

# Posttraumatic Stress Disorder

## Cultural Aspects of Trauma

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**Abstract:** This paper reviews some of the recent research and literature on the identification, diagnosis and treatment of psychological trauma and trauma-related illnesses in different cultures. The paper also explores effects of culture on the expression of symptoms and modes of communicating psychological distress.

**Résumé : Les aspects culturels du traumatisme**

Cet article examine les études et la documentation récentes sur le dépistage, le diagnostic et le traitement du traumatisme psychologique et des maladies liées aux traumatismes, au sein de différentes cultures. L'article recherche également les effets de la culture sur l'expression des symptômes et les modes de communication de la détresse psychologique.

**Key Words:** psychological trauma, posttraumatic stress disorder, PTSD, culture, immigrants, refugees

As with other major mental illnesses that have been widely studied around the world, such as depression and schizophrenia (1–3), there is a growing body of research and literature on identifying, diagnosing and treating psychological trauma and trauma-related illnesses in different cultures and also on culturally determined modes of communicating psychological distress and expressing symptoms. This increased focus is related to the need to provide culturally appropriate services to a rapidly growing population of displaced persons, immigrants and refugees uprooted in an ongoing global situation of armed conflict that unfortunately shows no signs of abating (4,5). It also aims to meet the needs of a multicultural population such as Canada's.

The World Mental Health Report (1995) provides a table summarizing 11 studies of posttraumatic stress disorder (PTSD) prevalence rates in different populations that have suffered natural or man-made disasters, war, torture or repression (1). The prevalence rates range from a low of three and one-half per cent among flood victims in Puerto Rico and four per cent among refugees at a health-screening clinic in the United States to 88 per cent in Laotian refugees attending an Indochinese mental health program in the United States (1). These wide-ranging

differences can be attributed in part to different assessment methods, scales and interview schedules and to differences between child and adult populations. However, it is generally accepted that certain refugees and in particular some individuals who have experienced torture are at particularly high risk for developing mental health sequelae (5–7). Another finding of note in these studies is the high frequency of comorbid psychiatric conditions, particularly major depression. Although substance abuse was not specifically mentioned, it is also very common in patients with PTSD.

A clinically useful strategy in assessing PTSD is to make no assumptions regarding patients' own explanations of their illness and their expectations for treatment. Rather, their explanations should be explicitly verified with them. The underlying rationale is that all clinical encounters are in fact cross-cultural encounters, and this remains worth considering even when patient and therapist are from the same cultural background. For example, the question, "What was the worst part of the traumatic experience for you?" can often yield very different and unexpected answers even among people who have experienced the same event. In his case description of a Cambodian refugee in France, Rechtman attempts to separate an individual's clinical history from her collective history and writes, "even if refugees have lived the same events, this does not mean that they have experienced the same trauma. Both trauma and culture shape human experience and may give the illusion of a common destiny that would flatten out varying individual fates, whereas in fact different destinies are contingently linked together . . . While knowledge of cultural differences is essential for clinicians, it is equally essential to be aware of how the individual's psyche may find hidden paths within the constraints imposed by culture, or even by trauma itself" (7).

Alongside our biomedical model of psychiatric treatments for PTSD, both psychological and pharmacologic, we can recognize that in many non-Western cultures nonpsychiatry-based trauma recovery involves witnessing, testimony and reparation, as occurred in South

Africa's recent Truth and Reconciliation process. As well, the World Mental Health report observes that refugees from some African and Asian countries "experience trauma and recovery in ways distinct from the narrative frames of many Western societies, which are often linked to Judaic-Christian notions of catharsis, confession, reparation, and redemption" (5). Often, if it is safe to speak out, social testimonies are needed before healing can occur. An example of this is the work being done internationally by the Vivo Foundation, which is developing a brief narrative exposure therapy (NET) that attempts to address these needs ([www.vivofoundation.net](http://www.vivofoundation.net), and Dr. Maggie Schauer, personal communication, 2001).

It is important to recognize that there is also controversy about diagnosing social and political problems related to violence, war or poverty as psychological disorders. By giving a diagnosis of PTSD, social protest or suffering becomes medicalized and pathologizes victims of a repressive regime (4,8–10). Authors like Zarowsky (8) and Elsass (10) argue convincingly for obtaining a full understanding of local situations through close ethnographic study for examining the "broken social worlds" that shape people's lives after a disaster or traumatic event. These steps must be taken before prescribing a Western diagnostic model for psychological distress which has itself developed in its own historical and cultural context, the culture of biomedicine. As Summerfield writes: "In many non-Western cultures, distress is commonly understood and expressed in terms of disruptions to the social and moral order and no particular attention is paid to internal emotions and items in their own right. Western psychotrauma models, which liken the brain to a machine and see PTSD—the flagship diagnosis—as due to incomplete emotional and cognitive processing within that machine, cannot make much sense to such people" (4). Summerfield critiques the overlap of "refugee mental health" and "trauma" and calls for more long-term studies of outcomes in people who have lived through war and other traumatic experiences, to have more realistic expectations regarding trauma effects of over time.

A South American study that explores reactions to trauma in two settings, Peru and Colombia, usefully illustrates culturally appropriate approaches to trauma treatment (10). Both countries have experienced extreme levels of organized violence. While posttraumatic symptoms were present in people from both locations, the Peruvian villagers showed a strong community spirit and were more oriented toward forgetting the trauma and coping through the use of spiritual or religious myths and metaphors. Indeed, they had been able to return to productive levels of

functioning. Psychosocial interventions were therefore focused more on strengthening the community as a whole, rather than on individual symptoms, processing or abreaction. In Colombia, villagers were found to be more individualistically oriented and more open to psychological interventions dealing with emotions such as guilt and shame. This illustrates the importance of matching the intervention to the setting and highlights the tightrope between respecting individual and collective memory.

The DSM-IV diagnostic category for PTSD is useful for widespread measurement and comparison of symptoms, aiming toward accurate diagnosis and, thus, treatment of this condition. Perhaps more than other psychiatric diagnoses, however, the concept of trauma requires a broader view to enable a thorough understanding of the experience, even when it is seen in a biopsychosocial formulation. This may be due in part to the unique cause–effect nature of PTSD, where an event that threatens life or limb is essential to the diagnosis. This etiology creates an opening for interpretation and a need to search for the meaning the traumatic event has for each individual. Further, psychological resilience and other social factors that protect people from developing PTSD must be explored to understand why large numbers of people who have in fact experienced trauma do not develop the illness as defined by our biomedical classification. Holocaust survivors and their children, as a whole, constitute one such group, although individual experiences and outcomes within this group may vary greatly, depending on war experiences, age at the time of World War II, the extent to which the war affected communities of origin and family support before, during and after the war.

More broadly, the literature on social suffering elaborates on traumatic experiences and human problems in a much more meaningful manner and allows for a more humanistic understanding of the challenges that we all face in our lives. Suffering is described by Arthur Kleinman as a social experience that connects the moral, the political and the medical, including health and social policy (11). Only by incorporating all these approaches with our clinical knowledge can we begin to address issues about trauma and posttraumatic stress in ways that are culturally appropriate, while keeping our promise to do no harm.

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