Chapter 5
Culturally Informed Manifestations of Trauma

Human beings have an inherent need to make sense of their experiences. This may be particularly true of traumatic experiences which have the potential to shake the bedrock on which one's belief systems are based (Drožđek & Wilson, 2007; Herman, 1992). Globally, the literature attests to substantial variations in how people worldwide respond to traumatic events. These culturally-determined variations are seen in how experiences of trauma are described and labelled, beliefs about the causes of psychological distress, ways in which people heal from trauma (including both formal and informal mental health interventions), and how people experiencing trauma are treated within their communities (Weissbecker et al., 2018). Furthermore, recent research has provided evidence that post-traumatic responses "involve bodily and social processes that are based on cultural models, social scripts and scenarios; much of this knowledge is tacit or implicit and emerges in response to specific cultural affordances that depend on social context." (Kirmayer et al., 2018, p. 173). Simply put, "culture matters when it comes to understanding and treating psychological sequelae of traumatic events" (Chentsova Dutton & Maercker, 2019, p. 1).

This chapter provides an overview of the literature exploring the pertinent question raised by Drožđek and Wilson (2007):

> Does culture (i.e. cognitive-affect belief systems) act as a perceptual filter to the cognitive appraisal and interpretation of psychic trauma? If so, how do internalized belief systems and culturally shaped patterns of coping and adaptation, govern the posttraumatic processing of traumatic experience? (p. 372).

Early approaches to the study of psychological phenomena from a cultural perspective was concerned with the application of biomedical psychiatric categories in non-Western settings. Since the mid-twentieth century, however, a variety of new fields have developed. These contemporary approaches (such as transcultural, ethno—and ecosocial psychiatry as well as new cross-cultural psychology) have shifted away from treating culture purely as a confounding factor to be taken

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G. Theisen-Womersley, *Trauma and Resilience Among Displaced Populations*,
https://doi.org/10.1007/978-3-030-67712-1_5

into consideration towards recognizing culture as constitutive of different worldviews with an inherently complex impact on experiences of trauma (Kaiser & Jo Weaver, 2019). Many are based on the seminal works of medical anthropologist and cross-cultural psychiatrist, Arthur Kleinman, who was among the first to highlight cross-cultural differences in "causal models" or narratives of traumatic experiences (Kleinman, 1977, 1978; Kleinman & Good, 2004). The approaches have particularly highlighted the importance of paying attention to the ways in which culture shapes expressions of distress and help- and health-seeking (Kienzler et al., 2019). Importantly, this also includes an acknowledgement of the broader political, social, and economic processes affecting mental health—such as the powerful effects of structural violence and social inequality (Kienzler et al., 2019; Kirmayer, 2019, 2018; Kirmayer et al., 2010; Kleinman, 1977, 1978; Petit & Wang, 2018). This chapter offers an exploration of these approaches. It aims in particular to examine the complex interplay between culture and trauma as it relates to refugee populations.

Defining Culture from a Sociocultural Perspective

Firstly, in order to enter into this debate, the word "culture" itself needs to be deconstructed and examined– as it is neither a static, reified, nor tangible concept. Culture is the ever-changing result of negotiated "compromises between the already established and the imaginatively possibly" (Amsterdam & Bruner, 2000, p. 231). According to Drožđek & Wilson (2007):

> The concept of culture is about the process of being and becoming a social creature, about the rules of a society and about the ways in which these are enacted, experienced, and transmitted … Culture regulates the impact and expression of emotions and shapes individual expressions and perceptions of how to suffer under stress and these modes are taught sometimes openly, sometimes indirectly (p. 6)

From the specific perspective of sociocultural psychology, Sharapova and Goguikian Ratcliff (2018) define it thus:

> Culture here is considered as a set of practices executed in a tangible and observable way by a social group, as well as internal patterns and belief systems, each level mutually reinforcing the other. Furthermore, culture is not a static characteristic of an individual who continually adapts to ever-changing environments. Human development is thus embedded in social networks, interpersonal relations, and local environment. Therefore, culture plays an important role in shaping our identity, and constructs our reality via a process of cultural representations within a specific historical and cultural context (p. 2).

Such sociocultural approaches to understanding experiences of trauma therefore consider it to be a process that exists both in the intrapsychic realm of the individual as well as within sociocultural realm of relations and interactions—that is "embedded, situated, distributed, and co-constructed within contexts while also being intrinsically interwoven into these contexts" (Stetsenko, 2008, p. 7).

According to Marsella (2010), culture is:

> Shared learned behavior and meanings acquired in life activity contexts that are passed on from generation to another for purposes of promoting survival, adaptation, and adjustment. These behaviours and meanings are dynamic, and are responsive to change and modification in response to individual, societal, and environmental demands and pressures. Culture is represented externally in artefacts, roles, settings, and institutions. Culture is represented internally in values, beliefs, expectations, consciousness, epistemology (i.e., ways of knowing), ontology, and praxeology, personhood, and worldviews. Cultures can be situational, temporary, or enduring (p. 19).

Culture here is thus considered both as a set of practices physically executed in a tangible and observable sense by the group, as well as integral to belief systems located internally within individual members, each level mutual reinforcing the other. Furthermore, culture is not static but continually adapts to ever-changing environments.

Culturally-Informed Narratives of Trauma: Perspectives of Diverse Theoretical Traditions

Tankink and Richters (2007) note that culture is created, maintained and sustained among groups through dominant narratives or discourses:

> Every cultural group creates its own cultural discourse which is built up from cultural assumptions, the tracks of its collective past, cultural notions of femininity, sexuality, gender identity and roles, discursive and symbolic formations and practices, and ideas of how to deal with order and chaos. Equally important are ideas of the values of personal responsibility, of how to control the environment, of how daily life should be arranged, and of an orientation toward the future. Those narrative constructions, often called cultural master narratives, inform a person about what gives life meaning and what is inspiring, and also what is dangerous, risky or worth taking a risk for. Such a cultural discourse has the function of a "cultural script, a kind of social character," directing individual narratives, behaviour and the making of meaning…It is important to realize that a cultural master narrative is not a fixed, static entity but the result of creative activity in which ideas and notions are developed and shared. Its production takes place in a continuous process of dialogue between individuals and the group they belong to; it is linked with specific contexts, and it is always culturally based (p. 198–199).

The importance of such culturally-informed narratives of trauma or collective representations of psychological distress has similarly been explored by, among others, those following in the French tradition of ethnopsychiatry founded by Georges Devereux (Baubet & Moro, 2003; Devereux, 1967, 1980; Moro, 1992; Nathan, 1986; Petit & Wang, 2018; Sturm et al., 2007, 2010). In order to examine the role of collective representations in healing from trauma, authors from within this French tradition have drawn on Foucauldian notions that language, political systems and religion are structures of culture. They argue that collective representations of trauma provide a frame for the construction of narrations. This frame informs the processing of traumatic experiences and the way in which the individual may be able to convey their distress in socially understandable and acceptable ways. Collective representations

of trauma enable coherent narratives to be constructed through establishing connections between the present and the past and by providing a meaning behind painful or frightening experiences—thereby bridging gaps between different aspects of an individual's life experiences which may have become shattered or disconnected as a result of the trauma. This includes, for example, theories about the origins of pain and the possibilities of healing, conceptions of family and social bounds, religious or metaphysical conceptions of the world, ideologies or positions in a field of political conflicts (Sturm et al., 2010). In other words, these theories assist in the construction of narratives as a fundamental part of the healing process. Despite the significant impact of collective representations and symbols in the processing of trauma, individuals necessary reproduce them with transformations in personal ways. They may be commented, questioned, or re-interpreted, or reorganised in a *bricolage* using different symbolic universes (Sturm et al., 2007).

Collective representations or cultural scripts of trauma have alternatively been conceptualised as narrative "master scripts" by the transcultural psychiatrist Laurence Kirmayer and colleagues (Kirmayer, 2019; Kirmayer & Jarvis, 2019; Kirmayer et al., 2018). He notes that "we are narrative beings, fashioning ourselves from the stuff of stories, locating our biographies and life projects in discursive webs of shared meaning" (Kirmayer, 2019, p. 31). He argues that culturally determined linguistic structures provide the context and rules for interactional processes that underlie complex emotions and provides a lexical base in which emotional experience is embedded (Kirmayer et al., 2010; Kirmayer, 2001). It are these narrative master scripts, or culturally determined linguistic structures which form the "landscape of memory" (Kirmayer, 1996). This emerging field of transcultural psychiatry (alternatively ecosocial psychiatry), spearheaded by Kirmayer among others, has provided some striking examples of how cultural variations in ways of life and social contexts shape embodied experience, and how experiences of trauma (including behavioral expressions of distress) vary with cultural knowledge, beliefs, and interpretations. He and others within this tradition (Greene et al., 2017; Kirmayer, 2019; Kirmayer et al., 2010; Kirmayer & Ramstead, 2016; Kirmayer & Minas, 2000) have demonstrated that, while evolutionary history reaches all the way up from brain circuitry to cultural forms of life, culture reaches all the way down to neuroplastic circuitry and epigenetic regulation. Cultural psychiatry, therefore, considers that

> human biology is fundamentally cultural biology and human environments are social environments, constituted by relationships with others and with cooperatively constructed institutions and practices… experience is always preceded by and embedded in cultural systems of meanings and practices, which influence modes of attention and interpretive frames or models. (Kirmayer & Ramstead, 2016, p. 3).

As illustrated in the above figure (Kirmayer & Ramstead, 2016, p. 48, Fig. 5.1)—cultural psychiatry explores how embodied experiences of trauma give rise to metaphors, which structure and shape individual experience, and to narratives, which are amplified, stabilized, and extended through collective enactments. In turn, discursive practices give rise to new metaphors and modes of embodiment.

Other approaches conceptualising mental health from a sociocultural perspective include "medical sociology"—which examines the interplay between social and

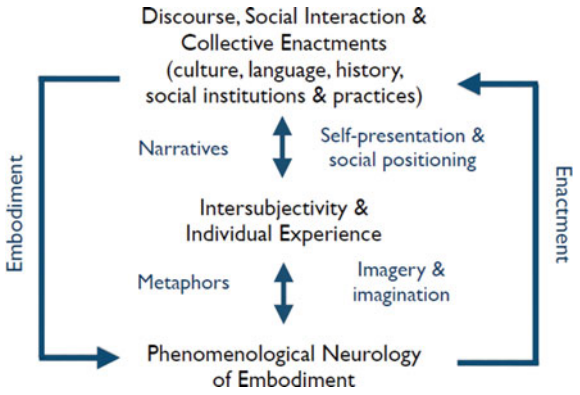


Fig. 5.1 Embodiment and enactment in experience

medical conditions, with the premise that mental health challenges are mediated and modified by social activities and the cultural environment (Nicolas et al., 2015), "social psychiatry" (Di Nicola, 2019), "transcultural psychiatry" (Schouler-Ocak et al., 2019)—which is particular concerned with mental health care for refugee populations—as well as "cultural-clinical psychology." The latter argues for an integrative approach to understanding clinical disorders in psychology with a consideration of the contextual embedding of these disorders within culturally-determined networks of local meanings, norms, institutions, and cultural products (Ryder et al., 2011). Within cultural-clinical psychology, master narratives of trauma have been referred to as "cultural scripts" (Ryder et al., 2011). Originally described by cognitive psychologists in the 1980s, these cultural scripts are defined in cultural-clinical psychology as "specific behavioural and experiential sequences of elements such as thoughts, memories, attention patterns, bodily sensations, sleep abnormalities, emotions and affective expressions, motivation, coping attempts, and ritualized behaviours that are relevant to posttraumatic adjustment" (Chentsova Dutton & Maercker, 2019, p. 1). They are partly culturally shared and intersubjective in nature. They are understood as sequences that are not only familiar to oneself, but also to others, serving to ground interactions between people. They are guides for understanding and interpreting behaviour as well as rules for behaving. Moreover, they need not be personally experienced to be understood and described by informants in a given cultural context.

Outside of these trans—or socio—cultural traditions, cultural narratives have equally been referred to in the cognitive sciences as "multirepresentational cognitive theorizing in psychopathology" (Brewin et al., 1996; Dalgleish, 2004). Dalgleish (2004, for example, refers to the role of various mental representational constructs (e.g., schemas, propositional representations, pictorial or image representations, distributed networks etc.) in the cognitive modelling of psychopathological states of trauma. The models originate in broader cognitive psychology work on schema and artificial intelligence and draws on the literature on the effects of schema on processing information (Chentsova Dutton & Maercker, 2019). Indeed, "cultural neuroscience" is another tradition exploring the culture-trauma nexus—attesting to

the influence of culture on the underlying neural mechanisms involved in the development and maintenance of PTSD Research within this field increasingly supports the view that mental processes are intrinsically social. It explores how the circuits of the mind extend out into the world, through our tools, discourse, practices, and institutions that enable cooperation. This social view of the brain has now received new recognition and precision thanks to advances in computational neuroscience (Kirmayer, 2019). In relation to culturally-informed narratives of trauma specifically, cultural neuroscience argues that those with PTSD have difficulty in updating these trauma narratives—which are shaped by culturally derived self-representations that manifest at both the collective and individual level. Such variations in trauma narratives, they argue, may strengthen specific neural processes that diverge by culture, consolidating particular culturally-informed responses to traumatic events (Liddell & Jobson, 2016; Liddell et al., 2017).

These diverse approaches seem to agree on the notion that the individual's processing of traumatic events is informed by internalized representational constructs, which is both influenced by and reflected through culture, which is in itself in turn influenced by and reflected through language. The process is inevitably socially situated. Culture thus constructs our reality via a process of socialization within a specific historical and cultural context (Marsella, 2010). It fundamentally affects how people understand and express psychological distress related to trauma. As summarized by Van Maanen (1995):

> Language is auditioning for an a priori role in the social and material world. Moreover, it is a role that carries constitutional force, bringing facts into consciousness and therefore being. No longer then is something like an organization or, for that matter, an atom or quark thought to come first while our understandings, models or representations of an organization, atom or quark come second. Rather, our representations may well come first, allowing us to see selectively what we have described. (p. 134).

The Impact of Trauma

From a sociocultural perspective, ruptures created by trauma are embedded within an intersubjective context wherein severe emotional pain cannot find a relational home in which to be held and integrated (Atwood et al., 2002; Stolorow, 2011). Trauma creates ruptures at the intersection of the individual and their social context and related to safety, trust, independence, power, esteem, intimacy as well as spiritual and existential beliefs. *S*hould this prove to be the case, the lack of connection of past and present can also be understood as preventing the emergence of possible futures. Viewed through the lens of a dialogic systems sensibility, the traumatic world's slipping away from the categories of meaning can be seen as a severe disruption of those relational processes in which meaning is formed (Sucharov et al., 2007). More recently, this rupture in core schemas has been theorised as representing a threat not only to one's core sense of self, but furthermore a violation of self-understanding and worldviews to the extent that it disrupts attachment and interpersonal processing systems necessary for meaning making in the social world (Liddell & Jobson, 2016;

Maercker & Hecker, 2016). From within this sociocultural paradigm, this lack of connection to the future is intrinsically linked to a severe disruption of the relational processes by which meaning is dialogically created—the bedrock of which is social recognition. Indeed, research attests to the importance of social recognition in protecting against the development of post-traumatic symptomatology—defined as "positive individual or societal reactions that recognize and acknowledge victims' traumatic experiences and difficulties" (van der Velden et al., 2019, p. 287).

Trauma begets trauma. Exposure to trauma, itself connected to a breakdown in social connection and exacerbated by the process of migration, risks the individual being caught up in a vicious cycle where no addressee may be found, no language exists to form a coherent narrative whereby the event may itself be collectively represented and made sense of. Indeed, many authors highlight that trauma remains simply inaccessible to verbal recollection (Brewin, 2001; Brewin et al. 1996; Brewin et al., 2009), paradoxically the very recollection itself necessary for healing. Returning to the specific context of migration in particular, itself characterized by a rupture in connection to "home" (and all the social, cultural, professional and linguistic connections that this implies)—the physical, social and political isolation so typically experienced by asylum seekers upon arrival to host countries and often imposed by the state through legal requirements, serves only to feed monstrous feelings of invisibility and disconnectedness (Bhimji, 2015). In such a state, there is no coherently constituted Self: no memory, no clear defining of the Self and of the world in the safe confines of time—only psychological rumination and speaking in embodied signs. Disaffiliation, de-culturation and de-linking both in terms of family and social ties similarly affects the internal capacity to make links between different events and moments in life. Without the container of home-as-it-was, there is little membrane to hold the symbolic (Goguikian Ratcliff, 2012).

According to Kirmayer (1996):

> Traumatic experience is not a story but a cascade of experiences, eruptions, crevasses, a sliding of tectonic plates that undergird the self. These disruptions then give rise to an effort to interpret and so to smooth, stabilize and recalibrate. The effect of these processes is to create a specific narrative landscape. This landscape must fit with (and so is governed by) folk models of memory (p. 14)

Narratives of trauma, then, may be understood then as cultural constructions of personal and historical memory: What is registered is highly selective and thoroughly transformed by interpretation and semantic encoding at the moment of experience (Kirmayer, 1996). Particularly in cases where trauma has been prolonged, "the survivor may be left with large chunks of endured experience with no meaning, creating disquieting gaps and discontinuities in the experience of one's life history" (Sucharov et al., 2007, p. 2).

For those whose landscapes have been ruptured by trauma, "their problem is not the limits of memory but of language—the inadequacy of ordinary words to express all they have witnessed" (p.4). When words fail, when "the temporality of linguistic convention, considered as ritual, exceeds the instances of its utterance, and that excess is not fully capturable or identifiable (the past and future of the utterance cannot be

narrated with any certainty)" (Butler, 1997, p. 1), it is naturally falls upon the body to become the site of (re-constructive) action. Métraux (1999a,1999b) explains this phenomenon as "memory-pain" sticking to the body with an intensity of experience untranslatable by words. Kirmayer (1996) further posits that when the image or content of a traumatic memory is unavailable, it is the bodily aspects of memory which persist. In the absence of narrative, the body holds what the mind cannot.

The Interplay of Factors

Given the complexity of the interrelation between culture and experiences of trauma, an examination of the interplay of factors regarding the impact of culture on trauma and trauma on culture requires consideration on several levels:

(1) The pre-existing cultural context

(2) The nature of the event

(3) What meaning is attributed to the event (individually and collectively)
Why did the event occur? What is considered "traumatic" or abnormal versus what is considered "normal?" Arguably, evaluating the 'toxicity' of an experience will depend in part on pre-existing cultural norms and "master narratives," belief structures and group experiences (including exposure to previous potentially traumatizing events) and the meaning attributed to that event on both an individual as well as a group level.

(4) How this sense making determines symptomatic responses
E.g. Guilt due to a belief that bad behaviour caused the rape; fear due to a belief that the tsunami was caused by angry gods who could strike again, acceptance due to a belief in fate…

(5) What meaning is attributed to the symptomatic responses
E.g. I'm experiencing flashbacks because I've been possessed by an evil spirit; I am a weak person because I cannot stop crying; my nightmares are messages from the ancestors…

Once again, the meaning attributed to the event is both individual and collective.

(6) Healing: How the meaning made of symptomatic response informs health seeking behaviour and treatment outcomes

For a more in-depth exploration of these mechanisms, Marsella (2010, p. 21) has developed an interaction model from within an ethno-cultural perspective of how culture influences the clinical parameters of the diagnostic criteria for PTSD and related stress disorders that may occur in response to "traumatic" events. These multi-layered factors may go some way in explaining the interesting cultural variations in response to trauma which have been noted in the literature, not only among individuals but also among different cultural groups (Bracken, 2002; Hinton & Lewis-Fernández, 2011; Lewis-Fernández & Kirmayer, 2019; Marsella et al., 1996; Perilla, Norris, & Lavizzo, 2002; Rousseau et al., 1997; Summerfield, 2001). (Fig. 5.2).

This model speaks to a larger theoretical debate over the meaning of medical diagnoses in transcultural settings in general. This debate has been well defined by Kleinman (1977, 1978; Kleinman & Good, 2004) who examines concepts of disease, sickness and illness. He defines the concept of "disease" as describing and categorizing disorders firmly within a Western medical model. "Illness," however, refers to the subjective experience of this disease, and "sickness" is the social phenomenon which defines the role of the patient and societal expectations around this (Goguikian Ratcliff & Rossi, 2015). As Maier and Straub (2011) note, illness according to Kleinman's definition is therefore based on conceptual models used by individuals, communities or cultures which provide an explanatory model for the illness. This explanatory model includes more than just ideas about the cause of an illness; they also incorporate ideas about estimating the severity of illness, appropriate treatment, and the meaning of the illness. In other words, explanatory models are based on a.

> "belief system about illness including which symptoms the ill subjectively experience, beliefs about etiology of the illness, assumptions of the time line or course that the illness will take, perceived consequences (e.g., social consequences) that occur as a result of the illness, and beliefs about what constitutes acceptable treatment options" (Benish et al., 2011, p. 281).

In relation to PTSD in particular, Maercker and colleagues (Maercker & Hecker, 2016; Maercker & Horn, 2013) have noted that it is one of the rare psychiatric diagnoses that requires an environmental context by its very definition. Not only does it require an exposure to a particular event—the event itself needs to have been interpreted by the individual as being traumatic. They have recently developed a framework model which situates the experience of trauma within socio-interpersonal context. The model describes three layers: (1) social affects comprising shame, guilt, anger, revenge, etc.; (2) close relationships including trauma disclosure, social support or negative exchange, empathy, etc.; and (3) culture and society, comprising aspects like the collective experience of trauma, social acknowledgment as victim or survivor, cultural value orientation, etc.

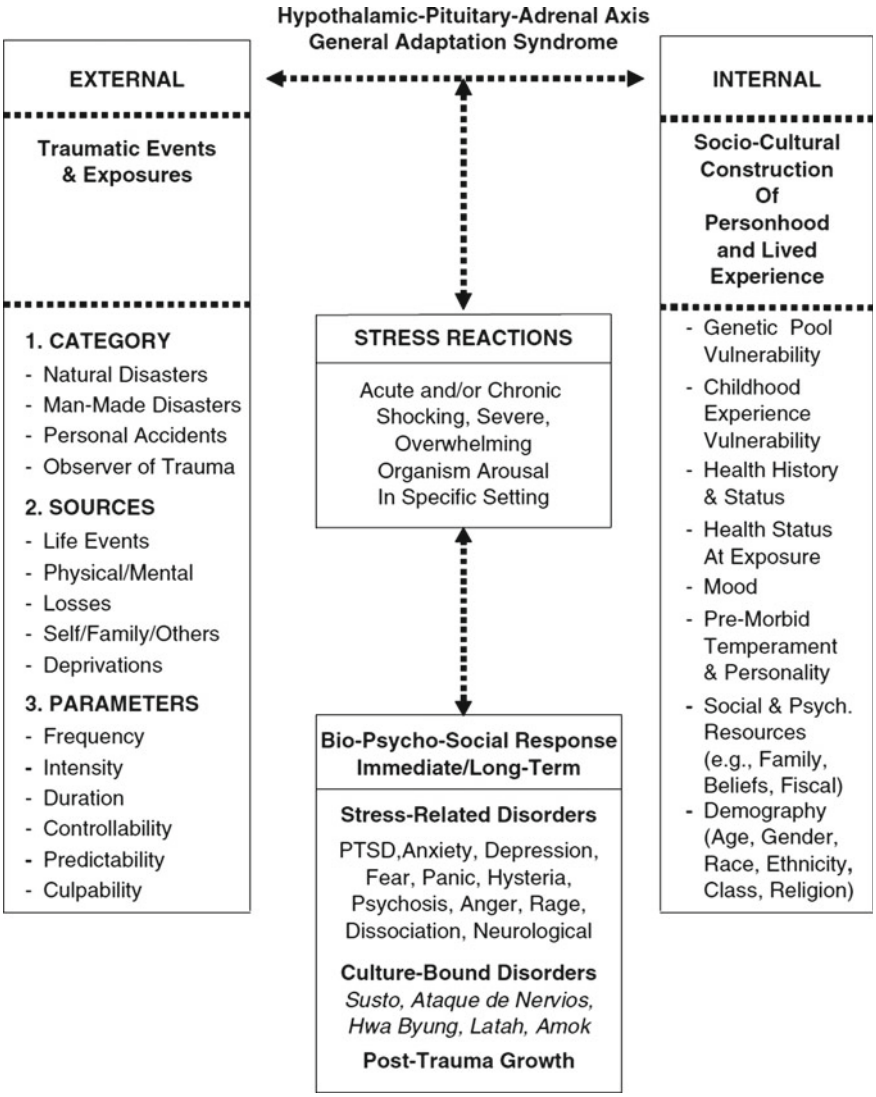


Fig. 5.2 The complex trauma and PTSD ecology: An interactional model

Culturally-Informed Responses to Trauma: Attributing Meaning to the Experience

Given the significance of the sociocultural environment on experiences of trauma, it is therefore no surprise that while symptoms of PTSD have been found among trauma survivors of both genders, all ages, and diverse racial, ethnic, and cultural groups, it is also true that particular events (such as incest, rape, or spousal abuse)

and symptoms (such as dissociation, somatic complaints, *ataques nervios*) may have quite different meanings across different cultural contexts (Harvey, 2007). Drožđek and Wilson (2007), highlight some of these differences: Among Cambodian refugees who had suffered multiple life-threatening trauma during the Khmer Rouge regime, many who suffered from PTSD and depression understood their symptoms in light of their Buddhist beliefs in karma as a station in life, an incarnate level of being and fate where personal suffering is considered from a particular religious-cosmological perspective on the meaning of life. Among the Native American people, illness is thought to result from imbalance, loss of harmony and being dispirited with oneself due to a loss of vital connectedness. A common explanation for the 1988 Yuannan earthquake in China was that a "great dragon" was moving below the earth because he was angry with the people…

Other examples from the literature include Sao Tomean explanations of trauma among migrants in Portugal—where idioms of mental distress typically involved supernatural phenomena rooted in a Christian religious discourse, mixed with indigenous beliefs around witchcraft, "unsatisfied spirits" and the evil eye (Trovão, Ramalho, & David, 2017). A study exploring causal attributions of mental health challenges among Somali refugees in Finland (Kuittinen, Mölsä, Punamäki, Tiilikainen, & Honkasalo, 2017) found that the most commonly endorsed causal attributions were jinn, jealousy related to polygamous relationships, and various life problems. The authors identified five attribution categories which they argue play a crucial role in shaping experiences of trauma: (a) somatic, (b) interpersonal, (c) psychological, (d) life experiences, and (e) religious causes. Similarly, in a recent investigation of lay beliefs among asylum seekers of African descent in Germany, asylum seekers attributed symptoms of post-traumatic stress less strongly to traumatic experiences, but more strongly to religious and supernatural causes such as sorcery, spiritual possession, and being cursed or bewitched (Grupp et al., 2018).

Many researchers and practitioners have made more concerted efforts to engage with these local "idioms of distress,"[1] and to use this knowledge to re-frame or re-orient interventions to fit with local understandings and lived experience (Kidron & Kirmayer, 2018; Lewis-Fernández & Kirmayer, 2019). A plethora of examples, in response to trauma in particular, have been documented in the literature (Afana et al., 2010; Hinton & Lewis-Fernández, 2010; Jayawickreme et al., 2012; Lewis-Fernández & Kirmayer, 2019; Summerfield, 1996). Afana et al. (2010), for example, highlight how Palestinian communities have processed continual exposure to war through particular linguistic constructs of trauma: *Sadma* (trauma as a sudden blow with immediate impact), *Faji'ah* (tragedy), and *Musiba* (calamity). *Sadma* is used metaphorically to refer to painful events that happen suddenly, *Faji'ah* is used to describe the reaction to an extraordinary event (mainly the loss of a loved one) and *Musiba* is used when traumatic events are persistent and have long-term consequences. They use these examples to show how such distinctive, historically-bound idioms illustrate communal reflections on the meaning behind experiences of

[1] Defined by Nichter (Nichter, 2010) as "socially and culturally resonant means of experiencing and expressing distress in local worlds" (p. 405).

violence, forced displacement, social exclusion, and humiliation. Behind all of the various idioms of distress found across the world lie the social representations of trauma and ways in which it is defined and processed on a socio-cultural level:

> The idioms we have described borrow from everyday language to make sense of the impact of violence in a situation of protracted conflict. They do not represent discrete syndromes or sharply delimited categories. Rather, they are familiar ways of speaking about traumatic events that invoke specific networks of meaning. They serve to communicate to others within the community about the dimensions of suffering through language that references collective experience and that conveys assumptions about the expected bounds of behaviour, the likely course of distress, and outcome of clinical or social intervention. Generally, these cultural idioms of trauma are not diagnostic entities that require treatment but a vocabulary through which distress is expressed and social support mobilized (Afana et al., 2010, p. 82).

In research conducted among the Adivasis indigenous people in tribal communities in Pune, India, the most prevalent metaphorical concepts of trauma were found to be related to shock and wound. The most predominant expression, which was used by all of the participants of the study, was "this should not have happened" (asa nahi vhayala pahije hota) (Rechsteiner et al., 2019).

If the meaning attributed to the event is significantly determined by cultural factors, so too are the responses. In a meta-review of 917 patients with symptoms of possessive trance disorders from 14 low—and middle-income countries, Hecker et al. (2015) found that spirit possession following trauma exposure is a phenomenon occurring worldwide which can be understood as a global idiom of distress. Indeed, Mozambique, a country that experienced almost three decades of war and devastation, exhibits a possession prevalence rate of more than 18% of the population. They similarly conclude that social and cultural factors also seem to play an important role in the reported disease models and healing rituals related to PTSD and other forms of pathological spirit possession.

A variety of "cultural concepts of distress" (CCDs) have been explored in recent decades throughout the literature. Hassan et al. (2005) note that many Syrian refugees attribute obsessive rumination to satanic temptations, using the Arabic word wisswas (وسْواسْ) meaning both the devil and unpleasant recurrent thoughts. Among Albanian migrants in Switzerland, this has been referred to as a "point in the heart" or "Brenge": the beginning of rumination triggered by different causes (Shala et al., 2020). Drožđek and Wilson (2007) highlight some more examples from the literature: In the experience of many Salvadoran refugees who report "attaques nervios," a somatic response involving feelings of anxiety, fear, and anger, and calor, an experience of intense heat that extends through one's body. Such high rates of somatic responses have equally been found among tortured Bhutanese refugees in Nepal (Van Ommeren et al., 2001), American prisoners of war and holocaust survivors (Herman, 1992), refugees seeking treatment for PTSD in Switzerland (Morina et al., 2017), as well as South African victims of torture during the apartheid period (Eagle & Kaminer, 2013).

Bowles and Mehraby (2007) write about a particular young male client in Australia from Afghanistan, had symptoms which were "consistent with symptoms of grief, anxiety (PTSD) and depression, although he described them as 'burning in his heart'

and understood them as part of God's will. If it was God's will, he would recover and find his family again" (p. 316). Weissbecker et al. (2018) classify these various idioms of distress noted in the literature according to:

- Idioms related to thoughts, e.g. kufungisisa meaning 'thinking too much' in Shona in Zimbabwe and yeyeesi meaning 'many thoughts' in Kakwa in South Sudan
- Idioms related to the heart, e.g. poil-heart meaning 'heavy hearted' in Krio in Sierra Leone, qalbi-jab meaning 'broken heart' in Somalia, qalb maaboud meaning 'squeezed heart' in Arabic (referring to dysphoria and sadness) and houbout el qalb meaning 'falling or crumbling of the heart' (referring to the somatic reaction of sudden fear)
- Idioms related to the head, e.g. amutwe alluhire meaning 'my head is tired' in Nande in the Democratic Republic of Congo
- Idioms related to the general body, e.g. jiu sukera gayo meaning 'drying of the body' used by Bhutanese refugee in Nepal to indicate a situation of loss and desperation or lashe mn grana meaning 'my body is heavy' in the Kirmanji Kurdish dialect

The list of differences in cultural responses to trauma is vast. The above examples are just the tip of the iceberg. A comprehensive review of various anecdotal evidence is beyond the scope of this chapter. What is noteworthy is the multitude of differences being noted across all layers of processing, from the meaning attributed to the event to the symptomatic responses to the meaning attributed to the symptomatic response. Furthermore, ethnographic research suggests that such "idioms of distress take on their communicative meaning in specific social contexts, and therefore require a broad understanding of complex and fluid cultural conceptions of wellness and distress and a detailed exploration of their actual use in a particular instance." (Kidron & Kirmayer, 2018, p. 3).

Pathways to Healing

A central concern of addressing trauma among refugee populations is the efficacy and cross-cultural applicability of methods of coping and treatment intervention (Kirmayer, 2018). Just as the meaning attributed to traumatic events and responses to them vary significantly among cultures, so to do healing practices and health-seeking behavior:

> Each culture develops specific forms and mechanisms… based on 'cultural wisdoms' ... for posttraumatic recovery, stabilization and healing… Considered from an evolutionary and adaptational perspective, cultures develop rituals, helper roles, ceremonies and other modalities to facilitate recovery from distressing psychological conditions including those produced by trauma. The viability of culture in the face of collective trauma illustrates … that there can be no experience of psychological trauma without a cultural history, grounding or continuity of background. (Boris Drožđek & Wilson, 2007) p. 381–382)

Culturally-determined metaphorical idioms for overcoming trauma—notably related to post-traumatic growth and resilience—have been aptly described by Meili et al. (2018). Elsewhere in the literature, in their study on trauma among a population of refugees in Switzerland, Maier and Straub (2011) identified 4 categories regarding their psychiatric patients' 'concept of illness' and healing regarding the diagnosis of PTSD: They termed the first concept drawn upon by patients a "scientific/technical" model. This fits most comfortably into the medical model paradigm on an individual level and medical care consequently is deemed the most appropriate treatment method. The second concept was a chronological, time-bound model implying that patients believed that the current psychological difficulties will naturally improve over time. A third concept was a model of "sociocultural depravity"—a model wherein suffering is linked to the current socio-economic and political context and in which healing can only occur once these material conditions have improved. The fourth and least common concept drawn upon by their patients was based on "personal guilt" and implies a more internalized, depressive state of psychological suffering.

Rousseau and Bagalishya (2007) refer to the African family council, a traditional way of resolving trauma or healing among families which may not be available to migrant communities in "Western" host countries:

> In many African societies, God is thought to be responsible for various social conditions, for the unequal distribution of good luck and bad, for the birth defects and for accidents of every kind. Ruin, illness, loss, premature death and accidents may all be punishments of an offended God, but more often than not they are attributed either to the anger of ancestors or to the witchcraft of living people (p. 262).

Bigfoot and Schmidt (2010) have emphasised the significant role that indigenous knowledge plays in cultural adaptation in the aftermath of trauma, demonstrating how native American communities intuitively rely on behavioral principles that they practiced for many generations before learning theory came into the literature. Eagle (2014) gives the example of "African cosmology" wherein falling victim to a traumatic event may be interpreted as an indication that one's ancestors have withdrawn their favour and protective function, and that the likely origins of their displeasure need to be identified and remedied. She similarly remarks that highly religious people of different faiths are likely to draw upon explanatory frameworks concerning suffering, victimization, aggression, violence and loss, located within the particular creeds of their belief systems. Among the Kubandwa cult across the African Great Lakes Area, people afflicted by trauma enter into a peaceful and accepting relationship with a possessing spirit in order to be healed. Part of this ritual includes a technique known as Gucekera, whereby unknown spirits are aggressively driven out of the individual in a form of exorcism (Ventevogel et al., 2018).

Tankink and Richters (2007) highlight the role of religion in healing in particular, which they argue allows people to convey an internal feeling to something outside them, to God, which can help to reduce their pain. They cite Geertz (1993) who notes that religion offers

> the formulation, by means of symbols, of an image of such a genuine order of the world which will account for, and even celebrate, the perceived ambiguities, puzzles, and paradoxes in human experiences. The effort is not to deny the undeniable—that there are unexplained events, that life hurts, or that rain falls upon the just—but to deny that there are inexplicable events, that life is unendurable, and that justice is a mirage (Geertz, 1993, p. 108 as cited in Tankink & Richters, 2007).

The importance of religiously- or spiritually-informed meaning making to inform healing from traumatic events has similarly been highlighted among Sudanese refugees in Australia (Copping et al., 2010), Filipino, Sao Tomean and Indo-Mozambican migrant mothers settled in Portugal (Trovão et al., 2017), and sub-Saharan refugees in Canada—where nearly half of participants privileged prayer as the best treatment for mental health challenges (Langevin et al., 2017). These studies highlight the role of religion in providing cultural resources aimed at transforming the trauma narrative—as well as the importance of religious networks as generating "social capital" (Tortelli et al., 2017) and opportunities for social mobility and activism.

In a study exploring resilience among Mexican refugees in Texas, the authors demonstrate how culture was a key mediating factor in healing from trauma. Culture assigned meaning to the traumatic events to which participants in the study had been exposed through the construction of narratives. The following cultural resources emerged as essential components in—family support, the ability to talk to others about their own experiences, the idea that there is no personal control over the circumstances (fatalism) and religious faith (Lusk & Baray, 2017a). In a study on the Cambodian idiom of distress known as *baksbat,* (Kidron & Kirmayer, 2018), ethnographic research among a population of trauma survivors suggests that the idiom itself may signify resolution and self-healing rather than continued distress. This highlights an inherent relationship, within the concept of *baksbat* itself, between the context of distressing events, responses to these events, and pathways to healing. The authors of the study note that in daily family life and in Cambodian communities, the idiom indeed referenced a far richer and dynamic network of meanings than for which the "static" concepts of trauma operating at the health clinics may account.

Within the "dynamic narrative" approach of Colette Daiute (Daiute, 2016, 2017; Daiute & Lightfoot, 2004; Daiute et al., 2015; Tarchi et al., 2019), she refers to the process of "narrative sense making" defined as a dynamic meaning of accounts of specific events and different perspectives towards these events which change over time. She uses the example of refugee communities involved in conflict and displacement during and after the 1990s wars of the former Yugoslavia to demonstrate how the changes afforded by narrative sense making allow for new perceptions and interpretations of potentially traumatic events experienced. She and colleagues argue that culturally-informed narratives are not only an important means of communication, but that they represent a "sophisticated decontextualized form of reflection and

meaning-making" (Tarchi et al., 2019) p. 80). This quality of connecting with others and the world through narratives, of assessing and developing meaning in relational contexts, is defined as "dynamic storytelling." From within this perspective, Daiute explains, we use storytelling as a complex process for connecting with others for a wide range of purposes:

> We use storytelling to do things in the world—to figure out what is going on, to connect with others, and sometimes to imagine how life could be. Language genres like narrative are thus human resources for making sense of extremely challenging circumstances, gaining symbolic control over them and possibly creating a path for action… In this way, the **narrative becomes a possible world** (Daiute, 2017, p. 9).

The act of narrating is thus understood to be a major relational and developmental tool, especially with positive engagement in collectives addressing bad situations in challenging and rapidly changing environments (Daiute, 2016). In this way, narratives can be resources for engaging critically and creatively with environments and their social structures.

(Daiute et al., 2015), a "potential process of possibility—imagining and enacting social change with narrative—a lifelike yet creative symbolic system" (Daiute, 2015, p. 157). Daiute similarly highlights the power dynamics inherent to narrative practice, including the flexible uses of narrating as a mechanism of socio-political engagement and change: "as mediators of human interaction, symbolic discourses, like narrative language, are created in cultures allowing for a range of dynamic relations, not only oppressive functions of master narratives but also counter narratives and complex interactions in daily life" (Daiute et al., 2015, p. 46). Further research in the field of narrative psychology has found that redemption—a narrative sequence in which people recount emotionally negative experiences as having positive endings—is a useful mechanism for coping with adversity; in other words, redemption may serve as a cultural master narrative providing individuals with a socially valued script for narrating challenging life experiences (Blackie et al., 2020).

This chapter has explored some key concepts of cultural psychiatry (transcultural psychiatry, cross-cultural psychiatry, or ethnopsychiatry): the interdisciplinary field of research and clinical practice concerned with the impact of culture on mental health and illness (Kirmayer, 2018). These different terms for the field reflect particular intellectual and research traditions as well as changing configurations of the social world, but all address questions of enduring importance concerning variations in the causes, experience, expression, and course of mental health problems and the efficacy of specific modes of individual or collective coping, social response, and healing practices.

As recently noted by Kirmayer et al. (2018),

> Exploring cultural meanings requires attention to over-arching discourse, embodied practices, and everyday engagements with an ecosocial environment. Restitution, treatment and recovery can then be guided by knowledge of cultural meanings, dynamics, and strategies for coping with catastrophic threats, injury, humiliation, helplessness and loss. (p. 84).

According to Kirmayer, then, any consideration of experiences of trauma among refugee populations therefore needs to include "biological processes of learning

and memory; embodied experiences of injury, pain, and fear; narratives of personal biography; the knowledge and practices of cultural and social systems; and the power and positioning of political struggles enacted on individual, family, and community and national levels" (Kirmayer et al., 2010, p. 170). Elsewhere, he notes that.

> In research, an ecosocial perspective urges us to move an exclusive focus on the brain to consider the developmental trajectories and situations that shape its architecture and function. We may function well in a range of contexts but expect certain resources to be ready-to-hand and find some kinds of situations, especially challenging. Understanding the mechanisms of mental disorders thus requires attention to the world beyond the individual, including families, communities, and networks, both local and global. (Kirmayer, 2019, p. 32).

Such ecosocial approaches to understanding trauma from a cultural perspective go beyond a reductionist focus on "cultural differences" wherein "culture" is perceived to be a reified, crystallised concept and viewed as a potential barrier to be overcome in a process of psychiatric classification (Watters, 2001). In other words, it is a move away from conceptual models dominated by implicit colonial hierarchies or reified notions of culture as a homeostatic variable to be taken into consideration. The aim is not to rely on overly-crude or misleading cultural stereotypes (Kirmayer et al., 2018). Instead, the focus is on ever-changing cultural and social systems which determine the various forms of an individual subjective experience of illness, an experience inevitably in constant flux (Goguikian Ratcliff & Rossi, 2015). This framework similarly recognises that healing from trauma is not an individual project, but a communal process which necessarily recognises the social, economic, and political context affecting the mental health of refugee populations (Sousa & Marshall, 2017).

These developments in theories of culture, and traumatology have enriched cross-cultural understanding of mental health dynamics and case conceptualization, informing the development of intervention models which aim to go beyond a single-trauma focus to address cumulative trauma dynamics as well collective identity and culture-specific traumas (Groen et al., 2017; Kira, 2010). The implications for both mental health interventions and for research is a focus on the dynamic inter-relationship of past traumatic experiences, ongoing daily stressors and the fundamental ruptures to core psychosocial systems extending beyond the individual to their sociocultural environment (Silove et al., 2017). I explore this by drawing on clinical examples from my work in the field—notably the case of 8 women from the Murle tribe affected by conflict in South Sudan who experienced an episode of mass fainting spells, as well as the case in Greece of a refugee victim of torture from Guinea confronted with a different cultural belief system of trauma between herself and her psychologist in Athens. These cases are used to highlight the important role of belief systems around trauma, the meaning given to the traumatic event, culturally determined idioms of distress and symptom manifestations, as well as implications for health seeking behaviour and explanatory models of healing.

Case Study 1: Mass Fainting Spells Among the Murle Tribe of South Sudan

Introduction to the Context

Gumuruk is a rural village in war-torn Jonglei state, South Sudan. It is populated by a tribe of people known as the Murle—predominantly nomadic cattle herders who have been heavily affected by conflict between themselves and the rival tribes of Dinke and Nuer. This is a conflict that dates back generations. It has been particularly intense over the past couple of years following the birth of South Sudan, the youngest country in the world. In the second half of 2011, relations between the Murle and Lou Nuer became increasingly strained. A number of clashes broke out with cattle raiding, looting and destruction of property, killing of civilians including women and children, in a dramatic escalation from the inter-communal conflicts of the previous years. In June 2011 the Lou Nuer perpetrated a violent attack on Pibor county (Gumuruk and Lekongole), with an estimated 430 deaths and 7000–10,000 people displaced. On 18 August 2011 the Murle counterattacked in Pieri (Uror county), with an estimated 340 deaths and 26,800 people displaced. Between 23 December 2011 and 3 January 2012, 6000–8000 armed youth, militarily organized and primarily of the Lou Nuer ethnic group, calling themselves the "White Army," launched a series of systematic attacks on areas inhabited by the Murle. Pibor was also attacked and parts of the town looted. According to the UNMISS, there were an estimated 612 deaths (including 88 women and 88 children) and 140,000 people were affected. As a result of this conflict, the majority of Murle men from this village were killed and nearly all of the cattle stolen during a violent clash. This has left the women of the village to take care of the children without any access to a food supply. Especially during the dry season, it's nearly impossible for vegetables or other sources of food to grow.

In August 2013, following interethnic clashes between Murle and Lou Nuer in July 2013, *Médecins Sans Frontières* (MSF) arrived in Pibor to run mobile clinics. I was part of the team as a clinical psychologist. We set up a hospital in Gumuruk, ready to receive victims of violence, but relatively few victims arrived to the clinic to seek medical care. This was possibly related to fears of being attacked by the Lou Nuer in coming to the clinic. Therefore, in an effort to reach those still hiding in the bush, MSF set up mobile clinics at the same time as the World Food Programme (WFP) organised food distributions. On these days, people would flock from neighbouring villages or, in some cases, come out from hiding in the bush. Many of them were women with young children. Many had to walk for two or three days to arrive. The WFP would mark all of their fingers with black ink—much like voting in certain countries of the world—to track who had received their bag of rice. On these days, our clinic would also experience a significant influx of patients. A lot took the opportunity to seek medical care in the same village. Otherwise, it was seen as too long a distance and too unsafe a risk to come to the clinic.

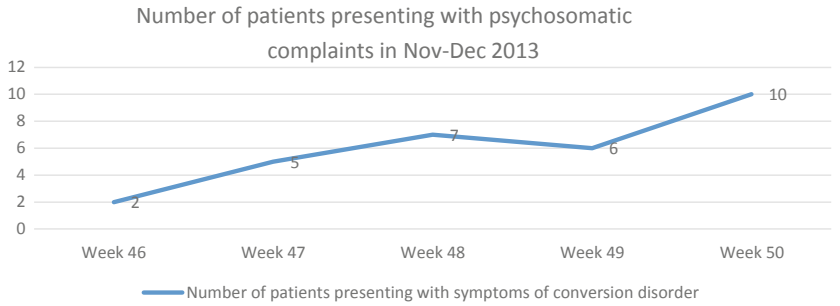
A Case of "Mass Hysteria"?

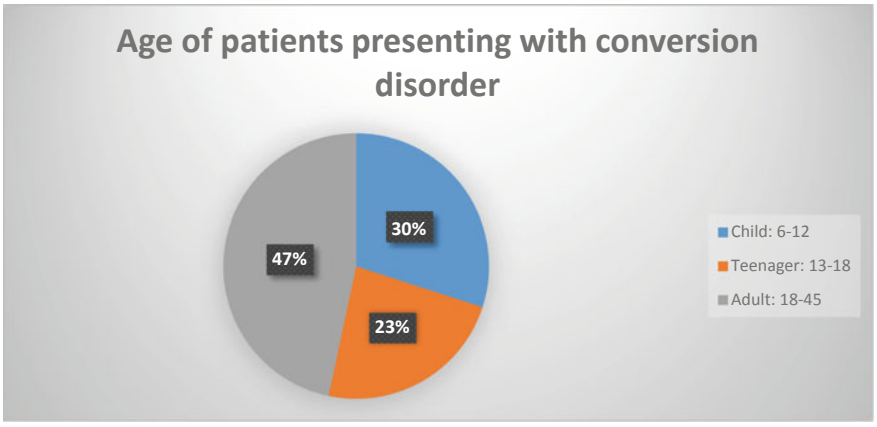
During one particular "food distribution" day, a group of community members arrived at our clinic carrying two women on a stretcher. The women had collapsed waiting in line to receive food. Both of their fingers were stained with a black ink that the WFP used to mark people who were in line to receive food. Neither of them were able to walk. They lay limply, occasionally jerking their entire bodies as though in a trance or experiencing a seizure. The two women were not related. The community was furious. Some of the other women were howling and crying hysterically and men were shouting angrily in Murle. We discovered that one of the women's three-month-old baby had just died while waiting in line to receive the food. The death was possibly linked to dehydration—her mother having had to walk for three days with her in the scorching heat in order to come to the food distribution. The baby's little finger had also just been stained with the same black ink. Rumours spread that the black ink was poisoned. It was the black ink itself that had killed the baby. It now also had poisoned the women. The community was blaming the neighbouring Lou Nuer tribe. The Nuer had allegedly cursed the ink using traditional African witchcraft. After that, we immediately heard cases of seven more women who had collapsed after having ink put on their fingers. Most experienced generalised pain all over their bodies followed by seizures and collapsing on the ground. Most couldn't open their eyes. All were too weak to walk. In my time in the clinic, I had already started to see such cases of what might be considered in psychoanalytic terms as "hysterical conversion." Nearly every evening in the clinic, the community would bring in women to the emergency room with the same presentation and same physical complaints. This became so common that as a psychologist, I was also 'on call' in the emergency room in the evenings. I became the "go-to" woman for doctors who understandably felt frustrated and lacked the time, patience, or expertise to attend to such cases.

The doctor explained to the community the likelihood that the child had died of starvation and dehydration, after having had to stand in line in 40° heat. This was not accepted by the community. The doctors' explanations were met with indignation, panic, and accusations that he didn't know what he was talking about. He and I went with some of our local staff and had ink put on our own fingers to prove to the people waiting in line that it wasn't poisoned. They answered that it was because we were both "Khawaja" (white people) that it had a different effect. Our translators (also from the Murle tribe) did the same. The community remained unconvinced. All seven women were brought for observation at the clinic, had a medical check-up and stayed overnight. They all slept soundly through the night. When I met with them the following day, they presented as calm, healthy and were able to walk easily. There didn't seem to be a sense of shame or distress. Four complained of headaches and three continued to experience generalised bodily pain but they all asked to be discharged. Feelings of sadness or anger were denied. Affect remained neutral or blunted. The main feeling was that they had indeed been poisoned but that the poison had been weak and was now metabolised.

Reflections

In the span of one month, I saw 30 cases of patients presenting at the clinic in Gumuruk with symptoms of psychosomatic complaints/conversion disorder. The vast majority were women (93%). There was a broad age range including children, teenagers, as well as adults. Just over half the cases (53%) were admitted to the emergency room at night. Typical presentation included collapsing, "convulsing," shaking, eyes forced close, arched back, intermittent hiccups or vocalisations of pain, extreme and exaggerated slowness of movement and generalized body pain. No other medical complications were found. The number of cases rose steadily over in this period.





The steady increase in cases could possibly be in response to increased tension in Gumuruk regarding potential conflict with the arrival of the dry season. Dry season in Gumuruk means that armed men are able to move more easily across the land. Conflict typically erupts during this period.

There are a few different ways in which we can make sense of this. From a psychoanalytic perspective, psychically painful memories or feelings are repressed and converted into physical symptoms. For Murle, this repression may be a necessary means of psychic survival. Repression protects people from experiencing unbearable

emotional pain. From the perspective of evolutionary psychology, non-combatants during or after times of attack unconsciously use these symptoms as nonverbal signal of not being a dangerous combatant/not carrying infectious disease. This explains group effect and gender difference in prevalence. From a sociological perspective, many studies have found prevalence to be higher in rural, lower socio-economic groups due to poorer understanding of medical/psychological concepts. From a neurophysiological perspective, symptoms are genuine and result from the physiological stress in the body (patient suffering trauma under continuous "flight or fright" response mode—leading to changes in hormonal levels, significant muscle tension etc.). Symptoms therefore result from an over-activation of the fear circuit/adrenaline response in the body. Research suggests that conversion disorder is associated with alterations in regional cerebral blood flow as well as greater functional connectivity between the right amygdala and the right supplementary motor area (Stone et al., 2005; Voon et al., 2010; Yazici & Kostakoglu, 1998).

None of these perspectives is necessarily at odds with the other. All offer relevant insights into the case. From a sociocultural perspective in particular, we need to ask ourselves the following questions:

- What systemic factors may be contributing to this group presentation of hysterical conversion?
- Is there a role for a more classically western psychoanalytic understanding or intervention?
- What ethical concerns might arise out of implementing a psychological intervention from a western/clinical perspective in this context?
- How would one work with such cases given the nature of short-term "humanitarian" interventions in such under-resourced settings?

Case Study 2: Psychotherapy with a Guinean Refugee Victim of Torture in Athens

Brigitte is a Guinean refugee victim of torture aged 40, diagnosed with the PTSD I met her in the course of my research among refugee victims of torture in Athens, Greece. She was referred to the clinic after presenting with symptoms of trauma. Nightmares were particularly troubling for her. In the course of the year that we spent together, she described her experiences of sessions with a psychologist:

> B: The psychologist told me that the nightmares are linked to the past, because I told him that I'm being chased. He told me that it's linked to the past, that's it.
>
> Interviewer: And what do you think?
>
> B: Me, I told him that it's spiritual, but afterwards, when he spoke, I told myself that "I don't know" but it's also possible that it's linked to what I'm thinking in my head. It's also that. Because I leave what's in my head. If I remove what's in my head, it can sort itself out. Apparently, when you have dreams where people are chasing you, we, we say that it's witchcraft. Among the Africans, we say that it's witchcraft. But he, he explained to

> me that … for example, I had a dream the night before last. I remember two dreams. Where they chained me up, he said that it's linked to my past and that it's me myself who is chaining myelf up. Because of, maybe, what I refuse to think, I chain myself. So it's me myself who has to cut the chains. Nobody is chasing me. I need to liberate myself. Even though it's not easy, I need to liberate myself, scientifically.
>
> Interviewer: He said that?
>
> B: Yes, he said, scientifically … me, I told him about the spirituality but he said that scientifically, dreams are expressing what we're feeling […] I think it's witchcraft, it's the ancestors […] Yes, it's someone who wants to … but he said that scientifically it's our thoughts, in my head, my thoughts because I have children at home [in Guinea] that I had with different fathers, not with the same man. And because I'm Christian, sometimes I feel guilty and I tell myself that it's not a good image as a Christian. He told me that that's what I think […] I told myself that it's also probable that it's the truth. Because maybe, in my head, I am guilty, it's true. Even though I listen to the word of God, one could say that I did something that I couldn't pardon myself for. But Christ has already forgiven me. That's also the problem […] spiritually, it's complex. What I see, I explain spiritually with the hand of witchcraft. It means that the family isn't leaving me in peace. Spiritually, they are following me, they followed me two nights ago until I was scared. I don't know, there are two explanations […] Apparently there is an explanation that's different to what I think myself. So I don't know which to leave or take. I don't know…but I told myself that maybe that one's right as well.

In this extract, Brigitte is confronted with a different explanatory model to that of her own ("apparently there is an explanation that's different to what I think myself"). Her understanding of the nightmares is framed as being a "spiritual" one—linked to the ideology of African witchcraft. According to this model, the nightmares are as a result of someone else chasing her and putting a spell on her. It is the family who will not leave her in peace. She is bewitched, and the nightmares are a cause of an external individual or group of individuals deliberately trying to harm her. She is then confronted with the psychologist who "explains" a "scientific" model to her. The use of the words "explain" and "scientific" hint at the asymmetry inherent to the therapeutic relationship mentioned above. They imply that the knowledge of the psychologist is to be taken as undisputed scientific fact (hierarchically superior to other forms of knowledge falling outside of the western scientific paradigm). The represented situation of the psychologist who is "explaining" this science to her places him in the position of knowledgeable teacher and her in the position of the hither-to ignorant learner.

The temporal challenges play a role in these two different conceptions: the scientific "model" represented by the psychologist is rather based on the past—and consequently, it is more static and unchangeable, it is a model in which the individual is the passive victim of what is happening to him or her. On the other hand, with the "spiritual" model there is a more active, dynamic and changing conception, based on the current and external, instead of the internalized past. Throughout her speech, her own position in relation to the "scientific" model appears ambivalent. It is a dynamic and constantly shifting one, where the psychologist's explanation is both contested and accepted. When confronted with the explanatory model of her psychologist, she begins by saying: "I need to liberate myself. Even though it's not easy, I need to

liberate myself, scientifically." Implied in these words is an acceptance of his model, based on an individualised and westernised understanding of trauma, where distress is solely located at the level of the individual and the individual has the power and obligation to heal themselves. The contradictions between this explanatory model and that of hers is highlighted in the words "me, I told him about the spirituality *but* [my emphasis] he said that scientifically, dreams are expressing what we're feeling." It is as though, metaphorically, she holds up the two models to examine them; it is the spiritual versus the scientific; her model *but* his. She then continues to directly contradict the model offered by the psychologist in saying "I think it's witchcraft".

Despite these contradictions, she continues by saying "he told me that's what I think". Let's consider the inherent imbalance of power implicit to these words: one individual telling another individual what they think. When faced with this interpretation, Brigitte grapples with the truth of what the psychologist is saying. She repositions herself once more. Faced with this interpretation, she continues: "I told myself that it's also probable that it's the truth." By telling herself this, she engages in an internal monologue where she grapples with the truth of the psychologist's words in light of the apparent dissonance between his explanation and hers. She appears to resolve this conflict, to some extent, by taking an "also" approach. His explanation is "also" correct, as is hers. The *"also"* instead of a *"but"* would therefore seem to suggest that she would like to incorporate this newfound understanding into her own explanatory model, thus accepting both points of view as valid. The conclusion of this is illustrated in her words "I don't know…but I told myself that maybe that one's right as well." The case of Brigitte offers an example of the fact that working with refugee populations in the field of mental health requires a knitting together a variety of worldviews brought together in the meeting between health professionals and the refugees themselves. Brigitte and her psychologist are both French-speakers, yet despite sharing a common language, the meeting of both worlds during a consultation necessitates constant mediation. Despite this challenge, she draws on the words of her psychologist as a resource to enhance her resilience. Weaving together the "spiritual" and "medical" explanations for the nightmares is a significant part of the process by which she comes to term with the traumatic experiences she's faced, and by which she constructs a new, more hopeful future for herself.

Conclusion: Introducing a Collective, Sociocultural Approach to Understanding Trauma and Recovery

In order to address some of the needs for more research on trauma among refugee populations, I draw on a socio-cultural framework that focuses on the intersubjective, mediational space between the individual and culture-society-interaction to account for the experience of humans in time and in particular social and cultural environments (O'Connor, 2015). Such an approach presupposes human beings inhabit shared forms of life, and utilize semiotic resources with reference to social structures and

institutions. Meaning is continually negotiated within the social sphere and "cultural products, like language and other symbolic systems, mediate thought and place their stamp on our representations of reality" (Bruner, 1991, p. 3). In other words, the sociocultural context informs symbolic realities—products of human beings embodying different histories—which objectify themselves in language, discursive practices, social representations, myths, normative systems, religions, and other cultural products. Within these symbolic networks of cultural facts, individuals, institutions, and groups develop their complex and singular subjective organisations. As noted by Dafermos et al. (2015), "the approach differs radically from theories based on the psychologisation and pathologisation of human development, primarily because it clearly posits that there are inexorable links between social and individual development" (p. 74). It focuses on the exploration of complex, multidimensional, dynamic phenomena (Dafermos, 2018).

Within this framework, the individual constructs the social and at the same time is constructed by the social (Zepke & Leach, 2002). Similarly, the meaning attributed to an event (for example, whether or not the experience of being forced to marry at 14 years old is experienced by a young woman as traumatic or not) is both a reflection of the individual and their sociocultural environment. Attributing meaning to events is itself a co-constructed activity—with human beings conceived of as communicational agents that are constantly responding to situations within their sociocultural environment, in dialogue with others (Gonçalves & Ribeiro, 2012).

As argued by González Rey (2008),

> social and individual subjectivities are configured recursively through the interactions of active subject's in the functioning of groups and social institutions. The dialogue between individuals is only a moment within these subjective social dynamic systems that integrate social practices and relations; systems within which the individual is an author rather than a recipient in the dialogical processes. These dynamics represent particular configurations within the broader scenario of social subjectivity. (p. 187)

To summarize a few fundamental tenants of the theoretical framework of sociocultural psychology:

- The focus is on the way in which individuals, within their sociocultural environment, render reality significant
- Individuals are inevitably situated within a specific sociocultural and historic time and place, and are actively engaged in the construction of the meaning of reality with others
- Thoughts, feelings and actions of individuals are formed within a sociocultural milieu, mediated by cultural resources (considered as a collective accumulation of experiences of past generations). This relates to Vygotsky's "first law of development" which states that every acquisition is first social, before being reconstructed on an individual, psychological plane through the process of mediation
- Consequently, social and psychological phenomena are processes that exist in the realm of relations and interactions—that is, as embedded, situated, distributed, and co-constructed within contexts while also being intrinsically interwoven into these contexts

This perspective therefore involves a focus on the thread of language and related underlying semiotic systems. It is inherently dialogical (Marková, 2006, 2016). It understands dialogue to be the fundamental dimension of language as well as of human experience (Greco, 2016; Salazar-Orvig & Grossen, 2008). It likewise includes a recognition that all languages are composed of different social languages (Bakhtin, 1981; Gee, 2014). It emphasizes the contextual and unfinished nature of meaning (Gillespie & Cornish, 2014), inevitably situated within a specific sociocultural, historical and political context. As such, this theoretical framework highlights the heterogeneous, fluid and dynamic nature of individual subjectivities (Gee, 2014; González Rey, 2016; Squire, 2008).

Within this framework, an individual's experience of a potentially traumatic event, for example, necessarily is influenced by and reflected through language and culture. Culture (as explored in a previous chapter) is considered both as a set of practices physically executed in a tangible and observable sense by the group, as well as integral to belief systems lying internally within individual members (Brewin et al., 1996; Drožđek & Wilson, 2007; Sturm et al., 2007, 2010). In other words, the approach highlights the ways in which life experience (in this case, experiences of trauma linked to migration) are mediated through language and culture.

Such an approach would include an acknowledgement that current concepts of mental health, notably a diagnosis of PTSD, are to some extent socially constructed objects produced within a specific historical period (Goguikian Ratcliff & Rossi, 2015). The perception of the potentially traumatic event, then, is mediated, among others, through collective memory and the inter-generationally transmitted historic experiences, myths or stories from the past shaping worldviews (Drožđek & Wilson, 2007). Here, elements of temporality are considered, as is the continual interaction of the person with their environment in a given social and historical context. It would therefore follow that not only do reactions to potentially traumatic events differ according to cultural norms, but the very making sense of what is or what is not considered to be "traumatic" may similarly be informed by socio-cultural context (Daiute, 2017; Zittoun, 2014; Zittoun, & Sato 2018). Simply put, "culture shapes and gives meaning to the whole of human experience, including potentially traumatic experiences. Both cultural idioms of distress and narratives influence the nature of a pathological experience" (Rechtman, 2000, pg 404). These socioculturally determined idioms of distress have been defined in the D.S.M.-V as "ways of expressing distress that may not involve specific symptoms or syndromes, but that provide shared ways of experiencing and talking about personal or social concerns" (APA, 2003; Lewis-Fernández & Aggarwal, 2013).

Manifestations of trauma from within this socio-cultural framework are seen as unfolding within the context of systems of relationships which form the ever-changing environment. As Harvey (2007) notes, this ecological perspective is needed to guide inquiries into the understanding of trauma resilience. This is because it incorporates a "resource perspective" which assumes that human communities, like other living environments, evolve adaptively and are deeply embedded in complex and dynamic social contexts in which resources are exchanged. Individuals within this system are capable of negotiating and influencing, as well as being influenced by,

this system. Equally, symptom severity is viewed as not static but fluid and changing according to a continuum of pathological reactions (Drožđek, 2015). For people whose lives are characterized by ongoing hardship, often shaped by discrimination, poverty and other current and future dangers, traumatic events may fall within a continuum of suffering and may not be singled out or experienced with the same precision as the definition of PTSD appears to demand (Eagle, 2014). This is a particularly relevant consideration for the mental health of refugees in light of the multiple and arguably ongoing environmental stressors and potentially traumatic experiences with which they are faced.

As noted by Daiute (2016), "trauma is *real, [my emphasis]* and many scholars are studying and treating trauma as a social as well as an individual phenomenon" (p. 130). Trauma experienced by displaced populations cannot be conceived of as a process having an inherent value occurring outside the network of sociocultural and historic experience. This is because it cannot be disconnected from its consequences for the *concrete* life of the individual. Trauma is related to individuals, as well as social histories and resources (Goulart, 2017; Goulart & González Rey, 2016; González Rey, 2008). It cannot be divorced from *daily-lived reality.* We cannot study the development of trauma trajectories among displaced populations without considering the concrete: concrete individuals and the concrete reality of their environment. Firstly, an understanding of the sociocultural resources drawn upon by various communities in the face of exposure to traumatic events should fundamentally inform mental health interventions for migrant populations. The under-utilization and mistrust of mainstream mental health services by migrants—and ethnic minorities in general—has been well documented (Bigfoot & Schmidt, 2010; Mattar, 2011; Watters, 2001) and may be in part due to the variations in healing practices determined by culture as noted above.

As recently highlighted in a study among mental health services for refugees in Greece, Karageorge et al. (2016) note the absence of knowledge regarding the acceptability and validity of current mental health interventions for this population. Their research highlights how both refugees and mental health professionals expressed challenges related to understanding and respecting respective cultures—a significant barrier to accessing such services. They identify the following barriers to the acceptability and validity of mental health services: (1) mistrust or uncertainty of intentions/expectations (2) having more immediate (practical) concerns than talk, (3) difficulty discussing trauma and (4) the inadequate cultural competence of health professionals. A recent desk review released by the World Health Organization (WHO) and UNHCR, the United Nations Refugee Agency, has argued that the development of effective mental health and psychosocial support programs requires knowledge of existing health systems and socio-cultural context, and that familiarizing international humanitarian practitioners with local culture and contextualizing programs is essential to minimize risk of harm, maximize benefit, and optimize efficient use of resources (Greene et al., 2017). Another key report recently released by the *International Society for Traumatic Stress Studies* (Nickerson et al., 2018) exploring trauma among refugee populations similarly highlights that the majority of current refugee crises of the twenty-first century are situated well outside the

cultural contexts in which DSM-5 and ICD-10 nosologies have been organized. The report highlights key cultural barriers to accessing adequate and culturally relevant mental health services include "differential symptom expressions across cultures, the potential for limited construct validity of disorders in different groups, and unclear cultural validity of clinical interventions" (p. 15).

Some concrete implications for interventions—as noted by Nicolas et al. (2015)—include an integrated, multi-disciplinary approach which recognises the importance of a social response. This might include, for example, addressing issues aligned with social role and social support disruption; including a focus on current material concerns around living conditions, family reunification, legal and social justice, employment, establishing sociocultural-informed systems of meaning etc. He and his colleagues (2015), for example, have argued for a "social ecology of trauma risk and recovery" wherein interventions addressing trauma take into account structures of family, community and wider social institutions—and a focus on the social positioning of the individual within these structures. They argue that such interventions must be based on the following premises: (a) a recognition that culturally shaped narratives of distress play a role in subjective experiences of trauma across cultures and (b) a degree of ethnocentricity is inherent in Western understandings of trauma. The field of community psychology, more specifically the "ecological analogy" of community psychology as defined by Harvey (2007) similarly argues for an understanding healing traumatic wounds within a collective, social context. What is required for healing within this "ecological analogy," she argues, is a deeper understanding of life trajectories, dynamic processes, interactions and the continual development and change in psychological symptoms. The past decade indeed has seen a rise in interventions considering trauma interventions from a cultural perspective which have expanded to include services designed and delivered by paraprofessionals who are refugees themselves working in a collaborative team approach with mental health providers (Mitschke et al., 2017).

It is with this perspective that the following two sections of the book address trauma among displaced populations: firstly through exploring collective experiences of trauma and recovery affecting entire communities of displaced populations (as well as aspects of resilience and aspirations for a better future), and secondly through exploring some practical applications for professionals working with this population.

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