UiT The Arctic University of Norway

Department of Social Sciences

Dealing with fear:
Managing life-threatening events in different cultural contexts

An empirical study with case design using qualitative interviews and participant observation

Jon-Håkon Schultz

Dissertation for the degree of doctor philosophiae, April 2021

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Trying to connect

In my first doctoral thesis, I conducted fieldwork in Norway among second-generation immigrant youth with Muslim backgrounds, exploring their views on Norwegian drug culture and the development of their own pathways of drug use. After the thesis had been submitted and defended, I became "tougher" in a methodological sense and accepted invitations to travel with my key informants to Pakistan, where I lived with them and their families for weeks. Previously, I had spent time with them in Oslo, hanging out on street corners and in local cafés – but mostly doing in-depth interviews. After three years of fieldwork in Norway, I thought I had gained an insider perspective, that we had become close. Travelling to Pakistan and living in a family setting opened totally new perspectives. I now understood I had been partly in the dark, not even aware of what I was missing out on. This taught me a valuable lesson on the importance of "home visits."

My research continued, with a focus on mental health and cultural aspects, when I made a field visit to Northern Uganda in 2006, only months after the ceasefire agreement. My research project concerned former child soldiers in the process of being reintegrated into their communities and going back to school. As I followed up a group of five young people, they started inviting me to their homes—and then I realized it was possible to build a qualitative project. A few years later, I joined a research group in Norway, spending four years focusing on Female Genital Cutting (FGC). Before the end of that study, however, on July 22, 2011, a bomb went off in government headquarters in Oslo, soon followed by mass killings on the small island where the Norwegian Labor Party was holding its annual summer youth camp. With colleagues at the Norwegian Center for Traumatic Stress Studies (NKVTS), my workplace at the time, I spent the next 10 years exploring how the survivors were dealing with their experiences of terror —as we also tried to understand our own reactions.

These three research projects have involved exploring fear reactions, and how they were understood and dealt with. Seeking to understand how they deal with fear, I have tried to connect with people, getting beyond the level of words. In the course of this scientific journey into the interior of fear, one specific aspect has become increasingly important: my desire to connect. By this I mean connecting with the people I was studying, in order to explore their experiences, perceptions, and reactions to fear, across cultures. This is what I have been trying to achieve—to connect with people in order to understand aspects of managing life-

threatening events within cultural contexts. Here I have drawn inspiration from the framework of social anthropology and the sub-field of medical anthropology.

The three studies on which the four papers of this theses are based have been a result of joint efforts and teamwork. Special thanks go to all the participants, for their openness and willingness to admit an outsider into their daily lives, and for sharing their thoughts and experiences. Their patience and participation made this work possible.

My two translators and research assistants, Neneh Boiang (The Gambia and Norway) and Ochara Ochitti (Uganda) were exceptional in their analytical approach, their patience, and their focus on strict translations, as well as explaining the "obvious." Our conversations stretched over years, proving vital for my connection with the context and participants.

I also wish to thank my three co-authors for their enthusiasm and participation in the three studies: social anthropologist *Inger Lise Lien,* with whom I traveled and did fieldwork in The Gambia, Ethiopia, Kenya, and Norway; psychiatrist *Lars Weisæth*, with whom I had long-term, in-depth discussions on treatment and psychiatry; *Dag Skarstein,* educational and linguistic researcher, who participated in fieldwork in Norway after the 2011 terrorist attack, and helped me to see some meaning in the meaningless. My thanks to the three of you for staying the course, amid the vast amounts of data and impressions, and for helping me to make sense of it all. These partnerships have inspired and modeled my way of academic thinking and analytical approach—imprints that will last a lifetime.

My thanks go also to my long-term colleagues Magne Raundalen and Åse Langballe, for years of insightful discussions and advice; to Daniel Rød, Svein Erik Andreassen, Pål Anders Opdal, and Jens Breivik for helpful discussions in the final stages of research; and to Susan Høivik for relentless proofreading. Thanks to NKVTS director, Inger Elise Birkeland, and project leader Grete Dyb, for their decisive action and leadership in setting up a national study, and supporting the school/student perspective on traumatic stress. The Uganda fieldwork was financed by the University of Oslo, Department of Special Needs Education. The two studies on FGC and the massacre were financed through the NKVTS. The writing of the last paper on the massacre and the extended abstract was financed by UiT, the Arctic University of Norway, Department of Education. My thanks go to these three institutions for supporting my research.

Jon-Håkon Schultz / Tromsø, April 2021

List of papers

Paper I Schultz, J-H. & Lien, I-L. (2013). Meaning-making of female genital cutting: Children's perception and acquired knowledge of the ritual. *International Journal of Women's Health,* Vol. 5, pp. 165–175. ISSN 1179-1411.

Paper II Schultz, J-H. & Lien, I-L. (2014). Cultural protection against traumatic stress: traditional support of children exposed to the ritual of female genital cutting. *International Journal of Women's Health,* Vol. (6), pp. 207–219. ISSN 1179-1411.

Paper III Schultz, J-H. & Weisæth, L. (2015). The power of rituals in dealing with traumatic stress symptoms: cleansing rituals for former child soldiers in Northern Uganda. *Mental Health, Religion & Culture,* Vol.18 (10), pp. 822–837. ISSN 1367-4676.

Paper IV Schultz, J-H. & Skarstein, D. (2020). I'm not as bright as I used to be: Pupils' meaning-making of reduced academic performance after trauma. *International Journal of School & Educational Psychology,* DOI: 10.1080/21683603.2020.1837698

Acronyms and Abbreviations

ACE	Adverse Childhood Experiences
DSM-5	*Diagnostic and Statistical Manual of Mental Disorders,* 5th edition
FGC	Female Genital Cutting
FGM	Female Genital Mutilation
GP	General Practitioner
HTQ	Harvard Trauma Questionnaire
ICD-10	*International Statistical Classification of Diseases and Related Health Problems,* 10th revision
KD	Norwegian Ministry of Education and Research / *Kunnskapsdepartementet*
LRA	Lord's Resistance Army
MHPSS	Mental Health and Psychosocial Support
NRC	Norwegian Refugee Council
NRK	Norwegian Broadcasting Cooperation / *Norsk Rikskringkasting*
NSD	National Centre and Archive for Research Data / *Norsk Senter for Forskningsdata*
PTSD	Post-traumatic stress disorder
REC	Regional committees for medical and health research ethics (Norway) / *Regionale komiteer for medisinsk og helsefaglig forskningsetikk*
SES	Socioeconomic Status
UN-CRC	United Nations Convention on the Rights of the Child (1989)
WFP	United Nations World Food Program
WHO	World Health Organization

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Abstract

Background: Life-threatening events come in various forms, affecting individuals and their societies by evoking fear. Collective dangers such as terrorist attacks, war, conflict, and natural disasters may create societal chaos and suffering. Children in particular appear to be vulnerable as regards dealing with fear from life-threatening events. Although most children and adolescents do not develop psychiatric conditions as a result of their exposure to danger, many do experience levels of distress, subsiding naturally over time. The research presented here explores how children and adolescents deal with reactions of fear, and how protective factors are present in different cultural settings.

The philosophy of science applied in my research has been inspired by an interpretative approach rooted in hermeneutic philosophy. The empirical study uses a qualitative case design. In three single-sited fieldwork studies, I employ qualitative interviews and participant observation as data-collection methods. The analysis is inspired by and draws on strategies from grounded theory, thematic analysis, and, in the fourth paper, a hermeneutic phenomenological approach. In connection with presenting the four studies in this extended abstract, the combined empirical material proved to enable comparison, thereby turning the combined study into a multi-sited design.

Methods: Three different cultural contexts and types of experienced life-threatening events were chosen: *female genital cutting* as experienced in Somalia and in The Gambia, *being a child soldier* in Northern Uganda and *experiencing a massacre* in Norway. My research questions were as follows:

- How do girls who have undergone female genital cutting understand the ritual? What characterizes the learning process and knowledge acquired in their meaning-making processes?
- How is psychological care provided for girls undergoing the ritual of FGC? What are the common belief systems underlying the provision of care in The Gambia?
- What are the potential therapeutic factors of a cleansing ritual in Northern Uganda, aimed at healing former child soldiers?
- How do pupils exposed to the trauma of the Norwegian terror attack of July 22, 2011, recognize and explain PTSD-imposed cognitive impairment as influencing their academic performance?

Results: The fieldwork has aimed at investigating how people deal with reactions of fear and how protective factors are present within different cultural settings. The findings indicate the following, as presented in the four research papers.

- The girls' learning processes of FGC are carefully monitored and regulated, but stop short of critical reflexive thinking. The knowledge tends to be deeply internalized, embodied, and morally embraced.
- These girls have generally managed to handle the potential trauma of FGC. The event is placed in a meaningful system of understanding, and the stress is dealt with in a traditional way that largely follows empirically-based and evidence-based principles of crisis intervention.
- The former child soldier studied here participated in a ritual involving elements that safely and effectively deal with fear-related symptoms in line with modern research on trauma therapy, perhaps more powerfully than Western-style therapy.
- The majority of the 68 students who experienced the massacre in Norway reported negative changes in academic performance, and feelings of chaos. This study identifies their attribution style, the use of metaphors and narrative structuring, and differences in the meaning-making processes.

Discussion and Conclusions:

The overarching research question discussed and presented in this extended abstract, was to explore cultural influence in shaping reactions to life-threatening events across three cultural contexts.

Three life-threatening events that took place in three cultural contexts have been studied and reported in this doctoral dissertation. Most of the persons who had been exposed were identified as having reactions within the PTSD spectrum. The following characteristics emerged as the major differences among the meaning-making processes across the various cultural contexts: content of explanations, beliefs regarding responsibility (including shame, guilt and stigma) and beliefs regarding then possibility of human control (as opposed to destiny). The specific meaning-making process in each case had clear consequences for the attribution of symptoms, for help-seeking activity, and finally for the integration and closure of the traumatic memories.

Each of the three cultural contexts has, in its own unique way, influenced and shaped the expression of clinical symptoms and the course of the distress. Such meaning-making is embedded in the cultural belief-system, which provides a cognitive template for assigning meaning when a traumatic event has triggered reactions and a need for explanations. When

reactions can be attributed, the cultural belief-system provides a behavioral template for the individual to take action and activate help-seeking behavior, and for society to activate support. This process leads to integration of the traumatic memories, and closure. The disruptive force of the life-threatening event is corrected as the individual returns to a state of a (new) normal. However, when the cultural meaning systems and support systems are distinctive rather than universal, support may become culturally encoded, with its supportive power being stronger within the given culture.

Both the cleansing ritual and the FGC ritual were identified as providing effective support that largely follows empirically- and evidence-based principles of crisis intervention. They served as "support packages" provided within the "cultural protection". Also the survivors of the Utøya massacre in Norway received a "support package," predominantly managed by the healthcare system. The survivors in focus in connection with this thesis were found mainly in the significant sub-group of young people who did not benefit from the support package or the cultural protection— partly because their symptoms were not actively attributed or assigned to the traumatic event, partly due to resistance to the victim-identity.

The analytical framework proposed here recognizes the process of cultural shaping of reactions and recovery after exposure to life-threatening events. The framework is based on empirical findings from three cultural contexts, aiming to sum up the steps or phases in the meaning-making process. It is intended as a contribution to the ongoing debate on how to understand and analyze cultural influence in shaping reactions to life-threatening events.

Four published research papers and an extended abstract comprise this doctoral dissertation. The four papers are part of three research projects involving fieldwork conducted over the following periods:

- Former child soldiers in Uganda 2006–2011
- Female Genital Cutting 2009–2013
- Terror attack in Norway 2011–2016

Keywords: FGC, mental health, PTSD & cultural influence on disorders.

1 Introduction

In the following sections, I present an overview of the three fieldwork studies, the research questions for the four papers followed by an outline of the structure of this thesis.

I start the introduction with a phone call. While I was conducting fieldwork in Northern Uganda, I experienced an urgent need to call home. The phone call was made, and became a direct inspiration for my line of research.

Calling home

After an earlier interviews with Patrick, my key informant in North Uganda, I simply had to call home. There were two reasons for that. I had spent two days with Patrick, and he had told me in considerable depth about his traumatic nightmares and how much he wanted help to get rid of them. He kept talking about his father, who had been killed by the rebels when Patrick was only 6 years old. At the age of 13, he was abducted himself and trained as a child soldier. I met him when he was 18 years old. Now he was struggling to deal with the forceful nightmares that made him re-live scenes of killing years ago. After two intense days, Patrick had told me his life story. He was haunted by the Ghost People—and felt that his life was ruined. After listening to these detailed descriptions, I felt terrible, disgusted by the brutality of war, and knew I had to connect with home.

My second reason was due not to emotions, but to curiosity. Patrick's experiences of a series of traumatic events, his post-traumatic nightmares, and his active post-traumatic stress symptoms were as if taken directly from the *Diagnostic Statistical Manual.* But there were also major differences: the Ghost People, traditional doctors, cleansing rituals—and there were good spirits. To me, Patrick appeared clinically depressed with severe PTSD, but also with a clear idea of what he needed: a traditional doctor, and to be cleansed through a cleansing ritual. Also here I felt the need to call home.

I contacted my mentor and friend, the highly acclaimed Norwegian child psychologist Magne Raundalen, via an expensive satellite phone. The bill was colossal, but that conversation marked a turning point in my research. Magne Raundalen has worked a lifetime as a psychologist, in Norway and internationally, spending considerable time in war zones working with children affected by traumatic stress. We talked about the need to see beyond a strict medical perspective, to acknowledge the healing potential embedded in the social fabric.

Magne ended our lengthy phone call by telling me that the conversations I had with Patrick would change my life and how I view the world. I instantly knew he was right.

That satellite call took place in 2008. Now, in 2021, I am still wondering, and trying to figure out *the change,* and what it means to me. This meaning-making process certainly stimulated the fieldwork, and vice versa.

Three fieldwork studies

Fieldwork I: Former child soldiers in Northern Uganda: 2006–2011

In the course of the above time-period, I frequently visited the towns of Gulu and Kitgum in Northern Uganda, working with the Norwegian Refugee Council (NRC) school program in the region. Education and school-based mental health and psychosocial support (MHPSS) were provided for former child soldiers. My fieldwork extended beyond the schools as such, as I followed the students in their villages as well. The overall fieldwork was "step in/step out," plus a selected observation conducted over a two-week period. Paper III presents this selected observation, where I followed one student, Patrick, through a local cleansing ritual, altogether over a period of three years and three months.

Fieldwork II: FGC in a Norwegian context: 2009–2013

The primary context was Norway and how women, men, and children originally from Africa thought, acted, and viewed the tradition of female genital cutting (FGC). Fieldwork in Norway was conducted among several different immigrant groups. A network of anti-FGC activists in Norway helped me to position myself in the context. Further, in order to understand the various FGC rituals and practices as they are used, I made field visits to The Gambia, Kenya and Ethiopia. However, the field as such is defined as being in Norway, complemented by study visits to the participants' countries of origin. The fieldwork started with a broad approach to FGC in Norway, before I narrowed in on two more specific themes, presented here in two separate papers. Paper I offers an embedded single-case study (Yin, 2018) with multiple units of analysis. Participants were selected through network recruitment within the case: women with FGC-experience living in Norway. There were two embedded units of analysis: women with origins from The Gambia and women with origins from Somalia. Paper II presents a single-case study of women originally from The Gambia, with FGC experience, now living in Norway.

How to name the practice of female circumcision has been, and remains, a contested issue. The various terms employed carry differences in understanding and modes of relating to the practice and the people affected (Johnsdotter & Johansen, 2001). In this extended abstract, I use mainly the rather neutral term *female genital cutting,* FGC. In some instances the more laden term *female genital mutilation,* FGM, occurs, mainly with reference to the network of anti-FGM activists.

Fieldwork III: Terror attack and massacre in Norway: 2011–2016

On Friday, July 22, 2011, a terrorist detonated a bomb in the government quarters in Oslo, and then proceeded to perpetrate mass killings on the small island of Utøya, where the Norwegian Labor Party was holding its annual youth camp. In the aftermath, I was involved in a comprehensive national research program set up as a longitudinal study with individual interviews of adolescents who had survived the Utøya massacre, and their parents. I followed 15 survivors and their parents over a period of two and a half years, often meeting the students in their high schools and their parents at home. The fieldwork was then extended beyond the formal research program, as I attended the court proceedings, met with the survivors' support group, and was involved in work on national communication strategies. Paper IV presents what can be defined as a single-case study, as the case comprises school students who survived the massacre committed on July 22, 2011.

Research questions

The fieldwork has aimed at investigating how people deal with reactions of fear and how protective factors are present within different cultural settings. Three different cultural contexts and types of experienced life-threatening events were chosen for single-sited fieldwork: *female genital cutting*, *being a child soldier,* and *experiencing a massacre*. Data collection has involved qualitative in-depth interviews and participant observation. The findings are presented in four individual research papers, with the respective research questions for each paper presented below.

Paper I	How do girls who have undergone female genital cutting understand the ritual? What are the characteristics of the learning process and knowledge acquired in their meaning-making process?

Paper II	How is psychological care provided for girls undergoing the ritual of FGC? What is the common belief system underlying the provision of care in The Gambia?
Paper III	What are the potential therapeutic factors of a cleansing ritual in Northern Uganda aimed at healing former child soldiers?
Paper IV	How do pupils exposed to the trauma of the July 22, 2011, terrorist attack in Norway recognize and explain PTSD-imposed cognitive impairment as influencing their academic performance?

The overarching research question discussed and presented in this extended abstract, was to explore cultural influence in shaping reactions to life-threatening events across three cultural contexts.

Structure of the thesis

The theses consist of four papers and the extended abstract. The extended abstract has three broad aims. Firstly, to present an overview of three fieldwork studies, as well as the methodology and ethical considerations underpinning the four research papers. Secondly, to present an overview of the four papers. Lastly, to highlight the connections among these papers and discuss the overall research question.

Theory and method

Chapter 2: Theory: In each of the four papers, theory is presented and used in the discussion sections. The extended abstract presents theory describing common reactions and symptoms experienced in the aftermath of exposure to life-threatening events. An overview of preventive measures and treatment, is followed by theoretical perspectives on the extent to which traumatic stress reactions are viewed as culture-specific or universal. The chapter ends with a presentation of the philosophy of science underpinning the combined research project.

Chapter 3: Methods: The first section presents the selected research design. An overview of the three single-sited fieldwork studies and data collection methods is presented, followed by a more detailed presentation of the three fieldwork studies. In each of the fieldwork presentations, I give examples from my field notes on the aim and strategy of achieving a state of resonance, establishing relations with the people I interview and socialize with, and myself as the researcher. To achieve reflexivity in the research work, I offer some

thoughts on my position as researcher. The chapter concludes a section on ethical considerations.

Summary of the research

Chapter 4: Results: To enable comparison, the central results on dealing with three distinct types of life-threatening events are presented in three sections. The first section presents *dealing with stress reactions from FGC*, followed by *being a child soldier,* and third, *experiencing mass killings*. Each section follows the same structure, starting with the type and nature of the exposure, followed by characteristics of the meaning-making process, and identification of potential supportive factors present in the various contexts.

Chapter 5: Discussion: This chapter outlines a discussion drawn from, and further building on, the discussions and conclusions from each of the four papers. The combined empirical material allows for a comparison, when answering the overarching research question. This lead up to my proposed analytical framework regarding possible cultural influence in shaping reactions to life-threatening events across three cultural contexts.

Chapter 6: Concluding remarks: In this final chapter, I summarize the findings connected to the overarching research question and indicate possible topics for further research.

The four studies

Papers I–IV are presented in the form in which they were published.

2 Theory and research

To set the background, I start with a rather condensed overview of the emergence and current state of the diagnosis of post-traumatic stress disorder (PTSD) as it defines common reactions and symptoms experienced in the aftermath of exposure to life-threatening events. This includes description of post-traumatic stress reactions as well as the duration and prevalence of PTSD. An overview of preventive measures and treatment is followed by references to the controversial debate as to whether traumatic stress reactions are viewed as culture-specific or universal. This chapter ends with a presentation of the philosophy of science leading up to modern anthropology and underpins my research project.

Reactions to life-threatening events

Post-traumatic stress disorder: PTSD

Fear, in one way or the other, has probably been there from the very beginning. Being a highly effective lifesaving mechanism for animals and humans, fear has kept species alive and affected the course of evolution. One could say that dealing with fear is a part of life and a rather important one. However, the cost of fear can be high. How you deal with fear has the potential to radically influence your well-being – both positive and negative. It could go either way, ruining your life or making it even more worth living. The major religions – Hinduism, Buddhism, Islam and Christianity – have incorporated wisdom and guidance for people on how to deal and live with fear. Life can be brutal, and people have always known that exposure to overwhelming fear can cause trouble. Fear and the consequences of fear have, to a various extent, been of interest to researchers in all academic disciplines within humanities. Within psychiatry, it can be argued that there have been "periodic denials" about the reality of psychic trauma's effect on the human soma and psyche. Hard-earned knowledge has been repeatedly lost and subsequently rediscovered over again (Van Der Kolk, Weisaeth, & Van Der Hart, 1996). Vehement arguments regarding the etiology of psychological trauma have been present since the earliest involvement of psychiatry with traumatized patients: is it organic or psychological? Is it the trauma itself or the subjective interpretation? Is the disorder caused by the trauma or preexisting vulnerabilities? Are the patients malingering and

suffering from moral weakness or is it an involuntary disintegration of the capacity to actively take charge of their lives? (Van Der Kolk et al., 1996).

The emergence of PTSD as a diagnostic category started after World War II, when a line of research emerged with the study of the long-term effect of trauma in survivors of concentration camps and other war-related traumas. With the definition of the following categories, namely "concentration camp syndrome," "war sailor syndrome," "Vietnam veteran syndrome," came a documentation of the devastating health effect of extreme and long-lasting stress. The line of research was expanded to the "rape trauma syndrome," the "battered woman syndrome" and the "abused child syndrome." All these different syndromes were eventually subsumed under the PTSD diagnosis in the DSM-3 (APA, 1980). For further in-depth presentation of the history and development of the PTSD diagnosis, see Herman, (1992) and Van Der Kolk et al., 1996).

The current DSM-5 definition of PTSD (APA, 2013) defines the diagnosis through eight criteria, listed below, valid for adults, adolescents and children over the age of six years. (See Figure 1 for an overview of symptoms under the criteria B–E.)

A. *Exposure* to actual or threatened death, serious injury or sexual violence in one or more of the following ways:
    1. Directly experiencing the traumatic event(s).
    2. Witnessing, in person, the event(s) as it occurred to others.
    3. Learning that the traumatic event(s) occurred to a close family member or close friend. In case of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
    4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g. first responders collecting human remains; police officers repeatedly exposed to details of child abuse).
B. *Intrusion*: presence of one or more intrusion symptoms out of five listed symptoms.
C. *Avoidance:* Persistent avoidance of stimuli associated with the traumatic event(s) by one or both of two listed symptoms.
D. *Cognition:* Negative alterations in cognition and mood associated with the traumatic event(s) through two or more of seven listed symptoms.
E. *Arousal:* Marked alterations in arousal and reactively associated with the traumatic event(s) through two or more of six listed symptoms.
F. *Duration* of the disturbance for more than one month.
G. *Functional impairment:* The disturbance causes clinically significant distress or impairment in areas of functioning.

H. The disturbance is not attributable to the psychological effects of substance or another medical condition.

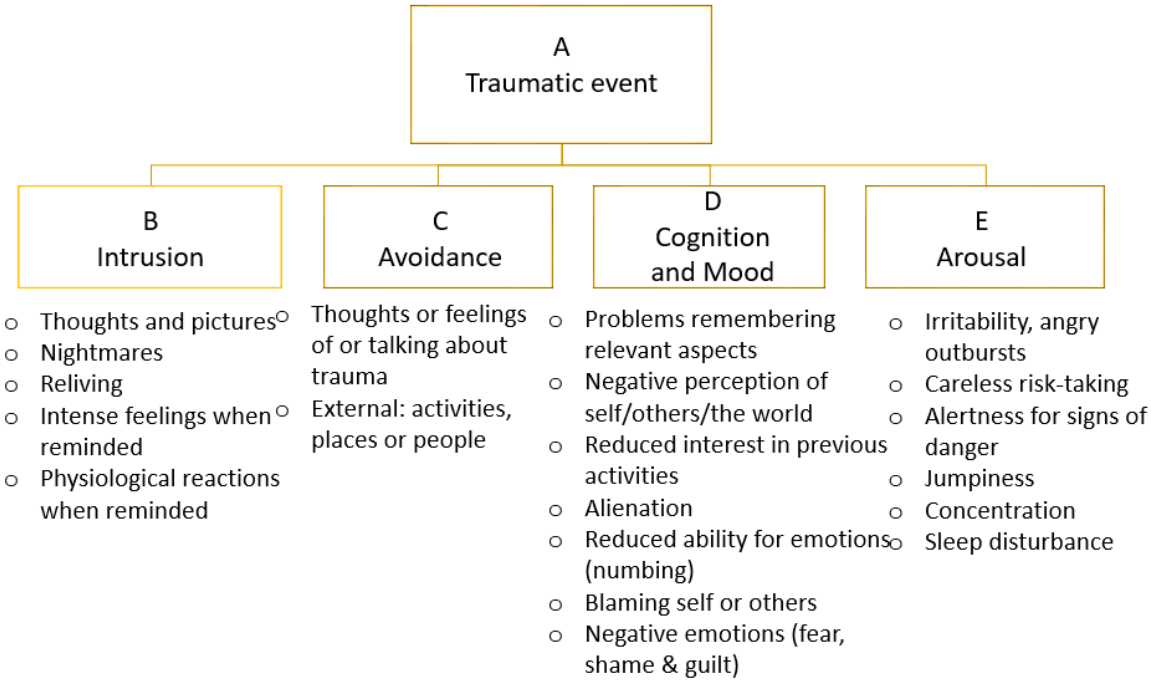

Figure 1: Symptoms of post-traumatic stress disorder (PTSD) classified according to the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*.

Prevalence, development and course

Lifetime PTSD prevalence in the USA, measured with DSM-4, is reported as being 7.8% and 12-month prevalence as being 3.9%, with considerable differences in lifetime prevalence between women (10.4%) and men (5%) (Kessler et al., 2005). Lower estimates are seen in other countries. A 12-month prevalence of only 1.3% was found in Australia, despite comparable levels of exposure to trauma (Creamer, Burgess, & McFarlane, 2001). Similarly, in Canada the PTSD prevalence is 2.7% (Stein, Walker, Hazen, & Forde, 1997) and 1.1% across 12 European countries (Darves-Bornoz, Alsono, & Girolamo, 2008). Estimates in Europe and most Asian, African and Latin American countries are clustering around 0.5–1.0% (DSM-5; APA, 2013).

Of those exposed to trauma, there are a relative small number who are qualifying for the full PTSD diagnosis. A meta-study of more than 3500 trauma-exposed children and adolescents showed an overall PTSD rate of 15.9%, varying according to the type of trauma

and gender. Least at risk were boys who had experienced noninterpersonal trauma, such as natural disasters; most at risk were girls exposed to interpersonal trauma (Alisic et al., 2014).

PTSD is observed at any age, beginning after the first year of life. Symptoms usually occur within the first three months after exposure, although there might be a delay of months or years before criteria for the diagnosis are met. A delay in meeting the full criteria was called "delayed onset" (DSM-4: APA, 1994), but is now called "delayed expression." The symptoms and the relative predominance of different symptoms may vary over time as well as duration. Approximately 50% of adults will recover within three months, with some remaining symptomatic for more than 12 months – and sometimes for more than 50 years (DSM-5: APA, 2013).

Symptom recurrence and intensification may occur in response to ongoing life stressors or newly experienced traumatic events – or as *trauma reminders* of the original trauma. Layne et al. (2006) distinguish between two channels for exposure to trauma reminders: *external trauma cues* include things one sees, hears, tastes, touches or smells in the external environment; *internal trauma cues* are internal phenomena, including thoughts, dreams, bodily sensations, images and emotions. Post-traumatic nightmares are an example of a disturbing and emotionally distressing trauma reminder with high prevalence: approximately 80% of adults with PTSD report nightmares (Kilpatrick et al., 1994). Findings indicate that experiences of distressing trauma reminders are relatively common post-trauma, and may play a central role in the development and continuation of PTSD (see Glad, Hafstad, Jensen, & Dyb, 2016). When the consequences of trauma reminders become severe and long lasting, they are often referred to as retraumatization—a relapse triggered by a subsequent event (Duckworth & Follette, 2012).

Risk factors, prevention and treatment

Research has identified a number of factors associated with increased risk of being exposed to trauma and risk of developing traumatic stress reactions and PTSD. In a meta-study of 77 studies, Brewin, Andrews, and Valentine (2000) focused on *demographic factors*, concluding that PTSD-risk following trauma exposure increased with the following factors: female gender; lower socioeconomic status (SES); racial/ethnic minority status; less education; prior behavioral health disorders; a history of childhood abuse; a history of other prior trauma; other adverse childhood experiences (ACEs); a history of behavioral health disorders in one's

family; and a lack of social support. Another complementary meta-study (Ozer, Best, Lipsey, & Weiss, 2003) included 476 studies focusing on factors associated with *psychological processing and functioning* and aspects of *the traumatic event and its sequelae*. The following seven significant risk factors for PTSD were identified: 1) A history of prior trauma; 2) Problems with behavioral health prior to the trauma, including preexisting mental disorders; 3) A family history of behavioral health disorders; 4) A perceived threat to one's life during the traumatic event; 5) Perceived social support following the trauma; 6) Intensely negative emotional responses immediately following the trauma (e.g., extreme fear, helplessness, horror, shame); and 7) Peritraumatic dissociation, i.e., dissociative experiences during or immediately following the trauma. In addition, stronger PTSD "predictors" were identified as factors that were more proximal to the traumatic event: perceived threat to life; perceived social support; heightened peritraumatic emotional responses; and peritraumatic dissociation (Ozer et al., 2003).

DSM-5 has combined risk and prognostic factors in three main categories with respective subcategories: *pretraumatic factors*: temperamental, environmental & genetic and physiological; *peritraumatic factors*: environmental (characteristics of the traumatic event); and *posttraumatic factors*: temperamental (e.g., coping strategies) and environmental (e.g., social support) (APA, 2013: pp. 277–278).

Several studies have identified children and youth as a vulnerable group. A review of 60,000 disaster victims from 160 samples (Norris, Friedman, & Watson, 2002) showed that school-aged youths are more likely than adults to be impaired, and more severely affected, by disasters. This indicates that children and young people seem, on average, to be less well equipped than adults to cope with disasters. The cognitive abilities and lack of life experience of schoolchildren may reduce their ability to, for example, handle acute helplessness, or comprehend and make sense of the world; and may cause a loss in perceived safety and social support.

It is unclear whether a specific intervention can prevent PTSD; however, there are consensus reports on how to prevent traumatic stress from becoming a mental health problem. A panel of experts (Hobfoll et al., 2007) completed a comprehensive review of intervention research on the treatment for those exposed to disasters and mass violence, examining related fields of

research to find generally agreed intervention principles as regards traumatic stress. Five empirically supported principles were identified as widely accepted and used to inform intervention and prevention efforts for the early to mid-term stages, ranging up to three months after the critical event. These five principles are: promoting a sense of security; calming; fostering a sense of self- and collective efficacy; promoting connectedness; and instilling hope. Many of the same principles and much of the thinking are also included in other consensus reports, e.g., the concept of psychological first aid (Brymer et al., 2013).

There are a variety of interventions and modalities available for the treatment of trauma-related health problems. Most reviews and meta-analyses have found variations of trauma-focused cognitive behavioral therapies (CBTs) to be the most effective. Several of the trauma-focused CBT interventions have taken measures towards cultural adaptions for various client populations, including Latino Americans, African refugees, Cambodians and Vietnamese (for overview, see Center for Substance Abuse Treatment, US (2014); Hinton et al. (2012)).

Cultural variation in prevalence and presentation of PTSD

From the turn of the nineteenth century until the mid-1970s, the study of trauma centered almost exclusively on its effects on white males. Women and children were left out, as was the cultural aspect (Van Der Kolk et al., 1996). As the PTSD diagnosis was included in DSM-3 in 1980, there was a steady increase for showing greater sensitivity to the experienced variations in symptoms. The universal view of trauma and PTSD was further challenged by the concept of culture-bound disorders, brought forward by medical anthropology and transcultural psychiatry, and included in DSM-4 in 1994. In the field of medical anthropology, Kleinman (1980) brought forward perspectives of the cultural shaping of disorders. Further, the book *Natural Disasters and Cultural Responses* by Oliver-Smith (1986) followed by a literature review (1996) and two anthologies – (Oliver-Smith & Hoffman, 1999; Hoffman & Oliver-Smith, 2002) – provided important academic stimuli. By the turn of the twentieth century, resistance to Western assumptions underpinning the diagnosis had grown, and numerous research continued to indicate widespread variations in PTSD across cultural boundaries (Marsella, 2010).

The academic debate in this field is whether this variation represents cultural differences in the phenomenology of universal disorders or the existence of unique culturally

constructed disorder (Marques, Robinaugh, LeBlanc, & Hinton, 2011). There is considerable variance in the research literature in the *prevalence of PTSD* found in cross-national and intra-USA studies. Much is probably due to differences in the types of trauma experienced and stressors preceding and following the event, such as living conditions and SES, making it difficult to draw conclusions on prevalence across cultures. However, the findings from these studies do suggest that PTSD symptoms are not exclusively observed in the context of industrialized Western countries (Marcues et al., 2011). Further, research suggests considerable cross-cultural variations in the presentation of anxiety disorders, including PTSD. The cause of such variation in the *clinical presentation of PTSD* remains unclear (Marques et al., 2011), but is an active and ongoing debate in medical anthropology and subsequent fields of research (e.g., Farmer, Yong Kim, Kleinman & Basilico, 2013: Wilkinson & Kleinman, 2016).

An outline for "cultural formulation" was introduced in DSM-4 (1994), intended to provide a framework for assessing information about cultural features of an individuals' mental health. This outline was further revised and extended in DSM-5 (2013). In addition, the PTSD description received a section describing culture-related diagnostic issues:

> The risk of onset and severity of PTSD may differ across cultural groups as a result of variation in the type of traumatic exposure (e.g., genocide), the impact on disorder severity of the meaning attributed to the traumatic event (e.g., inability to perform funerary rites after a mass killing), the ongoing sociocultural context (e.g., residing among unpunished perpetrators in post-conflict settings), and other cultural factors (e.g., acculturative stress in immigrants). (…) The clinical expression of the symptoms or symptom clusters of PTSD may vary culturally, particularly with respect to avoidance and numbing symptoms, distressing dreams, and somatic symptoms. Cultural syndromes and idioms of distress influence the expression of PTSD and the range of comorbid disorders in different cultures by providing behavioral and cognitive templates that link traumatic exposure to specific symptoms. (…) Comprehensive evaluation of local expressions of PTSD should include assessments of cultural concepts of distress. (DSM-5: APA, 2013: p. 278)

A wide range of neuro-biological studies have identified PTSD-related changes in the brain, indicating these changes to be of a universal character. Neuroimaging studies demonstrate specific changes in the brains of people with PTSD, such as increased activity in the amygdala and decreased activity in the medial prefrontal cortex, and reduced hippocampal

volume. Neurochemical changes have also been found, including increased dopamine levels and decreased concentrations of serotonin in parts of the brain (for overview see Center for Substance Abuse Treatment, US (2014)). Numerous studies on cognitive implications have shown PTSD to be associated with cognitive deficits leading to poor cognitive functioning. The neurocognitive domains most commonly affected are episodic memory, attention, executive functioning and speed of information processing – with the severest effects observed in verbal immediate memory and attention/working memory (see Malarbi, Abu Rayya, Muscara, & Stargatt, 2016; Scott et al., 2015).

It has been and remains a controversial debate whether cultural variation in the prevalence and presentation of PTSD represents cultural shaping of a universal disorder – or rather, the existence of PTSD as a unique culturally constructed disorder.

Such variations do not necessarily mean that PTSD is not a universal response, but rather that it cannot be decontextualized from the culture in which it occurs – because this isolates it from the etiological roots, references and methods of mediation (Marsella & Christopher, 2004).

Defining culture

"Culture" as a word is often used and frequently misunderstood. The concept of culture is broadly defined in this thesis as a system of common heritage and shared beliefs, norms and values that unite a group of people (Marcques et al., 2011). Culture refers to shared, learned behaviors and meanings that are transmitted socially, often across generations, for purposes of sustaining or promoting adaption, adjustment and development. Culture has external representations, roles and institutions – as well as internal representations, such as values, attitudes, beliefs systems, epistemologies and cosmologies (Marsella & Christopher, 2004).

This rather wide description emphasizes that culture involves the psychological construction of reality, as culture often becomes a template for reality by influencing how we experience the world.

Philosophy of science

Towards modern social anthropology

In the following paragraphs, I do not intend to present a complete and comprehensive overview of positions within philosophy of science—merely to offer a broad overview as a backdrop for presenting the philosophy of science that has underpinned my research design, research collection methods and my rationale for choosing an interpretive approach.

Bronislaw Malinowski, the founder of European (British in particular) social anthropology, focused on the social rather than the cultural. He was central in furthering the methodological development of participant observation as a distinct method used in anthropological fieldwork. According to Malinowski, the goal of the anthropologist, or ethnographer, is "to grasp the native's point of view, his relation to life, to realize his vision of his world" (Malinowski, 1922/1978). In the heyday of participant observation, anthropologists attempted to get “objective” accounts of “others”—often studied in “primitive” societies and cultures far away from American and European societies (Denzin & Lincoln, 1998). The Chicago school of sociology led the way in the development of participant observation within one’s own culture, and was a driving force from 1920s and until the mid-1960s. *Street Corner Society* by William Whyte (1943) became a classic, and an ideal for participant observation in sociology. The modernistic period reached a peak around the 1960s with ethnomethodology, symbolic interactionism and grounded theory. Phenomenology and structuralism was a part of this period. Edmund Husserl (1859-1938) was the prime mover of phenomenological philosophy—seeing the social world as organized into meaning contexts, a taken-for-granted stock of knowledge we share with others. The phenomenologist seeks to build a rationale and identify ideal types of social action (Benton & Craib, 2011). Structuralism, which came to dominate French academia in this period, cut across several disciplines, including anthropology. It entailed an emphasis on underlying structures—and an under-emphasis on the acting subject (Benton & Craib, 2011). In anthropology, the reflexive period (1970 to mid-80s) was influenced by Clifford Geertz’s *The Interpretation of Cultures* (1973) and *Local Knowledge* (1983). Geertz advocated for a “thick description,” opening for interpretive and reflexive approaches in analyzing cultures—as opposed to the positivistic and behavioristic perspective that had characterized earlier

anthropology. This reflexive period has extended into post-modernism, constructivism and feminism.

The philosophy of social science had provided a rich literature and heated debates on interpretive approaches—in particular when the subject matter concerns the meaning of human intentions, beliefs and actions. Hermeneutics is an influential philosophical approach for the science of interpretation and understanding. Clifford Geertz (1973) was influential in introducing hermeneutic interpretation in anthropology for the use on culture; and Hans-Georg Gadamer (1989) has been a central driver in a movement opposing what is seen as an instrumental and possibly manipulative spirit of natural science (Benton & Craib, 2011). Gadamer is critical to conventional conceptions of objectivity, arguing that knowledge is not a product of coming to understand the action of the individual but of achieving an understanding of the movement of history. Understanding is inevitably historical as the nature of human being itself is historical and open for historical change. Through the "hermeneutic circle" we cannot understand the part without understanding the whole of which it is a part—neither can we understand the whole without understanding the parts that make it up. Understanding includes a constant movement from the part to the whole and back again. Gadamer sees this as a description of our very existence as thinking beings—this is what we do when we think (Gadamer, 1989: Benton & Craib, 2011).

A key principle within hermeneutics is that we never meet the world without preconceptions. Whenever an action or a text is interpreted, this is influenced or based on prior experiences and knowledge. Primarily, we understand through our pre-assumptions or pre-judgements. Gadamer uses the term *prejudice* and *pre-assumptions* (Gadamer, 1987) while Dancy uses *a priori knowledge* (Dancy, Sosa & Steup, 1994). As the researcher may not be fully aware of pre-assumptions, they need to be brought into view as a part of a reflexive process—they are vital to the interpretive process.

A central concern of modern anthropology is the application of knowledge to solving various human problems. The American four-field approach here involves archaeology, biological anthropology, sociocultural anthropology and linguistic anthropology (AAA, 2021). In contemporary British social anthropology, the field still predominantly uses the term "social". However, much of the traditional difference between American and British anthropology has

diminished as theory, methods and interpretation approaches are more commonly exchanged and mixed. Differences and characteristics within the field of anthropology itself have become more pronounced and developed in a range of sub-disciplines targeting more specific research topics. For example, medical anthropology is an interdisciplinary sub-discipline studying human health and diseases and health care systems. The specific focus on the relationship between health, illness and culture favors interdisciplinary approaches.

Researchers of the classic Chicago school based their participant observation on co-residential long-term (several years) engagement, aiming for a holistic perspective. Whereas anthropological fieldwork tended to focus on distant societies, sociologists often located their fieldwork closer to home, focusing on sub-cultures, and over a shorter timespan. Today, it is increasingly common for anthropologists to conduct shorter-term fieldwork stays, often with a multi-sited design, and also within one's "own culture" (Fangen, 2010).

In a Norwegian context, several researchers have argued against the idea that anthropology "at home", doing fieldwork "within own culture," should reduce the researchers' analytical distance, making one blind to the data and unable to shift between emic and etic positions (see Gullestad, 1996; Wadel, 2014; Fangen, 2010). Like all other researchers, a native anthropologists will have a certain position that can have an influence, so the researcher should declare this position in a reflexive manner (Gullestad, 1996). The term "within own culture" can be misleading when researchers are studying social life within sub-cultures that themselves are not a part of (Fangen, 2010). It can reasonably be argued that anthropologists that "work at home" may have both an insider and outsider perspective. In my own fieldwork, studying immigrant women with FGC experience living in Norway, I am personally quite far away from my "own culture." Similarly, when it comes to the lives of mass-murder survivors living in Norway, the specifics of their new situation lie far beyond the realm of regular experiences, despite being located in a cultural context familiar to me as researcher.

3 Methods

This chapter presents the research design and the outline of my three single-sited fieldwork studies. I present and discuss the data collection strategies and how my research has benefitted from methodological triangulation. In engaging with people, I have aimed at achieving a state of resonance through an "experience-near" approach. My experience and results of this process are presented through excerpts from my fieldwork and diary notes. Further, I present the framework used in addressing reflexivity and validity, as well as my framework for ethical reflections concerning the four studies, with practical examples.

Research design and methodology

Three single-sited fieldwork studies

The philosophy of science applied in my research has been inspired by an interpretative approach rooted in hermeneutic philosophy. The empirical study uses a qualitative case design. In connection with three single-sited fieldwork studies I have used case studies with qualitative in-depth interviews and participant observation methods for data collection. Whereas hermeneutic philosophy underlies the interpretive approach, in the various papers my analysis has been inspired by strategies from grounded theory, thematic analysis, and in the fourth paper, a hermeneutic phenomenological approach.

Each of the four studies was carefully planned, but I had not initially intended to link them together in one combined study with a common research question. Slowly but surely, that project came together as time passed and the research took a specific direction. Driven basically by curiosity, I sought to follow reactions of fear and how these reactions were understood and handled in different cultural contexts. That became the common theme throughout the single-sited fieldwork studies. I did not start out with any pre-formulated concepts—the research questions were developed in close contact with the empirical material. In connection with presenting the four studies in this extended abstract, the combined empirical material proved to enable comparison, thereby turning the combined study into a multi-sited design.

I chose to define the research meta-method for the three studies as having a *case design* using case studies, rather than using the term "ethnography." These two meta-methods can in many ways be overlapping. By opting for a case design rather than ethnography, I have sought to signal a more restricted focus and more narrowly defined borders of the fieldwork as such, as constituted by the definition of the case.

Although I do not define my research design as ethnography, I have been inspired by the ethnographic fieldwork as an approach and its methodology. The character of the field of ethnography has changed and shifted, reflecting contemporary theoretical and intellectual currents. In a broad perspective, an ethnographic field provides an interrogative boundary for mapping a geographical and/or social and/or emotional landscape that is inhabited by a specific participant group. Thus, the ethnographic field is not equivalent to geographic or social space, nor is it a mental construct of the ethnographer—although it entails both these elements (Madden, 2017). The ethnographic field, then, becomes a synthesis of a concrete and investigative space that allows for description, exploration, formulation of questions to problematize, theorize and to attempt to solve regarding the human condition (Madden, 2017).

The last fieldwork on the massacre in Norway differs somewhat from the two others in several ways. Firstly, it was not originally planned as fieldwork. It started as a quantitative survey assessing trauma-related symptoms and mental health conditions post-trauma. My activity and participation developed into fieldwork. As I personally participated in research and activities while at the same time living in the terror-struck surrounding society, I decided that the best approach was to define all this as fieldwork—thereby benefitting from the theoretical background and the approach of a fieldwork study with defined boundaries. Secondly, the data used in research Paper IV are drawn from a predominantly quantitative study. The quantitative survey began with a qualitative face-to-face-interview that allowed myself and colleagues to draw qualitative data and analyze the survivors' speech acts. The formulation of the interview question, the research questions and the interpretative approach were all rooted in the fieldwork, and this fieldwork informed the study presented in Paper IV in a far wider context than did the quantitative survey.

Getting context—covering the temporal dimension

The three single-sited fieldwork studies provided rich information on the various contexts of the activity of *how people deal with reactions of fear following a life-threatening event.* The outer boundaries were set from the beginning: three cultural contexts and types of experienced life-threatening events. These broad boundaries allowed for wide-ranging exploration that extended into a process of narrowing and defining a particular focus of interest, defining a more specific line of inquiry for the observation and interviews. My presence in the field, and the stages of the fieldwork, nurtured this process.

In Uganda, I used a step-in/step-out approach over a period of five years. My first interviews with Patrick were held in December 2007, the ritual was conducted in April 2008, followed by visits including formal follow-up interviews 3, 15, 23 and 35 months afterwards. Even though the visits took place over a consider timespan, I felt that I managed to maintain a position that enabled a social relation between the two of us. In addition to observation of the ritual itself, the longitudinal perspective provided a unique possibility for searching for shifts and changes in Patrick's life, his recovery process and general life situation. This allowed for observation of the temporal dimension—the natural frequency of relevant behavior—regarding the recovery process following the ritual treatment.

Also with the fieldwork on the Utøya massacre survivors, the longitudinal perspective provided context for the temporal dimension. The first interviews were conducted 4 to 5 months after the massacre, the second interviews 14 to 15 months later, and the third, 2.5 years after. Even though only the third interview is used in the Paper IV in this thesis, the fieldwork was broader and included interviews conducted in all three waves of interviewing, generally with the same persons.

The research trips to The Gambia, Ethiopia and Kenya provided valuable context for the FGC-fieldwork in Norway. It gave our research team the possibility of getting closer to the ritual and its surrounding context. In FGC conversations with the women, we would often hear: "When I was growing up in The Gambia …" Actually being there supplied us with context that could be used later in conversations in Norway. Such conversations invited the women to go "back in time," bringing in several new dimensions.

Data collection

Participant observation

Below is a schematic presentation of my participant observation in the three fieldwork studies. The focus of the presentation is on the level of involvement (Spradley, 1980), defining my roles and showing how I alternated between roles and shifting level of involvement. In the fieldwork and observation, I was guided and inspired by three broad categories of observation: *descriptive*, *focused,* and *selective* (Spradley, 1980). With descriptive observation I sought to get an overview, trying to grasp what was going on—a fundamental type of observation that continued throughout the fieldwork. Second, focused observation requires a more narrow focus to investigate structural questions, like the structure of a ritual. Third, selective observations represent the narrowest focus of the social situation being investigated (Spradley, 1980). The in-depth investigation takes place gradually, as the type of observation moves into all three categories. The defined cases represent the chosen setting to be investigated.

Here I present the observation of the defined case, followed by a sub-listing of supportive observations. These observations are sub-listed because they were not defined as the primary data-set for writing up the four research papers.

Fieldwork I: Former child soldiers in Northern Uganda

- Passive to moderate participation in observation: participating in the planning and the conduct of a cleansing ritual for Patrick: one week preparation and three days for the ritual.
- Active participation in observation: meeting Patrick at home in his village over four time-periods after the cleansing ritual.
    - Active participation: maintaining contact with five former child soldiers by meeting them twice a year for over a period of three and a half years.
    - Complete participation: working with the NRC as an advisor for their school project and developing a school-based mental health and psychosocial intervention.
    - Complete participation: training and coaching teachers in piloting the intervention and interviewing the participating students.
    - Passive participation: presence at two NRC schools, observing students and teachers.

In the week of the preparation phase, I was present in the village—just being there, sitting under the big tree in the area that comprised the "village square," not far from the water pump. This village had a population of only about 200, but was located near a neighboring settlement. With my translator next to me, I engaged in frequent conversations with the local people, including the village elders and Patrick's family. During the week I met with Patrick only in the morning or evening, as he was busy preparing for the ritual and trying to obtain all the necessary items—like a black and white goat with specific characteristics. I took my meals with Patrick's mother as she waited for him to come home.

Fieldwork II: FGC in a Norwegian context

- Active participation in observation, with home visits for the in-depth qualitative interviews. The home visits were often repeated: whenever possible, I conducted a series of interviews.
- Active to complete participation in observation: following a network of anti-FGM activists in Norway: attending their meetings, working with them and traveling with members of the network, within Norway and to The Gambia, Kenya, and Ethiopia.
    - Active participation: engaging in small-scale workshops for discussions and more structured interviews. These were regularly held "reference groups" with a social aspect.
    - Complete participation: participating in a team that was developing governmental information and campaign material to raise awareness of anti-FGM information. Women with FGC experience were hired to participate; others were invited for discussion groups.

The in-depth qualitative interviews at the participants' homes were rich and informative; they also served as "door openers." What took place in these home visits was far more than an interview—it was fieldwork in a broader sense, setting the scene for participant observation, building resonance and laying the ground for longitudinal engagement. Note-taking followed the same principles as in the Uganda fieldwork: brief notes jotted down in the field were extensively written out as soon as possible, and extracts were included in the field diary.

Regarding the anti-FGM activists, I felt we had a somewhat equal position, as government-paid officials working to inform immigrant communities in Norway. That allowed for ongoing professional conversations on a range of relevant topics. When I switched to being an interviewer with a specific focus, very personal in the line of inquiry, this shift was clearly signaled by my asking the respondent to sign an informed consent form,

and turning on the tape recorder. Later, as relations developed over time, we could re-visit sensitive topics without the need for signatures or tape recorders.

Fieldwork III: Terror attack and massacre in Norway

- Active participation in observation: serving as a member of the national research team conducting interviews with survivors and their parents: a longitudinal study with three (mainly) home visits over two and half years.
    - Complete participation: advisor for the Ministry of Education and Research (KD) on developing a communication strategy to help teachers to explain the terror attack and the massacre.
    - Complete participation: advisor for Norwegian Broadcasting Cooperation (NRK) on their news broadcast for children, concerning the terror attack and massacres.
    - Passive participation: Attending the court procedures of the perpetrator.
    - Complete participation: engaging in workshops and meetings with survivors and their parents through support groups and the survivors' formal support group.

When I decided to include the qualitative interviews in a more comprehensive research design, defining a field for fieldwork and including participant observation, the home visits became the primary arena for participant observation in this study. As with the FGC-home visits, also these visits added context and rich information beyond the interview itself. The invitation into private homes for disclosure of highly private inner feelings, three times in two and a half years, set the stage. Defining this as fieldwork with participant observation supported me as a researcher in framing the research, also enabling me to observe and comprehend the richness of data. Observations were carefully recorded in my field notes and field diaries.

It might be discussed to what extent the sub-list of other activities would or should be classified as a part of the fieldwork—and to what extent the arenas and my roles qualify as participant observation here. My involvement and participation in these activities helped me to achieve a more explorative perspective of myself as a researcher doing fieldwork in my own culture. I hold that these activities should be seen as a sub-list of fieldwork activity where I conducted participant observation, with systematic field notes and field diaries in which I also recorded my thoughts and experiences

In research paper III, I described my two translators in Uganda as "cultural advisors." Their work was to translate between English and the local language Lwo in conversations and interviews. Also in the two FGC papers I use the term "cultural advisor." My two dedicated translators, Ochitti Ochora in Uganda and Nene Bojang in Norway and in The Gambia, were far more than conventional language translators. Both were also conversation partners eager to explain about cultural aspects that could otherwise be hard to detect. Here I have been uncertain as to what terminology to use. The term "cultural advisor" might be taken to indicate that the fieldwork itself is not sufficient for understanding the social and cultural context, but requires a separate advisor. However, I see the many conversations with my translators over the course of several years as an integral part of the fieldwork together with the research process, and would prefer to refer to these persons as translators and research assistants.

By its very nature, an ethnographic record consists of field notes, tape recordings, pictures, artifacts and anything that documents the social situation being studied. There are various kinds of field notes that make up the ethnographic record, and various ways of organizing this process (Spradley, 1980). In the course of my fieldwork, I gradually developed a system of notetaking. While in the field I made condensed accounts of key words indicating small or major events, half or full sentences to remember conversations, and I used a set of symbols to indicate feelings or appearances of people in the social context. In Uganda, each daily departure from the field involved one hour of driving, which allowed me to go through my observations mentally, adding more as necessary. Back in Gulu or Kitgum, I wrote the condensed notes in full text. Major events and special aspects under study and more analytical comments were written down in my field diary. Here, I had three specific aims: firstly, to record my analytical thoughts; secondly, to record my personal experiences of confusion, worry, as well as breakthroughs; thirdly, to make an introspective journal that could guide and challenge myself to be more aware of my personal feelings and biases, to understand their influence on my research. I followed the same logic of notetaking in the other two fieldwork studies.

Whereas the field notes constituted the ethnographic record, the field diary was a living document that was constantly revised. In all three fieldwork stays, I jotted down several

figures and models in my field diary. These were important for understanding what happened in the field: they served as incomplete structures that led and guided me in pursuit of finding out more to make the figures and models more complete. They kept changing and evolving as I stayed longer in the field and through the analytic process. None of these were included in the four papers, mainly because of the strict academic format of the journals in question. However, some of the figures and models have been included in this extended abstract under Chapter 4: Results.

Qualitative interviews

The theory-based planning and the structuring of the qualitative interviews were inspired by Kvale and Brinkman (2009). However, I followed their somewhat strict structure and formalized way of interviewing only initially in the field. There are clear variations in the interviewing approach for the three fieldwork studies concerning the formal structure, as interviews were combined with observations of several types. The most open and fluid interviews took place in the Uganda fieldwork, where no interview guide was used. The interviews started out by exploring the students' learning situation at school, followed up exploration of the content and nature of their traumatic nightmares, and then their experiences as (former) child soldiers. My interviews with Patrick and his family, neighbors and friends were fully open, shifting direction as the conversation progressed. These interviews were combined with observations. Some interviews with Patrick were more structured, when I inquired about his reactions and wellbeing.

The formal initial FGC-interviews were all planned with semi-structured interview guides. However, the second interviews were generally conducted without interview guides, taking up the themes that occurred—also these informed by participant observation. The interviews with the 15 Gambian circumcisers (used in both FGC papers) were multidisciplinary, involving four researchers with differing professional backgrounds—in medicine, anthropology, psychology, and education (see interview guide: Appendix 1). Preliminary analyses of the interviews were carried out in group discussions with the four researchers, together with the translator and research assistant—providing a rich basis for later analysis. In the first FGC paper, the first and the last interviews of the 18 women were conducted with two researchers present. Appendix 2 presents an example of the interview guide for mothers whose daughters had undergone the FGC procedure.

Interviews of the survivors of the Utøya massacre and their parents (Paper IV) were done individually. However, I travelled with a colleague, which allowed for and stimulated active discussions. These interviews, by far the most structured ones of the three fieldwork studies, followed more of a quantitative research paradigm aiming for high degree of fidelity. Each interview started with a qualitative part, lasting up to 30 minutes, followed by a comprehensive quantitative questionnaire, which was filled out partly together with the interviewer and partly alone. All nine interviewers for the 68 students involved in this study had been formally trained, in order to have a similar approach. However, the semi-structured interview guide allowed the students to tell their stories in the way they wished (see interview guide: Appendix 3).

Methodological triangulation

My two first fieldwork studies were more traditional in the sense that they followed a structured sequence. In establishing an ethnographic record, I started with descriptive observation, including systematic use of field notes. Research questions were formulated; they guided the in-depth investigation by focused and selective observations and interviews of members of the group that constituted the case. Each case represents the social contexts selected for study.

As to the nature of the research: the social contexts and the formulation of the research questions benefitted from the combination of two methods of data collection. For example, some elements of the cleansing ritual could be explained verbally, analyzed, and understood through interviews; other parts were more of a tacit nature, difficult (if not impossible) to verbalize. These types of experiences involved participant observation, for later inclusion in my field notes. Further, participant observation allowed for deeper contextualized knowledge, which could inform the interviews.

The combination of observation and interviews allowed for comparison between two rather different data-sets: discursive and observational data. These two data-sets can contrast each other, promoting new lines of inquiry. The two types of data can supplement and correct each other, leading to a higher level of validation. When interviews follow an observation, the interviewer can further explore and enquire about the observed situation (Fangen, 2010). In the two first fieldwork studies, the more formalized and structured interview functioned as a "door opener." Later in the fieldwork, most interviews became more interwoven, integrated

into participant observation, sometimes making them difficult to separate—but that was hardly necessary.

As frequently pointed out in methodology discussions within anthropology, in some studies verbal transcripts tend to be in focus, with lower status accorded to ethnographic descriptions (see e.g. Fangen, 2010). This tendency may have influenced me, but various research strategies were also applied. The data-sets for all my three fieldwork studies were constituted by *field notes*, *transcribed interviews*, and the *field diary*. However, the data-sets were differently used when it came to writing up the study. In my Uganda and FGC fieldwork, I define the two data-collection methods of observation as nearly equal methods. In writing Paper III (Uganda), I made fairly equal use of my field notes and interviews, also presenting quotes recorded in field notes and not from formal interviews. However, in writing the two FGC papers, I leaned more towards the in-depth qualitative interviews as the primary method. Paper IV offers a straightforward account of analyzing the students' speech acts as transcribed from the structured interviews. Still, also this study was embedded in fieldwork.

The step-in/step-out approach is quite different from participant observation based on co-residential long-term engagement. In the Uganda fieldwork, safety considerations prevented me from staying for a long time. However, I would argue that I benefitted from the step-in/step-out approach by having "fieldbreaks". Patrick and I had our meetings and conversations within a condensed timeframe, aware that I intended to return. We had an agreement, and we followed up on defined topics—his wellbeing and stress-related symptoms. This agreement made it possible to work towards gaining both an emic (insider) and etic (outsider) perspective. The relationship achieved and aspects of resonance between Patrick and myself allowed for emic perspective into his wellbeing. Then, two weeks later, I was back at my office in Oslo, writing my field diary with an etic perspective—achieving analytical distance.

Other examples of the interplay between emic and etic perspectives in my research can be found in the next sections, where each fieldwork study is outlined. Being aware of emic and etic perspectives, reflecting on my levels of engagement in participant observation as well as reflecting on my different roles and the transitions between them, helped me to be alert, to

try not to be blind to my collected data, and to differentiate between arbitrary and important data.

Aiming for resonance

In the course of my fieldwork, I have talked with people, been together with people, and looked at people. Connecting and engaging with people has been my method in seeking to explore their experiences in dealing with life-threatening events. Methodologically, I have been inspired by the anthropologist Unni Wikan's work on resonance, where the aim is to achieve a state of resonance with people through an "experience-near" approach (Wikan, 2013). A central point is to direct the focus towards the communalities in human experience in everyday life, as opposed to colorful rituals and ceremonies. Wikan advocates a focus on persons in lived situations, rather than discourse; she adds that aiming for resonance allows the researcher to go beyond words, and engage in people's compelling concerns. She refers to Rorty's (1989) perspective of seeing human solidarity needs to build on our ability to see traditional differences (religion, race, customs) as less important compared with similarities with respect to pain and humiliation and the ability to see widely differing people as all included in the range of "us."

It could be argued that the focus of the research presented in this thesis is precisely on the "colorful" rituals that stand out. However, my research has focused on exploring communalities in the practices of healing. Thus, the highly complex rituals are de-constructed and compared to Western-style, "evidence based" research on therapeutic factors. I would argue that such approach is in line with searching for communalities, even if the objects of investigation are "colorful" rituals and practices.

The concept of resonance described by Wikan has similarities to central elements in counseling skills (Carkhuff & Anthony, 1979) in client-centered therapy (Rogers, 1951). However, the similarity concerns not the therapy, but the humanistic approach, with its focus on empathy, respect, and genuineness in encounters with others.

In the following sections, I briefly present each fieldwork study, followed by key examples of resonance—indicating how resonance between the people I met and myself as a researcher was pursued and could be observed during the fieldwork. These examples draw on a combination of field notes and field diary jottings, showing my reflections on encounters that occurred in the course of the fieldwork.

Fieldwork in different contexts

Fieldwork 1: Former child soldiers in Northern Uganda

The fieldwork was conducted between 2006 and 2011. After a few meetings in Oslo with the Norwegian Refugee Council (NRC) in late fall of 2006, an agreement was reached: the NRC would facilitate my transportation and stay in Northern Uganda, in return for consultation and advice on improving their school program for former child soldiers and war-affected adolescents. The NRC had a country office in Gulu and had recently established five schools that provided accelerated-learning programs for 500 students, with a focus on basic education for adolescents with little or no formal schooling due to the conflict. They ranged in age from 14 to 20 and were considered to be among the most vulnerable in their communities. I arrived in Gulu in November 2006—three months after the ceasefire agreement was signed following a 22-year-long war between the Lord's Resistance Army (LRA) and governmental forces. The conflict had been brutal, with widespread abductions of children and the use of child soldiers. LRA leader Joseph Kony, with senior commanders, was indicted (in absentia) by the International Criminal Court for having established a pattern of brutalization of civilians through a series of acts that included murder, abduction, sexual enslavement, and mutilation. After the peace talks that were held in Juba in 2006, the LRA no longer operates in Uganda. Joseph Kony has never been found, but is believed to be operating in neighboring countries.

The five school centers built by the NRC were well organized, with qualified teachers, textbooks, and other educational materials—moreover, they provided one hot meal each day. Students were motivated and had been enthusiastic about going back to school. However, they were not learning. They were drowsy and did not pay attention to the teachers' lectures. Teachers and students alike were frustrated, as were staff at NRC headquarters in Oslo.

After one intense week of interviews and conversations with students, parents, teachers, and headmasters, I found that lack of concentration and poor sleep quality seemed to be sabotaging the learning process. On returning to Oslo, I agreed with the NRC to set up a research project. The NRC requested the country office in Gulu to provide a designated translator and to grant access to all five schools—as well as housing and safe transportation. During my next field visit three months later, qualitative interviews were arranged, so that I could understand more of the context and the students' needs. Secondly, with colleagues in Norway, a quantitative study was set up, for assessing trauma-related symptoms and mental

health among 81 war-exposed Ugandan adolescents, as a basis for improving conditions for re-attendance at school. Self-reports of exposure to traumatic events, trauma-related symptoms, and indicators of mental health were collected (Schultz, Sørensen & Waaktaar, 2011). In parallel, we initiated a series of six workshops with designated teachers to explore how nightmares and reactions to stress were dealt with in the local Acholi culture, and what kinds of educational measures could be effective in this context. Following the workshops, a trauma-focused intervention was designed, aimed at reducing students' post-traumatic nightmares (Schultz et al., 2009); this was later revised (Schultz et al., 2013). Those who experienced post-traumatic nightmares were recruited to form groups of eight students to group and individual sessions, led by two teachers. The ten teachers participating in this project received support and follow-up with in-depth discussions over a three-year period.

My key informant, Patrick, was involved in the first quantitative study (Schultz, Sørensen & Waaktaar, 2011), participating in qualitative interviews aimed at exploring his post-traumatic nightmares. From these initial rounds of qualitative interviews, Patrick and four other former child soldiers were chosen for long-term follow-up interviews. They were selected on the basis of their varied experiences as active child soldiers: moreover, all four were "warming" up in their interaction with us, becoming willing and able to communicate. These five informants were followed up through two yearly in-depth qualitative interviews in their homes, over a four-year period.

The follow-up of these five adolescents became the central focus of our fieldwork. When Patrick decided to participate in the cleansing ritual in 2008, that became a selected observation presented in the third paper included in this thesis (Schultz & Weisæth, 2015).

However, due to safety considerations and strict security restrictions, I was unable to stay overnight in the Kitgum area. The city of Gulu (administrative center of Gulu District) was located about one hour's driving time from the school in Kitgum and another 20 minutes from where Patrick was living. (See Fig. 2.)

Figure 2: Map of Uganda showing Gulu and Kitgum

In 2006, rebel groups were believed to be active and present in parts of Northern Uganda, and strict safety measures were enforced. In the following years, rebel activity moved further away from the Kitgum area, and usually occurred after nightfall. However, there was a threat from within: there had been several instances of former child soldiers killing or seriously injuring people. My translator Ochitti gave me protective advice, such as when inside the hut, always sit with your back against the opening for quick escape. Such advice made me alert and concerned. In the beginning I found myself constantly trying to decide whether it was dangerous to conduct interviews and spend time together with people. This was also the case when I first met Patrick, for interviews about his sleep problems and nightmares (see Fig. 3 of a similar type interview situation). We made a few attempts at chatting, but he always gave short, curt answers to my questions. The field notes below describe my thoughts when meeting Patrick for the third time.

> *Under the mango three*
> Third attempt at a conversation. I met Patrick at school, he had finished his lessons and came walking towards me, carrying two chairs. I was waiting in the shade of the huge mango tree. A firm handshake accompanied by smiles. We sat down on the chairs, with Ochitti right behind us. Patrick does not meet my eyes, it's more like he is looking beyond me. No words. My questions get short answers. Suddenly, in a split second, without warning, his right hand shoots towards my neck, and takes a firm grip.

Then he loosens his grip, and I see that he is holding a giant fire-ant right in front of me and saying: “We need to be careful with these, they cause a lot of pain ...” Could that be a sign of his taking control, and showing me this, like a warning? A rough alternative to “informed consent” and a reminder that I keep my conduct of silence? No, I think it’s more an act of care—he wanted to help me. Anyway, both perspectives are possible, and both would represent constructive communication through action.

I need to go deeper, I need to get to know him—I’ve only been scratching the surface. So many barriers. If my interpretation is right, things might be going in the right direction now. It might be possible—through more time spent together.

Figure 3: A typical interview situation for the initial interviews in Northern Uganda Photo: NRC/Mutto Robert

After a few more meetings we managed to achieve more of a dialog. I believe the breakthrough occurred when I visited his village and his hut. I came on his invitation; he served me tea and welcomed me into his “territory.” After tea, we spent almost two hours walking to his farmland and back. He proudly showed me around, explaining and eagerly sharing his detailed knowledge of farming.

Later, during the preparation for the healing ritual, quite a lot of time was spent just sitting around waiting, which also allowed for conversations. Below is an excerpt of my notes from conversations with the traditional doctor.

Two doctors—worlds apart

(…) I spent more than two hours sitting next to the traditional doctor waiting for Patrick to return with some necessary equipment for next week's ritual. In the days prior to this, there had been several in-depth interviews with the traditional doctor, about her healing abilities, her practice, her patients, various rituals and everything else I could think of to ask about. She had been eager to tell about her practice and about her life. Now we were sitting in silence—just waiting, with nothing specific to talk about. Just being together, having gone beyond the "descriptive" stage.

With my newly acquired doctoral degree, there were two doctors sitting next to each other, and yet worlds apart. I was struggling to take in her perspectives, her beliefs and her practice. I secretly hoped that she, in a collegial way, would send me a secret smile and whisper that she knew that the ritual worked only because of the placebo effect. That the explanations of the spirits were the result of creative explanations and the use of metaphors. That never happened. No secret smiles, no collegial whispering. Later, I kept wondering what she might have wished *me* to whisper to *her*.

I found it difficult to connect with the traditional doctor. There seemed to be so many barriers. I felt my recent exams for my own doctoral degree and all my reading in psychological and medical theories of mental health came between us. And then, the next week, the ritual could finally be held. By that time, I had been "hanging around" enough not to stick out too much. The villagers knew who I was, they were used to me, and they expected me to be there—and to leave before sunset, leaving the community dinners out of reach (see Fig. 4). However, gradually during the ritual, I began to feel a sense of resonance.

I was included—and I felt it

When I paid for the ritual I went in on their terms, I was taking their tradition seriously. This was several times stressed by Ochitti, who thanked me for supporting the Acholi culture. Actually, this was important for me. I felt a strong feeling of being included, for the first time. Not that I felt that I was one of "them," but I felt that we were in this together. We were acting together.

That dawned on me when I had been inside the hut with the women singing, the monotonous drums beating, the dancing and the dust—an explosion of rhythms, fighting evil spirits and approaching a state of ecstasy. After more than one intense hour of this, I was exhausted and needed fresh air. So, when I'd had my fair share of this, I left the hut and went over to the big tree where the elders were sitting together, the younger men in another group. I was invited to sit together with the elders. I sat

down. They offered me a taste of the brew—I drank it (with strong regrets). We just sat there in silence, listening to the distant sounds from the hut.

It was then I suddenly felt it, sitting there, relaxed in the shade with the men: I felt included. Nothing was said for a long time. The drums and the singing punctuated the silence. And I was part of it all. I could relate to this. Not the ritual as such, but the feeling I had. I had left the hut, with all the commotion, and joined the other men. In fact, this was very much like my earlier experiences with familiar rituals like christenings, birthdays, weddings, and funerals. At some point I would leave the "cocktail chatter," and sit down with a few men.

This truly embodied experience, when I felt exhausted by the intense commotion in the tiny hut, helped me see beyond the colorful ritual and relate to the real people around me.

Figure 4: Preparation of the community dinners served throughout the ritual

Fieldwork II: FGC in a Norwegian context

The fieldwork took place between 2009 and 2013. I came in early in the formation of a group of six researchers mandated to provide the Norwegian Ministry of Children, Equality and Social Inclusion with research-based knowledge on FGC/M in a Norwegian context. As a part of the mandate, information material for governmental "drop FGC!" campaigns were to be produced for immigrants living in Norway. The actual research design, approach and content

were fully up to the research team to decide. The group had been put together with a multidisciplinary profile: researchers in the fields of anthropology, medicine, psychology, sociology, and education. In addition, colleagues with a background in psychiatry were frequently consulted and included in the discussions.

In developing information material, we drew on the network of anti-FGM activists in Norway as expert consultants, both formally (through paid work) and informally (conversations and discussions). Several brochures were produced, with titles such as: "Your body is perfect by nature; and you're in charge of it" (NKVTS, 2010). An information film was made with a well-known Norwegian activist telling her story, also showing and illustrating a staged cutting procedure. The title of the film was "Why did you do this to me, mom?" (NKVTS, 2012). This collaborative project served as a door-opener for our active participation in the anti-FGM network as well as other related networks, and provided access to individual contacts.

In one research project, network members were engaged in a formal survey, and also participated in formal discussions informing our research planning. In this particular study, altogether 70 qualitative individual and group interviews were conducted with medical doctors, nurses and social workers, to explore their experiences and the practice of "preventive conversations" aimed at hindering FGM (Lien, Schultz & Borgen, 2012). This approach was a new measure applied by the health sector aimed at preventing the circumcision of girls in Norway.

Further, the network of anti-FGM activists was actively used for recruiting informants for the ensuing study where 46 informants described their change of attitude to FGC. We explored the process of paradigmatic attitudinal change—from being circumcised and proud of it, to seeing themselves as having been exposed to a harmful tradition that robbed them of their womanhood (Lien & Schultz, 2013).

Interviews with members of the anti-FGM activist network as well as other members of the diaspora communities in Norway (48 informants from Somali, Gambian, Eritrean, and Kenyan backgrounds) served as a secondary data source in another study (Lien & Schultz, 2014). This article explored the challenges and risks for nurses, teachers, and welfare officers in interpreting the early signs of an imminent FGM/C procedure in their attempts to

communicate during efforts to avert female genital mutilation—identifying and describing a dilemma within the Norwegian law against female genital mutilation/cutting (FGM/C).

The active outreach from our research center to the activist network provided exclusive contact. However, relations had to be built individually, over time—and I felt there were several barriers I had to overcome. How could I, as a white man from the frozen North, talk with African women about such a highly sensitive and private matter as circumcision, the removal of their clitoris? I was deeply concerned whether my participation in the research was possible at all. Would I be able to get past the obvious barriers, and connect? After several coffee chats and one in-depth interview with an early anti-FGC/M pioneer in Norway, I wrote the following enthusiastic fieldnotes:

> *The perfect stranger*
> I actually think it is possible—this can work! They rightfully see me as a novice, someone with no prior knowledge, no understanding of the ritual: how it's done, what it means and what it takes. They need to tell me everything, explain to me from the very bottom up. On top of that, I'm not a Muslim, and not even a woman! In a way I'm the perfect stranger. Someone they can talk to and relate their personal experiences, not restricted by morally encoded schemas as to what to do and not. Their stories are not violations that cause shame, guilt, or regret. These women appear to be "free" in their encounters with this "perfect stranger."

On our research trip to The Gambia, we met local women and professional circumcisers at a "conversion conference" arranged to persuade people to become anti-FGC/M activists (see Fig. 5). Connections were made and interviews were arranged. We visited remote villages and participated in their re-enactments of the FGC rituals, stopping short of the cutting procedure (see Figure 6). These rituals were facilitated by a nationwide anti-FGC/M organization as a way of maintaining parts of the ritual meaning. Our observations in villages, dinner conversations and interviews provided rich information. However, we spent far too little time with our informants to be able to say we had achieved an insider perspective. Even though the women were willing to talk, I felt there were barriers inside me. I had not felt similar barriers in the Norwegian context. The following field note was written on my return from The Gambia.

> *Pioneers in Norway—easier connections*

It's so much easier to relate to the pioneers maneuvering in the Norwegian system. In particular when meeting in their own homes, their apartments in Oslo and in the districts. Participating in their anti-FGC/M meetings. Eating with them, being invited to join them for local African food, just as we invited them to sample traditional Norwegian food. Traveling together in Norway and to The Gambia, Kenya, and Ethiopia. Observing their changed status as "outsiders" when visiting their home country, and discussing it together. Most of all, now I found it easier to relate to their Norwegian life, with its challenges. Their telling me about typical city vs. rural challenges. How to make friends in a new place, and feeling lonely even when surrounded by people. How to apply for project grants from the social welfare authorities —and sharing experiences and advice on how to get away with not meeting project deadlines! ☺

In Norway, our relations enabled me to connect through shared experiences and references—helping me see the individuals. In The Gambia, the lack of time and relations made it difficult for me to see beyond the ritual, beyond the cutting, the blood, the stitching, and the screams.

Figure 5: Conversion conference in The Gambia arranged to persuade people to become anti-FGC/M activists

Figure 6: A re-enactment of the FGC-ritual stopping short of the cutting procedure; girls wearing hoods for protection against evil spirits in The Gambia

I worked full time for two years in the FGC research group, right up until the July 22, 2011 terrorist attack and the massacre on Utøya. From that Friday and onwards, I came to spend most of my time in the new research project.

Fieldwork III: Terror attack and massacre in Norway

On 22 July 2011, a car bomb was detonated outside the main government building in Oslo, killing eight people and injuring more than 200. The perpetrator then carried out a massacre at Utøya, where the youth organization of the Labor Party was holding its annual summer camp, attended by 564 people. Sixty-nine were killed, many were injured, and 56 were hospitalized. The mass killings lasted for 72 minutes before the perpetrator was captured. The maps show the location of the island relative to Oslo, where the bomb was detonated, and Utøya island, with the route of the massacre (Figs. 7 and 8).

Figure 7: Map of Oslo and Utøya: the two locations of the coordinated July 22, 2011, attacks

Figure 8: Map of Utøya island showing the route followed by the mass murderer

My fieldwork took place between 2011 and 2016. The Norwegian Center for Traumatic Stress Studies (NKVTS) had an official role, providing information and consultation for various governmental agencies in the aftermath of the terror attack. The NKVTS also initiated two comprehensive research projects investigating the health and mental health consequences among those who survived the bombing of governmental headquarters in Oslo and those who survived the massacre on the little island outside of Oslo. More than 30 researchers were involved. I was engaged in the studies of young people who had survived the massacre,

heading a sub-section of researchers focusing on how school well-being and school performance could have been affected following the massacre.

The morning after the attack, I attended an emergency meeting with the Norwegian Broadcasting Cooperation (NRK) on how to communicate new of the terror and massacre to child audiences. A "breaking news" report account was produced the same day, with carefully prepared explanations of the events (NRK, 2011a). I continued to work with the staff in Supernytt, the NRK news channel for children (see e.g., NRK, 2011b). The work of supporting children in the meaning-making process of the complex situation of the terror continued in collaboration with the Ministry of Education. A national communication strategy for kindergartens and schools was crafted and distributed nationally by the ministry (Schultz, Langballe, & Raundalen, 2014). Two research projects were conducted to learn how teachers communicated with their students about the terror events (Strandbu & Schultz, 2015) as well as how the youngest students made sense of the information about the attacks (Jørgensen, Skarstein, & Schultz, 2015).

As my involvement in various terror-related projects was growing, I soon decided to define this as "fieldwork." Drawing on previous fieldwork experience, I set up a strategy for defining my participant observation and established routines for taking field notes and writing a field diary.

The study of 325 of the survivors of the Utøya massacre and their parents involved three waves of interviews: at three months, then at 1.5 years and finally 2.5 years after the attack. The survivors and their parents were individually interviewed. The first qualitative interview with the young people focused on free narratives of the massacre: what happened between the first shots until the survivors reached safety. In the second and the third qualitative interviews, the open question involved providing a narrative of their school functioning. The same structure was followed for their parents, describing how they experienced the day of the terror attack and later about their children's school functioning. There were 15 students and one or two of their parents whom I interviewed three times in the course of two and a half years, altogether nearly 90 interviews. Most interviews with the parents took place in their homes, whereas students were generally interviewed elsewhere, often at their high schools. To gain a better understanding of the school context, I made frequent field visits to the schools; teachers

with survivors in their classes were interviewed, and local school support systems (educational psychological services and school health care services) were visited, their professionals serving as discussion partners. Findings from this research were discussed with local groups of survivors as well as members of the July 22nd survivor support association. These "dialog meetings" became regular occurrences, often held at a retreat, and served as arenas for socializing and informal dialog as well.

In the qualitative report *Negotiating A New Day* (Røkholt, Schultz, & Langballe, 2016) we explored transcripts of 87 parents' experiences of having their children return home from the scene of mass murder, seeking to take up their daily life again and carry on with their schoolwork. Another qualitative study explored 68 survivors' identity configuration in re-adapting to their role as school students (Skarstein & Schultz, 2017). In addition, two quantitative studies on school functioning were carried out (Strøm, Schultz, Wentzel-Larsen, & Dyb, 2016; Stene, Schultz, & Dyb, 2018).

Also in this fieldwork, the home visits stood out as a particularly helpful pathway for achieving resonance in our relations. Being invited into someone's home carries meaning in itself: you are officially "welcomed in." The fieldnotes below were written after a home visit to the mother of a survivor living in Northern Norway. I had traveled by plane and boat to the little settlement, and had found the bus station when I had to call her again.

> *Sharing the kitchen table*
> "Take the bus, walk 5 minutes—can't miss it" The bus ride took about 20 minutes and it was indeed possible to miss the house. I had to make yet another call. By the time I arrived, we had probably had five or six calls to plan and organize the visit, so I felt I knew her a bit already. I was cold when I finally found the place and rang the doorbell. The house was warm, and coffee was ready. I was directed to the kitchen table. The coffee was accompanied by homemade cakes. A lot of small talk—like avoidance, I thought, avoidance for both of us. Finally, however, she started telling how her daughter had survived the massacre—while she herself had thought her to be dead. The daughter had called her mother from the island, had told her they were under attack, but had to break off the connection. Then she escaped the island by swimming to shore, but her mobile phone was ruined. More than one hour was to pass before she could call her mother up again and tell her that she had survived. All this time, the mother had been sure her daughter was dead.

> As she was explaining, we both spent long time, just sitting opposite each other and looking out through the window. Vacant stares—while our thoughts were all about life and death. We shared those empty stares. There was something about the kitchen table that made me feel the connection. That kitchen table was the link to the ordinary—it helped me to identify with her. It grounded me, overturning the pull of the extreme story that was trying to separate us.
>
> The silence and the empty stare brought us together in dealing with our strong emotions—all made possible by that kitchen table in North Norway.

I had taped the interview, and made transcripts of it. But in fact, such meetings were much more than regular interviews. Something deep and personal was shared by the informant, and acknowledged by me. The lived experience had to be dealt with—for instance, over the kitchen table.

Turning a regular qualitative interview into fieldwork became a way for me to approach the situation and process it, using research methods of participant observation combined with systematic field notes and field diaries of all my visits. I could frame myself as a researcher, with a purpose and with tools for dealing with the extraordinary.

Reflexivity

Types of validity

Validity, in a broad sense, pertains to the relationship between an account and something outside of that account—something constructed as objective reality, or various other possible interpretations. As observers and interpreters of the world, we are an integral part of it, unable to step outside our own experience to obtain an observer-independent account of what we just experienced (Maxwell, 2002). Validity has long been a key issue in methodology debates on the legitimacy of qualitative research. The core categories of validity are based on positivist assumptions underlying quantitative and experimental designs, and are less suitable for qualitative research (Maxwell, 2002).

In addressing validity threats and building validity for my research, I have been inspired by the five categories of validity for qualitative research introduced by Maxwell (2002). This typology is meant as a checklist for the kinds of threats to validity that should be considered, as well as a framework for thinking about the nature of such threats and how to deal with them (Maxwell, 2002).

The first category, *descriptive validity,* concerns the factual accuracy of the account, of what the researcher sees and hears. In my study, this was strengthened by field notes, recorded interviews with transcripts. I would further argue that the use of methodological triangulation by combining observation and interviews for the same inquiry has strengthened the descriptive validity. Second, *interpretive validity* concerns the interpretation of what the researcher sees and hears: what does it mean to the people involved? Interpretive accounts are grounded in the language and the presence among the people studied, as well as gaining access to an emic position or "experience-near" (Geertz, 1974). Spending time in the field and the longitudinal perspective provide major enhancements of this type of validity. Being able to follow up over time, interviewing and being with different people. The step-in-step-out approach I used in Northern Uganda had an overall longitudinal design of three years and three months. However, due to relative short time spent in the field, this approach can in no way be compared to long-term engagement, and my understanding of life in Northern Uganda is in many ways limited. I sought to compensate for this by leaning on other field specific research as well as defining a "limited" case for observation. The language barrier was compensated for by the availability of excellent translators. Methodological triangulation and having many people interviewed about the same topic to gain consensus strengthened interpretive validity. Maxwell has argued that both descriptive and interpretive validity depend on consensus within the relevant community about how to apply the concepts and terms used in the account, where any disagreement would concern their accuracy and not their meaning. Such concepts are accessed by the researcher through an "experience-near" approach (Maxwell, 2002).

The next category, *theoretical validity* goes beyond concrete descriptions and interpretations and concerns the theoretical constructions that the researcher brings or develops during the study. Further, it "refers to an accounts function as an explanation, as well as a description or interpretation, of the phenomena" (Maxwell, 2002, p. 51). In my study, this is relevant for each of the four research papers, as accounts are lifted as representative actions and meaning; and secondly, regarding how the four studies can be combined in addressing an overarching research question. Further, this category is concerned with validity threats related to the researcher, and the position of the researcher. Maxwell

(2002) argues that these three types of validity are the ones that are most involved in assessing the account as it pertains to the actual situation.

Descriptive cultural relativism and decolonialization

The term reflexivity is commonly applied to the process of a continual internal dialogue and critical self-evaluation of researcher's positionality, with an active acknowledgement and explicit recognition that this position may affect the research process and outcome (Berger, 2015).

I have used the validity framework described above, as well as the concept of reflexivity, to guide and illuminate my research process. I have employed various strategies for maintaining reflexivity, including repeated interviews with same participants, a longitudinal perspective, triangulation, peer support network, peer review, as well as self-examination. A process of continual self-examination was initiated to clarify my pre-conceptions, with particular attention paid to professional beliefs, theoretical orientations and emotional responses to participants' negative experiences. I did this together with my co-workers as well as through note-taking, writing an ongoing introspective journal. My field notes served as a record for retrospective analysis of my gradual transition from an "outsider" to an "insider" position. In analyzing my field notes and the field diary, observing this transition helped to sensitize me to myself as a researcher and my positioning.

The researcher's positioning may affect the research in three main ways: access to the field, shaping the nature of researcher–researched relationship, and shaping the conclusions, though influence of the researchers' worldview and background (Berger, 2015). As to my own worldview and background, my nationality is a relevant point. I was born and raised in Norway, a small country in the wealthy West or North with a national self-image of competence, goodness and innocence. "We" still play an important part in international peace negotiations, and are important providers of developmental aid. In an interview, social anthropologist Marianne Gullestad summarized Norway's "self-image":

> In sum, in popular belief Norway is a rich, innocent, humane, tolerant, egalitarian, anti-racist, gender-equal and peace-loving society that is committed to helping the needy and has the goal of being among the very best in the world in these respects. (Gullestad in Lien & Melhuus, 2011)

Even the slightest possibility of the existence of such a self-image of omnipotent entails the necessity of reflexivity, to shed light on my own background and my pre-conceptions of others, in order to avoid aspects of neocolonialism and to foster decolonialization within anthropological research.

Gullestad described the aim of anthropologists as being to examine the material conditions under which people live, the values they attempt to realize, as well as the justifications they present for their actions, while suspending judgment until what can be known about the actors' points of view (Gullestad, in Lien & Melhuus, 2011). I myself have aimed for descriptive cultural relativism as an approach or method in my observation and writing. However, my aim as regards descriptive relativism has not been normative in the sense of *normative cultural relativism*. Although studying terror, the use of children in any type of military activity, and circumcision of girls and boys, I have clearly distanced myself from these phenomena.

Ethical considerations

Evoking possible strong reactions through interviews

An ethical framework was prepared for each study. As new situations occurred during the fieldwork, decisions had to be made, through a process of ethical reflections grounded in my ethical framework. The reflections and the illustrative examples below present the development and the maintenance of this framework for my research.

A central ethical question that emerged in all four studies was whether an in-depth interview could cause harm when the informant recalled, described and expressed his or her feelings from a traumatic event. What would "harm" mean in these contexts? What might the consequences be? What measures could be put in place to prevent harm?

It is generally recommended that victims encountering severe trauma should not be encouraged to express their thoughts and feelings during the first month after trauma exposure, as that may interfere with the natural recovery processes (see, e.g., Brewin, 2001). Once the person has become "stabilized" in dealing with symptoms and managing daily life, there are specific prescriptions against inviting a previously traumatized person to talk about the traumatic event and experiences. However, caution is advised: the person should remain in control of the situation, rather than being pressured to disclose certain aspects of the

traumatic event. There is the risk of evoking distress during or after the interviews caused by trauma reminders, often referred to as "triggers" or "cues." The consequences might be brief or longer-lasting feelings of distress, relapse into a state of reduced mental health, and reduced daily functioning. If distress occurs, its duration would be affected by the participants' coping mechanisms, their assistance-seeking activity and the community's access to mental healthcare. "Harm" in this context would refer to longer-lasting distressing feelings that reduce the person's mental health and daily functioning (see Section 2: Reactions to life-threatening events).

In connection with my research, various measures were taken, aimed at reducing the risk of harm, and at safeguarding all informants. In order to avoid feelings of being pressured to disclose emotionally charged experiences, we sought to promote a sense of control among our respondents during the interviews, by making the topics predictable and clearly stating that our respondents could also say more later on, or not at all, as they wished. All key informants were followed up after the interviews. In the case of Patrick, the former child soldier, the NRC monitored him in-between my field visits and were ready to provide any type of medical support needed. The anti FGC-pioneers in Norway were all informed that the research institute NKVTS would organize and pay for medical or psychology consultation if needed. All interviewers working in the terror study received specific training in referral procedures concerning severe traumatic stress symptoms and suicide prevention. Also, every respondent in the terror study was regular asked whether he or she needed assistance in connecting with various parts of the Norwegian healthcare system.

In the FGC research group, the question was raised: could we / should we interview children about their previously conducted circumcision, in order to explore the child perspective on §aspects of the ritual? Such child respondents might potentially be recruited in Norway or on our field visits to Ethiopia, Kenya, and the Gambia. In the research group there were contradicting views whether this would be ethically feasible. We did not bring this forward for further ethical consideration, but instead shifted the perspective in our research by retrospectively asking women about their childhood experiences. However, I myself would hold that an ethically and psychologically sound approach could be used interviewing children, without causing harm. This issue gives rise to another ethical concern: the fact that the lack of such research prevents the research field from gaining insights from children and

their perspectives. This stands in contrast to the UN Convention on the Rights of the Child (CRC), its Article 12 in particular, which states that children have the right to be heard and have their views respected (UN-CRC, 1989). To my knowledge, the FGC literature still lacks such description, from the child's perspective, as of this writing in 2021.

Avoiding sanctions, stigma, and prison

During the fieldwork, maintaining the ethical framework required constant consideration and reflection as new situations occurred. I had to re-visit codes of ethics, not least Article 2 of the anthropological code of ethics:

> Anthropological researchers must do everything in their power to ensure that their research does not harm the safety, dignity, or privacy of the people with whom they work, conduct research, or perform other professional activities. (AAA, 1998: Article 2).

The following examples illustrate my reflections and actions taken in order to reduce the potential risks of putting people in harm's way.

In Uganda, a total of 50 USD was paid to Patrick for expenses for the cleansing ritual. This was used to pay the fees of the traditional doctor and her helpers, as well as for food for the whole village—thereby benefitting many people. However, the challenge was that this might put an extra focus on Patrick, perhaps creating envy among others who were not able to raise such an amount of money for their own cleansing rituals—and must continue to suffer. Previously, Patrick had ended up in trouble because of angry villagers who resented his being admitted to the NRC school and receiving expensive tools from the NRC to enable him to start up as a carpenter. Undue attention from others, especially regarding money, could put Patrick in challenging situations, even in danger. The possible consequences were discussed with Patrick and with NRC representatives. Further, my translator and research assistant enquired among the elders on my behalf, in connection with discussing procedures for rituals. I concluded that the attention and the money would not represent a risk, mainly because the ritual was a collective endeavor that extended beyond Patrick himself, and also because the elders accepted the payment to Patrick on behalf of the entire village.

Another ethical issue cropped up with when it became evident that some women in the FGC study had perhaps not entirely become convinced anti-FGC/M activists—and when some of

the “former” professional circumcisers we met in The Gambia appeared not to be fully retired after all. If such information became known in Norway, it could elicit reactions from the network of anti-activists, possibly resulting in withdrawal of governmental funding. Similarly, if they were exposed as still practicing, the (ex)-circumcisers in The Gambia could lose funding and possibly be socially stigmatized by some groups. Expressing critical or negative views on FGC/M could lead to stigmatization and sanctions, in the immigrant community in Norway as well as in the home country. At the time of our study, the FGC/M-discourse in Norway had become highly polarized and politicized, which required African women living in Norway to strike a very fine balance in their FGC/M communications.

A third issue occurred during our research trip to countries where FGC was practiced, our research team was invited to observe a circumcision. This was politely declined: instead, during interviews and conversations, we talked about the procedures. The possibility of observing the ritual had been discussed in the research team before we left Oslo; it was agreed that we would not seek such an opportunity, and would decline if it were offered. The reason was twofold. Firstly, there were ethical concerns. Our being present (even without actively participating) could be taken as indirect support to the procedure for that particular girl, which we considered a violation of her human rights. The research group, including myself, felt that this could/would compromise anthropological codes of ethics, due to the possible dangers entailed in the medical procedure (AAA, 1998). Secondly, there was the legal aspect. Even though FGM was legal in some countries, we might be bound by Norwegian law, and risk sanctions for our involvement. Ethically, this particular case was not difficult. However, others might be more complicated, making it difficult to foresee the negative consequences of our interaction—as described in the examples presented below.

After staying two weeks at one of the NRC schools in Northern Uganda, being served a daily warm lunch under the prevailing conditions of food shortage, I felt a deep need to be able to give something in return. In discussions with the headmaster, it was agreed that I should buy some vegetables and rice in order to provide some variation in the strictly fixed lunch menu of warm porridge. I presented the idea to my research assistant, who came up with a plan to buy the groceries at the local market. However, dealing with the large quantities of rice proved to be a challenge, involving a time-consuming process of transporting small bags from the

storage facility and into our car. I became impatient, and asked (demanded) to get the process speeded up, so we could get to the school in time. This worked: instead of those tiny bags, we got large sacks. In no time our white Range Rover was filled up with rice. I paid and our chauffeur sped away, to reach the school. I then realized that my replacement translator (my regular translator was sick that day) looked absolutely terrified. I looked and saw: the Range Rover was filled with large sacks marked WFP! The rice had been stolen from the UN World Food Program. The punishment for such a crime during the food shortage was harsh. In fact, I managed to solve this problem. However, I had inflicted immense risk on the driver, the replacement translator, the school, myself and ultimately the NRC.

In another incident I was detained by the Gulu police. I was temporarily released from custody the same day after agreeing to hand over my passport and be confined to the town of Gulu. Three days later, I was charged with taking pictures of a police station, potentially tampering with evidence in a murder investigation (photographing a car wreck) and not stopping after being told to do so by a senior police officer. Later that day, I was brought before the court, where I explained my case in front of two judges and more than 100 spectators. I was then cleared of all charges and officially released.

These examples illustrate potential risks of being an active researcher in an unfamiliar field. As an ethical participant, I also needed to maintain safety for my informants, their societies, and myself. That applies also to the NRC, as my host institution in Northern Uganda. These two incidents could have had serious consequences, and could easily escalated out of control. For me, this was a serious reminder that my outsider status and perspective was not sufficient in itself to avoid wrong and harm.

Anonymity, confidentiality, and informed consent

The importance of anonymity was accentuated due to the sensitive content of the interviews. The disclosure of fighting for survival during a massacre, illegal activity in planning and conducting FGC or previous killings—all involve extremely sensitive information. Such information could put informants in actual danger, as well as resulting in public shame or other unforeseen kinds of harm. The three fieldwork contexts involved different issues of sensitivity as to the provision of anonymity and confidentiality.

In Northern Uganda, Patrick (not his real name) had detailed knowledge of war crimes committed by former LRA commanders who now lived in the area but had not been brought

before the local legal system. Patrick took the initiative to discuss ethical matters with me concerning whether to step forward with such information or not. Fearing revenge, he decided against taking any criminalizing information or accusations to the village elders. He also asked me not to disclose such information. I accepted his decision—because of safety concerns for Patrick, the NRC and myself, as well as wanting to remain loyal to my confidentiality agreement.

After Patrick had been abducted from his village as a young child, he was later forced to participate actively in killing people from his own region. This was a deliberate strategy employed by the LRA, to reduce the possibility of escape by ensuring that newly recruited child soldiers could not return home. The details around the information that Patrick disclosed could not under any circumstances be brought forward. I also instructed Patrick not to supply me with names or other identifying information about the killings. This was in order to protect Patrick as well as myself, regarding not violating local, federal and international laws on withholding information on war crimes.

A similar procedure was followed in the FGC project for informants in Norway. African-origin women might tell about how they had violated Norwegian law by planning or having a girl-child circumcised despite being Norwegian citizens. If such information were revealed, the "duty to avert" might come into effect for the researchers, who, if they failed to act on this, risked being criminalized for not reporting to the police. In order for this law not to affect the researcher–respondent confidentiality agreement, specific information was given during the interviews: the women were told that Norwegian law prescribes the duty to avert FGC/M, and that could come into effect if plans for future FGC were revealed.

And the third case: fighting to survive during a massacre places people under extreme stress and pressure, where a split-second decision might make the difference between being killed and surviving. When the survivors give the details of how they managed to save their lives, that could involve recounting situations where they were unable to perform life-saving actions for friends or others, in order to save themselves. Such stories could not be revealed unless sufficient anonymity and consent were provided.

In all three fieldwork studies, fieldnotes and diaries were constantly revised in order to remove any written information that contained names, places or other types of information that could reveal the identity of people participating in the studies.

According to the code of ethics of the American Anthropological Association: "anthropological research must be open about the purpose(s) of support for research projects with funders, colleagues, persons studied or providing information, and with relevant parties affected by the research" (AAA, 1998: p. 2). Informed consent was obtained for all respondent who took part in formal interviews. Information about the research project, the right to withdraw, and routines for anonymity were presented, and a standard consent form was signed. In the case of Patrick, oral consent was obtained. During the fieldwork, people were informed about my status as a researcher and my affiliation with the respective research organizations. Regarding participation in workshops, conferences and types of formal and non-formal gatherings, we were always invited by the organizers, who were familiar with our research status.

My presence in Northern Uganda as an NRC visitor had been approved by NRC headquarters in Oslo as well as their field office. My fieldwork was explained to all headmasters and their teachers in the five schools. The schools had been set up by the NRC in cooperation with the refugee camp management and two village councils. All of them had been informed, and had approved my presence; likewise with the elders in the village where the cleansing ritual was held. Further, the data collection procedure was later approved by the Norwegian National Centre and Archive for Research Data (NSD) (Appendix 4).

Likewise, the data collection procedure for the FGC study was approved by the NSD (Appendix 5). The Utøya survivor study was approved by Norway's Regional Committees for Medical and Health Research Ethics, South-East and North (REC) (Appendix 6).

4 Results

This chapter provides a summary of the four studies, with comparison. The results are presented and structured according to common themes across the four papers. Firstly, the types of life-threatening events are presented as they were experienced by the respondent and compared against the diagnostic requirements of a potential traumatic event as described by DSM-5 (APA, 2013). Secondly, I describe the *meaning-making process,* followed by *supportive factors* as identified in the three different contexts. Several graphical figures further illustrate the empirical results.

Dealing with stress reactions from FGC (Papers I and II)

Exposure to life-threatening events

Female genital cutting takes many forms, from milder to more serious procedures. The World Health Organization (WHO) has defined four types (WHO, 2020). 1) *Clitoridectomy* involves partial or total removal of the clitoris and/or the prepuce. 2) *Excision* involves partial or total removal of the labia minora and/or the labia majora. 3) *Infibulation* involves narrowing the vaginal opening through the creation of a covering seal with or without removal of the clitoris. 4) *Other types* involve all other harmful procedures to the female genitalia for non-medical purposes, such as pricking, piercing, incising, scraping, and cauterization. The procedure are generally performed on girls from infancy to 15 years of age. Internationally, FGC is recognized as a violation of human rights, in view of the reported serious short- and long-term effects on the health and well-being of girls and women. Since 1997 and until the present, various UN agencies have made considerable efforts aimed at ending the practice, also issuing international resolutions condemning the practice (see, e.g., WHO, 2020). It is estimated that more than 200 million girls and women living today have been subjected to the practice, according to information from 30 countries where population data exist (UNICEF, 2016).

In Paper II (Schultz & Lien, 2014), we present an overview of research documenting the psychological consequences of FGC, and showing that this field is under-researched. Despite the lack of studies with a rigorous quantitative design to control for the type of circumcision

and whether it was performed with local anesthesia, there is a considerable body of qualitative and quantitative studies describing various types of FGC procedures as very painful, a potentially traumatic event with possible health and mental health consequences.

Descriptions of the cutting procedure given by our respondents varied, as did the descriptions of pain and shock. The descriptions ranged from accounts of clearly traumatic events, to lesser degrees of traumatic stress, and to a procedure that hurt at first but then became less painful. Several informants said that, at the time, they had viewed the circumcision as a very proud moment in their lives. They remembered the gifts, the homecoming ceremony and all the positive attention. However, the majority recalled that, immediately after the cutting procedure, they had strong reactions that lasted for weeks. The negative reactions described concerned varying degrees of pain, anxiety, being scared, feeling numb, disbelief, betrayal, and anger at the mother. More than one third of our informants in the second FGC study reported occasional PTSD symptoms as adults, symptoms that had become more pronounced, more frequent, and stronger after coming to Norway.

The PTSD A-criteria define exposure as actual or threatened death or serious injury, whether as a direct experience or as a witness (APA, 2013). In the case of FGC, various factors influence whether a situation is perceived as a potentially traumatic event. Major factors are the type of circumcision and the use/non-use of pain medication, as well as the care provided. In a study of the cutting procedures in The Gambia, Somalia and Eritrea, Lien (2020) asks whether these rituals fulfill the criteria for being a traumatic event, and concludes that it cannot be assumed that all cases would qualify. However, she adds that it cannot be taken for granted that a cutting ritual will *not* be an event which may lead to post-traumatic stress symptoms.

I consider it reasonable to put the FGC procedures, as experienced and described in the two FGC papers, in the category of an invasive or frightening procedure, as a potentially traumatic event for a child and perhaps for her mother as well.

The meaning-making process

In Paper I, two representative cases are described, showing two different preparation strategies that emerged in the material. These strategies were used to prepare the girls for their coming circumcision. They serve as prototypes representing the type and structure of the information given.

Nimba had just turned four when she was told that something fantastic was about to happen to hear. She was kept in the dark about what was going to happen, but was deeply involved in the ceremonies and festivities leading up to the event. The cutting came as a total shock: she had no idea that "this" was what it was all about. Nimba experienced the Gambian *closed information strategy*, which involves giving the girl child some preparatory information while keeping the ritual a secret.

Yasmin was six when she was cut—a moment she had long been waiting for. She felt very happy it was finally going to take place. She had been waiting for years, and knew that several good friends already had been through it. This was the procedure that was going to make her "smooth, clean and beautiful." She would now be a better girl than her un-cut friends. This approach was labeled the Somali *partly open information strategy*.

Further exploring the meaning-making process, we identified five phases where the girl child is provided with information. These five phases are built on and include the two communication strategies providing a more defined process. After the circumcision, the two strategies have much in common, but there are significant differences in the two phases prior to the cutting procedure. The five phases are listed schematically in Figure 9.

Figure 9: Five phases of girls' learning process of the concept of FGC

For Somali girls and the "partly open strategy," the two first phases are explicitly described, with preparatory measures provided for several years. The girls are primed and motivated to inquire and learn about the coming ritual. By contrast, Gambian girls, with the closed information strategy, get most of their information from the ritual itself and from later learning phases. The aim of the ritual is to make the girl a "clean and honorable" woman—through the circumcision as such, but also through the learning process. One of the mothers defined the minimum learning goal of the learning process as follows:

> You have to make her understand the importance of taking care of her vagina and make sure she understands the severity and gravity of it; if she isn't careful she will

> never get married, she will be excluded from social life and she will be a disgrace to her family and to herself. (Schultz & Lien, 2013, p. 169)

The meaning-making process stretches over time and follows clearly defined stages. The learning process is carefully monitored and regulated by the mothers, older sisters, grandmothers and other women. During this process, there is frequent and active use of metaphors describing the desired outcome, such as "Becoming like your mother", being "clean" or "smooth," emphasizing the girl's responsibility to "keep it beautiful, clean and closed" until she got married.

Identifying supportive factors in the cleansing ritual

It is the mothers' responsibility to prepare and make sure the ritual is carried out. Here the mothers are supported and supervised by their own mothers and older women in their society. The expected steps in the preparation phase are clear: A circumciser with a good reputation must be selected, as well as a *marabout* to provide religious support. The designated teacher, the *kantallalo,* must be contacted, to provide formalized instruction during the healing period. All actors have defined roles to play so that the ritual may take place, and to ensure that it proceeds according to the rule. Figure 10 shows the Gambian facilitators who have the overall aim of cutting and protecting the girl child.

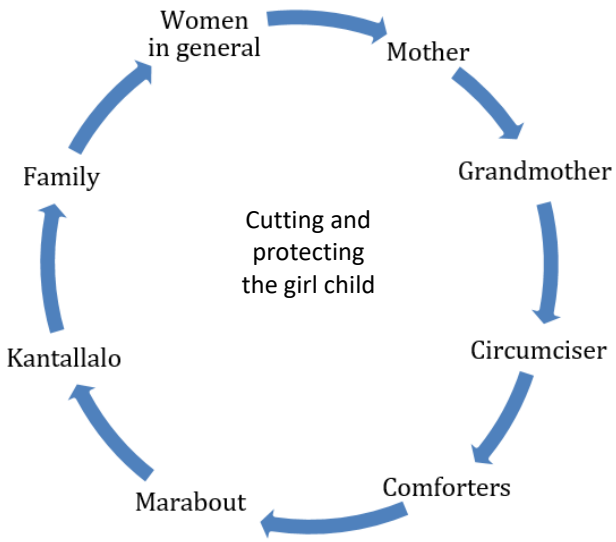

Figure 10: Facilitators of the FGC ritual in The Gambia: including the healing and learning process for the circumcised girl

For the FGC ritual in The Gambia, with its closed information strategy, the girls wear a hood, for protection against evil spirits, when they are brought to the place where the cutting procedure is to be performed. In urban settings, different rooms are used for different activities. The ritual can be described to take place in four "spheres" as regards the spatial refinements of the procedures. By using a term with connotations to three-dimensional space, we seek to broaden the interpretation of the spatial refinement (see Fig. 11: based on an earlier version: NKVTS, 2010).

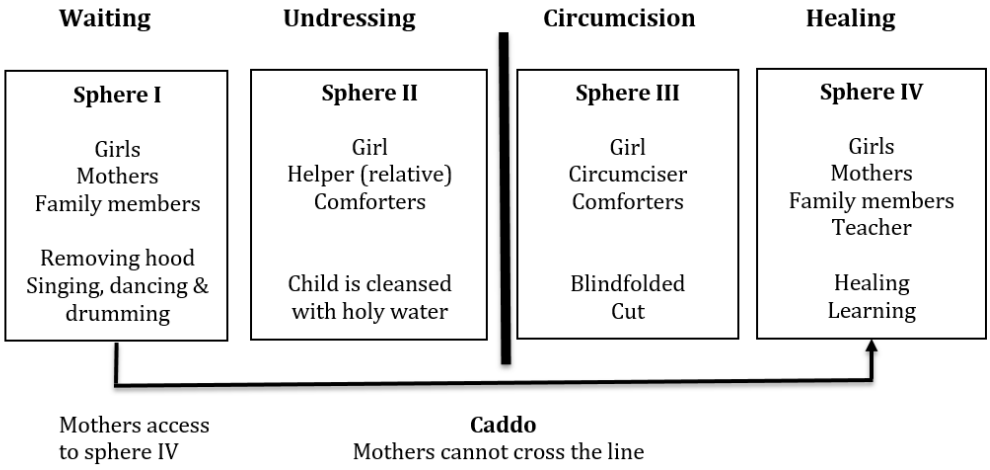

Figure 11: The four spheres of the FGC-ritual in The Gambia indicating spatial refinements of the cutting and healing procedure

The mothers may access all spheres except sphere III, the actual cutting. We were told that mothers usually did not enter sphere II and were in fact advised not to, in order to make the separation between mother and daughter difficult. Sphere II usually involved a trusted family member who accompanied the girl child for undressing. The *caddo* was the line that could not be crossed by mothers; either drawn physically or imaginary, it prevented mothers from entering the actual circumcision sphere. All actors had defined roles, contributing to ensure that the ritual would take place, that the girls understood the importance of the ritual, and that they were supported and guided on this journey to becoming proud and honorable women.

Dealing with stress reactions from being a child soldier (Paper III)

Exposure to life-threatening events

When Patrick was 8 years old, his father was abducted and shortly after shot by the LRA rebels. Five years later, on a Friday night in February 2000, Patrick, then 13, was himself abducted. Only two weeks later, he was forced to kill for the first time. He received combat training and was deployed as a frontline child soldier. Three years later, he was shot and captured by government forces.

Patrick has a history of being exposed to severe brutality over time. He was forced to kill, including killing two of his friends; he was tortured, forced to torture prisoners, and had several times been in armed and unarmed combat during which he fought for his life and killed enemy soldiers. During the first half of his LRA captivity, he was regularly beaten and punished, and constantly feared of being killed himself. He had episodes of severe nightmares, and frequent reliving of traumatic events. Afterwards, he experienced repeated post-traumatic nightmares, reliving episodes, somatization and other problems. Patrick described his situation as follows:

> I very often have headaches and I can easily get worked up and I am often sick even though I am not really sick. I feel the energy is drained out of me. I often feel afraid when there is no reason to be. Sometimes I stay alone, I just have to be alone and I want to hide from everyone.
>
> I started getting nightmares in the bush and I still get them. I dream about battles and some of the civilians I killed. I see soldiers standing over me ordering me to get up. They are screaming and take me back to the bush. I shout and scream…people think I am a mad man. When I wake up I am shaking and I can't sleep. When I came out of the bush, I had nightmares every night. Now just about twice a month. The days after the nightmares I see the Ghost People. (Schultz & Weisæth, 2015, p. 5).

In a separate quantitative study emanating the same fieldwork in Northern Uganda (Schultz, Møller-Sørensen & Waaktaar, 2011), involved a screening study assessing trauma-related symptoms and mental health among 81 war-exposed students from the school that Patrick attended. Half the group (51.9%) reported having been abducted by the rebel group and having been held in captivity. Trauma exposure was measured using the Harvard Trauma Questionnaire (HTQ) showing a mean of 19.4 discrete types of events. A total of 78% of the

group reported post-traumatic stress reactions of clinical significance. However, scores were within the normal range on conduct problems, hyperactivity, pro-social behavior, and self-efficacy. Even though they were clearly suffering from trauma-related symptoms, there were also marked areas of adaptive functioning and resilience.

The meaning-making process

Patrick's nightmares replay images from his military experiences, predominantly about combat and killings. His understanding of the nightmares and the Ghost People is that they are caused by evil spirits that entered him while he was forced to kill. This, in turn, causes other problems for him, "ruining" his life. His understanding of his problems shows a clear timeline: the cause is the traumatic event of killing; the effect is the presence of evil spirits causing nightmares and the presence of the Ghost People. He attributes all major problems in his life to the traumatic events.

Patrick is aware that his life as an ex-soldier also causes problems for him in his village, where some see him as a "madman" who screams at night. The villagers know that he killed people in the area, and Patrick has a feeling they still think he can be dangerous. He has few friends; people are skeptical to him. He also feels that he is behaving like a "madman". He does not fit in; he feels haunted and torn apart by the evil spirits. He tends to keep to himself, and says that he can no longer manage his daily life.

He asks for help by reaching out to his community, for a new cleansing ritual that is properly conducted this time, conducted by professionals in the correct way (he participated in a ritual after being captured by governmental forces: see paper III). Such a measure will help, he believes: "A ritual will help, and the people who join in could come to love me more."

Patrick needs help to remove evil spirits from himself. If this evilness can be remove, that should relieve him of his problems such as nightmares, headaches and loss of energy. At the same time, the cleansing ritual can mobilize the community to "love him more." This rationale is clear for Patrick. He has a clear understanding of why he is suffering, and how he can be helped. The traditional doctor provides him with an in-depth explanation. Through her explanations, accessed through communication between the traditional doctor and the evil spirits, and her spiritual guidance, Patrick learns the explicit of how the evil spirits entered him. This information provided him with a fairly complete description of *why* and *how* the

evil spirits were causing him problems. It also laid out a clear path for recovery—confirming his own understanding how he could regain his health.

Figure 12 shows how Patrick sees himself and his community, outlined to illustrate his understanding of the situation.

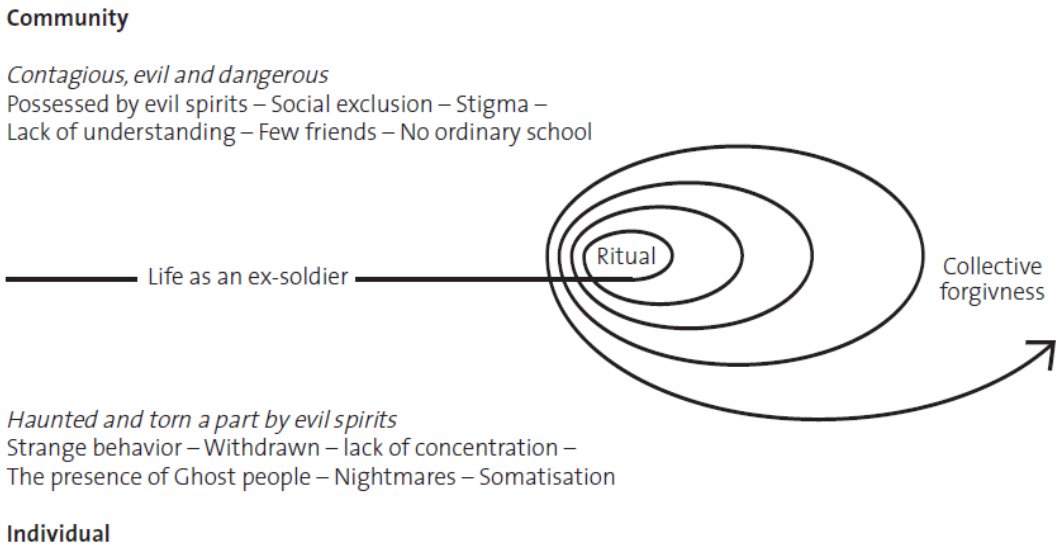

Figure 12: Removing evil spirits and building community support.

The ritual provides explanations making it clear that Patrick was not responsible for what happened, it was the evil spirits that had taken control over him. That information leads to a major end result: a cleansing that allows the community to collectively forgive the killings.

Identifying support in the cleansing ritual

Through the ritual, not only does Patrick receive collective forgiveness from his community, he also realizes that the evil spirits have been driven away—no longer able to haunt him and control his life. Gradually, he regains his daily functioning, and people "love him more." The ritual demonstrates a massive social mobilization, changing the general understanding of Patrick's challenges and providing him with social support. The whole village is involved, with many actors in clearly defined roles. The village is also involved in the preparation of the community dinners served throughout the ritual. His mother provides the traditional doctor with Patrick's life-history; she discusses with the elders, and she motivates her son to go through with the ritual. The elders give an authoritative explanation of what happened to

Patrick, directing the village in how to support him—now and in the future. The traditional doctor plays a key role, also following him up in the coming months. (See Fig. 13: Facilitators of the cleansing ritual for former child soldiers in Northern Uganda.)

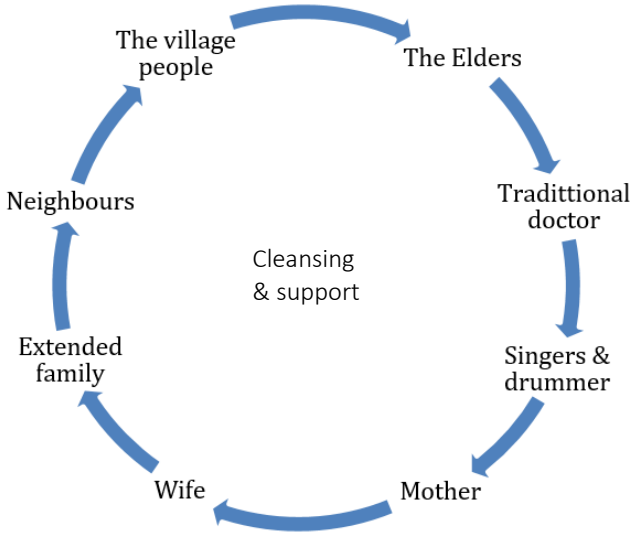

Figure 13: Facilitators of the cleansing ritual for former child soldiers in Northern Uganda

A thorough psycho-education is administered through the ritual, by means of authoritative explanations by the elders and the traditional doctor, with divine status. They also emphasize that we as human beings must accept that not everything can be explained and understood. However, once the evil spirits left Patrick, his stigma could be removed, and he is formally welcomed back to the village. The social order is restored, and he gets a new start as a free man—liberated from evil spirits, social stigma, shame, and guilt, he can once again be responsible for his actions and can set about rebuilding his social relationships.

Dealing with stress reactions after a massacre (Paper IV)

Exposure to life-threatening events

Interviews of the survivors of the Utøya massacre in Norway took place in Norway, 2.5 years after the terrorist event (Schultz & Skarstein, 2020). These survivors were young people who had been directly exposed to extreme trauma while trapped on the small (only 26 acres) island of Utøya. A screening study (Dyb et al., 2014) conducted four to five months after the massacre assessed trauma-related symptoms and mental health among 335 survivors. Many

had seen the terrorist or heard his voice (73.1%). All heard gunshots; they hid or ran (96.9%); many saw (64.1%) and heard (82.6%) someone being injured or killed (64.1%), saw dead bodies (86.7%); or saw the terrorist pointing a gun at them or realized that he had fired a shot (45.1%). Moreover, 74.5% lost someone very close to them, and 96.3% reported having lost a friend—indicating a high degree of bereavement and loss. Altogether 47% reported clinical levels of PTSD symptoms: 11% fulfilled the criteria for a full PTSD diagnosis and 36% for a partial PTSD diagnosis. Post-traumatic stress reactions in survivors were found to be highly significantly associated with general mental health problems, functional impairment, and reduced life satisfaction, four to five months after the terrorist attack. The psychological state of these young people may have had considerable impact on their ability to study, work, and maintain a normal social life (Dyb et al., 2014).

The 65 survivors participating in the qualitative study (Schultz & Skarstein 2020) had a mean age of 21 years. All of them were students (junior high school, senior high school, or college/university) during at least part of the period after the massacre. Out of the 65 survivors in this study, 45 (69%) experienced distinct negative changes in their school performance. Among these 45 students, 47% (n = 21) had found it necessary to make changes in their study plans, either by postponing or extending the timeframe for certain subjects. However, only 22% (n = 10) had temporarily abandoned their studies and returned later—for instance, postponing school start by one semester, or taking a year off due to long-term sleep related problems and impaired daily functioning.

The most frequently described changes in school performance were poor concentration, failure to remember what had just been read, difficulties in extracting information from a written text, and lack of "gumption." Lessons dominated by oral lectures were difficult to follow, and the students felt overwhelmed by too much information. Feelings of chaos were frequently reported, as were sleep problems, being restless and unmotivated. Students reported that their earlier study techniques were less effective or inadequate. They said they had not been prepared for these changes, and that the consequences were more severe and lasted longer than they6 had expected.

In the quote below a student tell of when he returned to school after summer holidays, three weeks after the massacre:

> No, I wasn't prepared at all; I understood on the first day that things were going to be different. After we were welcomed back in the schoolyard, we went up to the

> classroom . . . and I just felt I had to go, so I did. But I had to leave the first lesson. Then I realized: it might be hard, being at school. (. . .) Worst of all, I couldn't concentrate . . . when I was supposed to sit quiet and think. (Schultz & Skarstein, 2020, p. 5)

The meaning-making process

The analysis was focused on the narratives of the 45 students (out of 65) who experienced distinct, negative changes in their school performance. The majority of them (30 students) ascribed the change directly to the traumatic event, whereas 15 attributed the change to other reasons. Most students could give a clear description of the negative changes in their school performance and functioning, with several changes occurring simultaneously. Some changes were observed early on; others became more pronounced as the school term progressed. Only a minority reported distinct changes that appeared later, three to six months after a fairly normal school start. Less distinct changes were especially common among students with a history of poor school performance.

When students reported concerns about their reduced academic performance, this was mainly linked to not being able to understand the nature of those changes, and to uncertainty as to what to expect in terms of intensity, duration and help with their problems. This caused concern and worries. It was interesting to notice that they made frequent use of metaphors to express the self-observed changes. In the analyses of the students' narratives, three indicators stand out. First, their own observation of change as regard to when and how it occurred. Second, their attribution style, whether the changes are attributed to the traumatic event. Third, the use of metaphors in their narratives. See Fig. 14: Two pathways of constructing narratives for understanding reactions and behavior.

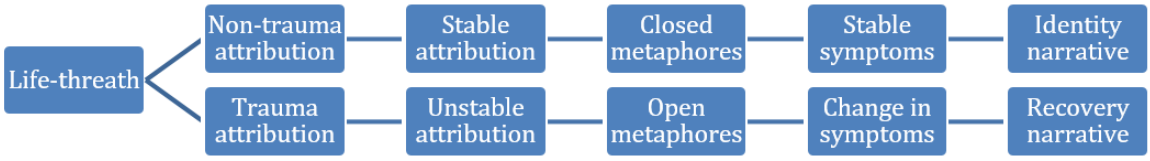

Figure 14: Two pathways of constructing narratives for understanding reactions and behavior

Students with trauma attributions generally had easily recognizable and multiple symptoms that occurred immediately after the traumatic event. By contrast, non-trauma attributions were

characterized by symptoms like late onset, a single reaction, not intuitively connected to the event and not among the expected patterns. Also, pre-existing learning challenges caused uncertainty when trauma-induced changes occurred within already affected cognitive domains.

The 30 students (66%) who used trauma-attributions provided clear explanations that assigned the cause of change to trauma-linked situational factors. These student completed their cause/effect narrative with unstable trauma-attributions, as the observed changes were seen as temporary. In the next phase of the narrative, the plot became recovery. The use of metaphors was characterized by open and explorative metaphors—helping to add information, as opposed to closed metaphors that halt the meaning-making process. The meaning-making was motivated by observing and describing ongoing changes aimed at regaining lost learning capacity.

The 15 students (33%) who presented narratives that assigned the dominant cause outside of the traumatic event, or were unclear, had no clear turning point in their narratives. Their observed changes were frequently internally attributed, with stable attributions followed by closed metaphors—"It all went to hell" and "went down the drain." Analysis further reveals that these stable changes are included in an identity discourse—is it only my school performance? Or have I changed myself? Many of these students started to re-think their future plans, experiencing periods of great concern about being able to complete their studies, and their academic future.

Identifying support for students' school functioning

In the meaning-making process, the initiation of the recovery narrative was identified as a desirable outcome. This type of narrative seems to provide a framework that initiates certain activities favorable to stimulating recovery. For students with long-lasting symptoms, the following appear to be the most constructive qualities of meaning-making: an unstable trauma attribution with use of open metaphors where the second phase of a recovery-centered narrative has been triggered. Such recovery narratives entail an active search for reduced symptoms, and experimenting with alternative study techniques to compensate for lost learning capacity or to restore impaired academic functioning.

Given the importance of these factors in the narrative, it was relevant to see to what extent students received support, either in their practical schoolwork or in conversations about

their school functioning. We found that many of the students ruminated and worried about their impaired academic functioning, but reported that there had been few or no discussions with teachers. They appear to have been left largely on their own, struggling to make sense of the complicated concept of PTSD-related cognitive impairment. Indeed, most of the students who were worried about their worsening academic performance said they had received little or no help from their teachers. However, there were many accounts where students were offered help from their teachers, but declined. It appears that these students operated with an understanding that negatively affected their help-seeking activity and reduced the willingness to accept adapted education post-trauma. In this study, these were predominantly students with a non-trauma attribution.

The survivors received school-related support from their parents and their teachers. In some cases students were referred to the educational and psychological services, and after consultation with their general practitioner they could be referred to the Department of Child and Adolescent Psychiatry, for mostly individual counselling or therapy. (See Fig. 15: Facilitators for providing help for terror survivors, with emphasis on students' school functioning.)

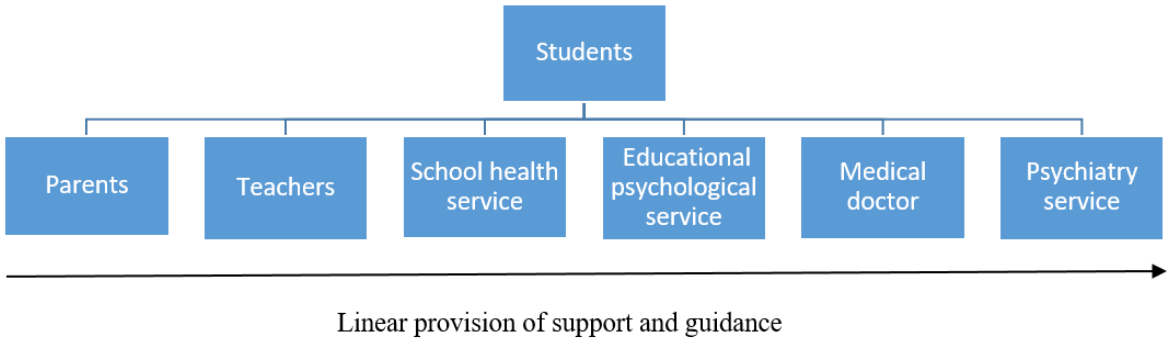

Figure 15: Facilitators for providing help for terror survivors, with emphasis on students' school functioning

At the time of this study, these 65 survivors had a mean age of 21 years and were students at various levels, ranging from junior high school, to senior high school, and college/university—which means different systems of health-support, making comparisons difficult. However, Figure 15 indicates a linear provision of support and guidance. Unlike the parents and teachers (and the school healthcare services), the agencies were not very pro-active, and a standardized referral process had to be followed to gain access. For students who

receiving assistance from several sources, there appears to be a weak connection and communication between the helpers and back to the student. There are somewhat mixed results when it comes to the provision of support and guidance regarding school functioning, a topic further discussed in chapter 5: Discussion.

This chapter has presented the results from the four studies, drawn from the "result" sections in each paper, without the addition of further empirical material. However, graphic figures have been included, in order to highlight the existing empirical material. The presentation has been structured according to three common themes across the four papers: types of *life-threatening events, meaning-making process,* and *supportive factors* identified in the three different contexts. In the next chapter I move towards a discussion based on the combined empirical data from all four studies, in order to deal with the overall aim of this thesis.

5 Discussion

Three types of experienced life-threatening events, in three cultural contexts were chosen for this study: *female genital cutting* (FGC), as experienced in Somalia and in The Gambia, *being a child soldier* in Northern Uganda, and *experiencing a massacre* in Norway. The combination of the empirical material from the four studies allows for a comparison and discussion of the overarching research question: to explore cultural influence in shaping reactions to life-threatening events across three cultural contexts.

I have structured this discussion around the possible cultural shaping, or cultural influence on the clinical presentation/expression of fear reactions and symptoms of distress. I start with a discussion about the three types of life-threatening events as they are embedded in their cultural contexts. I then present examples where I argue for a cultural shaping of the clinical representation of PTSD. Based on findings from the three cultural contexts, I build an argument on common features across the studies leading to a tentative description of an *analytical framework on cultural influence on reactions and recovery following life-threatening events.*

Cultural shaping of expression of PTSD symptoms

Life-threatening events being culturally embedded

The majority of female genital cutting (FGC) procedures, as described in the two FGC papers, could be interpreted as a potential traumatic event for the girl child. As for the two other types of trauma, they clearly qualify for being a traumatic event (Criterion A). In each of the three traumatic events, there are considerable numbers of risk and prognostic factors to take into account – as defined as pretraumatic, peritraumatic and posttraumatic factors (DSM-5, APA, 2013). One significant difference between the three traumas is found within the peritraumatic category of environmental factors. These are the traumatic event(s) themselves – e.g., the perceived life-threat and the severity of the trauma: the greater the magnitude of trauma, the greater the likelihood of PTSD. In an attempt to rank the three events according to severity (traumatic dose), FGC would be the least severe and qualify as a single traumatic event. The massacre would be a single traumatic event with multiple trauma exposures of high intensity and long duration (72 min.) with a high degree of perceived life-threat. Being captive for three years as a child soldier qualifies as multiple ongoing traumatic events, of high intensity

and with a high degree of perceived life-threat. This situation would qualify as a *complex trauma* and *developmental trauma*: these are terms not used in the DSM, but are frequently used in the literature (e.g., Herman, 1992: van der Kolk et al., 1996). These categories indicate exposure to multiple traumas over time and require more intensive and extensive treatment. For children/adolescents such conditions are likely to influence their psychological development.

In the next sections, I have presented some factors of importance for describing the cultural context of the various traumatic events.

FGC experienced in Somalia and in The Gambia

FGC is expected; this is supposed to take place with the goal of making the girl a "clean and honorable" woman. The alternative is disrespect and social stigma for the girl and her family. However, the intense pain is not expected by the girl child, particularly not for the Gambian girls. A systematic and careful system of support is put in place, buffering the potential trauma. See Figure 16 indicating the various components of the structured protective system for the Somali and Gambian girl child.

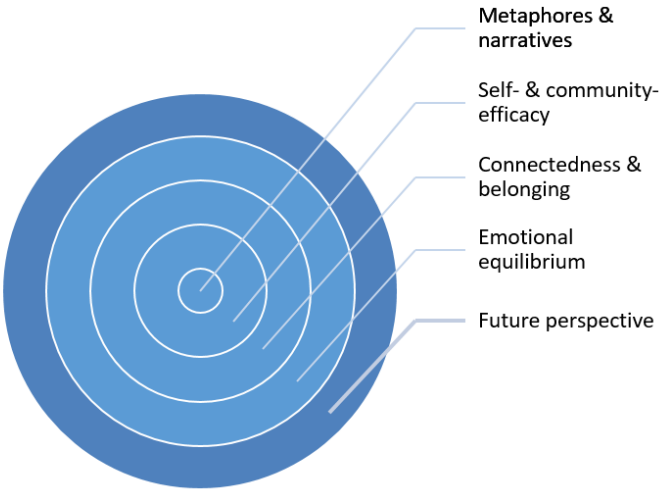

Figure 16: A meaningful and protective system of understanding FGC.

The meaning-making process is carefully monitored through the five formal phases while social support is massively delivered in a child-friendly way, with frequent appraisals. The girls are culturally protected through social support, the social context and the cultural belief system. The girl-child experienced considerable pain, and received massive support. The

disruption caused by the potentially traumatic event was dealt with by integrating it as a meaningful event, one that she completed with mastery. She is now included in a positive shared vision of the future.

Being a child soldier in Northern Uganda

It feels like an understatement to classify the brutality of Patrick's experience merely as a complex trauma, or simply PTSD according to DSM-5. No matter how extreme the experiences were, Patrick's situation was nonetheless rather frequent in Northern Uganda during the civil war. Many were in his situation, leading to a normalization of his symptoms and sufferings. In addition, the 20-year civil war involved the majority of Northern Uganda, leading to a *communal trauma*. When societies are disrupted by trauma, the shock it creates and the upheavals will stimulate individual and social attempts to try to correct the disruption. In this regard, cultures can be seen as a protective and supportive system of values, lifestyles and knowledge that are powerfully resilient and resistant to change. Culture, as a source of knowledge, locates experiences in a historical context and forces continuity on discontinuous events (deVries, 1996).

Another important feature concerning Patrick and his fellow child soldiers is the formalized training they received to become a soldier. During interviews (not a part of Paper III), the five former child soldiers told of the use of drugs to be "tough" during armed battle and other types of drugs for sleeping after battles, as well as a gradual training to desensitize their emotions and dehumanize the enemy. The process of turning a child into a soldier is often a long one, involving indoctrination, training and then battle (e.g., Allen, 2010; Eichstaedt, 2009: Singer, 2006). The indoctrination takes place at a time that the child is at his weakest emotionally and psychologically, being disconnected from family, traumatized, at a fundamental loss of control. The overall intent of the process is usually to create a sort of moral disengagement from the violence that children are to carry out as soldiers (Deutsch, 1990: Singer, 2006). It is difficult to say how such "training" will influence the perception of a certain traumatic event and the effect of the cumulative trauma of being a child soldier.

Experiencing a massacre in Norway

The Norwegian society was effectively disrupted by the car bomb in the governmental quarter targeting the prime minister, the core of the democracy, and the massacre of young members

of the labour party's youth organization. The Norwegian media covered the 22 July terrorist events by featuring a constant flow of interviews with survivors and family members of those who had lost their lives. The interviews revealed strong feelings and grotesque details. During the weekend after the terrorist attacks, people reported spending an extensive amount of time watching the news: a mean total of 17 hours in Oslo, and 16 elsewhere in Norway (Thoresen, Aakvaag, Wentzel-Larsen, Dyb, & Hjemdal, 2012). On July 26 a nationwide "rose march" took place in the nation's mourning as a tribute to Norway's dead. International media quoting the Crown Prince saying, "Tonight the streets are filled with love" and the prime minister saying: "Evil can kill a human being but never defeat a people. (…) By taking part you are saying a resounding 'yes' to democracy." He called the Rose March a "march for democracy, a march for tolerance, a march for unity" (e.g., *Daily Mail*, 2011). The media coverage continued, with an intensive focus on the perpetrator, describing a politically extreme right-wing terrorist, his ideology and prior life in Norway. The massive media coverage followed the nine-week court procedures throughout as two pairs of court-appointed forensic psychiatrists arrived at different conclusions regarding the perpetrator. One pair concluded with a diagnosis of insanity due to paranoid schizophrenia and the second pair found no signs of psychotic disorder and concluded the perpetrator had a narcissistic personality disorder. The court found the perpetrator capable of standing trial and sentenced him to 21 years in preventive detention. The divergent conclusions gave rise to a heated national debate.

Shortly after the start of the trial had started, on April 26, 2012, more than 40,000 people took to the streets in Oslo to sing "Children of the Rainbow," a song derided by the mass killer. This "soft" approach and reaction towards a mass killer drew attention and wonder in some international media. CNN covered the case by the following headline: *Norwegians sing to annoy mass killer* (CNN, 2012).

The national trauma of the Utøya massacres hit Norway as a country. Today, 10 years later, the nation is still in a healing process, and the individual suffering needs to be seen in the broader cultural context—as with the two other cases presented here. Each of these three traumatic events is embedded in its own unique cultural context, as well as being linked to a specific time in the history of the surrounding social context.

Before going into reactions and how they were attributed, I will round off this section by quoting a central description of how culture provides a framework for protection:

> Culture plays a key role in how individuals cope with potentially traumatizing experiences by providing the context in which social support and other positive and uplifting events can be experienced. (…) Culture thereby buffers its members from the potentially profound impact of the stressful experiences. It does so by means of furnishing social support, providing identities in terms of norms and values, and supplying a shared vision of the future (deVries, 1996: p. 400).

Reactions and attributions

A classic challenge described in trauma treatment and theory involves viewing the psychological trauma as an ongoing internal process with possibly lasting internal changes, as opposed to an external event occurring in the past. When the outer and inner worlds have changed dramatically, the balance needs to be restored. The individual must re-build the inner world by re-establishing positive fundamental assumptions of the world—and all this in a state of anxiety, fear and loss (Janoff-Bulman, 1992). In this turmoil, the search for a causal attribution is influenced by social surroundings, opinions, and available information. This is where the specific culture has the potential to play a key supportive role.

In northern Uganda, Patrick received a "support package" in the form of the cleansing ritual. A significant therapeutic element was the marked externalization of the cause of the problem: Patrick himself was not to blame, because evil spirits had possessed him.

> Once the evil spirits left Patrick, his stigma could be removed. He was declared not being responsible for the killings, and he is entitled to receive collective social support. When Patrick is welcomed back to the village, social order is restored and he gets a new start as a free man – liberated from evil spirits, social stigma, shame, and guilt, he can once again be responsible for his actions and can rebuild social relationships (Schultz & Weisæth, 2015: p. 14).

In that study, we concluded that the therapeutic factors identified in the cleansing ritual were largely the same ones that underlie modern trauma-focused therapy. Where Patrick's therapy differs most from Western trauma-focused therapies is the successful mobilization of social support and the fact that this element is to be controlled through the intervention itself. "The social support and connectedness further allow for a potential effective removal of external and internal shame and guilt – all elements highly associated with improved mental health following traumatic stress" (Schultz & Weisæth, 2015: p. 14).

Similarly, the FGC ritual was able to provide effective support largely in line with empirically and evidence-based principles of crisis intervention. Our findings indicate that the girls have generally managed to handle the potentially traumatic event of FGC—the event has been placed in a meaningful system of understanding, and the stress dealt with actively. In Paper II, we labeled this systematic support defined by the ritual as "cultural protection" against traumatic stress. An important factor in the cultural protection was rooted in the systematic meaning-making of FGC (Paper I), a learning process that was carefully monitored and regulated, resulting in understandings that tend to be deeply internalized, embodied, and morally embraced. Our findings indicate that the informants have largely managed to handle the potentially traumatic event of FGC (Schultz & Lien, 2014). However, it should be noted that the mothers and older circumcisers all said that there had been no negative symptoms related to the cutting procedures. Any complications that occurred were attributed to external factors, like evil spirits. There was no recognition of any illness, or linking such symptoms to the cutting—and thus no symptoms to identify or report.

In the case of Norway and the Utøya massacres, students with non-trauma attribution comprised a rather large sub-group of our informants who had survived. They faced some of the same challenges in trying to make sense of the complicated and unfamiliar concept of PTSD-related distinct cognitive impairment. Even though this specific symptom caused problems at school, we found only a few instances where informants reported support from teachers who could provide useful information and engage in dialogue. The majority seem to have been left on their own to understand and deal with their impaired school functioning (Schultz & Skarstein, 2020). The support and meaning-making process appears to have been influenced by culture-specific conditions: an influential medical perspective where the school is not defined as a part of the support system, and a culturally enforced external framing of identity causing possible stigma, as seen in the example of "playing the Utøya card" (see below). This is illustrated by examples from two other studies, one of the Utøya survivors and one of their parents and their home–school relationships. One study (Skarstein & Schultz, 2017) drawing on largely the same respondents as in Paper IV, revealed an interesting change in students' identity, before and after the massacre. The interplay between *student identity* and *social identity* caused challenges when new identities connected to the massacre were introduced in the school arena. This dynamic had two prominent contradictory aspects: (1) a

strong need to avoid being associated with the massacre, while (2) also experiencing a high degree of imposed external framing of identity configuration. This seems to have led to challenging identity work, where one likely outcome involved distancing oneself from the new, forced "victim" identity. One consequence of this was that ¨respondents turned down offers of help from their teachers, because of the perceived stigma attached (Skarstein & Schultz, 2017). Further, several parents noted that their adolescents refused to see problems at school as "officially" linked to the massacre. These parents thought the problems had become visible signs that linked the student to the stigma of being a survivor who needs all sorts of special attention (Røkholt, Schultz, & Langballe, 2016).

The expression "the Utøya card" is a phrase coined early in the social media and subsequently spread to the public media and daily conversation. It plays on the possibility of getting a "free entry card" for special treatment simply by being an Utøya survivor, regardless of whether such treatment is really needed: being given these rights somehow sets the recipient apart from or above everyone else. Further, the concept serves as an efficient rhetorical tool for discrediting arguments, as the "Utøya card" might be played to persuade others to adopt and act on the preferred understandings of the person and circumstances (Røkholt, Schultz, & Langballe, 2016: Skarstein & Schultz, 2017).

Most parents described the first school year after the trauma as a frustrating and lonely struggle: their teenagers were generally unable to return to normal daily life and school functioning—and in 40% of the cases, school–home relationships were reported as difficult or conflictuous because of poor understanding of needs and insufficient educational adaptive measures. The remaining parents surveyed were either positive or neutral; however, many of them did not see it as the role of the schools to provide advice or adaptions regarding a psychological trauma. This study concluded that parents remained a largely unused resource for the schools in supporting the students' academic functioning (Røkholt, Schultz & Langballe, 2016).

It could be discussed whether these are culture-specific conditions, or trauma-specific conditions—or a combination of the two. Regardless, these conditions appear to have influenced meaning-making and recovery through the external framing of identity, and a dominant medical perspective on psychological trauma that splits up the provision of care, leaving or transferring the responsibility to the medical profession. Despite the long-term

disruption in school functioning reported by the students, the educational system (schools and teachers) is not seen as a primary actor in the support system. Indeed, the school system does not appear to be structured for delivering what the literature describes as "trauma-informed support." (see, e.g., Luthar & Mendes, 2020). Moreover, there is no clarity as to the teacher's role in dealing with the results of trauma-specific symptoms that influence students' academic functioning.

This section has presented examples of how people have dealt with each of the three potentially traumatic events studied in this dissertation, and how this has been influenced by the surrounding cultural context. I now look more closely at specific characteristics of how the process of meaning-making and recovery could be culturally encoded.

Culturally encoded

In The Gambia, many informants said that they were "OK." In Paper II, a central question was asked: "Why did more than one third of the informants develop pronounced, frequent, and strong psychological symptoms connected to their circumcision after leaving their home cultural context?" (Schultz & Lien, 2014: p. 215). This was followed by a discussion of how cultural conceptions of "illness" influence the prevalence, symptoms, and course of a particular disorder. We found no recognition of any "illness" as a result of the potential traumatic event of the cutting. Without an illness, there is no significance attached to the disorder and no symptoms to identify or report. Due to the lack of local cultural recognition that various disorders might be linked to FGC, the symptoms were not framed or shaped into an illness until the woman was living in a different cultural setting, in Norway. This line of reasoning requires that the women had active symptoms, but they were not recognized as such. Further, the belief system underwent change in Norway: the meaning of the FGC procedure was challenged by a new set of cultural values. The women appeared particularly vulnerable to problems of cultural change precisely because of the characteristics of their acquired knowledge about FGC.

> We found that the limited instruction and explanations the children received were based primarily on tautological explanations at the level of metaphorical learning, producing a closed system of knowledge that was taken for granted. The learning process was carefully monitored and regulated, and was brought to a halt before critical reflexive thinking could set in. Such knowledge tends to be deeply

> internalized, embodied, and morally embraced. The informants possessed a limited cognitive frame of understanding that lasted until they left their home country and went into exile. (Schultz & Lien, 2014: pp. 215–216).

A separate study (Lien & Schultz, 2013) found that replacing deeply internalized, embodied, and morally embraced knowledge of FGC can be a long, hard, and painful process. Internalizing new information as adults, information that contradicts an old schema of knowledge internalized as children, can be experienced as epistemologically very painful. What is challenged is the woman's very identity, involving the upheaval and renewal of her belief system. What was once effective cultural protection has lost its power.

The "Ghost People" in the case of Patrick in Northern Uganda is an example of cultural shaping of the clinical expression of the symptoms of PTSD. Before the Ghost People appeared, Patrick had already begun to experience recurrent traumatic nightmares: they started after he had witnessed the killing of 20 soldiers.

> The "Ghost People" usually appear after a nightmare, and they are the same persons who figure in the nightmares: "I saw the dead soldier standing on the path in front of me. I stopped, and slowly walked toward him. As I came closer, he slowly disappeared in front of me." On this occasion, he could see the soldier for about three minutes before he disappeared. When Patrick saw him, he froze, but he says that he knew instantly the soldier belonged to the Ghost People, because he had seen the same man several times earlier and knows that he is dead. The Ghost People appear in periods, sometimes on a daily basis. Most often, Patrick sees a single soldier, but sometimes the Ghost People are from the civilians he killed. He never sees them when he is together with other people; they only show up when he is alone. They do not talk to him and he does not talk to them. He gets very frightened when they appear. This upsets him for the rest of the day and he fears their return. (Schultz & Weisæth, 2015: p. 5)

Intrusive recollection (Criterion B1) is identified by recurrent memories of an actual event, usually including sensory, emotional or physiological behavioral components. Recurrent dreams are common (Criterion B2). The individual may experience dissociative states lasting from a few seconds to hours or days, during which components of the event are relived (Criterion B3). Such events occur on a continuum from brief visual or sensory intrusions without loss of reality orientation, to complete loss of awareness of surroundings. These

episodes, or "flash-backs," are typically brief but are associated with prolonged distress (DSM-5: APA, 2013: p. 275). We interpreted the appearance of the Ghost People as a frequent reliving and intrusive memories of traumatic events. Patrick experienced these Ghost People as brief dissociative states without loss of reality orientation.

The cultural belief systems of fear and distress in Northern Uganda appear to have shaped the meaning-making and the expression of PTSD by providing cognitive and behavioral templates that link the specific symptoms closely connected to the traumatic exposure—"closely," because the symptoms were seen as being caused by evil spirits that literally entered Patrick through the blood of the killed person(s). The symptoms themselves (Criterion B1-3) appear to be in accordance with DSM-5. The difference lies in the clinical expression of the symptoms, in the way they are understood.

The traditional doctor confirmed that the Ghost People were a well-known phenomenon: If you kill a person, his spirit may return and haunt you, perhaps leading to serious illness, sudden pain, chronic pain, madness or even death—however, there is an effective cure available. Seeing the Ghost People caused prolonged distress for Patrick. However, this was a phenomenon well-known within the culture and even had a name; it was expected and had a clear explanation. The Ghost People and the recurrent nightmares were the two primary symptoms that prompted Patrick to seek help: he knew he had a problem, a common one, and one for which a cure was available, and he knew where to find help.

Patrick never left his cultural context, so his culturally encoded protection was never challenged. It is to be hoped that his belief system and recovery still remain intact. However, when people from similar cultural contexts receive psychological help from various types of Western NGOs, or as refugees/immigrants in Western countries, such cultural protection may be challenged by dominant models of Western psycho-education with narrow explanations based on cognitive and neurological perspectives. In addition, we could imagine that Patrick's culturally encoded protection would be challenged in Western cultural contexts by the explanation of how the "evil spirits" entered him—the very explanation that so effectively relieved him of external and internal shame and guilt.

In the Norwegian case, being a "Utøya-person" was highly specific, due to conditions of the traumatic event itself as a major national trauma, but also the cultural context. Meaning-

making and recovery here can be viewed as culturally encoded through a Western medical perspective enforced by a folk psychology with medical theories and perspectives on mental health. The mass media featured frequent interviews with medical and psychological professionals explaining common symptoms of traumatic stress and predicting prevalence and the typical course of the disease.

Students evinced a deep need *not* to be associated with Utøya, but to appear to be functioning as "normally" as possible. They were fighting a high degree of imposed external framing of a victim identity that complicated aspects of the rehabilitation process by confirming them as "victims." This tension between the informants' former and present student and social identities as a consequence of the new Utøya identities unfolded in the school arena (Skarstein & Schultz, 2017). Resisting a victim identity as traumatized individuals within a national trauma with high media exposure made these identity alterations particularly difficult for the survivors. It could be argued that this became the contextual and cultural imprint of the survivors—they became caught in the national trauma, which in turn weakened their possibilities of regaining control over their own recovery.

> This appears to leave them with feelings of lack of control and reduced self-efficacy. Too much of the defining power seems to be in the hands of others—the media, peers, teachers, and outside experts. In trying to take control of their own identity work, our informants would often focus on controlling the attention drawn to their Utøya identities, denying or hiding aspects of their traumatic experiences and trauma-related symptoms. (Skarstein & Schultz, 2017: p. 13).

I would argue that a combination of trauma and cultural-specific conditions complicated the meaning-making and recovery process for the surviving students—especially for those who developed a non-trauma attribution.

Characteristics of the meaning-making process

Interplay between culture and trauma

The meaning-making of the FGC procedure effectively integrated the experience, providing closure for the traumatic memory. This was done through the formalized and carefully monitored learning process. By contrast, survivors of the Norwegian massacre have had to fight an imposed external framing of a victim identity, trying to remain in control—with a significant sub-group struggling to find a meaningful explanation for their symptoms. They

have pondered and searched, without a solution. In stark contrast, Patrick has a clear explanation that links his symptoms to the trauma exposure, forming the cognitive and behavioral template for meaning-making and for taking control of his recovery. However, uncertainties remain. Patrick has accepted there is much that cannot be explained or understood, and says: "That's the way the spirits are." He accepts that there are things in life that can be controlled only by the spirits. The cultural protection appear to have effective mechanisms for "closing down" the traumatic memory—as opposed to Western Freudian tradition and trauma focused-therapies, with a far stronger focus on "opening up."

The culturally enforced stigma plays a central part in all three contexts by shaping the meaning-making and providing motivation for favorable actions. In the FGC context, avoiding the clearly defined social stigma of being an un-cut female buffers the impact of the stressful experiences, by emphasizing the desirable position of becoming an honorable woman. In Northern Uganda, the social stigma of not being fully accepted and integrated in the village due to being haunted by evil spirits guided Patrick towards the cleansing ritual. However, in Norway, the culturally enforced medical perspective of the Utøya victim identity seems to have forced some students away from the healthcare workers—and from others who reinforce the victim-identity.

From these three types of life-threatening events in three cultural contexts, the following characteristics emerge as the major differences among the meaning-making processes: content of explanations, beliefs regarding responsibility (including shame, guilt, and stigma) and beliefs of control possibilities (as opposed to destiny). The results of the meaning-making process have clear consequences for the attribution of reactions, for help-seeking activity, and finally the integration and closure of the traumatic memories. Figure 17 lists central stages in the meaning-making process as observed in the three types of life-threatening events across three cultural contexts.

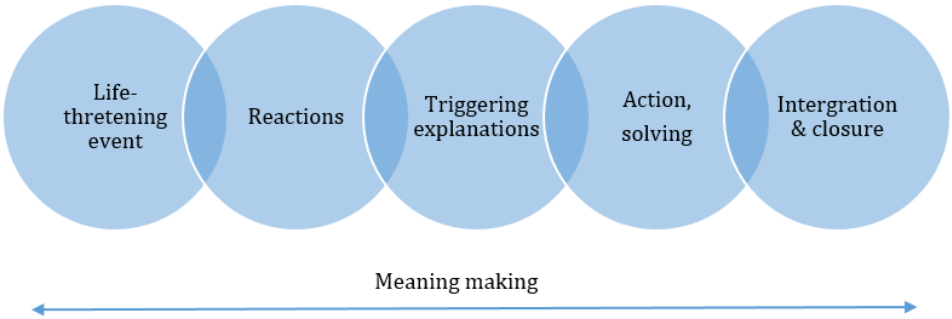

Figure 17: Stages in the meaning-making process after exposure to life-threatening events

One culturally significant factor influencing the meaning-making process is the extent to which people believe they can control their own destinies. Such a belief is in fact rather new, emerged only in recent generations. The legitimization of psychological trauma and its reactions to become PTSD can be said to follow the optimistic belief that people can in fact control their destinies (deVries, 1996). As opposed to many other psychiatric diagnoses, PTSD are defined as having been set in motion by an external event. The response to the traumatic event is described as a normal reaction to an un-normal situation. The rationale of the treatment is for the individual to regain control where control is lost (e.g., regular sleep, concentration, avoidance). In order for the individual to come in this position, it takes psychoeducation to understand the concept and work accordingly to regain control. This in itself is a cultural concept rooted in Western secular cultures. In cultures where life is seen as determined by faith and destiny, one must simply accept the will of the gods (deVries, 1996). In such belief systems, this must be taken into consideration in the meaning-making process, in order to steer the attribution of symptoms and the help-seeking activity, and define the responsibilities of the society and the individual for further action.

Figure 18 builds on the previous figure, introducing an outer frame illustrating the cultural belief system surrounding the entire meaning-making process. The vertical line indicates a possible divide between biology and culture—indicating that reactions are biological, but the expression and the illness is culturally shaped.

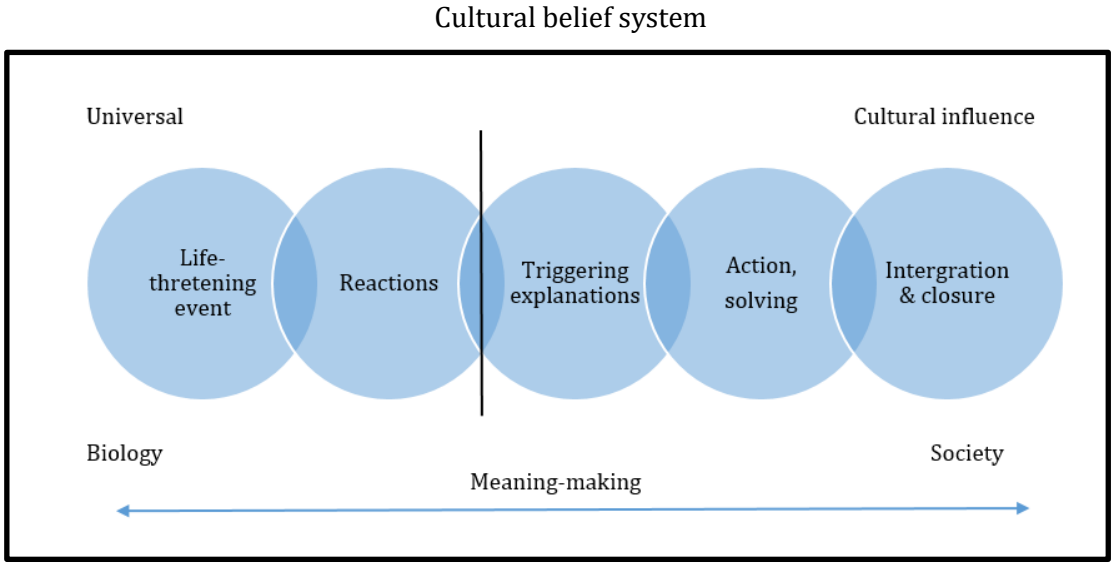

Figure 18: Analytical framework, indicating the process of cultural shaping of reactions and recovery after exposure to life-threatening events

The meaning-making is embedded in the cultural belief-system, providing a cognitive template for assigning meaning when the traumatic event has triggered reactions and there by a need for explanations. When reactions are attributed, the cultural belief-system provides a behavioral template for the individual to take action and activate help-seeking behavior, and for society to activate support. This process promotes integration of the traumatic memories and, ultimately, closure. The disruptive force of the life-threatening event is corrected, and the individual can return to a more normal state. If the cultural meaning systems and support systems are distinctive for that culture, that might lead to the support being culturally encoded: their supportive power is stronger within that specific cultural context.

The discussion of the impact of biology vs. society and culture remains controversial, and the empirical basis is still unclear. The essential conclusion of literature reviews on variations in PTSD is that, whereas the human response to stress may be universal in its biological and psychological experiences and processes, the specific PTSD response may vary across cultures (de Girolamo & McFarlane, 1996; Marsella & Christopher, 2004). The presentation and occurrence of specific PTSD symptoms and the rates of other mental disorders and/or symptoms following trauma vary considerably among nations/cultural groups, especially with regard to the re-experiencing and avoidance dimensions (Marques et al., 2011). That does not necessarily mean that PTSD is not a universal response—rather, that

it cannot be decontextualized from the culture in which it occurs, because that would break the linkage with etiological roots, references and methods of mediation (Marsella & Christopher, 2004).

According to DSM-5, the definition of cultural influence concerns *how the clinical symptoms are understood and expressed*:

> The clinical expression of the symptoms or symptom clusters of PTSD may vary culturally, particularly with respect to avoidance and numbing symptoms, distressing dreams, and somatic symptoms. Cultural syndromes and idioms of distress influence the expression of PTSD and the range of comorbid disorders in different cultures by providing behavioral and cognitive templates that link traumatic exposure to specific symptoms. (DSM-5: APA, 2013: p. 278).

This can be seen as a rather restrictive perspective on how culture influences PTSD. We could go further, and argue that the prevalence and the disease itself is shaped by culture. If the culture shapes not only the clinical expression of symptoms, but also the course of the disorder, then reactions can potentially be corrected before a disorder develops.

Under the construct of PTSD, the disorder is seen as being set in motion by the traumatic event, an external force. In turn, the human response to stress is often seen as caused by biological and psychological processes. The disease is "defined" by these natural responses when the duration exceeds four weeks and causes functional impairment. There is a fascinating dynamic involved when the cultural belief system does not recognize some of the premises set by PTSD: when it is not up to the individual to correct the disruption, or when the disruption is not recognized as such and when the reactions are attributed to other causes.

This intriguing line of questions remains open for scientific debate. Moreover, we still lack sufficient research on the interplay between culture and trauma—as PTSD cannot be decontextualized from the culture in which it is deeply rooted and embedded.

6 Concluding remarks

In this final chapter, I summarize the overarching research question and indicate possible consequences for further research.

Cultural protection – summary of findings

The fieldwork has aimed at investigating how people deal with reactions of fear and how protective factors are present within different cultural settings. These findings are discussed and presented in the four papers. The overarching research question discussed here, was to explore cultural influence in shaping reactions to life-threatening events across three cultural contexts. A summary of findings are presented below.

Three life-threatening events that took place in three cultural contexts have been studied and reported in this doctoral dissertation. Most of the persons who had been exposed were identified as having reactions within the accepted PTSD spectrum. The following characteristics emerged as the major differences among the meaning-making processes across the various cultural contexts: content of explanations, beliefs regarding responsibility (including shame, guilt and stigma) and beliefs regarding then possibility of human control (as opposed to destiny). The specific meaning-making process in each case had clear consequences for the attribution of symptoms, for help-seeking activity, and finally for the integration and closure of the traumatic memories.

Each of the three cultural contexts has, in its own unique way, influenced and shaped the expression of clinical symptoms and the course of the distress. Such meaning-making is embedded in the cultural belief-system, which provides a cognitive template for assigning meaning when a traumatic event has triggered reactions and a need for explanations. When reactions can be attributed, the cultural belief-system provides a behavioral template for the individual to take action and activate help-seeking behavior, and for society to activate support. This process leads to integration of the traumatic memories, and closure. The disruptive force of the life-threatening event is corrected as the individual returns to a state of a (new) normal. However, when the cultural meaning systems and support systems are

distinctive rather than universal, support may become culturally encoded, with its supportive power being stronger within the given culture.

The analytical framework proposed here recognizes the process of cultural shaping of reactions and recovery after exposure to life-threatening events. The framework is based on empirical findings from three cultural contexts, aiming to sum up the steps or phases in the meaning-making process. It is intended as a contribution to the ongoing debate on how to understand and analyze cultural influence in shaping reactions to life-threatening events.

Both the cleansing ritual and the FGC ritual were identified as providing effective support that largely follows empirically- and evidence-based principles of crisis intervention. They served as "support packages" provided within the "cultural protection". Also the survivors of the Utøya massacre in Norway received a "support package," predominantly managed by the healthcare system. The individuals in focus in connection with this thesis were found mainly in the significant sub-group of young people who did not benefit from the support package or the cultural protection— partly because their symptoms were not actively attributed or assigned to the traumatic event, partly due to resistance to the victim-identity.

Future research

More research and knowledge on culture-specific manifestations of PTSD can help to achieve a higher degree of cultural sensitivity within mental health and psychosocial support (MHPSS). Similarly, research should further explore the cultural protection that lies within the power of culture. Below are some suggested topics.

The interplay of culture and trauma

The interplay of culture and trauma is a distinct field of research within medical anthropology and cultural psychiatry. However, there is still a need for clinical as well as theoretical work in order to untangle the web of factors involved. The psychosocial experience and meaning of the disorder tap into biological and psychosocial processes that would benefit from a multi-disciplinary approach to research and the formulation of new research questions.

Searching for culturally viable support

Recent decades have seen a greater focus on the gap in access to Mental Health and Psychosocial Support (MHPSS) between low/middle-income countries and high-income countries. In addition, children around the world are exposed to traumatic events through the many ongoing conflicts. Given the high occurrence of mental health disorders in conflict-affected populations, and the large number of people in need, there is an urgent need to implement relevant, scalable mental health interventions (WHO, 2019). International guidelines for emergency response note the importance of cultural adaption when MHPSS is provided, as well as facilitation of local spiritual and religious healing practices where appropriate. Achieving the goal of cultural adaption will require research that evaluates intervention MHPSS programs with methodological clarity in defining and dismantling the intervention packages, in order to identify the therapeutic factors at play.

Assessments of cultural concepts of distress

Regarding clinical interviews, it is suggested in DSM-5 that comprehensive evaluation of local expressions of PTSD be conducted, including assessments of cultural concepts of "distress." This entails exploration of cultural constructs and psychosocial stressors, as well as features of vulnerability and resilience. More research is needed, in order to guide practitioners in conducting the cultural assessments necessary for the envisaged clinical work.

Conducting sensitive research

Interviewing traumatized people is challenging, and entails the potential risk of causing more distress. Moreover, researchers should take care of themselves, to avoid burnout and vicarious trauma. These topics would benefit from further exploration.

Postscript: then, and now

Sitting next to the traditional doctor in Northern Uganda, I had wondered what to say to her. It had been a long day, in terrible heat. We were sitting under a big tree, waiting for Patrick to return with the correct type of goats for the healing procedure: one black and one white. There we sat, two doctors, and I felt I ought to say something collegial and relaxed. But the distance between us made that difficult… and I did not say anything then. Now, fourteen years later, I have finally realized what I should have said: *Thank you for enlightening me!*

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Appendix

1: Interview guide – circumcisers: FGC

Profession
- How did you learn and practice. Selection and training process.
- Describe your first work. Where, when, how – empathy.

Practice
- Economy
- Special occasions you remember. Any deaths?
- How is the perfect circumcision?
- Preparations, how do you prepare the child?
- Inspection.
- Your social status.
- The taboo.

The ritual
- Your preparations.

- Describe your own circumcision.
- The cost of dropping the knife.

2: Interview guide – mothers: FGC

Forklaringer og forberedelser Mødre

Forberedelse	Hvilken type forberedelser ble gjort i forkant? Ga du barnet forklaringer på hva som skulle skje? Hvilke forklaringer ga du? Hva fortalte du? Hva sa datteren din til dette? Hvordan reagerte hun? (gledet / gruet seg) Hva visste barna dine om omskjæring fra før? Var de tilstede ved eldre søskens omskjæring? Hadde de snakket med noen voksne om det? Hadde de snakket med eldre barn?
Gjennomføring	Var du tilstede under omskjæringen? Hva gjorde du? Var bestemor tilstede? Har bestemor snakket med datteren din om omskjæring? Hva sa omskjæreren til datteren din? Ble det gitt noen form for opplæring rett etter omskjæringen.
I etterkant	Ble det gjennomført noen feiringer? Hva snakket du med datteren din om etter omskjæringen? Hadde datteren din noen spørsmål? Spurte hun deg om noe? Var hun sint, trist eller glad?
Det viktigste	*Hva er viktig å forklare – hva bør barna vite og hva bør de ikke vite? (Hvorfor bør de vite – hvorfor bør de ikke vite)* *Hvordan forbereder en barna best mulig for at omskjæringen skal bli vellykket?* *Hvordan følger en opp barna best mulig i etterkant av en omskjæring?* Tvilte du? Vakte det reaksjoner fra egen omskjæring? Vi vet at en del ikke viderefører tradisjonen. Hva tenker du om det? Hva tror du din mor vil tenke om at hennes oldebarn ikke omskjæres?

3: Interview guide – survivors: terror

Del I Åpne spørsmål

Åpningsspørsmål

Nå er det gått over ett år siden hendelsene 22. juli i fjor, og det er mye som har skjedd i løpet av denne tiden. Fortell meg hvordan dette siste året har vært for deg.

Rettssaken etter 22. juli 2011

Rettssaken etter 22.juli 2011 er over etter å ha vart i 10 uker, og dommen er avsagt. Tenk deg tilbake til tiden da rettssaken pågikk. Fortell meg hvordan du opplevde rettssaken.

(Hvis du ikke fulgte med i rettssaken, ønsker jeg å få vite bakgrunnen for dette.)

Instruksjon til intervjuer:

Vi ønsker både å få frem om- og hvordan ungdommen har engasjert seg i rettssaken, og hvordan den følelsesmessig har virket inn. Og om det er deler av rettssaken som har gjort spesielle inntrykk: eksempelvis gjerningsmannens forklaring, obduksjonsrapportene, vitneforklaringer.

Skole

S1 **Gikk du i 2. eller 3. klasse på videregående skole hele eller deler av skoleåret 2011/12?**

Ja ..... ☐1
Nei ..... (⇒ S2) ☐2

Fortell hvordan forrige skoleår var for deg, på godt og vondt. Jeg tenker spesielt med bakgrunn i dine opplevelser fra 22. juli 2011.

NØKKELTEMA:
Faglig fungering, trivsel, sosial/emosjonell støtte og faglige tilrettelegginger på skolen.

4: Approval of data collection procedure, NSD: Former child soldiers

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

Harald Hårfagres gate 29
N-5007 Bergen
Norway
Tel: +47-55 58 21 17
Fax: +47-55 58 96 50
nsd@nsd.uib.no
www.nsd.uib.no
Org.nr: 985 321 884

Jon-Håkon Schultz
Institutt for lærerutdanning og pedagogikk
Universitetet i Tromsø
Mellomveien 110
9037 TROMSØ

Vår dato: 30.05.2011 Vår ref: 26946 / 3 / MSS Deres dato: Deres ref:

TILRÅDING AV BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 06.04.2011. All nødvendig informasjon om prosjektet forelå i sin helhet 27.05.2011. Meldingen gjelder prosjektet:

26946	*Trauma Education for War-affected Adolescents*
Behandlingsansvarlig	*Universitetet i Tromsø, ved institusjonens øverste leder*
Daglig ansvarlig	*Jon-Håkon Schultz*

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, eventuelle kommentarer samt personopplysningsloven/-helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/forsk_stud/skjema.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://www.nsd.uib.no/personvern/prosjektoversikt.jsp.

Personvernombudet vil ved prosjektets avslutning, 31.05.2012, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Atle Alvheim

Marie Strand Schildmann

Kontaktperson: Marie Strand Schildmann tlf: 55 58 31 52
Vedlegg: Prosjektvurdering

Avdelingskontorer / District Offices:
OSLO: NSD, Universitetet i Oslo, Postboks 1055 Blindern, 0316 Oslo. Tel: +47-22 85 52 11. nsd@uio.no
TRONDHEIM: NSD, Norges teknisk-naturvitenskapelige universitet, 7491 Trondheim. Tel: +47-73 59 19 07. kyrre.svarva@svt.ntnu.no
TROMSØ: NSD, HSL, Universitetet i Tromsø, 9037 Tromsø. Tel: +47-77 64 43 36. martin-arne.andersen@uit.no

Personvernombudet for forskning

Prosjektvurdering - Kommentar

Prosjektnr: 26946

Formålet med prosjektet er å evaluere deler av flyktninghjelpens skoleprosjekt i Uganda, for ungdom som er påvirket av krig. I skoleprogrammet tilbys det elever som har mareritt å delta i en gruppe som samtaler med mål om å redusere elevenes mareritt.

Utvalget vil bestå av elever som har deltatt i disse gruppene, samt elever som står på venteliste for å delta, totalt ca. 40 personer.

Utvalget mottar muntlig informasjon om prosjektet, og det innhentes muntlig samtykke. Personvernombudet forutsetter at prosjektet er klarert med skolen, og at utvalget informeres om formålet med prosjektet, metode(r), hvilke opplysninger som samles inn, hva opplysningene skal brukes til, hvem som vil ha tilgang på opplysningene, konfidensialitet, at det er frivillig å delta, at de kan trekke sitt samtykke underveis, evt at et nei til deltakelse eller senere trekk fra studien ikke på noen måte får konsekvenser for vedkommende, dato for prosjektslutt og sletting av data, samt kontaktopplysninger for de som er ansvarlige for studien. Videre forutsettes det at det innhentes samtykke til barnas deltagelse fra foreldre eller verge.

Personvernombudet legger til grunn at nødvendige tillatelser innhentes fra rette instanser i Uganda.

Datamaterialet innhentes gjennom personlig intervju av den delen av utvalget som deltar i samtalegruppene, samt spørreskjema som besvares av begge utvalgene. Lærerne som underviser på skolen og som er involvert i skoleprogrammet, benyttes som tolker i forbindelse med undersøkelsen, jf. telefonsamtale med prosjektleder den 24.05.2011.

Det innhentes direkte personidentifiserende opplysninger i form av navn. Videre innhentes opplysninger om alder, kjønn, skole, om de bor med sine foreldre/er foreldreløse, om de har barn, samt hvorvidt de opplever å ha mareritt, marerittenes omfang og hyppighet. Avslutningsvis i spørreskjema blir de registrerte bedt om å beskrive et typisk mareritt, samt å fortelle/beskrive sin mest smertefulle/skremmende opplevelse. Forsker har i e-post av 25.05.2011 begrunnet hvorfor spørsmålene som i utgangspunktet kan virke svært inngripende og sensitive, sannsynligvis ikke vil ha denne effekten på dem. Ombudet finner forskers redegjørelse tilfredsstillende, og legger til grunn at de registrerte i tillegg har god oppfølging fra lærere i forbindelse med programmet.

Det behandles sensitive personopplysninger om helseforhold, jf. personopplysningsloven § 2, punkt 8 c).

Prosjektet er meldt til Uganda National Council For Science and Technology.

Dato for prosjektslutt er 31.05.2012. Datamaterialet anonymiseres ved at verken direkte eller indirekte personidentifiserende opplysninger fremgår. Koblingsnøkkel slettes. Indirekte personidentifiserende opplysninger fjernes, omskrives eller grovkategoriseres.

5: Approval of data collection procedure, NSD: Female Genital Cutting

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

Harald Hårfagres gate 29
N-5007 Bergen
Norway
Tel: +47-55 58 21 17
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nsd@nsd.uib.no
www.nsd.uib.no
Org.nr. 985 321 884

Inger-Lise Lien
Nasjonalt kunnskapssenter for vold og traumatisk stress
Unirand AS
Kirkeveien 166 Bygning Z
0407 OSLO

Vår dato: 30.06.2009 Vår ref: 22037 / 2 / JE Deres dato: Deres ref:

TILRÅDING AV BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 19.05.2009. Meldingen gjelder prosjektet:

22037	*Kjønnslemlestelse i en norsk kontekst: Erkjennelsesmessige og psykososiale forhold*
Behandlingsansvarlig	*Unirand AS, ved institusjonens øverste leder*
Daglig ansvarlig	*Inger-Lise Lien*

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, eventuelle kommentarer samt personopplysningsloven/-helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/forsk_stud/skjema.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://www.nsd.uib.no/personvern/prosjektoversikt.jsp.

Personvernombudet vil ved prosjektets avslutning, 31.12.2011, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Vigdis Namtvedt Kvalheim

Janne Sigbjørnsen Eie

Kontaktperson: Janne Sigbjørnsen Eie tlf: 55 58 31 52
Vedlegg: Prosjektvurdering

Avdelingskontorer / District Offices
OSLO: NSD, Universitetet i Oslo, Postboks 1055 Blindern, 0316 Oslo. Tel: +47-22 85 52 11. nsd@uio.no
TRONDHEIM: NSD, Norges teknisk-naturvitenskapelige universitet, 7491 Trondheim. Tel: +47-73 59 19 07. kyrre.svarva@svt.ntnu.no
TROMSØ: NSD, SVF, Universitetet i Tromsø, 9037 Tromsø. Tel: +47-77 64 43 36. nsdmaa@sv.uit.no

Prosjektet gjennomføres som fire delprosjekter.

Delprosjekt 1
I delprosjekt 1 vil utvalget bestå av ca 20 pionerer over 16 år fra Somalia, Gambia, Etiopia, Eritrea og Sudan.

En vil ta utgangspunkt i prosjektets referansegruppe bestående av 20 personer som har hatt en aktiv rolle i bekjempelse av kjønnslemlestelse. Telefonkontakt med enkeltpersoner med informasjon og forespørsel om deltakelse.

Delprosjekt 2
I delprosjekt 2 vil utvalget bestå av 15-20 jenter mellom 16 og 18 år innvandret fra Somalia, Etiopia, Eritrea, Sudan, Gambia eller Sierra Leone, fra to videregående skoler i Oslo.

Aktuelle skoler vil bli kontaktet våren 2009. Henvendelse til skolens rektor om jenter som er elever ved skolen kan bli forespurt om å delta, samt hvorvidt forskningsintervjuene kan foregå i skolens lokaler. Etter godkjennelse fra skolens rektor vil lærere fra aktuelle klasser bli informert om undersøkelsen og forespurt om å delta via et informasjonsskriv som deles ut av primærlærer.

Delprosjekt 3
I delprosjekt 3 består utvalget av 20 kvinner i Norge med bakgrunn fra land med høy forekomst. Utvalget rekrutteres via samarbeidspartnere og nettverk i de aktuelle miljøene som prosjektet samarbeider med.

Delprosjekt 4
I delprosjekt 4 består utvalget av 20 voksne menn, 20 unge menn over 16 år fra Somalia, Etiopia, Eritrea, Sudan, Gambia. En vil ta utgangspunkt i prosjektets referansegruppe hvor en allerede har etablert kontakt.

Det gis skriftligog muntlig informasjon i alle delprosjekter. Personvernombudet forutsetter at det gis skriftlig informasjon til alle i god tid før gjennomføring av intervju. Det forutsettes videre at førstegangskontakt opprettes av personer med tilknytning/kontakt med informantene.

Data samles inn gjennom individuelle intervjuer og gruppeintervjuer. Deltakerne vil også bli bedt å skrive noen korte skriftlige oppgaver i forkant av intervju. Det er utarbeidet to informasjonsskriv, ett til individuelle intervju og ett til gruppeintervju. Informasjonsskrivene som forelå 25.06.2009 finnes tilfredsstillende.

For deltakerne over 18 år kan behandlingen av personopplysninger hjemles i personopplysningsloven §§ 8 første alternativ og 9 a). Det vil også være noen deltakere i prosjektet som er mellom 16 og 18 år. Hovedregelen når det innhentes sensitive personopplysninger fra mindreårige er at foresatte skal samtykke. Det er ombudets vurdering at unge mellom 16 og 18 år på selvstendig grunnlag kan avgjøre om de vil gi sitt samtykke til å delta i dette prosjektet. Ombudet har lagt vekt på at ungdom over 16 år har selvbestemmelse på en rekke områder, som valg av videregående skole og til helsehjelp. Videre skal ungdom i henhold til barneloven gradvis få muligheten til å treffe selvstendige valg om forhold som berører dem selv. Denne undersøkelsen berører forhold som er viktige for disse ungdommenes levekår, og det er derfor relevant og nødvendig å innhente opplysningene fra ungdommene selv. Det må også legges vekt på at kjønnslemlestelse er et viktig forskningstema. Prosjektets samfunnsnytte er dermed stor. Temaet gjør også at det vanskelig kan innhentes samtykke fra foresatte for de som er under 18 år. På bakgrunn av dette finner ombudet at behandlingen kan hjemles i personopplysningsloven §§ 8 d) og 9 h).

Det registreres sensitive opplysninger om rasemessig eller etnisk bakgrunn, helseforhold og seksuelle forhold, jf. personopplysningsloven § 2 nr 8 a), c) og d).

Det kan forekomme sensitive opplysninger om tredjepersoner i prosjektet, f.eks. i tilknytning til familiemedlemmer til deltakerne. Behandlingen av opplysninger om tredjepersonene kan hjemles i personopplysningsloven §§ 8 d) og 9 h). Det legges vekt på at opplysningene om tredjepersoner vil være av lite omfang og at prosjektgruppen vil forsøke å unngå slik informasjon ved å fokusere på generelle aspekter heller enn på spesifikke familiemedlemmer. Fokus i prosjektet er også på informanten og ikke på tredjepersoner i seg selv. Som en hovedregel skal alle personer registrert i et forskningsprosjekt informeres om dette. Ettersom omfanget av opplysningene er lite og dette er et sensitivt tema, vurderer ombudet det slik at prosjektleder kan unntas fra informasjonsplikten i henhold til personopplysningsloven § 20 b), ettersom det vil være uforholdsmessig vanskelig å informere tredjeperson.

Prosjektgruppen er forberedt på at kvinner som har blitt utsatt for kjønnslemlestelse vil kunne oppleve ubehag når temaet bringes opp. Dersom en informant får sterke reaksjoner vil det tilbys hjelp i form av oppfølgingssamtaler. Prosjektgruppen vil også kunne være behjelpelig med å henvise informanten videre til fastlege dersom tilbudet om oppfølgingssamtaler ikke er tilstrekkelig.

Regional komité for medisinsk og helsefaglig forskningsetikk (REK) har bekreftet at prosjektet ikke er fremleggelsespliktig for REK.

Prosjektet skal avsluttes 31.12.2011 og innsamlede opplysninger skal da anonymiseres og lydopptak slettes. Anonymisering innebærer at direkte personidentifiserende opplysninger som navn og indirekte personidentifiserende opplysninger som en kombinasjon av opprinnelsesland, bostedskommune, skoletilknytning, alder og kjønn må slettes eller endres.

6: Approval of data collection procedure, REC: Terror attack in Norway

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK sør-øst	Tor Even Svanes	22845521	07.10.2011	2011/1625
			Deres dato:	Deres referanse:
			23.08.2011	

Grete Dyb
Nasjonalt kunnskapssenter om vold og traumatisert stress
Kirkeveien 166
0407 Oslo

2011/1625 Utøya-opplevelser og reaksjoner hos de som overlevde og etterlatte

Vi viser til søknad mottatt til møtet 26.09.2011 om forhåndsgodkjenning av ovennevnte forskningsprosjekt. Søknaden er blitt vurdert av Regional komité for medisinsk og helsefaglig forskningsetikk i henhold til lov av 20. juni 2008 nr. 44, om medisinsk og helsefaglig forskning (helseforskningsloven) kapittel 3, med tilhørende forskrift om organisering av medisinsk og helsefaglig forskning av 1. juli 2009 nr 0955.

22.juli ble politisk aktiv ungdom og ungdomsledere på Utøya ofre for de alvorligste terrorhandlingene i Norge i fredstid. 69 døde, 66 ble fysisk skadet, 650 direkte berørt, om lag 700 mistet nære og 4500 ble pårørende i angrepene. Terrorhandlingene 22.juli karakteriseres ved at de direkte rammede er unge, og at antallet døde og fysisk skadde er høyt. Dette prosjektet er en studie av de overlevende og pårørende. Undersøkelsen har som overordnet mål å studere hvordan opplevelser og tap har påvirket psykiske og somatisk helse, sosial fungering og funksjonsnivå. Det er mangel på kunnskap om hvordan barn, ungdom og etterlattes helse, utvikling og mestringsevne utvikler seg over tid, og hvordan denne utviklingen påvirkes. Studien vil også gi økt kunnskap om hvordan ungdom, pårørende og etterlatte opplevde møtet med hjelpeapparatet, og hvordan lokalsamfunn, skoler og arbeidsliv tok imot dem.

Prosjektleder: Grete Dyb
Forskningsansvarlig: Nasjonalt kunnskapssenter om vold og traumatisk stress (NKVTS)

Saksgang
Komiteen ønsker innledningsvis å bemerke saksgangen for dette prosjektet. Studien er søkt til frist 23.08.2011, men på bakgrunn av prosjektets spesielle karakter og etter avtale med sekretariatet i REK Sør-Øst, er revidert protokoll med vedlegg ettersendt komiteen. Komiteen har behandlet den dokumentasjonen som foreligger per 15.09.2011.

Forskningsetisk vurdering
Komiteen oppfatter dette som en meget viktig studie. Etter presisering i ettersendt protokoll fremgår det at studien utelukkende vil konsentrere seg om overlevende fra Utøya og deres pårørende. Utvalget omfatter kun ungdom over 13 år. Det vil utarbeides et eget prosjekt med tanke på gruppen av etterlatte etter hendelsene på Utøya 22.07.2011.

Postadresse:
Postboks 1130 Blindern
0318 Oslo

Telefon: 22845511
E-post: post@helseforskning.etikkom.no
Web: http://helseforskning.etikkom.no

Forskning på sårbare grupper krever at forskere utviser en særskilt aktsomhet i møtet med sitt utvalg. Utvalgsgruppen det her dreier seg om befinner seg i en uhyre sårbar situasjon. Søknaden har tatt full høyde for dette aspektet. Den er utarbeidet av en gruppe som er faglig meget godt kvalifisert, det er

lagt opp til en omfattende beredskapsplan underveis i prosjektperioden, og det skal kun rekrutteres trenet helsepersonell til å gjennomføre intervjuene. Det er også lagt opp til en egen beredskapsplan knyttet til selve intervjusituasjonen, med bistand i etterkant dersom behov for hjelp etter reaktivering er påkrevd eller ønskelig.

Komiteen finner den skisserte beredskapsplanen i prosjektet gjennomarbeidet og betryggende.

Som en del av rekrutteringsprosedyren vil overlevende fra Utøya og deres foreldre, motta et informasjonsskriv, før det tas telefonisk kontakt med spørsmål om deltakelse i studien. Det skal innhentes skriftlig samtykke i tråd med helseforskningslovens krav, før inklusjon i prosjektet.

Komiteen har diskutert denne fremgangsmåten, særlig med henblikk på telefonkontakten, og er kommet til at fremgangsmåten er akseptabel. Det informeres tydelig i det innledende skrivet at denne oppringningen vil komme, og deltakerne har gode og reelle reservasjonsmuligheter.

Frivilligheten i prosjektet er gjennomgående godt beskrevet, men komiteen vil likevel understreke at det må være en høy grad av oppmerksomhet hos den som tar telefonisk kontakt med ungdommene. Det påligger denne personen er spesielt ansvar i forhold til å formidle den reelle frivilligheten i prosjektet, og det må understrekes at ungdommene verken er under tidspress, eller under press til å si ja til deltakelse, dersom de ikke ønsker dette.

Et medvirkende moment til at slik informasjon må kommuniseres tydelig, er at ungdommene i tiden etter terrorangrepet har vært i flere lignende situasjoner, men hvor frivilligheten har vært mer begrenset, enten det har dreid seg om umiddelbar krisehjelp eller politiavhør.

Det anføres i informasjonsskrivene at det vil gis honorering for deltakelse i prosjektet: *De som deltar i studien er med på trekning av to gavekort på kr 10 000 og ti gavekort på kroner 1000.* Komiteen opplever denne honoreringen som problematisk, på bakgrunn av den helt spesielle situasjonen det her er snakk om. Denne skepsisen må ses i forlengelsen av punktet knyttet til frivillighet i studien. Det kreves således at all honorering tas ut av prosjektet.

Komiteen opplever protokollen som sparsom når det kommer til å konkret beskrive metode og intervjuguide. Dette nevnes også av prosjektleder i revidert protokoll: *Prosjektgruppen arbeider med å sette sammen semistrukturerte intervjuer. Intervjuguidene for 2. og 3. gangs intervjuer er ikke utarbeidet, og noen tema kan bli endret i forløpet.* Senere, under delkapittel **Intervjuguide ungdom**, anføres følgende: *Skolefravær måles via registerdata, i tillegg kan andre mål på kognitiv fungering bli inkludert.*

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Komiteen har stor forståelse for de utfordringer man møter i planleggingen av en studie som denne, og man har også forståelse for at deler av de valgene som er foretatt i arbeidet med søknaden er av tidsmessig karakter.

Det er imidlertid vanskelig for komiteen å fullt ut ta stilling til en intervjuguide som ikke er ferdig utarbeidet. Følgelig kreves det at det sendes prosjektendringssøknader til REK når intervjuguide ferdigstilles og/eller oppdateres, og når det foretas øvrige korrigeringer i metodologien, jf. helseforskningslovens § 11. Disse prosjektendringssøknadene må godkjennes før endringene kan iverksettes.

Informasjonsskriv og samtykkeerklæring
I denne studien ønsker man å benytte informasjon fra utdanningsregisteret for forhold rundt skolefungering, for å kunne kartlegge om skolegang påvirkes av katastrofen. Videre ønsker man å hente ut et skjema som beskriver psykiske stressreaksjoner de første ukene etter hendelsene fra helsejournal.

Komiteen krever at det utarbeides graderte samtykker til slik uthenting, ved at deltakerne samtykker til deltakelse i studien, og deretter spesifikt til innhenting av skoledata og helseopplysninger. Dette kan gjøres ved å inkludere avkrysningsbokser i selve samtykkeerklæringen.

Det skal videre inkluderes en setning i relevant avsnitt av skrivet som understreker forskernes taushetsplikt i forhold til bruk av disse opplysningene, slik at ungdommene på en ryddig og god måte får formidlet at dette er opplysninger som for eksempel ikke vil videreformidles til foreldre eller lærere. Det er unge deltakere det her er snakk om; deltakere som kanskje ikke er fortrolige med hva profesjonsbasert taushetsplikt består i.

Ut fra dette setter komiteen følgende vilkår for prosjektet:

1. Honorering skal utgå fra prosjektet.
2. Ferdigstilt intervjuguide skal sendes komiteen som endringsmelding – og godkjennes – før den kan benyttes.
3. Øvrige endringer i metodologi og design skal søkes komiteen fortløpende.
4. Samtykke til deltakelse skal være gradert. Det skal utarbeides egne avkrysningsbokser for uthenting av data fra utdanningsregister og journal.
5. Informasjonsskrivet skal revideres i tråd med det ovennevnte.

Vedtak:
Prosjektet godkjennes under forutsetning av at ovennevnte vilkår oppfylles.

I tillegg til vilkår som fremgår av dette vedtaket, er tillatelsen gitt under forutsetning av at prosjektet gjennomføres slik det er beskrevet i søknaden og protokollen, i tråd med supplerende opplysninger av 15.09.2011, og de bestemmelser som følger av helseforskningsloven med forskrifter.

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Tillatelsen gjelder til 31.12.2020. Opplysningene skal deretter slettes eller anonymiseres, senest innen et halvt år fra denne dato. Prosjektet skal sende sluttmelding på eget skjema, jf. helseforskningsloven § 12, senest et halvt år etter prosjektslutt.

Komiteens avgjørelse var enstemmig.

Forskningsprosjektets data skal oppbevares forsvarlig, se personopplysningsforskriften kapittel 2, og Helsedirektoratets veileder for *Personvern og informasjonssikkerhet i forskningsprosjekter innenfor helse- og omsorgssektoren:*
http://www.helsedirektoratet.no/samspill/informasjonssikkerhet/norm_for_informasjonssikkerhet_i_helsesektoren_232354

Komiteens vedtak kan påklages til Den nasjonale forskningsetiske komité for medisin og helsefag, jf. Forvaltningslovens § 28 flg. Eventuell klage sendes til REK Sør-Øst. Klagefristen er tre uker fra mottak av dette brevet.

Med vennlig hilsen

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Vi ber om at alle henvendelser sendes inn via vår saksportal eller på e-post. Vennligst oppgi vårt referansenummer i korrespondansen.

Paper I - IV

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ORIGINAL RESEARCH

Meaning-making of female genital cutting: children's perception and acquired knowledge of the ritual

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Abstract: How do girls who have undergone female genital cutting understand the ritual? This study provides an analysis of the learning process and knowledge acquired in their meaning-making process. Eighteen participants were interviewed in qualitative indepth interviews. Women in Norway, mostly with Somali or Gambian backgrounds, were asked about their experiences of circumcision. Two different strategies were used to prepare girls for circumcision, ie, one involving giving some information and the other keeping the ritual a secret. Findings indicate that these two approaches affected the girls' meaning-making differently, but both strategies seemed to lead to the same educational outcome. The learning process is carefully monitored and regulated but is brought to a halt, stopping short of critical reflexive thinking. The knowledge tends to be deeply internalized, embodied, and morally embraced. The meaning-making process is discussed by analyzing the use of metaphors and narratives. Given that the educational outcome is characterized by limited knowledge without critical reflection, behavior change programs to end female genital cutting should identify and implement educational stimuli that are likely to promote critical reflexive thinking.

Keywords: female genital cutting, metaphors, health education, immigrants

Video abstract

Point your SmartPhone at the code above. If you have a QR code reader the video abstract will appear. Or use: http://dvpr.es/13ulY1q

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Introduction

Female genital cutting (FGC) is still widely practiced, with some 140 million women worldwide estimated to have undergone this ritual, and about three million girls being circumcised each year,[1] with significant geographic and local variations in ritual and procedure. Studies have noted changes in the tradition, both locally and in exile.[2,3] The underlying meaning of the ritual also seems to vary and is subject to change. Commonly reported rationales for FGC are to purify the body, prepare the girl for reproductive maturity, and mark her belonging to a social group. The procedure may be performed on infants or, more commonly, on girls aged 4–10 years. In order to understand the ritual of circumcision, we need to explore its social meaning in the cultural context. From studies in Sudan, Boddy[4] argues that circumcision of boys and girls can be viewed together as a model of gender complementarity. Several ethnic groups perceive children as being born "unfinished". For instance, in Mali, Sudan, and Egypt, circumcision is performed to complete the social or spiritual definition of a child's gender by removing anatomical traces of ambiguity. The Sudanese remove the girl's "masculine" clitoris and labia, and the "feminine" foreskin of boys. In girls, excision of the clitoris is followed by infibulations designed to "cover" and protect the female reproductive tract, whereas the male's organ is "opened" or "unveiled".

Once circumcised, boys and girls live more segregated lives; they are treated differently, and their complementary dispositions mature.[4,5]

Studies in Somalia report that the parts of the body that are cut off are considered "childish" and "unclean". "They have to be removed in order to humanize and feminize the woman, to secure her moral uprightness and bodily beauty (…). It elevates her body to an aesthetic ideal and only as a 'sewn' woman may she represent her family later in life at marriage".[6] Some Somali women state the case in religious terms, seeing circumcision as a cleansing ritual that allows them to be "true Muslims" and helps them to pray properly. It is also believed that female circumcision curbs abnormal sexual desire, making women more dedicated wives and mothers.[3]

In explaining the continuation of FGC, Mackie[7] and Mackie and LeJeune[8] employ a convention model based on Schelling[9] and assume that all parents desire to raise their children successfully and that they make decisions with the best interests of the child in mind. Female circumcision, according to this view, can be understood as a strategy for optimizing the girl's future within a cultural context. Parents love their children and make the strategic choice to circumcise their daughters in order to enable them to get married and enhance their prospects of a good life.

Among the Madinga, the social meaning of female circumcision is related to and interwoven with initiation rituals. Female circumcision as practiced by the Madinga took place historically within the context of initiation rituals. As one of the gradual steps in the transformation from childhood towards adulthood, the initiation involved an instruction period in the bush lasting up to four months, followed by public "coming out" dances. The circumcision of girls and boys is seen as being connected to the initiation rituals, even though few girls and boys experience these events simultaneously, and others might experience only the circumcision without other initiation rituals.[3,10] Finally, several studies indicate how FGC has changed, with the procedure being performed on younger girls and with less ritual fanfare than before, possibly because of increased parental fears of outside intervention. Other reasons mentioned for separating female circumcision from initiation rituals are socioeconomic changes owing to urbanization and modernization.[3,4,11]

Boddy[4] explains that Sudanese children are circumcised when they are old enough to have achieved a minimum of reason or "social sense". "They are expected to realize that their bodies are being 'purified', made discrete by the social group".[4] Here a requirement for circumcision is that the child should be cognitively mature enough to understand the procedure. However, in other communities, circumcision is performed on infants, which means the instruction of the child and the meaning-making are initiated long after the procedure itself. The framework of knowledge which girls are supposed to understand seems to be that circumcision produces moral individuals by purifying their bodies and fostering virginity; further, it ensures girls are officially included in society, and prepares them for becoming adults and later wives and mothers. This knowledge has to be acquired by the child with seemingly little formal instruction or explanation.

Collective understandings of FGC and the meanings ascribed to it by various ethnic groups have been the subject of comprehensive studies in which the rituals have been compared and viewed from an abstract and theoretical perspective. Less research has focused on the individuals who undergo the ritual, and how they make meaning of it. Indeed, the child's perspective seems almost nonexistent in the literature. In addition to dealing with questions of cultural understanding, there has been research on the long-term damage to health and on the rights of adult women. There has been scant focus on elucidating how girls receive teaching and develop an understanding of FGC, or how they later manage to integrate the experience of FGC and develop an identity as a cut, proud, and honorable woman.

In recent decades, there has been an increased commitment to reducing and ending the practice of FGC. Nineteen African countries have implemented laws against the practice, and there are local action plans, national and international strategy plans, and a variety of information campaigns and behavior-change programs. Elements of education are integrated and appear to be a central component in the programs.[12] Evaluation research indicates that education, when appropriately organized and presented within a wider process of social mobilization, can be a powerful and effective means of facilitating rapid change in the longstanding traditional behaviors of FGC.[13] Although a wide variety of approaches and methods designed to end FGC are in use,[12,14,15] few have been systematically evaluated.[13,16] An understanding of the learning process and the type and quality of girls' acquired knowledge of the ritual is of relevance to the key education component of behavior-change programs, both in FGC-performing countries and programs targeting those living in exile in nonperforming countries.

The aim of this study was to explore the meaning-making of FGC for girls who undergo the ritual. The study analyzes the learning process and the characteristics of the knowledge the girls acquire. Two different strategies used to prepare girls

for circumcision are analyzed, ie, according to one strategy the girls are prepared in advance, whereas in the case of the other, the ritual is shrouded in secrecy.

Materials and methods

Participants

Purposive sampling was used to increase the range of data available on the two strategies for preparing the girl child. Potential informants were approached individually through Somali and Gambian networks after key persons within the networks had provided information about the research project. The selection criterion for the 18 women (aged 32–60 years) was that they had undergone FGC. The majority had either Somali or Gambian ethnic backgrounds, although four were from neighboring countries. They were all living in Norway at the time of the interview. The study was also informed by several research trips to the Gambia, Ethiopia, and Kenya, where we systematically interviewed doctors, nurses, religious leaders, elders, circumcisers, and anticircumcision activists. These interviews serve to enlighten this study as background data. We also attended workshops and conferences in Norway initiated by local nongovernmental organizations campaigning against FGC.

Procedure

Several preliminary meetings with Somali and Gambian women were arranged to translate and clarify common words used to describe the procedure and ritual of FGC. Interviews were mostly conducted in either English or Norwegian; four used their first language and translators had to be used. The authors performed the interviews either individually or together. All interviews involved semistructured and open-ended questions. To capture specific childhood experiences, respondents were asked for their own narrative about the ritual and the cutting. We stressed that they should talk about their experiences as freely as possible. In additional, various prompts were provided to help them elaborate on their experiences.

After the narratives had been told, the focus shifted to elaboration of aspects of the meaning-making process. The participants were interviewed twice. In total, we used three different translators who also served as cultural advisors during discussions throughout the research process. One of the cultural advisors was also present during background interviews with 15 circumcisers in the Gambia. The researchers and the cultural advisors attended several group discussions on the content of the interviews. Most interviews were audiotaped and transcribed verbatim.

The analysis was inspired by grounded theory. In each case, the data were clustered according to the following categories: use of metaphors, construction of narratives, and the process of instruction, education, and supervision. Core concepts were created by being grouped across the individual cases. The theoretical framework was based on educational psychology and cognitive and narrative psychology, using metaphors and narratives as instruments in meaning-making.

Results

The following two strategies for preparing a girl for the upcoming circumcision are presented as prototypes, representative of the type and structure of information given.

Closed information strategy from the Gambia

Nimba had recently celebrated her fourth birthday when she was told that something fantastic was about to happen to her. She saw that her grandmother and mother as well as her aunts were busy preparing for a ceremony. They told her that it would be a big celebration with lots of people coming, but where it would happen was a secret. "I was told I was going to a ceremony. I asked more about it but they said it was a secret. I only knew everybody would be there wearing their best clothes and there would be lots of presents. I was so excited." The evening before the ceremony, Nimba's hair was carefully plaited, she got to see her new clothes, and was given her favorite food. The next day she was woken up early, washed and dressed, and ate a little breakfast. She was then blindfolded and led away by her mother and aunt.

> "When the blindfold was removed, I was puzzled to see that I was in our neighbor's house. I was sitting on a mat, there were five of us. I only remember one of the girls that I already knew. Then they took the first girl, blindfolded her again and took her into another room. As I was waiting I heard the screams and I became very skeptical. I finally understood that this was not as rosy as they said it would be. I thought, 'This isn't right'. Then I was led into the bathroom. I can remember the cement floor. It all went so fast, and I couldn't fight it because they held my arms and legs. Then I felt the pain … I screamed … they had to carry me out."

When Nimba was cut, none of her family was present. She remembers seeing her mother and grandmother afterwards when she was lying in another room with the four other girls. The girls lay to heal in this room for two weeks. For the first few days, they could not walk and had to be helped to the toilet. During those two weeks, they received many visitors.

Nimba remembers everyone telling her how important this was for her and how brave she had been. Nimba clearly remembers the initial excitement, but she also remembers a trace of uncertainty because they had never talked about what was going to happen. The cutting came as a total shock to her, and for the next few weeks she continued to have the feeling that it was not right. Gradually, however, she became a proud girl. She developed a sense of pride in having been through the ritual and of what she had become: a clean girl.

Circumcisers in the Gambia often use drums and loud singing to suppress the screams, as well as blindfolds to shield the girls from seeing the cutter. They explain that the girls should never know who cut them, so subsequently they cannot point out the cutter and frighten uncut girls. It is also stressed that uncut girls should know as little as possible about the circumcision. Such knowledge would only upset the child and make her run away. "They are protected", explained one circumciser, "because they have no idea of what's going to happen".

Partly open information strategy from Somalia

Yasmin was six years old when she was cut. She lived in a large town with her family, who were financially well off. Yasmin had known for a while that the big day was coming. When her mother told her that the circumciser would be coming next Friday, Yasmin was extremely happy and immediately ran to tell her friends that it was finally her time. She remembers the triumphant feeling: now she would be a better girl than they were, because they were not yet cut. Her mother braided her hair, trimmed her nails, gave her a new dress, and made her go to bed early. Over the previous months, Yasmin had talked to several older friends and they had told her about the procedure.

> "Several of my older friends had gone through it and they were happy. They said it would hurt, but the pain would pass. But I definitely found out that they weren't right about the pain part. I got local anesthetic and never felt the pain when I was cut and sewn. I was afraid of the needle … I screamed and cried … they were holding me hard. My mother left the room, she couldn't take it. The pain came later."

The circumciser came from the local hospital. He was instructed in the process by Yasmin's aunt, who "was the expert on how women should look down there". After the effects of the local anesthetic had worn off, the pain hit Yasmin hard. She had problems urinating because of the severe pain. Her mother tried to comfort her and also explained that if she did not urinate her belly would explode and she would die. Yasmin was very scared, but gradually she got better and managed to urinate when she was carried to the toilet. For 14 days she had to lie still, and her mother comforted her. After 10 days her aunt came back to check on Yasmin's genitals. "I remember she was very happy and said it was perfect! It didn't hurt much anymore and I was proud … very proud. I was happy … and I was normal." She had become "smooth"; her genitals had been modified and were now "clean, smooth and beautiful".

Five phases of learning

There are variations and differences in how our informants, subject to each of the two strategies, experienced the information and preparation they received prior to the circumcision. The description of the procedure itself also varied: from traumatic experiences to lesser degrees of traumatic stress and to a procedure that hurt at first but then became less painful. Seeking to explore the meaning-making process, we identified in the interview material five phases where the girl child is provided with information. The five phases are based on the two strategies; there is much in common after the circumcision has been performed, but significant differences in the two initial phases.

In the initial preparation phase, the Somali girl child is gradually presented, both directly and indirectly, with certain social rules: uncut girls are not clean and they will not be able to get married, be respected, or be included in local society. If an unclean girl slaughters a goat or a hen and prepares the food, the food will be tainted and will not be proper halal. Our Somali informants frequently mentioned that older cut girls may exclude uncut girls from play. When cut girls enter a room, the uncut girls are asked to leave. Adults also differentiate, allowing only cut girls to pour tea for the women. One informant describes her restlessness when she was six years old, and she was cut the following year:

> "I was ready. I begged my mother to let me be circumcised soon. I was afraid of it, but I was more afraid of being bullied at school. I had seen 15-year-old uncut girls being bullied. All the children were divided into two groups, the cut and the uncut. I wanted to belong to the group that had been circumcised."

The next learning phase is the preparation phase. For the Somali girls, this starts about one year prior to the procedure, when the girl is told that within a year she will be ready for circumcision. The further information she receives is a mixture of direct information from adults and communication with older cut girls, which is encouraged.

It is the mother's responsibility to monitor what sort of information her daughter receives. She does this by paying close attention to whom her daughter talks, and then checks with their mothers what sort of experiences their daughters had and what sort of stories they are likely to pass on. If her daughter receives scary stories focused on pain, it is up to the mother to "correct" and supplement them. When a girl is informed that she is ready for circumcision she will say this at school and tell her friends. Older girls might then come to the family's home and ask the mother to confirm that the daughter is about to be cut. The mothers reported that the uncut girls are very active in this process: "They find it very exciting to explore who has done it and they engage actively in exploring what the older girls went through." It is the grandmother who is responsible for making sure the ritual takes place, and the mother has a vital supportive role. They must select a circumciser, arrange for a proper circumcision, and monitor the process carefully.

The first two phases described here are more explicit for the Somali girls, who are exposed to the partly open information strategy. The Somali girls are primed and motivated actively to gather knowledge about the forthcoming ritual. This is not the case for the Gambian girls, who are exposed to the closed information strategy and who mostly gain their knowledge directly from the ritual itself and from the later learning phases.

The ritual and explanation phase is rich in information, which, depending on the girl's age, may also include formal instruction. It is vital to the honor of the girl and of her family that she does not scream during the cutting. She must endure her pain "like the grown-up woman" she is about to become. After the circumcision, the mother and grandmother follow up the healing process, help the girl to urinate regularly, and make sure she does not walk for two weeks in order for the wound to heal. They must then ensure that she is properly inspected to check that the circumcision has been satisfactorily performed, after which they make the result public. The ensuing party is a celebration of the girl's successful circumcision, and also a celebration for the grandmother and mother who have performed their duties properly. The extent of further formal instruction on the topic depends on the girl's age. As a minimum, this education is as one mother describes it:

> "You have to make her understand the importance of taking care of her vagina and make sure she understands the severity and gravity of it; if she isn't careful she will never get married, she will be excluded from social life and she will be a disgrace to her family and to herself."

The reports of the participants reveal variations in the content and the degree of formal instruction in the ritual and explanation phase. These variations are connected with the age of the girls and whether the ritual was performed individually or in a larger group. The rituals performed in groups tend to carry more ritual fanfare and more formal instruction. Several of the older Gambian women who were cut at the age of 11–12 years reported that formalized instruction with, designated teachers went on for weeks and sometimes months. They learned traditional knowledge such as that contained in songs, dances, religion, and cultural norms, how to behave as a woman, and about menstruation, pregnancy, respect for elders, and food taboos. The formal instruction was given by a designated teacher known as a "Kantallalo" and in the form of songs, dances, recitation, repetitions, and questions and answers. It was not uncommon for the girls to establish a relationship with their Kantallalo in such a way that they could also ask her questions after the formal instruction ended. The participants reported that several of the educational topics that were previously taught by the Kantallalo are now taught in school.

If the girl is considered to be too young to profit from formal education in this phase, the formal education comes in a later learning phase that can be characterized as the education and conversation phase. This phase starts when the girl reaches puberty, at around 12 years of age. The previous role and responsibility of the Kantallalo is divided between the school, the mother, and other female family members. It is the mother's responsibility to emphasize to her daughter the importance of being an honorable woman in order to be married and what this means when it comes to sexuality.

The confirmation phase can be defined as a continuous process of confirming and reassuring the importance of the cutting after it is performed. Once the pain has subsided and the festivities are over, newly cut girls enter a new role, in that they are now one step closer to being honorable young women ready for marriage. They are admired by those who have not yet been cut, and are acknowledged by those who have already been through the ritual. They have become part of a broader fellowship. For girls aged around 6–7 years, circumcision represents an important rite of passage. They are questioned by uncut girls, serving as witnesses and deliverers of promises in the dissemination of information to the uncut girls. In this phase, the girls are instructed about why it is important to perform circumcision. The girls are told that if they were not cut they would exhibit abnormal social conduct through their sexual activity. They would be tormented by strong sexual desire and the clitoris would grow to the size

of a male penis. These and similar explanations are repeated and can be described as confirmative talk.

In this study, the Somalian girls were cut at the age of 6–8 years and the Gambian girls at around four years of age. In the Somalian approach, there is more interaction between mother and child before the procedure. The Gambian girls have little preparation and report being psychologically unprepared to a greater extent and also a feeling of being deceived.

When a girl has received and internalized the defined information, she has attained the educational goal of knowing how to behave honorably. As soon as she reaches the right age, she is ready to be married, and a suitable husband is selected, and then the mother becomes a grandmother and has the responsibility for making sure her grandchildren are properly circumcised.

Understanding from a child's perspective

During the partly open process in Somalia, there is limited talk between women and girls about the upcoming cutting. A Somali girl who was infibulated at the age of seven years had been told by her grandmother that the ritual would "make the girl like her mother and grandmother". When she later asked her mother if the ritual was the same as that her older brother had gone through, her mother confirmed that it was similar. As she approached the ritual, she knew at the age of seven years that it was important to change something in her vagina in order to become clean. She also knew that it would hurt, that everybody did it, that it would make her like her mother and grandmother, and that the procedure would be followed by a big celebration. During the recovery period, she was informed that she was now "closed" and that it was her responsibility to "keep it beautiful, clean, and closed" until marriage. Both the Somali and the Gambian informants recalled that there were no options for engaging in open exploratory talks about the circumcision after the ritual had been performed. As children and adolescents, they saw it as a partly taboo subject, and none of the informants recalled that they themselves had initiated a conversation about it with their mother or other grownups. As one girl explained, "I remember as a teenager I was afraid to ask my questions because she could interpret it to mean that I was interested in having sex. We couldn't talk about it at all."

At the age of 12 years, one informant and her friend were playing; they were climbing high in a tree. She fell down and hurt her shoulder. She cried, and both of them became scared and ran home. They were met by an aunt who rushed towards them, stopped, and immediately started inspecting her niece's vagina to see if the infibulation was still intact. "And then she said I was all right. I was puzzled by this … because I didn't know it was that important." The girls were then told to be more careful, and nothing more was said by the aunt. The two girls concluded that they would have to be more careful with "that place down there".

When our informants recalled their childhood experiences, the most common way of explaining why their mothers and grandmothers performed the ritual was that it was done "out of love". It was a tradition that was never questioned, and scarcely ever explained or talked about in an educational manner. Although the adults offered limited verbal information about the ritual, the girls themselves would talk about the topic with their peers. A few of the informants said that they had the feeling it was all wrong, and they channeled their anger towards their mothers and grandmothers. After they had left their home country and settled abroad, their reflections on the practice and the formulation of unanswered questions gained momentum. However, before they became aware that not all girls were cut, most of the respondents reported that they had very few critical reflections on and questions about the practice.

Discussion

The meaning-making process of the girls in connection with FGC was carefully monitored and supervised by their mothers, older sisters, grandmothers, and other women. The educational goal was that the girl should become a clean and honorable woman. This is achieved when the girl has performed the ritual, has understood and accepted its importance, and finally passes it on to the next generation. In order to reach this educational goal, girls are provided with formal and informal instruction structured in what we have identified as five phases of learning. The girls' meaning-making process is stimulated by their introduction to a set of metaphors for constructing their first meaningful narratives.

When our informants spoke of the ritual and the meaning behind it, their descriptions were rich in metaphors. Lakoff and Johnson[17] argue that metaphor is a natural phenomenon, and a natural part of our thought and language. Metaphors are not only about words and how we talk; they are also about conceptualization and reasoning. Which metaphors we choose and what they mean will depend on the nature of our bodies, our interactions with the physical environment, and our social and cultural practices.[17] Theories and research behind metaphors explore how, often unconsciously, they become building blocks in the understanding of aspects and dimensions of our experience. This is typically the case with human emotions, abstract

concepts, mental activity, social practices, and so on. Even though most of these can be experienced directly, none of them can be fully comprehended on their own terms. Instead, we must understand them in terms of other kinds of entities and experiences, ie, understanding via metaphor.[17] The cognitive importance of metaphor in instructional settings is acknowledged; it is argued that metaphor can play a central role in the pedagogical process of making what is learned more explicit.[18] Good metaphors suggest new connections by picking out an illustrative and familiar example from a certain category. If this is grouped with another example from another category not related to the metaphor category, a relevant similarity is created.

"Being like your mother" is a prototypical example of the new class of category that is linked with the unfamiliar category of FGC. The girl's cognitive structures or schemas are expanded, whereby links are made between the new concept and previous experiences are grouped into familiar categories. Being like your mother and grandmother is desirable, it is a part of growing up, and for a little girl both her mother and grandmother are familiar, clearly defined concepts. The child also finds the same clarity in the concept of being "clean" versus being "unclean". The key to understanding the meaning of the new category of FGC and the comprehending metaphors is that both processes are bound up with activities. It is not simply a matter of hearing and understanding words, it is about acting in one's surroundings. The learner classifies and is corrected; she sorts, perceives similarities and differences, and reclassifies. The same activities are done with the metaphors, ie, classifying, building new links, and testing hypotheses suggested by the new class-inclusion relationship.[18] Because they are not allowed to handle food in the kitchen or serve tea, the Somali girls are told and shown that they are not "clean" and that they are not living up to the two metaphors of "being like your mother" and "being clean".

Several of the infibulated Somali informants referred to the outcome of their circumcision as "being smooth". In their childhood, they had become familiar with the concept of "being smooth" and linked this to esthetics. Explanations of the smooth esthetic were often followed with a quick hand gesture indicating that you could stroke a closed and smooth genitalia that was free from any external visible parts. Somali women often consider the infibulated genitalia as beautiful and sexy.[19,20] Shweder[21] has pointed out that being smooth is not only popular but fashionable, and that unmodified genitals are seen as ugly, unrefined, uncivilized, and even not fully human.

Bruner argues for the narrative as an instrument for meaning-making because, in understanding cultural phenomena, people do not deal with the world event by event but rather frame events in larger structures.[22] Creating narratives is a cognitive process that serves understanding by organizing events and happenings into frames of meaning.[23] Within narrative psychology, narrative structuring and plots are essential to the meaning-making process. "Narrative structuring operates by configuring actions and events into a temporal whole. As concepts serve to give meaning to particular objects and actions by giving them a categorical identity, plots serve to give meaning to particular happenings and actions by identifying them as contributors to the outcome of an episode."[23]

Many of the daily life experiences of a child occur within an accustomed setting with familiar people, and do not entail the need for extended meaning-making. Through participation in daily activities, the child develops cognitive schemas or scripts that act as a framework for sequences of familiar situations.[24] The script serves as an adequate means for understanding events that conform to the expected, but when the unexpected occurs, the meaning becomes unclear. One of the chief functions of a narrative is to help the child deal with situations and experiences that are contrary to the expected. The narrative process is triggered by the unexpected; it reviews the unusual event in order to make sense of it.[23,25]

The two newly circumcised girls who climbed a tree reached a turning point in their understanding, which contributed a new understanding and meaning to the larger narrative about FGC. After falling from the tree, the girl was puzzled when her stitches were inspected by her aunt: "I didn't know it was that important." The plot in this episode constitutes a turning point in her understanding of the importance of FGC, clarifying the importance of and defining a conclusion on the need to be careful. In this and in similar reported episodes, the plots are about obscurity and not understanding. This is what structures the narrative. Lack of knowledge is the motive for constructing the narratives from all the episodes that are defined by the plot as having something to do with the child's puzzlement and attempts to understand FGC. Our informants mentioned a range of similar episodes, ie, not being allowed to participate in food preparation or serving tea, being teased about being uncut, the positive and overwhelming ceremonies after the ritual, and praise for having been "such a strong girl" during the cutting. The plots in such episodes define new meaningful components that bring clarity to the girls' ongoing composition of their FGC narrative. Commonly mentioned

metaphors are open-closed, clean-unclean, child-grownup, esthetic-ugly, and included-excluded.

If a metaphor continues to make sense after being tested both in real life and cognitively by creation of a relevant similarity between two categories, then it passes into literal truth, whereas the metaphor itself becomes "dead".[18] For our informants, the metaphors gradually made sense and became literal truth, and then ceased to exist as metaphors. Having served their purpose, they became "dead metaphors" and turned into explanations in themselves. In this context, we may note how the metaphors highlight the cultural ideas of being clean and honorable, while hiding matters such as medical issues and other possible rationales behind the ritual.

As argued above, the plots and specific meanings from different episodes are created in context, in play, and in social conduct. The FGC narrative is constantly readjusted and shaped. Through this process of narrative structuring, the girls achieve "an interpretation of life in which past events and happenings are understood as meaningful from a current perspective of their emplotted contribution to an outcome".[23]

However, the girls' learning process was actively stopped, in part as a result of the strong cultural regulation of communication about FGC. The strict limitations on how one can talk about FGC act to restrict the natural exploration and critical discussion that could have developed further and shaped the FGC narrative. Our informants' childhood and adolescent explanations and understanding of FGC must be characterized as limited, based on their use of metaphors and circular and tautological explanations like "that's the way it is", "it is necessary", "that's how we do it", and "we have always done it". The mothers' and grandmothers' explanation that "we do it out of love" indicates that they love the girls, and if the girls oppose the ritual, they are automatically rejecting their love. This is also another example linking honor and morality to the concept of cutting, which characterize the knowledge as morally embraced.

Green[26] argues that it is difficult to provide religious instruction without the use of metaphors because of lack of empirical data. We could argue that there are similarities between a child's first religious instruction and teaching about FGC. The abstract subjects of God and death and about FGC are made understandable through metaphors which both highlight and conceal certain aspects of the phenomena explained.

With FGC, the learning process is deemed a success when the educational goal has been achieved, ie, the circumcision ritual is accepted as a necessity, the girl is proud of it, and later on it is passed on to her own daughters. The educational goal has become established in thought, in language, and in conduct, and yet this learning process has been halted at the level of tautological explanations, not least because of the strict communication rules that effectively regulate open discussion. The communication convention defines the rules for talking about FGC, ie, what can be said, in what ways, at what time, and by whom. The tautological explanations based on half-understood ideas convey just enough knowledge for girls to be able to accept the ritual and carry on the tradition without questioning it, at least not openly.

In contrast, if there were a deliberate educational goal that involved the learners engaging in explorative discussions and internalizing knowledge into a reflexive mode of thinking, the educational process would have to be brought to the next level of learning. That would require introducing a metalanguage of FGC for formulating words and characteristics beyond the realm of the limiting metaphors. It is this level of education that needs to be fostered in settings where open and explorative discussion can be encouraged, and where the child or adolescent is motivated to ask questions and participate actively. The lack of these characteristics makes the knowledge embodied, and it is not being abstracted and cognitive accessible in a critical reflexive mode of thinking.

Tostan's community-based educational program provides a good example of the educational components of promising programs and approaches in terms of ending FGC. This program aims to empower women through a broad range of educational and health-promoting activities to define and pursue their own goals better. One of the key components is the creation of a forum in which women can safely engage in free and equal discussion about their challenges and problems, and in which the subject of FGC is freely debated and a trustworthy alternative to FGC is introduced. The strategy is to launch a process of basic education and discussion that spreads to public discussion and public declaration against the practice in order to achieve a collective shift in convention.[13,27]

Conclusion

This study has expanded the research on individual meaning-making of FGC among children and adolescents by identifying and describing the informants' learning process. We have shown how metaphors serve as building blocks in the

construction of narratives, and how the narratives structure the human experience, in this case integrating meaningful knowledge of FGC in a way which is only minimally accompanied by formal instruction.

The learning process is carefully monitored and regulated, and can be structured or divided into five phases of learning. The educational goal is clearly defined, although the learning process is highly informal. There is little formal instruction; it is a matter of learning by doing, and girls get feedback by corrections and praise for their conduct. The lack of directness in the educational process is compensated by the use of metaphors, which in themselves are unclear. This lack of clarity activates narrative processing and finding clarity is the motivation for such processing. In their daily lives, the girls are offered a rich set of metaphors that can help them to construct their FGC narrative. We have seen how the girls experience a range of episodes that are FGC-related in an indirect and subtle way. These episodes provide constant opportunities for working with their metaphors and further developing their own narratives. The shaping of the child's understanding is carefully monitored by the mother, but it is left largely to the girl herself and her peers to complete the process of making meaning from FGC. However, the educational process is then brought to a halt, stopping short of explorative and critical reflexive thinking, again in line with the cultural educational goal.

The "partly open information strategy" and the "closed information strategy" described here differ in their approaches, which in turn create different pathways for gathering of knowledge, but the outcome of the education process still seems to be similar. The informants seem to end up with a relatively similar knowledge and understanding. In both approaches, the limited instruction and explanations are primarily based on tautological explanations, a closed system of knowledge taken for granted that never becomes explorative. The knowledge tends to be deeply internalized, embodied, and morally embraced. In the interviews, our informants consistently presented a limited cognitive frame of understanding that lasted until they left their home country and went abroad. Only a few informants reported that as children they had felt "it was all wrong" and directed their anger towards their mothers and grandmothers. This might indicate that the level of meaning-making is sufficient within the cultural context, and is maintained through strict conventions. It could also mean that the internalized knowledge and the FGC identity remain protected within the cultural context, but become vulnerable when challenged from outside. If the learning process stops at the level of learning metaphors, this may confuse and give unclear knowledge, rather than stimulate the development of critical reflexive thinking.[18,26,28,29]

Implications

The findings of our study are relevant to programs that target change through education with the intention of reaching a level of critical reflexive thinking. There are various types of interventions that aim at ending the practice of FGC, and the educational component is a significant element of these both in countries performing the ritual and abroad. When refugees and migrants from areas where FGC is practiced come to countries where the practice is forbidden by law, they are often met with a range of actions and programs that are intended to alter any positive views they might have had about the practice. Our study may help to provide a better foundation for understanding these immigrants' previous learning process and the characteristics of the knowledge they may have internalized. This could in turn assist in the further development of educational programs and help facilitate and differentiate the learning process by identifying and implementing educational stimuli that can promote critical reflexive thinking.

Limitations

The purposive sampling in Norway gave us participants who had been exposed to two different strategies of preparing for the ritual, and who had a variety of FGC experiences. This provided us with rich empirical data to explore the participants' meaning-making on the basis of the instruction, education, and information given to them. The quality of the reported narratives is challenged by the retrospective approach taken for this study. Interviews of children and adolescents could shed more light on how children make meaning of FGC. The meaning-making is applicable to the cultures studied, but could be more or less different in other ethnic groups. The fact that one of the interviewers was male did not appear to limit the exploration of sensitive issues in the interviews. On the contrary, several participants reported that it was a relief to talk to a complete outsider who was not a Muslim, and not even a woman.

Further research

The effect of educational programs leading to a collective convention shift is explained by convention theory.[7,8] It is our understanding that further exploration of the educational and psychological factors leading up to the shift would give additional knowledge and provide further insight for

program design. Further investigation is needed to identify what sort of educational stimuli are most effective on an individual basis in terms of enabling critical reflexive thinking on the tradition of FGC, as well as on other potentially harmful traditions. When behavior-change communication programs in a foreign setting are designed, it would be helpful to have specific research on the extent to which the individual woman can acquire new and contradicting information about FGC. Will she be able to internalize the new information as an addition to her existing cognitive structure or schemas? Or is it necessary to discard totally the old embodied and morally embraced knowledge and, if so, what would the educational process look like? And what could be the psychological and emotional cost of such a process?

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Disclosure

The authors declare that they have no competing interests in this work.

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ORIGINAL RESEARCH

Cultural protection against traumatic stress: traditional support of children exposed to the ritual of female genital cutting

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Abstract: This study explores the factors addressed in folk psychology in The Gambia for protecting the girl-child from the potential traumatic stress of female genital cutting (FGC). The type and quality of the psychological care was analyzed and compared with research on traumatic stress and principles for crisis and trauma intervention. Thirty-three qualitative indepth interviews were conducted with mothers who had supervised their daughters' FGC, women who had been circumcised, and professional circumcisers. The findings indicate that the girls have largely managed to handle the potentially traumatic event of FGC. The event is placed in a meaningful system of understanding, and the stress is dealt with in a traditional way that to a great extent follows empirically-based and evidence-based principles of crisis intervention. However, the approach tends to be culturally encoded, based on the local cultural belief system. This puts circumcised individuals in a potentially vulnerable position if they are living outside the homeland's supportive cultural context, with consequences for psychological and culturally competent FGC health care in exile.

Keywords: female genital cutting, traumatic stress, trauma-informed care, cultural psychology

Introduction

The origins of female genital cutting (FGC) are uncertain, but there seems to be an association between FGC and slavery that dates the tradition back more than 2,000 years to ancient Egypt.[1] Today it is estimated that more than three million girls in Africa are at risk of being circumcised each year, and that the total number of circumcised females worldwide is close to 140 million.[2] Opposition to FGC was articulated throughout the 20th century by missionaries and colonial administrators. Since the 1970s it has featured as a discourse in women's health, empowerment of women, and later as a subject in international human rights. Despite the long and widespread tradition, little attention has traditionally been paid to the practice by researchers. FGC was for a long time considered too intimate, culturally marginal, and eccentric to be a part of serious anthropological analysis.[3] The literature is scattered in research fields such as anthropology, demography, epidemiology, history, public health, law, social work, psychology, and political science.[4] Recent decades have seen growing interest within the fields of anthropology,[5] medicine,[6,7] and psychology.[8] This heightened academic interest can be explained by the increasing immigration from African countries where FGC is practiced, which brings the ritual closer to Western society.[3]

FGC has no known health benefits; on the contrary, it interferes with the natural functioning of the body and causes several immediate and long-term health consequences.

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First and foremost, it is very painful.[2,6] In a systematic review of quantitative studies, Berg et al[8] note that the psychological consequences of FGC are an under-researched and neglected issue. They were unable to draw conclusions regarding causality, and the evidence base is insufficient to draw conclusions about the psychological effects. However, the results from the studies in their review substantiate the proposition that a woman whose genital tissue has been partly removed is more likely to experience more pain as well as psychological disturbances, have a psychiatric diagnosis, and/or suffer from anxiety, somatization, phobia, and low self-esteem. A study of the psychological impacts on 23 circumcised Senegalese women showed a significantly higher prevalence of post-traumatic stress disorder (PTSD) (30.4%) and other psychiatric illnesses (47.9%) than in an uncircumcised control group.[9] Similarly, a study of 92 circumcised Kurdish girls in Northern Iraq revealed a significantly higher prevalence of PTSD (44.3%), depression disorder (45.6%), and somatic disturbance (36.7%) than in a control group.[10] In a sample of 66 circumcised women living in exile, the prevalence of PTSD was 16%, and 30% reported anxiety and depression.[11] These studies are generally aligned with or show a somewhat higher prevalence of PTSD than the large body of research literature which shows about 30% of people exposed to traumatic events develop PTSD or strong PTSD symptoms.[12,13]

Despite the lack of studies with a rigorous quantitative design to control for the type of circumcision and whether it was performed with local anesthesia, there is now a considerable body of qualitative and quantitative studies describing various types of FGC procedures as painful and as potentially traumatic events.[9,11,14] According to diagnostic criteria, a potentially traumatic event consists of life threat, fear, horror, or helplessness, and might lead to a PTSD diagnosis.[15] In the research literature, there has been little focus on how the girl-child is psychologically cared for and supported during and after circumcision. A healthy way of dealing with the event would be paramount to achieving the cultural goals of continuing to practice the ritual and having the girls grow up with an integrated identity as cut, proud, and honorable women. Conversely, if a large group of women suffer openly from the procedure, this would threaten the continuation of the practice. Understanding the type and quality of the psychological care given is important for understanding and tailoring culturally informed psychological care for circumcised women, adolescents, and children in Western health care systems.

This study explores and analyzes the psychological care provided for girls undergoing the ritual of FGC, and describes the common belief system underlying the provision of care in The Gambia. The psychological care given through the ritual of FGC is analyzed and compared against research on psychological care.

Materials and methods

Participants

Purposive sampling was used to increase the range of data on circumcision experience and experience of having one's own daughter circumcised. Potential informants were approached individually through Gambian networks after key persons within the networks had been provided with information about the research project. The selection criteria for the 15 women and five mothers (aged 32–60 years) were the completion of any type of FGC, and that the mothers had had their girls cut before arriving in Norway. Participants reported a range of circumcision types, with a majority having type 3 circumcisions that seal or narrow the vaginal opening, also called "infibulation". FGC is defined by the World Health Organization as all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for nonmedical reasons. The different types of procedures are classified into four main categories: clitoridectomy; excision; infibulation; and type 4, which includes all other procedures for nonmedical purposes, for example, pricking, piercing, incising, scraping, and cauterization.[2]

Three of the informants had had the procedure performed with local anesthesia or pain medication, but the majority did not. The ethnic backgrounds were from The Gambia, with two from neighboring countries and three from Somalia. Informants with their origin outside The Gambia were used to contrast and provide nuances in the descriptions of the ritual in order for the researchers to understand the specifics of the rituals performed in The Gambia. All were living in Norway at the time of the interview. The 13 circumcisers were recruited and interviewed in The Gambia; eight had recently joined a local program for preventing FGC and had stopped their practice, whereas five were still active practitioners. The circumcisers had been practicing from 3 to 50 years, most of them between 10 and 25 years. The study was also informed by research trips to The Gambia, Ethiopia, and Kenya, where medical doctors, nurses, religious leaders, elders, and anti-circumcision activists were interviewed. The authors have also attended workshops and conferences in these countries initiated by local governmental organizations campaigning against FGC.

Procedure

Several preliminary meetings with Gambian women in Norway were arranged to translate and clarify common words used in describing the procedures and rituals of FGC. Interviews in Norway were conducted in English or Norwegian, with the five mothers all using their first language. The mothers were recruited and interviewed by members of their cultural community whom we had trained in how to use the interview guide. All interviews involved semistructured and frequently open-ended questions. To capture specific childhood experiences, respondents were asked to give their own narratives about the ritual. The majority of the participants in Norway were interviewed twice. In total, we used three different translators, who also served as cultural advisors during discussions throughout the research process. One of the cultural advisors was also present in The Gambia during interviews with the circumcisers. Most interviews were audiotaped and transcribed verbatim.

The interviews with the circumcisers were conducted in a multidisciplinary way, involving four different researchers with professional backgrounds in medicine, anthropology, psychology, or education. Each of the researchers conducted two interviews individually or in pairs; in the remaining interviews, all four researchers were present. In these interviews one researcher led the interview, while the others were observers and asked clarifying questions at the end. The group of researchers and the cultural advisor attended several group discussions where the content of the interviews was discussed. This methodological approach enabled a preliminary analysis drawing on a rich range of disciplines, including medicine, anthropology, psychology, and education. The analysis was further inspired by grounded theory. In each case, the data were generated and clustered according to the following categories: folk psychology, care and protection, and dealing with potential traumatic stress. Core concepts were constructed by grouping across the individual cases. The further theoretical framework builds on the theory of psychological traumatic stress and medical anthropology.

Results

Preparing for and carrying out the ritual

In the cultural context where our data were collected, it is the mother's responsibility to prepare and make sure the ritual is carried out. Mothers are supported and supervised by their own mothers and older women. When the daughter is of the right age, a circumciser is selected on the basis of reputation, availability, and cost. If the process of approaching a circumciser is dragged out, other local women intervene, asking when the ritual will take place. The daughter's classmates will also impatiently ask questions. Mother, grandmother, and the circumciser have an initial meeting where they agree on the type of circumcision, although this is usually not a subject for extended debate or negotiation since most of the professional circumcisers are already well known, as are the types of circumcision they perform. They further agree on when and where the procedure will take place and what sort of preparation they should carry out. One central point in the preparation is to seek advice from the local marabout, a man of spiritual and religious standing. He will help to prepare "jujus", small pieces of leather sewn together with an enclosed paper with passages from the Holy Koran. Several jujus with religious power should then be carried by the mother, the child, and the circumciser. The various preparations are religious or practical in nature. In The Gambia, the true content of the ritual is kept secret from the child, who is taken to the scene covered in a hood. For weeks now, the girl has been told that the whole family is about to have a big celebration and she will get lots of presents and many of her friends will be there. The secrecy makes it exciting and the young girls are eager to participate in the celebration. The hood is protecting the girls against evil spirits and is removed on arrival. There the girl finds herself together with other girls of the same age. The cutting ritual is organized into four spheres. In urban housing each sphere is often defined by different rooms. The child is first taken to a room where mothers and family members are together with the girls, singing and dancing. Drums and loud singing are used to suppress the screams from the room where the girls are cut. One by one each girl, usually accompanied by a relative, is taken to be undressed in the second sphere in the adjacent room. She is then cleansed with holy water, and brought into the third sphere, where she is blindfolded to protect her from seeing the cutting and seeing the professional circumciser who enters the room. The girl is held down by assistants, called comforters. The circumciser performs the cutting and then leaves the room while the comforters remove the blindfold and apply herbs to stop the bleeding. Gambian mothers are not allowed to participate in the cutting procedure and they are not allowed to enter this room that constitutes the third sphere. There is a line ("caddo") separating spheres two and three, which forbids the mother from crossing into the third sphere. The mother is permitted to see and comfort her daughter only when the girl is brought to the healing room in

the fourth sphere, where she must lie to heal for 2 weeks on a mattress alongside the other cut girls. Aja from The Gambia was cut when she was 7 years old. She explains:

> I was excited but a little unsure. Initially we had fun, we were dancing to the drums. Then my cousin came. She took my hand and led me into another room. I was asked to take my clothes off, and I did. Then I was blindfolded and led to yet another room. Somebody asked me to lie down on a mattress, and they held my legs. I did not know what was about to happen. My legs were spread. Then suddenly pain – the most terrible pain between my legs. I was shocked. I hated my cousin from that very day, really hated her. She had tricked me.

Aja lay on the mattress for about 2 weeks. Urinating is extremely painful for the first days while the urine passes through the open wound. At first, the girls urinate while lying on the floor. Later in the week they are helped to the toilet. Family members arrive with gifts and praise the girls for their courage. Seven days later the cut is inspected, followed by a further inspection after 14 days. Throughout the healing period, Aja received formal instruction on how to become a woman and how to behave as a woman.

> When you lie there you are given lessons. They inform you that men will trick you. You learn about menstruation, sex education, and how to behave with men. And they say this is all a secret, you cannot tell this to others. "What happens in the room stays in the room." They say they will take you back and do it again if you talk about it. It belongs to the room.

Fatou was cut when she was 4 or 5 years old. She remembers people holding her, the cutting, the smells in the room, and the cold floor tiles. "I don't remember if I passed out and I don't remember any faces – a lot of it is blocked out." But she remembers being comforted by her mother afterwards and she remembers the gifts. After 2 weeks of healing, Fatou, the four other girls, and their mothers walked through town in a parade, as the people cheered and waved to them.

> We had nice new clothes on, our hair was braided with gold strings and people were singing. When we came home more people were greeting us and more gifts were waiting. But the strange thing is that I don't remember any feelings. I don't remember if I was happy or sad. I was just there. I think I blocked it out.

Both Fatou and Aja received variations of formal instruction during the healing period. A few in this study had been cut at an older age, in the context of the coming-of-age ritual, which involved a more extensive ritual and more formalized instruction. Large groups of girls aged 11 or 12 years stayed in a "jujuyo", a circumcision hut, out in the bush for up to 2 months. During this period they received formal instruction in traditional knowledge, ie, songs, dances, religion, cultural norms, how to behave as a woman, menstruation, pregnancy, respect for elders, and food taboos. They report good social experiences and the development of close relationships among the girls. The formal instruction was given by a designated teacher called a "Kantallalo" and was provided in the form of songs, dances, recitation, repetitions, questions and answers. It was common for the girls to establish a relationship with their Kantallalo, and they could ask questions after the formal education ended. At the end of the period the girls had to take an oath of secrecy: they swore not to speak about the details of the ritual ("what happened in the room stays in the room").

The most important task for the mother and her supporters is to make sure that the ritual takes place, to help her daughter to understand the importance of the procedure, and how to behave, so she will later be ready for marriage. Immediately after the procedure, it is the mother's duty to calm her daughter down, and to make sure she follows the healing procedures so the cutting can be approved. In the retrospective interviews, the women report either that they remember their mother had played an active role in making the ritual happen, or that they do not recollect their mother's role, or they remember she was not involved in the cutting and that she had had a hard time during the procedure. The few Somali informants in this study who were connected with their mothers through the cutting, remember that this negatively affected their child-mother relationship in the initial weeks, and then the relationship normalized.

The mothers who were interviewed all spoke of the difficult process of having their own daughters cut. They tell of uncertainty and doubts about the ritual, based on their own painful memories of the same procedure. Two of the mothers reported sleep disturbances, nightmares, and the return of strong images from their own cutting. The remaining three mothers reported moderate to strong discomfort in connection with parts of the process. All the mothers felt comfortable about not being present during the actual procedure in order to protect themselves. They found emotional support in talking with other mothers who also had the same reactions. One mother expressed her uncertainties: "I was in doubt. But talking to other mothers I realized that the advantages of cutting by far overcame my desire and need to protect my daughter against the initial pain." When they could finally have the official celebration for their daughters, this was also a

celebration for the mothers, who had completed their maternal obligation. Also, the mothers received gifts, words of praise, and acknowledgment from family, friends, and neighbors.

Circumcisers and their professional care

To become a circumciser in The Gambia one first serves an apprenticeship for 2–5 years, starting as a comforter where one assists by holding the girl, and later cleaning the wound and staunching the bleeding. The profession usually runs in the family, and one is appointed at the age of 16 years or older, after having been cut and married. Most of our sample of Gambian circumcisers work or have worked only part-time, and have additional occupations, such as being a midwife and carrying out vaginal openings prior to marriage and births. The part-time cutters report more than 100 cuttings a year; and one of the full-time practitioners reported more than 1,000 cuttings a year. The recruitment process can be as follows:

> I was 35 years old when they informed me that I should start the training. Wife number one saw that I was interested and said I could start. I showed interest because it was a tradition in the family. I wanted to learn and help support my family. I was very proud when I started as a comforter.

Circumcisers describe a range of individual preferences and smaller rituals within their performance of the cutting ritual. It is common to invoke Allah and the good spirits. Prayers and jujus are used; several practitioners report using holy water to clean their instruments. The water becomes holy when small pieces of paper with writing from the Koran, prepared by the marabout, are dissolved in the water. The belief is that Allah and the good spirits will guide the circumcisers through the cutting and protect the girl from evil spirits. The selection of days is also important; Fridays and Sundays are viewed as "Allah's days, they enhance the closeness to Allah and his protection". Further, it is "better to cut in the morning or during the winter when the air is cooler because this prevents the blood from running freely from the wound". The circumcisers are very passionate when telling about their special herbal blends that help the wound to heal and chase away evil spirits that might cause problems. These recipes are handed down through generations, and the blend of herbs and their healing effect contribute to each practitioner's personal reputation.

Reasons for cutting and changes in the education process

It was never necessary to explain to mothers why they should circumcise their daughters. As one practitioner with more than 30 years experience said:

> Everyone did what they were supposed to do. No one ever refused … we got them all. It is a tradition, you know, and we have always done it.

When asked what would happen to those who don't carry it out, the unambiguous answer was that there is no option. It was further argued that Allah wants them to carry it out in order to make them clean and honorable women, it prevents sexual desire, and the cutting constitutes who they are as a group. It is also commonly argued that the ritual serves as a way of building character, and that handling the pain is a part of being a proud and courageous woman. As one circumciser explained:

> It is a very quick and easy procedure. They scream, you know, because it is painful. Some try to be brave and not scream. To become a woman you need to have courage, you have to be brave. That's what it is all about, being a woman. And yes, pain is a part of it.

The circumcisers report several recent changes in the ritual for two major reasons, ie, public campaigns and health issues. Because there have been campaigns to end FGC in the region and there is "information going around that it is a bad practice", people tend to minimize the ritual and the ensuing celebrations:

> The most important thing is to get it done – therefore we scale down the celebrating to make less fuss about it. The celebration is not the most important part, the cutting is … to get the girl clean.

Other reasons mentioned were that the celebrations are a costly practice, and, since there is a tendency to cut younger girls, they will not profit from the lengthy training that was originally involved. Another change is that it is no longer common to have big groups of girls circumcised together; now it is more private and individualized. This also means that the instruction is now more privatized, as opposed to the traditional formalized and community-based education which today has generally become institutionalized within the regular Gambian school curriculum.

The younger practitioners report that there are health concerns involved in cutting older girls:

> Now we cut them as early as possible because the older they are the more they get afraid and they can have more problems. The older children react more strongly and they bleed more. A child's body has a special healing capability; they heal very fast. I prefer them to be from one month to one year, maximum three years old.

> For the older girls the shock might be too much for them. They react strongly and can behave strangely. Therefore we have to take them earlier. Some cry, some get angry at their mothers. And some just get up without showing any feelings at all.

A commonly held view among practicing circumcisers is that it was the old practice that was harmful. Now important changes have been introduced: clean razor blades are used, they cut younger girls and less is removed, and sometimes local anesthesia and painkillers are administered. When asked about problems in not being able to staunch the bleeding or the possibility of death after performing the cutting, they acknowledged the possible dangers of bleeding to death. But most of the circumcisers we interviewed did not see any direct link between the cutting procedure and possible death. Hemorrhaging and possible death were caused by evil spirits, and had no direct causal connection with the cutting itself.

Circumcisers in The Gambia often use drums, loud singing, and blindfolds to protect the girls from hearing screams and seeing the cutter. They explain that the girls should never know who cut them, otherwise they might point out that person and frighten uncut girls. It is stressed that uncut girls should know as little as possible about the circumcision prior to the ritual. Such knowledge would only upset the child and make her run away and increase the risk of "difficult" situations during the cutting. "They are protected because they have no idea what's going to happen."

Reactions

When the women in this study were asked whether they could remember their circumcision, they all had clear recollections of it; some were even puzzled by the question. One woman said: "(…) it is all recorded down to every detail as if it was a film. My problem is not remembering, but trying to forget." She experienced periods of frequent nightmares and seeing images of her own cutting, which caused concentration problems and energy loss and could make it hard for her to function normally. The majority recalled that immediately after the cutting procedure they had "strong reactions that lasted for weeks". The negative reactions described were varying degrees of pain, anxiety, being scared, numbing, disbelief, betrayal, and anger at the mother. The effects on mother-daughter relationships seemed mostly short-term. But after exposure to arguments against FGC, usually in exile, several of the women said they experienced substantial emotional challenges in their relationships with their mothers. These were expressed as frustration, sadness, and anger, as well as a loss of trust in letting the grandmother be around her grandchildren, due to a fear of her organizing a cutting ritual. More than one third of our informants reported occasional PTSD symptoms as adults; such trauma-related symptoms became more pronounced, more frequent, and stronger in exile. It was only in exile that most of the women became aware that FGC is viewed as a health threat, physically and psychologically, and as a violation of the rights of the child. After being exposed to other views of FGC, they established a connection between their own symptoms and FGC.

There were also reports of positive reactions. Some respondents clearly remember all the gifts and the festivities of the homecoming ceremony, and how women were praising them. Several informants said that, at the time, they viewed this as a very proud moment in their lives. They were proud that they had managed to complete the ritual, and were curious about what now lay ahead of them in their new position.

Discussion

Five principles of trauma intervention

The structure of the ritual frames and defines the provision of care. The traditional FGC ritual can be divided into three phases, ie, cutting, seclusion and instruction, and finally the returning home ceremony.[16] Comparison between the preventive measures included in the ritual and results of research on effective crisis intervention show several similarities. There are consensus reports and international guidelines of evidence-based and empirically-based research that define intervention and prevention efforts following disasters, mass violence, domestic violence, and sexual abuse.[17–23] The intervention and prevention principles are overall the same, even though the practical unfolding of care would differ depending on the type of crisis, level of exposure, and individual factors. We find it relevant in this study to apply the general principles in the comparison with the care built into the FGC ritual due to the generalized manner of the principles. Hobfoll et al completed a comprehensive review of intervention research for those exposed to disasters and mass violence, and reviewed related fields of research.[23] Five empirically supported principles were identified; these have become widely accepted and are used to inform intervention and prevention efforts for the early to mid-term stages, ranging up to 3 months after the critical event.

The first principle is to promote a sense of security. When people are forced to respond to an event that threatens their lives, their integrity, or their loved ones, many report initial negative post-trauma reactions. Disaster-affected populations have high prevalence rates of mental health

problems, including acute stress disorders, PTSD, depression, incident-specific fears, phobias, somatization, traumatic grief, and sleep disturbances.[24] These post-trauma reactions tend to persist under conditions of ongoing threat or danger, and have been shown in studies of a range of cultures.[25] When security is introduced and maintained, reactions tend to show a gradual decline over time.[23] The circumcision rituals in our study involve a formalization of providing feelings of a sense of security and safety immediately after the potentially traumatic event by having the child reconnect with her mother. For children and adolescents, connection with parents is the primary goal in disaster-related interventions.[26] First separating the mother from her daughter and the scene of the painful cutting, and then bringing her into the healing room for comfort, seems to be a way of protecting the important mother-daughter relationship, allowing the mother to retain the vital position of being able to help and support her daughter. If the girl should feel betrayed and lose trust in her mother, the mother still has the chance to try to rebuild that trust and confidence. Throughout the ensuing healing period, all the mothers remained close by, making frequent visits that helped to rebuild and reinforce the child's sense of security. At least one mother was present at all times in the healing room, to make sure the girls were behaving appropriately, to provide assistance for toilet visits, and to ensure the girls did not share negative chat, spreading rumors or scaring each other. The mothers also provided food and small presents.

The second principle involves the promotion of calming. The research review indicates that individual initial responses of experiencing some anxiety, heightened arousal, and numbing responses are normal, and even healthy. The problem appears if these reactions remain at a heightened level and interfere with daily life, sleeping, eating, and decision-making. Most individuals will return to more manageable emotional levels within days or a few weeks. Persistent or extremely high emotional levels may lead to panic attacks, dissociation, and later PTSD. Hyperarousal can have a major effect on risk perception, so that the surroundings are perceived as potentially harmful beyond reality. In response to elevated levels of fear, processes of avoidance behavior may appear. Thus it is advisable to include calming as a key element in care intervention.[23] In the circumcision cases in our study, calming is effected in the seclusion and instruction part of the ritual, starting with the reconnection with the mother. The mother becomes a role model, calm and proud, and helps to regulate and shape the daughter's emotions by her own example. The mother explains that it is alright to be afraid and scared, and it is normal to feel pain: this is how it is supposed to be. In this way, she works to normalize the reactions. This involves another key intervention principle, ie, to enhance calming by helping the affected individuals to see their reactions as normal, accepted, and expected. As such, the mother's explanation is limited and would not qualify under the intervention principle referred to as "psychoeducation," which can have a calming effect by explaining the nature of how and why the body reacts to traumatic stress. All the same, the explanations given by mothers and the instructors do seem to be of a normalizing character.

The third principle, promoting a sense of self-efficacy and collective efficacy, is about re-establishing a sense of control over positive outcomes in one's own life. Bandura describes self-efficacy as the individual's belief that their actions are likely to lead to generally positive outcomes.[27] In our study, the women present in the healing room instruct and teach the girls how to behave in order to achieve proper healing and how to relieve pain when urinating. The children also face a motivational challenge, having to lie still for up to 2 weeks. The mothers explained how they had to keep motivating the girls to stay patient, so that they can heal properly and pass an inspection of the cut. Our respondents report a consequent line of praise that in various ways gave feedback on how courageous they had been in managing to bear their pain and carry out the necessary procedures. During this process, the girls are helped to break down the challenge into smaller, more manageable units of time, and they get praised for this. Strategies like this help the girls to gradually regain self-efficacy, a sense of control, and predictability in their lives.

Antonovsky describes collective efficacy as the sense of belonging to a group that is likely to experience positive outcomes.[28] The group focus is stressed throughout the healing period by conversations with the girls and the Kantallalo, the designated teacher. The formalized instruction involves a clear presentation of why the procedure is important and had to be completed. All our respondents had received this type of instruction, and all reported that after participating in the ritual they had no doubts about the importance of the procedure.

The fourth principle, promoting connectedness, relates to the large body of research on the central importance of social support and sustained attachments to loved ones and social groups in dealing with stress and trauma.[23,29] Being socially active improves the possibilities of engaging in a range of supportive activities like practical problem-solving, sharing of traumatic experiences, normalization of reactions and experiences, and sharing of coping strategies. Of the five

principles mentioned here, promoting connectedness is probably the most empirically validated, but there has been little empirical research on how to translate this into practical interventions.[23] Nevertheless, connectedness stands out as probably one of the strongest protective factors in traditional rituals, including circumcision.

The healing period is the beginning of the seclusion and instruction phase, which in the ritual theory of transitional rituals is defined as the liminal phase.[30] This is a transitional phase for healing and learning, as well as getting the cut approved before the girl can enter her new position as a "clean" girl ready to become a woman. In The Gambia, this liminal phase traditionally lasts for up to 2 months. Liminality as practiced in tribal rituals often includes elements of homogeneity, equality, anonymity, absence of property, humiliation, total obedience, maximization of the religious (as opposed to the secular), and acceptance of pain and suffering.[31] Our informants report establishing bonds and close relationships with the other girls who become fellow companions, sharing the same experience and faith. This phase is constituted by something out of the ordinary. It has what Turner would call an "anti-structure," and provides the opportunity to establish "communitas", ie, a feeling experienced here and now of spontaneous fellowship among persons reaching towards a perfect state of unison.[31] The older women in our study referred to social involvement, strong feelings of communitas, and the establishment of close and long-lasting relationships with the other girls. By contrast, such descriptions were not heard from those who had been cut at an early age or who had shorter more privatized rituals. The strength of the formalized rituals' potential for care lies in the various stages of connectedness.

The fifth principle, promoting hope, is the final key principle proven to be of central importance for mass trauma interventions. Those who can remain optimistic are likely to have more favorable outcomes after experiencing mass trauma, because they retain a reasonable degree of hope for their future.[32] Instilling hope is crucial, because trauma is often accompanied by feelings of a truncated future, a shattered worldview, and catastrophe.[23] Antonovsky describes a state of hope as the "sense of coherence" when one's external and internal environments appear predictable and one feels there is a high probability that things will work out.[28,33]

One of the circumcisers formulated the meaning of pain: "To become a woman you need to have courage, you have to be brave. That's what it is all about, being a woman. And yes, pain is a part of it." The importance of the procedure was communicated and repeated to the girls throughout the ritual:

> This is what will turn you into a proud and honorable woman, so that you can get married, have children and ultimately live a good life. That is the meaning of the ritual and it is the meaning of the pain. And those who have endured it have every reason to hope for a good life, and benefit from a positive self and collective efficacy that all circumcised women will have a successful life. You will also realize that you now belong to a special group, the group of circumcised adolescents and women: you are one of them.

The traditional ritual structure has incorporated an intentional closure of the possible traumatic memory by making the girls swear an oath of secrecy:

> What happened in the room stays in the room. You could talk about the traumatic memories during the seclusion and instruction phase, but not afterwards. Instead, you were encouraged to treat the memories as something belonging to the past, something "belonging to the room".

Role of the mother

In the seclusion and instruction phase, the mother seems to be the main provider of mental health care. She is helped by the structure of the ritual to organize and provide care at various stages, assisted by the other mothers, who together share the responsibility for caring and looking after all the girls in the healing room. She is instructed and advised by the circumcisers on what to do in order to promote the healing process, medically and spiritually. The mother is further advised by her own mother and by the other grandmothers. The grandmothers have experience; they take responsibility for the planning, organizing, and follow-up of the ritual and they are close at hand to support their own daughter in her duties. Finally the mother, often together with her own mother, may consult the marabout for spiritual advice.

During preparations for the ritual, mothers might feel uncertain. "I was in doubt. But talking to other mothers I realized that the advantages of cutting by far overcame my desire and need to protect my daughter from the initial pain." The ritual provides the mother with meaning and sufficient comfort to go ahead with the procedure. To a large extent, this structuralized empowerment of the mother provides her with the core principles of the five essential elements of trauma intervention. Again there is a focus on collective efficacy, and the returning home ceremony is as much a celebration of the mothers and their accomplishments.

In recent work on improving pediatric care, there has been a particular focus on the prevention and treatment of pediatric medical traumatic stress (PMTS).[34] PMTS is defined as a set

of psychological responses of children and their families to pain, injury, serious illness, medical procedures, and invasive or frightening treatment experiences. It is reasonable to put FGC, as described in this paper, in the category of an invasive or frightening treatment and a potentially traumatic event for a child, and perhaps for her mother. Recent decades have seen a gradual change from a clinician-oriented and disease-oriented focus towards patient-centered care, where the patient and the family are actively informed and involved in the treatment process, and several studies have shown that such an approach is associated with better clinical outcomes.[35] The Institute of Medicine has recommended that US health care delivery systems become patient-centered, and has outlined an empirically valid treatment model.[36] Comparing the FGC health care delivery described here with the research-based treatment model, we find that they are only partly similar. The way mothers are informed, empowered, and included in the treatment is up to the full standard of the research-based model. The significant difference lies in the lack of information and direct communication with the child prior to the procedure. There are many variants of FGC rituals, however, and the traditional way the ritual has been performed in Somalia would appear to be more in line with standards of informing and motivating a patient before a procedure (for descriptions, see Schultz and Lien).[14]

This study adds to the body of qualitative and quantitative studies describing various types of FGC procedures as painful and as potentially traumatic events that can lead to symptoms of PTSD or a full diagnosis thereof. The World Health Organization has reported an increase in medicalization of the FGC procedure. More than 18% of FGCs are currently being performed by health care providers with access to health care knowledge and medication.[2] When defining types of FGC procedures as potentially traumatic events, this is based on the sudden and lasting pain and the child's lack of understanding and control during the critical event. If appropriate administration of pain medications and explanations were provided for the child, the potential for FGC to be a traumatic event would probably be reduced.

Changing culture, beliefs, and reactions

Why did more than one third of the informants develop pronounced, frequent, and strong psychological symptoms connected to their circumcision after leaving their home cultural context? If we approach this from the angle of medical and psychiatric anthropology, it could relate to the classical and controversial question of how cultural conceptions of sickness influence the prevalence, symptoms, and course of a particular disorder. The work of Arthur Kleinman has shed light on the cultural construction of the illness experience as an individual and socially adaptive response, distinguishing between disease as the malfunction of biological and psychological processes and illness, which refers to the psychosocial experience and meaning of the perceived disease.[37] Commonly, a disease will have a typical course and characteristics independent of the setting, whereas an illness is more or less unique. Kleinman goes on to explain that the illness then becomes the shaping of the disease into behavior and experience; thus, illness must be understood within a specific context of norms, symbolic meanings, and social interaction. In our study, the mothers and older circumcisers all said that there had been no symptoms related to the cutting procedures. Any complications that occurred were seen as related to other factors, like evil spirits. Younger practitioners were influenced by the cause-and-effect thinking of anticircumcision campaigns, but justified the current cutting procedure because they had altered some of the "old procedures". In other words, here we could also see no causality connected to the cutting itself and later symptoms, and no recognition of any illness or linking such symptoms to the cutting. Without actually having an illness, there is no significance attached to the disorder and no symptoms to identify or report. This line of reasoning might indicate that, due to the lack of cultural recognition that illness could be linked to FGC, the symptoms did not become shaped into an illness until the woman was living in a different cultural setting, in exile.

Another line of reasoning is that the psychological care given was largely effective, but the previous care did not prove sustainable when the original belief system underwent change in exile. There are indications that, when moving from a society practicing FGC to a society with laws against the tradition, a significant number of individuals will tend to become skeptical, change their attitude, and finally reject or end the practice. This attitudinal change is partly explained by being exposed to and gradually being influenced by a new set of values.[14,38–40] Johnsdotter shows how the culture upholding FGC in Somalia is context-specific, and how each and every one of these aspects is challenged in exile.[41]

To further understand aspects of the attitundinal change, Schultz and Lien explored the type and quality of children's acquired knowledge of the ritual.[14] We found that the limited instruction and explanations the children received were based primarily on tautological explanations at the level of metaphorical learning, producing a closed system of knowledge that was taken for granted. The learning process

was carefully monitored and regulated, and was brought to a halt before critical reflexive thinking could set in. Such knowledge tends to be deeply internalized, embodied, and morally embraced. The informants possessed a limited cognitive frame of understanding that lasted until they left their home country and went into exile. The structure of this knowledge is what has to be changed, altered, or replaced in order to give way to new knowledge and new values. A further study by Lien and Schultz shows that replacing deeply internalized, embodied, and morally embraced knowledge of FGC can be a long, hard, and painful process.[42] We found that the new information could be met with resistance, disbelief, and ridicule. Those women who internalized the new knowledge and mentally "hit bottom" experienced an epistemological pain. As one informant explained: "I used to be a proud woman, but when I got information about FGM, I lost my pride and came to see myself as a victim of a harmful tradition. I fell into a deep depression and cried. Then I started to work against the tradition, and was proud again."[42]

Converting to a new system of belief and knowledge will force a shift in attitude, from seeing oneself as a clean and honorable woman, perhaps without a clitoris and infibulated, to seeing oneself as a mutilated woman and/or abused child, robbed of her sexuality and injured for life. Knowledge from the new exile context can be painful to internalize because it will contradict the idea of an honorable and proud woman based on FGC and perhaps lead to a feeling of shame instead of pride. The mother goes from having helped her daughter to a successful life in their home country to violating her daughter's human rights, and even risking prosecution and possibly jail in the exile context.

In a study of FGC among Somali women in Norway, Johansen concentrated her analyses on the subjective experience of the associated pain, and found that the experience of pain related to the procedure is deeply inscribed mentally, emotionally, and physically.[43,44] Johansen argues that acute pain, as well as intolerable pain, is not necessarily affected by the cultural models that justify it, rather it is so overwhelming that it is an "anticultural experience", ie, a counterpoint to culture. Women in her study did not easily talk about their pain. Some identified three painful events related to infibulation, when the procedure was done, the opening procedure at marriage, and the need for further opening while giving birth. Johansen argues that the anthropological literature on FGC seems to have ignored the importance of the pain experience. "Pain" was, in Johansen's study, the major argument that the bearers of the traditions held against continuation of the practice.

In our study, we can identify the descriptions of immediate pain as an "anticultural" experience, as found in Johansen's study. But the pain does not remain anticultural. As the physical pain resides and the meaning-making process continues, the experience becomes culturally encoded. Later, when the culturally encoded meaning is challenged and possibly lost in exile, the protective factors embedded in the cultural meaning-making seem to weaken, once again revealing the pain and the FGC experience as an anticultural experience without the cultural protection. What is challenged is the woman's very identity, due to the upheaval and renewal of her belief system. When the meaning disappears from the old belief system, the woman discovers that she has been lied to. Not only that, the person who lied the most was the one who also helped the most, ie, her own mother.

Conclusion

We have shown how crisis intervention principles empirically based on research are already built into the ritual of female circumcision in The Gambia. After the cutting, which might meet the criteria for a potentially traumatic event, the girls are provided with a sense of security over the next few weeks, in that they are calmed down and encouraged through the healing period. They are supported in building an understanding of the importance of the procedure, and manage to establish emotional equilibrium after the event. Self-efficacy is empowered; indeed, connectedness and collective efficacy, the feeling of belonging to a group, emerge as strong factors. The ritual is completed with a homecoming ceremony where the girls are cheered and praised. The girls are proud of their accomplishment and also curious and hopeful about their new status, position, and future identity as proud and honorable women in society.

Intervention principles were incorporated into the ancient ritual structure long before the principles became empirically sound in the fields of psychology and psychiatry. The ancient ritual structure provides the participants with care in an organized form. The marabouts, circumcisers, and grandmothers are all considered specialists in their fields; together they systematically empower, educate, and assist the mother so she can support her child. The mother is the main provider of mental health care, and gives her daughter guidance to sustain the effort needed for recovery. This deliberate empowerment of the mother and her active participation in the healing process is particularly in line with recent principles of client-centered and family-centered care. Having said this, it is necessary to point out that the principles of care are not necessarily built into the ritual to protect the girl-child. The care might equally be put in place as a necessary means to

ensure the mother enforces the cutting as well as protecting the culture and the ritual itself to make sure it is carried out across generations and centuries.

Our findings indicate that, to a large extent, the girls have learned to deal with the potentially traumatic event of circumcision. The event is placed in a meaningful system of understanding, and potential traumatic stress is dealt with on the basis of crisis intervention principles recognized in recent research. This seems to have contributed to fostering the girls' resilience.

On the other hand, more than one third of the informants reported trauma-related symptoms that they, mainly in exile, linked to their circumcision; moreover, these symptoms became more pronounced, more frequent, and stronger after the women were living in exile. From a medical anthropology viewpoint, it can be argued that the illness must be understood within a specific context of norms, symbolic meanings, and social interaction. Without a cultural recognition of any medical or psychological consequences of the FGC procedure, there is no significance attached to the disorder and no symptoms to identify or report. We can further argue that even if the traumatic event has been dealt with on the emotional level, the culturally encoded intervention remains deeply rooted in the traditional cultural belief system. That belief system consists of ideas and knowledge about FGC on a metaphorical level, deeply internalized, embodied, and morally embraced, all constituting a framework of meaning. Then, when the woman is exposed to another belief system that disapproves of and even criminalizes the practice, her culturally encoded therapeutic intervention is severely challenged. This puts circumcised females of all ages in a potentially vulnerable position when they live in exile, far from the supportive cultural context of their homeland.

Most informants in the study had had a medium-length ritual of 2–3 weeks, which is considerably shorter than the traditional ritual in Gambia, that used to last for up to 2 months. Today girls in The Gambia are cut earlier, and with less ritual and less formalized education. This finding from our interviews is supported by several studies that indicate how FGC has changed, with the procedure being conducted on younger girls and with less ritual fanfare than before.[38,45,46] When the ritual is shortened and changed, the built-in protective factors are weakened and the ritual gets stripped of many of its therapeutic functions. Thus, the medicalization of the ritual with the use of pain medication might reduce the potential of the procedure to be a traumatic event.

Due to the scarcity of research on the psychological consequences of FGC, it is a challenge to provide circumcised females in exile with psychologically and culturally competent care. In order to individualize psychological care, practitioners in the health care system should be encouraged to explore and familiarize themselves with the previous kinds of care provided during the ritual. Knowing and understanding the underlying protective factors and coping strategies previously proven to be effective in other cultures can help practitioners within the health system to assist in the rebuilding or empowering of coping strategies.

Limitations

The primary data sources of this study and indepth interviews of circumcisers, mothers, and cut women provide a rich set of data to address the research questions. The selection of informants also provided limitations to the study. Our retrospective qualitative interviews could not in a precise way differentiate between the psychological reactions that the women had experienced as children and adolescents. Nor could they precisely describe the FGC experience which happened decades ago. It is likely that descriptions of being afraid, being in pain, and other reactions and feelings would have been told differently if newly cut children were interviewed. Such a description, from a child's perspective, is lacking in the FGC literature. We refrained from interviewing children due to legislation and ethical challenges. Moreover, it proved difficult to recruit mothers in exile, because of Norwegian legislation against FGC, so we could not achieve the desired variation in the sample of mothers who had had their daughters circumcised. Nor did we have adequate variety in the sample of women who had undergone all the various types of FGC, with and without pain medication, and FGC performed in a medical setting with professional medical care. We also lacked a variety of women in exile who did not suffer from mental health problems related to FGC.

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Disclosure

The authors declare no conflicts of interest in this work.

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I'm not as bright as I used to be – pupils' meaning-making of reduced academic performance after trauma

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ABSTRACT

Post-traumatic stress disorder (PTSD) is associated with temporary, distinct cognitive impairment. This study explores how cognitive impaired academic performance is recognized and explained by young Norwegians who survived the Utøya massacre of July 22, 2011. Qualitative interviewing of 65 students (aged 16–29 years) was conducted 2.5 years after the traumatic event. A total of 25% (n = 16) respondents reported no or no distinct change; only 6% (n = 4) reported some degree of positive change. By contrast, 69% (n = 45) reported negative changes in academic performance, with impaired concentration and feelings of chaos. Previously effective study techniques became less effective or inadequate. Respondents worried about lasting impairment of academic functioning, but reported little or no discussion with teachers. From the characteristics of the changes reported, attribution style, the use of metaphors and narrative structuring, we identify differences in the meaning-making processes of these young people. Some were left with an understanding that negatively affected their help-seeking activity and reduced the willingness to accept adapted education post trauma.

KEYWORDS

Traumatic stress; meaning-making; metaphors; teacher role and adapted education

Introduction

Traumatic stress and academic performance

Mass trauma events such as terrorist attacks and natural disasters may be unpredictable, take various forms, and create societal chaos and disruption (Pfefferbaum et al., 2014). Adolescents' reactions to such disasters vary. Although most adolescents do not develop psychiatric conditions as a result of their exposure to a potentially traumatic event, many experience levels of distress that tend to subside naturally over time (Alisic et al., 2014). An event is considered "potentially traumatic" when exposure includes direct or indirect experiences of actual or threatened death or serious injury; post-traumatic stress disorder (PTSD) is a potential outcome from traumatic exposure (American Psychiatric Association (APA), 2013). The complexity in disaster settings is challenging for professionals seeking to develop and deliver disaster interventions – they must consider the various characteristics and needs of the population in question as well as characteristics of the disaster itself (Pfefferbaum et al., 2014). Studies of terrorist attacks and natural disasters provide a growing research base for predicting reactions and symptom levels and the need for post-disaster follow-up – immediate and long-term. A review of 60,000 disaster victims from 160 samples (Norris et al., 2002) found that school-age youth were more likely to be affected than adults. Further, exposure to events of mass violence such as terrorism and shooting sprees tended to result in higher symptom rates than the case with natural disasters. PTSD is among the most-observed post-disaster reactions among youth, followed by depression and anxiety, with prevalence varying according to the type and aspects of the disaster. In most samples in the Norris et al. meta-study, up to one third of school-age youths showed considerable PTSD symptoms post-disaster, generally peaking during the first year after exposure, followed by gradual improvement. However, for a significant minority of participants, symptoms lingered for months and years (Norris et al., 2002). Another meta-study of more than 3500 trauma-exposed children and adolescents showed an overall 15.9% rate of PTSD, varying according to the type of trauma and gender. Least at risk were boys who had experienced non-interpersonal trauma, such as natural disasters; most at risk were girls exposed to interpersonal trauma (Alisic et al., 2014).

The negative impact of trauma on cognition is increasingly recognized. A new symptom cluster, "Negative alterations in cognitions and mood" was included in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5: APA, 2013). In order to fulfill

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the PTSD criteria, two out of seven items from this cluster needs to be identified. DSM-5 draws on a strong foundation of studies for describing categories of potential symptoms of traumatic stress – behavioral problems, cognitive implications, somatic distress, and psychological reactions – all of which might interfere with learning. Further, numerous studies on cognitive implications have shown PTSD to be associated with cognitive deficits leading to poor cognitive functioning. The neurocognitive domains most commonly affected are episodic memory, attention, executive functioning, and speed of information processing – with the severest effects observed in verbal immediate memory and attention/working memory (see Malarbi et al., 2016: Scott et al., 2015). PTSD-related cognitive deficits are generally described as mild, temporary cognitive impairment (APA, 2013).

Several studies have investigated how trauma influences academic performance and functioning. A systematic review of research from 1990 to 2015 (Perfect et al., 2016) included 83 quantitative studies, with the focus on school-related outcomes of trauma exposure and traumatic stress symptoms in students. The review found that youth with cumulative or severe exposure to traumatic events were at significant risk for impairments in cognitive functioning, academic difficulties, and social-emotional-behavioral problems (Perfect et al., 2016).

However, there has been less research on how changes in academic functioning are experienced by the students themselves, and how impaired academic performance can be dealt with within an educational context by providing educational interventions.

Meaning making

In this study we explore aspects of the context of being a young person in school after having experienced trauma. We employ a meaning-making approach to the qualitative data, investigating conceptualizations of reality through the narrative and metaphorical linguistic structures (see e.g., Bruner, 1990, 2005; Fauconnier & Turner, 2008; Lakoff & Johnson, 2003). These are frames for thinking that influence how we feel and act. The narrative structures events temporally, and includes most often concepts of reason and cause. Narrative and metaphorical schema form the cognitive basis of any meaning making. Under the broader term of "meaning making," the cognitive metaphor theorists Johnson, Lakoff and Turner have created a new phenomenological field in recent decades. They define the cognitive as "any mental operations and structures that are involved in language, meaning, perception, conceptual systems, and reason" (Lakoff & Johnson, 1999, p. 13); the basic structures are narrative and metaphorical (Turner, 1996). Narrative psychology holds that, in terms of how we think and act, our ordinary conceptual system is fundamentally metaphorical in nature (Lakoff & Johnson, 2003; Polkinghorne, 2005). Our concepts structure what we perceive and how we relate to other people. We think and act rather automatically along certain lines, with the conceptual system playing a central role in defining our everyday realities (Lakoff & Johnson, 1999, 2003). Essentially, a metaphor involves understanding and experiencing one domain in terms of another, where we grasp the meaning through other concepts that we understand in clearer terms. Matters requiring metaphorical definitions are concepts that are not clearly defined in everyday language, such as emotions and abstract thinking (Lakoff & Johnson, 1999, 2003).

We tend to use two different categories of metaphors in our discourse – cognitive metaphors, which largely constitute our everyday language; and innovative, or poetic metaphors, which reflects creative capacity. Both types build on the human capacity to create similarities between two distinct domains or phenomena. However, cognitive metaphors are less products of innovative linguistic creativity: rather, they are building blocks in the linguistic system that constitute language and part of larger systems emanating from language (Lakoff & Johnson, 1999, 2003: Turner, 1996). Cognitive metaphors may have the opposite effect on our thinking than innovative metaphors. Instead of bringing new insights and creating new meanings and understandings, they may capture and lock our understanding in everyday thinking in accordance with widely shared "folk theories." To view metaphors as creative and innovative implies that some metaphors assist us in understanding aspects of reality that they themselves help to constitute (Black, 1996). Such innovative metaphors open up our thinking, enabling us to perceive reality in new ways.

The study presented here explores how school pupils exposed to a traumatic event have recognized and explained PTSD-imposed cognitive impairment as influencing their own academic performance. Characteristics of their meaning-making process are analyzed based on their use of differences in attributing self-observed changes in academic functioning, their narratives and the use of metaphors.

Method

Context

On July 22, 2011, a car bomb exploded outside the main government building in Oslo, Norway, killing eight

people and injuring more than 200. The perpetrator then headed for the small island of Utøya, where the youth organization of the Norwegian Labor Party was holding its annual summer camp. There he carried out a massacre that lasted for more than one hour. In all, 69 persons were killed, many were injured, and 56 were hospitalized.

In connection with the Utøya Research Program, 490 survivors and their parents were invited to participate in semi-structured face-to-face interviews conducted 4–5 months (wave 1), 14–15 months (wave 2), and 31–31 months (wave 3) after the massacre. (See Dyb et al., 2014 for details of this research program.) In the first wave, 325 participants were recruited, 245 of whom were part-time or full-time students. These survivors had been directly exposed to a life-threatening situation where they experienced extreme trauma, trapped on a small island of only 26 acres. All heard gunshots; most of them hid or ran from the terrorist (96.9%); many witnessed someone being injured or killed (64.1%) or saw dead bodies (86.7%). Furthermore, 96.3% reported having lost a friend, which indicates a high degree of bereavement and loss. Post-traumatic stress reactions in survivors were significantly associated with general mental-health problems, functional impairment, and reduced life satisfaction four to five months after the terrorist attack (Dyb et al., 2014). Symptoms above the clinical cutoff for PTSD were found in 22.0% of those interviewed at wave 1, 8.4% at wave 2, and 7.7% at wave 3. The proportion of those with clinical levels of anxiety and depression symptoms was 44.8% at wave 1, 29.1% at wave 2, and 24.5% at wave 3 (Stene et al., 2016).

Trauma reminders are a part of the diagnostic criteria for PTSD (DSM-5: APA, 2013). They are described as psychological distress and/or physiological reactions to cues that symbolize or resemble some aspect of the traumatic event. Findings from the second wave indicate that trauma reminders were common 14–15 months after the massacre: 33% reported experiencing at least one trauma reminder often or very often in recent months, whereas only 7.4% had not experienced any at all. Auditory reminders were reported to be especially frequent and distressing (Glad et al., 2016a). At the third wave, 2.5 years after the massacre, almost 20% of the survivors reported being very distressed by their worst memories of the event. Findings indicate that distressing reminders are relatively common and may play a central role in the development and persistence of PTSD (Glad et al., 2016b). Although 48.4% of the survivors rated their health as "excellent" or "very good" 2.5 years after the event, 37.7% said that their health had worsened; and 16.5% reported very high/high current need for help in dealing with psychological reactions (Stene et al., 2016).

The year following the attack a study investigated survivors' (N = 237) perceived academic performance and wellbeing, showing 61% (n = 143) reporting impaired academic performance and 29% (n = 66) impaired school wellbeing. Female survivors more often reported impaired performance. Sleep problems, post-traumatic stress, anxiety/depression, somatic symptoms, and lower life satisfaction were associated with both impaired academic performance and impaired wellbeing. The findings demonstrate how severe trauma can affect young survivors' academic performance and wellbeing at school (Stene et al., 2018). Another study investigated academic performance in survivors (N = 64) who had successfully completed their three-year senior high school program. Their registered grades were compared against the national grade point average, before and after the event. The results showed that academic performance was reduced in the year immediately after the traumatic event, but for students who completed high school successfully, the school situation improved two years after the traumatic event. These findings underscore the importance of keeping trauma-exposed students in school and providing longer-term support (Strøm et al., 2016).

Participants and procedures

For the study reported here, 68 participants were selected from the third wave (N = 261) of the Utøya research program. These 68 informants, selected as a purposive sample, were assigned to nine interviewers according to geographic proximity. Experiencing PTSD symptoms was not a selection criterion. Three pupils were omitted from the study because they had dropped out of school early. At the time of the interviews, respondents ranged in age from 16 to 29 years (mean age: 21): 38 males and 27 females. All 65 had been students (junior high school, senior high school, college/university) during at least part of the period after the traumatic event and until 2.5 years after. The study was approved by the Regional Committees for Medical and Health Research Ethics, South-East and North.

The nine interviewers, including the two authors, were trained by means of a qualitative interview guide to achieve a common approach and minimize personal differences during the interviews. Participants were interviewed in face-to-face qualitative interviews with an open-ended prompt: "Think back on your school situation after July 22, 2011. Please give examples of how your experiences from July 22 have affected your schooling." This prompt provided a direct association of school functioning as being affected by the massacre. The interview guide gave instructions for stimulating

free narratives concerning the broader school situation and for ensuring that aspects of learning and social environment were included. Interviewers were followed up by the two authors, who discussed experiences and made sure the interview guide had been followed. The interviews were conducted with a high degree of similarity among the nine interviewers. All interviews were audiotaped and transcribed verbatim. Responses lasted from two minutes to more than half an hour.

Academic achievement or *performance* is defined as to which extent students have achieved their educational goals, whereas *academic functioning* usually refers more to the cognitive process of learning.

Analysis

This explorative study examines various aspects of being a young person in a school context after having experienced a potentially traumatizing event. The analysis is phenomenological, searching for and describing how informants construct meaning of their self-observed changes in academic performance. Using an inductive approach, each author worked separately with the transcripts before discussing and conceptualizing phenomena that emerged in the empirical data. When uncertainty or disagreement occurred between the two authors, two additional researchers were consulted. Themes for analysis were derived from examining informants' self-observed changes in academic performance, and their explanations for such changes. The thematic analysis approach was employed when formulating analytic categories (Braun & Clarke, 2006). In analyzing informants' speech acts, we used theoretical perspectives on meaning-making, focusing on narrative, metaphor and attribution theory. In formulating aims and categories for further analysis, we drew on established knowledge on trauma-related cognitive impairment and academic functioning, and categorization and classification of traumatic stress and PTSD symptoms. Our initial identification of changes in academic performance and selection of four categories of change drew on a deductive approach based on trauma research.

The two authors have a background in educational psychology (including trauma research) and education. Both live in Norway and were indirectly affected by the terrorist attack, which has been recognized as a Norwegian national trauma. A process of continual and deep self-examination was initiated to enlighten our pre-understanding and our own role and influence during the analysis (Berger, 2015). Particular attention was paid to professional beliefs, theoretical orientations and emotional responses to participants' negative experiences.

Of the 65 informants in our study, 69% (n = 45) described distinctly negative changes in their academic performance in the 2.5 years following the massacre. Only 8% (n = 5) felt unsure as to whether any changes had occurred; a further 6% (n = 4) had experienced predominantly positive change, whereas 17% (n = 11) reported no change.

Our analysis focuses on the narratives of the 69% (n = 45) who reported distinctly negative changes in their academic functioning. The following themes emerged as two core categories: *"attribution to trauma,"* where the cause of change in academic function was assigned to the traumatic event; and *"attribution to other reasons,"* where the cause was assigned to other reasons beyond the trauma. Three sub-categories emerged when we explored characteristics of informants' recognition and meaning-making of changes observed: *"attribution"* of cause and effect, the use of *"metaphors,"* and characteristics of the *"changes"* observed. (See Figure 1.)

Results

In the following we present the two core categories on how students explained their changes in academic functioning as an attribution to trauma or to other reasons. We further describe their search for understanding and their concern and worries over their reduced academic functioning. Lastly, the use of metaphors are presented and how they support the meaning-making process.

Observed changes in academic performance

Among the 45 students who reported distinctly negative changes in their academic performance, 47% (n = 21) had made changes in their study plans, either by postponing or extending the timeframe for certain subjects. Only 22% (n = 10) had temporarily abandoned their studies and returned later – for instance, postponing school start by one semester, or taking a year off. Reasons given for the latter include long-term sleep-related problems and impaired daily functioning. The quote below is typical of those for whom severely reduced daily functioning made ordinary life and school attendance difficult:

> Well … first of all, when I walked into the school there were just too many people. I didn't have control; there were people everywhere. There was simply too much going on in my head. And when I managed to get to the classroom, I couldn't follow the teaching. I was constantly thinking: "Who's sitting there?" and "Who's that person?" … and suddenly I would hear noises. No matter what the teacher said – I couldn't grasp it. Just

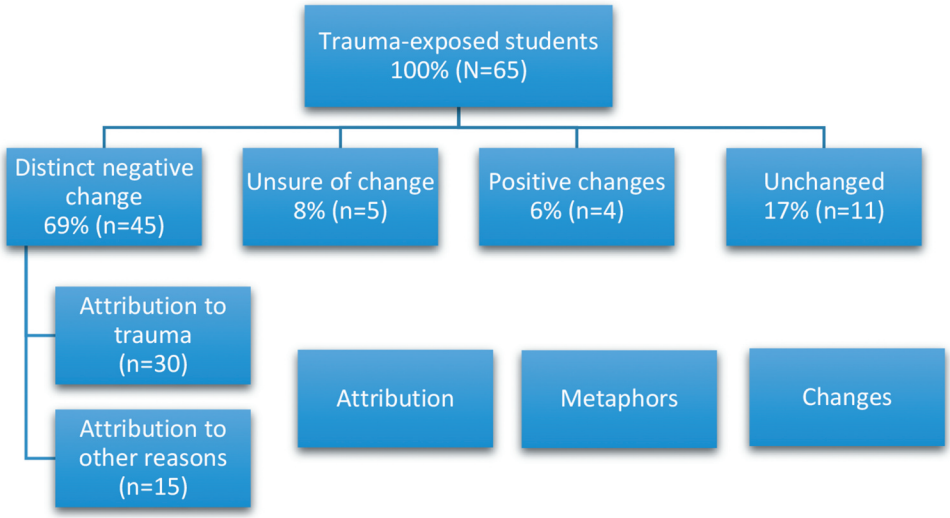

Figure 1. Analytic categories of students' self-observed change in academic performance and their attribution of cause and effect.

> getting up in the morning, showering and getting ready was such a struggle. So I decided to study as an external candidate, so I could stay home and work on my own. (Female, high school)

Most respondents gave clear accounts of immediate and distinct negative changes in their academic performance, as shown in the quotes below.

> No, I wasn't prepared at all; I understood on the first day that things were going to be different. After we were welcomed back in the schoolyard, we went up to the classroom … and I just felt I had to go, so I did. But I had to leave the first lesson. Then I realized: it might be hard, being at school. (…) Worst of all, I couldn't concentrate … when I was supposed to sit quiet and think. (Male, first-year high school)

> Everything fell apart! It used to take me one minute to read a page, maybe half a minute. But now I had to read the page over and over again. I spent 20 to 30 minutes on a page – I'm not kidding. I just sat there staring at it, reading over and over, trying to make it stick. And in math … well, I simply couldn't concentrate (…) Everything went so slow. I used to have top grades, and then I ended up with Cs. My plans for university were blown … just like that. (Female, third-year high school)

The most frequently described changes in school performance were lack of concentration, and failure to remember what had just been read and extraction of information from written text. Another common problem was lack of perseverance in performing tasks that took more than a couple of minutes. Lessons dominated by oral lectures were difficult to follow. Students felt overwhelmed by too much information, experiencing feelings of chaos. Also mentioned were sleep problems, being restless and unmotivated.

Weak or indistinct changes in school performance were reported, especially by those with a previous history of poor grades, and those with preexisting learning disabilities. In the quote below the student describes how his learning problems got worse after the massacre.

> I had concentration problems from before. I have ADD, which is ADHD without hyperactivity. So I've already struggled a bit with that, but … it is worse now. When the teacher or the topic wasn't interesting, I sort of faded out and did other things. Like sitting there and listening, without anything sinking in. (Male, first-year high school)

The majority of those reporting negative changes provided clear descriptions of the changes observed, with various changes occurring simultaneously. Some changes were observed early on; others became more pronounced as the semester progressed. Respondents who provided clear and detailed descriptions of change usually described themselves as being used to getting good grades; they appear to have an educational history of good or high academic performance. Some informants reported their school functioning as affected mainly by one dominant symptom, not a range of symptoms. A minority reported distinct changes appearing only three to six months after a fairly normal school start. Indistinct changes were especially common among students with a history of poor school performance.

That these changes were unexpected was a dominant theme in the interviews. The consequences were more severe and lasted much longer than expected, and made established study techniques less effective or even inadequate. Many respondents started to re-think their future plans, experiencing periods of great concern about being able to complete their studies, and their academic future.

That 69% (45 of 65 pupils) experienced periods of marked impairment of academic functioning after surviving a massacre should come as no surprise. What is striking is the frequent uncertainty as to the underlying reasons – with respondents often wondering whether the changes might have been caused by something else than the massacre.

Searching for reasons

Students were invited to tell a narrative concerning their school situation. Of the 69% (n = 45) informants who reported negative changes in their academic performance, 67% (n = 30) accepted this invitation and presented a narrative before and after the trauma, with the traumatic event as a clear turning point. Although 33% (n = 15) did not follow this narrative structure, they all reported distinct negative changes in academic performance, changes similar to those who reported a clear turning point. Naturally enough, a sudden, distinct change with negative consequences evokes worries and calls for explanation. The majority of those who reported poorer school performance ascribed the change directly to the traumatic event. Typically, our respondents would follow up the interview question by giving their narrative of how the massacre directly influenced their academic and/or social functioning. However, one third (n = 15) expressed considerable uncertainty whether, or to what extent, the observed changes in academic functioning could be ascribed to the traumatic event. The male student quoted below had just completed high school and was about to start university studies in mathematics and physics. He had always been a good student and enjoyed studying, but all that had changed.

> Yes … I have problems at school, but I don't know if it has much to do with July 22nd, I think there are other reasons. Because I didn't have any problems right away, but now I do. No, I don't believe that it has anything to do with July 22nd. Well, there was all the focus and attention, right afterward, and then the court proceedings that distracted me a bit. But otherwise I don't think it has influenced my schoolwork that much. (Male, first-year university studies)

This student described various changes, lack of concentration and motivation in particular. When asked why, he replied:

> I really don't know … I've been thinking quite a lot about it right now, that is what I try to figure out and try to get back on track. The last semester was terrible, I failed two exams and barely made it on the third. I failed in my favorite subject … because things simply went to hell, just like that. Then I lost all motivation, because I felt … I just can't make it anymore. The reason for the last semester going to hell was maybe because it all felt so meaningless … things like that. But I don't think it had much to do with July 22nd.

At the time of the interview, his problems had developed into serious academic difficulties. He was not able to follow the regular study progression; he was in doubt about continuing with his chosen subjects and unsure whether he could even manage to study at all. He said he spent a lot of time trying to figure out the reason for the changes, and mentioned several possible reasons. His main explanation was that university-level study was new to him, with unexpected challenges. Moreover, recent radical changes in the set-up at his university had brought organizational challenges combined with new lecturers with little teaching experience. He went on to explain:

> I set pretty high standards for myself, so when I don't perform well I get very frustrated – I think that's the main reason … then I sort of just give up. I struggle with not being able to concentrate anymore, because in a way I feel there's no point in it all.

Steadily worsening grades had made him very frustrated, ready to give up. The lack of concentration was caused by the fact that he saw no point in studying – mathematics and physics had lost meaning, he explained. The only direct consequence of the massacre, in his view, was that following the lengthy court proceedings against the perpetrator made him lose several weeks of studying – but he added that being present in court was his own decision.

This student's sole explanation for the changes he had experienced assigned the cause to forces outside the traumatic event, such as the poor quality of teaching now offered by his university. He further provided internally attributed explanations: not being properly prepared, setting overly high standards, and his own shifts of priorities and focus in life.

The student quoted below had a school history of special needs education due to dyslexia and attention-deficit/hyperactivity disorder (ADHD). He explained that he had always experienced poor concentration and occasional periods of low energy. Since the massacre, all these symptoms had increased, but he himself felt unsure why.

> In the beginning of the fall semester that year [2011], I tried to avoid large crowds and new situations, but that gradually passed away. And then, since that first semester, there hasn't really been anything that … that I could link to it [the massacre]. But I've had lots of problems with low energy, poor concentration and memory – probably because of poor concentration, I don't remember anything. But if this has any connection to the experiences from July 22nd is impossible to say. (…) It's hard to say when you don't … when there's

> nothing … no thoughts or intrusive things or anything like that … maybe it has something to do with it, maybe not. It's hard to say. (Male, third-year high school)

He explained his lack of concentration and problems in remembering by his low energy, with shifting energy levels directly affecting his academic performance. Although he held open the possibility that the massacre could have sapped his energy, mainly he felt that he had simply entered a low-energy period, as had happened before.

For the student quoted below, one clearly observed change was difficulty with keeping two thoughts in his head at the same time, as he put it. For instance, he felt overwhelmed if he had two tests coming up. He was unsure of the reason behind these changes, but mentioned absence from classes as a direct cause of his poor grades.

> I was absent quite a lot. I guess I was tired sometimes, and I don't know if this was because of Utøya, but I felt tired a lot of the time. … With some subjects like French and math, I didn't manage to attend class, so I fell way behind in math. My French grades were affected, too, since I couldn't manage to sit down and concentrate on the homework. (Male, high school)

The quote below provides another typical example of respondents finding internally attributed explanations for their worsening grades – they blame themselves for the change.

> Well, in a way I knew: "Well, no wonder you didn't pass, you should have read the book before you sat down for the test." It was obviously my fault. (Male, first-year high school)

In this section, we have presented quotes from informants who assigned the cause of the recent changes in their academic functioning to forces beyond the traumatic event itself. They did not necessarily deny a connection, but they focused on other causes – a mixture of externally and internally attributed explanations, especially the latter. In searching for explanations, they saw their own actions as having a direct cause–effect relation with their poor academic performance. Explanations were often constructed on the basis of practical and familiar causes – becoming tautological, as each component could potentially explain the other: *I failed the exam because I didn't study the book – because I couldn't concentrate – because I couldn't sleep – because I've developed bad sleep habits.*

Concern, worries and the use of metaphors

When students reported concerns about reduced academic performance, this was linked to not being able to understand the nature of the changes, and to uncertainty as to what to expect in terms of intensity, duration and help with these problems. The student in the quote below managed to maintain her grades by making great efforts. She is representative of the category of students who expressed concerns and rumination: they were worried about their worsening academic performance, but reported little or no help from teachers.

> I got through the year, but it came at a high cost. Studying was tough, and I had real problems with concentration and motivation. I kept thinking: "Why am I doing this?" And then I became more and more afraid, like: "Oh my God, I've always been so motivated for school and it's always been easy for me to learn new stuff" … but now everything just stopped. I wanted to do something else, just look out the window, just … just get away and do something else. (Female, first year, university)

At the time of the interview one student had no longer managed to follow the regular course of study. She had found it impossible to compensate for not being able to concentrate. Unsure whether she would manage to complete her bachelor's degree, she described her situation as "hopeless" and "extremely frustrating":

> It is … extremely frustrating, because I feel, I sort of feel that I've got brain damage, do you understand what I mean? Like: "Oh shit! Have my brain cells disappeared or something?" In a way I know that's not what happened, but … it's all so frustrating! (Female, third year, university)

The student quoted below had been following the normal course of study. Then, after the experience of July 22, 2011, he had fallen two semesters behind. His parents and his GP had "forced" him to apply for a reduction in his study loan, on grounds of "illness due to the traumatic event." However, he rejected the idea that experiences from the traumatic event had changed him and made him "stupid":

> I shouldn't have become more stupid … because of this [the massacre]. My brain should still be working. And it does, the logical part is still functioning. And my memory – yeah, everything still works. (Male, fourth year, university)

Now he has put off doing his academic work, instead spending time on non-study related projects, mostly alone. While acknowledging this considerable change in study behavior, all he can say was: "I don't know why it turned out like this, I honestly don't know."

The 45 respondents who observed distinctly negative changes frequently employed metaphors in trying to understand and explain what had been happening to them. This use of metaphors often came in a context where the student expressed worries and concern about

a lasting reduction in learning capacity, and did not know how to understand these changes.

We found two core types of metaphors, which we label *open* and *closed* metaphors. A metaphor becomes "closed" if it carries an explanation in itself, whereas an "open" metaphor is explorative and functions as a building block in the ongoing meaning-making process. In a typical closed metaphor, the study situation and grades were described as "going to hell" and "down the drain." This often appeared in a rather short narrative followed by internally attributed explanations that involved the respondent as a part of the cause–effect relation. There was no immediate need for further information: the explanation appeared sufficiently meaningful, and the meaning-making process ground to a halt.

Another example of a metaphor that restricted the meaning-making process was "getting back to normal," with its assumption that the situation would quickly return to "normal." On finding that there was no such thing as getting back to a "normal" school day, many respondents expressed surprise, and frequently concern and even fear. These pupils will need to reconsider their understanding and re-open their meaning-making process in order to understand their current situation.

Other examples: *I've turned into a "vegetable" because I don't sleep* or: *I was simply "out of myself."* These are metaphors that hold meaning. Such metaphors can be sufficient in themselves, or can at least create meaning for a while. By their nature they also bring closure to the meaning-making process, due to references to established facts in folk-theory and ways of speaking. Or, some respondents described their lack of verbal memory: *it went in one ear and out the other*. When not followed by further questioning, the metaphor becomes a self-sufficient bearer of meaning. By describing an unfamiliar situation with a familiar phrase, the metaphor turns it into a familiar situation, adding something known to the unknown.

By contrast, we noted very few instances of *opening* metaphors appearing in the narrative in an exploratory context. In one case, a high school student described his reduced academic functioning as being caused by a "dark cloud" that appeared in his brain, blocking out the regular functioning. This improved later, when his life and his brain finally regained "HD quality." The High Definition quality is a technical term for describing electronic picture definition, which he used to describe his lack of concentration and impaired executive functioning. This metaphor itself is "open" in the sense that HD quality can be improved if one has the right know-how and skills for fine-tuning the degree of definition.

Another example of open metaphors is the "collapsed bookshelf." Some respondents used this metaphor to explain a reduction in auditive memory, in short-term memory, in being able to accumulate new learning, and problems with retrieving stored knowledge. The metaphor also describes a lack of function: a broken bookshelf is no longer capable of holding books – but it can also be strengthened and repaired.

> The first half year was . . . it was really strange: first I was very apathetic, then I gradually took in more and more of what had actually happened, and then things went downhill, down and down. I kind of hit bottom around New Years, then it all started to go upwards again: I began to get hold of things, slowly. (. . .) So, in a way I kept on going upwards.
>
> That was in a way rock bottom. Slowly but surely the bookshelf started to give way and the books started to lean over and then, suddenly all the bookshelves collapsed – that was in those days where everything was in chaos. That's how it felt, everything felt wrong and threatening and . . . strange. So in a way I had to rebuild the library. Doing this is one of the things I'm most satisfied with, how I handled this and managed to rebuild myself from ground zero. In a way I've gained a lot of self-confidence and belief in myself . . . willpower and stuff like that . . . because I managed to fix it, in a way . . . in many ways. (Male, third-year high school)

Here the respondent used directional metaphors to describe the direction of the change in his daily functioning. This was described as a gradual process, first "down," hitting a "rock bottom" and then moving "up" again. He used the "collapse of the bookshelf" as a metaphor to explain aspects of how he observed and experienced the change. Before the traumatic event he had a good "library" (a working brain) full of "bookshelves" where everything he had learned was neatly arranged in proper order. He knew where to find everything. Then some shelves started leaning, books fell out, and some days he could wake up to find all the books in a huge heap, where it was impossible to locate anything in the chaos. With his teacher and his psychologist, he discussed ways of re-building the library by re-constructing the bookshelf, testing out alternative learning strategies and study skills. Together they found ways to adapt his school studies, so that he could maneuver in the chaos and could support, strengthen, and re-build those bookshelves.

This narrative carried an external attribution in describing the traumatic event as the direct cause of the change in his academic performance. His further systematic use of several open metaphors provided building-blocks of reasonable, manageable explanations. This meaning-making process enabled him to put himself in an active role where he could set about finding new and alternative learning strategies and study skills to compensate for his reduced learning capacity.

Discussion

Triggering the narrative process

A part of daily cognition is conceptualized as the process of storage and retrieval of action scripts, organized in narrative structures. It has been theorized that such scripts constitute schemas that incorporate generalized knowledge about event sequences, relations between events and causal understanding (see Schank & Abelson, 1977). Our respondents all have had many years of experience as school students, acquainting themselves with study techniques and their own learning processes. As part of their daily life experiences, studying and learning have become scripts and cognitive schemas that provide a framework for sequences of familiar situations. The script serves as a means for understanding events that conform to the expected – but then, when the unexpected occurs, the meaning becomes unclear. The narrative process is triggered by the unexpected; it reviews the unusual event, seeking to make sense of it. Creating narratives is a cognitive process that serves understanding by organizing and connecting events and happenings into frames of meaning (Bruner, 1990: Polkinghorne, 2005). The narrative is an instrument for meaning-making because we deal with the world, not event by event, but by framing events within larger structures (Bruner, 1990). Narrative reports tend to connect events in a structured way, with a beginning, middle, and an end – all motivated by *plots*:

> Narrative structuring operates by configuring actions and events into a temporal whole. As concepts serve to give meaning to particular objects and actions by giving them a categorical identity, plots serve to give meaning to particular happenings and actions by identifying them as contributors to the outcome of an episode.. (Polkinghorne, 2005, p. 6)

Of our 65 respondents, 69% (n = 45) reported changes in their academic performance that were so negative that they initiated a narrative process for exploring and understanding these changes. Explaining the cause of the change is the *plot* or the *motivation* for the narration. Of these 45, 66% (n = 30) provided narratives attributing the changes directly to the traumatic event as the turning-point, whereas 33% (n = 15) presented narratives assigning the dominant cause elsewhere – or were unclear, leaving their narratives with no specific turning-point.

Of course, there may be other factors causing reduced academic functioning for those 15 respondents. However, all our respondents had been exposed to traumatic events on Utøya, and 45 report self-observed, distinctly negative changes in their academic functioning. The way they describe these changes is in line with symptoms described in the diagnostic manual for traumatic stress reactions and post-traumatic stress disorder as being common and expected in the aftermath of traumatic events (APA, 2013). In addition, the Utøya study has found high clinical levels (24.5%) of anxiety and depression symptoms in the total population of Utøya survivors, 2.5 years post-trauma (Stene et al., 2016). There are co-morbidity and over-lapping symptoms between PTSD, post-traumatic stress, anxiety and depression (APA, 2013). How, then, can it be that 33% (n = 15) of 45 informants ignore the traumatic event in searching for explanations? Let us turn to their use of metaphors and characteristics of attribution in the meaning-making process.

Use of metaphors in the narrative process

Not surprisingly, metaphors are frequently used as building blocks in constructing a narrative to explain change. There is a categorical difference in the use of closed (cognitive) and open (innovative) metaphors. The metaphors used by those 30 respondents who employed trauma-attributions are dominantly *open* metaphors not intended to carry the full explanation. Whereas the open metaphor "collapse of the bookshelf" indicated temporary loss of function, the closed metaphor "brain damage" referred to functions as permanently damaged. Metaphors become open and explorative when their purpose is to add manageable bits of explanation. By contrast, closed metaphors provide a more comprehensive explanation: the student turned into a "vegetable;" everything "went down the drain". The closed metaphor "It all went to hell" provides a highly concrete image, explaining the result of wrong, morally bad behavior: I didn't read the book, I didn't do my job – so I got the punishment I deserved. Closed metaphors were employed mainly by the 15 (33%) respondents who used non-trauma-attributions, frequently combined with internally attributed explanations of observed changes. Using dispositional factors involved the respondents themselves in the cause–effect relation, making themselves responsible for the change.

Metaphors can provide understanding of aspects of the (concept of) changed academic performance, providing manageable explanations. The metaphors become open and explorative when their purpose is to add information to an ongoing meaning-making process, providing pieces of information needed to stimulate the construction of a framework for understanding the concept. By contrast, as closed metaphors appear to carry sufficient meaning in themselves for explaining the plot, the reason and cause for change, they halt the

meaning-making process. To what extent a metaphor provides closure or further stimulates meaning-making will depend on the context. In this study, the metaphors that served to halt the meaning-making process involved rather limited descriptions in brief narratives with predominantly internal attributions as to the cause of change.

Looking beyond trauma

We can note several differences between the narratives of respondents who attributed the change directly to the trauma and those who did not. Attributions of self-observed changes are generally influenced by when and how the changes are recognized. Respondents who assigned the cause to the trauma often described changes that were "quick and many" – not "late and few." Changes that emerge in close proximity to the traumatic event and do not appear in isolation are more readily recognized as linked to the traumatic event. Conversely, changes are less easily linked to trauma if they emerge as single, isolated changes relatively far removed in time from the event, and if they fluctuate. Those of our respondents who had a previous history of learning disabilities seemed to experience less marked changes, and were less likely to look for other explanations if the change was within domains of learning where they had already experienced challenges or low capacity.

In Western society today we can note widespread assumptions as to what "reasonable" reactions to trauma should be: immediately after the event there should be strong initial reactions, which subside gradually. Further, reactions should be readily recognized as a direct result of the trauma, as with sounds resembling shooting or screams, intrusive memories or images directly linked to the traumatic event. This "folk psychology" (Bruner, 1990) entails a set of descriptions or common understandings of what is to be expected in a certain situation. Any divergence from the expected reactions seems to open the way to attributional errors.

The narratives of all 45 respondents who reported changes in academic performance contained strikingly few references to diagnostic descriptions. In assigning cause, our respondents placed the negative changes in a context of ordinary language with general everyday descriptions: such references seemed to provide sufficient meaning.

The 30 (66%) respondents who used trauma-attributions provided clear external attributions that assigned the cause of change to trauma-linked situational factors: the event itself and the aftermath. Having completed their cause/effect narrative, they are in the first phase of their narrative structuring. Their trauma-attributions are unstable, as the observed changes are viewed as temporary. Western folk psychology expects the changes to subside gradually, and then disappear. This type of understanding triggers the second phase of the narration, where the plot is *recovery*. Meaning-making is now motivated by observing and describing ongoing changes, aimed at regaining lost learning capacity. A sense of control is obtained and self-efficacy is built by turning to alternative study techniques. Community efficacy (Bandura, 1997) can be built by consulting persons like teachers and psychologists. The total narrative has a clear structure: the traumatic event is identified as the cause of change, to be followed by recovery. The narrative can be closed once recovery is achieved, ending the meaning-making process.

However, the narratives of the 15 (33%) respondents with non-trauma-attributions involved no clear turning-point. Several hypotheses were often presented as a combined set of possible causes, with examples of situational (external: e.g., change of school) and dispositional (internal: e.g., laziness) attributions. Here, trauma-attributions appeared less stable than non-trauma-ones, but also the latter tended to be unstable – respondents saw themselves as currently undergoing a "phase;" they expected to resume old habits and regain academic capacity later on. However, as the changes had persisted for 2.5 years at the time of the interviews, the various hypotheses of unstable attributions must be questioned, making attribution to situational factors become less reasonable. Respondents now tended to admit that theirs may be a more stable condition attributable to dispositional factors.

In several instances, the narrative process of non-trauma attribution was headed toward a stable dispositional attribution. The changes were now seen as becoming permanent: "I simply don't function anymore" and "I lost interest – and it's stayed that way." Some students with trauma-attributions now found stable attributions more and more credible, for instance, wondering if they have permanent "brain damage." They have begun actively questioning the stability of their attribution, discussing and arguing with themselves: "It's not logical for one and a half hours on an island to define me for the rest of my life." Ehlers and Clark (2000) describe this type of negative appraisal as a dysfunctional strategy that can maintain PTSD by producing negative emotions and lead to negative coping strategies. When individuals fail to acknowledge symptoms as a normal part of the recovery process, this can produce a sense of ongoing threat to their physical or mental well-being, with the symptoms seen as being a permanent change (Ehlers & Clark, 2000).

Some one-third of our informants appear to have made attributional errors of cause and effect. Among the well-documented attribution biases is the *self-serving bias*, evident in the tendency to take credit for personal success but to deny responsibility for personal failure (see Zuckerman, 1979) – a psychological strategy used to enhance and protect self-esteem. The self-serving bias has been observed in various settings, influenced by the degree to which individuals feel that their self-concepts are threatened. Factors that influence the perception of self-threat include the importance of the task in question, the difficulty of the task, expectations of success or failure, and the competitiveness of the individual (Campbell & Sedikides, 1999; Coleman, 2011). Following the logic of this psychological protection strategy, the obvious option would be to use external attributions for impaired academic functioning – placing the blame on the traumatic event. Thus, we will argue that non-trauma attributions in our material may be interpreted as a protection strategy, and thereby a type of self-serving bias. The Utøya massacre became a national trauma with enormous mass-media coverage. A study of identity-work among survivors, with the same respondents as the present study, has shown how these young people systematically seek to avoid the stigma of becoming a "victim" (Skarstein & Schultz, 2017). They deny or resist the changes in their social identity and student identity (from high academic performance to low) by disassociating themselves from Utøya and trying to seem as "normal" as possible. They appear restricted in their ability to negotiate their identity. In trying to take charge of their own identity work, they focus on controlling the attention drawn to their Utøya identities, thereby denying or hiding aspects of their traumatic experiences and symptoms of traumatic stress (Skarstein & Schultz, 2017). Ignoring or downplaying the traumatic event as the cause of change can help to avoid stigmatization – you are in charge of your own identity-work, attributing the change to dispositional factors that you can control yourself.

The advantage of perceived control over outcome has been repeatedly demonstrated in classical social psychological experiments (see e.g., Glass & Singer, 1972). A similar function is found in a certain type of self-blame being a positive psychological mechanism in the aftermath of trauma. Behavioral self-blame is control-related; it involves attributions to a modifiable source (one's behavior), and is associated with the belief that negative outcomes can be avoided in the future. By contrast, characterological self-blame is related to self-esteem; it involves attributions to a relatively non-modifiable source (one's own character), and is associated with feeling that past negative outcomes have been deserved (Janoff-Bulman, 1979). Similarly, the tendency of our informants to use non-trauma attributions can be viewed as a desire to maintain a sense of control – and might be a short- term positive psychological mechanism for recovery. More problematic is when those with non-trauma attributions develop chronic stress-related symptoms. They lack the advantage of achieving the second phase of recovery-narratives, because there is insufficient information to trigger that second phase.

A classic challenge after exposure to trauma is viewing the psychological trauma as an external event of the past, or as an ongoing internal process with perhaps lasting internal changes. When the outer and inner worlds have changed dramatically, the balance needs to be restored. The individual must re-build the inner world by reestablishing positive fundamental assumptions of the world – and all this in a state of anxiety, fear and loss (Janoff-Bulman, 1992). In this turmoil, the search for a causal attribution is influenced by social surroundings, opinions, and available information. Our study found only a few instances where informants reported support from teachers who could provide useful information and engage in dialogue. The majority seem to have been left on their own, trying to make sense of complicated and unfamiliar concepts like PTSD-related, temporary and distinct cognitive impairment.

Finally, gender emerges as a factor regarding attributional style. Among the 46 students who reported reduced academic functioning there were slightly more females than males, whereas only two of the 15 students who employed non-trauma attributions were female. If non-trauma attribution is viewed as a psychological mechanism for remaining in control and avoiding the victim-label, it is noteworthy that this mechanism was employed predominantly by male adolescents. This finding is in line with studies that show males to be generally more likely to engage in externalizing rather than internalizing behaviors after trauma (Hankin et al., 1998; Tolin & Foa, 2006).

Strengths and limitations of this study

The study design provides unique qualitative data on how 65 Norwegian young people experience and explain their academic performance and functioning after exposure to traumatic stress. The large sample offers a broad picture, with in-depth examples that highlight prominent tendencies and patterns evident across different schools and genders. However, this study also has some limitations. The interview prompt invited the informants to make a direct association between academic functioning and the traumatic Utøya event. Even

so, 16 informants denied such an association or did not find it relevant, and another 15 were highly uncertain whether such changes could be ascribed to the traumatic event. Secondly, we cannot guarantee that all self-observed changes of academic functioning have been caused by PTSD-imposed cognitive impairment. Furthermore, the interviews were conducted at the beginning of a 60- to 90-minute standardized questionnaire; in some cases, this might have meant a somewhat hurried situation with insufficient time for follow-up questions and elaboration. Moreover, due to purposive sampling within the main sample of the Utøya study (Dyb et al., 2014), these 65 informants might not be a representative sample.

Conclusions

This study has explored how PTSD-imposed temporary cognitive impairment influencing academic performance and functioning is recognized and explained by young people who were exposed to a traumatic event, the 2011 Utøya massacre in Norway. Using a phenomenological approach to survivors' narratives, we have identified several prominent aspects of the meaning-making process of self-observed change in academic functioning.

Among our 65 respondents, self-observed changes in academic functioning in the aftermath of the traumatic event were significant to the extent that a meaning-making process was triggered in 75% (n = 49) of them. Further, 69% (n = 45) reported negative changes characterized by a sense of chaos, impaired concentration and auditive memory, and by experiencing previously used study techniques as less effective or inadequate. Our respondents said they had not been prepared for these changes: the consequences were more severe and lasted longer than expected.

From characteristics of the observed symptoms, the use of metaphors, attribution style and narrative structuring, differences emerge in respondents' meaning-making processes. Of the 45 respondents who reported negative changes, 67% (n = 30) offered clear trauma-attributions as to cause; the attribution was often unstable, with changes seen as temporary. Their narratives tended to be descriptive and complex. Stories revolved around a clear turning-point (the massacre), describing school-life after the trauma as opposed to pre-trauma by highlighting the changes. The use of metaphors was generally open and explorative. Narrative structuring extended into a second phase, of recovery, where the turning-point was a reduction in the intensity or number of changes/symptoms.

Non-trauma-attributions (33%, n = 15) were predominantly external (e.g., change of school), with some internal (e.g., "I've changed because I shifted my focus and priorities"). Narratives with internal non-trauma-attributions have no clear turning-point; indeed, the narrative process is characterized by an ongoing search for a turning-point. Non-trauma attributions are characterized by symptoms like late onset, single reaction, not intuitively connected to the event and not among the expected patterns set by folk psychology. Preexisting learning challenges or disabilities cause uncertainty when trauma-induced changes occur within already affected cognitive domains. Metaphors tend to be closed, without stimulating further meaning-making, leaving the individual with an explanation partly understood in metaphorical terms but lacking the precision and information necessary for a sound conclusion. Further, non-trauma-attributions in our study did not appear to trigger the second phase of meaning-making of constructing "recovery narratives."

If post-traumatic stress symptoms subside fairly quickly or do not cause significant long-term problems, the clinical correctness of the meaning-making might not be of importance. Examples of unstable non-trauma attributions, which we describe as attributional errors, can function as a psychological mechanism that fosters recovery by allowing the student to maintain a sense of control: "I didn't prepare for the exam *[so it's my own fault that I failed]*" and avoid the stigma of being a victim: "Oh, I can manage."

When symptoms persist for 2.5 years and significantly affect academic performance, the type and quality of meaning-making appear significant. A more clinically correct attribution becomes important for reducing rumination, correcting negative appraisals, stimulating help-seeking activity, the willingness to accept adapted education and recovery. Previous meaning-making is up for revision – in particular, all forms of unstable attributions are challenged when academic functioning has not been regained as expected. This is a vulnerable phase in the meaning-making process, where more information is needed to maintain the unstable attribution and trigger or maintain the recovery narrative.

The following appear to be the most constructive qualities of meaning-making with lasting symptoms found among our respondents: an unstable trauma attribution with use of open metaphors where the second phase of a recovery-centered narrative has been triggered. These recovery narratives entail an active search for reduced symptoms, and experimenting with alternative study techniques to compensate for lost learning capacity or to restore impaired academic functioning. They are characterized by sense of control, self-efficacy, and community efficacy.

Many of our respondents ruminate and worry about their impaired academic functioning, but report little or no discussions with teachers. They appear to have been left largely on their own in their meaning-making processes, struggling to make sense of the complicated concept of PTSD-related cognitive impairment.

Implications for practice and further research

Given the long-term disruption and impairment of academic performance, we hold that greater educational follow-up on the part of the teacher may offer a good point of intervention with these traumatized students. Improving the students' own understanding of their academic functioning may lead to positive effects on their academic work. Further, we would recommend that educational psychologists provide counseling for teachers, so that they can give psycho-education and help students in exploring their functional study skills to improve their self-efficacy – to recover their academic functioning.

A review of intervention research on the treatment of those exposed to disasters and mass violence (Hobfoll et al., 2007) identified empirically supported principles that are widely used to inform intervention and prevention efforts, in the immediate aftermath of a critical event and up to three months thereafter. Examples of practical and evidence-informed guidelines with modular approaches are Psychological First Aid (PFA) (Brymer et al., 2006) with a version adapted for schools (Brymer et al., 2012) and Skills for Psychological Recovery (SPR) (Berkowitz et al., 2010). In recent decades, the concept of *trauma-informed approaches* has spread, attracting interest among practitioners and scholars in various fields including education (Champine et al., 2019). Trauma-informed schools (see, e.g., Luthar & Mendes, 2020; Overstreet & Chafoulea, 2016) are often anchored in theoretical frameworks such as Guidance for Trauma-informed Approach (SAMHSA: Substance Abuse and Mental Health Services Administration, 2014). However, despite the growing support and increased implementation of trauma-informed approaches in schools, evidence to support this approach is lacking (Maynard et al., 2019). This is partly explained by the lack of rigorous evaluations, and by unclarity as to actual practice in schools that claim to use trauma-informed approaches. Several studies have noted teachers' uncertainty about their own role and how to go about supporting and teaching traumatized students (e.g., Alisic, 2012; Alisic et al., 2012; Røkholt et al., 2016).

In view of the limited literature on teachers' support of traumatized students, more research is needed on the use of specially adapted measures to stimulate and recover academic functioning. Students with lasting impaired academic functioning are a vulnerable group, and would benefit from investigations that can identify the most efficacious educational support to help their academic recovery from post-traumatic stress. More qualitative research on what teachers do and how students experience their situation and the educational support offered would be a valuable supplement to the empirical literature.

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