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The Problematic Nature of Using Western Treatments for PTSD in Non-Western Settings and a Discussion of Culturally Sensitive Interventions

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Introduction to Cultural Psychology

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In recent years, American clinicians have sought to diagnose and treat individuals with Post-Traumatic Stress Disorder around the world. Despite noble intentions, their faulty assumption that western treatments for trauma are universally applicable is highly problematic. Culture has an immeasurable impact on trauma that can range from differences in interpretations of traumatic events to symptoms of disordered behavior to societal norms about interventions. Most often, these issues become apparent in treatment settings, during which problems arise from the use of western methodology on non-western individuals. For this reason, some culturally sensitive psychotherapists have recognized the need for more culturally adjustable treatments and have adapted traditional western interventions for use with other populations. Recognizing the impact of ethnocultural factors on reactions to trauma and treatment is imperative if psychologists want to truly help individuals who are suffering from traumatic experiences around the world.

It is important to recognize that, first and foremost, the current conception of Post-Traumatic Stress Disorder (PTSD) is a western notion. Developed in the late 1970s, following the Vietnam War, added to the DSM in 1980, and supported by the antiwar movement, the diagnostic label was created to define and understand the seemingly bizarre behaviors exhibited by veterans. These behaviors included anxiety, depression, substance misuse, and symptoms relating to personality disorders and schizophrenia. In recent years, the use of the term PTSD has expanded tremendously, diagnosing individuals who have been through a variety of traumatic events in a variety of locations and cultural contexts (Summerfield, 2001).

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), to receive a diagnosis of PTSD, an individual must exhibit a pattern of symptoms including exposure to a fearful traumatic event, followed by re-experiencing the event through flashbacks

or dreams, avoidance and emotional numbing, and increased arousal not present before the event (DSM-IV-TR; American Psychological Association, 2000). However, despite its widespread use, symptoms described by the DSM-IV-TR are not necessarily applicable across cultures (Bracken et al, 2005).

For example, in a study on Salvadoran women following exposure to trauma, 19 out of 20 participants did not engage in avoidance behaviors or experience emotional numbing. Instead, they endured salient bodily symptoms that they labeled as *nervios* and *calor*, which were not labeled as possible severe reactions to traumatic events in the DSM-IV-TR. Despite their suffering, they could not be diagnosed with PTSD because they did not meet criteria for the disorder (Jenkins, 1999).

As demonstrated by the Salvadoran women example, DSM-IV-TR criteria apply to a specific cultural population. It is faulty to assume that there is universal cultural applicability of the disorder because individuals who have aversive reactions to trauma often demonstrate distinct symptoms from the western standard. Differences can be based on cultural appraisals of an event (Friedman and Marsella, 1996), resilience factors due to the protective role of culture (Johnson, Thompson, and Downs, 2008), and interpretations of the symptoms. While the topic of diagnosis is far greater than the scope of this paper, it is important to note the problematic nature of using DSM-IV-TR criteria to diagnose across cultures.

The problems cited above regarding diagnosis of PTSD across cultures are equally as applicable to a discussion of treatment for an individual's aversive reactions to trauma. Western treatments for PTSD today typically include Cognitive-Behavioral Therapy, including Exposure Therapy and Stress-Inoculation Training, pharmacotherapy, psychodynamic therapy, and group therapy (Eftekhari, 2006; Gerrity & Solomon, 1996). While seemingly effective in western

settings, Bracken et al. (2005) makes the argument that they are not appropriate for use in non-western settings for a number of reasons.

First, these treatments assume that western notions of individuality are universal, ignoring the fact that there are cultures in which the concept of the self does not include individuality and bounded-ness (see Markus and Kitayama, 1991; Roseman, 1990). Second, psychologists tend to focus on similarities among responses to trauma across cultures, while ignoring cultural differences. Finally, clinicians make the assumption that western treatment strategies are the best approaches for use in non-western societies.

This final problematic assumption builds off of the other two notions. Treatment such as talk-therapy inherently assumes that a person, as an individual, can be separated from his or her environment and placed alone in the clinical context. This treatment may have the effect of "individualizing the suffering of the person involved" and may be harmful in societies where "the individual's recovery is intimately bound up with the recovery of the wider community" (Bracken, 2005). More specific articles will demonstrate further why classical western treatments may not be the most appropriate method for treatment of aversive reactions to trauma.

The first study by Breslau (2000) demonstrates the problematic use of western treatment in Japan following the Kobe Earthquake. After the earthquake in 1995, a large number of western clinicians went to Kobe to treat the thousands of people who they believed needed intervention. These clinicians, after some brief confusion as to what to call their treatment, ended up using the term *kokoro no kea* ("care for the heart") to describe the services they offered. *Kokoro*, translated as "intention, emotion, thought mind, heard, subjectivity" referred to "unique, biographical experiences," and was put in contrast with *seishin*, or "stable sources of power and efficacy that are less susceptible to change." *Seishin igaku* meant "medicine of the

seishin," the name of psychiatry already extant in Kobe. By using a new term for psychological treatment, western clinicians put *kokoro,* their own practice, in direct competition with *seishin,* Japanese mental health practice. *Kokoro,* western clinicians argued, was more advanced than *seishin* because *seishin* did not know about PTSD and was thus poorly founded in science. By default, western clinicians imposed a new concept in Japanese culture, while denigrating previous known structures. Western clinicians received governmental and outside funding to increase their presence and the use of *kokoro.* By doing so, they forced a change in a society that already had adequate mental health services and imposed their own methods of treatments without regard for the frustration and confusion it caused Japanese therapists and patients (Breslau, 2000).

In his article on "A Critique of Seven Assumptions Behind Psychological Trauma Programmes in War-affected Areas," Summerfield (1999) furthers the discussion of the problematic nature of using western treatments by elaborating on faulty assumptions that are often a part of the use of western treatments in other cultures. Two are particularly relevant for this paper's discussion of treatment for trauma. The first faulty assumption is that "large numbers of victims traumatized by war need professional help." This assumption does not take into consideration the role of societal and situational factors that shape outcomes. The assumption further categorizes the clinician as the expert savior, while the survivor of the traumatic event is relegated to the role of a passive victim in need of help. In one example he describes by Somasundaram (1996), many survivors of a bombing in Sri Lanka did not consider themselves ill, despite the fact that clinicians ascribed the diagnosis of PTSD to them and insisted that, as scientists, they knew better. Clinicians were not comfortable with the idea that

their therapeutic services would not be necessary and reacted by diagnosing individuals, despite the fact that they did not experience any subjective distress.

The second faulty assumption described in Summerfield's (1999) article is that "Western psychological approaches are relevant to violent conflict worldwide. Victims do better if they emotionally ventilate and 'work through' their experiences." This assumption does not consider the fact that in many non-Western cultures, discussing intimate details with someone outside the family is unacceptable. In addition, some societies such as in Mozambique and Ethiopia engage in what Ethiopians call "active forgetting," the method they use to cope with difficult past experiences. There is no need for these individuals to speak about and "work through" these events because they have different effective coping measures.

Another problem with using western therapies for PTSD in other cultures is that, often, the terminology does not translate well. Western knowledge and concepts are forced onto confused individuals. Summerfield (1999) describes a manuscript by De Smedt (1995) about the use of psychoeducation in Rwanda and the difficulty the clinicians experienced when attempting to translate important concepts related to PTSD. For example, there is no word for "stress" in Rwandan and terms such as "family member" are problematic because they vary based on situational factors. After finally managing to put together a psychoeducation course translated as best as possible, the psychologists wanted to assess whether there was an increase in knowledge.

As Summerfield points out in his article, the question this study raises is "Whose knowledge were they talking about?" In this scenario, non-indigenous, western concepts of universal trauma were taught without regard for indigenous understanding. In fact, concepts did not translate, demonstrating that psychoeducation was entirely western in nature. This situation is

highly problematic and demonstrates one of the issues that arise from believing that PTSD is a universal disorder.

One final specific demonstration of the negative impact of western treatment on individuals from other cultures will suffice before moving toward the ways in which clinicians who want to cater western treatments to other cultures have attempted to do so. The specific treatment approach is known as psychoeducation, as mentioned earlier, involves the dissemination of information pertaining to reactions to trauma and coping skills and is a common aspect of many types of western treatment. Numerous studies have demonstrated the benefit that psychoeducation provides in western settings. However, in Yoeman et al (2010), in a study on individuals from Burundi, psychoeducation was demonstrated to be ineffective. In fact, it was harmful, leading individuals to improve less overall than those who received treatment without psychoeducation. In this study, researchers designed three conditions: a workshop with psychoeducation, a workshop without psychoeducation, and waitlist control. The workshop with psychoeducation was identical to that without, including interpersonal exchange and community building, except for the content on symptoms and relaxation skills. Psychoeducation diminished the effectiveness of the community building exercise, thus demonstrating that treatment cannot be assumed to be effective across cultures.

Some psychologists have recognized the problematic nature of assuming universal notions of western treatments and have worked to develop culturally sensitive interventions. Many of the approaches still do not address all of the issues mentioned above. However, the development of these treatments is a step in the right direction. A few examples of these treatments will be discussed.

First, Abueg and Chun (1996) cite some important overarching concepts that should be included in cultural treatment in their article on PTSD in Asian and Asian American populations. Most importantly, psychologists must understand the situation in which their patients come from. Specifically, many Southeast Asian refugees have been exposed to trauma over a long span of time including during pre-migration, migration, encampment, and postmigration phases. Psychologists must be aware of each group and individual's experience and note the differences between Vietnamese, Cambodians, Hmong, and Laotian collective traumatic experiences. Cambodian refugees, for example, report high ratings of depressive symptoms and low self-reports of happiness. However, they continue to engage in social and occupational roles. Abueg and Chun note that this finding may be due to their history of experience with traumatic stressors and cultural beliefs embedded in Buddhist ideology. Many Cambodians frame their traumatic experiences within their Buddhist beliefs and, thus, understand their life experiences, however difficult, as meaningful. By understanding variations in trauma between cultures, psychologists will begin to recognize the cultural influences on reactions to trauma and mechanisms for coping. Once this occurs, psychologists can incorporate elements of cultural treatment practices into therapeutic practice and creative interventions can unfold. As one example, Buddhist principals, such as meditation and mindfulness, can be actively incorporated into treatment for subgroups that hold those beliefs. Abueg and Chun's idea of incorporating Buddhist principals into therapy is a useful idea when considering how some individuals already use them to cope with traumatic experiences.

Otto and Hinton (2006) provide an example of a study in which Abueg and Chun's suggestion is implemented for treatment of aversive reactions to trauma in Cambodian refugees. In his article, "Modifying Exposure-Based CBT for Cambodian Refugees with PTSD", he

discusses a specific western therapeutic technique that was adapted for use with Cambodian Refugees and some of the challenges that arose in the process. Otto and Hinton describe four core challenges that had to be overcome when developing the modified treatment. First, the language barrier had to be overcome by providing treatment spoken in Cambodian. Translators had mental health experience, so they could deliver adequate translations of psychological concepts. Second, limited resources forced a group format for treatment. Third, cultural expectations had to be acknowledged in order to allow patients to accept the treatment interventions. Fourth, treatment had to incorporate a focus on the somatic symptoms demonstrated by the Cambodian refugees and their cultural interpretations of their symptoms.

Once these main challenges were bypassed, culturally appropriate treatment could begin. Otto and Hinton delivered the group therapy in a Buddhist temple in order to avoid a classroom format because of the negative connotation classroom sessions had taken on during indoctrination sessions in Cambodia during the Pol Pot reign. The Buddhist temple also allowed for a relaxation focus in the sessions, bridging CBT techniques with cultural practice. In addition, information was delivered using metaphors that operated across cultures to bridge the linguistic and cultural gap. Clinicians used straightforward language that could easily withstand the interpretation process, so concepts would not get lost in translation. For example, they used the metaphor of the “Limbic Kid” in order to help patients distinguish between a rush of emotions when subjectively re-experiencing a traumatic event and reality. The limbic system metaphor allowed patients to understand the automatic nature of certain emotional responses to traumatic triggers, while the kid metaphor helped them take on a parent role, nurturing this automatic system as if it were a frightened child and helping it get back to the best responses. Other methods through which Otto and Hinton used metaphor to portray concepts and skills was

through cooking metaphors of a common Cambodian dish, *num beunycok*, television metaphors that made sense within the Cambodian community, and the metaphor of three bows used address Buddha in the temple to explain the three steps through which individuals accept trauma: "acknowledgement that the trauma was severe," "acknowledgement that the trauma had enduring effects," and "returning to a focus on the present." Finally, exposure to PTSD symptoms was done through the use of Cambodian children's games involving holding one's breath.

Further Otto and Hinton focused on helping patients redefine their traumatic cues in new ways with the hope that they would utilize the coping skills in exposure outside of therapy. In addition, rather than believing that symptoms of PTSD are due to a blockage of *wind*, a potentially deadly disorder according to Cambodians, patients were taught to reinterpret symptoms as "mimicking" *wind*. Thus, they could see symptoms as non-life threatening and changeable without having to alter their prior beliefs. Results from the Otto and Hinton study demonstrate that these strategies encourage acceptability, feasibility and are efficacious.

Another treatment approach that was developed for cross-cultural use refers to treatment of children who have experienced trauma in new cultural settings. Known as Cultural Family Therapy, this treatment works best with children who have recently immigrated and is an adaptable, rather than specific, treatment for use with many different cultures. The therapy involves a number of important aspects that allow culture to become a main player in treatment. It emphasizes translation, the use of cultural metaphors to convey concepts, and understanding family boundaries and how the family is adapting to the new culture before beginning treatment. These methods allow the therapist to place the child within the family life cycle, which then allows the child's behavior and progress to be noted in a cultural context. Abnormal and normal behavior in development as well as adaptation and generational differences can all be understood

through this cultural lens. When PTSD occurs during this difficult transitional period in a child's life, the experience must be understood in its full social and cultural context. Using these methods allows the therapist to do just this (DiNicola, 1986).

A third treatment approach demonstrates the sort of specificity to which treatments can and often should be delivered. The treatment is called Post-Traumatic Psychocultural Therapy (PTpsyCT) and was developed specifically for African-American war veterans following the Vietnam war (Parson, 1990). The treatment is unique in that it integrates many different factors that affect these veterans experience of trauma and the aftermath, including the impact of Vietnam, history of African slavery in America, and the "Eurocentric and post-Vietnam experiential sectors of Black Veteran world." The goal of the treatment is to create a unified whole from the sum of these parts. The history of African slavery sector is composed of the "internalization of socially projected images of the black self as unworthy, incompetent, and stupid," leading to a source of problems of communication in psychotherapy. Meanwhile, as part of a Eurocentric world, the black patients are part of society that emphasizes autonomy, individualism, and competitiveness. Finally, as veterans of the Vietnam War, they have experienced scorn from the outside community on their return.

PTpsyCT seeks to alleviate these aspects of suffering due to war, stigmatization, and social degredation due to race. Focus is put on the patient's experience, real or not real, of racial discrimination, strengthening his capacity to find meaningful behaviors, and an emphasis on the individual's strengths. On the part of the therapist, variables are identified including "(1) countertransference; (2) cultural counterresistance; (3) achieving competence; and (4) achieving transcultural competence." Ideally, the therapist will focus on these aspects of him or herself to overcome cultural, social, and ethnocentric biases.

Finally, even with these culturally adaptable treatments, there are a series of steps that should be taken beforehand to ensure that therapeutic techniques are necessary. Summerfield (1999) describes Ager 's (1997) stage model for which culturally sensitive, community-based treatment should occur after periods of warfare. First, humanitarian responders must ensure that "community structures, meanings, and networks," protective influences for individuals experiencing trauma, remain intact, so individuals can cope by their own means. Second, if these structures are not functioning well enough, they should be reestablished and reinforced. Third, only if reestablishment is impossible given time-constraints, a "compensatory support" system can be introduced. Lastly, if all of the above steps have been taken and individuals still require help, therapeutic response can occur.

One final treatment option must be mentioned, though discussing all the different aspects of the approach is beyond the scope of this paper. Even culturally adaptable western treatments are limited in scope and can fall prey to a number of the problems discussed earlier, including espousing the view of the individualistic self and believing that individuals must "work through problems" to get better. Sometimes, western treatments should be discarded for the traditional healers already extant and practicing in a number of societies. A number of studies have demonstrated the success of American Indian Asian healers in treating veterans after the Vietnam War and healers in Zimbabwe and Mozambique to alleviate signs of aversive responses to trauma. It is important to recognize the beneficial roles that indigenous healers can play in treatment and that their practices can often be more beneficial than traditional western approaches, even with cultural adaptation.

There are numerous problems in the diagnosis and treatment of PTSD in non-Western and minority cultures. These range from clinician's difficulties in translation of cultural

concepts, ethnocentric ideas of western notions of mental health and individualistic attitudes, and general misunderstanding of the cultural impact on reactions to trauma. A number of treatments have developed in recent years to combat these issues in treatment, including Modified CBT techniques, Cultural Family Therapy, and Posttraumatic Psychocultural Cogntive Therapy, all of which seek to understand the influence of culture on reactions to trauma. These treatments are certainly a step in the right direction, as they place individuals within appropriate cultural contexts. However, much research needs to be done on these types of treatments and their efficacy. Most importantly, clinicians should continue to remember that culture plays an enormous role in development, interpretation, and healing of disorder, and should continue to adapt treatment approaches to take these factors into account.

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