CULTURAL THEMES IN POSTTRAUMATIC ADJUSTMENT

Caterina A. Zaiontz, Amar Sarkar

Abstract

This paper examines adjustment to trauma in a cross-cultural and transcultural context, particularly posttraumatic adjustment. Themes of cultural variation in psychological discomfort are first introduced, and processes underlying posttraumatic stress disorder (PTSD) are then discussed, with reference to cognitive accounts of psychopathological stress. We then briefly review evidence for cultural variation in psychopathological stress as well as the interplay between the self and autobiographical memory, and how these relate to cultural variation in self-construal. This analysis is then extended to consider how trauma impacts the self in different cultural contexts. We then examine transculturally relevant protective and risk factors for posttraumatic adjustment, namely: (1) social support and (2) the protective effects of mass trauma. Emphasis is placed on the current definition of trauma and how trauma may be perceived and interpreted across cultures. Finally, we summarise a new model proposed in the literature that will help integrate current, individually oriented theories of posttraumatic adjustment, and also extend the understanding of trauma and adjustment to social and cultural contexts.

Key words: trauma, culture, posttraumatic stress disorder, adjustment, adjustment disorder, autobiographical memory, cultural self-construal, risk and protective factors

Declaration of interest: none

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Culture, disorder, and trauma: a premise

Adjustment to stressors is the main theme of this paper, and we first examine the literature on cultural variation in posttraumatic stress responses, and then to extend its relevance in independent and interdependent cultural contexts (Markus and Kitayama 1991). We then move on to describe transculturally relevant factors that attenuate (or exacerbate, as the case may be) posttraumatic adjustment. In looking at these transcultural factors, the emphasis will be on the social and cultural forces that operate within them. Starting with a brief outline of the relevance of cultural differences in the PTSD diagnosis, and considering examples of how PTSD can be differentially represented across cultures, we will then briefly consider two influential theories of PTSD (Brewin et al. 1996, Ehlers and Clark 2000) that have helped researchers and clinicians approach PTSD. Special attention will be given to the concepts of self and autobiographical memory (the memory system devoted to storing self-related information) (Conway and Pleydell-Pearce 2000, Conway 2005), and how self-construal varies across cultures (e.g., Markus and Kitayama 1991), and also to the work of Jobson and colleagues (e.g., Jobson 2009; Jobson and O'Kearney 2006, 2008) in relating cultural construals of the self, autobiographical memory, and posttraumatic adjustment. We will use the principles and themes discussed here to examine how social support and the collective aspects of mass trauma are transculturally relevant protective factors following traumatic events. We will conclude with discussions the concept of trauma, and of the socio-interpersonal approach to PTSD and adjustment proposed by Maercker and Horn (2012), and how this framework is able to bring together currently disparate cultural findings and theories in the PTSD literature.

Culture, disorder, and trauma

One is at risk of stating a truism in claiming that nowadays the world's countries are experiencing greater extents of intercultural and intergroup contact than before. Indeed, *any* set of geographical and national borders enclose multiple ethnicities and diverse linguistic groups. However, the relatively recent influx of foreign ethnic groups into existing cultural setups seems particularly pronounced in the West. Histories of slavery (such as the mass enforced extraction of Africans to serve in the United States), current globalisation (which may increase migration for individual or familial betterment), as well as human-induced disasters (e.g., war, genocide, that necessitate mass migration) have resulted in marked, recent

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cultural and ethnic heterogeneity across the West. The current population of the United States, for example, is a result of all three of these processes, composed as it is of several groups, often uncomfortably juxtaposed. Such cultural contact, and the presence of multiple cultural groups within a single politically defined set of borders, makes cultural differences particularly salient, both to the general public and also to researchers.

Differences in cultural values and backgrounds are explicit on surface-level terms, for instance, in preferences (e.g., clothing, food), artistic manifestations (e.g., literature, music, monuments, artistic production), spoken language, or family relations (e.g., living in joint families, arranged marriages). It is not immediately apparent to what extent cultural differences persist in the unobservable *intra*personal realm. From a psycho-social perspective, one should keep in mind that within the phenomenon of globalization, temporary and permanent migration fluxes, in addition to weaving a complex multiethnic social fabric, also pose great challenges in addressing the overall health of individuals and their communities. If these considerations are translated into the clinical realm there is an emerging need to consider patients as "cultural selves" influenced by their own culture, unique in their way of developing and expressing discomfort, and enriched by the experiences interwoven in their existence (Bibeau 1997, Kirmeyer 2007, Kleinman 1988).

The importance of an articulated investigation of culture's role in shaping identity processes, feelings of belonging, and the individual's experience in health and suffering were identified and are being progressively shared amongst scholars. Hence the importance of developing a culturally competent approach to provide care and to understand the patient's pathology more clearly (Betancourt 2003, Gaw 1993, Lopez-Ibor 2003, Osasha et al. 2000, Yang et al. 2009).

Considerations such as these have created a greater need for clinicians to provide patients with a response that mirrors their suffering and is appropriate for the complexity of suffering which they may have developed, a response that is integrated with the expressed symptomatology, taking into consideration the ethnic background embedded within a cultural framework. Such reflections require a shift from a traditional, nosological approach that rests on a phenomenological-descriptive style to one that is more multi-faceted, which allows for a cultural "window" within psychiatric disorders. In bio-psycho-social terms, problems which are linked to mental health are not ascribed to a single domain of the human experience, but are rather assumed to be a product of the interplay between multiple factors of existence with effects on the individual's biological, psychological and social realms. Keeping movement due to globalization or enforced migrations in mind, the transcultural patient speaks to us of a greater need to discuss the role of the protagonist within the context of their existential journey, which can manifest in various forms, enunciating a greater vulnerability produced by the difficulties associated with adapting to a new context of living, personal stressors, problems in communication, and variance in the modalities with which the individual makes sense of their world. Each of these factors plays a role in accentuating the possibility of developing symptoms which may be connected to difficulties in adaptation or a lack of ability to adapt. This type of symptomatology can further augment the risk of masking specific clinical pictures – such as Adjustment Disorder (American Psychiatric Association 2000) or exacerbating pre-morbid psychopathological conditions. Bennett (1986, 1993) has proposed a multistage model of phases that an individual typically goes through before successfully adapting to new situations, and this is particularly relevant to individuals with transcultural experiences and backgrounds. Moving from one stage of cultural or experiential adaptation to the next involves elements of loss as well as parallel gains as new aspects of experience are acquired at each specified stage. Separation, Assimilation and Integration (Bennett 1986, 1993) represent a dynamic mosaic of experiences which include stressors and discomforts that perpetuate the process towards greater growth and acceptance of a new reality. Adjustment represents finding equilibrium between the elements of tradition and the uncertainties of change, between the old and the new. This homeostasis favours the subject's perception of an "optimal experience", translated into a sense of adjustment which solicits the individual as playing an active role in the dynamic progression between risk and growth, giving way to the concept of change as defined by Bennett (1986, 1993, 2004). This process reveals itself as multifaceted and complex, a constellation of potentially critical points in which a premise for Adjustment Disorder can incubate. Some authors (e.g., Maercker et al. 2007, Strain and Friedman 2011) have recently proposed a new diagnostic model based on the assumption that AD should be considered a stress response syndrome alongside Posttraumatic Stress Disorder (PTSD), Acute Stress Disorder, and Complicated Grief, in which intrusions, avoidance of reminders, and failure to adapt represent the core symptoms, as already indicated by Horowitz (1997). Individual differences, appraisals of the stressor and its sequelae, cognitive interpretations of the world and the self play a prominent role in the modality in which stress responses are manifested (Ehlers and Clark 2000).

The description of Adjustment Disorder emphasizes the concept of change – as discussed by Bennett (1986, 1993, 2004) – and highlights, as any event which produces a significant subjective and mutable experience, the risk of provoking maladaptive responses and generating stress. Cultural variations and interpretations of certain core psychopathological symptoms are not widely accepted and endorsed, and this was reflected in a formal section on culture-bound syndromes in the *Diagnostic and Statistical Manual of Mental Disorders* (APA 2000) (though, as Marsella (2010) points out, their treatment is rather perfunctory and relegated to the end of the text). These preliminary considerations allow us to delve further into the interplay between traumatic occurrences, the adjustment process, and cultural variables, in which the individual's self-related determinants and adjustment responses, characterizing the individual's cultural uniqueness, affect appraisal and adjustment to extreme stressors.

In line with these considerations, Chemtob (1996), Hinton and Lewis-Fernández (2011) and Marsella (2010), suggest that Western nosological frames are perhaps overused and overworked, applied beyond capacity and hence at risk of breakdown unless sufficiently expanded. Other work (e.g., Hinton and Lewis-Fernández 2011, Karam et al. 2010, McNally 2009, Pynoos et al. 2009) makes recommendations regarding appropriate revisions in the descriptions of several disorders, and many of these discussions are relevant specifically to the PTSD diagnosis. The study of cross-cultural aspects of psychological trauma has been a fruitful area of research in extending the psychological and psychiatric understanding of responses to stress. Posttraumatic stress is of special interest because of how

it differs from many other diagnoses. In particular, its aetiology is traceable to a specific event with a physical and temporal location, and the event itself is endowed with specific qualities that make it traumatic (discussed below). Studying traumatic stress in multicultural contexts is useful in delimiting Western psychiatric approaches to understanding the nature of psychological disorders, and their treatment. It is also not implausible to study stress responses to trauma in large groups. Other psychiatric diagnoses are essentially limited to individuals, or small groups of individuals. In case of collective trauma, however, important questions can be asked about the cultural and individual characteristics of those that develop psychopathological stress responses to trauma, and similarly, what characteristics protect those that do not. Studying collective trauma also yields important anthropological insights about the goals and values of the wider cultural contexts in which those traumas occur. Finally, over and above studying collective trauma, studying trauma in diverse cultures may allow researchers to "import" protective strategies that certain groups use to extraordinary effect.

Cultural variation in posttraumatic stress

The posttraumatic stress disorder diagnosis has, in comparison to other disorders, been relatively cognizant of possible ethnic and cultural differences in the perception and interpretation of trauma and the expression of stress. This may be attributable to the role of war trauma in history of the diagnosis. Within the United States and in response to military operations in Vietnam, government commissioned reports detected reliable differences in stress levels in different ethnicities (e.g., African Americans reporting more stress symptoms than European Americans, and Hispanic Americans reporting the highest symptoms of all) (Chemtob 1996). In some cases, differences in stress symptoms vanished when combat exposure was controlled for (as between African and European Americans). In others, the differences persisted (e.g., for Hispanic Americans) (Chemtob 1996). Such ethnoracial discrepancies in PTSD symptoms and adjustment precipitated investigations (e.g., Penk et al. 1989, Penk and Allen 1991) that examined ethnic minority status as risk factors for PTSD. Since then, a large body of research on ethnoracial differences in PTSD prevalence in the United States has accumulated (for a review, see Pole, Gone, and Kulkarni 2008 for a meta-analysis relevant to PTSD amongst Hispanic Americans, see Alcántara et al. 2013).

As mentioned above, the United States is composed of multiple ethnic and cultural groups that perceive one another as vying for limited resources, rather than as members of a single group with equal claim on cultural resources (Chemtob 1996). These groups include the European Americans, the African Americans, Hispanic and Latinos, Asians and Asian Americans, and Native Americans. Each of these groups has a temporal location in the country's history, beginning, of course, with the Native Americans. In contrast, European and African Americans are relatively newer, and Hispanics and Asian Americans are the newest groups. Each group possesses its own definitions of health and illness, and its own methods for treating them, and different groups have different experiences within the general cultural context. A review of differences in PTSD rates in the United States is beyond the scope of this article. However, there do appear to be reliable differences in these rates (Pole et al. 2008, Pole et al. 2005), and also in the symptoms reported. For example, in a comparison of Hispanic and Caucasian American police officers, Pole et al. (2005) found that their Latino samples were more likely to have greater avoidance and hyperarousal symptoms of PTSD, but not the core re-experiencing symptoms, which were equally prevalent. However, though re-experiencing seems to be a core symptom of PTSD, different cultural groups report different rates of specific symptoms (e.g., nightmares, flashbacks) within that cluster (for a review, see Hinton and Lewis-Fernández 2011).

Carrying out multicultural PTSD and adjustment research within a single cultural setting faces obvious limitations. In addition to residual stress from the trauma, individuals may also be dealing with issues of racism and bicultural identity (Parsons 1985, cited in Penk and Allen 1991). Therefore, many target populations are dealing with additional stressors that may be unique to their socioeconomic and demographic position in a country, rather than reflecting true cultural differences. Consequently, analysis may overestimate the role of "culture" in symptoms and adjustment. Second, acculturation may lead to modification or erasure of some cultural patterns of responding, and in this case, results may underestimate the role of cultural differences. Nevertheless, accumulation of findings from various studies has been important in reaching a more ethnoculturally sensitive understanding of PTSD.

Although some researchers have questioned the cross-cultural validity of the PTSD diagnosis (e.g., McHugh and Triesman 2007) studies in other countries on groups with less or no exposure to the Western notion of PTSD seem to share its diagnostic criteria (e.g., Ahmad et al. 2010, Hobfoll et al. 2008, Kar et al. 2007, for a review, see Hinton and Lewis-Fernández 2011). Indeed, as Marsella (2010) points out, there does seem to be a universal response to trauma (i.e., neuronal signals from the central nervous system increase activity in the hypothalamic-pituitary adrenal axis in order to face the stressor). How this universal physiological arousal is modelled and experienced is guided by cultural prescriptions.

The relationship between trauma and culture is an important one because traumatic experiences are part of the life cycle, universal in manifestation and occurrence, and typically demand a response from culture in terms of healing, treatment, interventions, counselling, and medical care (Chemtob 1996). To understand the relationship between trauma and culture requires a "big picture" overview of both concepts (Marsella and White 1989), and it is also important to understand if there are correlations between adjustment capacity, culture and trauma.

In fact, the concept of traumatic stress and the multidimensional nature of cultures requires a conceptual framework by which to address core issues that have direct relevance to understanding the nature of trauma as embedded within a culture and its assumptive systems of belief and patterns of behavioural regulation. In the case of complex reactions to trauma, post-traumatic stress may also have an effect on personality, self and developmental processes, including the epigenesis of identity within culturally shaped parameters (see Herman 1992, Wilson 2005).

Empirical research has shown that there are different typologies of traumatic experiences (e.g., natural disasters, warfare, ethnic cleansing, childhood abuse, domestic violence, terrorism) that contain specific stressors (e.g., physical or psychological injuries) that tax coping resources, challenge personality dynamics (e.g.,

ego strength, personal identity, self-dimensions), and the capacity for normal developmental growth (Green 1993, Wilson 2005, Wilson and Lindy 1994). Traumatic life events can be simple or complex in nature and result in simple or complex forms of post- traumatic adaptation (Wilson 1989, 2005). Clinicians should, therefore, make efforts to "understand how cultures utilize different mechanisms to assist those injured by different forms of extreme stress experiences" (Wilson 2005).

When does difficulty in adjusting become a disorder?

The definitions of AD, still in the DSM 5 have described adjustment disorders as maladaptive reactions to identifiable psychosocial stressors or changes in life circumstances. The symptoms, which by definition emerge within 3 months of the onset of the stressor, include a wide variety of impairments in social or occupational functioning, as well as maladaptive extremes of anxiety and depression, and impulse control problems. It is important to consider that clinicians and researchers often use the AD diagnosis as an exclusion criterion for affective or anxiety disorders. At the same time, AD is frequently used as a residual category for patients who do not meet the diagnostic criteria for other disorders. The most common points of criticism are the differentiation between AD and normal adaptation processes and the overlap with other psychological disorders. The new conception of AD is that they are characterised by the central symptoms of intrusion, avoidance and failure to adapt which, if not processed appropriately, could lead to marked alterations in behaviour (Maercker et al. 2007). Such functions thus require attentive analysis of self-related cultural determinants, which we take up in the next section.

Processes of posttraumatic stress

Posttraumatic stress disorder (PTSD) is characterised by the intrusive, vivid, sensory-rich and emotionally-charged re-experiencing of the trauma (e.g., reliving, flashbacks, nightmares, distressing reactions to objects associated with the trauma), the subsequent development of strategies to avoid cues associated with the trauma that might trigger intrusions (e.g., avoiding places or objects, topics of conversation, thoughts), and of increased psychophysiological arousal (e.g., insomnia, hyper-vigilance, difficulty concentrating) (APA 2000). This constellation of posttraumatic stress responses must occur in after a specific stressor, whose properties make it "traumatic". A number of cognitive models of PTSD have furthered the academic and clinical understanding of posttraumatic stress responses. Cognitive analyses of PTSD have a set of central features that are common across models (Brewin et al. 1996). Individuals possess certain core beliefs, assumptions and mental models of the world, which include the world as being essentially safe and a sense of relative invulnerability (Janoff-Bulman 1989). The information derived from traumatic experiences are contrary to the existing information and assumptions, and the individual is faced with the task of integrating this new information with an existing knowledge set with which it is initially incompatible. Unsuccessful integration of this information could lead to disordered stress responses such as PTSD (Brewin et al. 1996). Such psychopathological responses can only be avoided through the integration of trauma-related information within extant frameworks, or altering extant frameworks to accommodate the trauma-related information. However, major, negative changes in beliefs and values may lead to poor recovery and development of a trauma-centred identity (Berntsen and Rubin 2006, Sutherland and Bryant 2005) and the development of co-morbid nosological pictures. In their cognitive model of PTSD, Ehlers and Clark (2000) mention that PTSD poses a theoretical puzzle through its classification as an anxiety disorder, since anxiety is centred around perceived *current* threat, and posttraumatic stress occurs for past events. Thus, the usual time constraints applied to past experiences seem dysfunctional in PTSD. Ehlers and Clark (2000) solve the puzzle by drawing on work that demonstrates the stress response is maintained via (1) strong negative appraisals of the trauma or its consequences (e.g., overweighing unlikely probabilities of disaster, forming beliefs of universal danger, or interpreting their own responses to the trauma as indications of mental illness or loss of control) and (2) poor contextualisation of the trauma event within autobiographical memory. Thus, the trauma retains a dysfunctional level of salience in the individual's mind. The dual-representation theory (Brewin et al. 1996) is characterised by an emphasis on the encoding and representation of information in two memory systems: verbally-accessible memory and situationally-accessible memory. The verbally-accessible memory stores information through conscious processing, and includes autobiographical memories that are freely accessible to the individual, which are subject to the influences of decay and embellishment over time, appraisal, reappraisal, and the acquisition of new information. Information in this store can be made to cohere around life goals and themes. In contrast, situationally-accessible memory contains detailed perceptual information of the trauma (e.g., smells, colours, other perceptual features associated with the trauma). This information is not ordinarily accessible, but is activated when the individual comes into contact with those particular stimuli, which act as symptom-triggering cues. This store also contains information about meanings derived through non-conscious appraisals, and the individual's psychological and physiological states during the traumatic event. This information is not available to introspection or analysis, is not integrated with the existing autobiographical knowledge, and exists as event-specific information without any context. The nature and accessibility of the trauma information contained in these two memories (verbally-accessed and situationally-accessed) is subject to emotional processing, which involves consciously engaging with the trauma memory using situational, sensory information related to the event, and also engaging in meaning-making processes. The consciously accessible information is integrated with existing views of the self, and the world, and spontaneous elicitation of situationally-accessed trauma information is reduced. In such cases, the trauma is contextualised within general autobiographical themes and memory. PTSD and other psychopathological responses occur where emotional processing of the traumatic experience is incomplete or premature. In this model, the success or failure of emotional processing is closely linked to the eventual remission of stress responses.

Memory, the self, culture and trauma

The threat to conceptual self-analysis of PTSD (Jobson 2009) has particularly interesting implications

for cross-cultural research reflecting the notion of the construction of the self from memory and from cultural bases. The model's analysis of PTSD is carried out through understanding the interplay between the self-memory system and cultural differences in self-construal for trauma memories. Therefore, as Jobson (2009) does, we believe it will be useful to examine these elements first.

The self-memory system: The framework most relevant to our discussion is the self-memory system described by Conway and Pleydell-Pearce (2000), Conway, Singer and Tagini, (2004), and Conway (2005), which is composed of two interdependent subsystems: (1) the working self, and (2) the autobiographical knowledge base. The working self is the active hierarchy of goals currently represented in working memory (Conway and Pleydell-Pearce 2000, Conway 2005, for a recent review of the working memory construct, see Baddeley 2012). This currently active goal network is part of a larger, more complex, hierarchical system of goals. The hierarchical arrangement of the goal structure is such that the major, general goals are situated at the peak, with increasing downward goal-specificity. At any point, a particular sub-hierarchy of goals is at a higher level of activation relative to the remainder of the goal structure, though the entire network is assumed to be under permanent activation. The working self regulates cognition, emotion and behaviour in terms of the currently activate goal-set. Furthermore, the self-memory system constrains autobiographical memory largely in terms of achievement of or failure to achieve goals. If some experiences are contrary to important aspects of the goal-structure, then the working self can act on the associated memories of those experiences by either editing them to fit the goal-structure more appropriately, by reducing their accessibility to recollection and analysis, or by inhibiting them (Conway 2005). Thus, self-perception is goal-relevant. Conway (2005) also discusses the conceptual self, an additional structure that operates alongside the working self, which is socially constructed. It draws reference and definition from the individual's social reality, including interactions and relationships with others as constrained by cultural definition of the general nature of self-other relations. The conceptual self is built through socialization processes (e.g., through interactions with parents, schooling and education, and peers) and enculturation processes (e.g., media, stories, and myths that represent the culture) (Conway 2005).

One of the major aims of the self-memory system is to protect itself from goal-change, which would be very costly in "cognitive-affective terms" (Conway 2005, p. 597), since changing goals (especially in higher levels in the hierarchy) would simultaneously alter other related goals, which would in turn alter still other goals. An implicit assumption in this conception seems to be that the goal hierarchy is deeply embedded in the self-memory system, and major changes to goals could destabilise it. This is not to say that goal-change does not or cannot occur, only that it is resisted. This conservatism principle (Conway et al. 2004) operates to alter memories in ways that make them consistent with the goal hierarchy.

The second major component of the self-memory system is the hierarchically organised autobiographical knowledge base, the highest level of which is a general life story or life narrative, containing "factual and evaluative knowledge about the individual" (Conway 2005, p. 608). Information within autobiographical knowledge also includes general life themes (e.g., career, relationships), containing information that coheres around and represents them. Information in the autobiographical knowledge base is also organised in terms of lifetime periods (e.g., childhood, undergraduate education), within each of which further autobiographical facts are arranged.

Information can be retrieved from the autobiographical knowledge base via two pathways, generative retrieval and direct retrieval (Conway 2005). Generative retrieval uses meaning-based recall strategies (assessing the self-relevance or "gist" of the information to be recalled, such as the day one was accepted to a degree programme). The information is accessed *through* the hierarchical organisation of the autobiographical knowledge. The second is direct retrieval, which does not work through any arrangements of goals or life narratives to reach the information, but instead, uses stimuli in the environment (e.g., sensory and perceptual cues) to trigger recall.

The self-memory system and trauma: The self-memory system has been important in understanding psychopathological stress responses. The cognitive model of PTSD (Ehlers and Clark 2000) and dual representation theory (Brewin et al. 1996) are both consistent with notions of autobiographical memory presented in Conway and Pleydell-Pearce (2000). These approaches are thematically unified by an overarching emphasis on autobiographical memory. The generative and direct retrieval strategies discussed in Conway (2005) are reminiscent of the verbally – and situationally – accessible memories presented in dual-representation theory of trauma memories (Brewin et al. 1996). In fact, it might be argued that *any* important autobiographical memory has verbally – and situationally – accessible representations. However, situational representations of experiences and their direct retrieval are inhibited and become more difficult to access over time, while forming autobiographical links and associations with existing knowledge structures improves the retrieval of verbal representations (the gists, meanings, lessons, relevance and role in the life narrative) through generative processes.

The self-memory system and culture: Though it appeared over twenty-years ago, Markus' and Kitayama's (1991) discussion of cultural differences in self-construal remains one of most the cited articles not only within social psychology, but also across psychological research. They focus on how the self differs across individualistic and collectivistic societies, under the assumption that individualistic countries feature more independent selves in their cultural values, and collectivistic countries feature more interdependent selves in theirs.

The independent/individualistic and interdependent/collectivistic selves have the following characteristics (Markus and Kitayama 1991): (1) *Definition:* The independent self is decontextualised or separated from the social context. The interdependent self is contextualised or linked to the social context (2) *Structure:* The independent self is bounded and singular, clearly separated from others. The interdependent self has flexible boundaries between the self and others, and is therefore not a unitary structure. (3) *Important features:* The independent self is internal and private, and places emphasis on aptitudes, personal thoughts and emotions. The interdependent self is external and public, and places emphasis on roles and relationships. (4) *Self-Tasks:* The major tasks of the independent self are to express itself, to be distinctive, to promote its own goals, and to be straightforward in communication with others. The major tasks of the interdependent self are to belong to the group, fit in, and foster harmony,

to promote the goals of others, and adequately infer mental states of others without direct communication. (5) *Role of others:* For the independent self, others validate the self; they serve as references for upward or downward social comparison; Reactions and responses of others ascertain and confirm qualities of the self. For the interdependent self, others define the self through relationships and roles. (6) *Earning self-satisfaction:* For both selves, self-satisfaction is earned by fulfilling the self tasks described in (4). The superordinate culture shapes the self, and provides it with cultural prescriptions that model and guide culture-appropriate behaviour.

This description of cultural self-construal is certainly not to imply that selves are intra-culturally static. Markus and Wurf (1987) have reviewed its remarkable dynamism and ability to change across situations. Markus and Kitayama (1991) also discuss that selves vary in their degree of individualism and collectivism within cultures. Within a collectivistic culture, some selves will be more collectivistic than others. At the same time, the normative or *average* level of individualistic or collectivistic orientation is significantly different between both cultural groups (Fiske et al. 1998, Kagitcibasi 1996, cited in Jobson 2009). Markus and Kitayama (1991) suggest and demonstrate how psychological processes (cognition, affect, motivation, and hence, behaviour) vary predictably along the individualistic-collectivistic cultural continuum.

The self-memory system is itself a highly organised cognitive-affective-motivational unit whose conceptual self component also makes it sensitive to its sociocultural milieu. It is therefore plausible that differences in self-construal will affect the organisation of information within the self-memory system, including the perception and interpretation of trauma, and also how the self-memory system guides the development and expression of stress. To the best of our knowledge, Jobson and her colleagues (e.g., Jobson and O'Kearney 2006, 2008) are some of the first to examine trauma and posttraumatic stress while allowing for differences of self-construal. Indeed, the prominent PTSD theories mentioned do not refer to how the self differs across cultures, and in this regard, Jobson's work has been important in freeing a variable that has been held constant in earlier conceptions of psychopathological stress. It should be kept in mind that there are other forms of cultural distinctions. Researchers do acknowledge there are other ways to distinguish cultures, some of which may be even more relevant to understand symptoms. Along with these considerations, we should then place special attention in the clinic and therapeutic settings, to how the self constructs are thus explored and assessed. According to Kirmayer (2007), "the capacity to bring up memories with appropriate affect... is taken as a marker of the individual's ability to recognize what is of pathological significance for himself and that... a healthy self is 'true' and self reflexivity is the necessary and sufficient criterion of selfhood". Such considerations mirror a western and deeply engrained theoretical framework rooted in the notions of individual and partly inaccessible subconscious boundaries. The self is "agentic, rationalistic and univocal... and people's inner workings are revealed through self descriptions partly intuited by empathy or reconstructed on the basis of modules of psychological dynamics (Kirmayer 2007). If we instead take into consideration the complexity of the notion of the self in the light of its cultural determinants, the investigation of the patient's self representations should incorporate both structured assessment tools of personality such as SCID II (First et al. 2000) but also the use of other approaches such as the Cultural Formulation Interview in which self identity can be explored (APA 2013), as well as the use of tools that investigate the patient's perception of distress like the Illness Perception Questionnaire revised (Moss-Morris et al. 2002).

Furthermore, under the pressure of coping with the adjustment process to new realities (of traumatic nature or stress-related) the individual's self-resilience and social resources should be carefully examined. New schemes of reality testing and loss of familiar clues may challenge one's ego-boundaries and separation processes and fear of rejection or discrimination can pose heightened risks of self-dispersion which in turn may engender or rekindle co- and/or premorbid psychopathological pictures.

Threat to Conceptual Self Model: The threat to conceptual self model (Jobson 2009) is a working model that makes explicit connections between the self-memory system and cultural construals of the self in its analysis of PTSD. In particular, it examines the conceptual self proposed by Conway et al. (2004), discussed above. The conceptual self, owing to its construction from sociocultural influences, should be different in Western and non-Western societies, reflecting the values and goals of the circumscribing culture. One of its main proposals is that any individual's working self is composed of both individualistic and collectivistic self goals. However, the goal-system that is dominant (individualistic or collectivistic) is culture-dependent. The nature of the dominant goal-system and the autobiographical memories reflect the orientation of the conceptual self. Independent conceptual selves from individualistic cultures have high levels of autonomous orientation in their autobiographical remembering (memories feature a decontextualized, separated self), while interdependent conceptual selves from collectivistic cultures have lower levels of autonomous orientation and higher levels of social orientation in autobiographical remembering (memories feature a contextualised, socially connected self). This model proposes that traumatic experiences threaten the conceptual self in both individualistic and collectivistic cultures, but via distinct mechanisms.

In particular, trauma threatens the conceptual self by challenging one's self-appraisal of being an individual capable of accomplishing life goals. These goals are based strongly on cultural prescriptions. Therefore, the conceptual self of an individualistic culture is threatened when the trauma reduces one's sense of control, power or independence (Jobson 2009). These self-perceptions of reduced autonomy then have a negative impact on posttraumatic adjustment. The conceptual self of a collectivistic culture is threatened when posttraumatic self-perceptions include having disrupted relationships, failed to fulfil roles, or brought disharmony in group-functioning. For the collectivistic self, such self-perceptions lead to poor posttraumatic adjustment. These proposed differences in the general orientation of the conceptual self yield intriguing test implications, one of which is described below. Several researchers have suggested that a traumatic experience produces a change in self-perception and identity, such that they become trauma-centred. The individual develops an identity as a victim or survivor. For example, Sutherland and Bryant (2005) found that individuals with PTSD were more likely to state that they were defined by their traumas than individuals without PTSD. The trauma is viewed as a single major event in

the individual's life, which is treated as a turning point or defining moment (Berntsen and Rubin 2006), and develops high degrees of salience in the life narrative of the autobiographical knowledge base. Earlier, we had outlined the working self's need for goal-consistency based on work by Conway and Pleydell-Pearce (2000) and Conway (2005). Information about traumas may be difficult or impossible to contextualise in terms of existing assumptions and worldviews (e.g., the world as an essentially safe place). Therefore, the individual's identity may gradually alter to accommodate this new information about the trauma, the self as victim, and the world as no longer being essentially safe. The need to change is driven by the working-self's need for consistency and coherence, and since the trauma information cannot be made to cohere around the existing knowledge- and goal-structures, the existing knowledge- and goal-structures change to cohere around the information the trauma experience represents.

Jobson and O'Kearney (2008) point out that the above analysis many be particularly relevant for the individualistic self of Western cultures, since these cultures value a self that is unique, independent and consistent. The individual is able to take on the role of a victim, and continue to express cultural values of being unique (now as a victim or survivor). In collectivistic cultures that value a self that promotes group harmony and fitting in, emphasising a new identity as a victim or survivor may disrupt communal harmony, and will be received negatively (e.g., as being immature or selfish) (Jobson and O'Kearney 2008). Given these differences in cultural prescriptions, the authors hypothesised that subjects from an individualistic culture (Australia) with PTSD would describe their identities as being defined by the trauma, while Australians without PTSD would not show this tendency. However, the authors predicted that there would be no difference in the reports of self-concept provided by subjects from collectivistic (Asian) cultures with PTSD to those without. From a theoretical perspective, the socioculturally constructed conceptual self would not have permitted such a change in identity, as it would be contrary to interdependent cultural values by overstating the self in relation to others. To measure these aspects of self-concept, the authors asked participants to provide information about their current goals, a set of self-defining memories, and self-cognitions (by completing the Twenty Statement Test developed by Kuhn and McPartland 1954), where the participants have to provide twenty responses to the question "Who Am I?". These measures jointly provided an index of self-concept, which were later coded for themes of trauma. Greater frequency of trauma related themes in these statements were interpreted as evidence for a trauma-centred identity.

Both predictions were confirmed. Amongst Australians, it was possible to distinguish those with PTSD from healthy individuals based on greater emphasis on a self-definition as a victim. But such a distinction was not possible amongst the collectivistic sample, amongst whom statistical evidence for a trauma-centred identity was not found. These findings have implications for the aetiology of PTSD. The distribution and severity of PTSD symptoms was equivalent between both groups. But in the collectivistic group, there was no statistical evidence of a trauma-centred identity amongst those with PTSD. The authors concluded that identity and self-concept need not be altered in order for PTSD symptoms to develop. This evidence supports the notion that the maintenance mechanisms of PTSD symptoms are not universal but culture-dependent. The greater flexibility and plasticity required of the self in collectivistic cultures may prevent formation of such an identity. At the same time, given both PTSD symptoms and distribution were equivalent in the individualistic and collectivistic samples, not developing a trauma identify does not seem to be a protective factor.

Transculturally relevant risk and protective factors in posttraumatic adjustment

Do the above stated considerations apply to broader social contexts that involve multiple selves in relation to social support and issues of mass trauma?

Social support: Perceived posttraumatic social support has consistently emerged as a prominent predictor of successful posttraumatic adjustment, and correspondingly, its lack is related to higher symptom severity. Both of the major meta-analysis on PTSD risk factors (Brewin et al. 2000, Ozer et al. 2003) have made note of the predictive strength and explanatory power of perceived social support in the PTSD prognosis, though the *absence* of perceived social support was a particularly powerful risk factor in PTSD maintenance.

We draw the reader's attention to the concept of social acknowledgement proposed by Maercker et al. (2009), which refers to the degree to which an individual perceives that his or her status as a victim or survivor of trauma is accorded appropriate positive recognition and sympathy by others. Like social support, social acknowledgement also has bipolar properties, with social disapproval (e.g., blaming the victim: Guay et al. 2008) at the opposite end of the scale, exerting adverse effects on posttraumatic adjustment. In a sample of Chechen refugees, Maercker et al. (2009) hypothesised and confirmed that social acknowledgement was inversely associated with PTSD symptom strength. This finding extends the cross-cultural validity of social acknowledgment as a protective factor in posttraumatic adjustment. Of greater interest is their proposal of the individual's location within concentric social levels of interpersonal relations (Maercker et al. 2009, 2004). The first level consists of family and close friends, the second of other friends and acquaintances, and the third of general individuals in the community. Social support and acknowledgement can be derived from each of these levels. The authors have elaborated this conception into their socio-interpersonal model for understanding PTSD maintenance and adjustment (Maercker and Horn 2012) showing this tri-level concept of interpersonal relationships in relation to social support represent risk and protective factors in posttraumatic stress.

There are several combinations of interactions that are possible just between the levels (holding individual factors constant, for the moment). For instance, very supportive family relationships may buffer the individual against negative cultural feedback. The highest risk, of course, is likely to be a perceived lack of support at all three levels of interpersonal relations. This analysis can be applied to perceived racism. Chemtob (1996) reviews the deleterious effects of racism on posttraumatic adjustment (placing emphasis on military personnel), with individuals having to adjust not only to residual effects of combat stress, but also to perceptions of racism. Racism seems a likely candidate for the third-level of interpersonal relationships described by Maercket et al. (2009) and Maercker and Müller (2012). We feel that a closer examination of the influence of competing support and disapproval from different levels of interpersonal relations, and what individual-

level variables interact with them in the adjustment process would be particularly fruitful.

Mass trauma: The features of mass trauma constitute a reality that cannot be obtained by aggregation of individual traumas. For instance, with individual (or interpersonal) trauma, overarching cultural structures need not be challenged or altered. These intact structures then influence social support and the societal perception of individual trauma that play so critical a role in posttraumatic adjustment. In case of natural or artificial disasters, large scale systems and points of reference may be seriously affected as well.

Mass trauma also poses an important challenge to the study of stress responses. The bulk of the theoretical and empirical research is carried out in the developed West. However, the scale and frequency of disasters, both natural and human-caused, is much greater in the economically less developed non-West. Therefore, researchers face a double challenge when studying mass trauma: first, there are the issues of cultural differences in the perception and interpretation of trauma already discussed above. Second, they are attempting to use individualistically-oriented theoretical frameworks to draw conclusions about trauma experienced by groups or even entire populations. Therefore, caution must be applied in undertaking such research.

Johnson et al. (2009) used interpretative phenomenological analysis (see Smith 1996) to examine the reports and testimonies of trauma experiences of nine non-Western trauma survivors who had left their countries and subsequently taken up residence in Northern England, and self-reported as coping successfully. The goal of interpretive phenomenological analysis is the extraction of the meaning and understanding that an individual applies to and draws from a particular phenomenon (Smith 1996). It is theoretically interesting and methodologically challenging to investigate whether the meaning attributed to sustained trauma in oppressive environments during the experience is different from possible retrospective meanings imposed on the experience, and whether the former set of meanings are intact following the imposition of the latter.

The qualitative technique used by Johnson et al. (2009) uncovered intriguing themes in the trauma narratives, the first of which was that trauma was *not* an isolated event. Neither was it the repeated experience of a stressor or series of stressors, as would be expected in the definition of type II traumas (Johnson et al. 2009). Rather, the authors concluded that the narratives referred to a general environmental setup characterised by *constant* fear and a sense of danger in which "traumatic" events (e.g., torture) were entirely too expected. Any traumatic event was an inevitable manifestation of continuous oppression, and safety was the exception rather than the rule. In such environments, where individuals perceive their entire lives, or significant portions of their lives, as being a sustained trauma, it may become difficult to define specific traumas. In such contexts, it also becomes difficult to understand how individuals would interpret events such as loss of loved ones or torture, experiences that would, in other contexts, be a much less likely outcome. Indeed, part of the concept of trauma is that it forces individuals to question their basic assumptions about reality and the world (Janoff-Bulman 1989). The authors propose that living in such environments does not allow individuals to develop conceptions and assumptions that cohere around a belief system of an essentially safe world.

Another theme that emerged from the interpretive phenomenological analysis was an impression of general cultural protection which derived from a sense of shared experience. The authors mention that this perception of joint suffering enhanced a sense of group membership. In particular, they discuss depersonalisation of private experience to accommodate a shared experience. This interpretation is very much in line with social identity theory (e.g., Hogg 1993, Tajfel, and Turner 1979, Turner and Oakes 1986), which posits that individual depersonalisation occurs in the construction of group identity, enabling feelings of shared experience and perception of others and one's own group. Through depersonalisation, self-perception is able to expand and absorb aspects of other selves relevant to a unifying theme or principle (in this case, being victims of oppression together). In fact, following from our discussion of social support above, it seems that these individuals were able to generate perceptions of social support and acknowledgement amongst themselves in order to maintain a relatively positive outlook on the situation.

Several participants in the Johnson et al. (2010) study also reported that their suffering was the will of God, and in some cases, that their suffering would be met with eventual compensation. The role of God in their experience helped participants give meaning and purpose to the traumatic experience, which is typically without either. Indeed, as Chemtob (1996) points out, events may not be perceived as traumatic if they are believed to be a part of the natural order of the world. The disturbances of memory that seem to characterise poor integration of the trauma memory (for a review, see Brewin 2011) may not occur in such cases, simply because they do not challenge existing worldviews, and are hence more amenable to the integration and contextualisation.

We would be remiss in claiming that individuals in such environments do not suffer psychological consequences over and above the physical and mental stress of the situation itself. Instead, we merely underline that such a study demonstrates the protective role of a shared traumatic experience, and also requires us to reflect on how we define trauma.

What, then, counts as a trauma?

The DSM is very clear on this subject: The stressor is typically beyond the range of usual human experience (Maercker et al. 2007), and must threaten the physical integrity of the self or others (e.g., death or serious injury), and must be experienced with intense horror, fear or helplessness. The definition of trauma has been a controversial area within the PTSD diagnosis, and this draws attention to the role of the DSM criteria A1 (threats to the physical integrity of the self or others) and A2 (fear, helplessness or horror during the experience) in establishing a diagnosis. Both subcriteria A1 and A2 have been subject to close academic scrutiny (Breslau and Kessler 2001, Karam et al. 2010, Kilpatrick et al. 2009, Weathers and Keane 2007). Some, such as Karam et al. (2010) advocate the removal of A2 as a prerequisite for the diagnosis but its use as a risk factor. Others, such as Kilpatrick et al. (2009) advise the continued use of the criteria, but recommend greater flexibility in their use (such as using A1 *or* A2 to define whether a trauma has occurred). It is this notion of flexibility that we explore further.

Jobson and O'Kearney (2006) asked a number of Asian and Australian subjects to retrieve and list examples of traumatic experiences. A quarter of the Asian subjects listed academic failure, which none of

the Australian participants mentioned. Asian students' reports of academic failure as traumatic can be readily dismissed, and put down to two plausible reasons. Either the students themselves were exaggerating or overstating the effect of the event. Or, as Jobson and O'Kearney (2006) acknowledge, perhaps there were issues in translating instructions into their appropriate Asian equivalents, or else, that the tasks were too difficult. Given that these were university-level students, and that English language competence is required for university-level studies in Australia, both these reasons seem unlikely. However, there is also the possibility that the students were *not* exaggerating, understood the task, and reported a perception that academic failing was traumatic.

To repeat points made by Chemtob (1996) and Marsella (2010), the influence of culture is inescapable, and this includes the perception and interpretation of trauma. Chemtob (1996) discusses the Japanese tradition of *seppuku*, which refers to the taking of one's life in order to exculpate one's shame. Chemtob (1996) points out the events sufficient to elicit such shame in Japan would typically involve a failure to maintain clan structure or defend it. Failure to defend the clan (or rather, the shame one brings upon oneself and one's family) is clearly catastrophic to the point of requiring suicide. To carry further the point raised earlier about academic failing, Iga (1981) pointed out that suicide was still an endorsed form of adjustment in Japan, and discussed *shiken jigoku*, Examination Hell, which produced stress of a sufficient intensity in students for a substantial number of them to take their own lives. Suicide in response to academic stress is not a phenomenon one hears of further West (e.g., Advanced Placement exams in the United States). One does hear about academic related suicides in India. Each year, just after the Central Board of Secondary Education (CBSE) returns the school-finishing examination marks to the students in May, one reads about scattered suicides and suicide attempts across India. In India, these exams loom over students for their entire school careers. Performance on these exams is the sole criteria for admission to many Indian colleges and universities. Furthermore, doing well or poorly on these exams is also a matter of great pride (or shame) to the family and extended family, who frequently anticipate the exam results almost as much as the students themselves. Finally, the exam marks themselves are publicly released and accessible on the Internet, and marks are not private. In short, the pressure is intense, but from a Western-perspective, insufficient to precipitate suicide.

An idea of extended sense of self can be applicable to the exam-related suicides that occur in India each year. In this collectivistic culture, with the self being crucially tied to others, the repercussions of a poor performance are not limited to the student, but reverberate throughout his or her family and their social network as well. Poor performance, though not a physical threat to the self or another, does seem to constitute a major threat to the conceptual self. In particular, the culturally-defined goals of a collectivistic self (e.g., promoting others' goals, maintaining group harmony) seems to carry with a large degree of negative cultural feedback (Maercker and Horn 2013) from all three levels of interpersonal relations (e.g., disappointment from family, reduced likelihood of acceptance to a good college). The student must deal with the discrepancy between his/her expectations of passing the exams (expectations nurtured for the students entire schooling career), the current reality of failing them, and the extent to which he or she perceives themselves as having to adjust after having performed poorly in the exams, accentuated by feelings of disappointment from others and the shame of having let others down, if not physically traumatic, seems to be produce a trauma-like response. The integrity of the conceptual self seems to have been harmed in terms of the importance numerous others accord to performance on the exams. This work forces us to consider our definition of trauma, and poses an interesting inverse to that given above. Some individuals (usually from specific cultural groups), show tendencies to report non-traumatic events as if they were traumatic (e.g., Asian students reporting academic failure as being traumatic for them), when in fact, the stressor cannot objectively be considered a serious threat to the integrity of self or another.

Therefore, further investigations will help researchers understand whether a more culturally-sensitive definition of trauma provides greater predictive and explanatory power of how individuals perceive and interpret events that are non-traumatic according to Western frameworks. Such a definition would take into account, as Jobson (2009) suggests, threats to the conceptual self, and a recognition that for some groups (e.g. Indian students), threats to the conceptual self may be traumatic even if the physical self is not threatened.

In addition to the two characteristics of the stressor already described in the DSM, it appears that two additional features may add nuance to our understanding of how an event might be interpreted as trauma: (1) how unexpected it is, and (2) how it is perceived by the individual in terms of the consequences for the self and others. Thus, a failing exam mark or divorce can seem catastrophic, and sustained torture, though extremely painful, can seem part of a daily, albeit cruel, routine. The concepts discussed here, and the idea of a constructed culture of fear and its effects on stress responses, are open to, and in great need of, more sophisticated sociological, anthropological and political interpretations and discourse.

Precedent for this sort of social trauma does exist, as is briefly summarised in Brewin et al. (1996), where trauma is viewed an event that challenges fundamental beliefs regarding one's survival as a member of a social group. Though these beliefs could be challenged by direct threat to survival, Brewin et al. (1996) mention that social humiliation, social separation and violation of internal moral standards may also threaten survival of group membership, and may be construed as traumatic.

The socio-interpersonal model and conclusions

The proposal of the three-level socio-interpersonal model with the individual nested at the centre, surrounded by close interpersonal relationships, and then more distant ones embedded in the surrounding culture, may represent an important advancement in the conception of trauma (Maercker and Horn 2009, 2013). The main clinical theories of PTSD discussed in this article (dual-representation theory, Brewin et al. 1996; the cognitive model, Ehlers and Clark 2000) both focus almost entirely on intrapersonal variables (Maercker and Horn 2013) without particular reference to interpersonal and social variables, though they do acknowledge the positive effects of social support. The threat to conceptual self approach (Jobson 2009) allows for cultural variation in self-construal, which opens up the possibility of interpersonal processes. In the earlier section on mass trauma, we saw the application of social comparisons and social identity, two of the most prominent processes of social psychology. Maerker

and Horn (2013) point out that sufficient attention is not given to interpersonal and social interactions as risk and protective factors in PTSD, and research such as Johnson et al. (2009) and Sachs et al. (2008) demonstrate that social psychological insights (e.g., application of downward social comparisons to reduce the perceived intensity of one's own trauma) have the potential to inform the theoretical work on PTSD and other stress responses.

The socio-interpersonal approach (Maercker and Horn 2013) explores more fully the interactions between the culturally-constructed conceptual self and the wider culture. This approach also helps us view trauma as a social process, not just an individual one. By allowing for a socially dynamic self that receives and responds to interpersonal and cultural feedback, this model allows us to understand how posttraumatic adjustment occurs in the wider social context, and perhaps make predictions as to the probability of successful treatment outcomes

Dealing with stressors and stress responses is closely examined by Horowitz (1997), who included AD in the group of stress response syndromes, along with PTSD, acute stress disorder (ASD) and complicated grief. AD is also associated with disruptions to current social life. "The psychosocial stressors that may precipitate AD include divorce, difficulties with child rearing, illness or disability, financial problems, conflicts with work colleagues, moving, retirement and cultural upheaval". (Maercker et al 2007). Depending on the nature of self-other relations (culture-dependent) and individual differences, these social stressors will produce different levels of stress. Indeed, it seems plausible that any stressor will be followed by an attempt to adjust. Horowitz (1997) described consecutive phases in the course of stress response syndrome, starting with an initial phase of realisation that a stressful event has occurred, followed by a phase of suppression of the threatening news, a phase of alternating intrusion and suppression, and a processing (or working-through) phase, which results either in the threatening information being integrated into the person's cognitive schemata or in negative outcomes in the form of psychiatric disorders or changes in personality. According to the theory by Horowitz, intrusive symptoms occur because the stressful information is not yet integrated into the person's cognitive schemata, but still represented in the active memory, discussed in greater detail above.

The interpretation of these stressors is also likely to vary depending on the perceived support from the three levels of socio-interpersonal relations. For instance, the likelihood of successful adjustment seems higher in situations where all three levels of interpersonal relations provide positive feedback in terms of support and acknowledgement than one where all three levels show disapproval. The threat to conceptual self model and the socio-interpersonal model of PTSD also help unconstrain the definition of trauma, or rather, to apply culturally appropriate constraints on its definition through the use of social relations to others in one's social context. Overall, therefore, further research will be required on these social and cultural aspects of the self and trauma. At present, the general understanding of trauma, psychopathological stress, resilience and adjustment in non-Western groups may be seriously limited by a lack of attention to how the individual is connected to his/her social context.

On a final consideration, one might define culture as a "conglomerate of coordinates that give an individual a prefabricated vision of how they interpret their world, allowing them to develop the necessary tools to successfully interrelate within the realm of their environment" (Terranova-Cecchini 1991). This phenomenon manifests itself as a pattern of observable behaviours, attributable to points of view which give meaning to those behaviours, through a reference point of beliefs, values, and norms that are specific to its context (Tseng 2001, Tseng and Seltzer 2001). If culture is considered as a network of *meanings* which guide and support identity, guaranteeing efficiency in actions and relations within the individual's sphere of belonging, the potential of disorientation and distress engendered by the sense of self-inconsistency, when faced with unpredictable, highly destabilizing life occurrences such as trauma requires a complex and articulate process of adjustment to a new experiential state. Therefore, a transcultural approach to nosology but also to the understanding of the uniqueness of human complexities does not limit itself only to the care of migratory populations, but offers a window to the cultural elements of the self, which each individual possesses, in order to understand the unique web of meanings inherited from the original milieu and preserved through a process of psychological selection (Massimini et al. 1996).

Finally, the transcultural model gives the clinician another tool for recognizing the subjective experience of discomfort or psychopathology by carefully considering the patient's *impasse* from the myriad of cultural variables in which they may find themselves throughout their entire existential journey.

"Culture has the same ubiquity and transparency as water except at the junction of cultures, where the world is refracted and reflected" Kirmayer and Minas (2000, p. 438).

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