Nike-Ann Schröder

Discussing Psychotrauma with Tibetan Healing Experts: a Cultural Translation

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Thank you.

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Preface

Some 5400 kilometres south-east from Berlin, where I spent my time writing this M.A. thesis that you are currently reading…

...there lives an old monk.

He is about 77 years old now and stays in a small room which is approximately seven square meters in size and where all of his possessions fit. This place, where I met him a while ago, is located 3500m above sea level in a Tibetan refugee camp in Ladakh, which is a part of the Indian state of Jammu and Kashmir. The old monk was not born there, he is a refugee from Tibet. When he came over the Himalayan mountain ranges in 1960, his eyes had seen the destruction of his monastery, the deaths of family and fellow villagers , and the people who died while trying to escape from Tibet. Now, even though he is quite old, he spends his days curing sick people who live in the refugee camp.

Closing my eyes, I can see the situation of our first meeting: While we are sitting on the floor of his small room, having some cups of Tibetan tea and tasting the typical Ladakhi dried apricots, I ask my main question on whether he has come across anything like Psychological Trauma in his medical practice/among his patients. He thinks it over carefully, looks at me with shiny eyes and then smilingly answers with a soft voice full of compassion:

About that Psychological Trauma [bzod mi tub pa'i sdug bsngal dka' ngal myongs pa'i na tsha[1]] you described, that thing when for example someone is scared and shocked and gets ill when he sees someone who gets killed…this… I have not seen it so far.

(…)

During those days, a good Tibetan friend of mine had problems walking; he had blisters on his feet. When I went to his place to give him some medicine, it took me

1 "Having experienced 'unbearable suffering and hardship'-illness", term was created in cooperation with the Ladakhi Amchi Tsewang Smanla when discussing the Ladakhi and Tibetan version of my 'initial points of discussion', which serve as one part of my guideline for the open interviews.

only a short time to identify the problem: Looking at his very new shoes, I saw that the leather hadn't been walked soft yet, and this was where he got the blisters from. While taking the medicine he said: *I will go to this oracle you just met for the interview. The medicine might have no effect. She will know what I will have to do.* He walked to seek help, in pain, wearing his new shoes.

The oracle's treatment which included tying threads of five different colours around my friend's middle finger, was successful. I realized that my diagnosis had just been an assumption, or rather: what I had seen made sense and could be claimed as a fact only within a certain cultural framework: that of my own culture.

(…)

This thesis is about bringing the western concepts of Psychological Trauma and Post Traumatic Stress Disorder into dialogue with Tibetan and Ladakhi healers living in Ladakh. It is about culturally different understandings of approaches to health problems, which at first glance might seem to be incomprehensible, but slowly reveal themselves and include (for the western researcher) their different way of dealing with the question raised at a second glance, thus showing gaps between different cultural assumptions underlying the understanding and treatment of illness. I want to grasp and analyse how Tibetan and Ladakhi healers understand and approach the various issues enclosed in the western concepts of Psychological Trauma and Post Traumatic Stress Disorder (PTSD).

At points when medical and socio-cultural views, coming from different socio-cultural contexts, meet (either by transferring medicine from one society to another, for instance through the work of international aid programs, or through patients seeking health care in countries which are not their own, for example working migrants) manifold dynamics may arise. These dynamics may include a whole range of positive, neutral or negative effects. Positive effects are adopting new methods for an enrichment of treatment options. Neutral effects could be ignoring or non-compliance. Negative effects may result in the destruction of former possibilities of health care and healing, either in the form of ruling out former approaches or due to the arising of confusion regarding those former approaches.

These dynamics, which follow an application of medicine outside the cultural framework that it originally comes from or at least is socio-culturally embedded in,

can have different consequences, which may involve, or touch, on very different areas: changes in public health care and frequency of diseases, change of economic conditions, relations of power, social relationships and so on. Therefore different approaches to the topic include Epidemiology, Public Health, Sociology and Ethnology etc. This separation is artificial, as each of the included areas will have an impact on the others. However, in this thesis I will look at the field of cultural realities and their impact on the topic.

Exploring these kinds of culture-dependent dynamics that are arising in the field of practice and that may have consequences for all persons involved generally seems to be useful in the following ways: it can serve to (1) clarify cultural assumptions that may play a decisive role, *before* new concepts and their technologies are implemented. But first of all: (2) to understand whether or not the application of western concepts could have any positive effects on the health care sector in non-western countries and (3) to find out whether healers and patients dealing with it are actually interested in these western concepts and treatments (i.e. want to apply them or get help by them to better understand the illness).

These considerations may seem obvious, but I want to take into account the possibility that every person takes his or her cultural view on different topics, in the form of 'common knowledge', along to wherever he (or she) goes: thus, the application of a western concept is already in action when a western NGO-worker treats a Tibetan child in Ladakh in a way that he just considers as “normal”. On the other hand, he may not understand why some Ladakhi neighbours do not share his view on the treatment. A similar process occurs when a rural Ladakhi patient (or even a healer) who is unfamiliar with western medicine would go to a public hospital for biomedical treatment. He or she would have trouble understanding the disease concepts there and would probably need a ‘culture-broker’ in order to understand diagnosis and treatment in a culturally more appropriate way. This thesis seeks to start a cultural translation process on the particular topic of understandings among Ladakhis and Tibetans relating to western concepts, diagnosis and treatment of Trauma and PTSD.

The approach is interdisciplinary. The starting points are western concepts of Psychological Trauma and PTSD, which are developed and examined in the discipline of Psycho-Traumatology.[2] Ladakhi and Tibetan concepts of disorders,

2 I follow the approach of Fischer and Riedesser, who invented and developed the discipline of "Psycho-Traumatology" to combine knowledge and research concerned with the issue, which so far has been scattered throughout various disciplines such as

illnesses and treatment can be studied by western students (when not studied directly as an apprentice in order to become practitioner) in the discipline of Regional Studies (Tibetan Studies).[3] To put the two disciplines of Psycho-Traumatology and Regional or Area Studies into a relation, a third discipline that is integrating epidemiological and anthropological approaches is needed. Medical Anthropology looks at the field of interactions between culture, illness and healing. I will now give an introduction to my topic within the frameworks of those disciplines below.

Chapters 1 (Introduction) requires some space as the three fields mentioned above are all introduced, and chapter 2 (Research Design and Methodology) requires some space as well, as I present the development of a methodological approach for this research. The following chapters will trace the cultural translation process and present the socio-cultural concepts, interpretations and traditional methods of healing into which the healers 'translated' issues enclosed in the western concepts of Psychological Trauma and PostTraumaticStressDisorder.

This research work initially was titled “Cultural Concepts, Interpretations and Traditional Methods of Healing of which from a Western Perspective would be called 'Psychological Trauma' and 'Post Traumatic Stress Disorder' among Ladakhis and Tibetans in Ladakh”. The following introduction takes up all terms mentioned in this title.

psychology, medicine, jurisprudence, psychoanalysis and psychotherapy. (Fischer & Riedesser, 2003).

3 Though first of all, these topics are studied by Ladakhis and Tibetans in the relevant sciences in Tibet and Ladakh.

1
Introduction

Ladakh, Ladakhis and Tibetans, and Traditional Healing Methods

Since 1947, »Ladakh« has been a part of the Indian state of Jammu & Kashmir in the north-west of India, sharing borders with Pakistan, the Tibetan Autonomous Region (TAR) of China and the Indian state of Himachal Pradesh. It is located in the Western Himalaya region, between Karakorum, the Ladakh- and the Zanskar-range of the Transhimalaya, and the Himalayan mountains creating a natural barrier against the Indian plains. The landscape is dominated by mountain ranges and valleys in between, with lower valley areas still being located at more than 3000 m and mountain tops reaching up to 7672m in altitude. Ladakh's mountain region is very dry, therefore all settlements are located in the valleys where rivers and irrigation channels allow the farmers to grow crops in small gardens and fields. Besides farmers living in the valleys of Ladakh, there are nomadic families in the south-eastern part of Rupshu, among them also some semi-pastoralists.

To understand Ladakh's history and its present political and socio-cultural situation, it is useful to follow Bray's suggestion of doing this on three different levels: the local perspective in its uniqueness as well as regional and international perspectives which take into account the relations with Tibet, India, China and also Pakistan.[4]

The borders of the area that is today »Ladakh« differed throughout time due to political changes.[5] Ladakh was incorporated into the Tibetan empire from the beginning of 8th to the middle of 9th century AD. After the decline of the Tibetan empire it became an independent kingdom, first under the rule of descendants of the Tibetan Yarlung-dynasty from the middle of the 10th century, then under the Namgyal dynasty from the middle of 15th century AD, until, in the 17th century AD, Ladakh even covered parts of Western Tibet such as Guge and Purang. In 1834, the country got invaded by the army of Jammu, lost its independence in 1842 and became a part of Jammu & Kashmir which was at the time under the control of British-India, and since 1947 has been a state of the Republic of India. Ladakh today refers to the districts of Kargil and Leh, and includes the valleys of Nubra,

4 Bray 2005, pp.1ff.
5 Ibid.

Shayok, Suru and Zanskar, and the area Rupshu plateau.

There have been manifold relations between Ladakh and Tibet, political as well as economic, particularly in trade. Furthermore, Buddhist cultural and religious exchange has to be mentioned that included pilgrimage and the education of Ladakhi monks in Tibetan monasteries. This used to be a quite common relationship between the centres of Tibetan Buddhism in Tibet and its Central Asian neighbours (Mongols, Kalmyks, Buryats etc.). Nowadays in Ladakh, however, this relationship has shifted to an exchange between Ladakhi and Tibetan groups in Indian exile mainly. Ladakhis and Tibetans use the same (or a similar as Zeisler argues) written language while Colloquial Ladakhi has many similarities with Tibetan, being either regarded as a Tibetan dialect or as language of its own which developed from the same source as the Tibetan language.[6] But Ladakh is also a place, where Buddhism, art and culture has been developed independently. To understand Ladakh and its inhabitants, they should be seen as having, and identifying with, their own cultural heritage which is influenced by Tibet, as well as Central Asia and India. Thus Bray writes that "while acknowledging the importance of their historical links with Tibet, contemporary Ladakhis are keen to emphasize their region's distinct identity."[7]

Due to its position at important trade and pilgrimage routes, Ladakh was an important trading centre between Tibet, Persia, Yarkand, China, and Russia, with Kashmir, Punjab and Hindustan to the other side.[8] The capital of Ladakh, Leh, was an important place of trade, as many trading caravans didn't go further, but returned home from there. With the trade exchange, cultural influences from many regions reached Ladakh. Along with political changes in the 20th century, however, that situation changed fundamentally as well: being a formerly important meeting point of various international routes, it became a remote, but very contested borderland between Pakistan and TAR (Tibetan Autonomous Region) of China.

The status of Ladakh and Kashmir itself is questioned, and huge areas are claimed by India and both neighbouring countries with tensions resulting in fighting in the whole border regions, especially at the Siachen Glacier and the area of Aksai Chin.[9] This situation is the reason for the presence of the many soldiers that are stationed in Ladakh and Kashmir, with big military camps being located at major roads as well as in border regions. Though the old trade routes are blocked, Ladakh

6 See Zeisler 2004, pp. 595 ff.
7 Bray 2005.
8 Joldan 2006, p.43.
9 Bray 2005, pp.22f.

is related to broader national and international contexts, which is mirrored in the many languages that are learned and spoken additionally to the local Ladakhi language and languages of smaller ethnic groups in the region: Urdu is the language of the state, Hindi the official language of the Indian nation, Tibetan is spoken among the refugees and English serves as international language.

Many rural inhabitants of Ladakh, as well as Tibetan refugees, are very poor, because the area is remote and dry due to geographical reasons, and blocked or isolated because of political reasons. On the other hand, this situation of Ladakh led to an intensive development program and financial support by the Indian government. Indian army and international tourism, since the opening of Ladakh for foreign visitors in 1974, offer new job possibilities for locals. Many Ladakhis nowadays work in the one or the other. Also, immigrant workers and traders from Nepal and poor Indian areas such as Bihar and Rajasthan come to work in Ladakh during the summer months. The situation described creates a lot of social, cultural and economic changes that are seen as ambivalent and potentially conflicted by many Ladakhis.[10]

There are different population groups in Ladakh, such as Mons, Dards, Baltis, Kashmiris and Changpas. Among these groups of different origins, some have kept their own languages or dialects and socio-cultural customs. There are mainly Buddhists, but also Muslims (foremost from nearby Kashmir) in Ladakh, while other religions are represented in smaller groups. My first group of informants for fieldwork are »Ladakhis« who are Buddhists and speak Ladakhi as first language. The second group of my informants are »Tibetans«; they are refugees, who escaped the Chinese regime in Tibet, with the first reaching Ladakh after the Chinese invasion of Tibet in 1950/51 and particularly after the uprising in 1959. There are many refugees from western Tibet, whose native region is neighbouring Ladakh, but also Tibetans from other parts of the country. The refugees mainly live separately in refugee camps near Leh, such as Kalzangling, Choglamsar and Agling. The areas are very dry and there are not many trees and plants due to lack of water. Living conditions are poor, but the majority of refugees live in stable houses. There are

10 Several of my interview-partners mentioned the changes in Ladakh, seeing higher living standard and education possibilities positively, but judging the growing importance of economy and the decline of non-economic activities and family and village relations, as well as growing stress, worry, cheating and envy as problems. On general social changes due to modernization see (i.e.) Norberg-Hodge (1991); for a more recent article concerned with local interpretations and problems arising from social changes see: Kressing (2003).

educational institutions in the camps, such as the Tibetan children's village (TCV), the Central Institute of Buddhist Studies in Choglamsar, and the Mahabodhi Society, which also offers medical care. Though many Tibetans work in Leh, Tibetans and Ladakhis seem to live mainly separately. Only occasionally do they have exchange. Some Ladakhis of poor income live in the Tibetan refugee settlements.

The »traditional healing approaches and methods« in Ladakh will be outlined briefly by introducing different kinds of experts, who practice according to local traditions, and who are consulted by people in Ladakh[11] in need of help, when they fall ill and / or suffer from health related problems and disorders.

A doctor practising Tibetan Medicine is called amchi (*am chi, em chi)*[12] or *sman pa*. He is consulted in case of most health-related issues, when these are interpreted as resulting from an imbalance of wind-, bile- and phlegm-energies. According to field surveys conducted by Kala in 1998-2001, amchis in Ladakh looked after 60% of public health cases. The percentage was even higher in neighbouring remote areas, due to non-accessibility of other facilities.[13] The amchi bases his diagnosis on observation, interrogation, analysing the patient's urine and reading the pulse. The amchis mainly employ medicines for curing, as well as external treatments such as blood-letting, moxibustion and baths in mineral springs. Traditionally, the majority of amchis have learned their profession in family lineages, though there have been also institutionalized amchi education facilities.

An onpo or *rtsis pa* (astrologer) is a village healer, who in most cases is a non-ordained practitioner (the onpo shares similarities with a *sngags pa*) trained in divination and rituals. He will be consulted in case of fixing good dates for important undertakings and in case of problems related to bad influences. The onpo bases his diagnosis on an almanac (*lo tho*), other calculation methods and divination. He offers prevention of bad influences to avert misfortune, clears and prevents affliction by evil spirits and uses healing rituals. An important task is the making of different kinds of protection amulets (*srung ba*) that help against various

11 This work is limited to look at Buddhist Ladakhis and Tibetan refugees in Ladakh.
12 From Mongolian *эмч* "doctor, physician"
13 See Kala 2005, p. 1332 f., though his interpretation that the Ladakhi people mainly consult the amchis in case of lack of allopathic health care or because they cannot afford their high prices of allopathic medicines, may not cover the whole decision-making of patients' health seeking behavior.

problems such as evil spirits, dog bites or tooth ache.

The oracles (*lha pa*, *lha mo*, *lha 'bab pa*) are healers who diagnose and treat patients in trance. Thereby the medium person invokes and then gets possessed by a spirit or deity (*lha*), who is believed to embody the actual healing power. People will also consult the oracle for protection and advice. The oracle either heals the patients or advises them where to go to seek help or what else to do. As it is the *lha* who heals and advises, the diagnosis is considered to be based on its knowledge which is revealed to the medium in trance. The medium has to have the suitability for that, which gets mostly revealed through a time of severe illness or greater problems and through dreams. The oracle heals by sucking out illnesses through the skin, and by giving blessings, advice and protection amulets to his or her patients.

There are monks (and few nuns) who heal patients by giving advice and through rituals. Generally, offerings and contact to the Three Jewels (Buddha, Dharma, Sangha) are considered to have a healing effect. Additionally, there are few tantric practitioner monks whose healing abilities are highly appreciated by the people. They get consulted in case of severe illnesses, mental problems and obstacles. Usually, these practitioners are just called by their name, or with the usual title of a fully ordained monk: gelong (*dge slong*). They are considered to have healing abilities and clairvoyance;diagnosis and treatment are based on tantric practice and the power of their personal meditation deity (yidam). Monk healers perform different divination rites and rituals.

Rinpoche (*rin po che*) are incarnate high lamas and are assumed to have strong healing abilities as they are seen as persons who have acquired the qualities of enlightened beings. Just to be in their presence is considered to have a curing and blessing effect. The high lamas are said to have clairvoyance and base their diagnosis on that and also perform divination such as *mo*. They are seen as the strongest power against evil spirits and for curing severe illnesses. They heal with blessings, advice and rituals and give protection cords to the people. There are only few high lamas in Ladakh, and these spend much time on going to other places, therefore possibilities of meeting them are rare.

The traditional healing methods are still applied in Ladakh, parallel to allopathic medicine that is provided in the governmental Sonam Norbu Memorial (SNM) hospital in Leh, in institutions such as the Mahabodhi Society in Choglamsar and small first aid clinics in remote villages. The provision of allopathic medical care has been improved, but the village clinics are not always

occupied and are rather poorly equipped. The introduction of allopathic medicine and socio-economic changes have affected the traditional approaches of healing in many ways. There are Ladakhis who think of the allopathic medicine as superior in any case. However, there are also many Ladakhis and Tibetans who consult the different facilities due to the type of illness or disorder they suffer from.

Socio-economic changes have not only altered decisions in health seeking, but also influence the role of traditional approaches in society and their passing on to the next generations. Kala describes the decline of the amchi profession due to socio-economic changes and the "unwillingness of the younger generation to adopt amchi as a profession."[14] In former times, treatment was offered for free, and the neighbours and village people in turn helped the amchi family with fieldwork. With the economy becoming based on money, a non-income profession like that of a traditional healer loses the important role in society, so that many healers have no successors. The other development is that the healers charge money for their service,[15] aim to work for solvent tourists and move from the village to Leh.

There is an attempt by organizations and NGOs to preserve the amchi profession by offering educational and institutionalized courses. However, many amchis see a decline in this education level. The onpos mostly have no successors at all and it is not sure whether this profession will be preserved. In contrast, however, the number of oracles has increased, and explanations range from higher demand due to higher stress caused by modernization[16] as well as sturdy basic economic reasons. This might be one of the reasons why the authenticity of many oracles is nowadays questioned.

The monastic education of monks and nuns goes on, and traditional approaches are preserved. Though the structural facilities are given, most of the healing monks whom I met were old. One explanation is that the mastery of tantric practice training requires long stays in simple remote places under difficult living conditions; and there are only few people who are able or willing to perform this nowadays.

Next to the great changes in the traditional healing approaches due to modernization, there is also a development which doesn't see traditional and allopathic approaches as oppositional or mutually exclusive. Many traditional

14 See: Kala 2005, pp.1331 ff.
15 Besch describes this situation of change in detail for amchis from Spiti, see: Besch 2006, in part. pp.246 ff.
16 See: Kressing 2003.

healers seem to have included modern medicine as an option for their patients; during one healing session, the oracle in trance first sucked an illness from a woman's belly and afterwards advised her to go to the hospital to get a surgery done. Also monks explained that surgery, allopathic medicine, prayers and rituals are all curing methods which complement each other. The consulting of traditional experts may happen due to economic and access reasons; but also trust in the traditional methods and considering the hospital as appropriate to go to for certain disorders, and traditional methods to apply for certain other disorders nowadays determines the health seeking behaviour of Ladakhis and Tibetans in Ladakh.

Psychological Trauma and PTSD

In this section, the western concepts of »Psychological Trauma« and »Post Traumatic Stress Disorder (PTSD)« will be introduced. The conceptions and approaches concerning the issue of Psychological Trauma – which have originally been developed in the field of psychology – have spread into various directions and conceptions and are applied in a growing number of disciplines such as sociology and history. The process of spreading and applying the concept contributes to anchor the concept of "Psychological Trauma" in the common sense of Western societies. I want to present a brief account of the development of the concept of Psychological Trauma to clarify the concept in its original (western) meaning. My working definitions of Psychological Trauma will follow the "process model" developed by Fischer and Riedesser (2003). The concept of 'PTSD' will be introduced by conceptually relating it to that model, while the field of symptoms will be covered according to the international diagnostic handbooks *DSM IV* and *ICD-10.*

The term 'Psychological Trauma' is derived from two Greek expressions. *Psyché* is Old Greek and denotes 'soul', 'self', 'mind' on one side, within a dichotomy that sees 'soma' or body, anatomical structures on the other side; 'trauma' stems from Greek [*trauma*] and in medical context denotes a damage, injury or wound caused by force.[17] In that sense, Psychological Trauma can be understood as an injury of the 'soul', 'self' or 'mind', or the mental, emotional and perceiving abilities, as the definition of 'psyche' differs due to framework and context.

A short review of some landmarks in the development of the concept of

17 See Fischer & Riedesser 2003.

Psychological Trauma will illuminate some central considerations and perspectives on the concept.[18] In the complex of knowledge of Psycho-Traumatology, various approaches that were developed in the fields of psychoanalysis, research on ‘stress and coping’ and other disciplines are combined.[19] The foundation of the approach was laid when the French physician Charcot who employed hypnosis in research and treatment approaches discovered that various psycho-pathological disorders and symptoms were related to repressed memories of traumatic experiences. Pierre Janet (1859 – 1947) explained these observations with an overwhelming of the consciousness at processing traumatic experiences which results in a dissociation. Thereby the dissociated memories re-emerge in an uncontrolled way as emotions, physiological condition, perceptions or re-enacting of behaviour. Janet also conceptualized these occurrences as memory disorders, resulting in both, amnesia and very detailed flashbacks of the traumatic situation.[20]

The neurologist Sigmund Freud (1856-1939) took the contents of suppressed experiences as a relevant key point in order to apply his treatment-approach of psychoanalysis. He replaced the setting aside of experiences due to dissociation by the assumption of a deliberate resistance of the patient against certain memories that therefore fall into oblivion. Freud’s early assumption of the traumatic experience of child abuse as the main cause for 'hysteria' was later replaced by another explanation model, assuming the traumatic situation to be only a trigger for revealing pre-traumatic neurotic structures.[21] These models have been criticized in many ways, especially by holocaust-survivors and members of the feminist movement.

The Trauma-concept was further developed during and after World War II. Abraham Kardiner was a psychoanalyst treating American soldiers who had fought against the Germans and Japanese. By denoting 'a traumatic neurosis of war' as 'physio-neurosis', he referred to the various physiological symptoms which are accompanying the traumatic reaction and combined these to a syndrome that follows a traumatic situation. This syndrome can be seen as the first step towards the concept of PTSD. The neurosis was interpreted as attempt of adaptation and coping and was conceptualized in three leading categories of ego contraction,

18 There are many authors and many approaches, only some can be mentioned here, on behalf of many more, to show some basic points.
19 See: Fischer & Riedesser 2003, pp. 34 ff.
20 See: Fischer & Riedesser 2003, p. 35.
21 See: Fischer & Riedesser 2003, pp.36-40.

exhaustion of inner resources and disorganization.[22]

The internist Selye invented research on stress by creating a model of stress reaction (1936) which includes the three phases of alarm reaction, resistance and exhaustion. In case the stress triggers are enduring, massive damage and irreversible effects may arise.[23] This observation is essential for Psycho-Traumatology, since due to the non-processing of the traumatic experience, the actuality of the traumatic situation can be preserved over a long period.

Peter Levine takes up Wilhelm Reich's approach of emotions being reflected in physical manifestations, and explains PTSD as a result of a natural process providing the body with resources for a fight or flight-reaction, which are necessary for survival in a life-threatening situation. Psychological Trauma-reaction is ascribed as a final strategy in cases that allow neither fight nor flight: the threatened person stays in a 'freeze reaction' in which the state of consciousness is changed to avoid any sensation of pain. His approach follows the assumption that all tensions which have been build up first for 'flight or fight' and then are 'frozen' in last despair of life-threat, have to be released to set the situation free and let it become past.[24]

Though conceptualized within different approaches such as psychoanalysis or stress- and coping–research, a basic assumption that has been worked out through all these developments towards the concepts of Psychological Trauma and PTSD is the assumption that Psychological Trauma is an aetiologic category of its own, by which psychological and physical disorders can be caused without additional factors necessarily involved.[25]

Fischer and Riedesser invented the discipline of Psycho-Traumatology to combine knowledge and research concerned with an issue that has been scattered in various disciplines. Their approach emphasizes an ecological framework that sees the subject and its surroundings as related to each other, while both have an effect on each other. In doing so, each being creates its subjective universe and attaches meaning to situations.[26] The healthy relationship between subject and its surroundings is constituted by a constructive interaction.

A traumatic experience disrupts this interaction by finding the subject's strategies of problem solving not effective or overwhelmed: if in a life-threatening

22 See: Fischer & Riedesser 2003, p. 40.
23 See: Fischer & Riedesser 2003, p. 42.
24 See: Levine 1998.
25 See: Fischer & Riedesser 2003, p. 19.
26 On the subjective creation of reality, see chapter 2.1.1

situation neither defending nor coping-strategy is successful, a stress-situation turns into a traumatic experience or "crack between individual and surroundings [Umwelt]"[27], in which the situation and abilities to act don't fit any more. This approach is called *eco-psychological,* as it sees Trauma neither as a quality of the event that happened nor as a quality of the experience as such, but as a relation of event and experiencing person.[28] I employ this approach, because its ecological approach offers the possibility of explaining differences due to socio-cultural varieties. Additional to the experience of being helpless, the massive traumatic experience questions the kind of relation that the subject has to the world: it "breaks this basis [the fundament of events expected that give it a meaning] by destroying the trust into the common world, which is passed on by symbols and which links us in the pre-consciousness and which we assume in every interaction."[29] In my research I work with Fischer and Riedesser's definition of Psychological Trauma:

> "'Psychological Trauma' is an "essential experience of discrepancy between threatening situation factors and individual abilities of coping. This experience is accompanied by emotions of helplessness and being at the mercy of events without any shelter. That results in a lasting shake of faith in self-image and in assurance in reality."[30]

As Psychological Trauma is employed in various perspectives, I want to clarify the application of the term according to Fischer & Riedesser's 'process model' of Psychological Trauma. The model includes "traumatic situation", "traumatic reaction" and "traumatic process". Psychological Trauma as described in the definition denotes the "traumatic situation". The "central traumatic situation topic" of this situation is derived from objective circumstances and subjective attachment of meaning due to biography and socio-cultural key concepts. This 'situation topic' has an impact on the "traumatic reaction", which either leads to a completion of the experience and recovery, or becomes a chronic condition ("traumatic process").[31] As

27 Fischer & Riedesser 2003,p.76 ff.
28 Fischer & Riedesser 2003,p.61 f.
29 Bohleber 2000, p.826; my translation; original:"[die massive traumatische Erfahrung] zerbricht dann diese Basis [den Boden des Erwartbaren, das ihm einen Sinn verleiht], indem sie das Vertrauen in die gemeinsame symbolisch vermittelte Welt, die uns vorbewusst verbindet und die wir in allen Interaktionen voraussetzen, zerstört."
30 See Fischer & Riedesser 2003,p.82; my translation. Original: „vitales Diskrepanzerlebnis zwischen bedrohlichen Situationsfaktoren und den individuellen Bewältigungsmöglichkeiten, das mit Gefühlen von Hilflosigkeit und schutzloser Preisgabe einhergeht und so eine dauerhafte Erschütterung des Selbst- und Weltverständnis bewirkt."
31 See Fischer & Riedesser 2003, chart on p.131 and description pp.61-130.

the Psychological Trauma remains a real situation, as long as it is not processed, 'traumatic experience' is not limited to the original situation, but stays present over the course of all three phases. In that sense, Freud described Psychological Trauma as "it is, as if these sick persons haven't been able to deal with[32] this traumatic situation; as if they still are confronted with this [situation] as a current task they have not mastered yet."[33]

The chronic condition or 'traumatic process' includes specific symptoms according to specific traumatic situations and general symptoms that are grouped together in a general syndrome called 'Post Traumatic Stress Disorder'. This syndrome was introduced 1980 as a new diagnostic category. It is described and defined for diagnostic means in international diagnostic manuals such as the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, which gets published by the American Psychiatric Association or the *International Classification of Disease (ICD)* which is published by the World Health Organization (WHO).

The *ICD-10 Classification of Mental and Behavioural Disorders* lists PTSD in the group of *"*F43: Reaction to severe stress, and adjustment disorders", and in the DSM IV, PTSD is listed under the title of "anxiety disorders". In both manuals, the first diagnostic criterion for PTSD is a traumatic experience of a "stressful event or situation (…) of an exceptionally threatening or catastrophic nature".[34] In DSM IV, this criterion is described in a more detailed way as "exposure to traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury or other threat to one's physical integrity; or witnessing an event that involves death, injury or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or close associate." [35] That the traumatic experience is constructed by both, event and reaction, is considered by adding that "the person's response to the event must involve intense fear,

32 Note: the German expression "fertig werden" at this point has a double meaning: 'to be able to deal with', and 'to bring to an end'.
33 Freud (1916-17a): Vorlesungen zur Einführung in die Psychoanalyse. GW XI; cited in: Bohleber 2000, p.800; my translation, original: "Es ist so, als ob diese Kranken mit der traumatischen Situation nicht fertig geworden wären, als ob diese noch als unbezwungene aktuelle Aufgabe vor ihnen stünde."
34 WHO1992, p. 147.
35 American Psychiatric Association 1994, p.424.

helplessness, or horror"[36].

The PTSD syndrome that follows such experience is described by three symptom groups:[37]

1. *Intrusion*[38] or uncontrolled *re-experience* of the traumatic event in images, thoughts, perceptions, dreams, feelings, distress and / or re-enactment.
2. *Avoidance* of situations or other cues that could trigger the traumatic experience and general numbness with social withdrawal
3. *High Arousal* which mirrors enduring alarm reaction, can alternate with exhaustion.

I here employed the concepts of Psychological Trauma and PTSD as 'dialogue starting points' for my interviews during fieldwork. The operationalization of these concepts for fieldwork is described in chapter 2, preparation of fieldwork.

Illness, Healing and Culture

In this section a discipline shall be called in which enables to examine both, the Ladakhi / Tibetan understanding of illness and healing and secondly the concepts of Psychological Trauma and PTSD, and the relations of these two culturally specific approaches and illness categories through the application of medical anthropological methodology. The field of medical anthropology is the intertwining of culture, illness and healing as it not only looks at different cultural systems regarding the topics of illness and healing, but also seeks to clarify the impact of culture on issues related to illness and healing.

Kleinman (1980) differentiates between *disease* and *illness*: disease is a "malfunctioning of biological and / or psychological processes" and illness a

36 Ibid.
37 See WHO 1992, p 148; American Psychiatric Association 1994, p. 428f..
38 It is one possible perspective to look at the process of 'Psychological Trauma' as analogous to the body's self healing strategy of forming 'sequestra' as an attempt of isolating and eliminating an alien element which got into the body. See: Fischer & Riedesser 2003, pp. 22 f., though the authors point out that drawing analogies between physic and Psychological Trauma underlie boundaries. From that perspective, a 'Psychological Trauma' can be seen as a strain, that overtaxes the psychic coping system, and that subsequently is assumed to get dissociated from the normal dynamic of processing experiences into memories as a part of biography.