sexual feelings and wishes to engage sexually are part of what is routinely disowned in many cultures. [While the emphasis in this text is intentionally from outside North America, possession beliefs have included people living in the United States, as indicated in the infamous Salem Witch Trials of 1692 (http://www.salemweb.com/guide/witches.shtml].) Aggressive feelings are part of the demons who possess persons, in these reports. These are "Not-Me" experiences (Chefetz, 2004). Shame feelings are also very much at the core of intense emotional pain that is visible in many cultures where there is possession (see the papers from Iranian, Pacific Rim, and Hispanic cultures). The emphasis in the cure of possession experience is on the exorcism of these thoughts and feelings as embodied in the demon spirit. In a psychoanalytic therapy, the emphasis is on acceptance of these feelings representing a human response to living in adversity and reacting to the world around us. Feelings are distinguished from actions. However, for example, Catholicism has made a point of telling people that to have a thought or feeling that might be called criminal is equivalent to committing the crime. These kinds of beliefs make having discordant thoughts and feeling not just inimical to one's stability or acceptability in a social group, but run the risk of shunning or excommunication from a life giving social setting. It is this kind of threat that "stray" affects, wishes, motives, and thoughts presents to the one who beholds these experiences.

The work of Alan Schore, Mary Main, Karlen Lyons-Ruth, and many others (Schore, 2003) (Main, 1996) (Lyons-Ruth, 2003) (Beebe, 1997)

makes clear that it is in the interaction between infant and parent that the growing child develops their capacity to emote and to manage affective experience. Knowing feelings is a relationally based experience, a skill that is taught by interactive and unconscious implicit processes from the early moments of life onward. Listen to the histories of people with the illness described as "amok." The unmanageable rage is visible. This is also the case in some other culture bound syndromes with violent and amnestic episodes. This is the case in "latah," where there is a hypersensitivity to fright. "Ataque" seems to be related to symptoms of panic. In my experience, panic is related to fear of intense affects such as anger and shame. The affects cannot be consciously tolerated, and instead there is a dissociation of the manifest physiology of the affect from the knowledge of the named emotion that would result if the feeling was able to be felt. Somatization, as described in the work of Henry Krystal, is the somatic manifestation of an affect state that lacks translation from the affective physiological roots of emotional response to the felt and lived experience of a feeling (Krystal, 1988) (in this discussion an affect is the not-conscious psychophysiologic tension out of which lived, conscious feelings emerge to which we assign the name of an emotion). Somatization is a frequent corresponding symptom in people with culture-bound dissociative processes.

Support for the contention that we could track the affect regulatory styles between cultures as a way to understand culture bound psychiatric syndromes comes from cross-cultural attachment studies. In a chapter on the individual differences that occur in personality between persons, the authors describe the results of some attachment research (Oatley, 2006). They cite data in comparison to norms in English speaking countries where they state that 65% of infants are secure, 20% avoidant, and 15% ambivalent (this obviously leaves out data on what was formerly known as the "unresolved" or disorganized/disoriented classification that a vast majority of children show when their parent is frightened, frightening, or unresponsive (Schuengel, 1999)). Israeli Strange Situation studies showed a higher proportion of children who were ambivalent (Sagi, 1985), German studies showed that nearly 50% were avoidant (Grossman, 1985), and in Japan there were no avoidant children (Miyake, 1985). As Oatley and colleagues speculate "children . . . are likely to vary in how frequently they experience separation . . . [how parents] value independence . . . [how parents encourage] expression of fear and sadness . . . [and, how often parents] encourage bodily contact" (p. 297). How parents manage and communicate affect has a profound influence on the growth and devel-

opment of a child, and reflects culturally sanctioned and enforced modes of affective communication and behavior. Dissociative process, in this view, is fundamentally a result of the relational aspects of familial styles of affect regulation. Family styles of affect regulation are guided by cultural sanctions.

CONCLUSION

Whether you agree or not about the role that affect regulation, or the lack of it, plays in the genesis of culture bound syndromes related to dissociation, or to dissociation itself, my challenge to you is to track *something* of interest to you as you read through these pages and develop your own hypotheses that can lead to your own formulation of some meta-theory, some organizing principles, that allow you to translate what you read into what you can take with you to talk about with your patients. There is little that is as important as educating ourselves in the service of increasing our understanding of what it is to be human. The study of dissociative processes, their manifestations in different cultures, and the particulars of "the shapes, colors, and sizes" of these manifestations have a lot to teach us about each of our own cultures and the minds that are grown within. As you read through the pages that follow, I hope you will take the time to speculate about your own observations and the observations of others who study dissociative processes. If you do, then at least some of the wishes of the dedicated clinicians who have written about their observations will come true, and make a difference in this wonderful and terrible world in which we all try to live.

Some weeks ago, as I made preliminary plans to write this foreword, I came across these words, the source for which I've lost. I believe this is a fitting way to close my contribution to his book:

> In a small, ancient cemetery in Celigny, Switzerland, there is a gravestone
>
> with this message from the deceased occupant of the plot:
>
> "Listen my friends: There is still time for you to help change the world".

Richard A. Chefetz

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PART I

Introduction

George F. Rhoades, Jr.
Vedat Sar

It was 9:00 a.m. on the eastern shores/beaches of Sri Lanka, December 26, 2004. Without warning, the first tsunami wave hit, only to be followed by two even more devastating waves. People called the next town to warn them and as they were still on the phone, the wave came into sight of the new victims. It only took minutes, but 800,000 persons lost their homes and over 38,000 lost their lives. The tsunami was no respecter of persons; both locals and tourists, rich and poor were equally devastated.

The first author personally visited Sri Lanka approximately a month-and-a-half after the event and was astonished by the contrasts in the wake of this so-called natural disaster. One site visited was the empty passenger train that had come from Colombo (the capital city) on that fateful day. The train had over 1,000 people on board, but swelled to almost 2,000 as people climbed aboard to seek shelter from the killer waves; they all drowned. Four family members clung to a coconut tree and were able to survive. A father told of holding two children in his arms to only have one ripped from him and then the other child as well. The author met a fisherman in the southern city of Galle who lost all 11 members of his family in minutes: his wife, children, and grandchildren. He wondered why he was left behind. A camp leader (refugee camp) told of his 13-year-old daughter who was swept away by the fast mov-

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ing waters. He later found her dead in the mud; he cleaned her up and then carried her on a board, on his back to the hospital. The hospital refused to return the body for a burial.

Some people reportedly became greedy and started cutting off ear lobes and fingers to steal the jewelry and even tried to sell the bodies to the families. Due to these reasons and the need to maintain community health standards, the government decided to intervene and did mass burials, continuing the trauma for the families. They now lost their loved ones twice, once in death and then in not being able to say goodbye in a memorial service.

In a period of a month-and-a-half, the number of homeless has been reduced to around 400,000, with multiple refugee camps around the country. The camps are housed in Buddhist monasteries, Catholic schools/grounds and government-sponsored areas. Many of the camps are guarded by the Sri Lankan military, to provide order within and without the camp. The overcrowding, lack of water/resources in some camps and the overwhelming grief of the refugees extend the trauma of the tsunami and create daily dissociation. The refugees desire to have memorials for their loved ones, permanent homes, and to return to work.

In contrast, the inland of Sri Lanka has continued in many ways as it was before the tsunami. The streets of the cities/towns are very busy with a menagerie of vehicles and animals. Driving up the left side of a street in central Sri Lanka (traveling to Kandy) the author was passed by an elephant on the right side, along with buses, cars, trucks, "three-wheelers," "free" cows, goats, and dogs. Roadside vendors are smiling and ready to sell seasonal fruits and delicious locally-grown cashews. People work hard, parents are seen walking their children to school each morning and have celebrations such as weddings.

The people of Sri Lanka had never experienced a trauma as universal and devastating as the tsunami. They have responded to the trauma in a way unique to Sri Lanka, but also in common with other nations and peoples of the world. They have sought understanding of the trauma according to their religious beliefs (Buddhist, Hindu, Muslim, and Christian) and have tried to recover according to their cultural practices. They have also experienced intense grief, survivor's guilt, and the dissociation that is seen among trauma survivors around the world. The commonly seen anger in such situations is beginning to surface as the Sri Lankan survivors move out of the emotional numbness/dissociation into a more full realization of their losses. The dissociation of the rest of the country is similar to other countries

dealing with tremendous losses and even individuals that want to dissociate from pain and trauma to live their lives.

The people of Sri Lanka are a strong, proud people that will come through this crisis with the help of their families, their religious faith, fellow citizens, the government, and millions of concerned individuals and organizations throughout the world. We are truly an international community in times of crises. It is also increasingly apparent that we are also an international community in the experiencing of trauma and the resulting effects of that trauma.

This international mosaic of pieces has been formed through selection of the individual content by the authors themselves. The editors did not perceive any necessity to guide the authors in order to prevent repetitions as the chapters had a complementary nature already. It is noteworthy that so many contributors have perceived trauma and dissociation as a socio-psychological phenomenon and referred to sociological and even political aspects of long-lasting traumatization in various countries. In fact, besides man-made traumas such as childhood abuse and neglect, terror, and war, even the prevention of devastating effects of natural disasters has economic and political dimensions. An example would be the impact of the Marmara area earthquake in Northwestern Turkey in 1999, which led to twenty thousand casualties. The devastation could have been limited by more rational urbanization policies and human-centered economic investment.

This volume will look at international trauma around the world, including the uniqueness and the similarities of that trauma, both to the particular nation presented and the world at large. We will examine trauma and dissociation in the United Kingdom, Northern Ireland, France, Germany, Turkey, Iran, Israel, Africa, China, Japan, Philippines, Australia, New Zealand, Hawaii, Puerto Rico, Columbia, and Argentina. The book has purposely not included North America to show that trauma and dissociation is not just a "North American phenomenon."

What Is Trauma and Dissociation?

Vedat Sar
Erdinc Ozturk

SUMMARY. Although the official term of posttraumatic stress disorder implies the opposite, trauma is not identical with the noxious event itself. An adequate definition of trauma would require the inclusion of both the objective and subjective components of a traumatic experience. Moreover, trauma is not limited solely to the traumatic situation, but is better defined as a socio-psychological process which can be completed in the course of time, if at all. The superposition of multiple trauma processes throughout a person's life span can make this task even more complex. We propose that what turns an experience to be traumatic is not only the interruption of information processing, but the activation of a maladaptive process, i.e., trauma is a threatening experience which turns an adaptive process to a maladaptive one. The six concepts of traumatic double-bind, traumatic turning point, completion expectancy, traumatic time perception, traumatic obsessions, and traumatic whirlpool are presented to better clarify this maladaptive process. Traumatic experiences and the consequently altered self-perceptions contribute to the impairment of the mutuality between internal world and external reality of the affected person. This is accompanied by a renewed percep-

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tion of the self in context of a different reality accompanied by an alteration in vigilance, awareness, control, and sense of concentration. Depersonalization is the core clinical element of this resulting condition which is called dissociation.

KEYWORDS. Trauma, dissociation, cognition, time dimension, society

Trauma is not limited to or identical with a noxious event. Thus, the term posttraumatic stress disorder is a misleading one. Trauma is, in fact, an experience which is related to both the subjective and objective components of a situation. Accordingly, Fischer and Riedesser (1999) have defined trauma as the experience of vital discrepancy between threatening factors in a situation and individual coping abilities. Moreover, trauma is not merely a situational phenomenon, but a longitudinal socio-psychological process which develops in time and follows a course.

The resolution of traumatic experience is comprised of multiple components. The hallmark of trauma resolution is the ability and opportunity of the subject to respond to traumatic experience adequately. The available responses in a traumatic situation, however, may be rather limited. First, a person may escape from the traumatic situation. Second, the subject may process the situation until it is resolved. A third possibility is to deny some aspects of the experience. The latter results in the inadequate processing of the traumatic experience. Fischer and Riedesser (1999) even assert that, by definition, a traumatic situation is a condition where an adequate response is not possible despite existential threat. This inherent paradox, however, drives the trauma process.

Without immediate resolution of the traumatic experience, the subject will devote extensive energy for processing of the trauma after an interval following traumatic experience. Past trauma is then repeatedly handled in the context of present time in the person's active memory (Horowitz, 1986). This repetition is inevitable and different psychological realities emerge following each repetition. The new psychological realities contain cognitions which are designed to provide solutions for the perceived traumatic impasse. However, these cognitions usually have a self-destructive character, i.e., they do not lead to resolution of

the impasse. In contrast to that, the subject who is able to process the traumatic experience immediately has no need to produce further versions of realities or to distort realities in order to find solutions.

These repetitions only cease when the contents held in present, active memory have been terminated by the completion of the cognitive processing of the trauma. The word 'ukde' of everyday language in Turkey, which means 'knot' etymologically, refers to the inner experience about an unforgotten upsetting past event that the subject was not able to respond adequately and timely. The word 'ukde,' with both its meanings, accurately describes the situation of a traumatized person.

INNER WORLD AND EXTERNAL REALITY

The goal of the trauma process is the continuity of the traumatic experience with other life memories, and the reintegration of personal goals. However, a traumatic life event is, by definition, one that is not fully in accord with a person's usual inner working models (Horowitz, 1986). Thus, the continual revision of relatively enduring structures of meaning is necessary to bring these inner models into accord with current reality. They can then guide decisions toward the next most effective possible actions.

The harmony or synthesis of an organism and environment may be illustrated by internal regulation systems called schemas (Piaget, 1947). Schemas have the two functions of assimilation and accommodation. When there is no problem, the schema is active. It assimilates the constellation of the external world into a personalized environment. In this case, the environment does not resist the reproduction of the schema. If there is a problem, the schema needs to be transformed until the problem is solved through effective action. The accommodation process then involves an active modification of the person's schemas to allow the incorporation of the new experience or information. When the process of accommodation is successful, the environmental situation can then be assimilated (Fischer & Riedesser, 1999).

Relationship schemas contain cognitions, emotions, affects, wishes, and moods. General schemas which coordinate other schemas are called scripts. Persons in a healthy mental state maintain a variety of inner working models or 'cognitive maps' of basic factors in their lives. These factors include their body image, various other self-concepts, role relationship models, scripts and agendas, spatial layouts of their repeated environmental circumstances, and other schemata that help them organize their

perceptions and plan their future actions (Horowitz, 1986). Traumatic experiences which can not be integrated to the whole system of schemas remain as dissociated schemas, contradicting coordination rules, and scripts. There may be trauma-compensation schemas as well (Fischer & Riedesser, 1999).

INTERRUPTED PROCESS AND COMPLETION TENDENCY

The need to match new information with inner models based on older information, and the revision of both until they agree, can be called a completion tendency (Horowitz, 1986). The completion principle summarizes the human mind's intrinsic ability to continue to process new information in order to bring up to date the inner schemata of the self and the world.

Lewin (1935) stated that any intention to reach a goal produces a tension system that is preserved until a goal is reached. It was this theory that led to the prediction of the Zeigarnik effect, i.e., a tendency for interrupted, uncompleted tasks (not performed under stressful situations) to be better remembered than completed tasks. Mandler (1964) suggested that in addition to the completion tendency of initiated plans, interruption may lead to a state of increased arousal that is distressing and is maintained until the plans have been completed. The organism thus favors completion in order to end this distress.

Completion requires the resolution of differences between new information and enduring mental models. Every repetition may be a confrontation with a major difference between what is and what was gratifying and may invoke various responsive emotional states such as fear, anxiety, rage, panic, or guilt. If these emotional responses are likely to increase beyond the limits of toleration, the result may be overwhelmed states of mind. To avoid entry into such states of mind, therefore, control mechanisms are activated that will modify the cognitive processes (Horowitz, 1979).

WHAT IS TRAUMATIC?

According to the DSM-III's definition (criterion A) of Post-Traumatic Stress Disorder, a traumatic event creates significant stress symptoms and is outside of usual human experience (American Psychiatric Association, APA, 1980). The assumption was that the severity and un-

usualness of the event would lead to similar symptoms for an average person with similar sociocultural values and under similar conditions. However, this requires a decision by clinician as to what would be outside of the usual human experience and the the subjective experience of the person affected was not taken into account. In DSM-IV, for an event to be traumatic, "unusualness" was no more required and subjective experience was taken into account (APA, 1994). The criterion A was separated into two parts: (1) The person experienced, witnessed, or was confronted with an event or events that involved actual or theatened death or serious injury, or a threat to the physical integrity of self or others, and (2) the person's response involved intense fear, helplessness, or horror. Although this revision led to a more balanced view, as a phenomenological definition, it does not refer to the main psychopathological point what makes an event traumatic for a certain person.

Traumatic Obsessions and Completion Expectancy

The subject who has not resolved a traumatic process needs to work on the unmetabolized traumatic experience repeatedly. These repetitions may eventually take the form of 'traumatic obsessions.' From a psychopathological point of view, the traumatic impact of a noxious event depends on the activation of a maladaptive process. The starting point of this maladaptive process is the conversion of traumatic obsessions into a "traumatic whirlpool" The intensive urge to maintain the development of the life goals established before the traumatic experience is called 'completion expectancy.'

One of the most important aspects of processing trauma is not the issue of whether an adequate response was possible or not, but the degree of the preoccupation about developing an adequate response. The subject liberates all his or her devoted energy for this preoccupation and maintains an expectancy for the complete metabolization/resolution of the trauma. This expectancy of an exhaustive metabolization leads, in fact, to resistance against processing trauma in psychotherapy as well. Herman (1992) wrote that the "resolution of the trauma is never final and recovery is never complete." Nevertheless, the expectancy of completion of trauma process remains.

The completion expectancy is different than the completion tendency. The completion tendency is seen as the drive to complete an interrupted process. The completion expectancy consists of positive predictions, that one can or will be able to complete the goals/process of one's life. This is interrupted by traumatic experience suddenly and definitely. This inten-

sive and involuntary urge (i.e., the completion expectancy) and the repetition tendency of the information (which is interrupted by traumatic obsessions) end up in a traumatic whirlpool. It is crucial to stop the obsessions and to take the person from this maladaptive process to an adaptive one.

Unpredicted Possibility and Being an Object

The traumatic event would have been seen as an 'unpredicted possibility' (Öztürk, 2004a). The development of the fear response and its maintenance among human and animals are related to the unpredicted and/or uncontrollable nature of the stressor (Basoglu & Mineka, 1992). People tend to inquire into the causes of and attempt to understand stressful events in order to better predict and control them (Harvey & Weary, 1985; Weiner, 1986). The traumatic experience interferes with the ability to attribute meaning, diminishes associative capacities and leads to the temporary loss of control.

Trauma is often characterized by loss of control which may be experienced by the subject as helplessness (Fischer & Riedesser, 1999). As such, the person may be seen as merely an object of the unpredicted traumatic situation rather than being a subject, because the person can not save himself/herself. The person can not possess mastery about the experience. This may be seen as the main reason that a situation becomes traumatic. The traumatized individual often experiences anger. The person is at the center of this feeling at the beginning. The anger generalizes afterwords to involve the people in their life and can reach the level of rage. This generalized anger may be seen as the main motive of repeated suicide attempts and self-destructive behavior (Öztürk, 2004b).

These circumstances prevent the traumatic experience from being processed. The unprocessed traumatic experience leads to a dysregulation in the responsiveness of the individual. The person's behavorial reactions tend to polarize on a spectrum from unresponsiveness to excessive reactivity (Öztürk, 2004b). The person is seen as more fragile after the traumatic experience, i.e., more unprotected against external influences. The subject then tends to lose the leading capacity in their circle of life. Thus, the incomplete trauma process has the three clinical consequence of loss of temperance, loss of sense of control, and a sense of increased or diminished interpersonal distance in their life circle.

TRAUMATIC EXPERIENCE AND PERCEPTION OF TIME

Time is one component of the background which influences all perception (Beere, 1995). All experience, all perception occurs in and over time: the present moment comes from a past which leads to a future (Merleau-Ponty, 1962, as cited in Beere 1995; Levine, 1997; Stern, 2004). A traumatic situation does not end in the objective time, or not per se when the traumatic event ends (Fischer & Riedesser, 1999). On the other hand, the experience is not intially conceived as trauma when the noxious event is still happening. It becomes psychologically traumatic when the event becomes past. Each moment that the trauma is processed becomes the present whereas the traumatic experience remains in the past. Normal time perception is replaced by "traumatic time perception" during the trauma process.

Traumatic Obsessions and Time Perception

In the processing of the traumatic experience, the subject's concentration on the past traumatic experience is done in the present. The main difference between past trauma experience and its version(s) in the present time are related to both time and context. The traumatic experience which remains in the past tends to create new and distorted perceptions of reality. The existence of multiple versions of perceived reality make the processing of the originial trauma difficult. The current versions of the trauma may differ after each repetition and may detach from its original form gradually. The most recent version remains as the final form for a certain period of time. New versions of reality and new cognitions form according to the moment when the processing of the trauma is interrupted and according to the phase of the process in which the subject is stuck. These cognitions typically suggest that a solution is not possible or they do not provide one. Consequently, the subject is unable to complete the trauma process.

These traumatic obsessions dualize the perception of present time. Each traumatic obsession is an infiltration of the past into present. Although the traumatic experience belongs to the past, the subject experiences the present time as infiltated by the past due to these intrusions without being aware (Van der Kolk & Van der Hart, 1991). This phenomenon interferes with the integration capacity and leads to a loss of ability.

The traumatic experience is then characterized by a vast proliferation (inflation) of operational options in the subject's mind. They are based

on representations of inadequate operations in other past problematical experiences of the subject. One of these options takes the priority to deal with the trauma experience. This option, however, does not usually lead to a solution. The repetition of the representations of these operations in the active memory is an attempt to solve the trauma. All other operations which are excluded (from the perspective of time dimension that remain in the past) are transferred to inactive memory during these repetitions, either partially or totally.

The excluded operations may then lay the foundation for the immediate or future development of alter personalities seen among dissociative subjects. The various solution methods for recurrent traumatic experiences and repeated cognitions detach from each other. They become autonomous and reveal separate domains. They are transformed to alter personalities. Excluded operations, when formed alter personalities, are then tried to be utilized as solution methods in further domains of life problems.

Traumatic Turning Point and the Most Upsetting Traumatic Experience

Traumatic experiences interrupt the linear process of the complete psychological development throughout a person's life . These interruptions interfere with several capacities of the individual, e.g., social adjustment, defense mechanisms, problem solving and coping skills. At the same time, these interuptions can cause inadequacies in the person's intellectual and affective personality dimensions (Öztürk, 2003).

Traumatic experiences, that occur in childhood in particular, are unpredicted and unexpected. Thus, early traumatic experiences cause more intense interruptions in the aimed psychological integration more intensively. The traumatized individual has two life periods around the traumatic turning point: one life period before the traumatic experience and one after. The traumatic turning point does not refer to the first trauma which the subject has experienced, remembers, or realizes in time, but rather the most upsetting experience which happened most likely in childhood. The traumatic turning point refers to the most upsetting traumatic experience which takes a major role in the development of trauma schemata (Öztürk, 2004a).

The traumatic turning point may be perceived as a double-bind that interferes with the completion expectancy of a person's life. The traumatic event divides life in two parts. The expectancy and aim of a complete and whole life mostly consists of positive predictions. A person's