International Handbook of Human Response to Trauma

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Cultural Diversity in the Appraisal and Expression of Trauma

B. HUDNALL STAMM AND MATTHEW J. FRIEDMAN

... [and they], went on the assumptions that the Dakotas had nothing, no rules no social organization, no ideals. And so they tried to pour white culture into, as it were, a vacuum. After all, they concluded that the Indians were impossible to change and train. What they should have done first, before daring to start their program, was to study everything possible of Dakota life, and see what made it go, in the old days, and what was still so deeply rooted that it could not be rudely displaced without some hurt ...

Letter from E. C. Deloria to H. E. Beebe, 2 December 1952; DeMallie, 1990/1988, pp. 237–238

... it is important that the clinician take into account the individual's ethnic and cultural context in the evaluation of each of the DSM-IV axes ...

Appendix I, *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., p. 843

The challenge that we face, when considering post-traumatic stress disorder (PTSD) from a cross-cultural perspective, is to find an appropriate balance between modern and traditional conceptualizations of traumatic exposure and its consequences. Each perspective has a richness and complexity that must be respected and understood if we hope to provide effective clinical interventions for trauma survivors from traditional backgrounds.

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To state one conclusion at the outset, the important question is not whether PTSD can be detected among trauma survivors from traditional ethnocultural backgrounds. Indeed, PTSD has been found among Southeast Asians, Latin Americans, Middle Easterners, American Indians, and other trauma survivors from non-Western cultures (see below). Rather, the important question is whether PTSD or some other idiom of distress reflects the best conceptualization of the impact of traumatic stress on survivors from certain ethnocultural groups.

Universal, Cultural, and Personal Aspects of Human Existence

There is a rapidly growing literature on ethnocultural aspects of mental disorders in general and PTSD in particular (for overviews, see Danieli et al., 1996; Gaw, 1993; Marsella et al., 1996a; Suzuki et al., 1996; Ponterotto et al., 1996; Chemtob, 1996). However, there is little methodologically sound research on transcultural aspects of traumatic stress (Marsella et al., 1996b). This is unfortunate because such research would help us understand the generalizability of specific empirical observations.

For many clinicians and researchers, one of the most difficult aspects of this problem is defining culture. Herein lies a paradox. To understand a culture, it is necessary to have deep knowledge of it. However, it is that very understanding that prevents one from seeing that which it is *not*. Being embedded in a particular culture means interpreting the world through it. Yet, for many cultures, changes in global economics, communications, technologies, and ideas increasingly encourage appropriation of other cultures to create a blended modern culture (Gellert, 1994; Sampson, 1989; Stamm, in press; Stamm, 1999; Stamm & Stamm, 1999).

These transformations and adaptations of culture from one group to another only intensify the need to attend to culture, even it if does make it more difficult to measure. Marsella et al. (1996b) point out that there are actually three dimensions which need to be considered: (1) universal dimensions, (2) cultural aspects, and (3) personal uniqueness.

Universal Dimensions

Is it even possible to identify universal dimensions of the human experience? Universal elements are those that would be important to any person, regardless of cultural context. To answer this question, the most obvious place to look for universal elements is in human evolutionary biology (Cziko, 1995; Cosmides & Tooby, 1990; Izard, 1992). A number of authors have concluded that all humans are similar with respect to their capacity to experience and express a number of fundamental emotions such as joy, fear, anger, sadness, disgust, shame, and guilt (Averill et al., 1994; Eibl-Eibesfeldt, 1989; Izard, 1994; Scherer, 1994). Others have strongly challenged this proposition. Russell (1994) has questioned the fundamental hypothesis of universality, and Lutz (1988) asserts that emotions are cultural constructs. Matsumoto (1989) has taken an intermediate position and argued that fear is expressed and perceived universally, whereas the expression of other emotions may be modified by cultural influences.

With respect to PTSD, extrapolating from Matsumoto's formulation, we suggest that all humans have the capacity to experience and express fear, helplessness, or horror, when exposed to traumatic stress. In other words, all humans have the capacity

to meet the response criterion (A2) of the PTSD diagnosis (APA, 1994), although cultural factors may influence the likelihood that fear will be evoked or expressed by a person from a specific ethnocultural group when exposed to a specific traumatic event.

The question of universal versus culture-specific responses to traumatic events can be considered from a psychobiological perspective. We have argued elsewhere (Friedman et al., 1995), that the capacity to cope with stress is a crucial theme in human evolution. Psychobiological mechanisms characterized as "the fight or flight response," the "general adaptation syndrome," the startle response, fear conditioning, and behavioral sensitization have evolved to promote coping, adaptation, and preservation of the species. To carry this argument one step further, we proposed elsewhere that PTSD intrusion (B criterion) and arousal (D criterion) symptoms may be universal posttraumatic indications of the psychobiological evolutionary process, whereas expressions of avoidant/numbing (C criterion) symptoms may be determined more by cultural than by universal factors (Friedman & Marsella, 1996).

Cultural Aspects

According to Marsella et al. (1996a), culture is the second important dimension of the human experience. There is no universally accepted definition of culture. Marsella (1988) defines it as

> ... shared learned behavior which is transmitted from one generation to another to promote individual and group adjustment and adaptation. Culture is presented externally as artifacts, roles, and institutions, and is represented internally as values, beliefs, attitudes, cognitive styles, epistemologies, and consciousness patterns.
>
> But, individual subscription to these shared values may vary, as does the authority that the culture has in any individual's life. Therefore, knowledge of an individual's degree of ethnocultural identity is important for understanding the influence of culture on his or her perceptions of the world. (p. 10)

Draguns (1994) provides an overview of culture and mental illness and points out that although there is evidence that certain psychiatric disorders such as schizophrenia and depression affect people throughout the world, the range of cultural expressions of such disorders is nearly limitless. Based on a review of the literature, Draguns (1994) maintains that mental illness is a mix of universal and culture-specific factors. This is certainly consistent with the DSM-IV approach (Appendix 1) which recommends that ethnocultural factors be carefully considered in any diagnostic assessment. Such factors include: (1) cultural identity of the individuals, (2) cultural explanations of the individual's illness, (3) cultural factors related to psychosocial environment and levels of functioning, (4) cultural elements of the relationship between the individual and the clinician, and (5) overall cultural assessment for diagnosis and care.

Another way to characterize differences in culture is the individualism–collectivism dichotomy (Keats et al., 1989). People from traditional cultures are often collectivists who perceive the self as part of a larger whole (family, community, or tribe). They are concerned with the effects of their decisions on others, share material and nonmaterial resources, and are willing to accept the opinions and views of others. The Zulu concept of umbutu ("I am because we are") is a good example of collectivism. By comparison, individualists are motivated by their own preferences, needs, and rights, giving priority to personal rather than group goals (Hui & Triandis, 1986; Triandis, 1995). A person's position on the individualism–collectivism spectrum appears to have important impli-

cations for assessment and treatment of post-traumatic and other psychiatric syndromes (Rosenthal & Feldman, 1992).

Personal Uniqueness

Idiosyncratic aspects of the person, those that can neither be attributed to universal nor cultural aspects, are what Marsella and colleagues (Marsella et al., 1996a) call personal uniqueness. As previously stated, the influence of ethnocultural factors may vary from one individual to the next, so it is necessary to assess and to understand the importance of cultural heritage on every individual.

Western mental health clinicians generally focus on the patient as an individual. Sometimes, however, the family or small group is a more appropriate unit for treatment (Roland, 1996). Such an approach focuses therapeutic attention on the relationship between the individual and his/her family or small group. In this context it is necessary to understand that the subjective experience of patients may be collectivist rather than individualist, so that the clinician must address a more traditional "we-self" rather than the Western "I-self" for therapy to be relevant, accessible, and successful (Roland, 1996).

Diagnostic Issues

Does PTSD Occur in Trauma Survivors from Traditional Ethnocultural Backgrounds?

Because culture may modify the experience or expression of post-traumatic distress, it is important to identify key differences between trauma survivors from Western-industrialized cultures compared to those from traditional settings. However, regardless of the culture of origin, it must be emphasized that, according to empirical data, most trauma survivors do not experience profound long-lasting pathology or develop a psychiatric disorder as a result of such exposure (Marsella et al., 1996a; Kessler et al., 1995; Yehuda & McFarlane, 1995; Stamm, 1999). If psychopathology does develop, PTSD may not be the best clinical characterization of an individual's post-traumatic distress (Marsella et al., 1996a).

Some have argued that a DSM-IV diagnosis such as PTSD should never be applied in a cross-cultural context. Bracken et al. (1995) contend that the PTSD diagnosis should never be applied to non-Western children or adults. They claim the underlying assumptions of the disorder implicitly endorse a Western ontology and should not be applied to non-Western peoples. Lewis-Fernandez and Kleinman (1995) question not only PTSD but the cross-cultural validity of the entire DSM-IV. In their opinion, the nosology that undergirds the DSM-IV does not reflect the mind–body interaction often observed in non-Western cultures.

It is beyond the scope of this chapter to rehash the arguments for and against the DSM-IV approach. The DSM/ICD is the official taxonomy of psychiatric health care and the frame of reference within which we must address all questions of psychiatric nosology. Therefore, we believe we must review the literature on post-traumatic distress among non-Western people from the DSM/ICD perspective. We will assess the goodness-

of-fit of PTSD in contrast to other diagnostic formulations as the best conceptual tool for characterizing post-traumatic distress among non-Western individuals.

There is no question that PTSD can be detected among non-Euro-Americans. The list keeps growing as researchers assess post-traumatic distress among survivors of war, torture, forced migration, sexual assault, natural disasters, and industrial accidents. To be more specific, PTSD has been detected among Southeast Asian refugees (Kinzie, 1993, 1989; Smiths Fawzi et al., 1997); Sri Lankans exposed to civil war (Somasundaram & Sivayokan, 1994); civilian survivors of the war in Afghanistan (Wardak, 1993); cyclone survivors in Fiji and Sri Lanka (Fairley, 1986; Patrick & Patrick, 1981); earthquake survivors in Mexico, Ecuador, Japan, and China (Conyer et al., 1987; Lima et al., 1989; McFarlane & Hua, 1993; Odouia et al., 1993; Kato et al., 1996); volcano survivors in Columbia (Lima et al., 1987) and political torture detainees in South Africa (Simpson, 1993). In addition, PTSD has been detected in American Vietnam veterans from African-American, Hispanic-American, American-Indian, Asian-Pacific Islander, as well as Caucasian backgrounds (Kulka et al., 1990; Beals et al., 1997).

Are There Formulations Better Than PTSD?

Showing that PTSD can be detected among traumatized people from non-Western backgrounds does not tell us anything about the goodness-of-fit of the PTSD diagnosis with the experience and expression of post-traumatic distress among traditional people.

> The received categories of affective, anxiety, dissociative and somatoform disorders are not natural divisions in the world or in the phenomenology of disease, disorder, or illness. Once established, nosological categories tend to become reified and to obscure the variation and overlap between disorders in patients.... (Kirmayer, 1996, p. 154)

Two major components of post-traumatic distress among non-Western people are somatization and dissociation (Kirmayer, 1996; Jenkins, 1991; Hough et al., 1996). Somatization is completely missing from the PTSD diagnostic criteria, dissociation is the focus of only one symptom (DSM-IV A3: psychogenic amnesia), and one can meet the diagnostic criteria for PTSD without any evidence of dissociation.

Dissociation

Dissociative disorder has been observed in Turkish women, most of whom reported a history of childhood sexual abuse. PTSD was not assessed in this study (Sar et al., 1996). Berger and colleagues report that a history of sexual abuse was associated with dissociation among Japanese women 15–20% of whom also exhibited symptoms of post-traumatic stress, multiple personality, and eating disorders (Berger et al., 1994). Two studies investigated PTSD, dissociation, depression, and anxiety among Cambodian refugees. The first study, done after 4–6 years in the United States, detected significant symptoms of PTSD, depression, and dissociation in 80–96% of the refugees (Carlson & Rosser-Hogan, 1991). The second study, done on the same cohort of Cambodian refugees 10 years after resettlement, showed similar rates of distress. Ninety percent of the refugees exhibited marked symptoms of at least two of the following disorders: PTSD, depression, anxiety, or dissociation (Carlson & Rosser-Hogan, 1993). After the Exxon Valdez oil spill, 25% of the native people who lived in the close vicinity

met criteria for PTSD, and 29 and 42% exhibited depression and generalized anxiety disorder, respectively, one year after the oil spill (Palinkas et al., 1993).

Somatization

There is a strong clinical belief and growing empirical evidence to support the notion that people from traditional cultures experience somatic distress following extremely stressful events (Kirmayer, 1996; Jenkins, 1991; Hough et al., 1996; Robin et al., 1996). Furthermore, there is evidence that PTSD may also be a risk factor for medical illnesses (Friedman & Schnurr, 1995). Therefore, physical symptoms are often an important component of postexposure distress in traditional cultures. Among Asian and Central American refugees, there is an important association of physical health complaints and psychological symptoms, including post-traumatic distress (Palinkas, 1995). Among those native people who lived in the area of the Exxon Valdez oil spill, regardless of high or low exposure, there was a self-reported decrease in perceived health status and some believed that they had developed a medical illness as a direct result of the spill (Palinkas et al., 1993).

Although illness-oriented medicine may not adequately reflect the wellness orientation of traditional medicine, at least among indigenous peoples in North America, it is generally believed that illness can occur as a result of misfortune (Joe, 1994). Extending this concept, Kirmayer (1996) conceptualizes traumatic stress as a sociopolitical and psychophysiological experience that has an explanation and a narrative theme with cultural and sociopolitical variations.

Depression

Depression is often found comorbid with PTSD (Buchwald, Monson, Dinges, Keane, & Kinzie, 1993; Kessler et al., 1995; Kinzie et al., 1989). This may be so because traumatic stress is frequently associated with significant losses. In fact, one important conceptualization of PTSD is derived from a model of bereavement and impacted grief (Horowitz, 1976). According to Raphael and Martinek (1997), the Lidemann conceptualization of loss may have actually been a conceptualization of traumatic stress. Separating traumatic stress and depression is further complicated by the fact that the depression associated with PTSD may be neurobiologically distinct from the classic melancholia of DSM-IV major depressive disorder (Friedman & Yehuda, 1995). The nature of the relationship among trauma, PTSD, and depression is a fundamental question that transcends cross-cultural considerations. We mention it here for the sake of completeness and suggest that it is one of many important areas for future research.

Complex PTSD

Dissatisfaction with PTSD as the only official DSM-IV post-traumatic diagnostic formulation is not restricted to cross-cultural psychologists/psychiatrists and medical anthropologists. Researchers and clinicians who work with survivors of prolonged trauma (such as childhood sexual abuse or political torture survivors) among Euro-American individuals have also criticized the limitations of the PTSD diagnosis. They have argued that it omits a number of major symptoms seen in such patients and have proposed a new diagnosis, "complex PTSD." As first operationalized by Herman

(1992), complex PTSD includes symptoms such as dissociation, somatization, affect lability, pathological changes in relationships, pathological changes in identity, self-injurious or suicidal behavior, and revictimization. Complex PTSD applies to those who have experienced sustained stressors, frequently as hostages or captives. Thus, the post-traumatic distress of many of the world's traditional peoples, who have experienced profound oppression and loss of freedom (for example, black South African activists), may be better defined by complex PTSD than by other diagnostic formulations.

We are not aware of systematic attempts to diagnose complex PTSD among traumatized people from non-Western backgrounds. Turner (1996) has argued that political refugees and asylum seekers from non-Western cultures seem to exhibit complex PTSD rather than DSM-IV PTSD. One obvious cross-cultural advantage of complex PTSD is that it emphasizes both dissociation and somatization more than DSM-IV PTSD; however, it also includes some symptom categories that may not be applicable to people from traditional backgrounds when captivity is not an important aspect of the traumatic experience. Clearly, rigorous investigations are needed to determine the relative advantages of complex versus DSM/ICD PTSD as a post-traumatic diagnosis for trauma survivors from non-Western cultures. Such research must control for exposure to interpersonal violence (torture, rape, forced captivity, etc.) because many refugees and asylum seekers from non-Western cultures have been subjected to such abusive violence during their difficult flight to safety.

Post-Traumatic Culture-Bound Syndromes

There are idioms of distress specific to particular cultures. Moreover, as groups of traumatized people relocate around the world, there is a "migration" of these culturally specific syndromes. Littlewood (1985) suggests that the appearance of these syndromes outside their country of origin may be less an indication of a culture-bound syndrome and more a reaction to Western-industrialized biomedicine. For example, in one case history, similar symptoms were exhibited across two generations in a mother and daughter; the mother attributed her symptoms to possession by spirits/ancestors, and the daughter attributed her symptoms to depression (Ullrich, 1993).

Culture-bound syndromes may be expressed in the Western host country after migration from the original homeland. Van Boemel & Rozee (1992) reported on psychosomatic blindness (despite normal ophthamalogical examination results) among 150 female Cambodian refugees residing in California who witnessed and survived the atrocities of the Khmer Rouge regime. Van Boemel and Rozee believe that those traumatic experiences precipitated this symptom. In addition to the blindness, 90% of refugees reported severe crying spells daily, feeling isolated, experiencing a number of physical symptoms, being sad, and having nightmares. It is noteworthy that these symptoms, including the visual difficulties, improved during group therapy in which the women discussed their traumatic experiences and provided social support for each other.

A well-documented culturally identified syndrome among Latin Americans is *ataques de nervios* which is a "... culturally sanctioned response to acute stressful experiences ... characterized by shouting uncontrollably, trembling, heart palpitations, a sense of heat in the chest rising to the head, fainting, and seizure-like episodes.... [It] mobilizes the support of the person's social network ... the person regains conscious-

ness rapidly and does not remember the *ataque*" (Guarnaccia, 1993, p. 158). Following a disaster in Puerto Rico, 912 people were interviewed, and 16% reported having experienced *ataques de nervios*. These people were also more likely to have met the DSM criteria for PTSD, depression, and anxiety disorders than those who did not exhibit *ataques de nervios*. Although there appears to be a relationship between *ataques de nervios* and certain depressive and/or anxiety disorders, many diagnostic symptoms associated with the DSM-IV disorders are clearly distinguishable from those that characterize *ataques de nervios*.

Culture-bound idioms of distress must be carefully weighed in any post-traumatic assessment. They must also be rigorously evaluated with respect to specificity. In *ataques de nervios*, as an example, it is unclear whether *ataques* occur only after a stressful/traumatic event or whether they are a more general expression of distress that may occur (as do many affective and anxiety disorders) without a distinct traumatic precipitant.

To our knowledge, the only research in which individuals from different ethnocultural backgrounds were assessed for PTSD in response to the same traumatic event are the series of studies carried out on American Vietnam veterans (Kulka et al., 1990; Beals, 1997). These studies compared premilitary, military and postmilitary risk factors for PTSD among African-American, Hispanic-American, American-Indian, and Caucasian Vietnam veterans. Results indicated that race/ethnicity per se was a very weak predictor of PTSD. Premilitary factors such as exposure to childhood physical abuse or parental alcoholism were much more powerful predictors. The military risk factor of exposure to atrocities in Vietnam and the postmilitary factor of perceived social support were also powerful predictors of PTSD. In other words race/ethnicity was truly a risk factor for exposure to specific events such as physical abuse, parental alcoholism, atrocities in Vietnam, and social support. These events, in themselves, were the most important predictors of the development of PTSD. The current data, therefore, do not suggest that race/ethnicity per se is an indicator of intrinsic vulnerability or resistance to PTSD.

Treatment

Because there is a paucity of published randomized clinical trials of psychotherapy and pharmacotherapy for PTSD patients in general, it is especially difficult to discuss PTSD treatment for non-Euro-Americans (Soloman, in press; Friedman & Jaranson, 1994). Therefore, much of the following discussion draws on current knowledge concerning general psychiatric treatments for people from traditional cultures. In addition, we will cite some valuable writing on specific treatments for traumatized/PTSD patients from traditional cultures (Kinzie, 1989; Friedman & Jaranson, 1994; Marsella et al., 1996a).

Our specific emphasis will be on important considerations concerning the following: traditional healers, ports of entry to treatment, treatment context, pharmacotherapy, and individual as well as group treatment and disclosure.

Traditional Healers

The scientific revolution began in the mid seventeenth century. Therefore it is only during the past 350 years that traditional healers have had to compete with empirically

trained Western clinicians. In many non-Western cultures, the traditional healer remains the primary source of treatment during episodes of physical and emotional distress. Neither migration to a new country nor the encroachments of Western medicine into traditional cultures have changed this pattern of treatment-seeking behavior, especially when the sociocultural infrastructure supports the preservation of such traditions. Urban enclaves, such as Chinatown and Little San Juan, specific geographic areas, such as refugee camps, American-Indian reservations, or countries relatively unaffected by Western culture, are places where traditional linguistic, dietary, religious, and healing practices are preserved. For refugees, traditional healing that has been utilized for generations may continue to be favored over Western scientific approaches, even among second or third generation descendants (Kinzie, 1993, 1989; Lee & Lu, 1989). Indeed, one extreme example of the antipathy to Western medicine is Bernier's (1992) report that when a vaccination program was initiated in a refugee camp because of the outbreak of a serious epidemic, one Khmer tribe resisted the procedure and hid from medical authorities. For them, the concept of "contagion" was inconceivable because they believe that spirits rather than microorganisms cause illnesses.

We believe that such treatment-seeking patterns are based on powerful beliefs that should be respected. Educational initiatives on the "superiority" of Western technology and expertise are at minimum disrespectful and most likely fruitless attempts to "convert" traditional people to reject the "old ways." We suggest that partnerships with indigenous healers and the development of multicultural treatment approaches will provide better access to and for clients and will produce better clinical results than have been generally achieved to date (Hulkrantz, 1983; Joe, 1994; South-central Foundation, 1995). One successful example of this model was developed by Hiegel (1984) for Khmer refugees in Thailand, where Western professionals rarely saw patients themselves but rather provided support and consultation to traditional healers.

Ports of Entry

Euro-Americans with PTSD are less likely to seek treatment from mental health practitioners than from primary or specialty medical clinics (Soloman, in press) because PTSD is not only associated with somatic symptoms but is also a risk factor for bona fide medical illness (Friedman & Schnurr, 1995; Williams, 1995). Such concerns deserve even greater consideration with regard to trauma survivors from traditional ethnocultural settings. As noted earlier, such individuals are more likely to express their post-traumatic distress through somatic complaints and to seek treatment for bodily rather than psychological symptoms. This is where collaborative relationships with primary or specialty medical clinicians are important. For example, some Indochinese refugees spontaneously seek out medical but not mental health consultation both in refugee camps and in host countries (Kinzie, 1989) because they view mental illness as the result of an energetic disequilibrium and possession by evil spirits for which the remedy is purification with lustral waters and exorcism (Bernier, 1992). Therefore, medical consultation may be the only opportunity for mental health intervention.

The detection of any history of trauma should be a mandatory part of any medical assessment, especially for people from traditional backgrounds. If the trauma history is positive, a culturally sensitive assessment should be carried out to identify PTSD or some other expression of post-traumatic distress. If feasible, an appropriate clinical intervention should always be instituted when indicated.

Treatment Context

Awareness of cultural expectations about the healing/treatment process is necessary for patient retention and treatment compliance. For example, the age and gender of the clinician may have an important bearing on ultimate success. It may be harder for older persons to respect or accept the expertise of a young mental health professional if they believe that clinical wisdom can emerge only later in life. For example, some clients might refuse to see a young therapist whose age may preclude their qualification for healer status by prevailing cultural standards. From the traditional perspective, a twenty- or thirty-year-old could never acquire the necessary wisdom and spiritual power needed to treat psychic ills (Stamm & Stamm, 1999). Similarly, rigid gender role separation in some cultures may complicate attempts for a female clinician to treat male clientele and vice versa.

Perhaps the most obvious of these barriers is that of not having a shared language. Using translators adds a complicated dimensions to the clinical interchange (Berthold & Baker, 1997; Kinzie, 1989; Southcentral Foundation, 1995). Beyond accurate translation of the actual words, there are a host of potential complications. Using a family member as translator may put several family members at risk of learning information about one another that they would rather keep secret. Children may be asked to speak for their parents, thus causing role reversals and difficulties with familial authority. Sometimes, a translator will refuse to translate messages because of perceived cultural insult to one or the other parties in the interchange. Simple difficulties, such as tone of voice, time factors, whom to address (client or interpreter), and the like, must be worked out in advance of the session (Berthold & Baker, 1997).

There are many barriers to the therapeutic process that may inadvertently be created by lack of knowledge. For example, the question and answer method of obtaining a medical history may not yield useful information when confronted by the more slowly unfolding narrative style of self-expression utilized by many traditional people. Even if the pace is slowed, the question and answer process may seem puzzling to the patient. When asked why she would not answer the clinician's questions, an elderly Alaska Native woman commented: "Why would I tell him anything about me, he just kept asking me questions and never told me anything about himself." Kinzie (1989) described how he unwittingly activated traumatic memories of political detention and torture among Cambodian refugees when a physician in a white coat was present during a psychiatric assessment.

Pharmacotherapy

We have argued previously that there are universal aspects to the fear (helplessness and horror) experienced by all humans exposed to catastrophic stress. We have also proposed that the intrusive and hyperarousal symptoms of PTSD may have a common psychobiological basis and be less affected by cultural influences than the avoidant/numbing symptoms. This suggests that pharmacotherapy may be a very effective transcultural treatment for PTSD. After all, nonbiological psychotherapeutic approaches must incorporate a multitude of linguistic, behavioral, historical, conceptual, and spiritual factors that may vary widely from one culture to the next. Lacking experimental data, we will speculate on major factors that may affect pharmacotherapy for people from diverse ethnocultural backgrounds.

First, through centuries, if not millennia, of ethnocultural segregation, there are cross-cultural genetic differences with respect to the efficacy and pharmacokinetic properties of different drugs. For example, Line, Poland, Nuccio, and Matsuda (1989) have shown how the same dose of a given drug is metabolized differently by Asian versus Caucasian-Americans who suffer from the same disorder.

Second, there is robust scientific literature on coping and adaptation showing that appraisal is a psychological activity with psychobiological consequences. For example, two people, one of whom appraises a given stimulus as a threat and the other appraises the same stimulus as a challenge, will have distinctly different psychobiological responses to the same stimulus (Blascovich & Tomaka, 1996).

Third, cultural factors affect the symptomatic expression of psychological distress. This means that people with the same level of subjective distress may express it differently and that people who exhibit the same pattern and intensity of symptoms may actually experience different levels of emotional distress. For example, Norwegians and Japanese tend to be much less emotionally demonstrative than Italians and Filipinos, although their subjective distress may be comparable. It follows that when the expressed emotion of Norwegians or Japanese equals that of Italians or Filipinos, the former group may actually be suffering more subjective distress than the latter group.

Therefore, people from different ethnocultural backgrounds who were exposed to the same highly stressful event, exhibit similar symptoms, and are given the same dose of the same drug, may have very different qualitative and quantitative responses. Although the drug received by each individual is the same, it may be acting on different genetically induced pharmacological/metabolic receptivity, different culturally induced threat/challenge appraisal, and/or different culturally mediated expressions of psychological distress. This is obviously a rich area for future research.

Individual Versus Group Treatment and Disclosure

Choice of treatment may be dictated by cultural factors in a variety of ways. As noted earlier, individual treatment for someone whose self-identity is collectivist (I–we) rather than individualist (I–me) may be incomprehensible or at best, ineffective. On the other hand, when the trauma violates a cultural taboo (e.g., rape of an unmarried woman), cultural beliefs and practices may weigh strongly against group approaches. In such cases, the advantages of group treatment (e.g., normalization of responses, mutual support) may be overshadowed by the risks of publicly disclosing private catastrophes that are culturally indigestible. Here, the consequences of the trauma itself are amplified by the possibility of therapeutically induced social stigma, marginalization, and opprobrium. There are no hard and fast rules, however, except that any culturally sensitive treatment plan must pay careful attention to the way the traumatic event is experienced by each individual within his/her specific cultural context. Furthermore, there is much room for exploring these issues systematically because there are always important exceptions to any treatment guidelines. Clinical experience has shown that group therapy with unmarried women who have been raped has been both feasible and effective with Bosnian refugees and rape survivors in the Middle East as long as the therapist is also female and strict confidentiality is maintained. Again, more data is needed, but we must ensure that trauma survivors are not exposed to unnecessary therapeutically induced social risks as different treatment approaches are explored.

In some cases, the treatment of individuals may be best accomplished by treating

the community, as well as the individuals within the community. For example, one of the more successful treatments for alcoholism and related traumatic stressors (e.g., increased family and personal violence) among Native North Americans has been the Sobriety Movement. Healing circles (similar to a free-form group therapy) are held for both those with the drinking problem and for the community at large. Often a whole town or village agrees to enter supportive treatment activities for those who are recovering from traumatic stress and related drinking (Dill, 1997). Similarly, community development projects may be powerfully therapeutic for individual and community trauma. In South Africa, the KwaZulu-Natal Programme for Survivors of Violence conducted groups for various members of a community devastated by civil war. The youth groups chose to put on sports fairs, but the mothers asked for gardens. The effect of the gardens was far beyond what the clinicians had expected. While the mothers tended their gardens, they shared their stories of horror. From the stories of pain, they grew the food of their futures (Stamm et al., 1996). A similar successful approach was initiated in Chile in which mothers attended sewing circles during which they processed the traumatic deaths and disappearances of loved ones perpetuated by the government (Agger & Jensen, 1992).

Acculturation and Treatment

We are only beginning to understand which treatments are best and for whom. We have focused on additional concerns that must be addressed when considering treatment for non-Western individuals in exploring post-traumatic distress. Dichotomies such as traditional versus Western-industrialized culture may facilitate the construction of book chapters such as this, but they fall short of portraying the richness of the human experience. There is abundant literature suggesting that ethnocultural identity is a more important predictor of the way an individual will respond to a situation or treatment than genetic, familial, or social factors. It is not enough to know that a specific second-generation immigrant to North America or western Europe (who can trace his or her ancestry back many generations) is genetically 100% West African or Japanese or Brazilian. It is even more important to know his or her cultural identity, genetic pedigree notwithstanding. Broadly, there are four possibilities:

1. traditional people from traditional cultures whose ethnocultural identity remains traditional with respect to customs, beliefs, and behavior;
2. assimilated people from traditional cultures who have rejected their heritage and embraced Western customs, beliefs, and behaviors;
3. bicultural people who are comfortable and fluent in both traditional and Western cultural settings and who can easily match their cultural perspective and behaviors to the demands and expectations of the moment;
4. alienated people from traditional cultures who do not identify themselves in terms of their ethnocultural background but who also have been unable to identify with the beliefs and behaviors of the majority culture in their present home in North America or western Europe.

This chapter has focused primarily on treatment for trauma survivors with a traditional ethnocultural identity. We believe that these are people who may benefit most from (1) culturally sensitive diagnostic assessment; (2) collaborative treatment programs involving traditional healers and Western-trained doctors; (3) treatment

settings designed to foster access, comfort, and continuity; (4) pharmacotherapy that respects unique cross-cultural challenges; and (5) psychotherapy that incorporates crucial cultural factors both in format and process. In the case of refugees, it is also important that treatment address stress related to acculturation loss and change in addition to post-traumatic distress per se (Bernier, 1992). Assimilated individuals will benefit from Western approaches that research has shown appropriate for Euro-American clientele. Bicultural trauma survivors benefit from both traditional and Western treatment in the same way that they have been able to enrich their lives from two very different cultural traditions.

It is not at all clear what to say about alienated individuals as a group because there may be many roads to the end state of alienation. Some of these paths could include pretraumatic mental disorders, alcoholism, poverty, and homelessness among poorly functioning individuals, as well as anomie and cultural detachment among highly functioning individuals. Perhaps some subgroup of ethnoculturally alienated individuals may prove an important cohort on which to test some of the hypothesized universal aspects of post-traumatic distress because they may be less influenced by culturally mediated aspects of post-traumatic distress than traditional, assimilated or bicultural individuals. This is another important area for further research.

Conclusions

In addition to the extreme stressors of war, disease, sexual and family violence, another important stressor for traditional cultures is the speed at which they are being required to change as they are confronted by Western culture. Although Western-industrialized culture required centuries to evolve to its current form, traditional cultures must sometimes absorb the impact of Western values, beliefs, and practices in a matter of months or days. Consequently, a traditional culture sometimes becomes overwhelmed by the dominant culture that suddenly engulfs it, resulting in alienation, acculturation stress, and other consequences.

Sensitive and appropriate Western-trained clinicians must consider many issues when conceptualizing the sequelae of traumatic events among traditional people. Understanding the idioms of post-traumatic distress depends on our ability to identify universal aspects of human existence, as well as the patient's ethnocultural identity and fluidity with Western-industrialized culture. It also depends on the willingness of the clinician to understand, respect, and integrate such different beliefs and values into an appropriate treatment.

Until we know more, the fit between Western-industrialized science and traditional culture medicine will be uneven. There is obviously a need for culture-appropriate clinical approaches and carefully designed research. Future progress will depend on our determination to address diagnostic and treatment questions with patience, openness, sensitivity, rigor, and creativity.

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