
Cultural Factors in Traumatic Stress

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Posttraumatic stress disorder (PTSD) as a diagnosis was first recognized in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)* (APA, 1980). In this chapter, we highlight the relevance of and need for a better elucidation of the prevalence of PTSD in diverse settings and discuss its utility as a way of conceptualizing traumatic stress. Next we discuss critiques of this construct. One of the most central critiques lies in the debate as to the degree to which PTSD is a meaningful and useful construct in the context of cross-cultural psychological research and clinical treatment. We reference components of this debate and conclude with some specific recommendations for research and treatment. The PTSD diagnosis includes a prerequisite traumatic event, three subsets of symptom types, a requisite duration of symptoms beyond one month after the associated event, and a significant distress or decrease in functioning. The intrusion subcategory includes dreams or flashbacks reminiscent of the event, intrusive thoughts about the event, and emotional distress and physiological reactivity to cues associated with the event. The avoidance/numbing subcategory includes the avoidance of people and places that are reminders of the event, the inability to remember all the details of the event, feelings of detachment from others, a restricted range of affect, and a sense of a foreshortened future. The hyperarousal subcategory includes an exaggerated startle response, difficulty concentrating or falling asleep, outbursts of anger, and hypervigilance.

Since its inception PTSD has been embroiled in debate over multiple issues. Major controversies about the diagnosis include the political climate in which it was conceived, the recent broadening of the definition of the traumatic event that is required to meet a diagnosis for PTSD, that event's questionable association with symptom manifestation, and the theoretical view of the nature of traumatic memory (Herbert & Forman, 2005; McNally, 2004). For instance Mol et al. (2005) found that PTSD symptoms were as commonly associated with life events such as an illness or problems at work as they were with events that meet Criterion A. The construct has been a source of even greater

controversy in its implication that traumatic memories can be actively repressed and then made inaccessible to memory (Bloom, 1997), a notion that is not supported by research on memory (Lynn, Knox, Fassler, Lillienfeld, & Loftus, 2004; McNally, 2004). All of these controversies warrant substantial caution in our application of the PTSD construct cross-culturally. For instance, Terheggen, Stroebe, and Kleber (2001) reported that for Tibetans the most traumatic event was the witnessing of the destruction of religious signs. However such events do not typically find themselves on a traumatic event checklist.

Importance of Understanding Cultural Factors

The need to identify how people respond to traumatic events has become a central issue in both international psychological and humanitarian domains. Medical and mental health professionals find themselves with an increasingly diverse patient pool that may include recent refugees, asylum applicants, and immigrants from regions of the world that have experienced profound disruption, most often in the form of a war or a natural disaster. As an index of the vast numbers of people who have experienced traumatic events, there have been 190 armed conflicts between the end of the Second World War (WWII) and 1990 resulting in 310,000 deaths and many times more nonfatal casualties (WHO, 2002). In contrast to WWII, most of those killed and injured have been civilians (Zwi, 1991). At the close of 2006, there were over 12.8 million Internally Displaced Persons, 9.8 million refugees, and an additional 10.3 million "people of concern" as designated by the United Nations (UNHCR, 2006).

As the West has expanded its role in the provision of various types of resources to impoverished countries and displaced populations, such aid has increasingly included treatment for trauma-related psychological problems. These treatments have been developed in nations of relatively similar culture (United States, Europe, Australia, Israel) and are thus primarily based on industrialized cultures' conceptualizations of trauma and its sequelae, in particular the notion that PTSD is an expected, or at least likely, psychological reaction to extremely stressful events. The vast majority of the treatment methods and models for traumatic stress have been derived from studies of samples from industrialized countries and yet they are increasingly applied to diverse cultural populations. The validity of this conceptualization and even validity of the diagnosis is still in debate as applied to industrialized cultural populations; the degree to which PTSD is universally applicable is even less certain. The reliability and validity of our measurement of PTSD, what diverse groups consider traumatic, how they respond to trauma, and the type of treatment from which they will most benefit, needs continued attention (Marsella, Friedman, & Spain, 1996).

The debate over the appropriate application of these models in culturally different settings is born out of a larger effort to assist individuals and communities



in their recovery from devastating impact of human-caused or natural events. Successful conceptualization of a singular model facilitates research and treatment development, yet oversimplification of the model can cause additional problems. For instance, Kleinman (1977) warns us against the “category fallacy” in which we presume that mental health constructs will translate and be evident in other cultures. There are concerns that the PTSD label implies vulnerability within those who may in fact show more resilience (Frey, 2001). Other writers caution that the use of the PTSD diagnosis draws attention away from the political and social causes of an event and distracts us from the true causes of traumatic stress: political violence, economic injustice, and issues of security (Nader, Dubrow, & Stamm, 1999; Wessells, 1999). Biomedical conceptualizations and treatment of distress potentially reduce the critical consideration of economic and political forces that contribute to such distress (Bracken et al., 1995).

Studies of Prevalence

To understand the cultural factors that influence the presentation of traumatic stress, we must first investigate basic prevalence of PTSD in different settings. Evidence of prevalence demonstrates that the construct can be found in that setting, but does not tell us whether it is the most valid representation of traumatic stress. Conclusions about prevalence are often based on the questionable assumption of the validity of assessment techniques and measures. Nonetheless, it is a starting point for understanding how traumatic stress is manifest among different people.

In cross-cultural research, methodology significantly shapes the nature of findings. For instance, an *etic* investigation imposes preestablished constructs and methods from a cultural perspective foreign to the sample under study, whereas an *emic* approach aims to elicit more qualitative information from the subject by using open-ended questions on the principle that responses should not be forced to fit into preconceived foreign models. Both styles of research can contribute to appreciating cultural manifestation of traumatic stress and both have their limitations. An *emic* approach has the advantage of collecting indigenous models and descriptors of the experience of traumatic stress. Responses are not limited to those of a predetermined questionnaire and there is opportunity to fully assess the breadth of possible manifestations of distress. The main disadvantage lies in the likelihood of overlooking symptoms that are considered too private or insignificant by respondents. In addition, qualitative data offers limited opportunities for statistical analysis. Questionnaire-based (*etic*) methods, probe for expected signs and symptoms, and also yield quantitative data.

Studies measuring prevalence can be divided between samples of refugees having lived in or recently arrived in industrialized nations, and samples of nationals living in either their country of origin or having been displaced to



another culturally similar country (i.e., Rwandan refugees in Burundi). This distinction is important in that it potentially reflects different degrees of acculturation which may influence symptom presentation. It could be argued that as length of stay in industrialized countries increases, immigrants may be relatively more acculturated and therefore their symptoms may more closely resemble the PTSD model. This distinction also many indicate the extent of daily living stressors associated with refugee status that has been shown to contribute to the maintenance or exacerbation of traumatic stress.

Reported prevalence rates are predictably as diverse as the different samples in which they were solicited. For instance reports of PTSD after natural disaster have ranged from 1.5 percent to 67 percent (Wang et al., 2000), and after war or civil unrest as high as 99 percent (Raymond, 2000). Due to the diversity of samples and their concomitant traumatic histories, it is difficult to discern whether such differences are the result of methodological and sampling differences or the studying of a disorder with significant cultural variability. A comparison of traumatic stress reactions between two different cultural groups does not permit confident attribution of these differences to differences in cultural identity unless other factors are controlled for (SES, trauma exposure, urban versus rural). Nonetheless, a brief summary of the diverse findings is provided below.

Recent Immigrants to the Industrialized World

The following studies primarily used etic approaches such as standardized self-report measures, though they were sometimes read aloud to the participants. Carlson and Rosser-Hogan (1994) sampled Cambodian refugees who had lived in refugee camps in Thailand and had emigrated from Thai refugee camps to the US ten years prior to the study. Eighty-six percent of the sample met criteria for PTSD. Forty-three percent also surpassed cut-offs for substantial emotional distress and 40 percent exceeded cut-offs for clinical depression. Al-Saffar, Borga, Edman, and Hallstrom (2003) sampled foreign nationals (Turkey, Iran, Saudi Arabia) who had immigrated to Sweden at least four years prior to the study. All participants had previous trauma exposure, yet response across ethnic differences was highly variable. The study found the presence of PTSD in 69 percent of the Iranians, 59 percent of the Saudis, 53 percent of the Turks, and only 29 percent of the Swedes. Weine et al. (1995) reported PTSD in 25 percent of a sample of Bosnian adolescents recently relocated to the United States. Similar findings were reported among Kurdish youth refugees (Ahmad, 1992). Kinzie et al. (1986) found that 50 percent of a Cambodian refugee sample living in the US met criteria for PTSD. Observed differences across studies are likely due to some combination of factors such as differences in assessment, in culture, or the postconflict situation. Better identifying the specific factors responsible for these differences will require further study.

Establishment of prevalence begs the question of whether the factor structure of a given PTSD measure is comparable across cultures. Beyond evidence



of PTSD symptoms across cultures, we must then examine whether certain symptoms predominate or co-occur together. Sack et al. (1997) investigated the factor structure of the Diagnostic Interview for Children and Adolescents (DICA; Welner et al., 1987) with Cambodian youth refugees. Results revealed the same factor structure as found in samples from industrialized cultures. Similarly, the Impact of Event Scale (Horowitz, Wilner, & Alvarez, 1979) revealed the same underlying factor structure when used with Bosnian youth as when used with British youth (Smith, Perrin, Dyregrov, & Yule, 2003). A study that compared Russian and American youth found that while PTSD prevalence rates differed, the proportional severity of the symptom clusters and their correlation with other forms of psychopathology were comparable (Ruchkin et al., 2005). Whereas these findings lack sufficient validity to confirm that PTSD is the best universal description of traumatic stress, they do indicate that PTSD can be similarly measured across different settings.

Nationals Remaining in a Pre-Industrialized Setting

Several studies engaged samples who were either in their home country or had been displaced to a relatively similar cultural setting. However, there remains a paucity of data when it comes to the assessment of traumatic stress reactions in these populations. A comprehensive review assessed for PTSD prevalence rates and found that only 6 percent (8 out of 135) used samples from developing countries (De Girolamo & McFarlane, 1996).

Traumatic stress symptoms were solicited from a small sample of victims of domestic violence among the Ju/'hoansi (Kalahari Bushmen) of eastern Namibia, one of the world's last ethnic groups still transitioning from a hunter-gatherer lifestyle (McCall & Resick, 2003). Thirty-five percent met criteria for PTSD and 85 percent reported at least some avoidance/numbing symptoms, but not to the degree that *DSM-IV* criteria were met (i.e., three or more symptoms). One year after the Rwandan Genocide, 1,830 Rwandan children were interviewed using the Impact of Event Scale about their experiences and their reactions (Dyregrov, Gupta, Gjestad, & Mukanohehi, 2000). Seventy-nine percent of the children exceeded the cutoff for PTSD one year after the Genocide. In Sierra Leone, a study coordinated by the nongovernmental aid organization Medicins Sans Frontières (Doctors without Borders) assessed for the presence of PTSD in a sample of 245 residents and Internally Displaced Person (IDP's) near Freetown (Raymond, 2000). Based on their responses to a structured interview, the authors concluded that 99 percent of respondents met criteria for PTSD. In another study in Sierra Leone, PTSD symptoms were assessed among refugees in a camp in The Gambia (Fox & Tang, 2000). Forty-nine percent of the sample yielded scores indicative of PTSD, while 80 percent met criteria for anxiety and 85 percent for depression. In Northern Uganda, a structured clinical interview was used to broadly compare Sudanese children living as refugees to Ugandan children who had not experienced war and flight (Paardekooper, de Jong, & Hermanns, 1999). The Sudanese reported increased

disturbances from memories, suicide ideation, worries about their future, and worries about the risk of siblings being hurt. Even though the Sudanese children did report more symptoms commonly associated with PTSD, the authors appropriately abstained from classifying the symptoms as psychopathology given the lack of validated measures available for use with Ugandan and Sudanese children. Thus, studies utilizing etic methodology conducted in developing (African) countries have reported varying PTSD prevalence rates, ranging from 35 to 99 percent.

Elsewhere, a few prevalence studies examined possible cultural differences (or the lack thereof). The prevalence of PTSD among Filipinos six years after they were displaced by the eruption of Mt. Pinatubo was assessed (Howard et al., 1999). Results showed that prevalence rates for PTSD (and for major depression, generalized anxiety disorder, bipolar disorder, and alcohol abuse) did not vary between culturally traditional (Aeta) and nontraditional groups. PTSD was the most common single diagnosis across the two subgroups (27.6 percent) and was found in 32.2 percent of the Aetas studied. Shrestha et al. (1998) found that Bhutanese refugees who had torture histories had much higher PTSD prevalence rates than a highly similar cohort that lacked a torture history. A large-scale study used comparable assessment methods in four postconflict settings (Algeria, Cambodia, Ethiopia, and Palestine), and reported that PTSD and other anxiety disorders were the most prevalent disorders in all four settings. For those exposed to violence, PTSD was the most prevalent (except in Cambodia; de Jong et al., 2001). Yet, the authors highlight the various contextual differences that were most predictive of traumatic stress. These contextual predictors included torture, psychiatric history, poor living conditions, daily hassles, domestic stress, death in or separation from family, and alcohol abuse (de Jong et al. 2001). Table 11.1 provides a summary of studies of prevalence and their findings.

Research with Emic Approaches

Research using emic approaches are not well suited to assessing prevalence but can better characterize the local manifestation of traumatic stress. Emic approaches cast a broader net and are more likely to capture symptoms that do not fall within predetermined categories. In an ethnographic study with Mexican disaster survivors, participants described 14 of the 17 PTSD symptoms with little or no prompting (Norris et al., 2001a). Additionally, the rank order frequency of PTSD symptoms closely matched that of other postdisaster PTSD studies. Baron's (2002) qualitative analyses and focus groups with Sudanese refugees in Northern Uganda revealed a consistent pattern of symptoms: anxiety, numerous somatic complaints, standard depressive symptoms, estrangement from friends and family, and loss of motivation to care for family and self (Baron, 2002). Although some of these are symptoms of PTSD, others are not, and the list exhibits a broader symptom picture than offered by the diagnosis of PTSD. These same studies found that refugee and IDP complaints

Table 11.1 Summary of findings of cross-cultural adult PTSD prevalence studies

Citation	Sample	Measures	PTSD prevalence
Carlson & Rosser-Hogan (1994)	Cambodian refugees in U.S. ten years (n = 50)	PTSD checklist (DSM-III), HSCL-25	86%
Al-Saffar et al. (2003)	Foreign nationals (Turkey, Iran, Saudi Arabia) more than 4 years in Sweden (n = 115)	SIP	PTSD in 69% of the Iranians, 59% of the Saudis, 53% of the Turks, and only 29% of the Swedes
Weine et al. (1995)	Bosnian adolescents recently relocated to the United States (n = 20)	PSS	25%
McCall & Resick (2003)	Ju/'hoansi (n = 20)	Structured interview	35%
Dyregrov et al. (2000)	Rwandan children (n = 1830) 1 year post-genocide	IES (shortened version)	79%
Raymond (2000)	Sierra Leonean (n = 245)	IES	99%
Fox & Tang (2000)	Sierra Leonean refugees in The Gambia (n = 55)	HTQ, HSCL-25	49%
Howard et al., 1999	Filipinos after Mt. Pinatubo (n = 351)	PCL-S for DSM-IV	27.6%
Shrestha et al. (1998)	Bhutanese refugees (n = 526)	Clinical interview based on criteria	Prevalence (across all symptoms) higher than comparison group
de Jong et al., 2001	Algeria, Cambodia, Ethiopia, and Gaza	CIDI PTSD module	37.4% Algeria, 28.4% Cambodia, 15.8% Ethiopia, 17.8% Gaza
Wang et al. (2000)	China (n = 338)	CIDI PTSD module	24.2%

CIDI = Composite Interview Diagnostic Interview; HSCL-25 = Hopkins Symptom Checklist; HTQ = Harvard Trauma Questionnaire; IES = Impact of Event Scale; PCL-S = Posttraumatic Symptom Checklist; PSS = PTSD Symptoms Scale; SIP = Self rating Scale for PTSD

consistently focused more on concerns for survival (lack of food, poor health care, threat of violence), rather than on traumatic events they had suffered and their ensuing symptoms (Baron, 2002). Moreover, the majority of IDP's and refugees did not develop distressful symptoms as a result of traumatic events (Baron, 2002); the same has been said to hold true for civilians in industrialized settings (Bonanno, 2004). Another study in Uganda reported that whereas PTSD symptoms were often reported, they were less of the focus of distress

than were somatic complaints (Bracken et al., 1995). The results from these emic studies suggest that PTSD may be an overly narrow characterization of traumatic stress across these different cultures, and may not be the best descriptor of reactions to trauma in all settings.

One study drew from the advantages of both etic and emic approaches in order to capture the fullest possible representation of traumatic stress. Yeomans, Herbert, and Forman (2008) used a combination of qualitative and quantitative methods to solicit symptoms among internally displaced people in Burundi all of whom had a history of one or (usually) more conflict-related traumatic events. Standardized measures showed that distress was mostly manifest in symptoms of somatization, anxiety, and depression, and less so in specific PTSD symptoms. Content analysis of open-ended questions (that were asked prior to specific symptom solicitation) that probed for reactions to traumatic events revealed these to be, in order of frequency, material complaints, depression, PTSD, and anxiety. Thus, standardized and open-ended methods suggested that Burundians conceptualized their traumatic stress mostly in terms of material complaints – a likely function of both the culture and the economic realities of this sample.

Symptom Variation

Accumulating evidence suggests that there is substantial variability in the expression of specific traumatic stress symptoms between cultures. Among the findings of PTSD prevalence and some indications of similar factor structure in diverse parts of the globe, there is substantial variability in the specific traumatic stress symptoms. Marsella and colleagues (Marsella et al., 1996; Marsella & Christopher, 2004) have argued that intrusive symptoms may be universal whereas avoidance/numbing may be more culturally based (Marsella et al., 1996). This contention has been supported in a number of studies (Dyregrov, Gupta, Gjestad, & Mukanoheli, 2000; McCall & Resick, 2003). Marsella et al. (1996) suggested that PTSD prevalence rates may be highest in cultures where avoidance and numbing behaviors are more common, as such practices may serve to maintain the other symptoms (Foa et al., 1989). Norris et al. (2001) studied the psychological impact of Hurricane Paulina in Mexico and Hurricane Andrew in the United States and found that Mexicans endorsed significantly more intrusion and avoidance symptoms, whereas Americans endorsed more arousal symptoms. The authors suggest that whereas the high PTSD prevalence rates and their correlation to trauma exposure may support the utility of the PTSD construct cross-culturally, they caution against using PTSD solely as a unidimensional construct. The differences found would not have been evident if PTSD had been considered unidimensionally. Notably, Perilla et al. (2002) found that after Hurricane Andrew, non-White Hispanics and English-speaking (more acculturated) Hispanics had comparable levels of PTSD whereas Spanish-preferring Hispanics had significantly higher levels. Such differences



across cultural groups who have experienced comparable traumas point toward the possible influence of cultural differences, linguistic differences, and acculturative processes on symptom presentation.

Biological and Environmental Factors

A summary of the literature reveals considerable variability in PTSD prevalence and specific symptom presentation around the world. While observed variability may be attributed to methodological and sampling differences, we still seek to understand whether the results are more indicative of a culturally bound disorder or the inevitable variability of a more universal construct. There is a current trend in the research to investigate biological markers associated with PTSD and to present the presence of those markers as indicative of how PTSD is shaped by biological factors. These include hormonal and neurobiological correlates to PTSD symptoms. For instance, differences between those with and without trauma histories have been detected in cortisol levels, atrophy of the hippocampus (McNally, 2003), and dysregulation of the hypothalamic-pituitary-adrenal system. These biological investigations have also been extended cross-culturally. In one study, Armenian youth with greater earthquake exposure and subsequent PTSD symptoms had more depressed cortisol levels than nonexposed youth (Goenjian et al., 1996). However, it should be noted that the causality governing this relationship is not clear; we do not know if cortisol levels predisposed the youth to acquire PTSD symptoms. The correlation of biological markers to PTSD symptoms does not answer whether PTSD is more biologically or culturally determined. It does suggest that particular biological markers are associated with PTSD across different settings.

Despite the evidence that PTSD is a universal construct, a dissenting minority argues that PTSD remains substantially a cultural construct. According to this position, opportunity for secondary gain and a professional community's expectation of protracted symptomatology may be more the agents of the perpetuation of posttraumatic stress symptoms than the traumatic event itself. The vast reduction in British soldier war neuroses between the first and second world wars provides some support for the notion that posttraumatic stress is a culturally determined phenomenon. The reduction, is largely attributed to the fact that medical providers communicated an expectation of pathology to WWI trauma survivors, but did not do so to WWII survivors (Shephard, 1999). Further supporting the culturally-bound syndrome argument is the changing picture of traumatic stress over time from paralysis to hemianesthesia, fatigue, mutism and intractable trembling to the modern-day PTSD trinity of intrusion, avoidance/numbing, and hyperarousal (Herbert & Sageman, 2004). PTSD may be a product of an era in which we increasingly understand the psychology of an individual in terms of vulnerability instead of in terms of resiliency (Summerfield, 2004). Distress has become equated with psychopathology and the effect of the PTSD diagnosis is to emphasize the "traumatogenic nature" of an event over any resilience and protective factors (Kagee & Naidoo, 2004).



On the other hand, it has been argued that the refutation of the application of the PTSD construct cross-culturally is a manifestation of a larger dynamic in which professionals deny the existence of trauma in highly distressed populations (Dyregrov, Gupta, Gjestad, & Raundalen, 2002). The suggestion is that such perspectives serve to relieve the international community of its sense of responsibility and its substantial guilt over repeated failures to prevent or alleviate suffering. Yet, such accusations potentially inhibit unbiased scientific discovery. Questioning the applicability of PTSD in nonindustrialized settings appears to be valid given the dramatic cultural differences that exist. Though traumatic stress reactions, in general, may have a universal, biological underpinning, vulnerability to trauma, symptom manifestation, and response to treatment are very likely subject to contextual and cultural factors (Marsella, Friedman, & Spain, 1996).

Contextual Factors Influencing How Traumatic Reactions are Reported

Social desirability Actual reactions to traumatic events are not necessarily the same as those reactions that are reported. While there are occasions when reactions may be underreported, certain methods of assessing responses to trauma may create a context where it is socially desirable to endorse particular symptoms. Even a carefully translated and then validated measure is still subject to an effect of social desirability in which participants' responses are influenced by their perceptions of what a favorable answer might be. Kinzie and Mason (1987) observed that the responses of Indochinese refugees who lacked prior experience with psychological surveys and interviews were largely influenced by politeness and a desire to respond correctly rather than by their true feelings. The use of emic or ethnosemantic methods such as open-ended questions, free-listing, key informant interviews, and pile sorts – all techniques that solicit information without clearly revealing for what the interviewer is searching – may offer certain advantages over standardized measures (Kagee & Del Soto, 2003; Marsella et al., 1996; Wilk & Bolton, 2002).

Power imbalance A power differential exists in any therapeutic or health care relationship, yet it is particularly acute in the cross-cultural setting. Locals will often ascribe greater value to industrialized culture and the perceived knowledge and resources it embodies. "Hidden power dynamics and the tacit assumptions that western knowledge trumps local knowledge" can influence how participants choose to answer (Wessells, 1999, p. 275). Members of traditional cultures often denigrate and abandon their own models when confronted with those of the West, irrespective of their applicability (Peddle et al., 1999). Reading self-report measures aloud to illiterate populations increases the potential effect of the nature of the relationship between the participant and interviewer (Pernice, 1994). Similarly, it may also be possible that the presentation of expectations for specific symptoms or protracted vulnerability may



be especially acute in such settings. Yeomans et al. (2008) found a significant correlation between participant prior exposure to PTSD psychoeducation and the nature and severity of their symptoms.

Secondary gain Beyond the effect of social desirability mentioned above, patients may endorse the symptoms of interest to the outsider with hopes of receiving some sort of secondary benefit. People who are poverty-stricken and whose environment has been destabilized by violence may very necessarily shape their presentation to increase the odds that they will receive the care and attention that is being offered to those determined as in need (Wessells, 1999; Kagee & Naidoo, 2004). Such a dynamic is not limited to nonindustrialized settings, and PTSD has come to play an essential role in insurance claims, asylum applications, veteran benefits, and the assistance of victims in the United States and elsewhere (Frey, 2001). This is not to say that people are necessarily malingering for personal gain, so much as that their symptoms are in part determined by the climate in which they are solicited. De Jong (2005) has countered the secondary gain argument, citing the high prevalence rates among tortured Bhutanese refugees who he argues had no secondary gain to motivate them and who easily recognized PTSD symptoms from a long list of topics.

Cultural Factors

Social and institutional support Social support and family functioning is a well-established protective factor for traumatic stress reactions (Thabet & Vostanis, 1999). The level of support at an institutional level has also been shown to influence the prevalence of PTSD. Nine months after an earthquake in China in north Hebei province, one village that had suffered less damage but had received less reconstruction support had significantly greater PTSD rates than a comparable village that suffered more seriously and had received substantially more reconstruction support (Wang et al., 2000). Sattler et al. (2002) reported that across different Caribbean nations struck by Hurricane Georges, loss of resources and absence of social support was most predictive of Acute Stress Disorder four weeks after the event. Witmer and Culver (2001) argue that family and social variables are critical predictors of distress and recovery. Thus, both social support and institutional response after the event seems to reduce the level of subsequent traumatic stress. The more quickly the social fabric, the material infrastructure, and a sense of normalcy can be restored, the sooner the reduction in distress.

Notions of personhood and familism The notion of individuality on which the classification of psychopathology is based is relatively unfamiliar in more collectivistic conceptualizations of distress (Bracken et al., 1995). Nonindustrialized cultures often take more of a “sociocentric” than an “egocentric” view of society (Zur, 1996). Differences in the nature of traumatic stress symptoms have been linked to individualistic and collectivistic cultural differences (Elsass, 2001).



Understanding the nature of the traumatic experience must take place within a framework that considers the individual's larger familial and cultural experience (Morsette, 2006).

Cultural meaning of symptoms The literature offers numerous examples of how the subjective meaning of traumatic events or the associated symptoms may mediate the nature of the response to them (Zur, 1996). For instance, Punamaki (1996) found that ideological commitment moderated Israeli youth distress from political hardships. Zur (1996) discusses the Quiché Mayan who report recurrent dreams of those who died as a result of atrocities in Guatemala. These dreams are associated with positive valence for the comfort that they give. Bosnian adolescents understood memories of the events that had befallen them as normal as opposed to pathological (Weine et al., 1995). Furthermore, the absence of faith and conviction in the postmodern era and an increased orientation toward introspection may foster a sense of uncertainty and emotional vulnerability (Pupavec, 2004). The manifestations of traumatic reactions may be very different in settings in which there exists a relative orientation toward stoicism, where a fatalistic perspective dominates, and where primary import is placed on the social network of the family and the community rather than the individual (Summerfield, 2004). In such cases, the exportation of models presuming vulnerability may be contraindicated.

Social acceptance of expressed distress Cultures vary in the extent to which expression of distress is socially sanctioned and reported. For instance, Chinese are generally reluctant to express distress and often attribute such distress to external or physical causes (Wang et al., 2000). Differences in traumatic stress across gender has been observed both the US and Mexico after landfall of comparable hurricanes (Norris, Perilla, Ibanez, & Murphy, 2001). Moreover, the differences in PTSD severity were greater between men and women in Mexico than in the United States. The authors speculate that Mexican culture tends to adhere to more traditional sex roles in which male "machismo" inhibits disclosure of distress. These differences are considered less pronounced in the US.

Functional impairment The degree to which severity of symptoms is related to the inability to meet one's responsibilities of daily living may also vary across cultures, especially in settings where emotional expression is encouraged. Indeed, one of the dangers of a circumscribed interest in traumatic stress symptoms is the failure to fully assess functional impairment, the most often overlooked criteria of a PTSD diagnosis. A study in Nicaragua found that while peasants with traumatic histories reported PTSD symptoms, they were not otherwise distressed and remained highly functional (Summerfield & Toser, 1991). Witmer and Culver (2001) critique studies that presented high rates of PTSD among Bosnian refugees despite reported high rates of functioning (e.g., GAF scores up to 87), pointing to the potential for critical failure when a focus on pathology obviates consideration of resilience. Even the most



comprehensive battery of symptom measures may fail to critically assess degree of functional impairment (Kagee & Naidoo, 2004). Figure 11.1 summarizes some of the factors that determine the manifestation of traumatic stress.

Challenges of Assessment and Treatment

As always, the challenge that remains is the integration of theoretical perspectives and empirical findings into practical strategies and emphases for clinical work. This challenge is exacerbated by the complex issue of culture and the necessity of simultaneously attending to both group and individual differences. Ultimately, the client's individuality precedes his or her affiliation with any particular group. At the same time, cultural identity is typically associated with personal experiences and cultural perspectives relevant to conceptualization and treatment. The clinician, despite prevalence rates, biological factors, and cultural variables, must still fundamentally understand the patient's perspective and report. Familiarity with cultural factors that influence traumatic stress presentation leads to fluency with indigenous idioms of distress, alternative models, research methods best suited for cross-cultural investigations, the pitfalls of assessment techniques and specific measures, and culturally sensitive and effective treatments.

Idioms of Distress

Patient conceptualization and perception of traumatic stress is often not seen as related to the trauma history. Research on Bhutanese refugees found that most often distress is conceptualized in terms of angered gods, dissatisfied spirits, or some form of witchcraft (Shrestha, 1998). Youth in Palestine with trauma histories reported a preponderance of conversion fits, behavioral problems, and psychosomatic complaints (Abu Hein et al., 1993). Hinton et al. (2002) described "Weak Heart" syndrome among Khmer refugees that closely resembles PTSD and panic disorder. It should also be recognized that traumatic stress symptoms as we know them may not be the impetus by which people seek treatment (Marsella & Christopher, 2004).

Assessment

The fact that certain cultures do not have words for particular symptoms not only makes using PTSD measures cross-culturally potentially problematic, it could indicate that these reactions are simply not observed in that society. Studies have found the Impact of Event Scale (IES; Horowitz, Wilner, & Alvarez, 1979) impossible to translate because items within the intrusion and avoidance symptom clusters lost their specificity of meaning and became redundant (Terheggen et al., 2001). Three items (avoidance/numbing symptoms) on the Post Traumatic Inventory (PTI; Carlson & Rosser-Hogan, 1994) were eliminated because they could not be translated when used with a Cambodian



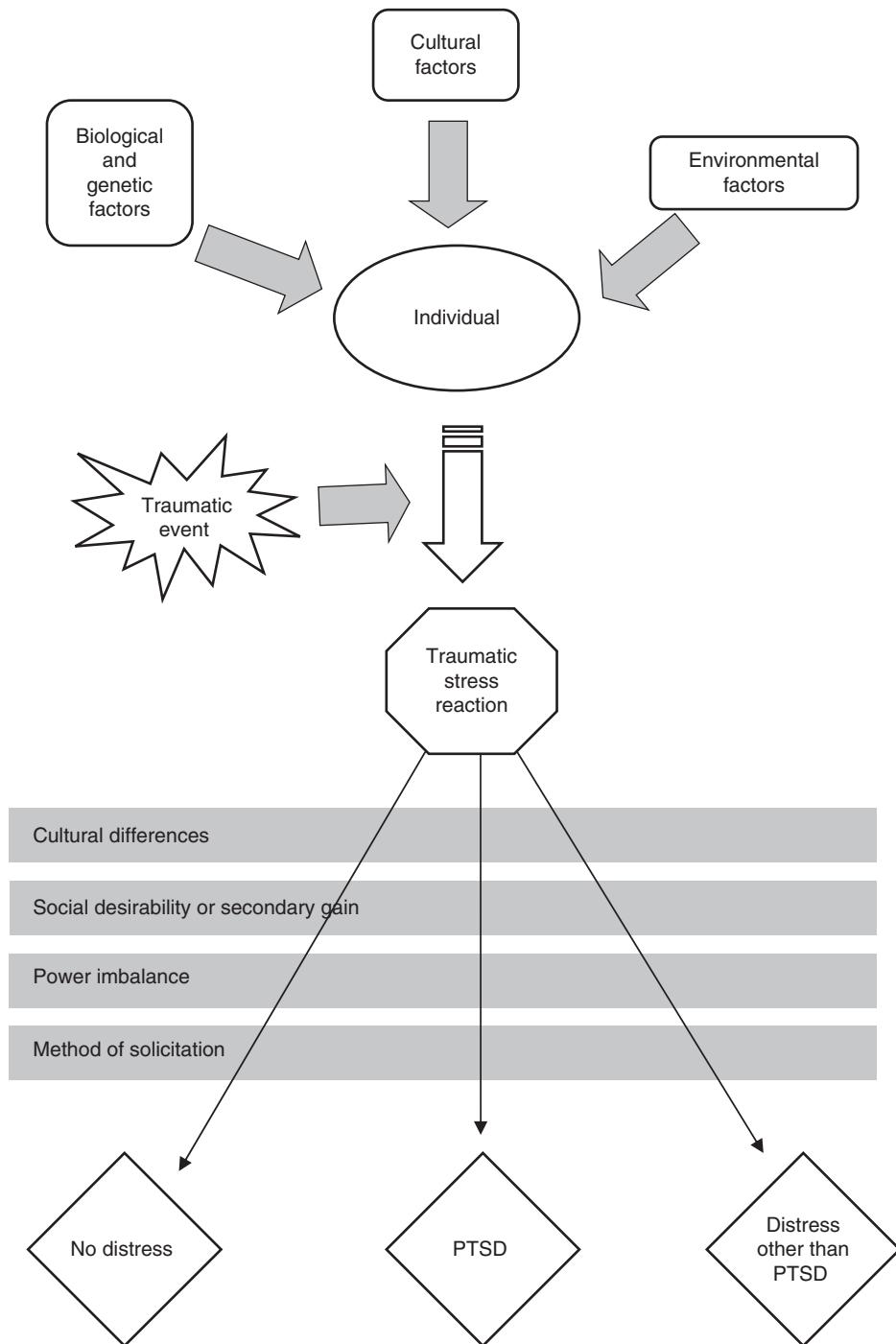


Figure 11.1 Factors shaping specific manifestation of traumatic stress



immigrant population (Carlson & Rosser-Hogan, 1994). As was discussed earlier, the vast majority of measures have not been validated for specific populations. We still have a considerable deficit of assessment tools with unproven reliability and validity in most pre-industrialized settings. We must remember, that even as there may exist a general universal response to trauma, the application of PTSD as a construct as the focus of assessment potentially minimizes the differences that do exist (Kagee & Naidoo). Clearly, given the challenges of successful translation, a PTSD measure should never be considered adequate for making a diagnosis, especially in the cross-cultural context (Green, 1991; Keane, Kaloupek, & Weathers, 1996; Pernice, 1994).

Treatment

The literature remains quite limited as far as the efficacy of different treatments for traumatic stress in diverse cultural settings. The majority of the cross-cultural treatment research has been conducted with immigrant or refugee populations who have left their home country and begun an acculturative process. Predictably, the limitations of many of the studies (e.g., no comparison group) preclude strong conclusions. There is some indication that the current "gold standard" treatment for PTSD of prolonged exposure therapy may also be efficacious cross-culturally yet further investigation is warranted.

A recent review paper found only eight PTSD treatment studies of adult refugee populations. Three of these were essentially case studies and most of the others lacked comparison groups and sizeable samples (for a full review see Nicholl & Thompson, 2004). For instance, one study treated 20 Bosnian refugees with Testimony Psychotherapy, an approach that incorporates substantial elements of imaginal exposure techniques (Weine et al., 1998). Significant decreases in PTSD and other symptom types could not be attributed to the specific intervention given the absence of a comparison group. Another study provided an analysis of CBT treatment compared to exposure treatment alone for a group of traumatized refugees (Paunovic & Ost, 2001). Goenjian et al. (1997) using a grief-focused psychotherapy significantly reduced PTSD symptoms among post-earthquake (1988) Armenian youth compared to a wait-list control. Kosovar youth ($n = 18$) recently arrived in Denmark were treated with a short trauma psychoeducational intervention (Staaehr, 2001). PTSD symptoms as measured on the IES (Impact of Events Scale) indicated significant decreases in symptoms. However, this study also lacked a comparison groups. Another study in Britain with children ($n = 26$) from diverse war-ravaged countries assessed the effect of an intervention that focused on PTSD psychoeducation and coping strategies. Results indicated a significant reduction in PTSD symptoms post-intervention compared to a waitlist control. However, these gains were not maintained at two months post-intervention.

A few studies report on components of humanitarian interventions with samples still in their home country. Trauma treatment and education programs have been developed for Eastern Europe (Bosnia and Croatia) and different



regions of Africa (Miller & Rasco, 2004). Given the challenges of such an environment and the meager budget on which many of these programs are administered, there is a paucity of outcome studies in existence. Even developers of recent innovative interventions for refugees acknowledge the legitimate difficulty and the unfortunate dearth of evaluative efforts (Hubbard & Miller, 2004). Of those that do exist, some have opted for anecdotal summaries or more qualitative methods, whereas others have taken more of an empirical approach. Fewer still have been published in peer-reviewed journals. However, a few randomized controlled trials in pre-industrialized settings exist.

A sample of 43 Sudanese refugees in Northern Uganda were randomly assigned to either one session of PTSD psychoeducation, 4 sessions of psychoeducation plus supportive counseling (SC), or four sessions of psychoeducation plus narrative exposure therapy (NET; Neuner, Schauer, Klaschik, Karunakara, & Elbert, 2004). NET was associated with significant decreases in PTSD symptoms at post-intervention and at one-year follow up. No significant changes were associated with SC, and psychoeducation was associated with significant increases in PTSD symptoms at post-intervention and one-year follow-up.

Five years after the Rwandan genocide, Staub, Pearlman, Gubin, and Hagengimana (2005) designed and evaluated an intervention for survivors. The intervention took the form of a nine-day training of workshop facilitators and included psychoeducational lectures on PTSD. Traumatic experiences, psychological symptoms, and orientation toward reconciliation were assessed in the participants of the subsequent workshops, not in the facilitators who were in direct receipt of the training. Controlling for Time 1 symptoms and trauma history, results showed that two months after the intervention, trauma symptoms (a combination of PTSD, traumatic grief, self-perceived functioning, Rwanda-specific trauma symptoms) decreased significantly more in the intervention condition than in either of the other two (traditional treatment, wait list control).

Finally, one study examined the specific effect of PTSD psychoeducation among subsistence farmers in Burundi who had little to no prior exposure with nonindigenous constructs of PTSD and traumatic stress (Yeomans, 2007). Participants of a four-day, inter-ethnic healing and reconciliation group workshop intervention showed greater decreases in distress when randomized to a condition that included *no mention* of PTSD symptoms and traumatic stress. All participants had endorsed some degree of symptoms at baseline. Therefore, these results cannot be explained by arguing that psychoeducation served to normalize symptoms that participants already had but were not initially able to recognize or articulate. This suggests that with this population, education about PTSD may have a morbid suggestive effect that can potentially undermine resilience and coping. While additional research is needed to replicate these results, such findings speak for careful consideration of the effects of introducing novel ideas about vulnerability to traumatic stress.



Treatment Guidelines

While the determination of the intervention of choice for cross-cultural treatment of traumatic stress will require additional research and will not likely ever lead to a singular answer, there are some general treatment principles that can be gleaned from the literature. Indigenous customs and local healing practices can be integrated into any foreign intervention (Wessells, 1999). These practices exist, can be identified, and used as a complement to outside models. For instance, the Indigenous Australians consider connection to land, kinship networks, and ritual as critical ingredients for the maintenance of well-being (Petchkovsky & San Roque, 2002). Others emphasize the sociocultural responses such as dances, ceremonies, and rituals, which westerners often overlook – for example the reconstruction of a community center, market, or gathering location. These components could all be integrated into a predominantly cognitive or behavioral treatment mode. However, dependence of cognitive processing to alleviate symptoms could be irrelevant and can undermine the attention to cultural healing rituals (Bracken et al., 1995). Finally, whether the inclusion of traditional healing approaches increases effectiveness of treatment is an empirical question that is in need of additional research.

Assuming that patients have a more collectivist and familial orientation to distress, some may prefer a group therapeutic format to individual psychotherapy. A clinician should be similarly cautioned against focusing on the traumatic event and the specific impact on the individual (Griffiths, 2001). In fact, the field should be wary about using treatment and prevention models that directly or indirectly suggest vulnerability and the likelihood of protracted problems in trauma survivors (Yeomans, 2007). These models, through the powers of suggestion, may be doing harm to those they intend to help. Instead, treatment should emphasize normalization of symptoms and of recovery. Patients from any culture will likely benefit from understanding that what they are experiencing is normal reaction to abnormal events and is expected to remit with time (Herbert & Forman, 2005).

Summary

A growing body of research points to the presence of the syndrome of PTSD in culturally diverse settings. Though utilitarian, the application of the construct of PTSD remains imperfect and associated with dangers that could undermine the greater purpose of providing culturally appropriate care for those who have suffered from war, natural disaster, or other traumatic events. As research continues to explore the degree to which PTSD can be considered a universal construct, we should remain cautious in its application cross-culturally.



A presumption that PTSD is the best model by which to recognize and treat traumatic stress cross-culturally has a number of pitfalls. Too much attention on PTSD constrains the search for a more sophisticated picture of how traumatic stress manifests cross-culturally. We are only beginning to understand how PTSD overlaps with or differs from local idioms of distress. The assumption that PTSD provides the best fit as a model limits our capacity to explore diverse symptoms sets that may also be occurring. The confidence in expectation of a particular symptom set can lead to the confirmation of its presence; some of the best scientists consistently discover exactly what they set out to find. Yet, not only can traumatic stress vary from the textbook PTSD model, evidence indicates that in most cases, traumatic stress symptoms either do not develop or are quickly resolved within the first month.

The overuse of a PTSD model may therefore falsely predict specific symptoms or overpathologize a temporary and normal reaction to a traumatic event. With PTSD comes a presumption of greater vulnerability and the absence of resilience. Marsella and Christopher (2004) argue that the normative response to crisis is the strengthening of communal relationships on the social level and resilience on the individual level. Such a response is beginning to receive more attention in the research (see Posttraumatic growth), but all too often, the PTSD construct presumes protracted vulnerability before it is necessarily evident. The call to reframe our investigations around resilience are slow to catch on (Witmer & Culver, 2001).

There is mounting evidence for biological correlates to PTSD and a growing number of international epidemiological studies concluding that PTSD is found across cultures particularly in samples exposed to violence. Nonetheless, the sole application of the PTSD model may not be the most useful model around which to focus prevention and treatment services across cultures. De Jong (2005), despite having researched PTSD prevalence rates around the globe, articulates the need to put more attention on other mental health issues that remain underinvestigated, such as mood disorders, somatoform disorder, dissociative disorders, and other anxiety disorders. The popularity of the PTSD construct in both academic circles and popular culture can distract us from other factors that may be more essential to formulating patient care cross-culturally. For instance, PTSD was found to be associated with the experience of violence but also with other factors such as living conditions and social instability (de Jong 2005). Similarly, Laban et al. (2005) found that among Iraqi asylum seekers postmigration challenges in the daily life were the best predictors of psychopathology, even more so than traumatic events themselves. Table 11.2 summarizes specific recommendations for both researchers and clinicians.

In summary, much of the literature indicates that in its different variations around the world, PTSD appears to be universally evident (Marsella & Christopher, 2004). Yet, there is also evidence that Criterion A and its associated symptoms may vary and are certainly influenced by cultural factors. Marsella & Christopher (2004) summarize their review of the literature by stating "PTSD cannot be decontextualized from the culture milieu in which it



Table 11.2 Considerations for researchers and clinicians working cross-culturally with PTSD

For researchers:

- Translate and back-translate measures
- Utilize locals at all levels of research team
- Use both qualitative and quantitative methods

For clinicians (and researchers):

- First line of treatment should be meeting material needs and restoring social network
- Be wary of overpathologizing: temper assumption of vulnerability with assumption of resilience
- Cast a broad net in the assessment of symptoms
- Carefully assess functioning independently of symptom endorsement
- Integrate local idioms of distress and treatment methods as appropriate
- Work to reduce clinician-client power imbalance that may be exacerbated by cultural differences.
- Consider cultural differences of fatalism and collectivism versus individualism
- Inquire as to the personal meaning of the endorsed symptoms

occurs, because this isolates it from its etiological roots, experiential referents, and its method of mediation" (p. 527). Treatment must take place within a cultural context but may necessarily integrate modern methods (Dyregrov et al., 2002). The literature documents an increased sensitivity to the risks of treatments without cultural considerations and the overmedicalization of traumatic stress, but we must remain vigilant and continue to recenter our clinical work and research around a contextualized view.

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