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A Depth Psychological Approach to Collective Trauma in Eastern Congo

Eberhard Riedel

Collective trauma is a major public health issue at home and abroad, leaving countless millions dead or physically and emotionally scarred. In this article, by blending Kai Erikson's sociological perspective with a Jungian-based depth psychological tradition, I develop a multifactorial approach to dealing with complex collective trauma and a paradigm for disrupting the cycles of violence characteristic of collective trauma. In my work in the eastern Democratic Republic of Congo (DRC) I found that complex collective trauma could not be understood in terms of the symptomatology of the individual trauma survivor. Rather, complex collective trauma spreads epidemically by psychic infection among individuals and communities and across generations. Understanding these complex dynamics requires an approach that is both holistic and specific to the system under consideration.

The dynamic model discussed in this article builds on a paradigm that conceptualizes trauma epidemics in terms of cycles of violence, and intervention in terms of purposeful action that can set into motion cycles of healing. I employ what I call the "purposeful action" paradigm to intervene with a core issue: the propagation of trauma. A pilot study of comprehensive trauma management, the Mobile Clinic Program, has been initiated in three rural areas of South-Kivu Province, DRC, in collaboration with local hospitals and community organizations. The pilot project is designed to test the efficacy of the depth psychological approach to dealing with trauma epidemics. These considerations are broadly relevant to all human rights work and humanitarian aids delivery.

Prologue

She was just 13 years old when she saw militia soldiers murder her mother and father. She tells me, "I was so angry, I just wanted to kill!"—so she joined the same militia that had killed her parents. At 15 she became disillusioned by life in the bush and by being used as a sex slave by her commander. She escaped and returned to her village. Five years later, still angry but determined, she admits to me, "I am still living here or there," and recounts how in dreams her parents instruct her to raise her three younger siblings, which she patiently does. She also manages to go to school and is two years from graduating. Even so, she tells me, "I feel trapped. My life's dream is to become a medical doctor—but I cannot imagine how I will ever get money for tuition." She comes up with the plan to learn tailoring so that she can make and sell clothing. A year later Friends of Cameras Without Borders donates a sewing machine to the local development organization specifically for her use. (Recorded interview with former child soldier, Eastern DRC, 2011)

Introduction

"Is it really only brute force that decides everything?" (Jung, 1945/1970, p. 215). Confronted with overwhelming human suffering and violence during fieldwork in the eastern Democratic Republic of Congo (DRC), I painfully experienced that in our globally connected world, the way we psychologically think about and deal with trauma epidemics can mean life or death for millions of human beings. Such horrendous suffering is caused by the violence and neglect that humans inflict on one another.

In his 1945 article "After the Catastrophe," C. G. Jung discussed collective psychological aspects of the trauma of World War II and the Holocaust in Europe. He used the terms *psychic infection* and *collective psychosis* to metaphorically describe the spread of the fascist virus in Europe during the 20th century.

The American sociologist Kai Erikson (son of Erik Erikson), exploring the human experience of "modern disasters," defined collective trauma as a "blow to the basic tissues of social life that damages the bonds attaching people together and impairing the prevailing sense of community" (1994, p. 233). He also observed that collective trauma creates a "centrifugal force" (1994, p. 232) that pushes already socially marginalized groups ever further from the cultural center. In other words, Erikson recognized that massive collective trauma fundamentally changes community functioning and identity and forces change upon an entire culture.

Witnessing the humanitarian nightmare in the eastern DRC, a paradigm shift occurred in my thinking: namely, that the perverse violence and genocidal warfare *are* expressions of *epidemic trauma* and should be approached as mental and public health issues rather than only as political problems. I found that, driven by an aggression–depression dynamic, collective trauma spreads epidemically among individuals and communities and across generations. In this article, I show that understanding and addressing the mechanisms of trauma transmission are keys to combating trauma epidemics.[1]

Traditionally, depth psychologists have focused on the symptomatology of trauma in individuals (e.g., Kalsched, 1996), though recently research has begun to explore the intergenerational transmission of trauma (e.g., Connolly, 2011). However, the phenomenology and treatment of complex collective trauma have remained largely unaddressed. Of course, when the trauma patient lives in a relatively healthy environment, treatment can focus on the "post" phase of posttraumatic experience, thus tending to the inner trauma environment. However, when trauma survivors live in psychologically toxic environments, the clinician must address a range of complex collective phenomena that transmit the disease.

Complex collective trauma and its consequences are far more widespread than acknowledged, and certainly there are varying degrees of toxicity. I view secular and religious forms of fundamentalism and genocidal tribalism and racism as expressions of collective trauma. In my analytical practice I have treated numerous adult patients and often found that the trauma issues with which they struggle were directly related to their upbringing in extremely fundamentalist Christian families (Riedel, 2009). The impact of radical political ideologies is no less toxic. Having grown up in Germany during and after World War II, I directly experienced how the pervasive collective trauma and collective denial put me on edge. We know that collective trauma spreads in the face of collective denial. In the United States gang violence in inner cities, gun violence across the country, and ravaging addictions on Native American reservations are markers of trauma epidemics. Yet, whereas great efforts are directed at conquering infectious physical diseases, such as malaria and HIV/AIDS, the causes and horrific consequences of collective trauma are ignored.

In essence, I believe that collective trauma is at the heart of contemporary global anxiety and fear. Work in extreme crisis areas, such as the eastern DRC, can help illuminate the general condition. There are historical antecedents to the current trauma epidemic in the DRC. The centrifugal force of collective trauma has subjugated the indigenous population of Congo for centuries, first through slave trade, then barbaric colonial oppression, and now the repercussions of the Rwandan genocide of 1994 and international

mineral exploitation. The toxic confluence of the latter two factors set into motion a human tragedy of unspeakable brutality in which, since 1994, an estimated six million Congolese citizens have died—a horror the world ignores (see Riedel, 2012, 2013).

In the summer of 2013, utilizing the ideas developed in this article, I began a pilot project of comprehensive trauma management at three sites in rural South-Kivu Province, DRC. This Mobile Clinic Trauma Management Program, involving hospitals and the community, offers a new approach to humanitarian assistance, complementing the standard focus on crisis intervention with the positive paradigm of *purposeful action* towards effecting long-term change. The shift in focus is based on the insight that a self-sustaining healing process requires a *method*—purposeful action—that empowers traumatized communities to strive for shared goals, and a *process* that energizes local people so that they can gradually overcome the paralysis of trauma and move forward again. The pilot project offers a *template* that can be replicated by members of other afflicted communities. This approach puts the initiative in local hands, with the potential of effecting substantial change across large areas.[2]

Trauma Epidemics

Field Notes

Most people with whom I work in the eastern DRC are survivors of torture and violence, violated in their basic human rights, robbed of their voices, raped physically and/or emotionally, their humanity trampled. Unarmed civilians are caught in a deadly web of violence perpetrated by rebel militia groups (many supported by foreign powers) that use perverse and sadistic tactics to terrorize and intimidate. Such is the massive trauma that permeates these communities and creates the toxic soup of collective trauma. For all involved, collective trauma is a humbling and humiliating experience, engendering feelings of fear and anxiety in the presence of overwhelming affective energies.

Witnessing the epidemic trauma and its acute and severe consequences, I asked myself: *How can the disease carriers, which lead to ever more violence and suffering, be addressed in order to combat trauma epidemics?* This painful inner confrontation changed my life. I was struck by the insight that the resolution of such trauma epidemics is not *logically foreseeable*. This was a strangely liberating moment: It focused my attention on *patterns* and relations between events and, most notably, in a cyclical rather than sequential temporal order. I realized that trauma epidemics

are characterized by *cycles of violence* and that this cyclical pattern propagates by transmission of trauma. I discovered that collective trauma is a process that feeds on itself—that is, trauma epidemics are the breeding ground for new cycles of trauma via general and intergenerational transmission of trauma and *singular psychopathic events*. The latter are violent outbursts that catalyze the viral resurgence of warfare and violence. Psychic infection is a serious factor in collective trauma transmission. Audergon (2004), a psychologist who has dealt with community trauma in Kosovo, warns, "When we imagine that our psychology is separate from politics, we support violent conflict" (p. xv).

The collectivity of trauma epidemics cannot be understood in terms of the symptomatology of the individual trauma survivor. Rather, dealing with trauma epidemics, I became aware that collective trauma spreads epidemically by psychic infection, back and forth among individuals and communities and across generations. The observation of the *virus-like nature* of the disease process suggests that the phenomenon of collective trauma involves complex nonlinear processes. As such, the resolution of collective trauma is, again, not *logically* foreseeable.

The collectivity of trauma epidemics cannot be understood in terms of the symptomatology of the individual survivor. . . . Collective trauma spreads epidemically by psychic infection . . . among individuals and communities and across generations.

Needing a reference point, I searched for patterns that might characterize the normal, healthy state of a community and came to see such a state as associated with *cycles of generativity*. Certainly, the cycles of trauma and the cycles of generativity are antithetical patterns, and, once established, both are relatively stable. I then asked how might a traumatized community return to a state of relative health? I found that this restoration could be achieved by community-based psychosocial interventions that create a third cyclical pattern, and I called such interventions *purposeful action*.

Under the pressure of fieldwork, a model evolved that takes a dynamic view of collective trauma and that can be summarized by three distinct *cyclical* dynamics that demonstrate the essence of the healthy, the traumatic, and the intervention-focused situations. The purposeful action strategy, which is

the focus of this article, is designed to function as an antidote to collective trauma—that is, as a means to disrupt cycles of trauma and restore, step by step, a traumatized community's resilience.

Theoretical Observations

When investigating models that guide intervention in trauma epidemics, I follow two principles. The intervention strategy must (1) counteract societal fragmentation and (2) deal with a depression–aggression dynamic characteristic of collective trauma situations. Out of this struggle a new spiritual self will develop.

Biologically, the powerful emotional forces associated with massive trauma are deeply ingrained in the trauma survivor's autonomic nervous system. Furthermore, there is emerging evidence of mechanisms that transmit trauma via epigenetic imprinting. These insights should urge us to treat trauma epidemics as public and mental health problems.

How the emotional energies associated with trauma epidemics propagate and permeate the social fabric of traumatized communities is not well understood. In the language of depth psychology, complex collective trauma involves states of possession by powerful affective energies, a numinous possession that maintains and increases societal fragmentation. Traumatized communities are vulnerable to psychic infection. Politicians and warlords exploit such fragmentation and vulnerabilities to inflame groups against each other, a mechanism by which numinous persecutory energies keep vulnerable groups emotionally imprisoned or worse. Readers familiar with Kalsched's (1996) work on the inner world of personal trauma may see parallels between the roles of malevolent complexes at the personal level and singular psychopathic events in traumatized communities.

Cycling back and forth between requirements for intervention and the need for a guiding model, the picture of a bipolar collective trauma complex emerged. The image of a psychological complex with a fragmented core first occurred to me in a dream while working with schizophrenic patients. Collective splitting and societal fragmentation are major aspects of trauma epidemics, and these psychic epidemics exhibit a dynamic determined by possession through powerful, disavowed affective energies of (1) depression and shame, and (2) aggression and rage, respectively. I discuss details in the "dynamic model" section below.

In light of the fact that there is no logically foreseeable resolution to these horrifying trauma epidemics, intervention requires transmitting a method to the community and helping the community to commit to a process that can set into motion gradual change by forging connections with equally strong regenerative energies. This procedure is characteristic of a

depth psychological intervention, offering change via a step-by-step process. Here is an example.

When trauma strikes in rural areas of the eastern DRC, the first responders are volunteer social assistants associated with local community organizations. For me, the social assistants are the bridge to the communities in which I work. As much as possible, I form working relationships and offer them training seminars. Most social assistants are trauma survivors themselves and are easily retraumatized by the trauma they witness every day. These volunteers have little formal training, but they do understand heart-to-heart communication. My mantra of de-traumatization means humanizing the situation. So in training seminars, I model and work on how we develop a capacity to think and hold overwhelming feelings, such as anger, fear, grief, confusion, and shame. I seek to transmit a three-step method: (1) listening with the heart (where Africans locate emotions), (2) reflecting and thinking (with an emphasis on emotional and dream thought), and (3) out of this experience, responding and taking action; and subsequently looping back to listening. I call this the *1–2–3 method*, and we practice it using their case materials.

Out of listening to thousands of people in countless communities in East Africa, utilizing the same 1–2–3 method, the idea of a purposeful action paradigm emerged to combat the spread of trauma. I sense congruence between the Jungian and African traditions of healing that include holistic physical, psychological, and spiritual dimensions.

Interlude

Because collective trauma can be seen as an archetypal phenomenon, the crisis in the eastern DRC calls for a thoughtful analysis. The following vignettes from fieldwork in South-Kivu Province, DRC, offer examples of the *synergy* between local and global social dimensions, and the psychological and political forces that propagate trauma. My fieldwork was conducted during three visits, totaling seven months between 2011 and 2013. The eastern DRC, mountainous and rich in minerals, borders Uganda, Rwanda, Burundi, and Tanzania to the east, and the Congo River basin to the west (see map).[3]

In this contested area of the eastern DRC sexual atrocities and torture are employed as weapons of warfare; such crimes against humanity are committed with impunity by militia rebels and Congolese Army soldiers and are largely ignored by "civilized society" around the world.

Ms. A, age 32, appears anxious, depressed, and withdrawn. She tells me, "My husband left me; he said, 'I can't share my wife with soldiers.'" Brutally gang-raped three months earlier, Ms. A reports that she has received no

Area of fieldwork in the eastern DRC, 2011–2013.

help and has avoided the company of friends and her church community. A familiar and depressing picture of *circular oppression* emerges: The traumatized community scapegoats its victims. The community itself has become toxic, unaware of its fears, unaware of its collective shame and anger, unable to protect its women and children.

Such *transmission of trauma* back and forth among individuals and communities, including intergenerational propagation of trauma, are key factors leading to ever-more vicious cycles of violence and trauma. I facilitated a support group for eight former child-soldiers; their average age was 16, but they had spent a cumulative total of 43 years in captivity in the bush (on average, 5.4 years each). Militia gangs kidnap children long before their executive function and moral compass are developed. The lucky ones who survive and make it back home are then often scapegoated by their communities; many committed crimes, but ostracizing them sends them straight back into the bush and the arms of the militias. I have also worked with groups of parents of former child-soldiers and know about their struggles.

Some children join militias as a consequence of the trauma they suffered. An example is the young woman highlighted in the Prologue. She was eventually able to escape and return to her village, a place where people still live in shock ten years after a terrible massacre in which six hundred people perished.

Mass murder, mass rape, and other *singular psychopathic events* catalyze the viral resurgence of warfare and genocidal violence—and seem deliberately employed for that purpose. Political agreements made since the Rwandan genocide of 1994 have swallowed political reason (which, of course, depends on one's viewpoint) and opened the door to the infiltration by foreign soldiers and officers into the Congolese Armed Forces (FARDC).[4, 5] A string of singular psychopathic events has followed. In 2012, I witnessed one such event: the formation of the M23 militia group, triggered by actions of the rebel general, Bosco Ntaganda. This man was a Rwandan Tutsi militia fighter, and, though indicted for war crimes by the International Criminal Court in The Hague in 2006, he was put in charge of a major operation of the Congolese Army in 2009, and thus continued a reign of rape, torture, murder, and kidnapping child-soldiers. Three years later Ntaganda deserted in mutiny, formed a new rebel militia group, the M23 militia, which, with tacit support from Rwanda and Uganda, caused yet another *resurgence* of violent terror and social fragmentation in the Kivu Provinces of the DRC.

How traumatized communities perceive the response of the world impacts their *resilience;* empathic witnessing *does* matter.

How traumatized communities perceive the response of the world impacts their *resilience*; empathic witnessing *does* matter. When large human disasters strike, such as the thousands of massacres and mass rapes occurring in the eastern DRC, international aid organizations provide short-term help (e.g., Doctors Without Borders). But there is no follow-up, and individuals and communities are left to manage on their own. Many thousands of survivors have no access to medical care, and many of them die. The Congolese trauma epidemic rages out of control in the rural areas, where most such violent incidents occur. It is estimated that as many as six million Congolese citizens have died since 1994, when the Rwandan genocide and tribal conflict crossed the border into eastern Congo. Indigenous ways of life and local infrastructure lie in ruins, and feelings of depression and aggression permeate the social fabric.

Questionable behaviors of Western humanitarian aid industries have corrosive effects. Many knowledgeable people have told me that nongovernmental organizations (NGOs) appear more interested in justifying their projects back home than in taking responsibility for the outcome of their projects on the ground. Unpaid volunteers confided that they were "hired" by an NGO to record the names of victims, but they never received the promised community support—emotional, physical, or financial. A patient of mine angrily complained, "We are tired; we become the *merchandise* of the organization." Such behaviors on the part of NGOs are dehumanizing, retraumatizing, and thus increase suffering. Pointing to abuses of power by NGOs, Gourevitch (2010), a staff writer for *The New Yorker*, raised the thought-provoking question, "Can you provide humanitarian aid without facilitating conflict?" (p. 102).

Finally, the role played by the international community in the eastern DRC is very problematic. Political and economic interests, both inside and outside the DRC, depend on the status quo and take advantage of the instability—for example, to gain billions of dollars annually from mineral exploitation (see Gettleman, 2013). Even international institutions, including UN peacekeeping forces, have been implicated in serious wrongdoing. In two areas in which I worked (Bunyakiri and Mwenga Districts), eyewitnesses accused Pakistani UN soldiers of systematically aiding the Hutu Democratic Force for the Liberation of Rwanda (FDLR) by supplying provisions, weapons, and ammunition, and, in the village of Kamananga, of joining Hutu FDLR rebels in slaughtering 65 villagers. The latter crime thrust survivors into the icy hell of despair, such that they were still shuddering when I arrived four weeks later. As painful as the physical and emotional traumas are, *moral trauma* is, in many ways, more destructive. With basic trust eroded, even in international institutions, some people

give up and lose their will to live, whereas others turn manic and become violent.

The Dynamic Model for Collective Trauma

As noted previously, I propose a psychodynamic model for collective trauma that is characterized by three distinct cyclical dynamics: the healthy, the trauma, and the intervention situations. I visualize the affective force driving the trauma dynamic as a "bipolar collective trauma complex."

Healthy Situation: Cycles of Generativity

I characterize the healthy situation by cycles of generativity (Figure 1). Individual and community life takes place in the ordinary, everyday world, with a dynamic balance maintained between needs and resources (*needs axis*), and community life and expectations (*expectations axis*). This dynamic balance is anchored in core qualities, belonging at once to the individual and

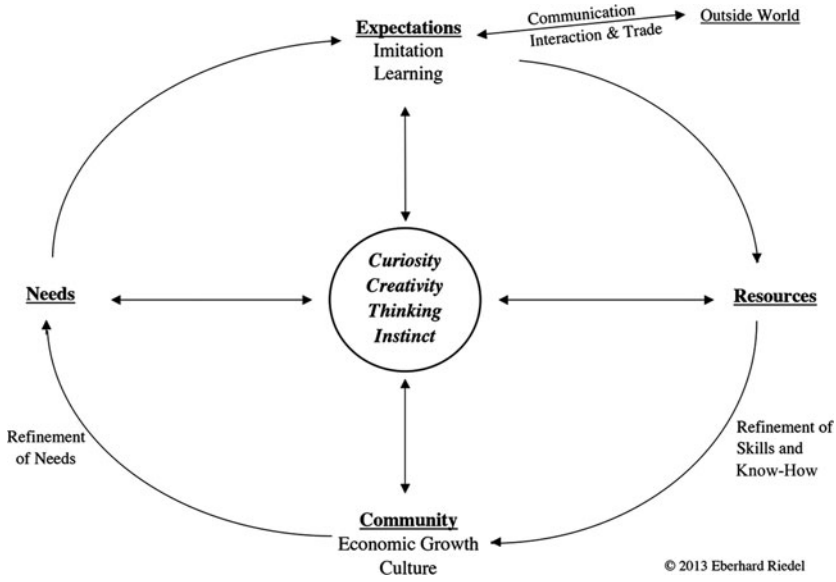

Figure 1. The healthy state of a community characterized by cycles of generativity.

the community, such as an innate capacity for curiosity, imagination, thinking, creativity, and instinct. The refinement of needs is intimately connected to the development of community and culture; likewise the refinement of skills and know-how leads to economic growth and fosters desire for learning. In turn, these dynamics, paired with openness to relational development, both internal and external, increase the self-regulating core strengths and capacity for creative imagination and thinking. The healthy dynamic is one of ongoing flow and movement that provides a foundation for trust in process (psychological, economic, cultural, and spiritual) and resilience in the face of adversity.

I view the emotional energy associated with the central core strengths as a *psychosocial field* (or, depending on emphasis, psychospiritual field) that envelops the community. In the healthy situation the psychosocial field induces self-organizing generative forces. As long as the central core of the individual and communal psyche remains intact, indigenous societies show remarkable resilience in managing challenges, not only temporary or local setbacks and occurrences of disintegration, such as personal trauma or shadow aspects of the community, but also collective trauma due to natural disasters and, on occasion, war and violence. Often in such situations individual and community resources, inner and outer, are mobilized and new skills and a deeper sense of coherence develop.

Collective Trauma: Cycles of Trauma

Complex collective trauma shatters the core, the healthy self-regulating center, thus fundamentally changing most, if not all, aspects of community functioning. Figure 2 conceptualizes trauma epidemics as repeated cycles of trauma. What are the mechanisms that drive this repetition?

Communities suffering trauma epidemics can never escape the terror of this split: the black hole of *depression* . . . and the volcano of *aggression*.

Massive trauma, as has occurred and is occurring in the eastern DRC, shatters the human mind and emotionally imprisons individual victims and communities alike, resulting in loss of inner and outer relatedness. In Figure 2, this loss and imprisonment are represented by a black box labeled *Collective Trauma*. Fragmentation

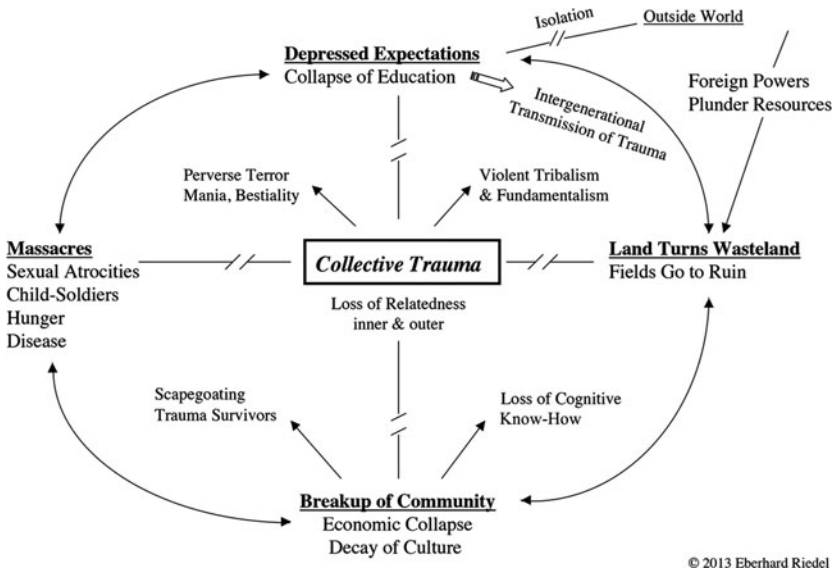

Figure 2. Trauma epidemics characterized by repetitious cycles of violence and trauma.

rules, temporality is lost, and core capacities for imagination and thought are damaged or destroyed. The result is a horrifying *split* in the individual and community psyche. This split *is* collective trauma, a crazy-making mess of evil done and evil suffered.

Living with collective trauma, as in the eastern DRC, is like living on the arc of an ellipse, which, by definition has two fixed points: in this instance, one being a metaphorical *black hole* that threatens to devour everything, and the other a metaphorical *volcano* that erupts in violent attacks. I refer to this bipolar configuration as the *collective trauma complex*, as noted. Communities suffering trauma epidemics can never escape the terror of this split: the black hole of *depression* (with symptoms of victimization, helplessness, dependency) and the volcano of *aggression* (with symptoms of sadistic violence, perverse terror, bestiality). The population is split roughly along these lines and continues to fragment further because communities cannot escape the divisive dynamic of depression and aggression. Typically the collective trauma complex wipes out the capacity for imagination and grief, and *disavowed* emotion takes on a life of its own, internally and externally: despair, withdrawal from life, and paralysis that threaten to devour everything, *coupled with* the panic, violent anger, and hot eruptions that attack life with annihilating force.

In the absence of self-regulating core strength, the split is *acted in* or *acted out*. When acted in, the community turns against itself. However, one must avoid simple labels such as *victim* and *perpetrator* because the depression–aggression dynamic affects both, though in different ways. All are affected by this split dynamic, which powers the centrifugal force that increases fragmentation and polarization internally and externally. Fear and anxiety create conditions that foster secular or religious fundamentalism, leading to tribal violence and racism (see Riedel, 2009). Feelings of abandonment and depersonalization also drive the *environmental destruction* I observe in many crisis areas. Acted out, the tensions created by the split fuel primitive collective defenses of omnipotence and mania, resulting in mass murder, torture, and terrorism.

In the collective trauma situation, the psychosocial field is toxic and engenders destructive emotional storms, societal disintegration and polarization, doom and dread of depression, pressure to discharge aggression, and ever more destructive cycles of violence, trauma, and marginalization. The dynamic of trauma epidemics is evil breeding evil. In the deepest sense, collective trauma is a *disease of the spirit*, a dissociation of the spirit-self from body and soul.

It is instructive to briefly compare Figures 1 and 2. Under conditions of collective trauma, resources are destroyed, needs cannot be met, communities fragment, expectations are depressed, and the central core strength is overwhelmed. This, in essence, is the collective trauma complex.

Singular psychopathic events in the psychosocial field of traumatized societies can cause a viral resurgence of trauma epidemics. People with psychopathic character traits (secular and religious leaders, warlords, but also minor figures), who are expert in intuiting the psychological dynamics of conflict, often trigger such events intentionally. Such perpetrators uncannily incite already traumatized people to commit acts of terror that propagate new cycles of trauma. The birth of the M23 militia group is an example.[6]

Figure 2 shows details of the cyclical dynamic of the trauma epidemic in the eastern DRC. On the one hand, marauding militias engage in massacres, torture, and sexual atrocities (sanctioned as weapons of warfare), as well as the kidnapping of children (used as child-soldiers or sex slaves). The resulting fear and insecurity keep people from tending their fields, which go to ruin, leading to famine and disease. Lawlessness attracts international exploiters (gangs) who, with the help of local criminals or rebel groups, rob the mineral riches of the land, leaving behind a wasteland.

On the other hand, general states of community degradation deplete people's resilience, and this decay fuels new cycles of trauma. I have observed that trauma and fear lead to a fundamentalist mindset

in tribal cultures, thus replacing indigenous values of mutuality with an aggression–depression dynamic typical of collective trauma.[7] Communities scapegoat rape victims and the babies born of such violence, and they shun returning child-soldiers. Husbands abandon wives who were raped, leaving them socially degraded and without means to raise their children and pay school fees. Community breakdown leads to broader economic collapse, and decay of cultural traditions and cognitive know-how affects all aspects of life. Thus collective trauma cuts a people off from their culture, their rituals and ceremonies, the very rituals of mourning and grief that could rekindle healing and rebirth of self-respect.

Purposeful Action: Cycles of Healing

Purposeful action is an intervention strategy that starts with a simple question that I ask the people I am working with and myself: *What is going to help this community move forward again*? I ask this question to evoke curiosity and explore how to set into motion psychosocial processes that could return the traumatized community to relative health, remembering that there is no logically foreseeable solution to the root causes of collective trauma.

The clinician's task is to find and fan the spark that reminds people who are paralyzed by collective trauma that indeed there exists another reality, the reality of ordinary life. Elsewhere I discussed an approach to working with groups of trauma survivors (Riedel, 2013). Here I explore working with traumatized communities and the culture at large in ways that can counteract the imprisoning determinants of collective trauma.

As I commence my work, I hold a very practical question in mind: *Are people and communities free enough from trauma to grieve?* This is how I have come to think dynamically (and patiently) in terms of cycles of healing. As such, purposeful action as a community intervention faces the third cyclical challenge of dealing with interrelated demands: creating sufficient conditions for reconciliation and peace, and addressing collective trauma and the mechanisms propagating it. By carefully listening to the community, I get an idea of how to start the process.

Actualizing the paradigm of purposeful action requires that I transmit a method and find ways to help people commit to a process; the suffering community members know more about the issues facing them than I do, but in the moment they may lack the tools to deal with them. My method offers the community a process with which to gradually approach previously nonnegotiable areas, a standard psychoanalytical procedure. Slowly attitudes change and people realize, "I can think about this, I can learn something new." *These are the steps on a path of transformation from being paralyzed by trauma to living with trauma.*

What I seek to achieve with purposeful action is to help traumatized communities reconnect with enlivening psychic energies. Of course, working in the rural areas I need tools that transcend language and cultural differences. It is not about succeeding at first try. But as the communities' expectations grow, their motivation to stay with the process increases.

Purposeful action opens a transitional space and stimulates curiosity and forward thinking about possibilities.

Let us consider an example of a vocational training project I have started in Fizi Territory, South Kivu Province, DRC, in collaboration with staff and volunteers associated with the Great Lakes Foundation (GLF) for Peace and Justice, directed by Pastor B. Aembe (Figure 3). I am in an area plagued by severe collective trauma and the resulting food shortages. The community reaches consensus to start an agricultural project, and I provide the seed money. What is the potential of this psychosocial intervention for setting into motion processes of healing?

Actualizing this project requires that people plan and work together, which, in itself, rekindles community.[8] It introduces a forward-looking element: reclaiming the land so that it will once more be productive. This challenge induces people to connect with the past, with their indigenous culture, and to redevelop their skills for farming. It provides vocational training for trauma survivors and helps deal with food shortages. Overall the project stimulates curiosity and creativity. It engenders innovative thinking and opens participants to new possibilities for reinvesting in life—*expectations grow*. Through their own experience, the community members see the agricultural project as an opportunity to generate income. Pursuing their shared goals, trade relationships with neighboring communities begin to build.

In essence, purposeful action opens a transitional space and stimulates curiosity and forward thinking about possibilities. Such communal action can counteract fragmentation, restore a sense of inner and outer relatedness, and rebuild resilience.

Depth Psychological Social Engineering

The *Mobile Clinic Program* is a specific implementation of the purposeful action paradigm that offers comprehensive collective trauma management. The aim of the intervention is to combat the trauma epidemic in the eastern

DRC. One might view the Mobile Clinic Program as a depth psychological approach to psychosocial engineering.

Depth Psychological Considerations

Many times during fieldwork in crisis areas of the eastern DRC, I have witnessed the numbing effects of devastating violence and collective trauma, a numbness that kills the soul, leaves people distant and uncaring, and suffocates curiosity and the will to live. During a particularly stressful phase, exhausted and overwhelmed myself, I had this dream:

> We have a flat tire in a small Congolese village. It is Sunday. The mechanic wants to postpone the repair until tomorrow, but I have an urgent appointment Monday morning and say, "*When you are a doctor, you don't have the option of not being there.*"

Faced with collective trauma in today's global world, what is the "doctor's" role? What is *our* role?

"You have given me something more important than money," a former child-soldier said to me. The real problem with collective trauma in the long run is that people come to see the inhumanity they experience as a natural feature of human life rather than the psychospiritual disease it is. Just by modeling a different stance, we can contribute to building resilience and counteract "imitative violence" in the afflicted regions.

Working with traumatized communities, I seek to actualize innate healing powers of the psyche. The chief function of artistic and religious engagement is an embodiment of the interpersonal process dimension of the transcendent function, which can assist communities in reconnecting with their culture, rituals, and ceremonies. This idea underlies my psychotherapeutic photography workshops, which encourage groups of trauma survivors to develop their own narratives (Riedel, 2013). In essence, artistic engagement restores temporality in an immediate way, enabling individuals and communities to reconnect with the realm of past trauma and death, but also with healing and life.

Likewise purposeful action is offered as a sacred pursuit, a ritual reengagement. For example, in the agricultural project (see Figure 3), reclaiming the barren land and making it fertile again *connects* a pillaged community *with* the abandoned environment in an embodied healing process that offers an avenue towards liberating the imprisoned psyche.

Much as collective trauma is a cyclical process that propagates through feeding on itself, cycles of psychosocial healing must reach a "critical mass"

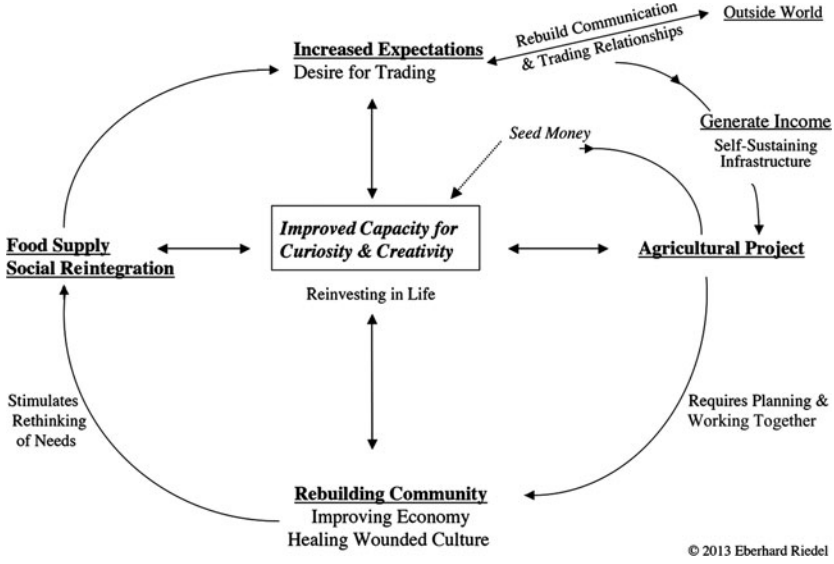

Figure 3. Intervention through purposeful action, promoting cycles of recovery exemplified by a vocational training agricultural project.

to generate sufficient energy to continue. A self-sustaining regenerative healing process requires that purposeful action *empower communities* to strive for shared goals and, in the process, to build an appreciation in people for their *own* capacity to learn and move forward again.[9] Purposeful action generates vitality and restores resilience, enabling a community to deal with inevitable setbacks. This is what I mean by the mantra, detraumatization equals humanizing the situation.

The Mobile Clinic Program

The Mobile Clinic Program transmits a method to the community that can awaken and enliven reanimating energies. Psychologically speaking, the approach fosters repair of the broken links in the social and spiritual fabric of traumatized communities. This multidimensional trauma management approach is summarized in Figure 4.

First, consider the resources–needs axis. Seed money and mentoring provide the resource, Mobile Clinic Program, which in turn tends to the needs—that is, to the management of physical and emotional trauma on the

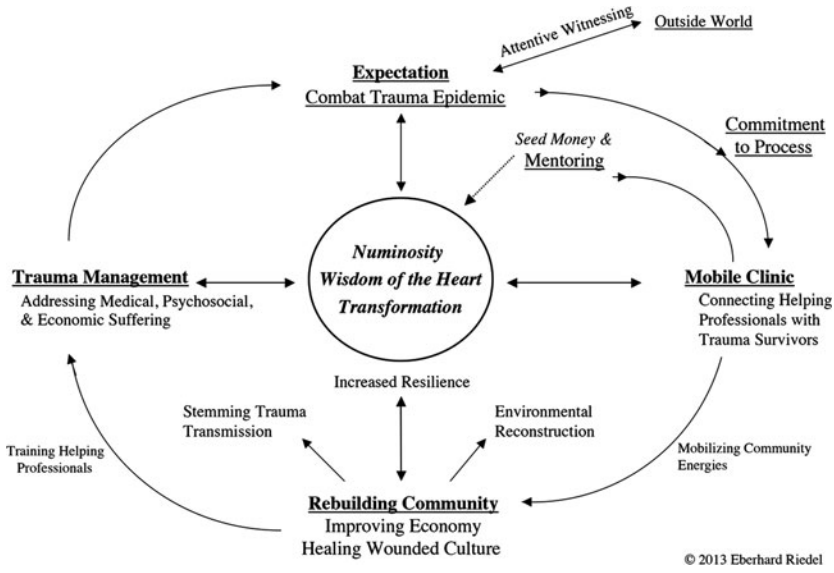

Figure 4. Intervention through purposeful action, generating cycles of community healing exemplified by a Mobile Clinic trauma management program.

individual and community levels. The Mobile Clinic connects medical doctors, nurses, and hospital staff with psychologists, social assistants, and community organizers in an outreach effort to trauma victims in rural areas.

This work takes place in crisis areas ravaged by twenty years of violence and warfare, where female and male survivors of sexual atrocities and torture have had few, if any, opportunities to obtain physical and emotional help. Similarly, the three reference hospitals involved in the pilot project, though traditionally charged with serving large rural areas encompassing populations in the hundreds of thousands, found themselves vastly underequipped to deal with the current trauma epidemic, including the lack of vehicles to serve as mobile clinics or ambulances.

Early results of the pilot project demonstrate the overwhelming need for the outreach component of the clinic program. We had hugely underestimated the number of victims requiring surgical and other medical treatment. From a public health perspective, "making doctors mobile" is essential to stem the spread of infectious diseases, in particular, sexually transmitted diseases (STDs) and HIV/AIDS. From a sociocultural perspective, medical outreach sends humanizing signals to victims and communities struggling with the agony of shame and defeat caused by sexual atrocities, torture, and massacres.

Achieving the goals of the Mobile Clinic Program is a gradual cyclical process. Psychoanalysts working in the consulting room are accustomed to slow progress. Likewise, the key to successful community interventions is helping the community to *stay with* the process. Of key importance is creating continuity and holistically addressing the medical, psychological, and economic injuries of a traumatized community.

Next we consider the *community–expectations axis* in Figure 4. When the population becomes aware of the benefits of mobile clinic action—for example, continuity of care, collaborative efforts of medical doctors and psychologists, and vocational teaching projects that yield tangible results—the transformative processes in the community begin. On the one hand, there is growing awareness about the scapegoating of victims and a reawakening of a social spirit of inclusivity and tolerance, both of which stem trauma transmission. On the other hand, people begin to realize the extent of the environmental destruction, hearing the voices of their ancestors calling out, "You are destroying what is nourishing us." Inherently the mobile clinic approach encourages communities to reconnect with indigenous healing rituals and spiritual practices. Genuine cultural grieving brings people together and counteracts the centrifugal force of trauma that pushes marginalized groups ever further from the cultural center (see Erikson, 1994, p. 232). As societal health improves and resilience increases, community expectations rise and the recovery process turns multidimensional, signaling a return to life in the normal everyday world (see Figure 1).

Vocational programs, such as the agricultural project discussed earlier (see Figure 3), are an integral component of the Mobile Clinic Program, serving to stimulate economic healing and community development.

Finally, when focusing on core qualities, we bear in mind that East African traditions address healing in a holistic physical, psychological, and spiritual manner. In the sacred pursuit of healing, the community's capacity to be in relationship with the mythopoetic layers of its cultural psyche increases. In essence, the psychospiritual field then engenders the numinous energies of transformation that are essential to deal with the toxicity of collective trauma.

Mobile Clinic Pilot Project

In 2013, in collaboration with local hospitals and community organizations, I initiated a pilot project of the Mobile Clinic Program at three sites in rural areas of South Kivu Province, DRC.[10, 11] What does the pilot program do? What are expected outcomes? Is the approach scalable?

Thus far the major components of the mobile clinic pilot project include medical treatment for about one thousand male and female survivors of war-related sexual atrocities and torture, psychosocial treatment of such victims, social reintegration of former child-soldiers, community sensitization concerning circular oppression (e.g., scapegoating victims), training seminars for social assistants, and vocational teaching projects.

Currently there are three vocational training projects—an agricultural project, a soap-producing project, and a furniture-making facility, which all have a dual purpose: to offer psychosocial treatment for trauma victims and to generate income for the local organizations. These teaching operations allow staff to learn all aspects of running a small business, in effect mentoring trauma survivors towards social reintegration. The training projects encourage the local organizations to develop a sense of independence, engage in local decision-making, and accept responsibility for making the Mobile Clinic Program self-sustaining. These expectations are *strategically* important to empower the community and to counter the pervasive sense of helplessness and dependency associated with the collective trauma disease.

The Mobile Clinic Program . . . [uses] a cyclical empowerment concept driven by homegrown community expectations rather than preconceived foreign solutions.

In spirit, the Mobile Clinic Program is designed to reverse fragmentation and restore a sense of inner and outer relatedness. From a psychological perspective, this process helps people reconnect with split-off emotions so that depression, aggression, and other affects can be embodied and grieved or processed in ritual. From a psychosocial perspective, the program rebuilds community and promotes resilience through sustainable local infrastructure development.

Thus the Mobile Clinic Program offers a comprehensive approach to dealing with the major components of trauma epidemics. The intervention strategy mobilizes the energies of the local community to own the program. The approach is flexible, using a cyclical empowerment concept driven by homegrown community expectations rather than preconceived foreign solutions. My contact points are small, grassroots organizations, and my experience suggests that the program will permeate and eventually take hold in

other communities devastated by collective trauma. The pilot project puts a prototype or template into the hands of local community leaders. With training, the template can be easily replicated and healing be effected across large areas, reaching many people.

After twenty years of warfare and destruction of indigenous infrastructure, planning ahead with a future in mind is a big challenge. Yet at all three pilot sites, I found people who felt re-spirited by the challenge, curious, and motivated to learn something new.

Concerning the impact assessment of the pilot project, a key dimension I plan to measure is determining where the program generates sufficient energy to become self-sustaining, where it does not, and why. Eventually, to be successful the intervention needs to create a change in people's attitudes and expectations, parameters that I monitor closely.

With early data at hand, I have little doubt that the Mobile Clinic Program can be expanded. First results of the pilot project overwhelmingly confirm the need for the outreach component of the clinic program; for example, a vastly larger number than expected of trauma survivors require surgical or other medical treatment. One community leader said, "The Mobile Clinic is the answer to the needs of the people in the valley" (an area suffering a serious trauma epidemic). Already three other communities in different seriously afflicted regions of South-Kivu Province, DRC, have asked to be considered as sites. To firmly ground the program, improved training and support for select community leaders and social assistants are needed, with the goal to strengthen and develop the psychosocial component of the program.

Interdisciplinary Trauma Center

There is an overwhelming need for research and the training of professionals in trauma management in eastern Africa. A promising collaboration is developing at Makerere University in Kampala, Uganda, with Professor P. Baguma, Dean of the School of Psychology. An Interdisciplinary Psychological Trauma Center is taking shape to address challenges of collective trauma in the African Great Lakes Region. As I proposed elsewhere, the challenges in that region require an innovative *systems approach* that integrates fieldwork, academic research, and training professionals, and that is *interdisciplinary*, involving different psychological disciplines, visual and performing arts programs, as well as socioeconomics and public health programs (see Riedel, 2013). The Interdisciplinary Psychological Trauma Center will engage in cross-cultural and cross-ethnic research and training of professionals in trauma management.

Numinous Energies of Transformation

Traumatized Culture

Depth psychological insights can inform the management of trauma epidemics in additional ways by focusing attention on the central role that emotional energies play in collective trauma. By definition, states of *numinosity* are characterized by the presence of powerful affective energies, positive or negative, that engender strong emotional resonances. I call raw, unhumanized affect *primordial*. Basically, complex collective trauma involves numinous possession by primordial emotional energies that maintain and increase societal fragmentation, environmental destruction, and cultural ruin. Under these conditions, each and every aspect of life—that is, the soul of the world, the *anima mundi*—is engulfed in trauma.

To deal with collective trauma, the task is to puncture such states of numinous possession. To succeed, purposeful action must generate equally strong numinous healing energies. Mythological traditions offer examples, where, after decades of suffering and decline, regreening energies emerge. Jungian depth psychology speaks of the religious function of the psyche, whereby psyche is available to numinous experience that opens to liminal states of transformation (see Riedel, 2013, pp. 27–28).

The dynamic model described here offers purposeful action as a practical *ritual* of reengagement with collective trauma. Through cycles of healing (see Figure 4), embodied action can rebuild community and generate resilience to defend the reclamation work against adversarial forces. When humans truly engage with moral trauma and struggle with making sense of disturbing feelings, qualities emerge that have the strength to forge connections, even across ethnic or cultural boundaries. Then numinous images may arise from mythopoetic layers of the psyche, the "sphere of the sacred," that have the power to transform reality.

Numinous Power of Images

Many singular achievements of great artists came from their wrestling with personal and collective trauma. One such is Wolfram von Eschenbach's epic poem *Parzival*. Others include the prisoner scene in Beethoven's opera *Fidelio*, Picasso's painting *Guernica*, Messiaen's symphony *Turangalîla*, and Lanzman's film *Shoah*. These artworks belong to humanity, the world community, and are expressions of the soul of the world, the *anima mundi*. In the deepest sense, these masterpieces reflect an intense *struggle for humanization* and a striving towards a new paradigm for relating to self, other,

and the divine (see Riedel, 2009). Such a paradigmatic shift cannot happen by the will of consciousness alone, but derives from inner necessity of steadfastly striving to surpass the problems created when psyche is incarcerated by trauma.

I mention examples from Western culture, but working in the African context I sense an overlap with the spiritual dimension of African indigenous healing approaches, such as harmony restoration therapy (see Ebigo, Igbokwe, & Adiele, 2010). I believe that in developing the research and training components at the Makerere University's Psychological Trauma Center, "we need to think about following a [principle] of indigenization that supports the value and sustainability of human well-being in its *many* forms" (Riedel, 2009, p. 475), thus preparing local professionals for work in their own communities. However, a comparative approach to research must be cognizant of regional and other differences to avoid premature closure. By this I mean, "jumping to a conclusion, making an assumption, and then acting as if we know the truth" (Riedel, 2009, p. 469).

Images of Transformation

Images of transformation hold emotional energy that can spark curiosity about issues of collective trauma. For example, environmental destruction in the eastern DRC is both fact and symbol; for me, seeing virgin forests turned into charcoal pains me with grief and loss that haunts me even now. In one of my workshops a survivor of sexual violence said, "The camera is pregnant"; she sensed a soul-spark as she used the camera to record her own trauma narrative that may rekindle her struggle to give birth to her future. The teenage, former child-soldier exclaiming, "You have given me something more important than money," expressed a felt sense of hope, despite his long dark night of captivity imposed by marauding militias.

Many times during fieldwork a dream has given me energy or insight. Working with traumatized communities in the eastern DRC took a toll on me. During one bleak period I dreamed of "making a breathtaking wide-angle color photograph of a tree in fresh green foliage backlit by the rising sun." The feeling tone was otherworldly and numinous, uplifting and regenerative.

Another time, after a particularly difficult trauma experience, I felt uneasy traveling to the location of a future assignment, even though the technical details of travel had been resolved. I was quite aware that, on the one hand, collective shame wants to stay invisible, and on the other hand, that witnesses are not welcome—the "slaughter of the innocent" was supposed to have happened during the darkness of night.[1,4] A dream occurred:

> First there is the image of a tree and the message, "*More than half the tree is growing underground*"; then comes the image of a tree on a large boulder and the question, "*Can its roots penetrate and shatter the rock?*"

The first part of the dream draws my attention to the African saying, "You talk during the day, but also need to know what's going on during the night." The second part invites reflection on strengthening root understanding, garnering emotional strength—trauma work is about listening with the heart, "attentive noticing" (Hillman, 1982/1992, p. 115), embodied witnessing (Osband, 2013, p. 110), and, as the dream warns, not to be thrown from the rock. The dream may have saved my life.

Active Imagination as Purposeful Action

I shared my findings about collective trauma in the eastern DRC (Riedel, 2012) with a colleague. Her psyche responded with a dream, presented here with permission.

> Dream deep inside the night that I am witness (almost if outside the frame) to a mass killing of one group of people by another group. Then the scene is slightly changed. There is a well, made of shaped rectangular stone, and into it is forced to jump, quickly, a procession of men, women, and children. There is a crowd around the well, back from it, cheering as the procession of persons is herded to their deaths. I think all of the people who jump into the well are naked. I don't see the ones herding them, but sense they are forced to jump to their deaths. The last one I see, as the scene freezes, is a blond girl of about seven years. I just can't bear to look any more and that seems to freeze the action so that she is left, mid-leap, going into the well with a couple of others.

The action freezes in mid-air—an image of dissociation. The dreamer is horrified. A psychoanalyst herself, she decides on purposeful action, namely, to engage the scene in active imagination.

> I wake up with a feeling of horror. I am awake for a while. Then I try to think about it and image about it. I try to take the image into the tree, but it is too heavy for me to carry. I put it into the Garden Way cart and shrink it down so I can move it. We get

> into the woods and, just by the first tree root, the people in the well want to get out. How can I carry them all? They seem to come out and jump onto my body like little beings attached all over. The handles of the cart get longer so that it is farther from me. Then I can move it more easily. My heart is heavy, but as I walk past where the wild ginger grows, it all comes into leaf and blooms. Other plants also leaf out, and I can't do anything but look at them—I don't feel any joy. At the intersection by the tree the weight of the cart is very heavy, but I lean forward and push hard, go fast. Finally I get to the tree and set the cart down. All of the little people jump off of me into the space around the tree and go into the roots. The well seems to resolve into the soil as well. The tree seems to shudder. I put my arms around the tree and hold on to it, apologizing for how humans are. The tree and I stand there.

Faced with unspeakable trauma, how do we see ourselves moving forward? The doctor goes back to the moment of horror and dissociation. Taking in her situation, she focuses and engages imagination as a form of purposeful action. She realizes that she needs more than her physical strength and thinks of the wheelbarrow. The moment she commits to the task, the little people swirl all over her and she recognizes the relationship. The doctor follows the formative process of active imagination that creates a storyline of images—what filmmakers call a *storyboard*. The images have the capacity to transform reality; for example, the images of regreening and the shuddering tree. In the end, the doctor embraces the tree of life; she is held by the *anima mundi* in a moment of rest, gathering strength, open for something new to evolve.

The paradigm this internal process suggests is to allow the trauma to touch us, to connect with us so that we come to carry it as an embodied experience. This is the meaning of *embodied witnessing*. The paradigm of purposeful action involves setting into motion and committing to a process. It is key that we not burden ourselves by an "ideal" preconceived solution, outcome, or ideology.

Concluding Remarks

My experiences in the eastern DRC have convinced me that employing psychological perspectives would not only aid the analysis of the trauma, but also help deal with the trauma epidemic itself, including the serious political, military, and human rights issues. The highest priority must be the prevention

of further genocidal behaviors and restoring the rule of law. Truth and reconciliation efforts in South Africa were successful because the international community united in modeling principled humane behavior. In this article I offer a dynamic model that addresses collective trauma as a nonlinear cyclical process. To interrupt cycles of trauma and combat its transmission, the model suggests employing a strategy of community-based purposeful action. I have initiated a pilot project for comprehensive trauma management, the Mobile Clinic Program, that addresses medical, psychosocial, and economic suffering and counteracts forces that propagate trauma.

There are numerous caveats that need addressing and require the collaboration of many groups and organizations, local and international. Examples include tribal issues—eastern Congo is divided by strong ethnic allegiances; security concerns—there is no unified strong Congolese military or police force to generate security; mineral exploitation—there is no enforcement of international law to prevent foreign countries and corporations from exploiting the riches of the eastern DRC; and psycho-/sociopathic aggression—there is no psychosocial solution to the brute force of such primal aggression (see Gobodo-Madikizela, 2003).

Sometimes a spark of light restores a bit of the human spirit. I cherish these moments.

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NOTES

1. I use the terms *complex collective trauma* and *trauma epidemics* synonymously, often preferring *trauma epidemics* because it draws attention to issues of *trauma transmission*, whose understanding is necessary for combating the disease that collective trauma is.
2. I view communities as *organisms* with psyche and soul.

3. Detailed field observations concerning the collective trauma situation in the eastern DRC are available upon request.
4. Following insurgencies by neighboring countries into the DRC in 1996 and 1998, a Comprehensive Peace Accord was signed in South Africa in 2002. One goal was to integrate all armed militia groups into the Congolese Armed Forces (FARDC). The Peace Accord also required all foreign combatants to leave the territory of the DRC (but see the next note).
5. Instead the year 2004 brought new military conflict in North-Kivu and South-Kivu Provinces. For example, rebel forces, aided by the Rwandan Army, captured both provincial capitals, Goma and Bukavu. In the 2008–2009 "peace talks" with the Congolese government and the militias, "mixage" was imposed as a new integration principle, which means mixing rebel units into the Congolese Armed Forces (FARDC) "without asking questions." The process of "mixage" opened the door to infiltration by foreign soldiers and officers into the Congolese Army (FARDC).
6. For details, see the section titled "Interlude."
7. As a psychologist working in crisis areas, I distinguish between tribal developmental issues and psychological injuries related to collective trauma. However, note that normal tribal development is also arrested by trauma.
8. Social reintegration of ostracized trauma survivors is one of the goals of the vocational training initiatives.
9. By contrast, when humanitarian aid is turned into a commodity, as is often done by humanitarian aid industries, the result is further societal fragmentation.
10. These Congolese communities and the author gratefully acknowledge a generous grant by the Furlotti Family Foundation that made possible this initiation of the Mobile Clinic pilot project possible.
11. With heartfelt gratitude I express my deep appreciation for the selfless contributions of my participating medical doctors and their staffs, especially Dr. Frev Achacha in Fizi, Dr. Esther Allenge in Nundu, and Dr. Crispin Milenge in Mwenga.

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