Coping Strategies and Psychological Interventions Among Traumatized African Migrants in the Western World: a Comparison Between Rwandans in Finland and Belgium

Jean d'Amour Banyanga

Åbo Akademi University, Vasa, Finland

Kaj Björkqvist

Åbo Akademi University, Vasa, Finland

Karin Österman

Åbo Akademi University, Vasa, Finland

Abstract

The objective of the study was to investigate coping strategies and the experience of mental health interventions in Rwandans traumatised by their experiences during the 1994 genocide and its aftermath, living in Belgium and Finland. A questionnaire was completed by 341 Rwandans above 20 years of age (166 males, 175 females), with the purpose to investigate similarities and differences in coping strategies and psychological interventions in the two host countries. The participants were also interviewed. The results show that Rwandans in Belgium were more satisfied than those living in Finland with the therapeutic interventions, survivors' group activities, and social support they had received in their host country. Rwandans in Finland, on the other hand, relied more on psychopharmaca and the use of alcohol as coping mechanisms than those living in Belgium.

Keywords: Coping, psychological intervention, Rwanda, genocide, PTSD

Introduction

In contemporary times, the world has witnessed ethnic conflict, political instability, wars, genocide, economic depression, unemployment, natural disasters, and widespread poverty that have led to waves of migration from Sub-Saharan Africa and from Arab countries to the Western world. According to the United Nations High Commission for Refugees (UNHCR, 2017), 65.6 million people worldwide are refugees from their countries or displaced within their own country. This figure is higher than ever before in human history. Europe is one of the desired destinations for asylum seekers with a number of arrivals of 250,000 people per year (Schouler-Ocak & Kastrup, 2015; UNHCR, 2017). For instance, newspapers frequently about migrants risking their lives to cross the Mediterranean Sea looking for sanctuaries and a better life in the Western world. Many of those immigrants have experienced persecution, ethnic violence, wars, even genocide, and they suffer from psychological wounds. Many accounts highlight how people struggle to cope with their trauma (Bolton, 2001, p. 4).

Although flashbacks and nightmares caused by traumatic experiences may force themselves into their consciousness, many traumatized people still have difficulties of remembering and relating exactly the details of what has happened to them (Van der Kolk & Fisler, 1995; Van der Kolk, McFarlane, & Weisath, 1996, p. 10; Yehuda, 2006, p. 54). Research among Cambodian refugees in the United States shows that victims who were tortured during the Pol Pot regime in the late 1970s are still suffering from severe PTSD 30 years later (Hinton, Marques, Nickerson, & Pollack, 2010). Likewise, among Rwandan genocide survivors, there are individuals with significant post-traumatic mental health problems, who are likely to continue suffering from trauma-related conditions for years to come. Other studies suggest that refugees and asylum seekers are substantially at high risk of developing PTSD and other mental health problems which can burden their future and affect their school performance and working life negatively (Bornstein & Lamb, 1999, p. 110; Boss, 2006, pp. 4−5; Figley, Bride, & Mazza, 1997, pp. 18−19).

Traumatic experiences hurt not only individuals but also families, groups, and whole communities. Research has shown that some traumatized individuals succumb to self-destructive activities, as an attempt to cope with their trauma (Simpson & Porter, 1981; Van der Kolk et al. 1996, p. 11).

Traumatic experiences are also associated with neurological damage in survivors (Simpson, 1992; Van der Kolk, 2005, p. 11). Traumatic incidents occurring during childhood can lie dormant for years, but still cause permanent damage to the hippocampus, which is part of the brain's limbic system dealing with memories (Lobban, 2012, p. 3; Figley et al., 1997, pp. 22—23). Trauma may continually influence mental health functions of individuals during their entire life.

The objective of the present study is to investigate survivors from the Rwandan genocide and its aftermath in the diaspora living in Belgium and Finland, their ways of coping with their traumatic experiences, and the therapeutic and other interventions they have been offered by the society in their new countries. Are there differences between the utilization of mental health services between Rwandans in Belgium and in Finland? To what extent do they use culturally familiar methods, such as indigenous healing and helping approaches, for help-seeking and support? To what extent do they experience the treatment they have received to be beneficial? These are the research questions that will be addressed in the present study.

Individual and Collective Trauma

Trauma has been a central concept for psychotherapeutic practice since more than 100 years, starting from 1866 (Fassin & Rechtman, 2009, pp. 33−31; Mitchell & Black, 1995, pp. 1−3). From a psychoanalytical viewpoint, Sigmund Freud defined trauma as "accretion in excitation in the nervous system, which the latter has been unable to dispose of adequately by motor reaction" (Freud, 1882−1894, p. 137; Mitchell & Black, 1995, pp. 10−12). Freud restricted trauma to the sexual sphere, while later researchers included all potentially traumatic events (Freud, 1892−1894, p. 154; Fassin & Rechtman, 2009, pp. 32−33).

A special type of trauma is formed by collective memories, which affect not only one individual human being, but also an entire population who has experienced the same physical and psychological suffering. For example, memories of the slave trade were still relived in various ways in pre-war Sierra Leone (Antze & Lambek, 1996; Shaw, 2001). Thus, trauma treatment may not be entirely successful and meaningful if a psychologist neglects clients' life stories and their historical and social backgrounds in the therapy. Exposure to racism and xenophobia to already traumatized migrants could worsen their mental status, because they continually live under the pressure of social influence.

Implications of Culture

Exposure to severe traumatic events is a common experience for asylum seekers worldwide. However, the way Western societies support traumatized migrants and refugees has not always been consistent. A study by Maercker (2015) found that up to 40% of non-Western traumatized individuals do not benefit from the Western therapy model. Other research suggests that the inclusion of the different social and cultural contexts in the treatment of trauma should be further promoted (Bäärnhielm, 2016; Van der Kolk et al., 1996, p. 17). For instance, Ghanaians have exported anti-witchcraft healing shrines to Paris (Parish 2011), and Somali immigrants in Finland complain that Western doctors cannot understand or deal with spirits, the evil eye, and witchcraft, which to them are all common causes of mental distress. Therefore, Somalis seek treatment from Islamic or other specialist healers either in Finland or in Somalia (Tiilikainen & Koehn, 2011). Thus, the understanding of the impact of society across cultures is crucial in trauma treatment due to the fundamental differences that exist between the Western and non-Western world.

A study by Nordström (1997) showed that inhabitants of Mozambique were told by counsellors to keep life as normal as possible during the war, by planting crops even if it would be ravaged, constructing houses though they would be destroyed, and using traditional healing rituals to take the war out of people who have been witnessed the fighting. Moreover, Finnström's (2008) study from the Northern part of Uganda, where the Lord's Resistance Army has been fighting a civil war since 1986, shows that the Acholi tribe in that area sought opportunities to make a possible future for themselves, as they simultaneously struggled in surroundings and circumstances in which peace and stability were not imaginable, even during calm periods during the combat. In maintaining their counsellors' advice, the Acholi people increased their attention to the spiritual realm and reasserted their ties to history and the wider world; thus, they were able to cope with their traumatic experiences (Finnström, 2008).

Culture is viewed as the beliefs, practices and symbols of people within a society, including guidelines for their behavior in given situations (such as religious ceremonies, funerals, weddings, reaching puberty, maturity, and so forth) (Gibson & Mitchell, 1999, p. 263; Marks, Murray, Evans, & Estacio, 2011, p. 65). African health beliefs commonly attribute mental illness to the work of ancestors, sorcery and witchcraft, and to supernatural intervention (Marks et al., 2011, p. 73). Thus, Khawaja, White, Schweitzer, & Greenslade (2008) report that the main trauma coping strategies used by Sudanese refugees in Australia are dependence on religious beliefs, social support, and cognitive strategies such as reframing the situation, relying on inner resources, and focusing on future aspirations. O'Connor (1998, p. 25) suggests that the practice and adherence to Christianity as well as the beliefs and practices from the various traditions are beneficial to traumatized individuals. Therefore, Western psychologists should be aware of the refugees' cultural background, because culture provides not only meaningful structures but also mental luggage that they carry with themselves wherever they go. Culture gives the individual guidance about how to think, how to feel, and how to act (Furniss, 1994, pp. 18−19). For instance, a study by Mölsä, Kuittinen, Tiilikainen, Honkasalo, and Punamäki (2016) on 128 Somali refugees living in Finland who were traumatized, found that their cultural religious commitment had helped them to make sense of what happened during the war, and provided them with ways of healing their psychological wounds. Thus, therapy efficiency would benefit if therapists understood the lifestyle and values of the traumatized African.

Story-telling as Therapy

Relationships to other humans are probably the most powerful psychological/behavioral transformer known to man (Dayringer, 1998, p. p. 7; Hedman, 1980, p. 82; Hofmann & Otto 2008, p. 82). Story-telling enables the patient's voice to be heard, listened to and learned from (Learmonth & Gibson, 2010; Melliar & Brühka, 2010). Empathic understanding between therapist and client may increase feelings of being loved, and bring hope to a traumatized person (Vick, 2000, p. 217). Narrative exposure therapy is an evidence-based approach for the treatment of trauma-related mental disorders which is based on story-telling. It focuses on the autobiographical elaboration of traumatic experiences, and it is suited for populations affected by multiple traumatic experiences. This helps to build episodic memory, foster a sense of identity, and gives a deep personal understanding of schemas and social emotions that have developed across the lifespan (O'Connor, 1998, p. 19; Schiraldi, 2000, p. 66). Story-telling testifies about human rights violations, allowing the clients to regain their dignity. Story-telling provides a context from which we can extract relevant definitions (Snyder & Ford, 1988, p. 4). Narratives of a traumatic event have the power to convey underlying sensory images of memories connected to the event (Pillemer, 1998, p. 138). Individuals who suffer from PTSD and victimization symptoms are still captured by their history and feel trapped in their wound. As a therapist, the purpose of hearing the details of the traumatic event is to revisit the scene of terror and shock and, in doing so, mitigate its effect (Ochberg, 1998, p.15). Traumatized individuals can also join a group of survivors of a trauma in which they can meet others who are struggling with the same problem and are able to understand them (Scott & Stradling, 2006).

The act of sharing personal details with others communicates meaning over and above the particular informational content of the memories, and thereby it helps the traumatized individual to achieve important interpersonal goals (Pillemer, 1998, p. 140). Thus, talking about personal events is painful, but it is necessary and unavoidable (Ochberg, 1998, p.15). The benefits from talking about traumatic memories that lead to psychological wounds are apparent not only in clinical contexts but also in daily life (Pillemer, 1998, p. 169). Remembering and telling the truth about the terrible events one has experienced are prerequisites both for the restoration of social behavior and for the healing of individual victims. This can also lead to acknowledgment, apology, forgiveness, and reconnection (Brahm, 2004, pp. 2−3).

The Need for Social Support

Traumas may occur in the lives of every human being; in fact, the overview of epidemiological findings by Wittchen, Gloster, Beesdo, Schönfeld, and Perkoning (2009) showed that between 50% and 90% of the population will be exposed to at least one PTE (Potentially Traumatic Event) during their lifetime. Trauma victims engage in various types of behaviors in their attempts to cope with their experience and rebuild shattered assumptions. A common response to trauma victimization is to turn to others for emotional and social support (Figley, 1985, p. 27). The study by Miranda (2012) on psycho-trauma and PTSD, with a focus on the role of social support and the oxytocin system in traumatic stress, found that among 900,000 of Dutch trauma victims aged 18-80, 70% were benefited from social support. She found that an absence of social support is one of the most consistent risk factors for PTSD.

The perception of social support has a beneficial effect on degrees of post-traumatic hyper-arousal and consequently on well-being (Maercker, Schutzwohl, & Zahava, 1999, p. 215). Social support is helpful in reducing the traumatic experience (Hodgkinson & Stewart, 1998, p. 215).

Social support has a direct effect on adaptation, serving as a buffer for the individual against negative consequences of stress. People have needs for social integration and attachment that are met through their personal relationships (Yule, 2003, p. 81). Accordingly, research on social support indicates that it has a beneficial effect on the individual's ability to cope with trauma (Maercker et al., 1999, p. 205). Social support gives wounded individuals the confidence that there are people out there who will respond positively to them and will provide help when they need it (Snyder & Ford, 1988, p. 204). Moreover, the therapeutic interventions against posttraumatic stress reactions can be effectively supplemented by social skills training, which may help the victim to avoid the memories of the wound and get support from others (Maercker et al., 1999, pp. 215−216). Finally, positive social support following victimization helps the victim to re-establish psychological well-being, and enhance self-esteem (Figley, 1985, p. 27).

Method

Sample

A total of 341 respondents (166 males, 175 females), 50 from Finland and 291 from Belgium, participated in the study. The mean age of the respondents was 44.4 years (*SD* = 11.9); there was no difference between males and females regarding age. The respondents had come to Belgium and Finland either as refugees or on other grounds after the 1994 genocide. At the time of the interview, they were staying in 13 different locations in Belgium and 14 locations in Finland. The participants were selected according to the following criteria: They had to be above 20 years of age, they should be native Rwandans or born as a consequence of rape during the 1994 genocide and its aftermath, they should speak the local language, Kinyarwanda, and have a residence permit.

Instrument

Both quantitative and qualitative data were collected. The quantitative data were collected with a paper-and-pencil questionnaire. It included several parts related to experiences and coping with traumatization due to the 1994 genocide and its aftermath. In the present study, items regarding methods of coping with the trauma and their experiences of psychological treatment received in their new country are analysed. The exact wordings of reported items are presented in Table 1.The response range to all items ranged from 0 (does not agree at all) to 4 (agrees completely).

The participants were also interviewed about their experiences of the genocide and its aftermath, the possibility to experience love and forgiveness towards those who wounded them, the counselling they had received, and the healing mechanisms they use to cope with their trauma.

Procedure

The questionnaires were dispatched in 27 different locations of Finland and Belgium. Narrative interviews were conducted in local languages Kinyarwanda and French. The data were collected during 13 months in the period of 1.8.2015−30.8.2016.

Ethical considerations

Due to the potential sensitivity of the questions and the vulnerability of the target group, ethical questions were considered very carefully. The study adheres to the principles concerning human research ethics of the Declaration of Helsinki (World Medical Association, 2013), as well as to the guidelines for responsible conduct of research issued by the Finnish Advisory Board on Research Integrity (2012). The respondents were informed of the purpose and procedure of the study. They were aware of that their participation was voluntary and that no consequences would follow if they refused to participate in it.

Results

Quantitative results

A multivariate analysis of variance (MANOVA) was conducted measuring differences between Rwandans living in Belgium and in Finland on the thirteen dependent variables of the study, with age as covariate. The results are presented in Table

1 and Figure 1.As shown in Table 1, there were significant differences between respondents from Belgium and Finland on eight of the thirteen variables. Those living in Belgium scored higher on "received social support in host country", "therapy given in host country perceived as valuable", "received support from friends to cope with trauma", "received support from pastor/priest to cope with trauma", "joined trauma survivors' group to cope with trauma", and "benefitted from trauma survivors' group attendance". Those living in Finland scored higher on "used psychopharmaca to cope with trauma", and "used alcohol to cope with trauma". Thus, the results clearly suggest that Rwandans living in Belgium were more satisfied with the psychological support and interventions they had received than those living in Finland, who instead had to rely on psychopharmaca and alcohol to cope with their psychological wounds.

As Table 1 also shows, age was a significant covariate in the MANOVA. In order to find out which variables were associated with age, a Pearson correlation analysis was performed. The results are presented in Table 2. Eight of the thirteen variables correlated moderately, but significantly, with age. Seven of these were positive correlations, and only one was negative: the use of alcohol. That is, younger respondents tended to rely more on alcohol than older ones. The participation in survivors' groups and support from pastor/priest showed the highest correlations with age.

Table 1

Results of a Multivariate Analysis of Variance (MANOVA) Measuring Differences between Rwandan Respondents from Belgium and Finland on Thirteen Dependent Variables with Age as Covariate (N = 337). For Mean Values, see Fig. 1.

	F	df	p ≤	η_p^2	Country with Higher Mean
Effect of Age as Covariate, Multivariate Analysis	6.42	13, 322	.001	.206	
Effect of Country of Residence (Belgium vs. Finland)					
Multivariate Analysis	7.29	13, 322	.001	.227	
Univariate Analyses					
Received social support in host country	9.57	1, 334	.002	.028	Belgium
Therapy given in host country perceived as valuable	4.72	"	.030	.014	Belgium
Personal benefit of therapy received in host country	1.96	"	ns	.006	
Received support from friends to cope with trauma	5.24	"	.023	.015	Belgium
Received support from family to cope with trauma	0.27	"	ns	.001	
Received support from pastor/priest to cope with trauma	3.89	"	.049	.012	Belgium
Received support from spiritual healers to cope with trauma	0.06	"	ns	.000	
Used traditional means to cope with trauma	0.13	"	ns	.000	
Used Christian prayers to cope with trauma	0.77	"	ns	.002	
Used psychopharmaca to cope with trauma	21.54	"	.001	.061	Finland
Joined trauma survivors' group to cope with trauma	19.17	"	.001	.054	Belgium
Benefitted from trauma survivors' group attendance	17.01	"	.001	.048	Belgium
Used alcohol to cope with trauma	13.31	"	.001	.038	Finland

Table 2

Correlations between Age and the Thirteen Dependent Variables of the Study (N = 341)

Variables	Age
Received social support in host country	.18 ***
Therapy given in host country perceived as valuable	.12 *
Personal benefit of therapy received in host country	.00
Received support from friends to cope with trauma	.10 †
Received support from family to cope with trauma	.06
Received support from pastor/priest to cope with trauma	.23 ***
Received support from spiritual healers to cope with trauma	-.06

Used traditional means to cope with trauma	-.04
Used Christian prayers to cope with trauma	.16 **
Used psychopharmaca to cope with trauma	.18 ***
Joined trauma survivors' group to cope with trauma	. 27 ***
Benefitted from trauma survivors' group attendance	.24 ***
Used alcohol to cope with trauma	-.17 ***

Note. *** $p \leq .001$; ** $p \leq .01$; * $p \leq .05$; † $p \leq .10$

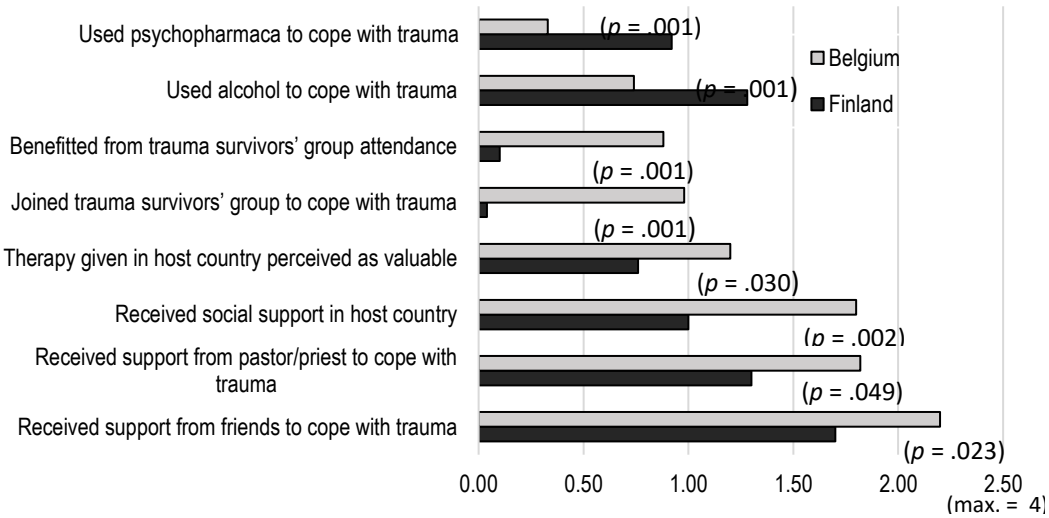

Figure 1. Differences in mean values on eight dependent variables for respondents living in Belgium and Finland (N = 337). Cf. Table 1.

Qualitative results

Relatively few Rwandans were able to receive counselling from Finnish and Belgian psychologists. However, there were still a substantial number of Rwandans who did not benefit from the counselling they received. In their verbal reports, they claimed that Belgian and Finnish psychologists do not understand the genocide and their personal experiences. Consequently, some Rwandans rely on traditional means, church-going, reading of the Bible, and testimonies to cope with their traumatic experiences. Others listen to Rwandan songs and dances; they watch their traditional Rwandan wedding on film, they read books about other peoples' experiences or watch Rwandan cultural activities on you-tube, which help them to feel that they are not alone. Many of the respondents argue that Belgian and Finnish authorities should talk to asylum seekers more, in order to get to know about their good and bad experiences. They feel that they need to be listened to.

Most Rwandans in Belgium and Finland have suffered in some ways from the 1994 genocide and lost one or several members of their families: siblings, parents, wives, husbands, children, as well as neighbours, friends, and property. Some have family members still scattered in the refugee camps in African countries while others have family members in prison. There were also respondents who had been imprisoned many years in Rwanda without any formal charge against them, and they did not get any compensation. The young Rwandans, on the other hand, feel that they do not know much about their country and that they have lost their culture.

When asked about how reconciliation among Rwandans could be accomplished, many respondents suggested that the only way is through forgiveness, talking about their history, discuss what is important for them rather than talking about what separates them. They also spoke about the importance to learn to speak the truth about the genocide and about those

who have been wounded without any omissions; to tell the whole truth in order to find a solution. They should avoid and not promote ethnicity, and they should learn from Finns and Belgians about how to live peacefully with each other, even though they do not agree on all things. The study also showed that religion has played an important role in trauma healing and reconciliation among Rwandans in Belgium. Rwandans are born into environments in which religion is felt as alive and present.

Discussion

The study shows that Rwandans in Finland seemed to get less support from society in terms of psychological interventions and survivors' group discussions than Rwandans living in Belgium. Those living in Finland relied instead on psychopharmaca and alcohol to get relief from their mental pain. It appears that they suffered more from their trauma, due to loneliness and the language barrier.

The Rwandan diaspora Finland is a relatively small community, while Belgium has a huge Rwandan community, the largest in the Western countries. Belgium has a particular status owning to the historical ties between Belgium and Rwanda. At the time of the genocide in 1994, a very significant amount of the educated class had studied and received vocational training in Belgium, through government scholarships or private means. This also applied to the members of the army and national gendarmerie, as some undertook their academic, medical professional, and other training in Belgium. In addition, a large numbers of Belgians lived in Rwanda before and during 1994, working in organizations in the private sectors, in NGOs, schools, in churches and in governmental institutions. Therefore, Belgians and Rwandans had been work colleagues since many years, both in Rwanda and in Belgium, creating strong ties at both professional and personal levels (Prunier, 1998, p. 33). In 2012, the number of Rwandans living in Belgian territory was between 30,000 and 40,000 (Schildt, 2013, p. 17). According to Statistics Finland (1990-2017), by 2017, Finland hosted 484 Rwandans who had come as refugees, as students and on other grounds.

In Belgium, there is a big Rwandan community with many restaurants, bars and associations, where Rwandans can meet and discuss their issues. As a French speaking country, it is easier for many Rwandans to integrate into Belgium's system and culture, while in Finland; it takes three years of learning the country's language and culture. This might be the main reason why there appear to be, in relative terms, more traumatized Rwandans in Finland in comparison with Belgium.

There could be more and better efforts from both Belgian and Finish authorities to reconcile Rwandans who live in their country. They should fight against racism and show love towards immigrants, because people who are traumatized feel even if they face racism. Rwandans in the diaspora suggest that the Belgian and Finnish authorities could organize activities such as conferences, games, seminars, sports, summer camps, etc. so that Rwandans can discuss their problems, as part of the reconciliation and healing process.

References

[1] [1] Antze, P., & Lambek, M (Eds.) (1996). *Tense past: Cultural essays in trauma and memory.* New York: Routledge.
[2] [2] Bäärnhielm, S. (2016). Refugees´ mental health - a call for a public health approach with focus on resilience and cultural sensitivity. *European Journal of Public Health*, *26*, 375−376.
[3] [3] Bolton, P. (2001). Local perceptions of the mental health effects of the Rwandan genocide. *Journal of Nervous and Mental Disease, 189*, 243−248.
[4] [4] Bornstein, M. H., & Lamb, M. E. (1999). *Developmental psychology: An advanced textbook*. (4th ed). Mahwah, NJ: Lawrence Erlbaum.
[5] [5] Boss, P. (2006). *Loss, trauma, and resilience: Therapeutic work with ambiguous loss*. New York & London: Norton.
[6] [6] Brahm, E. (2004). *Beyond intractability*. http;//www.beyondintractability.org/action/ author.jsp
[7] [7] Dayringer, R. (1998). *The heart of pastoral counselling: Healing through relationship*. New York, London: Routledge, Taylor & Francis Group.
[8] [8] Fassin, D., & Rechtman, R. (2009). *The empire of trauma: An inquiry into the condition of victimhood.* Princeton, NJ: Princeton University Press.
[9] [9] Figley, C. R. (1985). *The study and treatment of post-traumatic stress disorder: Trauma and its wake.* New York: Brunner/Mazel.

[10] [10] Figley, C. R., Bride, B. E., & Mazza, N. (1997). *Death and trauma: The traumatology of grieving*. Washington, DC: Taylor & Francis.
[11] [11] Finnish Advisory Board on Research Integrity (2012). *Guidelines for responsible conduct of research and procedures for handling allegations of misconduct in Finland*. http://www.tenk.fi/sites/tenk.fi/files/HTK_ohje_2012.pdf
[12] [12] Finnström, S. (2008). *Living with bad surroundings: War, history, and everyday moments in northern Uganda*. Durham, UK: Duke University Press.
[13] [13] Freud, S. (1892−1894). *Extracts from Freud's footnotes to his translation of Charcot's Tuesday lectures*. Standard Edition 1, pp. 129−154.
[14] [14] Furniss, G. M. (1994). *The social context of pastoral care: Defining the life situation.* Louisville, KY: Westminster John Knox Press.
[15] [15] Gibson, R. L., & Mitchell, M. H. (1999). *Introduction to counselling and guidance*. Upper Saddle River, NJ: Merrill.
[16] [16] Hedman, F. (1980). *Människosyner och vårdmodeller. En studie i terapi och själavård*. Åbo, Finland: Åbo Akademi Forskningsinstitut.
[17] [17] Hinton, D. E., Pich, V., Marques, L., Nickerson, A., & Pollack, M. H. (2010). *Khyâl* attacks: A key idiom of distress among traumatized Cambodian refugees. *Culture, Medicine and Psychiatry, 34,* 244−278.
[18] [18] Hodgkinson, P. E., & Stewart, M. (1998). *Coping with catastrophe. A handbook of post-disaster psychosocial aftercare*. 2nd ed. London, UK: Routledge.
[19] [19] Hofmann, S. G., & Otto, M. W. (2008). *Cognitive behavioural therapy for social anxiety disorder: Evidence-based and disorder-specific treatment techniques.* New York & London: Routledge, Taylor & Francis Group.
[20] [20] Khawaja, N. G., White, K. M., Schweitzer, R., & Greenslade, J. (2008). Difficulties and coping strategies of Sudanese refugees: A qualitative approach. *Transcultural Psychiatry, 45*, 489−512.
[21] [21] Learmonth, M., & Gibson, K. (2010) Art psychotherapy, disability issues, mental health, trauma and resilience: Things and people. *International Journal of Art Therapy*, *15*, 53−64.
[22] [22] Lobban, J. (2012). The invisible wound: Veteran's art therapy. *International Journal of Art Therapy*, 19, 1−16.
[23] [23] Maercker, A. (2015). You are not alone! The power and pitfalls of social contexts in PTSD. Keynote lecture at *XIV Conference of European Society for Traumatic Stress Studies*, 11 June, Vilnius, Lithuania.
[24] [24] Maercker, A., Schutzwohl, M., & Zahava, S. (1999). *Post-traumatic stress disorder: A lifespan developmental perspective*. Toronto, Canada: Hogrefe & Huber.
[25] [25] Marks, D. F., Murray, M., Evans, B., & Estacio, E.V. (2011). *Health psychology: Theory, research and practice*. Los Angeles, CA: Sage.
[26] [26] Melliar, P., & Brühka, A. (2010). Round the clock: A therapist's and service user's perspective on the image outside art therapy. *International Journal of Art Therapy*, 15, 4-12.
[27] [27] Miranda, O. (2012). Bonding after trauma: On the role of social support and the oxytocin system in traumatic stress. *European Journal of Psychotraumatology*, 3:18597. http://www.tandfonline.com/doi/full/10.3402/ejpt.v3i0.18597
[28] [28] Mitchell, S. A., & Black, M. J. (1995). *Freud and beyond: A history of modern psychoanalytic thought*. New York: Basic Books.
[29] [29] Mölsä, M., Kuittinen, S., Tiilikainen, M., Honkasalo, M. L., & Punamäki, R. L. (2016). Mental health among older refugees: the role of trauma, discrimination, and religiousness. *Aging & Mental Health*, *21,* 829−837. doi: 10.1080/13607863.2016.1165183
[30] [30] Nordström, C. (1997). *A different kind of story to tell*. Philadelphia, PA: University of Pennsylvania.
[31] [31] Ochberg, F. M. (1998). *Traumatic stress and PTSD: Gift from within posttraumatic therapy*. http://www.giftfromwithin.org/html/articles.html
[32] [32] O'Connor, T. J. (1998). *Clinical pastoral supervision and the theology of Charles Gerkin.* Waterloo, Ontario, Canada: Wilfrid Laurier University Press.
[33] [33] Parish, J. (2011). Social suffering and anxiety: Deciphering coughs and colds at Akan anti-witchcraft shrines in Paris. *Anthropology & Medicine, 18,* 303−313.

[34] [34] Pillemer, D. B. (1998). *Momentous events, vivid memories: How unforgettable moments helps us to understand the meaning of our lives.* Cambridge, UK: Harvard University Press.
[35] [35] Prunier, G. (1998). *The Rwanda crisis: History of genocide*. London: Hurst.
[36] [36] Schildt, J. (2013). *The "here and there" of Rwandan reconciliation: Individual actors take centre stage*. Louvain, Belgium: University Press. [PhD Thesis]
[37] [37] Schiraldi, G. R. (2000). *The post-traumatic stress disorder source book: a guide to healing, recovery and growth.* Los Angeles, CA: Lowell House.
[38] [38] Schouler-Ocak, M., & Kastrup, M.C. (2015). Refugees and asylum seekers in Europe. *Die Psychiatrie*, *12,* 241−246.
[39] [39] Scott, M. J., & Stradling, S. G. (2006). *Counselling for post-traumatic stress disorder: Counselling in practice*. London, UK: Sage.
[40] [40] Shaw, R. (2001). *Memories of the slave trade: Ritual and the historical imagination in Sierra Leone.* Chicago, IL: University of Chicago Press.
[41] [41] Simpson, C. A., & Porter, G. L. (1981). Self-mutilation in children and adolescents. *Bulletin of the Menninger Clinic*, *45*, 428−438.
[42] [42] Simpson, M. A (1992). Amnesty means never having to say you're sorry: Amnesty and its potential to damage survivors of trauma. *Critical Health*, *41*, 23−26.
[43] [43] Snyder, C. R. & Ford, C. E. (1988). *Coping with negative life events: Clinical and social psychological perspectives*. New York: Plenum.
[44] [44] Statistic Finland (1990-2017). *Country of birth according to age and sex by region: Both sexes*. www.stat.fi/til/vaerak/tau_en.html
[45] [45] Tiilikainen, M., & Koehn, P. H. (2011). Transforming the boundaries of health care: Insights from Somali migrants. *Medical Anthropology, 30*, 518−544.
[46] [46] United Nations High Commissioner for Refugees (UNHCR) (2017). *Global trends: Forced displacements in 2016*. http://www.unhcr.org/globaltrends2016/
[47] [47] Van der Kolk, B. A. (2005). Developmental trauma disorder: Towards a rational diagnosis for chronically traumatized children. *Psychiatric Annals*, *35*, 390−398.
[48] [48] Van der Kolk, B. A., McFarlane, A. C., & Weisalth, L. (1996). *The effects of overwhelming experience on mind, body and society*. London, UK: Guilford Press.
[49] [49] Van der Kolk, B. A., & Fisler, R. (1995). Dissociation and the fragmentary nature of traumatic memories: Overview and exploratory study. *Journal of Traumatic Stress*, *8*, 505−525.
[50] [50] Vick, R. M. (2000). Creative dialogue: A shared will to create art therapy. *Journal of the American Art Therapy Association, 17,* 216−219.
[51] [51] Wittchen, H. U., Gloster, A., Beesdo, K., Schönfield, S., & Perkoning, A. (2009). Posttraumatic stress disorder: Diagnostic and epidemiological perspectives. *CNS Spectrums*, *14,* 5−12.
[52] [52] World Medical Association Declaration of Helsinki (2013). Ethical principles for medical research involving human subjects. *JAMA*, *310,* 2191−2194.
[53] [53] Yehuda, R. (2006). Psychology of post-traumatic stress disorder a decade of progress. *Annals of the New York Academy of Sciences, 1071*. Malden, MA: Wiley-Blackwell.
[54] [54] Yule, W. (2003). *Post-traumatic stress disorder: Concepts and therapy*. Chichester, UK: Wiley.

National Leveling of ELT Educational Programs and Their Harmonization with European Requirements for Competitiveness on the Market - Opportunities and Challenges

Jovanka Jovanchevska, MA

Abstract

The poor international competitiveness and the debatable language competences of the English language teaching staff educated in the Republic of Macedonia impose the need to revise the framework of higher education requirements for this profession and educational programs implemented by higher education institutions in the first place, as well as the professionalization of already existing staff. In this process, the main challenge resides in raising the operational level and standardization of the profession, followed by harmonization of national descriptors with the Common European Framework of Languages.

Keywords*:* ELT, Modern English Language, educational programs levelling

Introduction

„At any point in language teaching history there are always items of faith which nobody questions..."

Guy Cook

In the context of existing technology and the extent of today's communication, it is unnecessary to speak about the importance of English in the world. This tendency, except for the last thirty years with the emergence and the flickering development of the Internet, in the R. Macedonia has been recognized since the state's mere beginnings.

Having only the Department of English Language and Literature at the state university in the last century kept things quite simple – one higher education institution with limited number of options: staff, students, native speakers, and funds; limited options for students to stay in English speaking countries in order to practice and upgrade their proficiency in the language. The preset proficiency levels theoretically reached up to C1 (CEFR), but realistically, the average operational level was about B2[1][2].

Today in R. Macedonia there are several higher education institutions offering educational programs for future English language teachers. With the existence of English as subject (course) in primary, secondary and tertiary education, the need for such staff is obvious, but the demand, which was particularly rising 10-15 years ago, failed to maintain the level due to the influence of various factors. One of these factors is the lack of competitiveness of Macedonian English language teachers on the international labor market. At first glance, the reasons for this failure are in the classical dogma that there is no better teacher for a particular language than a native speaker of that language. We will leave this debate for a further occasion because the purpose of our research is another. The main reason for the inability of Macedonian English language teachers to teach in other countries is the lack of international recognition of Macedonian English language teaching programs' diplomas. The reasons for this reality are of a different nature, the most important ones (supposedly) including

[1] Personal unofficial view of foreign native speakers language instructors

[2] "Since 2012 France requires primary and secondary teachers to obtain a certificate147 which proves that the teacher masters a modern foreign language at level B2 of the CEFR" – as mentioned in the Study "The implementation of CEFR in European Education Systems"