INTRODUCTION TO THE SPECIAL ISSUE: “TRAUMA AND CULTURE: IMPLICATIONS FOR RESEARCH AND TREATMENT”

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In the last 15 years, there has been an explosion of research in psychotraumatology contributing to a significant growth in the field. A similar expansion has occurred in the advances of Cross-Cultural Psychology and Psychiatry.

Psychotraumatology has paid a significant amount of attention to evidence-based treatments and randomized controlled trials and has marginalized the cultural context of suffering (Mattar et al. 2010); consequently, the relationship between the role of culture and trauma research and treatment remains poorly understood. Considering the broad range and universality of traumatic experiences, what are then the dimensions of psychological trauma and what are the dimensions of cultural systems as they govern patterns of daily living? How do cultures create psychosocial mechanisms to assist its members who have suffered significant traumatic events? The special issue: “Trauma and culture: Implications for research and treatment” addresses the above questions and the need for critically integrating culture-competent studies and practices with psychotraumatology.

Traumatic life events can be simple or complex in nature and can also result in simple or complex forms of post-traumatic adaptation (Wilson 2005). Similarly, cultures can be simple or complex in nature with different roles, social structures, authority systems, and mechanisms for dealing with individual and collective forms of trauma. In terms of mental health and counselling interventions, this includes a broad range of posttraumatic adaptations that include posttraumatic stress disorder (PTSD), mood disorders (e.g., major depression), anxiety disorders, dissociative phenomena (Spiegel 1994), and substance use disorders. In terms of mental health care, cultures provide many alternative pathways to healing and integration of extreme stress experiences which can be provided by shamans, medicine men and women, traditional healers, culture-specific rituals, conventional medical practices, and community-based practices that offer forms of social and emotional support for the person suffering the adverse, maladaptive aspects of a trauma (Moodley and West 2005). But how does culture influence an individual’s reaction to trauma? How do they make sense of their experiences in situations of extreme stress? In this regard, Smith et al. (1993) state: “Humans in general have an inherent need to make sense out of and explain their experiences. This is especially true when they are experiencing suffering and illness. In the process of this quest for meaning, culturally shaped beliefs play a vital role in determining whether a particular explanation and associated treatment plan will make sense to the patient”.

The concept of traumatic stress and the multidimensional nature of cultures require a conceptual framework by which to address core issues that have direct relevance to understanding the nature of trauma, how it is embedded within a culture and its assumptions about the nature and causes of problems specific to their world view and construction of reality; (2) a set of assumptions about the context, settings, and requirements for healing to occur; (3) a set of assumptions and procedures to elicit particular expectations, emotions, and behaviours; (4) a set of requirements for activity and participation levels and/or roles for patient, family, and therapist; and (5) specific requirements for therapist training and skills expertise criteria” (p. 3). These sets of assumptions are useful as they define a necessary conceptual matrix for examining how different cultures handle psychopathology, behavioural disorders, and complex posttraumatic syndromes (Kirmayer 2007). Why place so much emphasis on culture?

In the Textbook of Cultural Psychiatry, edited by Bhugra and Bhui (2007), the opening line reads “People eat, drink, breathe culture. Without any conscious effort we absorb culture and culture becomes an integral part of us. We become acculturated and a part of culture”. We can define Culture as an intrinsic, no renounceable part of our own essence. Indeed cultural determinants shape and mould our self identity and identifications but also impact our appraisal of events including trauma and extreme stressors, manifestations of symptoms and course of psychopathological pictures. It ensues that health and illness are experienced in cultural, social, historical and economic contexts and psychopathological phenomena are interpreted from culturally coloured frames of reference and theoretical assumptions. It becomes of paramount importance to examine how culture permeates expressions of distress but also help seeking behaviour, provision of care and acceptance/stigmatization of mental disorders within a given cultural milieu.

The experience of psychological trauma can have differential effects to personality, self and developmental processes, including the epigenesis of identity within culturally shaped parameters (Wilson 2005). When we address the question of how individual cultures deal with psychological trauma in its diverse forms, it is
useful to examine commonalities and differences among approaches to counselling, healing, psychotherapies, treatments, and traditional practices. If traumatic stress is universal in its psychobiological effects (Friedman 2000, Wilson et al. 2001), are therapeutic interventions, in turn, designed in culture-specific ways to ameliorate the maladaptive consequences of dysregulated systems of affect, cognition, and coping efforts (Brown LS, Marsella et al.1996, Wilson 2005, Wilson and Drozdèk 2004)?

Scientific evidence, especially neurobiological studies, has documented that affect dysregulation, right hemisphere alterations in brain functioning, and strong kindling phenomena are universal in PTSD (Friedman 2000, Schore 2003). If there is a common set of psychobiological changes associated with either PTSD or prolonged stress reactions, is the emotional experience universal in nature (e.g., hyperarousal, startle, anger, irritability, depressive reactions) or do cultural belief systems “override” or attenuate the magnitude or severity and intensity of dysregulated emotional states? This question goes to the heart of the culture–trauma relationship. Firstly, how does a given culture define trauma? Is a traumatic event in one culture (e.g., natural disaster, incestuous relations, traffic deaths, political oppression, motor vehicle accidents, murder, etc.) necessarily viewed as a traumatic occurrence in another culture? Secondly, what sets of expectations for resiliency in coping does the culture possess?

Although clinical trauma psychology has acknowledged relevance of the ethical principle of respect for differences in trauma treatment, this has not so far motivated a systematic effort to improve our understanding of how culture is intertwined with our cognitive and emotional responses to trauma. Kirmayer and colleagues (2007) remind us that “the ways that individuals adapt to trauma reflect their personalities and psychological resilience and resources, but also depend on the social, cultural, and political contexts in which they find themselves” (p. 15). This is a core issue in terms of the “globalization” of knowledge about the relation of trauma to culture. At present, we have no standardized ethic (universal) measurements of trauma and PTSD (Dana 2005). Similarly, we do not have standardized cross-cultural treatment protocols for persons suffering from posttraumatic syndromes. There exist empirical and clinical voids in the knowledge base and what “treatments” work best for what kinds of individuals and under what set of circumstances. To respond effectively to the mental health needs of all trauma victims intervention programs must be sensitive to the unique experiences, beliefs, norms, values, traditions, customs, and language of each individual. The term “cultural competence” suggests a broader concept than “cultural sensitivity” implies. The word “competence” implies the capacity to function effectively, both at the individual and organizational levels. “Competence” is associated with “culture” to emphasize that being aware of, or sensitive to, the differences between cultures is not sufficient. Instead, service providers must have the knowledge, skills, attitudes, policies, and structures needed to offer support and care that is responsive and tailored to the needs of culture.

At the individual level, cultural competence requires an understanding of one’s own culture and worldview as well as those of others. At the organizational and programmatic levels, cultural competence requires a comprehensive, coordinated plan that cuts across policymaking.

The continuum assumes that cultural competence is a dynamic process with multiple levels of achievement. It can be used to assess an organization’s or individual’s level of cultural competence, to establish benchmarks, and to measure progress. Training in cultural competence in trauma should be a necessary component of trauma education (Courtois and Gold 2009). Psychiatric Disorders mirror the outcome of the interplay of bio-psycho-social factors over the developmental trajectory of an individual’s life span. The notion that a comprehensive or complete nosology can be created without regard to culture and context therefore, can be sustained only by adapting a reductionistic perspective that minimizes or ignores the fact that human beings are fundamentally social and cultural beings” (Gone and Kirmayer 2010)

The Cultural Formulation Model – included in Appendix 1 of the DSM IV (APA 2000) – facilitated the investigation of the role of culture in shaping identity, adjustment processes, feelings of belonging and the individual’s experience of health and suffering and a progressive importance of developing a culturally competent approach to provide care and to clearer understand the patient’s and context of knowledge (Betancour 2003, Gav 1993, Lopez-Ibor 2003, Okasha et al. 2000, Yank et al. 2009). Hence, understanding the bio-psycho-social-cultural aspects of human behaviour and dynamics of diversity represent the starting point for the construction of a clinical/therapeutic setting aimed at increasing healthcare awareness, patient’s satisfaction and the promotion of a culturally unbiased clinical environment (Baarmhielm and Scarpinati Rossos 2009). The Diagnostic and Statistical Manual of Mental Disorders (DSM-V) expanded on the cultural formulation and on the role of explanatory beliefs for mental illness, help-seeking patterns, barriers to diagnosis and care, and systematized stigma and racism in helpseeking behaviors and diagnosis.

In this issue, Pross outlines in his crisp and enlightened analysis what defines a culture competent centre of care. He warns us of the dangers hidden in the overemphasizing of passion, enthusiasm, idealism as core features at the expenses of, in the Author’s words of ‘monitoring and accountability’ that together with clearly defined guidelines ensure that interventions are effective, staff is properly trained and qualified to treat culturally diverse patient and that a comprehensive approach to care is implemented. Emphasis is placed on the need to place the patient at the centre of a team oriented approach to care with “regular communication and exchange of information among caregivers through informal and formal channels”.

The explorative phase of the clinical assessment, the appraisal of the therapeutic process at the end of therapy should always be discussed placing, in this way, the Patient’s uniqueness and proactivity at the centre of the clinical encounter. This is a notion that epitomizes one of the pillars and future directions of culturally competent clinical settings, namely a patient-centred approach to diagnosis and care which aims at creating awareness, empowerment and exchange of knowledge between the Patient and the Clinician engaged in the quest for a common language and mutual adjustment to each other’s ‘weltanschauung’.

The themes that revolve and characterize the process of adjustment both from the perspective of its nosology but also as an essential feature of others. At the organizational and programmatic levels, cultural competence requires a comprehensive, coordinated plan that cuts across policymaking.
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individual’s sense of Self and Self identifications. Cultural adjustment is also delved further in this contribution where the notion of Adjustment Disorder is elaborated and challenged through the lenses of cultural variations in the expression of PTSD. Self-memory system and trauma are discussed alongside questions on what defines the Self constructs which, in the western nosology, tend to reflect an individualistic and rationalistic view. Risk and protective factors in post traumatic adjustment from the perspective of socio-international models in current literature are explored.

Bala and colleagues remind us that culture competence “describes the knowledge, skills and attitudes of therapists dealing with cultural differences” but provides an insightful account of the complexities encountered in the therapy process with a multicultural patient population of refugees families trough a systemic approach to care in a Trauma Centre (Arq 45) in Amsterdam.

Culture competence challenges us clinicians in rethinking our western ethnocentric views where the crux fact of ethnocentrism is that things merely ‘feel right’ in one’s own culture. Therefore it is not sufficient to know and understand the values and common patterns of one’s own culture, it is essential to comprehend the feeling of appropriateness that accompanies those patterns. Culture competence therefore attempts at understanding and incorporating into clinical practice the way in which individuals perceive and interpret their distress, their behavioural patterns in relation to their illness, help seeking behavior and acceptability of specific interventions (Bhui et al. 2007)

Warfa and colleagues provide a unique perspective on a theme scarcely investigated in international literature, namely the provision of culturally competent and sensitive interventions in psychotrauma management in the face of natural disasters. If the universality of trauma is obviously not questioned neither are the clinically significant consequences that affect sufferers of PTSD, the response to such ailment and psychiatric distress is mostly offered in a “universal and often ungrounded way”. The Authors delve into a comprehensive and detailed analysis of what characterizes an effective, empowering and culturally competent approach following the 2010 earthquake in Haiti.

In her paper, Ardino addresses the importance of implementing a trauma-informed system of care sensitive to culture. A trauma-informed system uses that understanding to design service systems that accommodate the vulnerabilities of trauma survivors and allows services to be delivered in a way that will avoid inadvertent re-traumatization and will facilitate consumer participation in treatment. It also requires collaborative relationships with other public and private practitioners with trauma-related clinical expertise. The next steps for an improved effectiveness of trauma-informed approaches to service delivery involve the inclusion of culture-competent practices to gain more positive responses to trauma-informed changes in the system of care.

The relationship of culture and trauma provide a framework for understanding the diversity of posttraumatic psychological outcomes. The issue brings into focus critical assumptions that each person’s posttraumatic adaptational patterns is a variation on culturally sanctioned modalities of coping with extreme stress experiences that impacts the psychobiology of the organism (Kirmayer et al. 2007b). Clearly, posttraumatic adaptations fall along a continuum from pathological to resilient (Wilson 2005). By examining the continuum of culturally sanctioned modalities of posttraumatic adaptation, the second and third hypotheses can be understood more precisely. Healing and recovery is person specific and there are multiple pathways to posttraumatic variation (Kirmayer et al. 2008). The DSM-V revised version of cultural formulation affirms: “Understanding the cultural context of illness experience is essential for effective diagnosis assessment and clinical management” (APA 2013). Psychotraumatology is, thus, facing the challenge of integrating culture in the understanding of human reactions to trauma. This special issue aims at fostering reflections in both researchers and clinicians on the complexity and manifold experience of trauma which cannot be fully grasped unless analysis of the individual’s and society cultural realm are embedded in the assessment and treatment of traumatised people.

References


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