Andreas Maercker
Eva Heim
Laurence J. Kirmayer
(Editors)

Cultural Clinical Psychology and PTSD

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Preface

Andreas Maercker, Eva Heim, & Laurence J. Kirmayer

Traumatic stress and its consequences have been a major focus of investigation and clinical innovation for the last several decades, with a fast-growing body of research on the causes, clinical conditions, and best practices in prevention and treatment. However, honest reflection on the state of the art in traumatic stress studies makes it clear that many questions are unresolved, and much remains to be done to put the field on a firm footing. Among the reasons for this knowledge gap are the varied expressions of traumatic stress and the diversity of responses of individuals both within and across cultures. The most frequently cited and best known "face" of overwhelming stress response is the mental disorder of *posttraumatic stress disorder* (PTSD). PTSD has received a lot of attention, driven by concerns about the mental health effects of war, political conflict, interpersonal violence, and natural disasters. The construct has been used both to advance research and to organize clinical services with the goal of improving the lives of individuals affected by trauma. To those alert to its varied manifestations, trauma may be hidden behind a broad variety of disorders, symptoms, and forms of suffering (Maercker, Schützwohl, & Solomon, 2000). Indeed, *trauma* has become a common trope for describing many forms of structural violence and social injustice. This has prompted a critique of the over-extension of the metaphor of trauma, posing the challenge of how to decide which constructs are genuinely useful in clinical work, mental health promotion, or other settings (Fassin & Rechtman, 2009).

A cultural clinical perspective offers the most promising road to broadening and deepening our understanding of the great diversity of manifestations of traumatic stress. This perspective tries to disentangle the multitude of clinical expressions of distress and coping or survival strategies after experiences of adversities. One major lesson of the cultural clinical perspective is that not all human beings regard themselves as entirely autonomous individuals that have to overcome the most severe hardships on their own. Rather, many people see themselves as deeply imbricated in their close networks of family, kin, and community, reflecting Aristotle's dictum "humans are social animals." This is expressed both in the ways people describe their suffering and in their accounts of resilience and recovery. As a participant in a study in an Indigenous community in Brazil put it: "If something serious strikes us, we bend like the bamboo in a plantation … and just as bamboo rises together, we will spring back" (Meili, Heim, Pelosi, & Maercker, in press). Consistent with Indigenous concepts of personhood, the classic metaphor of resilience in terms of the bending of bamboo is mentioned not as a feature of a solitary plant, but as a collective response of the whole (Kirmayer, Sehdev, & Isaac, 2009).

Despite many illuminating discussions of culture and trauma over the last 30 years (e.g., Hinton & Good, 2016; Kirmayer, Lemelson, & Barad, 2007; Marsella, Friedman, & Spain, 1996), the application of a cultural clinical perspective to understanding the experience of survivors of potentially traumatic events from a genuinely cultural perspective remains the exception rather than the rule. This is clear from reading the research reports on traumatic stress in international scientific journals as well as most of the treatment literature on PTSD. The vast majority of contributions take for granted the Western notion of autonomous individuals who are self-reflective and can readily express their inner mental states. This assumption may be true for many individuals in Western societies, but such modes of self-construal and expression are not the norm for members of many other

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cultures. More generally, the cultural clinical perspective poses questions about the extent to which our knowledge in the field of traumatic stress can be universally applied, and which aspects of theory and practice need to be adapted – or even set aside – to respond adequately to specific contexts.

This volume outlines approaches to cultural clinical psychology in three broad areas: (1) culturally sensitive approaches to PTSD and related mental disorders; (2) cultural values, metaphors, and the search for universals; and (3) global mental health and intervention challenges. In addition to mapping key issues for research, the volume aims to provide a wealth of description of diverse contexts, theoretical approaches, and intellectual journeys – as well as potential applications in clinical and other settings.

The chapters in the first part of the volume examine these questions of cultural generalizability and describe culturally specific expressions of stress-related disorders. Kirmayer and Gómez-Carrillo (Chapter 1) outline an *ecosocial* approach to integrating culture and context in mental health theory and practice. They emphasize the importance of recognizing the production of knowledge within psychiatry and psychology as itself shaped by cultural assumptions and background knowledge. Hence, every clinical encounter is an intercultural encounter. Diagnostic assessment and labeling has its own impact on the experience and course of trauma-shaping memory, symptom attributions, coping strategies, and outcomes in ways that may help or hinder recovery. Hinton and Bui (Chapter 2) demonstrate the variability of PTSD across cultures by presenting a *cross-cultural model of trauma-related disorder*. This model includes a variety of dimensions of psychopathology, which cover many of the *Diagnostic and Statistical Manual of Mental Disorders,* 5th edition (DSM-5) criteria along with somatic symptoms and cultural syndromes, all of which are important to assess in culturally diverse settings. The model further emphasizes the key role of the catastrophic interpretation of trauma symptoms in some contexts – for example, among Cambodian refugees. Salis Gross and Killikelly (Chapter 3) introduce the concept of *sociosomatics*, originally proposed by Arthur Kleinman (1998). Based on interviews with Bosnian and Turkish refugees in Switzerland, the authors outline culturally specific examples of how distress is closely interlinked with interpersonal conflicts, and expressed mainly through somatic complaints.

The second part of this volume addresses the interplay of cultural specificity with universal patterns and processes found across the globe, starting with an overview of possible approaches to integrating local and specific (*emic*) perspectives with general and universal (*etic*) models. In Chapter 4, Maercker argues that cultural values can help place the construct of PTSD in cultural perspective. The study of values has been central to cultural psychology for decades. As developed and applied by social psychologists, the measurement of values has been a productive way to capture latent features of culture empirically. In this context, values research has looked at how cultural values change along with the economic growth and modernization of societies. In particular, Maercker suggests that the increase of modern values such as self-determination or emancipation may be associated with an increase in the acknowledgment of posttraumatic suffering – or even an increase of PTSD prevalence – around the globe.

Although we have contrasted the culture of "the West" with "the Rest" (i.e., the very diverse cultures of the majority world), it is important to recognize that there is also great social and cultural diversity among and within Western societies. Social contexts influence how stress-related symptoms are perceived and expressed, which is addressed from three different perspectives in this volume. Pietikäinen (Chapter 5) discusses the history of labeling of symptomatology of cognate mental disorders in northern Europe. Papadopoulos (Chapter 6) discusses the ecological concept of *Umwelt* (drawn from ethology) or local environment and applies it to the experience of a Somali refugee. In her contribution, Malich (Chapter 7) focuses on the historical interrelation between gender and traumatic stress in Western culture.

Metaphor analysis provides another means of exploring the bodily, personal, and cultural mediation of illness experience (Kirmayer, 1992). Two chapters in this volume show how a focus on metaphors can yield important insights into the cultural grounding and consequences of exposure

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to traumatic stress. Rechsteiner and Meili (Chapter 8) examine metaphors used to describe aversive or catastrophic events in India and Brazil, as part of a larger study that also included samples from Switzerland and Lithuania. Based on data from the same cross-cultural research project, Meili, Gegieckaite, and Kazlauskas (Chapter 9) emphasize metaphors related to posttraumatic growth and resilience. Indeed, we might ask if the dominant metaphor of *trauma* itself – which is drawn from the Greek for *wound* – is adequate to the task, or whether it colors our theory and practice in ways that may reveal some features (analogous to wounding and healing) while hiding others (like resilience, moral development, forms of posttraumatic growth, or changes of identity and social position). Perhaps other metaphorical expressions are needed to capture these alternate experiences, states, and trajectories of people who have experienced various forms of adversity, including terrifying and violent disruptions to their lives. To conclude the second part of this volume, Dückers and Brewin (Chapter 10) discuss and further explore the seeming paradox that, despite high levels of exposure to violence, PTSD is rarely diagnosed in non-Western countries.

The third part of this volume addresses cultural aspects in psychological interventions, including the usual Western setting of face-to-face psychotherapies or counseling, work in individual or group settings in the countries of origin of traumatized persons, and scalable interventions developed for countries with large numbers of people affected by adversities and with restricted resources to address the mental health needs of these people. Stammel (Chapter 11) provides a comprehensive overview of frameworks and methods regarding the cultural adaptation of psychological interventions. In Chapter 12, von Lersner describes aspects of cultural competence in psychotherapy, mainly in face-to-face encounters, along with training components for therapists working in culturally diverse settings. Heim, Harper Shehadeh, van't Hof, and Carswell (Chapter 13) focus on the cultural adaptation of scalable interventions, arguing that easy-to-understand core interventions developed in the West, such as problem solving or behavioral activation, can be adapted to culturally diverse contexts, leading to considerable symptom reduction and increase in functioning.

Two of the contributions to this volume (Chapters 4 and 14) extend the area of investigations from traumatic stress and its consequences, to the closely related domain of grief and loss. This reflects changes in the field of traumatic stress studies, with the recognition of *prolonged grief* (also labeled *pathological* or *complicated grief*) as a new disorder category in the leading classification systems of mental disorders. Interestingly, it appears that this new category of prolonged grief has received more attention from academics, practitioners, and the public in several Asian countries than from Western cultural psychology or psychiatry. In the last chapter, Xiu and Killikelly (Chapter 14) describe a culturally adapted grief intervention in China. The authors present a case example of how a cultural practice, Chinese painting, can be minimally adapted to become a grief intervention for parents who have lost their only child (a more common predicament because of the one-child policy in China). Including grief along with trauma, as closely related (and frequently co-occurring) forms of suffering, is one way to advance an integrative, pluralistic, person-centered approach to cultural clinical psychology and psychiatry.

This volume brings together authors and topics from many different disciplines and fields of expertise. We are grateful that all of the authors engaged with this effort to begin to build a foundation for a cultural clinical psychology of trauma and its consequences. We also hope that this colloquy and collaboration of psychologists, psychiatrists, epidemiologists, philosophical and social anthropologists, and sociologists will continue. Much remains to be done to build a multifaceted knowledge base for further progress in the science and practice of traumatic stress studies.

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Part 1

Culturally Sensitive Approaches to PTSD and Related Mental Disorders

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1

Culturally Responsive Clinical Psychology and Psychiatry

An Ecosocial Approach

Laurence J. Kirmayer & Ana Gómez-Carrillo

Introduction

Cultural clinical psychology and psychiatry aim to address the mental health needs of diverse communities by integrating attention to cultural differences in knowledge, social institutions, identities, and practices. These differences affect mental health by influencing the causes and mechanisms of psychopathology, shaping illness experience and expression, and guiding processes of coping, adaptation, healing, and recovery. Various theoretical models, borrowed from the social sciences, have been used to understand the interaction of culture and mental health and the nature of psychiatric disorders. These models reflect the cultural assumptions of psychiatry itself, and becoming aware of some of these tacit assumptions is essential to open up a space for intercultural work. In this chapter, we will advance an ecosocial approach to culture in mental health in terms of *culturally responsive care.* This aims to identify crucial dimensions of culture and social context relevant to the lived experience of those with mental health problems and apply that understanding to clinical assessment and interventions.

Definitions of culture change over time with changing configurations of the social world. Contemporary cultural psychiatry approaches culture as the social matrix of experience. This includes all of the socially constructed aspects of life that shape neurodevelopment, everyday functioning, self-understanding, and experience in illness and health. While some aspects of culture are explicitly marked, as norms, values, ideologies, and practices, most of culture is implicit, involving taken-for-granted systems of knowledge, beliefs, values, institutions, and practices that constitute social systems, including families, communities, and societies. The culturally implicit may only become apparent at moments of culture change or during intercultural encounters. Difference, otherness, and alterity are central to our thinking about culture because tacitly shared references of meaning and affordances become apparent when we are confronted by the "other."

In mental health research and practice, cultural difference is often reduced to constructs such as race, ethnicity, or national origin. However, these forms of identity are themselves cultural constructions based on norms and conventions (Kirmayer, 2012a). To develop a culturally responsive approach to clinical practice that does not simply reproduce conventional social categories that

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result in stereotyping or over-generalization, we need to consider local history, context, and intersectionality.

Attention to culture is crucial to understand illness experience and to the ways in which social structure privileges or marginalizes particular groups. Focusing excessively on cultural difference may "culturalize" problems that are related to structural issues of power, conflict, and social inequalities. Hence, cultural competence needs to be supplemented with *structural competence* (Metzl & Hansen, 2014). There is great variation within any ethnic group, and this is further amplified by the ongoing intermixing of cultures and the creation of new hybrid identities that draw from local communities as well as transnational networks. The concept of culture must also be expanded to include local subcultures and global flows of knowledge and practices shared by groups of experts, including mental health professionals (Bibeau, 1997).

In clinical practice, attention to culture serves multiple functions: (1) it can enable patients to communicate their concerns in ways that are experience-near and meaningful to themselves and to others in their family and community; (2) it can help clinicians interpret the diagnostic significance of symptoms and behaviors and assess patients' predicaments in relation to relevant norms and contexts; (3) it can guide the development of culturally appropriate treatment plans and interventions; and (4) it is essential for negotiating the delivery of interventions and assessment of outcomes (Kirmayer & Swartz, 2014).

Locating Culture

Culture is located in the interaction between people and their life worlds, which includes material and symbolic aspects of the socially constructed environment (Seligman, Choudhury, & Kirmayer, 2016). As such, culture is embodied and expressed through forms of socially meaningful bodily action and communication (e.g., verbal and nonverbal language, metaphors, idioms, symbols). The forms of action and communication that constitute culture shape experience from its inception through looping effects between embodied developmental processes and social enactments such as giving a narrative account of one's experience or telling stories. Understood in this way, cultural knowledge and skills are necessary for navigating and adapting to particular social worlds or contexts. Identifying the impact of these contexts on the feedback loops that contribute to dysfunction and distress or to healing and recovery is an important task in clinical assessment.

The emerging paradigms of embodiment and enactment within the *4-E cognitive science framework* provide new ways to think about the influence of culture and context on behavior and experience (Kirmayer & Ramstead, 2017). In this framework, action and experience are understood as *embodied* (occurring in a body as opposed to just in the brain), *embedded* (within a social context), *enacted* (through interaction with the world), and *extended* (reaching beyond the boundaries of the physical body to include aspects of the world in the process of cognition). These approaches from cognitive science emphasize the co-emergence of mind and culture over evolutionary, developmental, and everyday time scales (Seligman, Choudhury, & Kirmayer, 2016). A key element of these processes for psychiatry is the intersubjective grounding of experience through modes of embodied interpersonal interaction, cooperation, and collaboration (Fuchs & De Jaegher, 2009).

Individuals pursue their own life goals by engaging with others in their networks and with social institutions. To do this, they employ cultural background knowledge that guides their interactions. Some of this background knowledge involves *schemas* or models. However, much cultural knowledge is not stored as mental representations within the individual but consists of strategies for attending to specific cues and exploiting the resources of particular contexts. Cultural knowledge resides in the social environment, with its material structure, distributed roles, and opportunities for cooperative activity with others. We can thus view an environment or local niche as providing *cultural affordances* – that is, opportunities for perception and action. For the culturally prepared

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and attuned individual, specific contexts afford particular ways of experiencing the world and acting on it, alone or in concert with others.

Cultural affordances provide possibilities for action and sense making that vary with an individual's identity and position within a social system, community, or local world. Mental health problems may alter how the individual engages with cultural affordances both by changing the person's expectations and patterns of activity and because a diagnostic label confers a new identity and social position which comes with its own set of affordances in a given context. This altered mode of engaging with a social world will influence the trajectory of the illness over time, affecting both how the individual copes with symptoms and how the illness fits their identity. Both individuals' illness narratives and the autobiographical narratives stories through which they express their identities are shaped by the wider meanings conferred by participation in particular social and cultural contexts (Kirmayer, 2003, 2007).

Symptoms arise from the interaction of psychophysiological, cognitive-affective, and social processes that include culture-specific explanations of distress, and thus are more than just indices of disorder (Kirmayer, 2015; Hinton, Lewis-Fernández, Kirmayer, & Weiss, 2016). Symptoms are shaped and amplified by bodily, psychological, and social processes. Sensations, experiences, and events are perceived and interpreted in terms of available cognitive schemas and cultural models, as well as through ongoing interactions with others. To make sense of symptoms, clinicians therefore need to consider the specific contexts, including the clinical setting itself, in which illness experience emerges and its meanings are negotiated (Kirmayer, Guzder, & Rousseau, 2014).

Dynamics of Culture in a Globalizing World

Viewing culture as a stable set of traits tends to reify and essentialize differences between groups that are better understood as negotiated and context-dependent (Seligman, Choudhury, & Kirmayer, 2016). Culture is an abstraction that points to dynamic processes that involve creativity, improvisation, and contestation among individuals and groups participating in different ways of life, with issues of power and agency always at stake. This more dynamic and agentic view of culture can counter the tendency to exoticize and caricature others in terms of simplistic dichotomies such as traditional/modern, Eastern/Western, or individualist/collectivist.

Of course, in any community or geographic region, there are specific cultural, historical, and political factors that define the available categories of identity and their social implications. These may be important for a given individual because they affect the kinds of social stresses they experience and their access to resources for coping and recovery. Any of these may be clinically relevant for a given patient in a given context and require careful exploration (Groen, 2009). However, many of these categories are applied by others and may not be intrinsic to patients' own identity and experience. The local politics of identity and alterity determine what forms of difference and diversity are viewed as important to address in health care systems, and which kinds of difference are discounted or simply ignored. For example, in the US, until recently, research on cultural diversity and training programs for cultural competence have generally approached identity in terms of the five broad ethnoracial blocs defined by the Census. When people are able to provide their own categories of identity, the predefined categories are shattered, resulting in a wide array of new identities constructed on many different bases including migration status, religion, sexual orientation, occupation or vocation, and illness (Good & Hannah, 2015).

Any cultural system is the product of interactions among multiple communities and institutions. In a world of mass migration and intermingling of people over generations, identity is necessarily hybrid, multiple, and fluid (Bibeau, 1997). Globalization, migration, and telecommunication have contributed to situations of *hyperdiversity* in many cities. As a result, most individuals present hybrid forms of identity that reflect influences from their families and the multiple local

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