traumaclinic
counselling

Traumascape:
Traumatic stress in the context of culture with particular reference to African cultures

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Course outcomes:

When you have completed this course you will have an understanding of:

- The interaction between extreme stress, the individual, social ecology, history and culture.
- An interdisciplinary framework to understand and study the under-researched domain of the complex interaction between trauma, culture and history.
- How to develop policies and practices within a culturally and historically informed public health framework
- How to become competent in crossing cultural borders.

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A note on the learning and teaching approach

This course is built on the principles of supported open learning pioneered by the UK Open University and developed by South African Institute for Distance Education (SAIDE) and The SACHED Trust. Course participants (Students) are asked to do all the tasks as they appear in the text in order to take full value from the course. There are two kinds of task:

Fact check – to memorise key knowledge items

Reflection and analysis – to take time to actively engage with the ideas in the course

OVERVIEW

The experience of trauma is shaped to a large extent by the environment within which it takes place. I have proposed a concept 'traumascape' to describe the ways that communities, locally and internationally, react to mass traumatic stress. This course is largely based on work I have done with others in Africa (De Jong, 2002a). Traumascape refers to the systemic dynamics of local and international representations and actions around extreme stress. For example, why did the world react immediately with massive aid after the Tsunami whereas it stayed deaf and blind to 30 years of appalling armed conflicts in the Sudan?

In our current world the conceptualization of distress and traumatic stress and the social and power relations related to the cultural construction of these concepts are in constant flux. For example, a cascade of events – determined by the media, the role of UN /NGO /government/ local stakeholders, funders and health professionals – will often determine the focus, the size and the nature of assistance a group of survivors of a natural or human-made disaster will receive. Media hypes in combination with e.g. geopolitical considerations, or upcoming elections may determine whether terrorism, human rights, child rights, quality of governance, gender-based violence (GBV) or child soldiers are the main concern of the international community, and, subsequently, whether funds will go to a specific region or a specific type of disaster, often to the detriment of other catastrophes.

It is very complex to find out where these trends originate and how they permeate the agendas of the UN and the donors. It is also difficult to understand why most large western donors tend to copy each others' humanitarian priorities, while on the other hand they diverge in the assistance they provide to war affected areas. Some countries decrease their aid based whether a community is harbouring or bordering a conflict, while others increase their aid. (Balla & Yannitell Reinhardt, 2008).

Some examples of where the traumascape may lead: Over the past years, dozens of projects on GBV (Gender Based Violence) have been set up in the African Great Lakes region, especially in east Congo, compiling lists of rape survivors at the village level. Of course there is a serious problem of rape in the area, but until recently many projects lacked a view on more general psychosocial programming, and focused on GBV to the detriment of other serious problems, such as a wide range of other war-related traumatic stressors, or of GBV-related consequences in terms of HIV.

A local traumascape is also shaped by international opinions, and the wealthy who identify with the victims. For example, after the Balkan war and the Tsunami, several areas were invaded by psychosocial programmes – deflecting funds from other human-made or natural disasters – often resulting in an inflation of the word trauma. In the preceding chapters we described how even daily trivialities and hassles could gain the status of a 'traumatic event'.

Another example: after the genocide in Rwanda the international community for the first time in history showed interest in mental health which before the genocide, like in Burundi, where mental health services had previously been limited to a single residential facility in the country for people with serious mental disorder. The interest of the international community suddenly created a local traumascape that resulted in a massive influx of NGOs. It even resulted in the invention of two local words for trauma, one of them called guhahamuka.

In a post-war or post-disaster situation, stakeholders have divergent perceptions of the traumascape, eliciting interventions that may be scarcely related to the needs and concerns of the local communities, or to scientific evidence-based professional considerations. For example, a local UN office, or the military, may think that an epidemiological sensible target figure of PTSD or psychosis has to be treated per month, as would be done in communicable or infectious diseases such as tuberculosis, whereas, many people may only start suffering from PTSD many years after the events are over. (Ironically this also happens with tuberculosis when migrants leave a country with high prevalence rates to arrive for a new country where tuberculosis is not endemic at all).

Another example: Christian or Islamic groups may propose daily prayer to deal with the problem of trauma, while the local population complain about spirits that remain unharmed by the prayers of foreigners. In the Gulu-Kitgum area in northern Uganda Christian NGOs tried to convince former child soldiers who were haunted by ancestral spirits, the Cen, to pray, because it was supposed to help them chase the spirits away. In West Africa an NGO felt that a 3-day or 5-day training of local professionals was enough to train suitable psychosocial counsellors without considering the ethical implications of such a decision. Other proponents again may harbour the view that talking is a Judeo-Christian invention that does not help (Summerfield, 2000; Tricket, 1995) and should be replaced by work, play, theatre or music-making, while much talking and discussion in communities is traditional all over Africa.

The belief that talking is a Judeo-Christian invention – which could be regarded as a post-colonial guise for the belief that non-Westerners are psychologically less sophisticated – is often supported by another stereotype, or 'cognitive scheme', namely that non-Westerners somatise rather than psychologise their distress, even though there is a substantial body of evidence supporting the view that somatising is universal (Ustün & Sartorius, 1995) and that

cultures distinguish themselves in certain preferred patterns of somatisation (Kirmayer et al., 2004; De Jong, 2004). Examples are, the ‘scratching of a chicken leg at the inner part of the skull’ described in Ethiopia, the ‘heated foot soles’ or the wide range of somatisation described in West Africa.

A third cognitive schemata commonly held by donors and relief workers, is the notion that it is impossible to do anything substantial or meaningful regarding massive traumatic stress. This astonishing view has resulted in an avoidance of the issue of psychological suffering and its consequences, and a ‘conspiracy of silence’. There appears to be a degree of universal ambiguity that surrounds the expression of distress when dealing with a traumatic past. People are ambivalent about what they reveal about their trauma in their daily discourse, and about what they actually do to cope with extreme stress, or about what assistance they would appreciate. However, in our experience people feel relieved after verbally expressing distress when interventions are culturally congruent. They may not want to embarrass their fellow survivors by expressing their haunting past, and yet find enormous relief in sharing their memories with others, whether through a palaver under the village tree, a self-help group, an individual or family session, or another form of ritualized healing.

Understanding these and other factors that result in local traumascapes, and their interaction with other ecologies, will enable practitioners and policy makers to determine appropriate coping strategies that satisfy universal human necessities while taking the specific socio-cultural context into account.

Mental-health professionals have to bear in mind that debates such as the one about the importance of treating PTSD vs. the relevance of dealing with all kinds of psychosocial, mental or material predicaments, are often dominated by these (inter)national dynamics of the traumascape. We have to make sure that the message of the importance of psychosocial and mental health problems gets across to policy makers and politicians in our countries, while also trying to influence these higher order systemic levels that determine the traumascapes in which we often live.

Within the dynamic framework of the traumascape, this course presents a model for understanding and studying the interaction between extreme stress, the individual, social ecology, history and culture. The model has three objectives. The first is to provide an interdisciplinary framework to understand and study the under-researched domain of the complex interaction between trauma, culture and history. The second objective is to develop policies and practices within a culturally and historically informed public health framework. War, terror and disasters, as in today’s Zimbabwe, often do not recognize national boundaries, and drive migration, sometimes creating multiracial societies. Therefore, the third objective is to invite professionals to become competent in crossing cultural borders.

Fact check 1

Question 1

What does 'traumascape' describe ?

Question 2

Name 2 factors that shape the local traumascape

1.
2.

Reflection and analysis

Discuss how stakeholder's divergent views of a traumascape can lead to interventions which do not serve the needs of the community.

1 AN ECOLOGICAL-CULTURAL-HISTORICAL MODEL FOR EXTREME STRESS

The ecological–cultural–historical model for extreme stress presents the person as part of a hierarchy of levels of organization. The person is first presented as an organism composed of inter-related parts of the central nervous system and the body, then on to the level of the family and, finally, the community and society (Fig. 1). From a wider ecological perspective, the person is enveloped and interacts with corresponding historical, political and economic processes. Within the historical processes, one can distinguish a collective and an individual dimension. These two dimensions have a time perspective and interact with each other.

Simultaneously, the person is embedded in a cultural context as well. The cultural context similarly has a collective and an individual dimension interacting with each other. The collective dimension of culture represents schemes that guide the meaning of such processes as suffering, healing and reconciliation. The individual dimension represents cultural influences on traumatic stressors and their appraisal, their modification by protective and vulnerability factors, and their individual expression in suffering, distress, psychopathology, post-traumatic growth and its concomitants of disability, functioning, quality of life, well-being and resilience.

History and culture are intertwined. In the past both disciplines have evoked debates about the extent in which they should be regarded as separate (Kuper, 1999). The capriciousness of history in the course of extreme stressful events such as wars or disasters warrants a separate discussion. Both collective and individual history challenge culture to an extent that it has to adapt its collective and individual survival strategies and coping styles.

1.1 Ecology and history: Individual

The life history of an individual is embedded in the traumascape of a collective history in a specific era. Both individual and collective histories add a time component to the model outlined here. Individual and collective histories have a reciprocal relation, as the debate about the nature and origins of PTSD shows.

Shay (1991) suggested that elements of the post-traumatic stress disorder could be identified in Homer's Iliad. Ben-Ezra (2003) asserts that the symptoms of nightmares, sleep disturbances and increased anxiety have not changed in 4000 years. The symptoms reported in a family trapped in the Bergemoletto avalanche have been quoted as evidence for the disorder's existence in the mid eighteenth century (Parry-Jones & Parry-Jones, 1994). Dean (1997) identified symptoms of PTSD in the accounts of veterans of the American Civil War. Trimble (1985) concluded that 'this relatively common human problem has been known for many hundreds of years, although under different names.

Young (1995), however, argued that PTSD is a culture-derived diagnosis that only existed in the late 20th century '. . . glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated and represented and by the various interests, institutions, and moral arguments that mobilised these efforts and resources'. Jones et al. (2003), in their study of UK servicemen who had fought in wars from 1854 onwards support the hypothesis that some of the characteristics of PTSD, such as intrusion and avoidance, are culture-bound and that earlier conflicts showed a greater emphasis on somatic symptoms.

One may conclude that – as in many other psychiatric syndromes – the symptoms of post-traumatic stress change over time and that an historical era, to some extent, expresses itself in an idiosyncratic way in the presentation of individual suffering. This idiosyncratic process starts before birth when individuals are equipped with genes that promote resiliency or vulnerability (see Fig. 1: sub Ecology and History, Individual level).

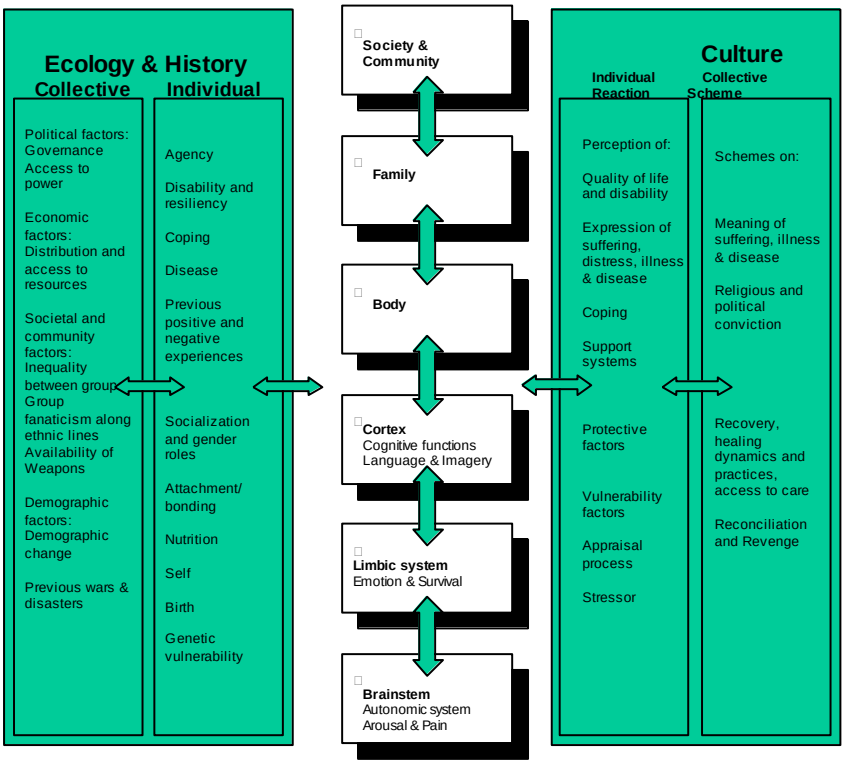

Figure 1. An ecological-cultural-historical model for extreme stress

Future studies will likely show that worldwide variations in the human genome equip individuals with different degrees of resiliency against traumatic stress. For example: research has identified an allele for the serotonin transporter gene that affects vulnerability to stress. People with the short allele are at increased risk for anxiety and depression. Most people of European descent carry the high risk allele and are at higher risk of depression. However, studies also show that carriers only develop depression if they are exposed to stressful and traumatic events, especially early in life (Caspi et al., 2003; Kendler et al., 2005).

Similar to genetic vulnerability and protective factors, the next individual historical determinant, sex, is determined at conception. The first influences of the individual's life history start in utero with the interaction between a person's genetic make-up and the environment. Birth itself can be a risk factor in many regions in Africa, often compounded by complex emergencies, where poor prenatal and perinatal care and a collapse of the public health care sector. Famine, starvation, nutritional deficiency, environmental health hazards, cerebral malaria, parasites, diarrhoeal diseases and respiratory infections may further negatively influence cognitive and bodily development both in utero and later in life (West, Caballero and Black, 2001; Bangirana et al., 2006).

Walker et al. (2007) reviewed the evidence linking compromised development with modifiable biological and psychosocial risks encountered by children from birth to 5 years of age. They identified four key risk factors where the need for intervention is urgent: stunting, inadequate cognitive stimulation, iodine deficiency, and iron deficiency anaemia. The

evidence is also sufficient to warrant interventions for malaria, intra-uterine growth restriction, maternal depression, exposure to violence, and exposure to heavy metals.

Family disruption, parental illness and death, possibly aggravated by the AIDS pandemic, can affect attachment, bonding, separation and socialization and contribute to anxiety, depression, PTSD, attachment disorders of childhood, and antisocial, borderline or traumatic personality development, such as Complex PTSD or DESNOS (Herman, 1992; Van der Kolk et al., 1996).

Prior to the onset or during episodes of political violence, the individual may be exposed to positive or negative life experiences that may either contribute to resiliency and post-traumatic growth, or to further vulnerability later in life. Post-traumatic growth manifests itself in an increased appreciation for life, more meaningful interpersonal relationships, an increased sense of personal strength, changed priorities, and a richer existential and spiritual life (Tedeschi & Calhoun, 2004; Aldwin & Levinson, 2004). The interaction of these resiliency, vulnerability and growth factors may result in a proneness to disorder and the development of disability. Alternatively, it may result in a more or less diversified repertoire of coping skills. This may, in turn, influence the ability of the individual to display agency and to survive in an adverse environment.

1.1.1 Culture: Individual

Within current models of stress in psychology and psychiatry, cultural factors modulate the relationship between the events, moderators, mediators and outcomes. Here, some examples of the influence of culture on an individual will be presented by following common stress models with a cultural lens (De Jong, 2002, 2004). These stress models primarily distinguish traumatic stressors as independent variables being appraised by an individual and resulting in psychological and psychiatric problems moderated and mediated by a range of protective and vulnerability factors. Common psychological disorders or more serious mental disorders are regarded as dependent variables that in turn affect functioning, quality of life, personality growth, disability and resilience. Although these models have universal applicability, they can be enriched when we obtain more insight into the transformation of its components by the work of culture.

1.1.2 The traumatic stressor, protective and vulnerability factors, coping, social support, and expression of distress and disability.

Threats to survival are at the core of traumatic experiences, as clarified by the revision of the definition of post-traumatic stress disorder (PTSD) in DSM-IV (APA, 1994). However, the perception of threat as traumatic varies across individuals and across cultures. One may even doubt if stressors are ever traumatic per se and argue that an event can only become traumatic after appraisal (as mentioned in the second part of the DSM-IV stressor criterion). For instance, was the premeditated loss of thousands of people on a single day on the ancient battlefields in Europe or Southern Africa perceived as traumatic, and did this differ for those ordering the battle or the individuals surviving it? Is the loss of a child a universal stressor? Based on experience with mothers across cultures who heard about the (impending) death of their child, we tend to regard the confrontation with the death of a child as a universal traumatic event.

Similarly, Einarsdóttir (2004) argues that, despite high infant mortality, there is no normalization of child death among the Papel in Guinea Bissau. Our views contrast those of Schepers-Hughes (1992), who states that high infant mortality in Brazil protects mothers from suffering as compared to countries with low infant mortality. In our view the mothers' wording of their previous loss during an anthropological encounter reflects a useful defence mechanism that may differ from their true suffering when their child died.

In contrast to the death of a child in Africa, the death of an older loved person who has children and some accumulated wealth is typically acceptable in sub-Saharan African cultures, since it is believed that the deceased will travel to the reign of the ancestors and occupy an intermediary position between the living and the dead.

Is loss of wealth traumatic? Higher levels of socioeconomic status and education before displacement are associated with worse mental-health outcomes (Porter & Haslam, 2005). However, adult Tibetans did not perceive the loss of their personal possessions as traumatic, but the desecration of their religious symbols by the Chinese was perceived as a traumatic loss (Terheggen et al., 2001). When a Middle Eastern or a northern African family realizes that an unmarried female member is flirting with a man, the event can be devastating to the family honour and result in violence or even revenge killing. It is the culture-bound appraisal of the flirting, innocent in many other cultures, that evokes emotions that result in culturally prescribed action.

This example also illustrates how protective and vulnerability factors can depend on cultural context. The concept of honour may function as a protective factor in the context of Middle Eastern or Maghreb cultures by promoting endogamy, chasteness and peaceful coexistence of families and clans. The culturally prescribed revenge killing related to the appraisal of loss of honour can result in positive coping in the countries of origin, while the same behaviour may be a negative coping style resulting in social exclusion or imprisonment in another cultural setting.

Both problem-focused and emotion-focused coping are influenced by culture. Once indigenous coping strategies and resources are identified and understood, salutogenesis can be encouraged as a form of prevention or intervention.

Grief is an essential task of survivors and provides a good example of the influence of culture on coping. There are several dimensions distinguishing cultures regarding grief and bereavement. High-income countries use concepts such as grief counselling or terminal care. In contrast, in low-income countries, people's attention is especially focused on varying supernatural beliefs (a) that the dead communicate with the living; (b) that other people's supernatural abilities such as witchcraft can cause death; (c) that the ghost of the deceased will take revenge if one does not complete proper rituals for the deceased, for example, in cases of suicide or homicide as often happens in conflict settings or ethnic cleansing; (d) that verbalizing the name of the deceased is dangerous; (e) that a newborn is a reincarnation of a deceased person; (f) that hearing or seeing the deceased person is normal, and (g) that tie-breaking customs are useful to cope with loss (Rosenblatt, Walsh, & Jackson, 1976; Irish, Lundquist, & Nelsen, 1993; Parkes, Laungani & Young, 1997; De Jong & Van Schaik, 1994).

Anger toward the deceased is another difference in grief between African and Euro-American cultures. The common Christian habit is to encourage saying nothing but good

about the dead, possibly hindering the expression of negative feelings toward the dead. In many African cultures, the expression of emotions such as anger towards the deceased is often permitted in a ritual context. This may be done in a benign and mocking way, since the family needs the help of the deceased – who just rose to the status of ancestor – to cope with life. Later, this ancestor may transmit messages through an elected person whom we might regard as hallucinating and may lead to an erroneous diagnosis of psychosis. Nevertheless, local culture often deals in a ruthless way with that same anger and despair by accusing the living of causing the death of a family member. In some (West) African cultures the accusation of magic manipulation may involve parents being accused of the death of their own child. It seems that the anger caused by death is expressed in a highly ambivalent way. Both the deceased and his or her family members or co-villagers may become the target of a witchcraft or sorcery accusation. The accusation may correspond with pre-death conflicts or be in line with structural tensions such as that between generations, sexes, co-wives, or the poor and the rich.

The nature of the expression or the presentation of distress and suffering in response to threats also varies across cultures. Working in post-war circumstances in West Africa, presentation of PTSD symptoms was rare, while patients regularly presented stiff or contracting catatonic bodies, accompanied by bouts of shouting and twisting movements of body parts. One of the authors soon realized that these were local idioms of distress in the guise of dissociative reactions reminiscent of scenes of 1890s Salpetrière in Paris in the time of Janet, Charcot and Babinski. From a cross-cultural perspective, it is interesting that one often still comes across expressions of idioms of distress or psychopathology in low- and middle-income countries that have gradually disappeared in the West over the past 100 years. The expression of repressed feelings, often related to abuse, greatly varies and evolves over time, resulting in dissociative states such as classical ‘hysteric’ attacks, spirit possession, ‘hysterical’ blindness or aphasia, or psychogenic convulsive attacks.

An additional problem in diagnosing psychopathology across cultures is that the reactions to trauma are often expressed in narratives that express both distress and the explanation for the distress at the same time. Moreover, these narratives are often intertwined with the cultural transitions and losses that confront the survivors resulting in acculturative stress, culture shock and cultural bereavement (Eisenbruch, 1984). In low-income settings families are often the main providers of social capital and mental wellbeing. As such, families are a protective factor when a person is confronted with extreme stress. However, Norris and Kaniasty (1996) showed that following mass trauma, initial periods of a high degree of social support are followed by a quick deterioration of the support system under the pressure of overuse, and the need for individuals to get on with their lives. This problem is compounded when large numbers of adults die due to war or AIDS, or when families seek refuge in the abodes of other family members. A large extended family then becomes into a vulnerability factor (De Jong, 2004).

Furthermore, Western concepts of disability and social and psychological functioning are often not appropriate in local settings. Research instruments used in high-income countries may not measure the same concepts of disability and well-being in other cultures. Bolton and Tang (2002) developed a useful method for cross-cultural and sex-specific assessment of disability and functioning. Over the past 15 years similar qualitative techniques have been

used for pre-program assessments, but also for research to prepare functioning instruments for children (Tol et al., 2008; Tol et al., submitted).

1.1.3 Culture: Collective

The individual level of perceiving and dealing with threats, interacts with the collective level of the traumascape. The collective level operates through schemata defined as structured cognitive representations of sets of rules of human populations. Culture-based schemata are part of the traumascape. Schemata are dynamic and provide a means for cultural prototypes to be revised as a function of individual experience (Rumelhart et al., 1986; Chemtob, 1996). We will limit ourselves here to schemes related to recovery and healing, and to religious and political conviction.

Schemes on recovery and healing

Psychiatrists and psychologists tend to apply psychodynamic or cognitive interventions based on Western concepts of autonomy and individualization. This may be out of place with patients with other views of the ego and the self, living in collective societies that promote interdependency (or 'wego' instead of 'ego'). For example, in these cultures Western interventions promoting for example assertiveness may be perceived as selfish (De Jong, 2004).

The two major impediments to the implementation of appropriate psychosocial and mental healthcare programmes, are stigma and dogma. Stigma schemes around deviant behaviour may be a major impediment to develop interventions in the local culture. Stigma may result in self-stigma when members of subgroups internalise the prejudices of their environment (Corrigan & Watson, 2002). A similar process of internalisation may take place among family, friends and helpers and result in what is called affiliate stigma.

Similarly dogma about the appropriateness of certain interventions among helpers may equally influence the local traumascape. For example, Western helpers may have non-founded views about the effectiveness of all kinds of interventions, ranging from culturally non-adapted versions of EMDR, CBT, family interventions, or testimony methods, to new-age therapies. Or, they may handle religious or other paradigms that are incompatible with the problems of those they want to assist.

Over the last decade, a major step forward is the development of a series of guidelines and books on providing psychosocial and mental healthcare by the UN, WHO, consortia of NGOs and professional societies. These guidelines are obligatory reading for anyone who wishes to enter the 'trauma field', despite the heterogeneity of traumatic events, the lack of empirical support for specific interventions, or the need for adaptations of interventions to local needs and culture (IASC, 2008; De Jong & Clarke, 1996; De Jong, 2002; Green et al., 2003; Weine et al., 2002; Eisenman et al., 2006). An expert panel gained consensus on empirically supported intervention principles that cover the period to several months after a disaster (Hobfoll et al., 2007). They are defined as promoting:-

1. Safety, on an individual, family, group and community level to prevent threatening situations from recurring, and where reminders may contribute to an ongoing sense

of exaggerated fear. It includes safety from bad news and rumours (Ehlers and Clark, 2000).
2. Calming of extreme emotions through interventions such as breathing retraining, muscle relaxation or mindfulness, through a 'normalization' of stress reactions by survivor education about reactions, and by fostering positive emotions including joy and humour.
3. A sense of self and community efficacy, reinforced by practising increasingly difficult situations in which increments of success build to a reality-based appraisal of efficacy which supports calming as well.
4. Connectedness, promoting social support; activities such as problem-solving, sharing of experience and emotional understanding, and mutual instruction about coping. Research indicates that social support is related to better emotional well-being and recovery Therefore, interventions have to identify those who lack social support and who are socially isolated and promote social support networks in communities (De Jong, 2002b). However, one has to remain sensitive to the potential for social undermining based on racial, ethnic and tribal divisions.
5. Hope, or the expectation that a positive future outcome, is possible. Hope for most people in the world has a religious connotation and is not action-orientated (Antonovsky, 1979). Antonovsky underscored that one's belief that things will work out well is based on past experience. In view of the protracted duration of several conflicts around the world one may question this statement. On the other hand, even in LAMIC (lower and middle income countries) where a whole generation has endured human rights violations or war (e.g. Burma, Cambodia, Kashmir, Tibet, Sri Lanka, Vietnam, Angola, Sudan, South Africa, Zimbabwe), people often seem to have internal resources and resilience that are beyond the imagination of middle-class Westerners.

Within the global traumascape, schemes of recovery and healing are influenced by divergent views on the value of diagnostic categories, of epidemiology and of interventions. The next section will briefly examine these issues and attempt to indicate directions to bridge some of the divergent views.

1.1.4 Nosology and diagnostic categories

The trauma field could benefit from giving up the debate about the universal validity of a core diagnosis of PTSD (Kleinman, 1977; Young, 1995; Summerfield, 2000). Biological adaptation to extreme stress is necessary for survival in a Darwinian sense and hence it is not surprising that these adaptive reactions are embedded in the brain (Hobfoll, 1998; Panksepp, 1998). Recent insights into the role of brain structures, such as the amygdala in fear response, both in animal models (Le Doux, 1996) and neuroimaging (Shin et al., 1997), changes in neurotransmitters such as norepinephrine (Southwick et al., 1993), and neurohumoral responses such as cortisol (Yehuda, 2002), provide evidence for a biological substrate of PTSD. Moreover, respondents in a variety of countries appear to easily recognize PTSD symptoms in studies that address numerous variables, and explain those symptoms with local explanatory models without any notion of words such as trauma, stress or PTSD (De Jong, 2005).

However, despite these arguments in favour of a universal phenomenon of PTSD, Kendell and Jablensky (2003) have convincingly argued that validity is flawed by a lack of boundaries in any psychiatric syndrome. Validity does not mean uniformity across the globe (De Jong et al., 2005). Although scholars do find PTSD in many different cultures, the conclusion that PTSD is similar in all cultures is premature. Studies generally do not look for differences that might have yielded as yet unknown (sub)types or variations of the disorder. Future interdisciplinary studies should enable the scientific enquiry in the field to parse out the unique and interactive contributions of biology and culture to the PTSD 'syndrome' (Osterman & de Jong, 2006). It will also increase our understanding how PTSD, posttraumatic idioms of distress, posttraumatic growth, traumatic personality development or DESNOS are modified by cultural beliefs and meaning systems (De Jong, 2004).

Without a refined inventory of idioms of distress in a variety of cultures, diagnostic errors can occur. For instance, a clinician could miss the PTSD diagnosis because associated culture-related socio-somatic or socio-physiological features are prominent and thus blur the judgment of the clinician. Similarly, the associated features can be overlooked because of the presence of PTSD. One of the challenges of the coming decades might be the compilation of a worldwide inventory of local expressions of unusual or 'deviant' behaviour, including traumatic stress reactions, based on a phenomenological approach employing a combination of qualitative and quantitative research methods (De Jong & Van Ommeren, 2002). It is conceivable that such an enterprise would yield a neurobiological and universal core at the biological end of a continuum, with a large variety of culturally induced phenomena at the socio-psychological end of the continuum.

A series of steps toward constructing such a universal core module have been described, to capture the consequences of extreme stress across cultures, with local modules that fit culture-specific expressions of extreme stress (De Jong et al., 2005). One might even go one step further and extend this view to all psychiatric diagnoses, envisioning a global network of researchers that collect and update local expressions and idioms of distress in line with the previous anthropological Human Relations Area File (i.e. a large database of anthropological data from over 400 cultures). This requires intensive collaboration between mental-health professionals and social science, especially anthropology. Clarifying the debate around diagnostic categories and nosology will also help to clarify the role of epidemiology and treatment.

1.1.5 Epidemiology

Although epidemiology purports to guide intervention efforts in post-disaster contexts epidemiological figures often only capture a portion of the true need. Moreover, prevalence figures are often highly elevated and may contribute to the treatment gap that exists in many areas worldwide, even after correction for help-seeking behaviour, medication or disability (Narrow et al., 2002).

The post-9/11 efforts to provide services in New York were a vivid example of the discrepancy between epidemiological figures and the availability of adequate intervention models and services, especially for immigrants, in the city with the highest density of mental-health professionals worldwide (Herman & Susser, 2003). But even in normal times there is a huge discrepancy between prevalence rates and service provision. The WHO World

Mental Health Survey Consortium (2004) showed that 35.5% to 50.3% of serious cases in developed countries and 76.3% to 85.4% in less-developed countries received no treatment in the 12 months before the interview. These figures are not representative of any current post-disaster area where the treatment gap is invariably larger.

In a cross-cultural context, psychiatric epidemiology is often further compounded by the use of non-validated instruments, or by including subjects without disability in prevalence counts. In addition, epidemiological instruments may ask root questions for specific disorders that exclude some participants and that may result in skewed or unreliable prevalence rates. Moreover, one has to carefully test a diagnostic or research instrument developed in one culture before applying it to another culture. This helps to bring understanding of the concepts underlying the items of the instrument, testing them for their content, semantic, conceptual and technical validity. How to properly adapt instruments has been described elsewhere (Van Ommeren et al., 1999; De Jong & van Ommeren, 2002).

Psychiatry and psychology are also flawed by the discrepancy between the wealth of epidemiological figures and the scarcity of attempts to translate these figures into secondary and tertiary preventive efforts. The use of epidemiology in post-disaster settings is further complicated by discussions on focusing interventions when there is a scarcity of means and of evidence-based trained human resources (De Jong et al., 2003).

1.1.6 Interventions

Disaster-affected populations show high prevalence rates of mental-health problems including acute stress disorder, PTSD, depression, anxiety, incident-specific fears, phobias, somatization, traumatic grief and sleep disturbances. These reactions typically show a gradual reduction over time, yet negative post-trauma reactions, including adverse coping styles such as substance abuse or family violence, tend to persist in a variety of cultures. For example, in northern Uganda we witnessed how Sudanese refugee women brewed alcohol from their food rations. They pitied their idle husbands and provided them with alcohol resulting in an epidemic of serious alcohol abuse.

The past few years showed a growing consensus for the need to include common mental disorders such as depression and other anxiety disorders instead of focusing solely on the treatment of PTSD (Weine et al., 2002; De Jong et al., 2003, Eisenman et al., 2006; De Jong, 2005; Osterman & de Jong, 2006). When selecting priorities for interventions, professionals have to consider to what extent they focus on the needs and concerns of the local population in comparison to ‘scientific’ epidemiological figures. This will often result in balancing psychiatric needs with public-health and psychosocial needs, such as access to general healthcare, poverty, daily hassles, substance abuse, spirit possession, gender-based and family violence, or access to human rights resources. It implies developing intervention models that include mental health within primary care. It simultaneously implies addressing local psychosocial needs by building upon local strength such as family networks, upon resources such as village and women’s associations, or commemoration ceremonies, and by building upon key figures such as community and religious leaders and complementary and alternative medicine (CAM).

Whereas prevalence rates remain fairly constant, the overall burden of a population group is related to the ever-changing longer-term psychosocial needs that are often compounded by

cycles of violence and its sequelae. Because it is impossible to provide services to all people in need, programmes must assess high-risk groups and track potential modifications in vulnerability over time. Moreover, one has to decide how to allocate funds and human resources to universal, selective or indicated preventive interventions (United States Committee on Prevention of Mental Disorders, 1994). This process may be complicated by stigma, which in turn may shift over time. For example, in the past decade stigmatizing witchcraft accusations in Central Africa have shifted to children who were subsequently killed, because they allegedly machinated the plight of the local population.

Massive conversion to healing churches that articulate with previous mass-possession cults, must be taken into account in the process of service delivery. Moreover, although healers are regarded as a potential source of psychosocial support, there exists widespread ambivalence towards collaboration, especially among professionals with an academic background who distance themselves from what they consider 'primitive thinking'. But, like most human beings who get sick, they may regress to an earlier developmental level, and make sure to get the healer's support through a family member that they despise in public. (And they show a similarity with those African presidents who make sure that their citizens know that they have access to the highest healing powers in the country in the hope to be saved from magic-religious manipulations).

1.1.7 Political and religious conviction

Political convictions are part of the traumascape and moderate the processing of distress. Political conviction can mediate grief or mourning (De Jong, 2004; Qouta, 2000; Qouta & El-Sarraj, 2002). A child soldier may be regarded as a human rights violator, or, alternatively, as a hero who helps his family to survive in harsh economic times. A rehabilitation programme must formulate its objectives and interventions depending on the child soldier's local context. For instance, vocational skills training appeared to be a suitable strategy to reintegrate child soldiers in Burundi but not in northern Uganda where their newly acquired skills were already widely available in the local economy.

Similarly, exposure to the grotesque can be mediated by religious convictions, such as the role of karma in Buddhism in Asia, explaining, for example, the plight of the Cambodian people under the Khmer Rouge regime as the punishment for previously generated karma, or by divine persecution during the Holocaust (Abramson, 2000; Van de Put & Eisenbruch, 2002).

To summarize, culture-based schemata protect the group by moderating the impact of disaster. They provide guidelines for appraisal of potentially traumatic events in local or Western cultural terms. They also guide expected behaviour in terms of response to survival threats such as mobilizing social support or stimulating help-seeking among local or allopathic healers or ritual contexts.

1.2 Ecology and history

1.2.1 Collective

Population growth, economic interdependence and ecological vulnerability, combined with the availability of weapons and the contagion of hatred and incitement to violence, make it

urgent to find ways to prevent disputes from turning massively violent. In the post-Cold War, wars within states vastly outnumber wars between states. Internal conflicts commonly are fought with conventional weapons and rely on ethnic expulsion or even annihilation.

The UN, governments and the non-governmental (NGO) sector have proposed a public-health paradigm to prevent the (re)emergence of violent conflicts. Effective preventive strategies rest on a few public-health principles: uncovering basic knowledge about violence; reacting rapidly to early signs of trouble; a comprehensive approach to alleviate the pressures and risk factors that trigger violent conflict; address the underlying root causes of violence; and implement, monitor and evaluate interventions that appear promising (Carnegie Commission, 1997).

The World Health Organization (WHO, 2002) divides violence into self-directed violence, interpersonal violence and collective violence. Collective violence is subdivided into social, economic and political violence. Political violence includes war and violent conflicts, state violence, terrorist acts and mob violence. Economic violence includes attacks by larger groups motivated by economic gain, such as attacks carried out with the purpose of disrupting economic activity. Collective violence is often the outcome of steps along a continuum of antagonism (Staub, 1993). Within a historical context, progression of retaliation may start with small acts that escalate, resulting in a 'malignant social process' (Deutsch, 1983).

The escalation of conflict is often the result of 'us' – 'them' differentiation (e.g. Aryan–Jew, Tutsi–Hutu, Israeli–Palestinian, Indian–Pakistani, Arab world–US). If the societal self-concept is based on superiority, self-doubt or their combination, it may give rise to war-generating motives (e.g. Germany after the Treaty of Versailles, the Khmer Rouge dreaming of restoring the old Khmer empire). A societal self-concept often designates the territories that are part of a nation, and may include some that the nation has not possessed for a long time (China claiming Tibet; Israelis and Palestinians claiming Jerusalem; Iraq claiming Kuwait; Argentina reclaiming the Falklands).

Alternatively, a part of the territory may want to split off from a country to which it 'belongs', while the concept of belonging is disputed by those seeking liberation as compared to the country that defines it within its borders (Biafra from Nigeria; East from West Pakistan, Eritrea from Ethiopia; South Sudan from the North; Kurdistan from Turkey, Iran, Iraq and Syria). Groups, like individuals, project unacceptable aspects of themselves onto others; those who are repudiated become 'bad', whereas the group that projects, remains pure and good (Pinderhughes, 1979) (the genocide of the Armenians in Turkey; the tensions in Africa/ Kinshasa leading to witchcraft accusations and murder; the accusations of 'parasitism' to the Jews in pre-WW-II Europe, to Indians in Uganda, or the Chinese in Indonesia; Mozambique's Renamo claiming to restore traditional values that were felt to be derogated by Frelimo).

Leaders have great power to shape relations between nations. They have the capacity to enlist the loyalty of their citizens, may initiate a cycle of hostility, but they are also the products of the history of their societies. Citizens rarely criticize hostile acts of their own country, but they are aroused to patriotic fervour by hostile acts against their country, even retaliatory ones (Staub, 1993).

The process of leadership may produce faulty decision making, such as ‘groupthink’ (former Yugoslavia). Groupthink creates an illusion of invulnerability that leads to excessive optimism and risk taking, a collective rationalizing of warnings that might temper a position, an unquestioned belief in the moral superiority of the group, negative stereotypes of an out-group making negotiation unfeasible, direct pressure on dissenters from group ideology, self-censorship of deviation from an apparent consensus, a shared illusion of unanimity, and the emergence of self-appointed ‘mind guards’ to protect the group from adverse information so that dissent to violence is voiced at risk of death (Janis, 1982). To understand group think, one might reflect on the apartheids regime and its army within South Africa, the group process within SWAPO resulting in the SWAPO Goelag of ‘traitors’ in South Angola, or the liberation movements and the way they behaved when they came to power as happened e.g. in Zimbabwe, Algeria, Angola, Eritrea or Guinea Bissau.

1.2.2 Risk factors for collective violence

Prevention requires identification of risk factors and determinants of collective violence, and developing approaches to resolve conflicts without resorting to violence. A range of risk factors for major political conflicts have been identified and are listed in Table 2 (Carnegie Commission, 1997; Esty et al., 1995; Baker & Ausink, 1995). An accumulation of risk factors or a critical mass of these symptoms increases the likelihood of collective violence. The relation between risk factors, shown in Table 2, are circular and the different categories of indicators influence each other in a systemic way.

Although the ingredients of collective violence are universal and global, it’s prevention and resolution are particular to a local traumascape, context and culture. Preventive policies to reduce the potential for violent conflicts should address civil society and the quality of policy making decisions. Moreover, it should develop legal standards; reduce inequality between groups; develop regimes for controlling destructive weaponry, embrace development strategies that reduce poverty; and develop public (mental)-health strategies to deal with the sequelae as illustrated elsewhere (De Jong, 2002b; Green et al., 2003).

Fact check 2

Question 1

Fill in the blanks:

The cultural context similarly has a collective and an individual dimension interacting with each other. The collective dimension of culture represents schemes that guide the meaning of such processes as suffering, healing and reconciliation. The individual dimension represents cultural influences on traumatic stressors and their _____, their modification by protective and _____ factors, and their individual expression in _____, _____, psychopathology, post-traumatic growth and its concomitants of disability, _____, quality of life, well-being and _____.

Question 2

Name three risk factors related to traumatic stress from the perspective of early individual history.

a)
b)
c)

Reflection and analysis

Critically discuss the conclusion that "… as in many other psychiatric syndromes – the symptoms of post-traumatic stress change over time and that an historical era, to some extent, expresses itself in an idiosyncratic way in the presentation of individual suffering. This idiosyncratic process starts before birth when individuals are equipped with genes that promote resiliency or vulnerability"

2 CONCLUSIONS

Since prehistory cultures have developed coping strategies to deal with extreme stress. Each era and culture expresses the consequences in semantics, explanatory models and idioms of distress, and develops ways of healing that fit its cosmology. Ever-changing traumascapes show that there are universal similarities and major differences that constitute the 'human' responses to trauma. The concept of a traumascape is presented as the scaffolding to explore the complex global and local interactions among vital systems that define how an individual, a society and a culture respond to emergencies that make up the daily life of many. The model presented here provides a framework for scholars to study the dynamic interactions of culture, history and social ecology. The factors described in the model contribute to the understanding of vulnerability and resilience of population groups

and individuals. The components of the model will guide us in describing the variety of expressions of human suffering and the way cultures, individuals and families cultures, try to cope. The model may also guide us to develop policies and practices and effective interventions to deal with extreme stress.

Table 2. Indicators of states at risk of collapse and internal conflict with examples and sequelae

2.1 Indicators	2.2 Signs	2.3 Examples	2.4 Consequences
Inequality	Widening social and economic inequalities, both between and within population groups. Globalization, failed states, privatization, decline of social safety nets, deprivation, competition for resources, increased availability of weapons and landmines	Former USSR and Yugoslavia	The state is unable to manage political challenges and to maintain control over the use of force Increased mortality and physical disability, high death rates among civilians
	Struggle over access to resources such as oil, diamonds, gems, timber, and rivers	Angola, Congo, S Leone, Chad, Nigeria, Sudan, Cambodia, Indonesia	National army and rebel/guerilla forces engage in armed conflicts to secure access to the resources. Manipulation of resource shortages for hostile purposes (e.g. using water as a weapon)
	Struggle over access to illicit drugs	Afghanistan, Columbia, Myanmar	Competition for income from narco-traffic
Rapidly changing demographic characteristics	Rapid changes in population structures including large-scale movements of refugees and IDPs	Darfur	Pre/post-conflict massive population movements (eg refugees, IDPs) and competition for resources in areas into which people move. Environmental degradation
	High rates of (infant) mortality	Uganda, Angola, Mozambique, Zepa (Balkan) Rwanda, Burundi	Decline vaccination coverage, increase infectious diseases, reduced access to health services
	Excessively high population densities	Liberia, S Leone, S Lanka	Overcrowding, resource depletion, environmental degradation, high exposure to vectors, high risk of HIV infection, poor nutrition, increased risk diseases

		Sudan, Tigray, Eritrea	Discontent, recruitment into rebel forces
	High levels of unemployment, especially among youth	Ethiopia, Eritrea	Conscription or looting of farmers, destruction water and sanitation infrastructure
	Insufficient supply of food or access to safe water		Create a climate of warfare and involve civilian populations
	Disputes over territory or environmental resources claimed by distinct ethnic groups or governments		
Lack of democratic processes	Violations of human rights	Bhutan, Cambodia, Iran Yugoslavia, Guatemala, Iraq, Mozambique, S Leone, Ethiopia	Torture, imprisonment, mutilation
	Criminalization or de-ligitimization of the state		High military expenditures
	Corrupt governments, faulty leaders		Use of violence to survive or to achieve their aims
Political instability	Rapid changes in regimes	Somalia, East Congo, Liberia, S Leone, Angola, Mozambique	Failed states
	Ethnic composition of the ruling elite differing from the majority	Rwanda, Burundi	Protracted cycles of violence and eruptions of ethic clashes
	A legacy of vengeance – seeking group grievance	Balkan (Bulgaria, Hungary, Romania, Slovakia)	
Ethnic composition of ruling ethnic group different from the population at large or ethnic groups straddling interstate boundaries	Political and economic power exercised - and differentially applied - according to ethnic or religious identity	Rwanda, Burundi, S Lanka, Balkan, Caucasus,	Inter-ethnic strife
		Nagorno-Karabakh/ Azerbaijan,	

	Desecration of ethnic or religious symbols	Afghanistan Tibet	
Deterioration of public services	A decline in the scope and effectiveness of social safety nets designed to ensure minimum universal standards of service		Poverty, deprivation, discontent and subsequent involvement in armed struggle
Severe economic decline	Uneven economic development Grossly unequal gains or losses between population groups or geographical areas resulting from large economic changes Massive economic transfers or losses over short periods of time	West Africa, Great Lakes Region of Africa	Reduced public expenditure on e.g. health and education
Cycles of violent revenge	A continued cycle of violence between rival groups	Great Lakes region of Africa	Rise of complex humanitarian emergencies

Fact check 3

Fill in the blanks

2.5 Indicators	**2.6 Signs**	**2.7 Examples**	**2.8 Consequences**
1. _____	Widening social and economic inequalities, both between and within population groups. Globalization, failed states, privatization, decline of social safety nets, deprivation, competition for resources, increased availability of weapons and landmines	Former USSR and Yugoslavia	The state is unable to manage political challenges and to maintain control over the use of force Increased mortality and physical disability, high death rates among civilians
	Struggle over access to resources such as oil, diamonds, gems, timber, and rivers	Angola, Congo, S Leone, Chad, Nigeria, Sudan,	National army and rebel/guerilla forces engage in armed conflicts to secure access to the resources.

	Struggle over access to illicit drugs	Cambodia, Indonesia Afghanistan, Columbia, Myanmar	Manipulation of resource shortages for hostile purposes (e.g. using water as a weapon) Competition for income from narco-traffic
Rapidly changing demographic characteristics	Rapid changes in population structures including large-scale movements of refugees and IDPs High rates of (infant) mortality Excessively high population densities High levels of unemployment, especially among youth Insufficient supply of food or access to safe water Disputes over territory or environmental resources claimed by distinct ethnic groups or governments	Darfur Uganda, Angola, Mozambique, Zepa (Balkan) Rwanda, Burundi Liberia, S Leone, S Lanka Sudan, Tigray, Eritrea Ethiopia, Eritrea	Pre/post-conflict massive population movements (eg refugees, IDPs) and competition for resources in areas into which people move. Environmental degradation Decline vaccination coverage, increase infectious diseases, reduced access to health services Overcrowding, resource depletion, environmental degradation, high exposure to vectors, high risk of HIV infection, poor nutrition, increased risk diseases Discontent, recruitment into rebel forces Conscription or looting of farmers, destruction water and sanitation infrastructure Create a climate of warfare and involve civilian populations
2. _____ _____ _____	Violations of human rights Criminalization or de-ligitimization of the state	Bhutan, Cambodia, Iran Yugoslavia, Guatemala, Iraq, Mozambique, S Leone, Ethiopia	Torture, imprisonment, mutilation High military expenditures Use of violence to survive or

	Corrupt governments, faulty leaders		to achieve their aims
Political instability	Rapid changes in regimes Ethnic composition of the ruling elite differing from the majority A legacy of vengeance –seeking group grievance	Somalia, East Congo, Liberia, S Leone, Angola, Mozambique Rwanda, Burundi Balkan (Bulgaria, Hungary, Romania, Slovakia)	Failed states Protracted cycles of violence and eruptions of ethic clashes
Ethnic composition of c_____ different from the population at large or ethnic groups straddling interstate boundaries	Political and economic power exercised - and differentially applied - according to ethnic or religious identity Desecration of ethnic or religious symbols	Rwanda, Burundi, S Lanka, Balkan, Caucasus, Nagorno-Karabakh/ Azerbaijan, Afghanistan Tibet	Inter-ethnic strife
Deterioration of d)_____	A decline in the scope and effectiveness of social safety nets designed to ensure minimum universal standards of service		Poverty, deprivation, discontent and subsequent involvement in armed struggle
Severe economic decline	Uneven economic development Grossly unequal gains or losses between population groups or geographical areas resulting from large economic changes Massive economic transfers or losses over short periods of time	West Africa, Great Lakes Region of Africa	Reduced public expenditure on e.g. health and education
Cycles of e_____ _____	A continued cycle of violence between rival groups	Great Lakes region of Africa	Rise of complex humanitarian emergencies

Reflection and analysis

“The model may also guide us to develop policies and practices and effective interventions to deal with extreme stress.” Discuss some policies, practices and interventions you might like to see implemented or changed (min. 2).

3 REVIEW

In this course, you have read about the following topics. Check whether you feel you understand each section by ticking the relevant box. If you feel you need to do more work in the area, re-read the section and do the tasks again.

An ecological–cultural–historical model for extreme stress ( )

Ecology and history: individual ( )

Culture: individual ( )

The traumatic stressor, protective and vulnerability factors, coping, social support, and expression of distress and disability. ( )

Culture: collective ( )

Nosology and diagnostic categories ( )

Epidemiology ( )

Interventions ( )

Political and religious conviction ( )

Ecology and history ( )

Collective ( )

Risk factors for collective violence ( )

Indicators of states at risk of collapse and internal conflict with examples and sequelae
( )

Though you may feel now that you have mastered all the sections, it is worth trying an objective practice test before you undertake the multi-choice assessment. Write your responses to the following questions and check the answers in the key on the next page.

End of course self-assessment questions

1. The ecological–cultural–historical model for extreme stress presents the person as part of a hierarchy of levels of organization. Name/ describe the three levels.
2. How does post traumatic growth manifest itself?
3. To what does ‘wego’ refer?
4. What are the two major impediments to the implementation of appropriate psychosocial and mental healthcare programmes?

Key:

1. The person is first presented as an organism composed of inter-related parts of the central nervous system and the body, then on to the level of the family and, finally, the community and society.
2. Post-traumatic growth manifests itself in an increased appreciation for life, more meaningful interpersonal relationships, an increased sense of personal strength, changed priorities, and a richer existential and spiritual life.
3. ‘wego’ refers to other views of the ego and the self, that promote interdependency.
4. The two major impediments to the implementation of appropriate psychosocial and mental healthcare programmes, are stigma and dogma

Summary

The learning outcomes for the course are:

1. The interaction between extreme stress, the individual, social ecology, history and culture.
2. Integrate an interdisciplinary framework to understand and study the under-researched domain of the complex interaction between trauma, culture and history.
3. Understand how to develop policies and practices within a culturally and historically informed public health framework
4. Become competent in crossing cultural borders.

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