The applicability of Western trauma models to non-Western populations: a study in Burundi (Preliminary results)

Background

- Rise in violence around the globe.
- Increasingly common psychological component to humanitarian interventions.
- Increasing popularity of PTSD construct and Western trauma discourse both at home and abroad
- Need to further assess the applicability of such constructs to these culturally foreign settings before applying them both in the U.S. and the country of origin.

Constructs

- Post-traumatic Stress Disorder specifically
- “Traumatization” in general

Post-Traumatic Stress Disorder

- First defined in 1980 in DSM – III
- Criteria: identifiable event causing intense fear, horror, or hopelessness
- Symptom subcategories: intrusion, avoidance/numbing, hyperarousal
- Symptoms lasting more than one month after the event
- Significant distress or decrease in functioning

PTSD Controversies

- The Criterion A event - criterion creep
- Nature of traumatic memory
- Many symptoms overlap with other disorders
- Overemphasis on traumatic event as causal
  - 70% don't develop PTSD (Bryant, 2004)
- PTSD as universal entity or cultural artifact?

PTSD as a cultural construction?

- The search for biological correlates and mechanisms
- The search for PTSD symptoms across cultures
- Some important dissenting voices:
  - Shephard (2003) argues that British military history shows that WWI war neuroses were the product of incentives and an expectation of pathology.
  - Summerfield (2004) : PTSD as a product of a culture focused on vulnerability rather than on resiliency; a medicalization of distress that overlooks resilience and protective factors

Potential impact of importing PTSD

- Risk of pathologizing people who in fact show resilience (Kagee & Del Soto, 2003)
- Failure to recognize broader symptom set (Pupavec, 2002)
- Draws attention away from the underlying political and social causes of an event (Wessells, 1999)

Central Question

- To what degree do the symptoms of PTSD describe a universal response to traumatic events? To what degree might it be a culturally determined construct?

Literature on PTSD in non-Western cultures

- Namibia: 35% (N=20) met criteria for PTSD
  method: asked about PTSD symptoms (McCall & Resick, 2003)
- Sierra Leone: 49% (N=55) met for PTSD, 80% exceeded anxiety cut-off; 85% depression cut-off (Fox & Tang, 2000)
- Sierra Leone: 99% met for PTSD (Raymond, 2000) N=245
- Sudan: diverse symptoms; commonly somatic in nature, primary concerns were not psychological; used semi-structured interviews (Baron, 2002)
- South Africa: 20% (N=201) met for PTSD; depression and somatization also high
- Rwandan children 79% (N=1800) met for PTSD
- Trends suggest intrusion and hyperarousal are universal and avoidance/numbing are culturally determined (Marsella, 1996)

Limitations within current research

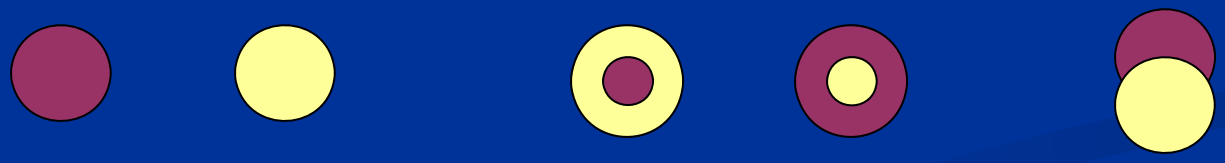
(Much depends on how you try to answer the question)

- Diverse findings
- Poor translation; lack of back-translation
- Lack of involvement of local staff in design and data collection
- Commonly only assess for PTSD
- Use of unvalidated questionnaires

The Need for a Broader Assessment

- Jenkins' (1996) category fallacy
- De Jong's (2004) overlapping constructs

Separate constructs One within the other Overlapping



PTSD Local idiom of distress

Additional Influences

- Power Differential
- Social Desirability / Secondary Gain
- Prior exposure to Western Trauma Discourse

Power Differential

- Overvaluation of Western culture (Wessels, 1999)
- Denigration of local perspectives (Peddle et al., 1999)
- Western knowledge is privileged (Summerfield, 1999)

Social Desirability/ Secondary Gain

- Influence of suggestion
  - Symptom suggestibility - iatrogenesis (Skelton, 1996)
  - Sick Building Syndrome (Rothman & Weintraum, 1995)
- Local need for resources
- "Being a victim is more advantageous than being a survivor" (Summerfield, 2001)

Exposure to Western Trauma Discourse

- An aspect of social desirability/ secondary gain which may increase persistence of symptoms (Kagee & Del Soto, 2003)

- Given the realities of iatrogenesis, could there be a relationship between symptoms and familiarity with Western models?

A study in Burundi

- My Master's thesis: examining a relationship between exposure to western trauma models and the variability in symptom type presentation
- African Great Lakes Initiative
- May 2005

Possible types of exposure to Western trauma discourse

- Visits to non-traditional health care staff
- Radio programs about stress or mental health
- Brochures read about stress or mental health
- Workshops attended about stress or mental health
- Contact with foreign humanitarian organizations

Specific Hypotheses

- Hypothesis (1): That prior exposure to Western trauma discourse will be related to a greater severity of PTSD symptoms.
- Hypothesis (2): That prior exposure to Western trauma discourse will be related to the greater presentation of PTSD symptoms (as opposed to non-PTSD sx).
- Hypothesis (3): That prior exposure to Western trauma discourse will be more highly correlated with PTSD symptoms when solicited by self-report measure than it will when solicited in an open-ended interview.

Burundi

Burundi

Burundian Civil War, 1993-2001
(approximately)

200,000 - 250,000 killed **(AFSC, 2001)**

National Burundian context

- South of Rwanda, similar culture and ethnic groups, yet a different history
- History of post-colonial conflict between Hutu majority and Tutsi minority
- 1993 – first Hutu president assassinated, leading to civil instability over the last 12 years
- 2005 – end of three year transitional period; new president elected in August, 2005

Local Burundian context

- Burasira in Ngozi province, north central Burundi
- Many Tutsis resettled in what have become Internally Displaced Persons (IDP) camps
- IDP camp residents often walk 2-3 hours to their fields
- Gradual return to homes and land

Participants

- Rural Burundian sample (N=80), ages 18-50 of mixed ethnicity and gender in two different Internally Displaced Persons camps (Burasira and Ruhororo)
- Varied traumatic history
- All future participants of the Healing and Reconciling Our Communities (HROC) workshop

How to solicit symptoms

- As reported in a semi-structured qualitative interview using open-ended questions
- As reported on the Harvard Trauma Questionnaire – IV(HTQ-IV) (Mollica et al., 1992)
- As reported on Hopkins Symptom Checklist -25 (HSCL-25) (Hesbacher, Rickels, & Morris, 1980)

Qualitative Semi-structured Interview

- In the days and weeks after the event, what were you thinking and how were you feeling?
- Did your experience change you? In what ways?
- When you think about your experience now what comes to mind?
- Did people notice anything different about you as a result of your experience?

Preparation

- Development, translation into Kirundi, and back-translation of measures in consultation with Burundian program staff
- Review items for content and semantic equivalence (Flaherty, 1988)
- Pre-assessment training of staff on issues of responding to distress, confidentiality, rapport building

Procedures

- Description of purpose: general health and past experiences prior to workshop
- Assess traumatic experiences history
- Assess symptoms and prior exposure to Western culture
- Conducted by Burundian trauma counseling staff

Coding of Qualitative Data

- Responses to open-ended questions
- Responses to Western trauma discourse questions
- Interrater reliability established

Ethical Issues

- Causing additional distress to participants - terminate interview, offer supportive counseling and referral
- Interview may create expectations of assistance
- How to respond to requests beyond HROC's domain
- The effect of further concretizing constructs and using unvalidated measures
- Cultural variations on informed consent and confidentiality

Sample Descriptives

- Average age: 38
- 36% female
- Education
  - 65% completed 4-6 years
  - 21% less than four years
  - 14% more than 6 years
- Residence: 45% live in IDP camps with an average stay of 11 years

Sample Descriptives

- Ever Married: 74%
- Widowed: 19%
- Children born: 5 (mean), 0-15 (range)
- Children dead: 1 (mean), 0-11 (range)
- Unrelated children in the home
  - .5 (mean), 0 - 4 (range)

Trauma History

- Forced to Hide 100%
- Combat situation 100%
- Lack of shelter 97%
- Lack of food and water 96%
- Ill health and no medical care 91%
- Loss of personal property 91%
- Narrowly escaping death 78%
- Unnatural death of family member 72%
- Betrayed and placed at risk of death 33%

Trauma History

- Serious physical injury from combat 20%
- Imprisonment 20%
- Forced to harm or kill a stranger 17%
- Disappearance/kidnapping of spouse 13%
- Forced to hide among the dead 13%
- Forced to harm or kill a friend/family 12%
- Rape 12%
- Sexual abuse/humiliation 8%
- Disappearance/kidnapping of child 5%

Trauma History

- Total events experienced (from list)
  - Mean 9.5 (1.9); range 5-15
- Total events (experienced, witnessed, or heard about)
  - Mean 16.0 (3.0); range 9-19

Self-selected "most distressful event"

Family member(s) killed	28.2%
Almost killed	23.1%
Flight and homelessness	12.8%
Loss of house and possessions	10.3%
Arrest/prison	3.8%
Family member almost killed	2.6%
Other	19.2%

Note: 69% of these events occurred prior to 1996

Prior exposure to general Western culture

- Spoken with foreigners previously 15%
- Has foreign born friends 2%
- Received assistance from NGO's 85%
- Received non-traditional medical care 93%
- Heard radio or watched TV "most days" 78%

Prior exposure to Western trauma models

- Have learned about traumatic stress
  - Attended trauma workshops 14%
  - radio transmissions or reading (1-2x each) 76%

- Do you know the word?:
  - Post-traumatic Stress Disorder No: 97%
  - Trauma No: 73%
  - Ihahamuka No: 25%

Responses to open-ended questions

	Had 1-2 symptoms	Had 3 or more symptoms
PTSD (liberal)	76%	13%
PTSD (conservative)	32%	3%
Nonspecific anxiety (conservative)	27%	0%
Nonspecific depressive (conservative)	32%	0%
Material (conservative)	88%	3%
Anger (conservative)	10%	0%
Somatic/medical (conservative)	22%	0%
"Evil thoughts/revenge" (conservative)	38%	0%

Response examples

- Intrusion:
  - Even today when I meet those people, the images of the event come back to me and I feel bad
  - If those thoughts come back in me, I feel as if I become crazy. It is why I do not like thinking about it again.
- Avoidance:
  - I decided to no longer greet anyone from my native area because these people reminded me of what happened
- Arousal:
  - Whenever I hear something making noise, my heart jumps high. When someone calls me, first I feel jumpy.

Response examples

- Nonspecific anxiety
  - I had much fear and shakiness inside
  - Much worry
- Nonspecific depression
  - I felt emptiness in my heart
  - I am very silent person; before I was a laughter person. Now I'm lonely person

Response examples

- Material
  - I fled at harvest time; I suffered from hunger.
  - No food, no money to go to the doctors, raising children without my husband
- Medical
  - I have trouble in my stomach
- Dissociation
  - My mind goes blank and I am not thinking anything; just standing there
- Evil thoughts/revenge
  - Bad thoughts were coming into my mind. I will revenge.

PTSD subcategories (open-ended questions)

- Intrusion
  - Intense psychological distress at exposure to cues associated with event (63%)
  - Physiological reactivity to cues (17%)
  - Least common: Recurrent dreams (2%)

PTSD subcategories (open-ended questions)

- Avoidance
  - Sense of a foreshortened future (56%)
  - Restricted range of affect (22%)
  - Least common: inability to recall aspect of the traumatic event and diminished participation in significant activities (0%)

PTSD subcategories (open-ended questions)

- Arousal
  - Irritability or anger outbursts (40%)
  - Hypervigilance (35%)
  - Least common: difficulty falling or staying asleep (0%)

Conclusions from open-ended questions

- Complaints of material needs predominate
- PTSD and depressive/anxious symptoms are both reported
  - Difficult to compare frequencies in qualitative data
- Intrusion (43%) and Avoidance (33%) more frequently reported than Arousal symptoms (24%)
- Some specific PTSD symptoms not evident

Conclusions from self-report measures

- Strong relationship between traumatic events experienced and different symptoms types
  - With PTSD symptoms (r = .50)
  - With depressive symptoms (r = .42)
  - With somatic symptoms (r = .31)
  - With anxiety symptoms (r = .26)

Yet, only 11% were considered "symptomatic for PTSD".

Conclusions from self-report measures

- Exposure to western trauma models not significantly related to severity of trauma symptoms; but were more strongly related than to severity of depressive/anxious symptoms
  - HTQ and WTDE, r =.15
  - SCL and WTDE, r =-.02
  - Hotelling's test: t=-1.88, p=.06

Conclusions from self-report measures

- Participation in workshops and trauma-related media were significantly related to severity of symptoms
  - $r = .28$, $p=.02$, $R^2 = .08$
- And when controlling for events experienced . . .
  - $R=.53$, $R^2 = .28$, adjusted $R^2 = .27$, change in $R^2 = .03$ ($p=.07$)
  - $b= .12$, $SEb = .03$, $p<.001$, 95%CI: .07-.17 (events experienced)
  - $b= .039$, $SEb = .02$, $p=.07$, 95%CI: .00-.08 (trauma media/workshops)

Possible Interpretations

- We can only conclude that there may be a non-causal relationship
- Possible explanations
  - Exposure to western trauma models influence severity of PTSD symptoms
  - People with more severe PTSD sought out western trauma model information
  - A third variable is responsible for the relationship

Conclusions from self-report measures

- Prior exposure to Western trauma models was significantly related to PTSD symptoms when solicited by self-report measure but not when solicited with open-ended questions
- What's going on here?
  - Prior knowledge is influencing symptom presentation either truthfully or via malingering
  - People don't think of the symptoms they have unless specifically asked
  - Poor methodology in open-ended questions

Summary

- PTSD remains a controversial construct even in the West
- Symptoms should be assessed broadly even when traumatic history is evident
- Material needs outweigh psychological issues
- Whether exposure to western trauma models can influence symptoms needs further investigation
- Caution against conveying an expectation of vulnerability and pathology over and an expectation of resilience

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