A SYSTEMATIC REVIEW OF OPERATIONALIZATIONS OF CULTURE IN POST TRAUMATIC STRESS

RESEARCH

By

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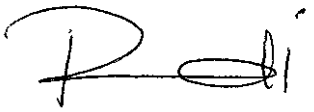
Declaration of Authenticity

I, Precious Ramasodi (student number: 210140151), hereby declare that the treatise submitted in partial fulfilment of a Master of Arts in Clinical Psychology is my original work. The following work has not been previously submitted for assessment purposes at Nelson Mandela University or any other institution.

I am aware that presenting the work of another individual as my own is a criminal act punishable by law. Thus, all material that influenced the writing of this document is duly acknowledged as emanating from elsewhere. The American Psychological Association's 6th edition citation rules were used to guide the naming of different sources.

Student's Signature: 

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Dedication

This treatise is devoted to my late grandmother Mrs Mantombana Priscilla Ramasodi.

You were the only grandparent I met and I feel truly blessed to have your name and a little resemblance to you. Whilst you were here, I spent just a few years with you and I am grateful for every memory. Since your passing, with age and through your spiritual guidance, I have come to know you better now than I did as a child.

Love you Koko.

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Abstract

Research which looks at the influence of culture on posttraumatic experience has explored the culture construct through many differing lenses. This is because of the complex nature of culture. Since investigators may delineate culture in any number of ways there are a host of ways in which culture can be operationalised. The presence of differing operationalisations of culture in the literature is not necessarily a hindrance to the furtherance of knowledge. However, researchers may find it beneficial to employ similar operational terms in order for studies to be compared and amalgamated. The present study reviewed literature studies published between 1980 and 2018 that explored Post Traumatic Stress Disorder (PTSD) in different cultural cohorts. Thirty qualitative and quantitative research reports were assessed and six different operational terms were found. These were namely: geographic location, nationality, race, language, religion and ethnicity. Many articles in the pooled articles employed more than one operational to delineate the taget population. The key themes which emerged from the pooled articles were the impact of differences between researcher and study participants, the differences in symptom expression and the stigma of posttraumatic disorder.

Keywords: trauma, posttraumatic stress, posttraumatic stress disorder, PTSD, culture

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Chapter One

Introduction

"If we knew what it was we were doing, it would not be called research, would it?"

- *Albert Einstein*

1.1 Chapter Preview

Traumatic events are distressing experiences that can befall any person from any background. The research by academics in the posttraumatic stress field has highlighted how differences in experience exist between cultural cohorts, and even within singular cohorts. By being more knowledgeable about how ethnocultural distinctiveness is constructed, treating professionals can intervene more effectively without unwittingly imposing generalisations that reproduce racial bias (Ford, 2008).

This chapter of the treatise is aimed at orienting the reader to the current study. Aspects that are covered include the context and motivation for the investigation as well as a description of the study methodology. With regards to the data that was collected, a brief description of the manner in which the information was analysed and the reflexive process by which the author engaged with the data is also elucidated. To conclude, the chapter looks at pertinent ethical concerns that the author considered and finally outlines the forthcoming chapters.

1.2 Context to the Study

It is a small number of Diagnostic and Statistical Manual of Mental Disorders (hereafter referred to as the DSM) disorders that necessitate a basic environmental condition in order to be diagnosed (Maercker & Hecker , 2016). The Post Traumatic Stress Disorder (hereafter

referred to as PTSD) label is one of them. To make a diagnosis of PTSD, one has to fulfil the criteria of a traumatising event. This distressing incident is what precedes the expression of various symptoms. The symptoms that ensue following a distressing event and the process of recuperation occur in a particular context. Some researchers have argued that to understand trauma, academics should examine the social and interpersonal (or socio-interpersonal) contexts more closely. The reason for this is that traumatised persons exist in a socio-interpersonal setting and they engage with their environment through persons such as their partner, family and community (Somasundaram, 2014). By looking at psychological trauma through a contextual lens, researchers may be able to gain a new awareness about traumatic experiences. Currently, there is consensus among scholars that trauma and its context are inseparable, and understanding of human distress requires that equal importance be placed on the settings in which trauma incidents occur (Marsella, 2010).

Research has shown that cultural identity is central to how persons interpret a potentially traumatic experience (Van Rooyen & Nqweni, 2012). Culture (often erroneously interchanged with ethnicity, race, language and nationality) plays a major role in what one perceives as threatening. This is because culture is the pair of "spectacles that frame our views of reality" (Marsella, 2010, p. 19). Given that posttraumatic events are managed differently by different cultural groups, understanding the manner in which cultural identity is shaped and influenced can unlock greater insights for professionals working with psychological trauma phenomena. It has been said by authors such as Ford (2008), that the United States (hereafter referred to as the US), which has higher prevalence rates of trauma among ethnic minorities, should carefully observe the manner in which ethnocultural delineation has historically been undertaken. Although Ford (2008) speaks specifically of the US, the statement would be similarly valid in other countries.

1.3 The Gap in the Knowledge

Culture is important to our understanding of posttraumatic stress disorder. However, many authors argue that this variable has not received as much attention as it deserves (Kagawa-Singer, Dressler, George, & Elwood, 2014). One of the reasons for this may be because the concept of culture is multifaceted. Since culture is an amalgamation of many parts that form a composite whole, the manner in which academics have operationally applied the construct has varied throughout the literature. A few organisations have made attempts to standardise how culture is used in mental health literature, but it would seem that these efforts did not improve the rigour with which the variable is reported

The task of operationalisation follows from delineation. When a construct has been defined in a manner that is explicit, the process of efficiently conceptualising the construct and also developing a strong basis for operationalisation can be more easily achieved. The benefit of researchers employing a consistent operational term for a concept is that the findings of different studies can be compared and newer insights can be formed by gauging results across a large number of investigations (Clarke, Colantonio, Rhodes, & Escobar, 2008).

Examples of measurement terms which are often used to represent culture include variables such as race, ethnicity, political and geographic margins, home language, and or nationality (Consortium of Social Science Associations, 2014). These operationalisations have been described by researchers such as Kagawa-Singer et al. (2014) as being rudimentary proxies of culture. It can thus be said that a gap in the knowledge regarding efficient operationalisation of culture exists.

It is possible that the previous attempts to standardise culture may have possibly missed the mark by not being specific enough in terms of the purpose and utility of different cultural operational terms. The author of the current study argues that effective operationalisation will be determined by the other variables under study in investigations of posttraumatic phenomena.

1.4 Self-reflexivity

In the main, studies with a qualitative component in the social sciences field have received some criticism. Some of the denunciations against qualitative studies are that such investigations are conducted with poor methodological rigour and yield findings that cannot be replicated. Qualitative studies have also been labelled as producing evidence which cannot be generalised or applied to other contexts and that is unfocussed and anecdotal. The cynics of qualitative research believe that the bias of the investigator plays a chief role in this (Patnaik, 2013).

As a way to counteract the many criticisms levelled against the qualitative studies field, researcher reflexivity has been proposed. This approach to qualitative investigation openly incorporates the researcher's outlook into the clarification of the findings. Researcher reflexivity has gained a footing in fields such as anthropology, psychology, sociology, and medical and psychiatric case studies. It is the process of reflexive engagement with the data that fosters reliability in findings and defendable interpretations (Patnaik, 2013). Thus, whenever qualitative analysis of information is part of a study, it is necessary for a researcher to be aware of their values and biases that may influence the process. Of chief concern in this study is methodological reflexivity. Methodological reflexivity involves making certain that the standardised procedure chosen for a study is adhered to. Achieving dependable study

findings was a chief concern in this study, and thus the services of an independent consultant were sought in order to realise inter-rater agreement in coding and analysis of the data.

Regarding the author's interest in the present topic, it was during an internship as a Registered Counsellor that a true curiosity regarding culture and trauma developed. Through working as an intern at the Port Elizabeth Rape Crisis Centre and the Dora Nginza Hosiptal in the Thuthuzela Centre, the author encountered many Xhosa women with harrowing stories of pain and hardship. It was in this environment that the author witnessed the manner in which social circumstances interact with the processing of a trauma incident.

Many of the women appeared resilient despite the kind of sexual violence they had endured, and it seemed that all of the women spoke of the importance of their family and friends during this painful time. Stories of how a neighbour had assisted with taxi fee to come for a counselling session, or of how the victims were focusing on their children as a way to temporarily distract themselves from ruminating over the trauma, were common. Each woman seemed to connect the traumatic event to what the experience meant for the collective (e.g. family or household). It was these counselling sessions that peaked the researcher's interest into the interface of trauma and culture.

Given that the resilient spirit of the women appeared to be spurred by their social network, the author elected to investigate the present topic to uncover how other researchers were operationally handling the culture variable in posttraumatic stress studies. It is hoped that this investigation will further the field of psychology by reflecting and amalgamating the findings of cultural operationalisation.

1.5 A Brief Description of the Methodology

The methodology of this investigation is a mixed-method systematic review. Systematic reviews are research investigations which aim to amalgamate the findings of numerous other studies. Reviews of this kind developed as a means to enable the development of improved treatments and as a way to deliver outlines on the state of knowledge within a given field. Although the exercise of analysing or providing commentary on already conducted research investigations has always been present in academia, systematic reviews are thought to be distinguishable because of their adherence to particular criteria (Gough, Thomas, & Oliver, 2012).

The present systematic review is a mixed method review, given that it sampled both quantitative and qualitative journal articles. Both qualitative and quantitative means of interpretation were also employed in analysis of the data. The main aim of the study was to identify and explore the operational use of culture in posttraumatic stress studies. The methodical procedure followed in this review were the twelve steps prescribed by Petticrew and Roberts (2006), and the exact limits employed to search for literature were the following: peer-reviewed research reports, quantitative and qualitative articles written in the English language, published between 1980 and 2018.

Given that many studies mention culture in posttraumatic research, only articles that aimed to identify and explore unique symptom presentations in particular cohorts were included. Research reports that focused on exclusively investigating prevalence and comorbidity in subpopulations were not included. Investigations with a narrow focus on validating a trauma measure in a cohort were also not included. By employing this strategy, the pooled articles were only those which answered the objectives of the study.

1.6 Data Analysis

After completing searches on the selected electronic academic databases, the final tally of articles were gleaned for information using a data extraction form. The pertinent content from each article was effectively summarised using this form. To interpret data extracted from included articles, the researcher employed thematic analysis. Thematic analysis is a qualitative interpretation method which allows researchers to find, examine and report on themes in a set of data (Braun & Clarke, 2006). Thematic analysis is described by researchers Braun and Clarke (2006) as being flexible, since it can be applied in tandem with a theoretical approach or independent of theory. By employing this analytic tool, the researcher was able to gain a detailed account of the studies sampled. The chief focus in amalgamating the data was providing an overview of the operational terms for culture used in the literature and describing the manner in which investigators delineated cultural groups in their investigations. The study was also interested in exploring the reasons provided by researchers for operationalising culture in a particular way for their study.

The data gleaned from included studies was analysed inductively, and at a semantic level. A theme summarising map was drawn up to tabulate each topic covered in the included articles. With regards to analysing quantitative information, percentages were calculated to determine the frequency of operational term use in the data.

As a means of ensuring reliability in the findings, a separate independent consultant scrutinised the manner in which articles were sampled and coded for themes. Through a process of consultation, the final themes were mutually agreed on. Regarding validity concerns, the exact procedure prescribed by Petticrew and Roberts (2006) was followed during each step of the review investigation. A detailed account of this can be found in Chapter 4 of the treatise.

1.7 Ethical Considerations

By and large, ethical matters of interest in research are concerned with averting harm to those participating and also in assisting participants and in the scholarly field as a whole. Upholding ethical standards as a researcher entails not acting in a manner that is to the detriment of study subjects, and in providing a detailed account of data collection, interpretation, and proper citation of material sources (Walliman, 2011). An important ethical consideration during this investigation is the maintenance of neutrality throughout the research process.

To avert possible researcher bias, the methodological protocol prescribed by Petticrew and Roberts (2006) was strictly adhered to. In addition, all material that shaped the writing of this document has been acknowledged in the reference section. Despite there being no ethical concerns relating to participation of a human sample, the study's proposal was submitted for approval from the university's ethical review committee.

1.8 An Outline of the Treatise

Chapter 2 of the treatise deals with the operationalisation of culture in psychological research. In this chapter, aspects such as the definition of culture, cross-cultural psychiatry and global mental health initiatives are discussed.

In Chapter 3, trauma and PTSD in the nomenclature are explained. The chapter includes a summary on the history of the trauma diagnosis, the PTSD diagnosis in the South African context, and, finally, a model of culture and trauma is described.

In Chapter 4, the research methodology is discussed. The history of systematic reviews is given and the methodology employed in the current study is presented. Thematic analysis as

a method of scrutinising the qualitative evidence collected is applied. Lastly, the ethical concerns are also discussed.

In Chapter 5, the findings of the review are presented and discussed. The themes of the review are explained in depth, and the four objectives of the study are also conferred.

Chapter 6 discusses the limitations and strengths of the study and makes recommendations for future investigations.

Chapter 7 is the final chapter of the treatise. This chapter is the conclusion chapter and closes by summarising the entire study.

Chapter Two

The Operationalisation of Culture in Psychological Research

"Culture is the widening of the mind and of the spirit."

- Jawaharlal Nehru

2.1 Chapter Preview

In a cautionary statement, the Diagnostic and Statistical Manual of Mental Disorders (5th ed; DSM-5; American Psychiatric Association [APA], 2013) states that practitioners and academics should be aware of problems of diagnosis where culture, religion, and socioeconomic background result in striking differences between patient and clinician. This provision in the DSM makes having an appreciation of cultural diversity an imperative for all professionals in the psychology field.

The following chapter explores culture by providing the context of how psychiatry as a field and how the nomenclature developed. Some of the contentious issues of psychiatry such as medicalisation and cross-cultural issues are also discussed. The definition of culture is provided and how culture as a research variable has been handled is also touched on. Lastly, the challenges to global mental initiatives are deliberated.

2.2 The History of Psychiatry

To understand culture and posttraumatic stress disorder thoroughly, it is beneficial to gain an appreciation of the development of psychiatry first. By examining the contextual period in which psychiatry was born, one can see the heavy influence of that era on the current study topic. Researchers Oda, Banzato and Dalgalarrono (2005) state that the psychiatry field has influences as far back as the 1800s. It was during the 1800s that a great

deal of social change occurred within the world. Capitalism and the domination of smaller nations by more industrialised nations occurred and new groups of people met for the first time. Understandably, many comparisons and distinctions were made. However, this also resulted in the early years of psychiatry being marked by a great deal of discrimination (Oda et al., 2005).

Psychiatry has its roots in Western ideology, and many of the central concepts about selfhood in psychiatry are based on Western thinking. As a result, many of our existing psychiatric maladies have been conceptualised and categorised with a skew towards Western philosophy. Despite the inherent skew in rationale behind many psychiatric disorders, it appears that contemporary psychiatry is making a move towards integrating knowledge of cultural distinctiveness into the nosology. The research done in this area has helped to establish that culture plays an integral role in how illnesses are recognised and experienced by individuals (Kirmayer, 2012). Apart from influencing how illnesses may manifest, culture is also thought to impact on the likelihood that persons will seek assistance for their ill health. Individuals' thinking regarding who to consult, and at which point help is deemed necessary, is also a function of their cultural leaning. In the interaction between patient and clinician, a cultural power dynamic may also come into play, and the manner in which the illness is articulated is also affected by culture (Kirmayer, 2012).

2. 3 Development of the Nomenclature

The categorical classification of disease within psychiatry has undergone much change since mental illness was first recognised and treated. To begin with, in the early years of psychiatry (around the 1800s), practitioners were largely opposed to the development of an organised taxonomy (Grob, 1994). This is because it was believed at the time that mental illness was an inherently complex and multifaceted phenomenon. Incidents of mental

dysfunction were seen as arising from the breakdown of various systems (i.e. society, nature, and the individual). Those researchers thus attempted to capture the nuanced ways in which this might occur, but it was believed to be a futile exercise. The psychiatrists of this time were more interested in endeavouring to comprehend each individual psychiatric presentation, and then to intervene in whichever curative manner that would best fit. This sentiment prevailed for much of the 19th century (Grob, 1991), and even in the present day, there are still those who feel that the development of the nomenclature is a largely co-opted endeavour. These persons feel that despite how the introduction of nosology brought organisation to the field and enabled greater insights into epidemiology, the present growth of mental disorder diagnoses is possibly a concealed conspiracy by pharmaceutical and insurance agencies. It is thought that pharmaceutical and insurance companies might be most invested in this since they benefit directly from the growth in tendered ameliorative treatments (Alarcon, 2009; Fitzpatrick, 2005; Moynihan, Heath, & Henry, 2002).

With regards to diagnosing a mental disorder, the taxonomies used by professionals most extensively are the DSM compiled by the American Psychiatric Association (hereafter referred to as APA) and the International Statistical Classification of Diseases and Related Health Problems (hereafter referred to as ICD) which is a product of the World Health Organisation (hereafter referred to as WHO). These two manuals are currently in their 5th and 10th editions respectively. The manuals have been compiled in such a way that their separate coding systems are in accordance with one another and this allows for one to easily locate a relevant DSM diagnosis within the ICD for any billing purpose (Sadock, Sadock, & Ruiz, 2015). Although there are variances in how some disorders are expounded on, the DSM is generally considered the customary text which is consulted when diagnosing in psychiatry (McWilliams, 2011).

Much of the debate which plagues the APA is around the manner in which the organisation has begun increasingly to brand many common social experiences as symptoms of illness or as disordered behaviour. It would appear that, together with our advancing of the scientific knowledge of disease, we have also seemingly increased the number of recognised illnesses. Some detractors in the field believe that the reason for our growing number of designated mental disorders is because of financial motivations. This outlook suggests that the industry of psychiatry chiefly operates as a business and is thus driven by the medicalising of human experience (Burns, 2013; Kleinman, 2012; Stein et al., 2010). Ultimately, as authors Maercker and Perkonigg (2013) observe, the chief objective of developing the nomenclature is so that more suitable interventions are devised.

2.4 Criticisms of the DSM

The APA has received a lot of condemnation for its most recent revision of the DSM (i.e. DSM 5). This is because many high profile academics and professionals have openly disapproved of the manual's depiction of mental illness ("Statement of concern", 2013). It would seem that the discontent regarding the fifth edition began even prior to it being released during the Taskforce's research process. Whilst putting together the manual, different field trials were conducted in order to ensure the reliability of the proposed diagnoses. Not all of the findings from these trials were satisfactory, and a second trial of quality control tests was not able to be carried out because of overstretched time constrictions. The second batch of field trials would have enabled researchers to scientifically authenticate their process, nonetheless despite the lack of clarity surrounding the results, the Taskforce opted to continue with their programme because of mounting financial pressures and also to avoid further postponements (Burns, 2013).

Over and above the lack of scientific rigour (validity and reliability concerns) used in establishing the new disease classifications, people are also upset that clinicians can now more easily diagnose certain conditions. Disorders such as Substance Use Disorder, Major Depressive Disorder, and Attention Deficit/Hyperactivity Disorder have been called into question. Grief is also no longer a disqualifier for depression and this, for detractors, is yet another example of how the DSM has seemingly pathologised a highly subjective process (Burns, 2013; Kriegler & Bester, 2014; Haarman, 2014).

Another chief concern for the opponents of the DSM is the possible conflict of interest of the professionals in its taskforce. More than half of the people who were members of the taskforce also declared that they had direct/indirect affiliations with the APA or with the pharmaceutical industry. This begs the question one should ask: have they been swayed by financial interests? With all of the debates and uncertainty which the DSM has faced recently, South African psychiatrist Professor Burns (2013) believes that our country could benefit more from using the ICD as the bar for diagnosis. This transition, he suggests would not be a major change since the ICD is already used as the means by which billing and itemisation are conducted. The ICD is also promulgated by the WHO which receives no monetary gain from the distribution of the manual. Given that South Africa is such a culturally diverse country, careful consideration of illness expression within different cultures is certainly important (Kriegler & Bester, 2014). In the following section, the definition of culture is explored and its operational use is also discussed.

2.5 Defining Culture

When one speaks of culture one may be making reference to a number of different concepts or paradigms. For this reason, an exploration of culture would be best prefaced by delineating between race and ethnicity from culture (Kagawa-Singer et al., 2014). When one

refers to a particular racial group, one is typically referring to persons who have recognisable physical features. One's race is usually based not on biological grounds but on distinctions which are socially constructed. Authors Feller, Ballyram, Meyerov, Lemmer and Ayo-Yusuf (2014) contend that race can be measured both through physical features and through anthropological stratification such as caucasoid, negroid, etc. Although in recent times the concepts of race and ethnicity have been somewhat amalgamated into one (Feller et al., 2014), ethnicity is historically referred to as the identity which is assumed by a collective group of persons who share a heritage. This shared custom may be a language, a belief system, a cultural practice, or even a shared geographic origin. Ethnicity is a notion which persons either personally identify with, or which they are assigned to by others (Kirmayer, Rousseau, Jarvis, & Guzder, 2008).

Ethno-racial categorisations are based on historical social constructions, but the distinctions or the salience of category features may change over time (Bobo & Fox, 2003). Examination of the biological markers between racial groups has shown that systematising persons, and using their physical traits, is an inaccurate way in which to categorise people. Many individuals have a large degree of genetic overlap with racial groups with which they do not identify themselves. In the research, one will find that authors have moved towards using the term race/ethnicity as a broad way of denoting the race and ethnicity categories (Feller et al., 2014). Seeing that culture, race and ethnicity can at times be challenging concepts to work with, it would appear that most researchers have sought to lessen the ambiguity and indistinction by encouraging participants to self-identify with whichever group they believe best represents them. Authors Feller et al. (2014) report that self-identification is the system of classification used in the United Sates and extensively all over the world.

Although race and ethnicity are often used operationally to represent culture (Consortium of Social Science Associations, 2014), they are not characteristic of it. Author Taylor (2003) emphasises that culture is a multipart gestalt of beliefs and practices. Thus narrowing it down to race (a category which is socially constructed and based on physical features) or ethnicity (an assumed identity based on shared customs) may be focusing on a single aspect of the complex whole. Marsella (2010) explains that culture can be defined as the behaviours and meanings which are learned and shared amongst a group of persons. This system of meaning and behaviour is passed on generationally and is intended to assist the group in adapting and surviving in the context in which it exists. Culture can be embodied externally through institutions, artefacts, settings and roles. One can also perceive another's culture by observing their epistemology, beliefs, ontology, values and world views.

Culture is a somewhat neglected variable in most research investigations (Straub, Loch, Evaristo, Karahanna, & Strite, 2002). More often than not, researchers will make mention of culture towards the end of their investigations as a way of accounting for their findings. It is also less common for studies to be concerned with this variable from their outset (Kagawa-Singer et al., 2014). The operational use of culture in research projects has varied (Kagawa-Singer et al., 2014). While some investigators have sought to include culture in studies by means of participant self-identification, others have simply classified participants as they saw fit (Gravelee, Non, & Mulligan, 2009). Examples of commonly employed measurement terms for culture include race, ethnicity, political and geographic margins, home language, and or nationality (Kagawa-Singer, Guamaccia, & Szalacha, 2014).

2.5.1 Individualist and collectivist orientations

When contrasting different cultural groups, researchers commonly cite the collectivist versus individualist orientation as a way to distinguish between cohorts. It has been said that

many insights can be gained from delineating where one falls along the collectivist and individualist dimension. For instance, scholars have reported that aspects such as the manner in which the self-concept is formed, the relational patterns among a cohort, cognitive styles, and key perceptions surrounding wellbeing are can be ascertained using this delineation (Oyserman, Coon, & Kemmelmeier, 2002). People in a collectivist culture are thought to intrinsically view themselves as being part of a larger social group (Straub et al., 2002). They are more likely to put the needs of the group above their own and find a sense of self-assurance in preserving peaceable relations with others (Du, Li, Lin, & Tam, 2014). In contrast to this, cultures that are individualist are oriented in such a way that the individual often prioritises their personal sense of independence and self-determination above the larger communal interests (Nisbett, Peng, Choi, & Norenzayan, 2001). The research by Nisbett et al. (2001) suggests that the collectivist and individualist orientations are the chief determinant in shaping the philosophical and metaphysical outlook of a cultural cohort. This philosophical rationale will inherently incline the group towards a particular method of epistemology.

2.5.2 Operationalising Culture

When a variable has been defined in a manner that is explicit, the process of conceptualisation and operationalisation are easier tasks. Nevertheless, even when studies employ similar definitions of a construct, they may still use different operational terms (Clarke et al., 2008). The reason why investigating culture has been such a challenging endeavour is because there is not only uncertainty around the construct of culture (Kagawa-Singer et al., 2014), but it is also possible for a single cultural cohort to have many heterogeneous elements (Department of Health and Human Services, 2001). If one considers the US as an example, then even though one can group all US Citizens as Americans (sharing

a culture which is characteristic of the US), not every person that is a US citizen is of the same culture One could still find a lot of variability within this single group called "Americans". American Hispanic nationals differ from African Americans, and African Americans have traits which separate them from the White majority of America. A researcher who groups all US citizens into one group may lose sight of nuances which could inform their study. Researchers Kagawa-Singer et al. (2014) state that studies which are not sensitive to in-group differences are likely to typecast and over-generalise.

Establishing in which way to operationalise a construct once it has been defined is a task researchers have to determine before they can investigate it (Miller et al., 2009). An investigator could decide that Americans in their study (or their target population) are only persons that have legal citizenship in only that country, and they may disqualify persons with dual citizenship status. They may choose to exclude persons of foreign descent (such as immigrants or refugees) who reside in the country but who have not as yet achieved citizenship status. What researchers should keep at the forefront of their minds during this narrowing down process are the health beliefs and behaviours of these subgroups which form part of the larger US collective. (Kagawa-Singer et al., 2014) If a researcher suspects that a person who has lived outside of America (either first generation immigrants, refugees, or persons with dual citizenship) holds health beliefs that differ greatly from the US norm, this will make the distinction in operationalisation crucial for the interpretation the study findings.

With regards to operational use of the culture variable in trauma research, it appears that scholars have differently judged how culture should be solidified from the conceptual to the measurable (Clarke et al., 2008). Given that culture is complex, culture is often cited in the literature using dichotomous variables such as ethnicity, race, or ancestry. This methodology of operationalisation has been criticised as employing overly simplistic terms as

proxies in place of a multifaceted construct. Variables such as race, ethnicity and ancestry for example do not take into consideration contextual factors that explain heterogeneity within a group (Kagawa-Singer et al., 2014).

The handling of the culture concept in the literature has been lacking in some respects. However, it appears there is growing cognisance of this. There is also increasing scholarly interest in cultures closely related to the concepts of race and ethnicity. Although race, ethnicity and culture (REC) were not always consistently reported on in the literature, efforts have been made in improving the overall rigour with which all of these three variables are dealt with (Lewis-Fernández & Aggarwal, 2013).

In the United States, it appears that four organisations have attempted to improve the mental health literature pertaining to race, ethnicity and culture (REC). These bodies are the Department of Health and Human Services (DHHS), the Centre for Disease Control (CDC), the National Institutes of Health (NIH is a separate agency of DHHS), and the US Institute of Medicine (IOM). The NIH and DHHS have separately put organised guideline documents together which were meant to assist at standardising the REC concepts (Department of Health and Human Services, 1997; National Institutes of Health, 2001). They also launched initiatives in 2001 and 2011 respectively. The IOM also published a list of ways in which the REC variables could be standardised in 2009 (US Institute of Medicine, 2009). However, the work done by these organisations in this regard has not resulted in notable improvements in the research studies (Lewis-Fernández et al., 2013). Although, there has been an increase in the number of articles which report on REC variables, not all researchers have adopted the prescribed definitions and operationalisations for their studies (Lewis-Fernández et al., 2013).

Though the DHHS, CDC, NIH, and IOM have endeavoured to standardise the reporting of REC variables, to the researcher's knowledge, no study has focused on

examining the operational use of culture in PTSD literature specifically. Thus, a systematic review that takes a closer look at how culture is operationalised, may assist researchers to improve their efforts at studying this concept.

2.6 Cross-cultural Psychiatry

The field of cross-cultural psychiatry was established through the efforts of researchers who were trying to investigate the manner in which culture, race and social influences affect mental health. This branch of psychiatry has been given many names over the years and one may find it mentioned in the literature as cultural psychiatry, comparative and transcultural psychiatry, or as ethnopsychiatry (Oda et al., 2005). Although much of the literature often attributes the genesis of the field to the work of Emil Kreapelin, researchers such as Kirmayer (1993) and Oda et al. (2005) state that the field has influences that date as far back as the 1800s, which was during the period of colonialism and imperialism.

Colonialism and imperialism are two major movements in history which shaped the modern world. Whereas some describe colonialism as the takeover of a nation by another foreign nation, imperialism is generally viewed as a process similar to colonialism but which is driven more by emotional and negative reasons (Stuchtey, 2011). In the chronicles of history, it is noted that the domination of different territories was carried out in ancient times by the Chinese, the Aztec nation that controlled Central America, and even the Roman Empire. However, these earlier fights for power were not marked by the development of the colonised. For this reason, it is events such as the signing of the Treaty of Tordesillas in 1494 by Spain and Portugal that are viewed as the true beginnings of colonial rule. Scholars report that modern colonialism originated in Europe, and every European country is thought to have taken part (either directly or indirectly) in the process of apportioning territories (Stuchtey, 2011). History reports that Spain and Portugal controlled parts of Latin America,

and the British, Dutch and French laid claim in Southeast Asia. Many African countries were taken over by countries in Western Europe (Böröcz & Sarkar, 2012). Academics believe colonial rule was largely pursued for capitalist profit, scientific exploration, as a means to relieve overpopulation in the colonising nations, for religious motives and even for racist causes (Stuchtey, 2011).

In the written accounts of history, some of the earliest mentions of cultural comparison came from the historical records written by colonisers who were encountering new civilisations that differed greatly from their home nations. Many interesting theoretical arguments were made regarding the reason for the stark differences in cultures (Hunter & MacAlpine, 1963). For instance, natural historian Alexander von Humboldt argued that nations that were more industrialised and advanced had more instances of psychological irrationality because of their excessive and chaotic way of life. This thinking was shared by many other theorists, and it was proposed that improving the observation of moral standards would cure people of their excessive and liberal ways which supposedly caused insanity. Once it was found that simply being more virtuous did not in fact cure abnormal psychology, a more biological approach was adopted (Oda, et al., 2005).

Although looking at factors within individuals which contributed to mental breakdown was a step in the right direction, some of the theoretical assumptions made during this time were inherently prejudiced and discriminatory (Hunter & MacAlpine, 1963). For instance, some physicians singled out groups such as Negros and half-breed Brazilians as being susceptible to mental illness. Other thinking was that perhaps a particular religious outlook or climatic conditions could be to blame for higher incidences of mental illness (Oda et al., 2005).

It would seem that even in the present day, racial and cultural issues have still remained a strong influence in psychiatry (Dein & Bhui, 2013). Research suggests that these dynamics play a noteworthy role on the manner in which people consume psychiatric services (Oda et al., 2005). Despite epidemiological studies which point to higher prevalence of mental illness among minority groups, some have suggested that these differences in prevalence could be accounted for by language difficulty, cultural differences, or ethnocentrism. There are also many historical issues which incline minorities to have a higher incidence of mental illness. These include problems such as the extensive emotional impact of years of racial subjugation and persecution, as well as a higher predominance of unemployment amongst minorities (Oda et al., 2005).

It has been suggested that the ethnocentric and racially skewed history of psychiatry could be amended through objective studies which seek to fully appreciate the cultural idiosyncrasies of minority groups (Oda et al., 2005). A large national health survey of Latino and Asian minorities living in the US found that not having sufficient baseline information regarding the psychiatric health of immigrants made it harder to track improvements in these communities and also affected the manner in which national goals were formulated (Algeria et al., 2004).

2.7 Cultural Conceptualisations of Mental Health

During the 1950's to 1960's, researcher Pow Meng Yap discovered a cluster of psychiatric symptoms which he believed were culturally specific to persons in Hong Kong (Crozier, 2018). He termed the illness as a culturally bound phenomenon, since he had only witnessed the condition in persons of a particular culture. What he had in fact discovered was a malady known as Koro, a syndrome which is observable and which is marked by feelings of derealisation and slight depersonalisation in afflicted persons. The condition also

produces intense anxiety and terror around the safety of one's sexual organs. Specifically, his research found that Koro resulted in men dreading that their penises would possibly disappear into their bodies, whilst in women Koro manifested as a fear that the breasts would in some way disappear into the chest cavity (Kohrt et al., 2014).

This discovery represented the first culturally specific syndrome in psychiatric history. This spurred on much research into new and unusual cultural maladies which did not fit into already known notions of illness. The phrase culturally bound syndrome was included in the DSM-IV (Crozier, 2018) as a way of acknowledging the gains made in this area. In the DSM 5, this phrase which speaks of culturally specific conditions is now cultural conceptualisations of distress or CCD. As a result of scholarly displeasure with the culturally bound syndrome label, other labels were proposed. These include "idioms of distress, popular category of distress, cultural syndrome and explanatory model" (Kohrt et al., 2014, p. 366). Despite the proliferation of investigations into culturally unique maladies, some of the challenges of the research in this area are parallel syndromes described by different cultural cohorts, a large array of causal factors being identified, inconsistent symptom patterns which depict the illness, specific groups being susceptible to such illnesses, and particular symptoms which impact on how the cultural cohort labels the malady (Kohrt et al., 2014).

Mental illness and the manner in which it develops and is branded is a complex and intriguing process. Research suggests that mental illness cannot easily be separated from the context within which it occurs. Psychiatric maladies are socially constructed notions and investigations have pointed to the influence that environmental conditions can have on a person's biology and genes. As Kohrt et al. (2014) suggests, all psychiatric conditions are culturally created. Some researchers have gone beyond describing culturally specific syndromes but have also attempted to match the illnesses to already known conditions in the

nosology. Although there is the opinion that this is a good way to authenticate known psychiatric illnesses in different cultural settings, there is also the view that making links between CCD and other known conditions pushes CCD into existing illness categories. Cultural syndromes often have unique aetiological beliefs which go hand in hand with them, and much of the terminology used to depict the conditions is specific to the lay people and professionals of that area (Kohrt et al., 2014).

The global move in psychiatry towards the provision of quality mental health care to persons of all cultural and ethnic backgrounds has increased the need for there to be clarity and consensus around different cultural concepts of distress. There have been ample studies which compare cultural conditions with the existing concepts of psychiatric illnesses. Besides Koro, other examples of cultural conditions that have been discovered include Brain Fag among West Africans (Ola & Igbokwe, 2011) and Dhat among persons from South Asia (Sumathipala, Siribaddana, & Bhugra, 2004). Brain Fag was discovered in the year 1960 by Canadian psychiatrist Raymond Prince. Dr. Prince, who had been working in Nigeria found that among students a certain kind of "brain fatigue" manifested during times of excessive mental exertion. This condition was marked by symptoms such as an apprehensive facial expression, gestures such as rubbing of the person's head, distinctive deficits in sensory ability, deficits in intellectual ability, somatic grievances particularly such as pain and burning sensations in the head and neck region. Other investigations conducted among African students also established the same malady in persons that had been engaged in intensive study (Ayonrinde, Obuaya, & Adeyemi, 2015). Authors Ayonrinde et al. (2015) noted that the Nigerian psychiatrists in their study often recommended that patients receive psychotherapy, medication, and advice on sleep hygiene and better studying approaches.

Another culturally bound condition is Dhat. Found among the male population in India, China, Sri-Lanka and Pakistan, Dhat is an illness that arises from a fear that too much semen is being lost. It may manifest in various somatic, emotional and sexual signs. Symptoms of Dhat can range from panic attacks, to low mood, disproportionate worrying, forgetfulness, generalised weakness, fatigue, loss of appetite, and guilt amongst other signs. Dhat which is essentially a hypochondriac-like fear of losing semen comes from ancient Asian beliefs about the function of semen in the body. In India for instance, the Sanskrit language symbolises semen as strength and courage, and excessive loss of this bodily fluid is believed to result in poor health. Given that this belief is based on folklore, clinicians generally treat Dhat by psycho-educating patients and attending to other primary psychiatric symptoms that may be present. This might include medicines to reduce the acute anxiety in these patients (Chhabra, Bhatia, & Gupta, 2008).

Although the above mentioned conditions may be novel to some, these illnesses are recognised and familiar among the cultural groups in which they occur. The review by Kohrt et al. (2014) found that while many investigations are conducted into culturally specific illness, many of these studies do not elaborate sufficiently or reinforce and build on the understanding of these concepts. In trying to understand culturally specific conditions, researchers have often made comparisons with the existing categories of illness and although this has helped in uncovering areas of overlap, the comparisons also water down indigenous concepts into Western biomedical understandings.

2.8 Challenges to Global Mental Health Initiatives

Cultural orientation influences how individuals experience illness, how they articulate their symptoms, and also their likelihood of seeking help for their condition. Additionally, culture plays a central role in the manner in which a clinician and patient interact. Factors

such as social standing and dissimilarities in power are significant dynamics which influence the patient-physician relationship. Since culture is embedded into people's personalities, certain racial groups are inclined to be at a disadvantage because of the manner in which their social identities are formulated (Kirmayer, 2012).

In societies which have varied cultural cohorts, it is usually the most dominant cultural orientation which has the most influence. The social institutions of a community (for example, schools and health care facilities) will typically express the views of the majority. This has a direct influence on the type of issues which are acknowledged by the collective and also how the issues are prioritised. To increase the sensitivity of professionals to such issues, clinicians have sought to increase their knowledge on all of these influencing variables. The term cultural competence was coined to denote this area of professional development (Kirmayer, 2012).

Even with our awareness of the impact of cultural factors on mental health care service provision, it would seem that often our literature and learning material does not give sufficient context to information. Further, some key psychiatric concepts regarding personhood originate from a particular ethnocultural milieu. To assist in advancing the cultural capabilities of professionals who engage with patients within varied types of contexts, the Department of Health and Human Services in the US has devised its own system of implementation. The system is largely based on the management of cultural differences between patients and clinicians. This system is thought to have both benefits and disadvantages. An adapted version of the strategy is provided below in Table 1. (Kirmayer, 2012).

Table 1 Levels of Cultural Competence

	Institution	Practitioner	Technique
Strategy Examples	Adapting to an organisational culture. Institutional policies of equity, anti-racism, cultural diversity awareness. Ensuring that administration and staff are representative of ethnocultural composition of communities served. Engaging communities in policy making, planning, and regulation of services.	Clinicians' cultural competence. Ethnic matching of clinician and patient. Training of professionals in specific and generic cultural knowledge, skills and attitudes. Referral to other professionals and helpers in the community. Use of culture-brokers or mediators (e.g. translators)	Adapting interventions to meet needs of the specific culture one is presented with. Adjusting style of communication and interaction. Matching intervention to patient. Cultural adaptation of interventions. Adoption of new interventions. Referral to other sources of help or healing.
Advantages	Can organise systems and services in ways that are responsive to needs of specific groups. Can address issues of power and discrimination, empowering community and resulting in greater equity, safety and trust in institution. Can improve access and acceptability through community relationship to the institution and through design of specific programs.	Can facilitate initial trust Linguistic match facilitates communication. Shared cultural background knowledge facilitates mutual understanding. Can provide role modelling of successful or resilient individuals from similar background.	Can tailor intervention to take into account specific psychological or social issues and processes. May improve acceptability of intervention. Can mobilise personal and community cultural resources for resilience and recovery. Can identify culture-specific goals and outcomes that require alternative therapeutic approaches.
Disadvantages	If focus is primarily on representativeness of governance and staff, actual delivery of services may be conventional. Institutional policies may not result in actual changes in behaviours of staff. Ethnospecific services may constitute a form of social segregation and fail to transform the general health care system.	Match may be crude or approximate (owing to differences in ethnicity, subculture, social class, education, dialect, etc.) Clinicians may not know how to apply their own tacit cultural knowledge to clinical care. Clinicians may feel typecast, professionally limited or marginalised. Patients may feel singled out, racially categorised, or stereotyped. Patients may feel exposed to scrutiny by their own community and may wish for the psychological distance or privacy associated with meeting a cultural 'outsider'.	Adaptation may be superficial or purely cosmetic. May lose elements essential for efficacy. Culturally-grounded methods may not address issues related to cultural hybridity or culture change. Culture-specific or traditional methods may be socially conservative and do not allow patients opportunity to escape from culturally rationalised forms of oppression. Interventions may not be familiar or appealing to patients who avoid tradition and value other (''modern'', scientific) approaches.

Adapted from Kirmayer (2012)

The WHO has in recent years made concerted efforts to improve the delivery of scientifically based psychiatric and psychological services to people throughout the world. Their Movement for Global Mental Health (hereafter referred to as MGMH) initiative represents one such endeavour. The philosophy which underpins the MGMH campaign is that psychological health care is vital and should be afforded to all (Patel, Collins, Copeland, & Kakuma, 2011. Despite the campaign's forward thinking viewpoint, some argue that the notion of mental health varies diversely for people throughout the world and thus the seemingly well intentioned efforts of the MGMH campaign signify the indiscriminate application of Western ideology. Some of the counterarguments which have surfaced are that firstly, there is literature which supports the effectiveness of Western interventions among minority groups and secondly, withholding mental health care from certain groups of the demographic because of assumptions regarding possible ill fit harkens back to the racist practices of yesteryear (Bracken, Giller, & Summerfield, 2016).

Currently, psychiatry views mental health issues as entities which can be objectively studied and rectified using empirically based approaches. This technique of mental health care often places dynamics such as relational issues and values on the back burner. The widespread application of this methodology can be problematic since the ontological assumptions which underpin it are integrally related to a particular cultural setting. This outlook has also been described as essentially reductionist since it places emphases on brain malfunctions that result in disorder. Anthropologists however have noted that in other cultural settings, mental illness is seen as a condition which is interwoven with spirituality and other communal dynamics. This viewpoint which prioritises moral and cultural concerns also employs different mechanisms by which it tries to cure mental illness (Bracken et al., 2016).

Researchers Bracken et al. (2016) assert that the WHO's initiative to improve mental wellbeing is essentially an imposition of Western ideology onto nations with differing belief systems. Even though the WHO's MGMH initiative worked in tandem with a diverse group of mental health care workers, there is still a large disparity between developing nations and their developed counterparts. Thus more should be done to include the worldviews of previously disregarded cultures.

2.9 Chapter Outline

This chapter explored the definition of culture and its operational use in research investigations. The history of psychiatry was briefly discussed and cross-cultural issues were also elaborated on. Some chief concerns around clinician sensitivity to cultural matters were also elucidated.

In the following chapter trauma and the PTSD diagnosis are explored.

Chapter Three

Trauma and PTSD in the nomenclature

"Without memory, there is no culture. Without memory, there would be no civilisation, no society, no future."

- Elie Wiesel

3.1 Chapter Preview

Research into trauma has uncovered a wealth of information over the last few years and scientists have learned much about the aetiology, evaluation, and treatment of post-traumatic stress disorder (PTSD). However, a key concern that still remains is how context-specific factors interact with the disorder (Eldridge, 1991).

This chapter explores the construct of trauma and the development of the PTSD diagnosis in the DSM. Aspects such as secondary trauma, complex trauma, and trauma in children are explained. Some research on prevalence of PTSD across different race groups is also explored. Lastly, the chapter looks at a proposed theory of how culture influences the development of PTSD.

3.2 Traumatic Stress

The term trauma has its origins in the ancient Greek language. In that era, trauma suggested a "wound" or an "injury" (Courtois & Ford, 2009). In around the 17th century, the word found its way into the English vocabulary and was used when speaking of a physical injury or acute emotional distress (Oxford University Press, 2016). Within psychiatry, it appears that the word "trauma" was first used in the 19th century in reference to train accidents. During the 1870s, a great number of legal cases were pursued by travellers who

had been involved in railway accidents. The diagnosis of "railway spine" was given to passengers who displayed symptoms such as nightmares, sleep disturbances, post-concussion syndrome, and an aversion to railway travel. Scholars began to debate if "railway spine" resulted from organic brain injury or from psychological distress, and thus the term "traumatic neurosis" was also used to refer to this condition. Given that, in hysteria memories of traumatic events were seen as the cause of symptomology, scholars such as Sigmund Freud, Jean-Martin Charcot and Pierre Janet argued that "railway spine" was quite similar to hysteria (Doctor & Shiromoto, 2010).

It appears that knowledge of "railway spine" was pioneered by Doctor John Erichsen, a surgeon in the United Kingdom (UK). As a medical doctor, Dr Erichsen was called to give testimony in the many litigation cases against railroad companies. Initially, Dr Erichsen hypothesised that physical injures to the spine and head were the likely cause of a number of diffuse symptoms (Bynum, 2001). However, following years of further research and with due consideration of the secondary gains to the complainants in such cases, Dr Erichsen later revised his theory and noted that symptoms could also result from psychological distress. It is interesting that, during court trails, doctors who appeared in the defence of railway companies often gave more credence to the psychological reasons for symptoms, whilst doctors who appeared on behalf of accident survivors often highlighted the physical reasons for symptoms. Author Bynum (2001) notes that generally most contemporary practitioners conceptualise "railway spine" as one of a variety of reactions that could occur following a traumatic incident.

In the present day, the American Psychological Association (APA) recognises a traumatic event as one in which a person's life is threatened, or in which they are confronted with the possibility of grave bodily harm, or sexual brutality. The APA also recognises that

one may be traumatised by witnessing frightening occurrences happening to others, or possibly through hearing about dreadful events occurring to persons to whom they are close. Lastly, it is also thought that frequent exposure to minutiae facts of a traumatic event can bring about a traumatic response (American Psychiatric Association, 2013). Although the APA provides criteria and guidelines for what may represent a traumatic experience which could elicit PTSD symptoms, many authors (McNally, 2004; Rasmussen, Rosenfeld, Reeves, & Keller, 2007; Weathers & Keane, 2007) highlight that the experience of trauma is uniquely subjective for each person and that persons often become symptomatic due to a breakdown in their personal system of meaning.

Researcher Susan L. Ray (2008) suggests that the notion of a traumatising event, put forward by the DSM, is described in Western terminology and is quite individualistic. She believes that this conceptualisation limits our appreciation of the experiences of persons who endure collective violence such as mass killings. For instance, in the studies of human rights stories, it has been shown that some survivors experience trauma over a large portion of their lives. Therefore, employing the term "post" as a way to refer to a particular time following an event, may be erroneous. Often such persons have witnessed people who are dear to them being killed. They have often also endured displacement and loss of significant personal property. Thus, using the term "post" when mentioning this category of people who have experienced unremitting trauma can be complicated.

In the case of persons who have endured extended traumas, terming their reactions as "disordered" can also be morally tricky. It would seem that simply viewing them as naturally reacting to their context would be a more apt description. The label of PTSD carries with it much humiliation and suggests that such persons' reactions are inherently pathological. To label an individual as having PTSD without taking into account the unique social and cultural

contexts that influence their personal appraisal of what they have endured, would be erroneous (Ray, 2008). It has been suggested that an alternative view of such persons be fostered. As opposed to naming them as victims of tragedy, we could choose to empathise with how they have survived the violence in a very brutal society. More could also be done to try to understand the perpetrators of such acts. Surely it is the perpetrators' actions which are a direct rebellion against the cultural and social order in their communities. Thus, examining the reasons behind this level of dysfunction could lead to greater insights (Ray, 2008).

An interpretive phenomenological approach has been suggested as an alternative means of trying to understand the experiences of persons traumatised by collective devastation. This is because the violence which is perpetrated against groups of people obliterates their sense of belonging to a larger whole. Therefore, employing an interpretive approach would better enable us to understand their experience of having a reduced amount of social dependence (Ray, 2008).

With regards to exposure to trauma and the development of PTSD, the research indicates that simply being exposed to a traumatic incident does not guarantee that one will certainly develop the disorder (Maercker & Horn, 2013). Individuals who become exposed to traumatic stressors and do not develop PTSD are typically diagnosed with Acute Stress Disorder. This diagnosis is made if the symptoms have not continued for longer than a month (Doctor & Shiromoto, 2010). In Appendix A of the treatise, a description of the DSM-5 criterion for diagnosis of PTSD is provided.

Factors which researchers believe could be indicators or precursors of PTSD include peri-traumatic dissociation (Johansen, Wahl, Eilertsen, Hanestad, & Weisaeth; 2006), and the perceived imminence or probability of death (Dyregrov, Gupta, Gjestad, & Mukanoheli,

2000). Aspects within individuals which are thought to play a role in how traumatic experiences are perceived include aspects such as personality, previous experiences and cultural perspective (Van Rooyen & Nqweni, 2012). Authors Johansen et al. (2006) suggest that if professionals have more extensive knowledge about the sub-acute reactions that people display following traumatic events, less traumatised persons would develop PTSD. They advise that a study of sub-acute reactions is required in order for there to be better preventative strategies.

3.3 Post Traumatic Stress Disorder (PTSD)

When the diagnostic label of PTSD was first introduced into the nomenclature, it greatly advanced our understanding of human traumatic experience. This is because prior to the diagnosis, clinicians in the field had been examining specific kinds of trauma experiences (e.g. war, natural disasters, motor vehicle accidents, etc.) and had yet to deduce chief psychological features suggestive of severe distress across all kinds of trauma. The DSM construct of PTSD thus put forward the criterion for psychological distress which would potentially account for any severely distressing experience and not only the commonly cited experiences of war, sexual violence, and natural catastrophes. The label also validated that such extreme responses were not exclusively the product of flaws within the trauma exposed persons, but due to the horrendous nature of the stressors they encountered (Doctor & Shiromoto, 2010). Despite the success of the APA in putting forward the first outline, as it were of traumatic distress, the diagnostic label was critiqued and has since undergone considerable alteration as the research in this field advanced (Weathers & Keane, 2007).

At the centre of the debate regarding PTSD was the prerequisite stressor or trauma criterion. Clinicians were concerned that the DSM's description of a traumatic event was too vaguely defined. As a result, the description could not account for instances where persons

experienced profound distress without necessarily facing a "life threatening" event or a "threat to their bodily integrity" as the text described. The APA recognised some of the flawed aspects of their depiction of the illness and later revisions of the DSM sought to correct some of the ambiguity around the disorder (Weathers & Keane, 2007).

The revised DSM III added only minor changes to the PTSD depiction. However, the examples of trauma provided were less narrow and showed an appreciation of the primary reasons for traumatic distress. Additional information regarding differential diagnosis was also provided to assist clinicians avert any misdiagnosis. To prevent the diagnosis of PTSD in persons who experienced subjective distress in the face of relatively low level stressors, the DSM recommended that the diagnosis of Adjustment Disorder was more fitting (Weathers & Keane, 2007). The fourth edition of the manual, released in 1994, gave more benchmarks by which the stressor could be assessed. Despite this, there were still concerns that the representation of a traumatic occurrence remained quite vague. The modified descriptive text gave new specifications which stated that the trauma must have been witnessed or experienced by the person in question. The experience must have also invoked a strong sense of fear and terror in which the individual felt that their life or physique was in danger (Elwood, Hahn, Olatunji, & Williams, 2008; Weathers & Keane, 2007).

When PTSD was proposed as a disorder, its symptoms were presented in three major groups, these being re-experiencing, hyper-arousal and avoidance symptoms (Elwood et al., 2008). In the most recent edition of the DSM, several modifications have been made to the PTSD construct. Primarily, the illness has been reconfigured from a reaction which is solely rooted in anxiety to one which may be also chiefly characterised by feelings of anhedonia or dysphoria. As explained by authors Sadock, Sadock and Ruiz (2015), anhedonia is a "loss of interest in and withdrawal from all regular and pleasurable activities" (p. 1408). Dysphoria,

on the other hand, is a "feeling of unpleasantness or discomfort; a mood of general dissatisfaction and restlessness" (p. 1411). The most crucial criteria which must be met in order for the PTSD diagnosis to be made have been increased to avoid possible over inclusion of persons not significantly clinically impaired by their symptoms. It is thought that the upcoming ICD-11 will also offer an amended conceptualisation of PTSD (Stein et al., 2010). A fourth new category (i.e. cluster D) of symptoms has been added (Maercker & Perkonigg, 2013). This category is named the "negative alterations in cognitions and mood" group (American Psychiatric Association, 2013, p. 271). The disorders criterion A2 is no longer present and 3 more symptoms have been added. This makes the total amount of symptoms for PTSD 20. Other notable changes in the PTSD model are that the disorder is no longer seen as being a problem of anxiety. The chapter named the Trauma/Stress and Dissociative Disorders groups illnesses such as PTSD, Adjustment Disorder and similar other diagnoses under one roof (Friedman, 2014). Appendix B of the treatise is a table that charts the major changes to the PTSD diagnosis.

3.3.1 Historical trauma

Historical trauma has been defined as a multifaceted form of PTSD that is passed on between generations of peoples. As a construct, historical trauma first appeared in the literature of the 1990's on postcolonial adjustment of North American indigenous people (Gone, 2014). When the term was first introduced, it was intended to address several issues. These are: to assist in giving context to the health issues of indigenous people, to reduce the stigma around rehabilitation of indigenous persons, to reduce the levels of self-blame in these communities, and to validate indigenous cultural enactments as therapeutic. In the present day however, the meaning of the term historical trauma is diverse and the term is used widely in academia and in grassroots conversations. Although, colloquially historical trauma refers

to a wide array of issues, the technical definition of historical trauma refers to the damage that resulted from colonial subjugation, the harm done to the collective identities of colonised groups, the cumulative results of colonisation, and the cross-generational effects that are carried over from ancestor to descendant. It is thought that impacts of historical trauma can only be stopped through necessary therapeutic work or "healing" (Kirmayer, Gone, & Moses, 2014).

3.3.2 Secondary Traumatic Stress Disorder (STSD)

STSD is a condition which affects persons who come into contact with traumatised individuals. The illness is described as a pattern of symptoms which manifest suddenly and unexpectedly and that are similar to that of PTSD. STSD or secondary traumatic stress (STS) is considered to be dissimilar from conditions such as emotional exhaustion and burnout because of its characteristic sudden onset. The illness is often seen in health care workers whose professions involve direct contact with traumatised persons. Research has also shown that spouses and family members of PTSD sufferers can also present with the condition. Despite the distinction between STSD and illnesses which are closely related to it, (burnout, emotional exhaustion and PTSD) there are occurrences in the literature where general psychological distress is named in relation to secondary traumatisation. This is particularly so in studies which have looked at the distress experienced by partners of war veterans (Renshaw et al., 2011).

3.3.3 Complex trauma

Complex Post Traumatic Stress Disorder (CPTSD) is a psychiatric construct which was first put forward in 1999 by researcher Judith Herman. Through her studies with persons exposed to trauma, Herman discovered that individuals who were repeatedly traumatised or who had had protracted exposure to deleterious events presented somewhat differently. She

mainly noted that such persons were more likely to present with troubled interpersonal relations, an altered perception of their wrongdoer(s), a changed view of themselves, trouble regulating their affect, changes in consciousness and in their belief system. Herman supposed that such symptoms could be attributed chiefly to the multifaceted nature of the triggering traumatic events (Resick et al., 2012). The fourth edition of the DSM made acknowledgement of the findings in this regard by designating complex post traumatic symptoms under the label of Disorders of Extreme Stress Not Otherwise Specified (DESNOS). Since the construct of CPTSD was relatively new at the time and there were still questions around the distinctiveness of the disorder, the indicators of DESNOS were proposed as additional indicators of PTSD.

Given the growing research into PTSD, since being proposed in1999, CPTSD as a construct has also evolved. However, some ambiguity still clouds the label. For instance, though the literature regarding PTSD will often use DESNOS and CPTSD similarly, the terms refer to different symptom presentations. Whereas DESNOS denotes symptoms of PTSD not included in the DSM criteria, CPTSD denotes symptoms of PTSD as well as other related signs of distress. This uncertainty around CPTS is also evident in a review by Resick et al. (2012) which found that the construct is understood differently by researchers all over the world. In the studies looked at, CPTSD tended to have divergent symptoms listed and also had various kinds of traumas cited as stressor events.

CPTSD as an illness is thought to manifest with symptoms like that of PTSD but with added difficulties in regulatory capacity. These difficulties are often grouped in five sets, these are emotional, attentional, relational, somatisation, and changed unreceptive beliefs. A review of the literature shows that studies often mention different symptoms under each of these five categories. This has made the task of establishing the exact set of sequela uniquely

identifiable as that of CPTSD challenging. For instance, even though affect regulation is commonly alluded to as a chief feature of CPTSD, there are diverse operationalisations provided for the construct. Symptoms such as self-harm, shifts in personality, and hopelessness are also frequently mentioned as signs of CPTSD, however, these are not listed in either of the five symptom categories (Resick et al., 2012).

There is no present psychometric assessment which has been developed to quantify the presence of CPTSD in traumatised persons, however, the Structured Interview for Extreme Stress (SITE) was put together to assist clinicians in assessing DESNOS. The SITE assessment is helpful in that it offers insights into severity of distress, as well as current and lifetime presence of distress. SITE has been criticised since the symptom of dissociation which is thought of as a significant feature of DESNOS is not well factored into the psychometric tool. There are various other psychometric assessment tools which researchers have employed to try and gauge the features of CPTSD. These include scales such as the Beck Depression Inventory, the Negative Mood Regulation Scale, Dissociative Experiences Scale, and the Inventory of Self-Altered Capacities, among many others (Resick et al., 2012).

With regards to how the construct has developed over time, the qualifying stressor is one example of how the concept of a complex trauma has changed. Initially the description of CPSTD stated that that qualifying incidents must have occurred over an extended period or have been compounded by other intensifying factors. However, the research has shown that even a single harmful incident can result in a complex presentation of traumatic symptoms. This is because any event which upsets a person's sense of character can be extremely damaging. Some of the most crucial periods at which individuals are often forming their unique sense of self, is during adolescence and childhood (Resick et al., 2012).

Distinguishing which traumatic events may be more complex than all other trauma events that one might experience can prove to be a difficult task. The research has shown that very often a traumatised person will have endured more than one traumatic incident and thus most presentations that professionals encounter of trauma are in fact complex. There is not yet sufficient evidence which suggests that exposure to complex types of trauma unequivocally causes CPTSD. At present, it would appear that more lucidity and consensus is required if we are to establish that there is a link between exposure to complex trauma and the sequela proposed as CPTSD (Resick et al., 2012).

The current symptomology of CPTSD shares a lot in common with the sequela of symptoms listed for disorders such as Major Depressive Disorder (MDD), Borderline Personality Disorder (BPD), and PTSD. The knowledge that exists has helped separate CPTSD from BPD and PTSD. However, more studies are required in order to differentiate the symptoms of CPTSD from presentations of MDD (Resnick et al., 2012). Due to a lack of empirical backing, the DSM has not yet included the CPTSD syndrome as a diagnosable illness. Despite this, some researchers believe that the changes made to the PTSD criterion echo the features of complex trauma presentations (Maercker & Perkonigg, 2013).

In developing the current fifth edition of the DSM, the Sub-Work group of allied professionals that developed the Trauma/Stress-Related and Dissociative Disorders section had the challenging task of revising the PTSD label, and also studying the literature on prolonged grief disorder (PGD) and CPTSD. Their objective was to determine the distinctiveness of PTSD from these other closely related conditions. During this process of pooling together all of the available knowledge, PGD proved to be a strong contender for inclusion in the DSM-5. However, the condition was relegated to the subdivision of conditions that require further research (Jordan, & Litz, 2014). The condition was also

retitled as Persistent Complex Bereavement Disorder. It is expected that the upcoming ICD-11 will certainly include PGD as a classifiable illness since there is much scientific research into the condition. There has also been a growing amount of research which explores the treatment of conditions such as CPTSD and PGD (Maercker & Perkonigg, 2013).

3.4 Traumatic Stress Reactions in Children

Childhood and adolescents have fluctuating levels of vulnerability to PTSD. This is because childhood and adolescence are crucial times in which one endures many emotional and cognitive changes (Louw & Louw, 2007). Adolescents for instance have been found to be more at risk for PTSD than any other age group. In childhood, one is inherently vulnerable because of the particular cognitive and emotional development taking place at this time, and adolescence presents its own challenges of identity establishment that make dealing with traumatic events even more perplexing. Some of the risk factors making PTSD more likely in persons of a young age include: the death of a parental figure, issues with self-esteem, the presence of a psychiatric condition in a first-degree relative, poor socio-economic standing, and living in a single-parented home (Calitz, de Jongh, Horn, Nel, & Joubert, 2014).

Research has found that there are differences in the manner in which traumatic distress manifests among children in comparison with adults (Anderson, 2005). The symptoms of PTSD are observable in children through re-experiences of the traumatic incident at times when they are possibly resting or bored as opposed to the unexpected flashback memories experienced by adults. Children with PTSD may also re-enact the event through play. They may experience an increase in nightmares of a variety of scary phenomena not necessarily pertaining to the traumatic incident. Traumatised children are also more likely to display particular anxieties, whereas adults will often have a vague sense

of fear. Being highly affected at such a young age can also lead to a child becoming unenthusiastic and feeling that he or she may never reach adulthood (Calitz et al., 2014).

A South African study of children and adolescents that has encountered deeply distressing events found that such children can present with changes in their character and short-temperedness. This in turn has an emotional impact on their relationships with friends and family. They may also be inclined to engage in risky behaviours such as substance use or deliberate self-harm. The difficulties that children have in sharing about their anxiety can result in children acting this emotion out. These behavioural problems can mask PTSD and could be misdiagnosed as possible conduct disorder or problems with attention. PTSD and these conditions can also co-occur, and thus, the conditions should be diagnosed and treated accordingly. The study, which was conducted in the Free State, found that the malady which most often co-occurred with PTSD in their sample was major depressive disorder (Calitz et al., 2014).

After the Rwandan ethnic cleansing which occurred in 1994, thousands of children who were exposed to extreme traumas became displaced. They had met exceptionally traumatic events such as witnessing their family members being killed, having to walk past dead bodies, and watching community members whom they knew commit very brutal acts. Many of the children experienced countless symptoms of PTSD and were visibly affected by what occurred. A study by Dyregrov et al. (2000) found that although the children that lived in shelter organisations also witnessed violent acts, it appeared that what was most predictive of PTSD for the children living in the community were any personal experiences of loss and the feeling of their lives being in danger.

The course of action which was followed in order to assist the traumatised children involved timely reintegration with family and community. This was found to be most

helpful. Organisations such as UNICEF and other NGOS's also established a Trauma Recovery Programme in an effort to help with the healing (Chauvin, Mugaju, & Comlavi, 1998). This programme was guided by the research regarding treatment and employed techniques such as narrative storytelling, and other creative means of expression that helped the children foster a positive outlook following the genocide.

The findings by Dyregrov et al. (2000) show the incredible terror and distress that wars leave in their wake. Therefore, it is important that professionals working with children remember that, despite the notion of children having an incredible capacity for resiliency, they are most certainly human. Not being sensitive to their reactions equates to a disavowal of their distress.

3.5 PTSD in South Africa

South Africa's history contains many interesting contrasts that make its story lively and engaging. Despite the county's past of oppressive political reign and racial segregation, there have been great strides made towards reconsolidation of our diverse cultures and progress towards democratic rule. South Africa's violent past exposed many of its inhabitants to traumas of varying kinds. Yet studies conducted show that, even with the political structure that is currently in place, more than 70% of South Africans have been exposed to events that are gravely psychologically distressing. A study which examined the findings of the South African Stress and Health Survey (conducted over the years of 2002 and 2004) found that, contrary to previous findings which cited interpersonal violence as the predominant type of trauma, it was the untimely death of a someone dear and being witness to a death that were the most prevalent traumatic occurrences (Atwoli et al., 2013). Despite the frequency of exposure to traumatic events, the lifetime prevalence of PTSD for the country was estimated to be 2.3%. Atwoli et al. (2013) note that a possible reason for these

discrepant findings may be due to the DSM's qualifying criterion for PTSD. This opinion regarding the rigidity of certain criteria is shared also shared by academics. Authors Zlotnick, Franklin, & Zimmerman (2002) state that the avoidance criteria may often resultin PTSD not being diagnosed.

Interestingly, the South African Stress and Health (SASH) study found that bearing witness to traumatic incidents was the most common trauma among South Africans. Witnessing trauma also resulted in the most protracted manifestations of PTSD. Authors Atwoli et al. (2013) suggest that South Africans are possibly more affected by witnessing traumatic events because of the cultural spirit of Ubuntu. The spirit of Ubuntu equates personal wellbeing with social cohesion and welfare. Thus, for South Africans who believe in Ubuntu, witnessing violence perpetrated against others can be highly distressing. For individuals exposed to numerous traumas (which was the case for most participants in the SASH study), the sentiment of being helpless was even more prominent. Atwoli et al. (2013) further hypothesised that witnessing multiple traumas possibly influenced the manner in which these memories were shaped. They theorised that since the traumas were witnessed, the memories of these events were perhaps more detailed. Their conclusions are in line with other international studies which looked at the influence that witnessing such events has on persons such as war journalists and rescue workers. Further exploration of the SASH findings suggests that demographic factors did not play a significant predictive role in the development of PTSD (Atwoli et al., 2013).

3.6 PTSD and Culture

The concepts of race, ethnicity and culture are often mentioned in studies of PTSD. This is because researchers have endeavoured to investigate the reasons for disparities in PTSD symptomology and prevalence. Despite the fact that race and ethnicity are commonly

cited as operational terms in the trauma literature, authors such as Feller et al. (2014) report that the use of these notions is marred by controversy. The disagreement around the use of the concepts arises from the history of stereotyping and discrimination of certain racial groups within the field of biomedical research. Scholars that have employed these concepts as variables in their studies have often done so using the rationale that biological differences in racial groups could yield insight into the disparities of illness prevalence. However, authors who are against the use of the race/ethnicity variable contend that exploring socio-economic aspects may be a more effective manner in which to investigate illness, and may also possibly be less offensive to certain parties.

In the US, research has shown that PTSD is more common among certain ethnic groups than in others. Roberts, Gilman, Breslau, Breslau and Koenen (2011) found in their review of a national epidemiological survey that Black or African Americans were more likely to have been diagnosed with PTSD in their lifetimes than White, Hispanic or Asian nationals. Asian citizens were the least likely among all other ethnicities to suffer PTSD. Black persons together with other minority populations were also least likely to seek professional support for their symptoms.

Delineating between racial group, ethnic group and cultural identity has been a challenging task for researchers. As Kagawa-Singer et al. (2014) point out, the stratifying of groups historically has been somewhat erroneous. In the US for example, the Census Bureau of 1977 only provided five racial/ethnic categories which the inhabitants of the country could be designated to i.e. American Indian/Alaskan Native, Asian or Pacific Islander, Black, White, and Hispanic (ethnic origin). There have been several changes made to the manner in which these race/ethnic categories have been stratified, and to date the existing classification system allows for an individual to identify with more than a single race group. The term

Hispanic has also since been expanded to include the group Latino. Hispanic denotes all persons originating from Cuba, Mexico, South or Central America, Puerto Rico, and other countries of Spanish culture or origin (Kagawa-Singer et al., 2014), irrespective of the persons' racial group (Andrews et al., 2015).

The labelling of race/ethnic groups has differed from study to study. For example, in the study by Andrews et al. (2015), the stratification system prescribed by the US Census Bureau was divided into three major groups of people. These are non-Hispanic Black, non-Hispanic White and Hispanic. This study by Andrews et al. (2015) represents just one example of racial and ethnic grouping. However, authors could go about delineating these categories using whichever rationale seems most appropriate to them. The Census Bureau prescribes that the group "White" are all those persons who are part of the lineage of people originating from Europe, the Middle East or North Africa. The term "Black", according to the Census Bureau, refers to those individuals who have roots among the black racial groups of Africa, and the term "Hispanic" is reserved for persons originating from Cuba, Mexico, South or Central America, Puerto Rico, and other countries of Spanish culture or origin, even when those persons are of a different racial group (Andrews et al., 2015).

In historical research on race and PTSD, Roberts et al. (2011) point out that many investigators typically sourced respondents exposed to limited types of trauma, or sampled from particular geographic locations. Roberts et al. (2011) argue that sourcing respondents in this way weakens the generalisability of the findings. This is because certain kinds of trauma are higher in specific minority groups. It is often Hispanic and Black people who experience the kinds of traumas that are most likely to result in PTSD. The events which are thought to be more traumatising are events such as domestic violence and direct assault. Roberts et al. (2011) found that Black people (in the US) have a higher chance of enduring grievous

physical assaults. On the other hand, their White counterparts are more likely to experience the trauma of hearing of an unforeseen traumatic event happening to a person to whom they are close, or of learning about an unanticipated death. Asian persons are more likely to have been exposed to traumas in war related contexts.

With regard to seeking assistance for symptoms, Roberts et al.'s (2011) investigation showed that Black people are often deterred from seeking professional treatment because of perceived prejudicial treatment, racially driven stigmatisation, and / or racial verbal attacks. Interestingly, having a higher socio-economic standing was found to be a protective factor against the development of PTSD. The researchers posited that possibly having greater educational achievement and a higher income (as was found among the Asian population) accounted for the decreased incidence of PTSD amongst some cohorts of the population.

The epidemiological study analysed by Roberts et al. (2011) showed that risk of exposure to trauma can be separated from risk of developing PTSD. Their analysis suggests that Black persons have the greatest vulnerability to developing posttraumatic symptoms despite them being less likely to experience a potentially traumatic incident than their White counterparts. This study by Roberts et al. (2011) illustrates that more could possibly be done to understand what inclines one to develop PTSD.

3.7 A Framework for Understanding Culture and PTSD

The theoretical framework by Van Rooyen and Nqweni (2012) offers a theory of how culture might interact with traumatic memory. The model consists of three legs and considers the dynamic interaction between trauma memory and cultural beliefs and practices in the development of PTSD. In the first component of the theory, the impact of trauma on a person's core cognitions is explored. The second component focuses on the behaviours (i.e

cultural practices) that persons exposed to trauma engage in, and in the final leg of the theory, the symptomology which a traumatised person displays is explored as a function of culture.

3.7.1 How culture influences intrusive memory

Despite that fact that culture is ultimately expressed and experienced differently by all individuals, there may be a common narrative amongst a group of people regarding their collective culture. Understanding that two persons who share a cultural heritage may not necessarily share the same views and or practices helps investigators to uncover more information regarding the reasons for differences in traumatic reaction amongst persons of the same cultural leaning (Van Rooyen &Nqweni, 2012).

A person's memory of a traumatic event may be irreconcilable with their already established core beliefs. These core beliefs that a person holds are their central beliefs of themselves, of other people, and of the world at large. The memory of a traumatic incident which occurred is thought to be traumatising for a person for the very reason that it seems incongruent with what they know to be true about themselves, about others as well as about the world (Van Rooyen & Nqweni, 2012). An example of this can be seen in the instance of a car accident. When an individual experiences a horrific accident in a motor vehicle they may find it difficult to adjust following such an experience. This is because their notion around the safety of cars has been challenged. The person may question their own ability to drive. They may feel terrified about the safety of their loved ones when travelling, or they may feel frightened by the driving of other motorists. Such a person might even feel that automobiles altogether are an unsafe means of transportation.

3.7.2 How culture impacts on the aetiology of PTSD

From research it is well known that exposure to symptom triggering cues can greatly assist to restore one's sense of safety and control following a horrifying experience. (Bradley, Greene, Russ, Dutra, & Western, 2005). It is thought that this method of treatment works when a person is able to feel secure again in a setting that is similar to that in which the trauma occurred. Through exposing themselves to their symptom provoking cues, the person learns that their traumatic experience was an anomalous event and is not likely to occur again. This curative exposure experience helps an individual to restructure their cognitive schemas in a helpful and healthy way (Van Rooyen &Nqweni, 2012).

By looking at the specific cultural practices and behaviours that individuals adopt following a traumatic event, we may be able gain insights as to which persons may be at greater risk of developing PTSD. It is possible for a culture to aid a person's healing by promoting exposure and or seeking assistance for symptoms. On the other hand, a person's culture may also hamper healing if it does not foster an attitude of emotional expression (Van Rooyen & Nqweni, 2012).

3.7.3 How culture influences symptom expression

When one looks critically at culture's influence on PTSD symptoms, it is possible to group the features of the disorder into the categories of involuntary or spontaneous symptoms and effortful or behavioural symptoms. Researchers that make this distinction are able to delineate between symptoms which occur as a result of the neurobiology of PTSD and those which could be considered as being context or case specific. Rasmussen et al. (2007) contend that the flashback memory intrusion marker of PTSD can be seen as an unconscious and automatic symptom of the disorder. This symptom is thought to be caused by the neurobiological reaction which is indicative of trauma. In contrast, the symptoms of

avoidance and emotional numbing can be seen as controlled behaviours which a person erroneously engages in as a means of coping (Van Rooyen &Nqweni, 2012).

Cultures differ in how they choose to express and verbalise their experiences of suffering or distress. By examining these differences in symptom language, (which can also be viewed as differing phenomenological outlooks), researchers may be able to gain valuable insight into the experience of posttraumatic stress within different cultural contexts. The Van Rooyen and Nqweni's (2012) model proposes that culture may in fact also influence symptoms which are thought to be unconscious or automatic. This is because culture influences how one conceptualises one's reality. PTSD (as with any other illness condition) may be conceptualised differently within disparate cultural groups, and thus the specific language of distress which that group uses to understand their condition may have its own set of language cues which trigger symptoms (Van Rooyen & Nqweni, 2012).

3.8 Conclusion

This chapter explored the construct of trauma and the PTSD diagnosis throughout the editions of the DSM. Evidence in existing trauma literature was explored and the differing prevalence rates among specific cultural cohorts were also briefly discussed. A proposed theory for understanding how culture may influence the probability of a person developing PTSD was briefly described.

In the next chapter the research methodology employed in the present study is explained. A detailed account of the research procedure followed in gathering and synthesising articles is also given.

Chapter Four

Research Methodology

"Research is to see what everybody else has seen and to think what nobody else has thought"

- Albert Szent-Gyorgyi

4.1 Chapter Preview

Any endeavour to discover or test new information can be described as research, and a research methodology is the modus operandi by which a quest for knowledge is carried out. The rigour of a study, together with other factors directly contributes to the overall quality of the findings (Walliman, 2011).

This chapter begins by presenting the research aims of the study. It explores the benefits of different kinds of reviews and looks at where the practice of reviews started. Further, reliability and validity concerns are addressed, and a detailed account of the research procedure followed by the author is given. Lastly, the chapter concludes by addressing ethical considerations.

4.2 Research Aims

All research investigations essentially strive to elucidate phenomena or scrutinise theory. Scholars pursue research in order to provide an informed view of the world and, in so doing, not only is present knowledge furthered, but understanding is also advanced (Walliman, 2011). Since researchers began to identify the influence that culture plays in the experience of trauma, there have increasingly been studies which delve into trauma among

different groups of people. Although researchers have achieved consensus around how to define culture, operational use still differs in many health studies (Kagawa-Singer et al., 2014).

By means of a mixed-method systematic review, the present study aimed to identify and explore operational terms for culture used in PTSD literature. The objectives of the present study were:

1. To determine what operational terms for culture are used in posttraumatic stress studies.
2. To identify which operational terms are more widely used.
3. To describe how researchers of PTSD delineate boundaries for cultural groups of interest.
4. To describe different rationales provided by researchers for employing specific operational terms

4.3 The History of Systematic Reviews

In the latter part of the 20th century, research grew tremendously in medicine and allied health professions. This proliferation of research reports has continued into the current millennium and has made the task of keeping abreast with new discoveries a mammoth one. Given that an internet search on a said topic can possibly yield a multitude of hits, reviews appear to be an expedient and practical choice for all scholars (Eysenbach, 2009). This is especially true for medical practitioners, therapists and policy creators interested in the effectiveness, feasibility and suitability of various treatment approaches. Considering that research reports on a topic can range up into the thousands, and that individual studies often provide conflicting results, examining each report one after another may provide limited

insight. Systematic reviews developed in order that studies could be collated to reveal commonalities and inconsistencies in the evidence (Hemmingway & Brenton, 2009).

Endeavours to review and assess existing literature have long been present. However, stringency in the review process only began with the introduction of the systematic review. Typically, systematic reviews have been used as a means to establish treatment effectiveness (Wells, Kolt, Marshall, Hill, & Bialocerkowsk, 2013; Linde et al., 2015). However, more recently systematic reviews have also been employed to assist in demonstrating feasibility. One might find research reviews referred to as narrative reviews, literature reviews, critical appraisal articles, or as commentary articles. Given that such reviews are not conducted according to set protocols, their findings may not always be successfully replicated. Additionally, where enquiries into literature have lacked rigour, reviewers may have included articles to support their subjective view. Paradoxically, though some authors have approached reviews in an objective manner, explicit information on how included articles were selected, examined and amalgamated is often not provided (Hemmingway & Brenton, 2009).

The shortfalls of research reviews became apparent in the 1980s when literature summaries overlooked information in the treatment of heart attack patients (Mulrow, 1987). Had a thorough research review been conducted, the small yet noteworthy effects of clot busters would have been demonstrated more plainly across all the existing literature. In retrospect, this error occurred due to differences in individual researcher speciality as opposed to inaccuracies in the actual primary studies. The summative narrative reports written at the time also proved unhelpful in that they failed to indicate effective therapies, or when reference was made to useful treatments, it was stated that more enquiry was required when, in reality, the amalgamated evidence was undeniable. This case proved how scientific

rigour in review articles is as imperative as the thoroughness of primary studies (Spector & Thompson, 1991).

Similarly, a 1998 study by The Cochrane Library made erroneous claims about the effectiveness of a certain children's inoculation. The article by authors Wakefield et al. (1998) received much scrutiny by fellow scholars in the field. Following this, the majority of the study's authors distanced themselves from the incorrect findings. Nonetheless, the study caused a notable decline in usage of the vaccination. The controversy around the vaccination was later cleared by means of a systematic review which produced credible and conclusive information regarding the safety of the inoculation. Since systematic reviews have differed in quality over the years, several checklists have been produced to enable readers to assess review standards. In recent times, it has become a growing trend for researchers to conduct systematic reviews as a prerequisite in funding endeavours (Hemmingway & Brenton, 2009).

4.4 Criticisms of the Systematic Review

When the systematic review was first proposed, it was intended to bring an equal level of scientific rigour to the literature review process as is expected in all research reports (Hemmingway & Brenton, 2009). Given that systematic reviews have become increasingly popular, this methodology which had in the past been used almost exclusively for improved statistical examination, has also grown to include reviews of qualitative information. Scholars who have used systematic reviews to address qualitative questions have done so, in some cases, to refine theoretical knowledge, to assist in interpreting statistical data, or in a mixed-method synthesis. Authors Gough, Thomas and Oliver (2012) argue that increasing diversity in systematic review types has created discrepancies in the use of review terminology. Although the growth in reviews being conducted is a positive indication of the pace at which scholars are endeavouring to advance knowledge, the variance of approaches

may impact on how future reviews develop and on how findings are applied. At times, the methods in some systematic review procedures are not detailed enough and this makes it possible for researchers to be vague or apply terminology incorrectly (Gough et al., 2012).

The application of systematic review methodologies in qualitative research has generated much discussion. The deliberation over qualitative reviews has only added to the variances in use of terminology and concept application. A typical case of where scant descriptions have resulted in incorrect use is with regards to the notion of quality assurance. The notion of quality assurance can in reality differ according to the research problem. Likewise, PROSPERO (created in order for reviews to be formally registered) and PRISMA (created to improve review quality) are concerned mainly with particular kinds of reviews. What has made the challenge of finding consensus more elusive is that review methodologies are still evolving, and thus, more changes are anticipated as protocols are updated (Gough et al., 2012).

Academics and scholars who are informed on the overall robustness of each review type can make better choices regarding which review method to use. Researchers who have an understanding of the cogency of different review methods are able to: address quality concerns in each step, have better bookkeeping during projects, interpret reviews in an informed manner, commission for studies more appropriately, improve techniques of appraisal of reviews and formulate innovative methods (Gough et al., 2012). Although constructing a classification system for systematic reviews might assist scholars to avert employing review methodologies incorrectly, a careful analysis of the types of reviews demonstrates a large degree of resemblance. The extent of overlap among reviews can also be seen across individual steps of various reviews. Authors Gough et al. (2012) contend that

consensus with regards to terminology use may be difficult to achieve because of the rate at which reviews are multiplying.

4.5 Research Method

A research method is a tool used by an investigator to uncover new knowledge. In order to reach conclusions that are reliable, scholars employ exact research techniques to gather, and analyse data. A researcher may decide to employ any of a variety of different methodologies to address an exact question they have in mind. Selecting a methodology best suited to the hypothetical question at hand persuades reviewers and fellow scholars of the validity and soundness of the newly generated knowledge (Walliman, 2011). A systematic review can be focused on amalgamating primary research reports that are quantitative or qualitative in nature. In recent years, a mixed-method of review has also become established (Harden, 2010).

Since systematic reviews were intended to avert the faults inherent in traditional academic reviews, systematic reviews typically follow a formal procedure. Many different systematic review protocols have been put forward, however there is some criticism around the level of detail in the step-by- step descriptions of review protocols (Gough et al., 2012). Authors Hemmingway and Brenton (2009) argue that the research method of a systematic review should suggest certain basic steps. These steps are described below:

4.5.1 Defining an appropriate healthcare question

This entails delineating clear research objectives, providing exact descriptions of the population of interest and the kinds of studies that would contain the necessary evidence. It is required that an investigator have precise and thorough descriptions as this is essentially the inclusion criteria for research reports (Hemmingway & Brenton, 2009).

4.5.2 Searching the literature

In this step of a review, published and unpublished literature is meticulously searched for studies to be included. To be truly impartial, all the databases should be covered together with non-English sources. However, for the sake of practicality, researchers often search databases using filters. Where possible, experts on the topic and significant authors are consulted. The reference lists in research reports are also hand searched for additional material (Atkinson & Cipriani, 2018).

4.5.3 Assessing the studies

When a researcher has found all the literature on their said topic, he can begin to judge the research reports according to certain criteria. Authors Moja et al. (2005) suggest that all systematic review protocols should assess the following four standards:

4.5.3.1 Eligibility

At this point, the researcher will examine articles against inclusion criteria which they have formulated. It is the full texts of the research reports which meet the pre-set standard that are accessed for further analysis (McCrae, Blackstock, & Purssell, 2015).

4.5.3.2 Methodological quality

At this point, after examining the full texts, a researcher may remove additional studies from the pooled articles. It may transpire that despite an article's abstract appearing relevant to the research question, the full text reveals content that does not adequately address the research aims. From the remaining articles selected, the investigator must then evaluate the methodological quality of each study. This is typically done using a critical appraisal framework (Hemmingway & Brenton, 2009).

4.5.3.4 Data extraction

From the studies which remain, a data extraction form of findings is compiled (University of Wisconsin, 2017). An author might still exclude articles at this point. All of the research reports from which information was taken should be summarised into a list of included articles.

4.5.3.5 Independent reviewers

In principle, reviews should be guided by two independent reviewers.

4.5.4 Combining the results

The outcomes from all of the included studies should then be collated and synthesised. This can either take the form of a meta-analysis, meta-synthesis (also called a meta-ethnography) or a mixed-method approach (Hemmingway & Brenton, 2009).

4.5.5. Placing the findings in context

From the collated findings, a balanced picture can be mapped out of the research problem originally identified. An investigator is then able to comment on aspects such as the overall quality of the studies sample, the likelihood of bias influencing the review, and heterogeneity amongst the studies. Though the usual procedure described in a systematic review protocol appears to be a linear process, it can in actuality be iterative (Harden, 2010). A good quality systematic review will find all the published and unpublished literature on a topic, evaluate the quality of each research report, select articles to include, and then amalgamate the findings in an impartial manner. Nevertheless, it is the good bookkeeping of how each step in the process unfolded that allows for a study to be rightly labelled as systematic (Hemmingway & Brenton, 2009).

The present study is a mixed-method systematic review, since it aimed to descriptively explore the operational use of culture in posttraumatic stress literature. Although reviews that qualitatively explore phenomena are traditionally referred to as narrative reviews, or meta-ethnography, researcher, Harden (2010) asserts that reviews which included both qualitative and qualitative studies fall into the category of mixed-method reviews. In the following section, a brief description of the mixed-method systematic reviews is given

4.6 Mixed-method Systematic Reviews

A researcher's investigation question and overall project aims are what inform the selecting of a research design. Systematic reviews of a quantitative nature (meta-analyses) are compiled using the rationality of aggregation. Conversely, reviews of qualitative information (or meta-ethnographic studies) are compiled using the logic of interpretation. Mixed-method systematic reviews are developed through shared mutual engagement with decision makers in the health field. By observing findings from many systematic reviews, researchers realised that often insufficient evidence hindered scholars from making convincing conclusions (Harden, 2010). In addition, many studies sampled were not methodologically sound enough to be considered for inclusion. As a result, the mixed-method of review was produced to guide scholars in sampling literature that would pertinently address a research problem. The mixed-method form of review is appropriate because it integrates qualitative and quantitative data and is better able to assist in informing policy creation and professional practice. For instance, in the area of social studies as opposed to medical research, it is highly beneficial to look at the pooled synthesised numbers alongside policies and practices in the field. In this way, one is able to uncover not only what the statistics are, but for whom in the population segment (Harden, 2010).

According to author and researcher Harden (2010), a review can be labelled as a mixed-method systematic review if it has any of the following features:

- The study reviews mixed kinds of data reports, i.e. qualitative and quantitative research reports.
- The study amalgamates the findings in both quantitative and qualitative formats, i.e. the data extracted is both statistical (meta-analysis) and qualitative (meta ethnography).
- The study employs more than one mode of analysis, i.e. it attempts to build theory and test theory.

The present study may be termed as a mixed-method systematic review since it aims to answer a numerical research question and also explore and describe the findings. Qualitative and quantitative studies that meet the inclusion criteria were sampled for the purpose of this review, and the combining of the findings entailed using thematic analysis as well as calculating the statistical frequency of operational term usage. The descriptive features of the present study include the intention to name the operational terms in the literature; to explain how investigators have delineated cultural cohorts; and also to describe the rationales provided by researchers for their choice of operationalisation. In the section that follows, a detailed account is given of the research procedure by which research reports were located.

4.7 Research Procedure

Undertaking a systematic review can be a laborious task that entails meticulous scouring of literature and detailed accounting of each step taken in selecting and examining articles. It is this commitment to detailed bookkeeping that makes the systematic review a truly 'systematic' investigation. Systematic reviews conducted without adhering to a

stringent protocol may yield results which are misrepresentative of a topic (Hemmingway & Brenton, 2009). The methodical procedure followed in this review are the twelve steps prescribed by Petticrew and Roberts (2006). The procedure observed may also be referred to as the research design and is essentially the framework employed for gathering and examining data (Walliman, 2011). The steps of the review process are outlined below.

4.7.1 Defining the question

During this stage of the review process, an investigator will determine the question(s) which the review intends to answer. It is recommended that a researcher develop limits for the population which will be investigated, the time frames to be used, and the exact outcome(s) which are of interest (Petticrew & Roberts, 2006).

The initial phase of developing a research question was conducted during the compiling of the research proposal. By becoming acquainted with the literature on posttraumatic stress, the researcher uncovered that a variety of operational terms are employed throughout research reports. The desire to explore reasons behind the diversity of operational terms, and also the rationalisations provided authors for their particular manner of delineating and measuring culture is what inspired the present study.

The limits for the investigation were informed by prior reading on the research topic. The filters described below form part of the inclusion criteria by which the articles were judged. A detailed account of the benchmarks by which articles were examined is included as Appendix C of the treatise. The filters employed to search for studies on different academic electronic databases were the following:

- **Peer-reviewed research reports:** Authors Hemmingway and Brenton (2009) argue that since systematic reviews are an assembled picture of the knowledge in a field,

studies included should be peer reviewed as this allows for medical and allied health professionals to discern treatments which hold greater evidential support for patients. Employing peer-reviewed research reports also enables the review findings to be easily replicated. The present study only pooled journal articles from peer-reviewed publications. This is because unpublished work such as working papers may be subject to change by the author or may be deemed as below scientific standards by fellow academics in the research field (Hemmingway & Brenton, 2009). Although choosing to search for articles from published journals opens a review to the probability of publication bias, careful consideration of this was included as part of the limitations to the study.

As Joober, Schmitz, Annable and Boska (2012) explain, publication bias occurs in instances were investigators refrain from publishing findings that are not largely positive. In the case of journal editors, publication bias may creep in whenever there is incentive to publish research that may secure funding for the journal or that increases the likelihood of being cited.

- **English language studies:** The studies included were only those written in English. Although it was noted that this may open the results to potential language bias, because of funding and time constraints, it was not possible to secure translation of original research reports.

  Authors Morrison et al. (2009) have noted that although English is the universal language in the field of science, English studies that describe positive findings are put out more than those written in non-English reporting negatively. This effect is termed the Tower of Babel bias. This may be critical in areas such as medicine where the international highest ten medical journals are all English periodicals (Morrison et al., 2009).

- **Quantitative and qualitative research reports**: Investigators have explored posttraumatic stress qualitatively among different cultural groups and also quantitatively examined this phenomenon. Although quantitative studies of posttraumatic stress are typically concerned with aspects such as illness prevalence, comorbidity and symptom correlates, in the present study, only quantitative articles with an additional focus of identifying the distinctiveness of PTSD presentations were included in the amalgamated findings.
- **Published between the years of 1980 till September 2018:** The year 1980 was considered to be a good marker from which to begin collecting data since this is the year in which the PTSD label first surfaced in the third edition of the DSM (DSM-III) (Weathers & Keane, 2007).
- **Types of data**: Grey or informal literature such as technical reports, patents and standards were not included as part of the review. The definition of "grey literature" is unclear as publishers of such material do not conform to an identical standard (Nahotko, 2008). However, author Nahotko (2008) states that a few basic characteristics of such literature may be outlined. These are listed below:
    - material that is problematic to identify, access and locate;
    - material that is typically limited in edition;
    - material that is typically not accessible in bookstores and libraries;
    - material that lacks a bibliography registration and is often absent in publisher's catalogues;
    - material that is not available in library collections and catalogues; and
    - literature that is speedily disseminated, unpublished or published with delay.

Books and individual chapters of books were also not included as these are not peer-reviewed (Petticrew & Roberts, 2006). Analysing journal articles which are only sourced through

electronic databases opens the review to possible location bias and time-lag bias (Cochrane Methods Bias, 2018). Time-lag bias occurs when research reports cannot be accessed due to a delay between the publication of an article and its initial submission. With regards to location bias, it has been shown that more accessible journals generally publish studies of poorer methodological quality. Conversely, mainstream high-impact journals generally publish studies of better quality (Cochrane Methods Bias, 2018).

For the reason that studies often mention culture in posttraumatic research, it was decided that articles would be limited only to those which aim to identify and explore unique symptom presentations in particular cohorts. Research reports that focused on exclusively investigating prevalence and comorbidity in subpopulations were not included. Articles which aimed to validate a trauma related psychometric assessment were also not included. By employing this strategy, the researcher was able to catch in the pooled articles investigations which would answer the objectives outlined at the start of the investigation.

4.7.2 Drawing up an advisory group

Petticrew and Roberts (2006) propose that researchers consult with knowledgeable persons who can give direction on a review protocol. This may include practitioners who have used a specific intervention, or possibly other researchers who have already investigated an intervention.

The steering group that assisted in the present study comprised of two research supervisors who played an overall oversight role, as well as an independent consultant who assisted in reviewing the coding and theme development.

4.7.3 Writing a protocol and having it reviewed

The third step of the process prescribed by Petticrew and Roberts (2006) entails that a researcher develops a protocol which describes questions to be answered by the study, the exact type of research reports to be sourced, and the manner in which studies will be evaluated and synthesised. The protocol should be reviewed by persons who have expertise on the topic of interest.

In the present study, the research questions were formulated as study aims and objectives. The study's overall aim or purpose is to identify and explore operational terms of culture in posttraumatic stress disorder literature. From the study's aim, four derived objectives were outlined. The formulation of study aims and objectives was conducted with the assistance of the research supervisors.

To guide information gleaning from included journal articles, a data extraction form was compiled. This enabled that the researcher to assemble the findings in uniform manner. Appendix D of the treatise contains the completed data forms of included research reports. A theme summarising map was also completed to capture the range of topics covered in the articles. The theme summarising map has been included as Appendix E.

4.7.4 Carrying out the literature search

The fourth step of the process prescribed by Petticrew and Roberts (2006) involves searching the literature. This may be done through consulting books, electronic databases, engaging with experts, or looking through material presented at conferences. Authors Morrison et al. (2009) suggest that in order for a systematic review to be deemed as comprehensive, it should at least include searches of two databases. Given that searches in each selected database using the individual search terms ("trauma", "post-traumatic stress

disorder", "PTSD", AND "culture") would yield an astounding amount of hits, a succinct Boolean phrase was created to condense the process. A search using the term "culture" alone yielded 1,734 research reports on the JSTOR database.

The Boolean phrase formulated was the following: ("trauma" OR "posttraumatic stress disorder" OR "post-traumatic stress disorder" OR "PTSD") AND "culture". Searches were limited to the titles, keywords and abstracts of articles. Employing this strategy allowed for the researcher to eliminate research reports that discuss culture in their findings as an afterthought, but that have not operationalised the construct at the outset of the investigation.

The databases used to locate relevant articles included the Nelson Mandela University's online library system which is known as UPECAT and SEALS academic. The site EBSCOhost was also consulted. EBSCOhost is a large directory of research reports that can provide access to numerous other scientific journals, newspaper publications and magazines. EBSCOhost links to several other academic databases which contain valuable information from different allied fields. For the present study, databases that were accessed through EBSCOhost include: Academic Search Complete, E-Journals, ERIC, CINAHL, Health Source: Nursing Academic Edition, Masterfile Premier, Psych Info and Medline. Other valuable sites consulted were Sage, Springer, Science Direct, Taylor & Francis, Emerald, PUBMED, Sabinet (SA e-publications, African Journal Archive, ISAP) and JSTOR.

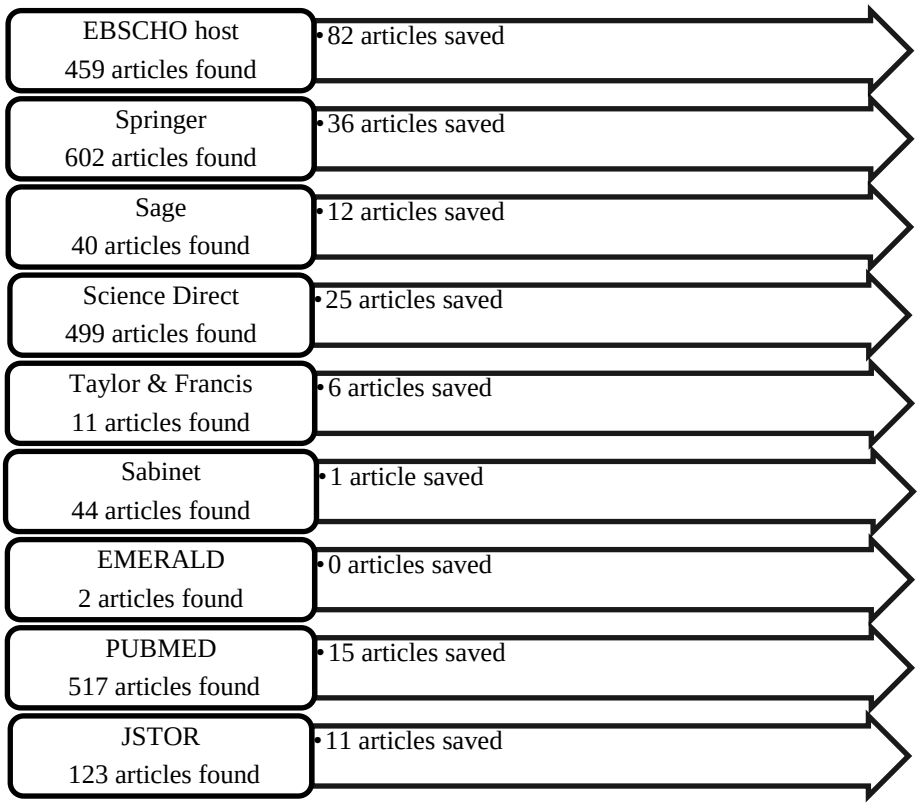
Searches for articles were conducted over a two week period, from 14 September 2018 till 01 October 2018, and a total of 2,297 hits were found in the listed databases. In the database EBSCOhost, additional filters in the form of subject headings were employed to further narrow the results. The headings selected are detailed in Appendix F, under the EBSCOhost results.

Following the searches, Microsoft Word folders were created for each database in which the included articles were stored. Appendix F of the treatise contains the visual images of the database search results.

4.7.5 Screen the references

As prescribed by Petticrew and Roberts (2006), results from searches were examined closely to determine studies to be included for analysis. Examination of search results during this step of the review process entailed inspection of article abstracts. Articles that had abstracts that were irrelevant were disregarded. Journal articles which were deemed applicable as judged by their abstracts were downloaded in PDF format and stored into the respective database folder. A diagram of the filtering down process undertaken is provided in Table 2 below.

Table 2 Filtering of Search Results



4.7.6 Assess the remaining studies against the inclusion/exclusion/relevance criteria

In the sixth step, the articles' full texts were inspected against the relevance criteria. Articles found to be irrelevant after analysis of the full text were discarded. Of the total 188 articles saved, 158 articles were discarded after a full inspection of the full texts.

4.7.7 Data extraction

Using the data extraction form was sourced from the included articles. Important information captured included aspects such as details about the target population, information on interventions, and the methodology of each included article. The completed data forms for the present study are included as Appendix D.

4.7.8 Critical appraisal

Step eight of the review process entailed examining methodological reliability of included articles. Given that articles had to be peer-reviewed to be included, the researcher mainly considered the impact of aspects such as over-representation of articles from a particular journal, author or organisation in the limitations of the treatise.

4.7.9 Synthesis of the primary studies

Findings of included articles were amalgamated. By employing an inductive thematic analysis approach to data analysis, the researcher was able to glean themes in the data.

4.7.10 Consider effects of publication bias, and other internal and external biases.

To assess for bias, in the limitations section of the treatise, the researcher considered aspects such as over-representation of articles from a particular journal, author or organisation.

4.7.11 Writing up the report

The findings from the synthesised results are presented as chapter five of the treatise.

4.7.12 Wider dissemination

At the beginning of the systematic review process, a researcher is expected to decide on the audience for whom the research is targeted (Petticrew & Roberts, 2006). A bound hardcopy of the present treatise will be made available as the Nelson Mandela University South Campus Library.

4.8 Data Analysis

To interpret data extracted from included articles, the researcher employed thematic analysis. Thematic analysis is a theory that guides researchers in unearthing and evaluating the recurring themes in research data. Apart from assisting researchers to describe a set of data, it also often is additionally used to help find understanding. With regards to clarity around the theory, there are those who feel that thematic analysis does not have a distinct title as is the case with methods such as narrative analysis for instance. This confusion around thematic analysis arises from the fact that all techniques of qualitative analysis are premised on thematic exploration. Given that exercises such as thematic coding and general thematising of data occur across various qualitative methodologies, scholars contend that

thematic analysis represents a process common to all qualitative studies and should thus not be viewed as standalone method. As a result, though thematic analysis is frequently employed by academics, not all research work acknowledges use of the theory. It does occur in many research studies that authors use thematic analysis and state it to be a different approach, or they do not state an application of the theory at all. This occurs in instances where authors state that qualitative examination for recurring themes took place but no specificity in describing how this process unfolded is provided. The challenge that imprecise depiction of analysis methods poses to the scholarly field is that it hampers the comparison and amalgamation of studies on a topic (Braun & Clarke, 2006).

Despite many scholars referring to the process of analysis as one where themes are "discovered" or "emerge" from the data, Braune and Clarke (2006) argue that analysis is an active process in which the researcher finds themes and decides on those which are relevant for their purpose. When this is referred to as themes simply "appearing", it is can be misconstrued that themes are located in the literature, whereas themes actually result from a researcher pondering over the data and generating associations.

Authors who subscribe to the realist paradigm of qualitative investigation would assert that a researcher's task is to share the perspectives of their participants, without letting their own subjectivity influence this process. This realist view of research is based on the principle that a "real world" exists and it is free of the investigators' assumptions or constructions. The converse view is held by those who subscribe to a constructivist epistemology. The constructivist approach asserts that all accounts of reality are constructed and there is no way that a researcher can present evidence without it being coloured by their inherent views (Maxwell, 2011). Given that systematic reviews are aimed at reducing bias in synthesis of many studies, a strict methodological procedure is followed in conducting such

an investigation. In regards to the present study, the agreement of an independent consultant was sought to eliminate prejudice in the review process. Authors Braun and Clarke (2006) iterate that it may be somewhat naïve for one to think their research endeavour is totally void of their position. Thus, although no theoretical framework or epistemological approach was chosen at the outset of the study, it would be circumspect to state that the themes and synthesis are a construction by the author. However, this process was also supervised and guided by other persons involved on the project. This is also referred to as triangulation (Walliman, 2011).

Since qualitative interpretation involves mining meaning from data, the process is directly influenced by socially constructed meanings. Reflexivity aims to analyse the lens itself through which the data is viewed. Reflexivity essentially involves an investigator being self-aware during the research process. Given that human beings are subjective, it is the human inter-subjectivity and dialectical engagement that allows for the research process to be thoroughly scrutinised. It has been said that the investigator should be exposed to an equivalent level of analysis as well as the research itself. Although the use of reflexivity in excess can, in some instances, become self-indulgent, it is equally important that the investigator's viewpoint be heard. This not only validates the researcher's thinking in conducting the study but gives integrity to the study in its context (Patnaik, 2013).

The initial step in summarising the literature studies included reading and re-reading the articles in order to become familiar with the article content. It was after a familiarity with the research reports was gained that the developing of initial codes could take place. Codes were generated by means of summarising the prominent arguments in the text of article. By highlighting statements in the articles that appeared prominent, the researcher created succinct labels which condensed the ideas being communicated. Once a first attempt at

creating codes was completed, the researcher then assembled codes together on the basis of similarity. These grouped codes represented prospective themes. Lastly, the final themes were chosen. In Appendix G, a table that demonstrates the code generating process undertaken is provided.

As Braun and Clarke (2006) explain, there are no concrete guidelines regarding how to identify patterns in a data set. Generally, researchers tend to go by which information appears prevalent. Prevalence may refer to the number of topic repetitions throughout the data, or to the level of detail with which a topic is described. In addition, an investigator may simply decide that information most prevalent in a data set is that which is significant to the entire research project.

The author of the present study decided on the themes to be synthesised, or on the "key" themes by reverting to the initial research questions (i.e. objectives) identified at the outset of the investigation. By so doing, the author essentially selected themes that were prevalent by virtue of addressing the intent of the study.

4.9 Inductive and Semantic Analysis of Data

The present study employed an inductive method of analysis to locate patterns in the data. This is also called a "bottom-up" approach, since it aims to find themes that originate in the text as opposed to extrapolating that which will fit into a prior determined framework. Analysis that is guided by a theory mines data that thematically is in line with the theory to be applied. In contrast, the inductive method is driven by the data, and derives themes that bear great similarity within the original data material. Given that themes were developed using actual quotations from the articles, it is the data that informed the final chosen themes.

When data is reported at a semantic level, the surface level meanings are taken as they are and no further meaning is inferred. It is for this reason that the semantic level of analysis is also referred to as explicit analysis. In the present study, the different delineations of a cultural interest group, as well as the rationales for employing a said operational term were taken at face value. No further inferences were made regarding possible core ideas that were suggested in the data. In the following section, the results from the systematic are presented.

4.10 Reliability and Validity

In order for a research study to have merit, besides uncovering information that was previously unknown, the investigators should be able to demonstrate the trustworthiness of their findings (Walliman, 2011). Reliability of a research study refers to the consistency of results during a sequence of assessments (Neuman, 2011). Petticrew and Roberts (2006) assert that reviews which clearly state the method by which research reports are included and excluded ensure transparency and increase the reliability of results. The validity of a systematic review is calculated as the degree of possible bias in the studies on which the review is based, as well as the likelihood of researcher bias existing in the review development (Tricco, Tetzlaff, & Moher, 2011).

In a systematic review, validity may also be considered as the extent of literature studies being reviewed. The Cochrane organisation states that a comprehensive search is one which is also detailed and replicable (Morrison et al., 2009). To ensure that the present study findings may be repeated, a detailed account of the search process is included. In addition, the coding and theme development was assessed by an independent consultant.

4.11 Ethical Considerations

For the most part, ethics in research is concerned with avoiding disadvantaging participants, and where possible engendering benefits to those participating and the scholarly field. An investigator concerned with upholding ethical standards will strive to do no harm to participants, give clear and detailed accounts of data collection and interpretation, and also appropriately cite the work of authors who have inspired the work (Walliman, 2011).

To maintain neutrality and avoid possible researcher bias, the methodological protocol prescribed by Petticrew and Roberts (2006) was strictly adhered to. The studies included and all material that influenced the writing of this document were duly acknowledged as emanating from elsewhere. Although no ethical concerns relating to participation of a human sample were applicable in the present study, the study's proposal was submitted for authorisation at the university's ethical review committee.

4.12 Chapter Conclusion

This chapter provided the aims and objectives of the study. To orient the reader to the methodology employed some history of where systematic reviews originate from and major criticisms against the methodology were discussed. With regards to review research methods, a few key features considered as essential to all systematic review procedures were provided. A detailed description of the exact procedure and protocol adhered to was given. Regarding analysis of the data, the process by which the mined data set was scoured for themes was clarified. In the following chapter, the findings of the systematic review are presented and discussed.

Chapter Five

Results and Synthesis of Findings

"In the middle of difficulty lies opportunity"

- Albert Einstein

5.1 Chapter Preview

Scholar Harden (2010) contends that mixed-method reviews are a powerful way by which researchers make an impact in their respective fields. Since mixed-method reviews are summative reports of both the pertinent qualitative and quantitative evidence, meaning in the data is more easily observable. Where the quantitative information is possibly inconclusive or contradictory, the qualitative data is what may help us understand why this is so.

The following chapter presents the results and discusses the findings in accordance with the objectives of the review. The major themes in the pooled articles are also discussed.

5.2 Results

A total of thirty peer reviewed journal articles were included in the present study. The articles were both qualitative and quantitative in nature and covered countries as far and wide as the United States of America, China, Japan, Cambodia, Uganda, Peru, Namibia and Slovakia amongst many others. Through analysis of the articles, many common subjects were spoken of by the investigators. From the many commonly discussed topics in the pooled articles, three key themes were identified. The three themes are described in the section.

5.2.1 Researcher and participant differences

The differences between researchers and their participants influenced interactions between investigators and participants and also influenced psychometric assessment of symptoms. In studies where authors felt that language and culture hinder effective communication, interpreters and local anthropologists and psychologists were consulted to assist. Author Mennen (2004) noted in her study with abused Latino children that although some children opted to participate in the English language, 42% of children and 72% of caretakers chose to complete Spanish versions of the assessments. Bilingual investigators were also co-opted to aid communication. In addition, Mennen (2004) found statistical differences in PTSD scores between English and Spanish participants which further highlighted that language does influence the research process.

Sensitivity to differences between investigators and their subjects was also observed in the article by Shorer, Goldblatt, Caspi and Azaiza (2018). In this study, one of the authors describes himself as an Arab person, and the fellow three authors are delineated as Jewish. However, the authors assert that they are outsiders to the Bedouin minority community. Thus, despite the ethnic similarity between a single author and the participants, this "outsider" disclaimer is provided to account for the many in-group differences that influence the identity of Bedouin soldiers in Israel.

Many studies addressed language and other cultural differences by employing established alternative psychometric tools. In a study that explored the latent structure of PTSD among adolescent Chinese persons, Chinese versions of the Screen for Child Anxiety Related Emotional Disorders (SCARED) and the Center for Epidemiologic Studies Depression Scale for Children were used. In another study of Kalahari Bushmen, conducted by McCall and Resick (2003), a feasibility study was first done to develop the Ju/'hoan

equivalent of the DSM-IV's description of PTSD. Authors McCall and Resick (2003) acknowledge that translation was an iterative and flexible process in which nuances in the wording were carefully considered in order to find equivalent terms.

Regarding the cultural orientation of the researcher and where this may have differed from the participant(s), it was found that many articles did not mention this detail (Engelbrecht & Jobson, 2016; Karsberg, Lasgaard, & Elkli, 2012; Soysa, 2013; Uji, Shikai, Shono, & Kitamur, 2007). In the article by Tay, Rees, Chen, Kareth and Silove (2015) it was noted that psychiatrists from West Papua New Guinea were consulted in order to assist with the interpreting of the idioms of distress expressed by the participants in the study.

A second theme that was present throughout the articles was the diversity in expression of distress among the cultural groups.

5.2.2 Different expressions of posttraumatic distress

Differences in symptom expression were seen between cultures, and between children and adult groups. Researchers accounted for these differences by highlighting the differing values emphasised by culture and by explaining the historical and circumstantial factors that impacted on the people of a particular group set. For instance, Jobson, Cheraghi, and Moradi, (2016) found that among persons that meet the criteria for PTSD. Persons from an individualistic orientation are more likely to recall specific memories that persons form a collectivist orientation.

Among Cambodians exposed to traumatic events, nightmares appear to be the strongest indicator of trauma maladjustment. Cambodians who experienced nightmares in the study by Hinton, Hinton, Pich, Loeum and Pollack (2009) often also suffered from flashbacks when waking up, trouble returning to sleep and panic attacks. Nightmares are

considered in this culture as a window to the spiritual realm and as indicators of a psychological condition. Thus, interpretation of nightmares and the trauma overtones within them was found to be the method by which Cambodians sought healing following a distressing event. Many cultural rituals and practices were also conducted in to order preserve ontological security.

Researcher Elsass (2001) who interviewed Peruvian and Columbian nationals discovered that PTSD as depicted in the DSM-IV was present among these two cultural groups. However, other additional indications were also mentioned as part of their distress. In Peru, participants spoke of evil thoughts that triggered a burning sensation in the head and bouts of tearfulness. From an ontological framework of the Peruvians, they believe that trauma and its afflictions are caused by spirits of deceased persons and can only be cured through forgetting. The participants who spoke with Elsass (2001) worked to forget their trauma through alcohol consumption or ingesting tranquilisers. The services of medical practitioners, psychologists or indigenous healers were not sought for healing. In contrast, Columbians with posttraumatic symptoms considered treatment as the necessary means by which emotional restoration takes place. Often traumatised persons would seek the services of both a psychologist and a healer. In the context of Columbia, it was also common for diagnosing professionals to fit the additional symptoms expressed by patients into the existing PTSD notion.

For the Kalahari Bushmen, culture hindered the expression of avoidance symptoms. McCall and Resick (2003) found that intrusion and arousal symptoms were acknowledged by all 20 participants in the study but very few participants endorsed avoidance symptoms in the interviews. The authors hypothesised that cultural factors influenced the acknowledgement of these signs of distress.

Many of the studies in the review found similarities in the PTSD diagnosis depicted in the DSM and in symptoms reported by participants. Although some studies did make mention of culturally distinct symptoms among respondents, not as much detail was typically provided regarding the cultural practices which may have possibly worsened or ameliorated their condition.

5.2.3 The stigma of posttraumatic stress disorder

Among some cultures, investigators noted that approaching others for assistance was socially undesirable. In Japan specifically, it was noted that reporting traumatic events (be it a crime, or even sexual violence) was typically met with secondary victimisation. Author Konishi (1998) asserts that the Japanese generally avoid expressing their emotional distress to others. In this context, being resilient and silently handling one's distress is admired, while needing professional assistance for posttraumatic illness is frowned on. In professional interactions, this is seen in the cases of patients who report only their somatic issues. Many times, clinicians have to actively elicit emotional content.

Similarly amongst Arab women, sharing personal problems with intimate partner violence is not readily done. This is mainly because the Arab culture does not socially sanction violence against women. Author Pharaon (2008) asserts that the Arab-American women in her study not only experienced domestic violence a significant stressor, but they experienced discrimination from fellow Americans. The reason for much of the prejudice was for the Arab-American empathy with the committers of the September 11 terrorist attacks. Pharaon (2008) asserted that sensitivity to the possible conflicts that come with being an Arabic person living in America is needed by therapists.

The three core themes that featured across the articles included in this research encapsulate the range of issues that face researchers investigating trauma in different contexts, and the experiences that trauma exposed persons have in seeking assistance. In the section below, the objectives of the present study are addressed.

5.3 Objective one: Describing the operational terms used in the literature

From the thirty articles evaluated, six different operational terms for culture were observed in the research reports. These were namely: geographic location, nationality, race, language, religion and ethnicity. Many studies used two or more terms to delineate their population of interest. This can be seen in the case of authors Shorer et al. (2018) who employed nationality, ethnicity and religion to demarcate the Bedouin military soldiers with whom their probe was conducted. Authors Uji et al. (2007) employed nationality in conjunction with ethnicity to delineate the Japanese women in their investigation. It was also common for studies to rely on a single aspect to classify persons of interest. Nationality was often employed in isolation as an identifier. For instance, this occurred in the studies by Humphries and Jobson (2012), Shannon et al. (2015) and Thielman (2004).

5. 4 Objective two: Establishing the frequency of the operational terms used

In Table 3 below, the operational terms used across the studies are displayed. The combinations of variables used to demarcate the cultural groups under investigation are also given.

Table 3. Operational Terms used Across Included Studies

Operational Term(s)	Articles	Number of articles
Nationality	Articles 5, 6, 8, 9, 13, 14, 15, 16, 17, 21 and 29	11
Ethnicity	Article 18	1
Ethnicity and Race	Article 30	1
Nationality and ethnicity	Articles 19, 23, 25, 26 and 28	5
Nationality and race	Article 22	1
Nationality, ethnicity and religion	Article 10	1
Geographical location, nationality and ethnicity	Articles 1,2 and 11	3
Geographical location and nationality	Article 3, 12 and 27	3
Geographical location and ethnicity	Articles 4, 7 and 20	3
Geographical location, nationality and language	Article 24	1

To demarcate culture groups, 36.67% of article authors employed nationality alone as the operational term. Seventeen percent of authors operationalised using nationality and ethnicity in tandem. Ten percent used location, nationality and ethnicity variables in combination, another 10% of articles used location and nationality, and location and ethnicity respectively. Location, nationality and language were used in tandem in one (3.33%) of the articles sampled. Nationality, ethnicity and religion were used to demarcate a group in one

(3.33%) of the articles, and ethnicity was employed singularly in one (3.33%) article. Lastly ethnicity and race were used to demarcate a cohort in 10% of the articles included.

5.5 Objective three: Describing researchers delineation of cultural groups of interest

In the main, very little information was provided by authors regarding the boundaries set in place for the cultural groups being studied. Although authors that provided a definition for culture also gave context regarding the cohorts being investigated, information regarding the rules applied in choosing this group was almost never given. For example, in the article Ross, Kaliská, Halama, Lajčiaková, & Armour (2018) nationality was used to choose participants, however, no explanation was provided regarding whether Slovakian nationality was restricted to natural born citizens, or also included persons that had acquired citizenship. Similarly in the journal article by Thielman (2004), participants are delineated on the basis of nationality, but no further information regarding what qualified persons as Kenyan is available.

Articles that described the different racial, ethnic, religious and linguistic groups in a location where an investigation was conducted assisted by providing specificity. By giving sufficient contextual information, it became more apparent why the authors had chosen to probe further with a particular cohort of persons. For instance, in the article by Shorer et al. (2018) the Bedouin Israeli veterans with whom the study was done are described as Muslim believers of Arab ethnicity. They are a minority ethnic and religious group in Israel and as a result, they often feel tension between themselves and their fellow soldiers. Given that joining the army is optional for the Bedouin community and conscription is enforced on to the Jewish majority, the authors' exploration of trauma in this cultural cohort appears justified. The culture being investigated was also clearly described.

Many articles employed geographic location in tandem with other variables as an operational term (McCall & Resick, 2003; Schnyder et al., 2016; Soysa , 2013; Weierstall, Schalinski, Crombach, Hecker, & Elbert, 2012). This was done by authors that were investigating trauma among refugees, immigrants, people indigenous to specific locations, and among persons who endured distress at specific locations. For example, the study by Mennen (2004) assessed trauma symptoms in abused children from the Latino community in North America, and location and ethnicity were used to operationalise culture. The investigator states the population with whom the study was conducted are of Spanish descent currently living the US. No further information was given by the author regarding whether the children were citizens of the US, or migrants from South America. In the article by Soysa (2013) location, nationality and ethnicity are employed to demarcate the population studied. The investigator explored trauma in two groups. One group is described as the Sinhalese ethnic group located in specific villages of Sri-Lanka, and the second group are simply described as Sri-Lankan. Contextual information regarding the number of ethnic groups in Sri-Lanka was not provided.

Authors Kagawa-Singer et al. (2014) contend that with respect to mental health research, specificity in delineating cultural cohorts may assist with subsequent operationalisation. Since it is thought that subgroups in a populations act in accordance with their own beliefs sets, it may be most beneficial for researchers to observe health beliefs and behaviours when selecting operational terms.

5.6 Objective four: Describing the rationales provided for operational term usage

Almost all studies provided the rationale that the population groups investigated where "understudied", however, no additional information was provided that described the logic behind the manner in which culture was operationalised. Although authors that prefaced their

investigations with context were able to demonstrate the unique features of their said cultural groups, explicit statements explaining the including and excluding criteria were not always presented. For example, in the article by Phillips, Rosen, Zoellner, and Feeny (2006), the authors cite the dearth of non-Western studies as the rationale for their investigation. The participants in the study are Malaysian women of various ethnicities (i.e. Chinese, Malyan and Indian), and the symptoms of the women are contrasted with the presentations of an ethnically diverse US female sample. The in-group differences in each of the respective groups are discounted, and nationality alone is used to measure culture, since it is presumed that the Western and non-Western dichotomy is not sufficiently explored.

In some articles, it was unclear if authors had relied on ethnicity or nationality as an identifier. For such research reports, both ethnicity and nationality were taken as the operational terms. This occurred in studies such as the Uji et al. (2007) article, as well as the Tay et al. (2015) article. In the study by Uji et al. (2007) traumatic sexual experiences are explored with a Japanese population. However, in line with the ambiguity that exists around this cultural group, the authors do not explicitly state whether participants were accepted on the basis of the language they spoke, by virtue of being Japanese nationals, or because of the ethic group to which they subscribe. Japan actually consists of many diverse ethnicities, some of whom were colonised generations ago during the Japanese Imperialist movement (Lu, Menju, & Williams, 2005). The term Japanese can be used to connote both ethnicity and nationality. In addition, many experts and non- experts categorise Japanese under the broad category of the Asian race group.

Authors that provided reasoning for their operationalisation included Humphries and Jobson (2012) and Jobson and O'Kearney (2008). In the aforementioned articles, culture is defined using the collectivist and individualist conceptualisation. The persons sampled are from various countries. However, a psychometric assessment is used to measure the

participant's orientation along the collectivist/individualist continuum. The psychometric tool used is the Twenty Statement Test (TST) which requires that respondents reply to the question "Who am I?" by giving 20 statements. The Humphries and Jobson (2012) and Jobson and O'Kearney (2008) research reports also provide context on the collectivist/individualist dimensions, and explain how the collectivist and individualist orientations are anticipated to interact with trauma memories. The aforementioned articles are also set apart from other studies in this review since they included a psychometric assessment of culture.

Although all the research articles included in this study endeavoured to explore trauma in diverse cultural settings, not all articles provided a clear definition for culture. In addition, though many authors cited the lack of knowledge from non-Western cohorts as the motivation for their investigations, many did not provide adequate descriptions of the cohorts with whom their investigations were conducted. It appears that in line with the sentiments expressed by Kagawa-Singer et al. (2014), regarding culture in mental health research in general, culture is presently poorly operationalised in the traumatic stress literature. Thus, although scholars agree that greater understanding of the culture construct is required in order for us to learn more about the different expressions of traumatic distress, culture itself is still somewhat glossed over in many studies.

5.7 Chapter Outline

This chapter presented the findings of the investigation and the themes derived from synthesis of the articles. The three key themes were also discussed in detail. In the following section, the strengths and limitations of the current review are presented.

Chapter Six

Strengths, Limitations and Recommendations

"The greatest obstacle to discovery is not ignorance - it is the illusion of knowledge"

- Daniel J. Boorstin, 1984

6.1 Chapter Preview

Investigations that centre on human ideas and judgements are enriched through scholarly explanation. In addition, since qualitative information is generally communicated through words rather than numbers, qualitative investigations typically hinge on the expanding of concepts (Walliman, 2011). In this chapter, a discussion on the strengths and limitations of the study is presented. Recommendations are also made for future studies in this field.

6.2 Strengths and Limitations

Some of the limitations in the present study include the possibility of publication, location, language and time-lag bias. Given that not all scholars submit their research reports to the databases selected herein, it is possible that this review missed other germane and pertinent articles. Searching for articles from electronic databases made the current review vulnerable to time-lag bias. Scholars believe that the time lag between when articles are submitted to academic journals until when they become published is influenced by the outcomes of the article for the following reasons: Research has shown that studies which find positive results reach publication earlier than studies which find negative outcomes. The consequence of this is that research reports with positive findings are generally overrepresented in many databases (Reyes, Panza, Martin, & Bloch, 2010). In the current systematic review, it is likely that studies which did not find unique features of PTSD were delayed in their publication, and were thus not able to be pooled. Given that the current study only sourced English language studies, it may be said that the findings are influenced by

language bias. Since studies with positive findings are found more in English language journals, it is possible that other articles which did not find positive results of unique expressions of PTSD were missed.

Only 2 articles of the total articles found were from scholars on the African continent. It can thus be said that European, American and Asian studies are overrepresented. A strength of the current study is that it relied on peer-reviewed reports and searched from 9 different locations. In addition, since an independent party was consulted, it may be said that a fair degree of interrater reliability was able to be achieved. The articles sampled included cultural groups from Japan, Namibia, Uganda, America, the United Kingdom, China, Cambodia, Israel, Kenya, Brazil, Germany, Peru, Columbia, Sri-Lanka, Greenland, Iran, Britain, Netherlands, Australia, Slovakia, Ethiopia, Somalia, Indonesia, Vietnam, India and Malaysia. The large number of countries included may be viewed as strength since a wide array of posttraumatic reactions were explored.

6.3 Recommendations

Co-ordinating health initiatives on a global scale can be a challenging task. However, given that many studies found similarities between the PTSD depiction in the DSM and the cultural groups investigated, it may be necessary for a list of groups in which the diagnosis has been validated to be compiled. This may focus future investigations in the field. By creating a database for PTSD studies, or possibly by adding other discovered manifestations of traumatic distress to the DSM, more clinicians would have access to this knowledge. This would also enable future research regarding culturally distinct expressions to be collated into one source.

For the clinicians who diagnose and work therapeutically with traumatised persons, in line with what the DSM (and the psychotherapy philosophy as a whole) prescribes, it is necessary to keep an open mind to the many cultural dynamics that influence posttraumatic

distress. As author Kirmayer (2012) asserts, the most circumspect approach may involve modestly managing the differences between the culture of the professional and that of the patient. For practitioners who are diagnosing in a context that differs drastically from their own, being considerate of other cultures may mean using the services of culture-brokers such as translators, local physicians or anthropologists who can provide necessary context. With respect to counselling, therapeutic interventions can be tailored to meet the specific concerns of the patient. However, it has also been noted that too much amendment may impact on the efficacy of the treatment. Clinicians should keep in mind that with increasing globalisation, many cultures are a hybrid mix and rarely maintain their traditional form.

Researchers of PTSD may need to consider the unique contexts of the target population being studied in order to ensure that the best operational terms of culture are employed. Societies around the world are increasingly becoming multi-cultural and people adopt and adapt their cultural views in response to their evolving contexts. Hence, self-identification is most commonly used as a means for participants to choose the cultural orientation that they believe best describes them. Thus, for future investigations to be successful researchers may need to keep in mind how complex culture is and how individuals adapt their views in their own individualised way

6.4 Chapter Outline

This chapter reflected on the strengths and limitations of the current study. The influence of possible bias was considered and recommendations for future research were also briefly discussed. In the following chapter, a few closing remarks are made.

Chapter Seven

Conclusion

What I've found in my research is that realism and self-honesty are the antidote to ego, hubris, and delusion.

- Ryan Holiday

7.1 Closing remarks

Aspects such as ethnicity, racial category, and nationality all influence identity formation (Ford, 2008). Thus, for an individual's traumatic experiences to be fully appreciated, not only do practitioners need to take into consideration personal experiences of trauma (sometimes in the family context) but also communal group experiences that impact on a person. Although authors Lewis-Fernández et al. (2013) argue that standard use of the culture variable is necessary in the mental health field, the present study has shown that optimum operationalisation could differ from case to case. This is because subtle differences in health beliefs and behaviours exist in between groups. For instance, in the South African context, using the race categorisations of Black, Caucasian, Coloured, and Indian may be inadequate for a traumatic stress study. Xhosa speaking Black South Africans and Setswana speaking South Africans share a nationality, but have other distinct cultural traits that distinguish them from each other. Whereas a Tswana speaking person may be more likely to self-medicate their illness using herbal potions and avoid seeing a professional, a Xhosa may be more likely to consult a traditional healer and even possibly a medical practitioner concerning their malady. Researchers into posttraumatic phenomena should thus always take the ontological perspectives of a cultural cohort, as these are what determine what the group will perceives as traumatic, how they recognise symptoms of distress in themselves, and also from whom and at which point they seek assistance.

There may be a need in the posttraumatic stress research field to amalgamate the global findings and to consolidate this into a single and accessible form. By doing this, practitioners would be able to better diagnose and treat people that do not come from the Western hemisphere. This is because different cultures have their own notions of what constitutes mental health and disease. Thus, efforts at intervening within different communities should first be informed by the unique epistemology of that particular context.

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Appendix A

DSM-5 Posttraumatic Stress Disorder 309.81(F43.10)

Note: The following Criteria apply to adults, adolescents and children older than 6 years.

Diagnostic Criteria	
A. Exposure to actual or threatened death, serious injury or sexual violence, in one (or more) of the following ways:	
1.	Directly experiencing the traumatic event(s).
2.	Witnessing in person the event(s) as it occurred to others
3.	Learning that the traumatic event(s) occurred to a close family member or a close friend. In cases of actual death or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4.	Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse) **Note:** Criteria A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.
B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:	
1.	Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). **Note**: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
2.	Recurrent distressing dreams in which the content and/or affect of the dream are related to traumatic event(s). **Note**: In children, there may be frightening dreams without recognisable content.
3.	Dissociative reactions (e.g. flashbacks) in which the individual feels or act as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum with the most extreme expression being a complete loss of awareness of present surroundings.) **Note:** In children, trauma-specific re-enactment may occur in play.
4.	Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5.	Marked physiological reactions to internal or external cues that symbolize or resemble

	an aspect of the traumatic event(s).
	C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one (or more) of the following:
1.	Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
2.	Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situation) that arouse distressing memories, thoughts or feelings about or closely associated with the traumatic event(s).
	D. Negative alterations in cognition and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by tow (or more) of the following:
1.	Inability to remember an important aspect of the traumatic event(s) (typically due to dissociate amnesia and not to other factors such as head injury, alcohol, or drugs).
2.	Persistent or exaggerated negative beliefs or expectations about oneself, others, or the world (e.g. "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
3.	Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
4.	Persistent negative emotional state (e.g. fear, horror, anger, guilt, or shame)
5.	Markedly diminished interest or participation in significant activities.
6.	Feelings of detachment or estrangement from others.
7.	Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).
	E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
1.	Irritable behaviour and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression towards people or objects.
2.	Reckless or self-destructive behaviour.
3.	Hypervigilance.
4.	Exaggerated startled response.
5.	Problems with concentration.
6.	Sleep disturbance (e.g., difficulty falling or staying asleep, or restless sleep).

F. Duration of the disturbance (Criteria B, C, D, and E) is more than one month.
G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
H. The disturbance is not attributable to the physiological effects of a substance (e.g. medication, alcohol) or another medical condition.

Specify whether:

With dissociate symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalisation:** Persistent or recurrent experiences of feeling detached from and as if one were an outside observer of, ones mental processes or body (e.g., feeling as if one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, distorted).

Note: to use this subtype the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behaviour during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Specify if:

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

Taken from the Diagnostic and Statistical Manual of Mental Disorders (5th ed; DSM-5; American Psychiatric Association [APA], 2013, pg. 271-272)

Appendix B
Changes to Criterion A in PTSD diagnosis

Criterion A and Accompanying Text in DSM-III
Existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone. **1.1**. . . . a psychologically traumatic event that is generally outside the range of usual human experience. **1.2.** The stressor. . . would evoke significant symptoms of distress in most people, and is generally outside the range of such common experiences as simple bereavement, chronic illness, business losses, or marital conflict. **1.3.** The trauma may be experienced alone (rape or assault) or in the company of groups of people (military combat). Stressors producing this disorder include natural disasters (floods, earthquakes), accidental man-made disasters (car accidents with serious physical injury, airplane crashes, large fires), or deliberate man-made disasters (bombing, torture, death camps). **1.4.** Some stressors frequently produce the disorder (e.g., torture), and others produce it only occasionally (e.g., car accidents). Frequently there is a concomitant physical component of the trauma, which may even involve direct damage to the central nervous system (e.g., malnutrition, head trauma). The disorder is apparently more severe and longer lasting when the stressor is of human design. **1.5.** In Adjustment Disorder, the stressor is usually less severe and within the range of common experience; and the characteristic symptoms of Post-traumatic Stress Disorder, such as reexperiencing the trauma, are absent.

Criterion A and Accompanying Text in DSM-III-R
The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone, e.g., serious threat to one's life or physical integrity; serious threat or harm to one's children, spouse, or other close relatives and friends; sudden destruction of one's home or community; or seeing another person who has recently been, or is being, seriously injured or killed as the result of an accident or physical violence. **2.1**. . . . a psychologically distressing event that is outside the range of usual human experience (i.e., outside the range of such common experiences as simple bereavement, chronic illness, business losses, and marital conflict). **2.2.** The stressor producing this syndrome would be markedly distressing to almost anyone, and is usually experienced with intense fear, terror, and helplessness. **2.3.** The most common traumata involve either a serious threat to one's life or physical integrity; a serious threat or harm to one's children, spouse, or other close relatives and friends; sudden destruction of one's home or community; or seeing another person who has recently been, or is being, seriously injured or killed as the result of an accident or physical violence. In some cases the trauma may be learning about a serious threat or harm to a close friend or relative, e.g., that one's child has been kidnapped, tortured, or killed. **2.4.** The trauma may be experienced alone (e.g., rape or assault) or in the company of groups of people (e.g., military combat). Stressors producing this disorder include natural disasters (e.g., floods, earthquakes), accidental disasters (e.g., car accidents with serious physical injury, airplane crashes, large fires, collapse of physical structures), or deliberately caused disasters (e.g., bombing, torture, death camps). **2.5.** Some stressors frequently produce the disorder (e.g., torture), and others produce it only occasionally (e.g., natural disasters or car accidents). Sometimes there is a concomitant physical component of the trauma, which may even involve direct damage to the central nervous system (e.g., malnutrition, head injury). The disorder is apparently more severe and longer lasting when the stressor is of human design. **2.6.** In Adjustment Disorder the stressor is usually less severe and within the range of common experience; and the characteristic symptoms of Post-traumatic Stress Disorder, such as reexperiencing the trauma, are absent.

Criterion A and Accompanying Text in DSM-IV
The person has been exposed to a traumatic event in which both of the following were present: ***(1)*** *the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.* ***(2)*** *the person's response involved intense fear, helplessness, or horror.* ***Note****: In children, this may be expressed instead by disorganized or agitated behavior.* **3.1**. . . . an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (Criterion A1). **3.2.** The person's response to the event must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behavior) (Criterion A2). **3.3**. Traumatic events that are experienced directly include, but are not limited to, military combat, violent personal assault (sexual assault, physical attack, robbery, mugging), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disasters, severe automobile accidents, or being diagnosed with a life-threatening illness. For children, sexually traumatic events may include developmentally inappropriate sexual experiences without threatened or actual violence or injury. Witnessed events include, but are not limited to, observing the serious injury or unnatural death of another person due to violent assault, accident, war, or disaster or unexpectedly witnessing a dead body or body parts. Events experienced by others that are learned about include, but are not limited to, violent personal assault, serious accident, or serious injury experienced by a family member or a close friend; learning about the sudden, unexpected death of a family member or a close friend; or learning that one's child has a life-threatening disease. **3.4.** The disorder may be especially severe or long lasting when the stressor is of human

design (e.g., torture, rape). The likelihood of developing this disorder may increase as the intensity and physical proximity to the stressor increase.

3.5. In Posttraumatic Stress Disorder, the stressor must be of an extreme (i.e., life-threatening) nature. In contrast, in Adjustment Disorder, the stressor can be of any severity. The diagnosis of Adjustment Disorder is appropriate both for situations in which the response to an extreme stressor does not meet the criteria for Posttraumatic Stress Disorder (or another
specific mental disorder) and for situations in which the symptom pattern of Posttraumatic Stress Disorder occurs in response to a stressor that is not extreme (e.g., spouse leaving, being fired).

Taken from Weathers & Keane (2007) The Criterion A Problem Revisited: Controversies and Challenges in Defining and Measuring Psychological Trauma

Appendix C

Inclusion, Exclusion and Relevance Criterion

Criterion	Yes	Can't Tell	No
Inclusion Criterion			
Article explores posttraumatic stress in a particular cultural group			
Article is between the years of 1980 and 2018			
Article is written in the English language			
Article is peer-reviewed			
The study employs either a qualitative or quantitative research methodology (study may be a non-randomised intervention study, observational study, quantitative study, qualitative study or randomised controlled trial)			
The article author (s) has operationalised culture in the investigation			
The article refers to an identifiable / distinguishable traumatic event			
The traumatic event(s) described seem reasonably threatening enough to generate a pathological reaction (i.e. the response is out of the normal range behaviour for the particular culture being examined)			
Exclusion Criterion			
The article is not an original research report (is a commentary paper, or a secondary research report)			
The article deals with historical trauma amongst a cultural group			
Relevance of study			
Article deals with unique clinical traumatic stress symptoms of a cultural group			
Article trauma symptom profiles among differing cultural groups			
Included or Excluded (if excluded, provide reasons)			

Appendix D

Data extraction form

Article 1: War and Tsunami PTSD Responses in Sri Lankan Children: Primacy of Re-experiencing and Arousal Compared to Avoidance-Numbing (2013) **Author(s): Soysa, C. K.** **Name of peer reviewed journal: Journal of Aggression, Maltreatment & Trauma**	
Data of Interest	**Information Provided**
Objectives of the study; rationale for including culture as a variable:	Article investigated the possibility of a cultural pattern in the presentation of PTSD symptoms in Sri Lankan children; Re-experiencing and arousal symptoms are understudied in South Asian population
Definition of culture:	No definition is provided
Culture of interest; Specific boundaries set for the investigation (inclusion/exclusion criteria):	Sri Lankan culture; Study 1: Sinhalese Sri Lankan children living in villages along the northern and eastern borders; and study 2: Sri Lankan children
Cultural operational term used:	Geographical location, nationality, and ethnicity
Origin of study population: (include current country of residence for immigrant and refugee groups)	Sri Lanka
Description of Cultural group(s) sampled: (include data on the culture of the practitioner if this available)	Participants aged between 9-16 year olds; Study 1 comprised of Sri Lankan children of Sinhalese ethnicity; Study 2 comprised of children of Sri Lankan nationality (Cultural information of researcher not provided).
Method of sampling (representative or convenient); Location from where the was sample obtained: (e.g. school/health care facility/community)	Purposive sampling from local schools
If the study has a control group and a comparison group, what description is given:	No control group was included
Type of trauma event(s) experienced by the sample:	Exposure to war- related and a natural disaster
Is symptomatology self-reported by the sample, observed by the clinician, or both:	Children self-reported symptoms through individual interviews
Psychometric assessments used:	Harvard Trauma Questionnaire (HTQ) completed
Comorbid conditions among participants:	None mentioned.
Culturally specific symptoms that are explored:	None.
Potential confounding variables:	None.
Conclusion and recommendations for future studies:	Results indicated that Sri Lankan children, re-experiencing and arousal symptom severity are greater than avoidance-numbing symptom s

Article 2: Victimisation and PTSD in a Greenlandic youth sample (2012) **Author(s): Karsberg,S.H., Lasgaard, M. & Elkit, A.** **Name of peer reviewed journal: International Journal of Circumpolar Health**	
Data of Interest	**Information Provided**
Objectives of the study; rationale for including culture as a variable:	To estimate the lifetime prevalence of potentially traumatic events (PTEs) and post-traumatic stress disorder (PTSD) and to examine the relationship between PTEs, estimated PTSD, and sociodemographic variables; Little known about trauma exposure among Greenlandic adolescents.
Definition of culture:	No definition is provided
Culture of interest; Specific boundaries set for the investigation (inclusion/exclusion criteria):	Greenlandic culture adolescents from Northern Greenland
Cultural operational term used:	Geographical location, nationality, ethnicity
Origin of study population: (include current country of residence for immigrant and refugee groups)	Discobay area in north-west Greenland.
Description of Cultural group(s) sampled: (include data on the culture of the practitioner if this available)	269 students, aged 121-8; Greenland nationals (researchers culture not stated)
Method of sampling (representative or convenient); Location from where the was sample obtained: (e.g. school/health care facility/community)	All participants were treated by Hinton, D. E. (convenient sampling)
If the study has a control group and a comparison group, what description is given:	No control group was included
Type of trauma event(s) experienced by the sample:	Death of someone close, near drowning, threat of assault/beating, humiliation or persecution by others and attempted suicide amongst others.
Is symptomatology self-reported by the sample, observed by the clinician, or both:	Children self-reported by means of a questionnaire
Psychometric assessments used:	Harvard Trauma Questionnaire (HTQ) used to estimate level of trauma relative to events reported by children.
Comorbid conditions among participants:	None mentioned.
Culturally specific symptoms that are explored:	None.
Potential confounding variables:	None.
Conclusion and recommendations for future studies:	Findings revealed that Greenlandic adolescents have considerable mental health issues. Girls in particular were more exposed to traumatic events than boys.

Article 3: Assessing the latent structure of DSM-5 PTSD among Chinese adolescents after the Ya'an earthquake (2017) **Author(s): Zhoua,X., Wua, X. & ZhenA, R.** **Name of peer reviewed journal: Psychiatry Research**	
Data of Interest	**Information Provided**
Objectives of the study; rationale for including culture:	To examine the underlying substructure of DSM-5 PTSD in an Chinese adolescents
Definition of culture:	No definition is provided
Culture of interest; Specific boundaries set for the investigation (inclusion/exclusion criteria):	Chinese culture; originating from Lushan county in the province of Sichuan
Cultural operational term used:	Geographical location, and nationality
Origin of study population: (include current country of residence for immigrant and refugee groups)	China, Sichuan
Description of Cultural group(s) sampled: (include data on the culture of the practitioner if this available)	813 adolescents; mean age was 16.26 years, ranging from 13.0 to 20.0 years. 445 (54.7%) were female and 367 (45.1%) were male, and 1 did not report his/her gender Chinese Lushan residents; no information on investigators culture given
Method of sampling (representative or convenient); Location from where the was sample obtained	Convenient sampling
If the study has a control group and a comparison group, what description is given:	No control group was included
Type of trauma event(s) experienced by the sample:	Exposure to the Ya'an earthquake
Is symptomatology self-reported by the sample, observed by the clinician, or both:	Children completed various assessments under supervision of researchers.
Psychometric assessments used:	Child PTSD Symptom Scale (built on the DSM-VI criteria), PTSD Checklist for DSM-5, Chinese version of Center for Epidemiologic Studies Depression Scale for Children, and Screen for Child Anxiety Related Emotional Disorders
Comorbid conditions among participants:	None mentioned.
Culturally specific symptoms that are explored:	None.
Potential confounding variables:	None.
Conclusion and recommendations for future studies:	Study tested six competing theoretical models of PTSD and found that all were appropriate in the study sample.

Article 4: A Pilot Study of PTSD Symptoms Among Kalahari Bushmen (2003) **Author(s): McCall, G. J. & Resick, P. A.** **Name of peer reviewed journal: Journal of Traumatic Stress**	
Data of Interest	**Information Provided**
Objectives of the study; rationale for including culture:	Article assess posttraumatic stress disorder (PTSD) in the Kalahari Bushmen; to ascertain if PTSD can be diagnosed in this ethnocultural cohort
Definition of culture:	No definition is provided
Culture of interest; Specific boundaries set for the investigation (inclusion/exclusion criteria):	Culture of the Kalahari Bushmen; participants were villagers from districts in Namibia
Cultural operational term used:	Geographical location, ethnicity
Origin of study population: (include current country of residence for immigrant and refugee groups)	Tsumkwe, Namibia
Description of Cultural group(s) sampled: (include data on the culture of the practitioner if this available)	10 males and 10 females.; Kalahari Bushmen; culture of researchers not provided
Method of sampling (representative or convenient); Location from where the was sample obtained:	Convenient sampling; locations ranged across three districts in Namibia
If the study has a control group and a comparison group, what description is given:	No control group was included
Type of trauma event(s) experienced by the sample:	Domestic violence
Is symptomatology self-reported by the sample, observed by the clinician, or both:	Participants reported symptoms in interviews
Psychometric assessments used:	None.
Comorbid conditions among participants:	None mentioned.
Culturally specific symptoms that are explored:	None.
Conclusion and recommendations for future studies:	Results indicated that PTSD can be diagnosed in this cultural cohort; 35% of 20 people interviewed met the criteria for PTSD.

Article 5: Nightmares Among Cambodian Refugees (2009)

Author(s): Hinton, D. E., Hinton, A. L., Pich, V., Loeum, J. R. & Pollack, M. H.
Name of peer reviewed journal: Culture, medicine, psychiatry

Data of Interest	Information Provided
Objectives of the study; rationale for including culture:	Explore the role of nightmares in the trauma ontology of Cambodian refugee population.
Definition of culture:	No definition is provided
Culture of interest; Specific boundaries set for the investigation (inclusion/exclusion criteria)::	Cambodian culture; refugees in the US; sourced from outpatient clinic; at least 40 years old (old enough to remember experiences)
Cultural operational term used:	Nationality (identified by researcher); no further explanation for choice of operationalisation is provided
Origin of study population: (include current country of residence for immigrant and refugee groups)	Cambodian refugee population living on the U.S.
Description of Cultural group(s) sampled: (include data on the culture of the practitioner if this available)	40 men and 60 women; Cambodians; cultural leaning of researchers not stated
Method of sampling (representative or convenient); Location from where the was sample obtained:	All participants were treated by Hinton, D. E. (convenient sampling); sourced from local psychiatric facility
If the study has a control group and a comparison group, what description is given:	No control group was included
Type of trauma event(s) experienced by the sample:	Civil war of 1975; Pol Pot period of social unrest;
Is symptomatology self-reported by the sample, observed by the clinician, or both:	Symptoms were observed by clinicians conducting interviews
Psychometric assessments used:	assessed with Structured Clinical interview for DSM-IV (SCID)
Comorbid conditions among participants:	None mentioned.
Culturally specific symptoms that are explored:	Significance of nightmares within Cambodian culture explored; participants engaged in a variety of practices such as "cupping" to gain sense of ontological security.
Conclusion and recommendations for future studies:	The study found that nightmares are common in Cambodian population following a traumatic event. Nightmares were also the most distressing symptom. Given that nightmares are considered spiritual messages, treatment sought by traumatised persons was spiritual.

Article 6: Cross-Cultural Response to Trauma: A Study of Traumatic Experiences and Posttraumatic Symptoms in Cambodian Refugees (1994)

Author(s): Carlson, B. E. & Rosser-Hogan, R.
Name of peer reviewed journal: Journal of Traumatic Stress

Data of Interest	Information Provided
Objectives of the study; rationale for including culture as a variable:	Article aimed to explore traumatic presentations in the outlined population; To determine if the PTSD construct is universally applicable.
Definition of culture:	No definition is provided
Culture of interest; Specific boundaries set for the investigation (inclusion/exclusion criteria):	Cambodian culture (also referred to in the study as Southeast Asians); no other criteria appears to have been set.
Cultural operational term used:	Nationality
Origin of study population: (include current country of residence for immigrant and refugee groups)	Cambodia; living in U.S.
Description of Cultural group(s) sampled: (include data on the culture of the practitioner if this available)	50 adult subjects (26 female and 24 male); from rural areas of Cambodia with no formal education; 21 to 65 years old Cambodian refugees; nationality of researchers not stated
Method of sampling (representative or convenient); Location from where the was sample obtained:	Convenient sampling; Cambodians living in Greensboro
If the study has a control group and a comparison group, what description is given:	No control group was included
Type of trauma event(s) experienced by the sample:	Varied from trauma related to civil war, to living in fear, labour camp experiences, and deaths of spouses, children, relatives, and friends.
Is symptomatology self-reported by the sample, observed by the clinician, or both:	Participant completed various assessments
Psychometric assessments used:	Post- Traumatic Inventory; PTSD Check- list; Dissociative Experiences Scale (DES); Hopkins Symptom Checklist-25 (HSCL-25)
Comorbid conditions among participants:	None mentioned.
Culturally specific symptoms that are explored:	None.
Conclusion and recommendations for future studies:	Symptom s in this cohort are similar to what has been observed in U.S. survivors of trauma.

Article 7: Brief Report: Comparing the Autobiographical Remembering of Iranian Immigrant Trauma Survivors with That of Iranian and British Trauma Survivors (2016) **Author(s): Jobson, L., Cheraghi, S. & Moradi, A. R.** **Name of peer reviewed journal: Applied Cognitive Psychology**	
Data of Interest	**Information Provided**
Objectives of the study; rationale for including culture as a variable:	Article aimed to investigate culture and auto-biographical memory; Trauma memories in different populations do not have sufficient empirical evidence.
Definition of culture:	The Western individualistic cultural places emphasis on self, whereas in contrast collectivistic cultures give emphasis to conformity and interdependence.
Culture of interest; Specific boundaries set for the investigation (inclusion/exclusion criteria):	Individualist (British) and collective (Iranian) cultures; participants were born in Iran but had immigrated to Britain in adulthood.
Cultural operational term used:	Geographical location, ethnicity
Origin of study population: (include current country of residence for immigrant and refugee groups)	Iranian nationals currently living in Brittan
Description of Cultural group(s) sampled: (include data on the culture of the practitioner if this available)	I43 Iranians living in Britain ;
Method of sampling (representative or convenient); Location from where the was sample obtained:	Convenient sampling; Advertised throughout the community.
If the study has a control group and a comparison group, what description is given:	Findings were compared to previous studies of the same cultural group.
Type of trauma event(s) sample:	Varying kinds of trauma
Is symptomatology self-reported by the sample, observed by the clinician, or both:	Individual interviews and assessments were conducted
Psychometric assessments used:	Posttraumatic Stress Diagnostic Scale (PDS), Autobiographical Memory Test, Autobiographical Memory Questionnaire, Trauma History Questionnaire; Part II of the Hopkins Symptom Checklist—25
Comorbid conditions among participants:	None mentioned.
Culturally specific symptoms that are explored:	None.
Conclusion and recommendations for future studies:	Results indicate that immigrants with PTSD may experience similar disruptions in autobiographical remembering as the persons in their host cultures.

Article 8: A Cross-Cultural Exploration of Posttraumatic Stress Disorder: Assessment, Diagnosis, Recommended (Gestalt) Treatment (2012) **Author(s): Perera-Diltz, D. M., Laux, J. M. & Toman, S. M.** **Name of peer reviewed journal: Gestalt Review**	
Data of Interest	**Information Provided**
Objectives of the study; rationale for including culture as a variable:	Article explored appropriate treatments for Sri Lankans exposed to trauma; To explore the use of narrative therapy techniques among Sri Lankan persons
Definition of culture:	Collectivist leaning of Sri Lankan culture is briefly described
Culture of interest; Specific boundaries set for the investigation (inclusion/exclusion criteria):	Culture of Sri Lankans; no specific boundaries set by authors
Cultural operational term used:	Nationality (researcher identified)
Origin of study population: (include current country of residence for immigrant and refugee groups)	Sri Lanka
Description of Cultural group(s) sampled: (include data on the culture of the practitioner if this available)	348 participants 9culture of practitioner not provided).
Method of sampling (representative or convenient); Location from where the was sample obtained:	Participants sampled purposively from two locations in Galle and Kegalle regions
If the study has a control group and a comparison group, what description is given:	No control group was included
Type of trauma event(s) experienced by the sample:	Affected by the tsunami of 2004
Is symptomatology self-reported by the sample, observed by the clinician, or both:	Participants self-reported symptoms
Psychometric assessments used:	Impact of Events Scale Revised
Comorbid conditions among participants:	None mentioned.
Culturally specific symptoms that are explored:	None.
Conclusion and recommendations for future studies:	The findings show that gestalt therapy seeming is a theoretical match for treatment of PTSD in collectivist groups, however more studies are required.

Article 9: Culture and the Remembering of Trauma (2014) **Author(s): Jobson et al.,** **Name of peer reviewed journal: Clinical Psychological Science**	
Data of Interest	**Information Provided**
Objectives of the study; rationale for including culture as a variable:	Article investigated culture and autobiographical memory; To explore the influence of culture on traumatic memory
Definition of culture:	Western cultures conceptualize the self as independent, collectivistic cultures honour a sense interdependence.
Culture of interest; Specific boundaries set for the investigation (inclusion/exclusion criteria):	Australian, British, and Iranian trauma survivors; only persons that were diagnosed with PTSD were included;
Cultural operational term used:	Nationality
Origin of study population: (include current country of residence for immigrant and refugee groups)	Where located in their country origin.
Description of Cultural group(s) sampled: (include data on the culture of the practitioner if this available)	British (n=38); Australian (n=43); and Iranian (n=40) living in their country of origin
Method of sampling (representative or convenient); Location from where the was sample obtained:	Purposive sampling; recruited from community by advertisements in local newspapers, and contacts with organizations.
If the study has a control group and a comparison group, what description is given:	No control group was included
Type of trauma event(s) experienced by the sample:	Either exposed to a motor vehicle accident, diagnosis of a serious illness or psychical assault
Is symptomatology self-reported by the sample, observed by the clinician, or both:	Both semi-structured interviews and assessments were used to collect data
Psychometric assessments used:	Self-Memory Scale (SMS), the Twenty Statement Test (TST), HTQ, HSCL-25, Trauma History Questionnaire (THQ), and Hofstede & Hofstede categorisation of cultural orientation used to stratify persons into either of the two categories
Comorbid conditions among participants:	Depression symptoms.
Culturally specific symptoms that are explored:	None
Conclusion and recommendations for future studies:	Cross-cultural similarities and differences discussed ; findings suggest that pan-culturally, individuals with PTSD have similar disruptions and distortions in their autobiographical remembering

Article 10: Culture as a Double-Edged Sword: The Posttraumatic Experience of Indigenous Ethnic Minority Veterans (2018) **Author(s): Shorer, S., Goldblatt, H., Caspi, Y. & Azaiza, F.** **Name of peer reviewed journal: Qualitative health research**	
Data of Interest	**Information Provided**
Objectives of the study; rationale for including culture as a variable:	Article aimed to explore the subjective meaning of living in Bedouin veterans
Definition of culture:	Distinction between individualist and collectivist nations is made.
Culture of interest; Specific boundaries set for the investigation (inclusion/exclusion criteria):	Bedouin military service men are an ethnic minority in northern Israel. Are identified as Muslim Arabs.
Cultural operational term used:	Nationality, ethnicity, religion
Origin of study population: (include current country of residence for immigrant and refugee groups)	Israel
Description of Cultural group(s) sampled: (include data on the culture of the practitioner if this available)	10 veterans described as emotionally stable enough to participate and 3 therapists; All servicemen had a high school education; Bedouin are described as an ethnic and religious minority in Israel, comprising of various tribal groups, and part of the Muslim cultural group (1 researcher was Arab and three were Jewish, however the group referred to themselves as outsiders to the culture)
Method of sampling (representative or convenient); Location from where the was sample obtained:	Purposive sampling; sample obtained from two general hospitals treating military servicemen population
If the study has a control group and a comparison group, what description is given:	No control group was included
Type of trauma event(s) experienced by the sample:	Exposure to war- related (all diagnosed with chronic PTSD).
Is symptomatology self-reported by the sample, observed by the clinician, or both:	Were diagnosed by psychiatrist, those thought to be stable participated. Symptoms were identified by a clinician
Psychometric assessments used:	None
Comorbid conditions among participants:	None mentioned.
Culturally specific symptoms that are explored:	None.
Conclusion and recommendations for future studies:	Results show that thorough inquiry into cultural backgrounds of indigenous minority is required; there is often conflict in identities and multiple "realities" which such persons try to manage.

Article 11: A Cross-Cultural Assessment of Posttrauma Reactions Among Malaysian and US Women Reporting Partner Abuse (2006) **Author(s): Phillips et al.** **Name of peer reviewed journal: Journal of Family Violence**	
Data of Interest	**Information Provided**
Objectives of the study; rationale for including culture as a variable:	Examined issues of women experiencing partner violence in Malaysia
Definition of culture:	No definition is provided
Culture of interest; Specific boundaries set for the investigation (inclusion/exclusion criteria):	Malaysian women; no other criteria appears to have been set.
Cultural operational term used:	Geographical location, nationality, ethnicity
Origin of study population: (include current country of residence for immigrant and refugee groups)	Malaysia
Description of Cultural group(s) sampled: (include data on the culture of the practitioner if this available)	Female residents (n=17) In a suburb of Malaysia's capital, Kuala Lumpur; 26-49 years old
Method of sampling; Location from where the was sample obtained:	Purposive sampling; Sourced from a local shelter.
If the study has a control group and a comparison group, what description is given:	Compared to a U.S. sample
Type of trauma event(s) experienced by the sample:	Domestic violence
Is symptomatology self-reported by the sample, observed by the clinician, or both:	Women completed a semi-structured interview and standardized measure
Psychometric assessments used:	Severity of violence against women scales; PTSD symptom scale-self-report and revised impact of events scale
Comorbid conditions among participants:	None mentioned.
Culturally specific symptoms that are explored:	None.
Conclusion and recommendations for future studies:	Results indicated that abused women in Malaysia endure similar psychological problems to other females experience partner violence.

Article 12: Culture-sensitive psychotraumatology (2016) **Author(s): Schnyder et al.,** **Name of peer reviewed journal: European Journal of Psychotraumatology**	
Data of Interest	**Information Provided**
Objectives of the study; rationale for including culture as a variable:	Study motivated by need to uncover effective treatment for trauma in different cultural contexts
Definition of culture:	Culture defined as a dynamic and changing set of beliefs and attitudes. Collectivist and Individualist distinction also made.
Culture of interest; Specific boundaries set for the investigation (inclusion/exclusion criteria):	Therapists from diverse countries; no other criteria appears to have been set.
Cultural operational term used:	Geographical location and nationality
Origin of study population: (include current country of residence for immigrant and refugee groups)	Cultures considered: UK, USA, the Netherlands, Kenya, Brazil, Germany, Japan, and Australia
Description of Cultural group(s) sampled: (include data on the culture of the practitioner if this available)	No clear boundaries set for inclusion apart from being a resident in the sampled country.
Method of sampling; Location from where the was sample obtained:	Purposive sampling of therapists from across the globe
If the study has a control group and a comparison group, what description is given:	No control group was included
Type of trauma event(s) experienced by the sample:	Varied.
Is symptomatology self-reported by the sample, observed by the clinician, or both:	Therapists shared their experiences from patients they had worked with.
Psychometric assessments used:	None.
Comorbid conditions among participants:	None mentioned.
Culturally specific symptoms that are explored:	Info on cultural practices provided (Kenyan beliefs re burial)
Conclusion and recommendations for future studies:	Empathy and non-judgemental attitude were found to be the right approach to culture-sensitive psychotraumatology

Article 13: Cultural differences in personal identity in post-traumatic stress disorder (2008) **Author(s): Jobson, L. & O'Kearney, R.** **Name of peer reviewed journal: British Journal of Clinical Psychology**	
Data of Interest	**Information Provided**
Objectives of the study; Rationale for including culture as a variable:	Culture included as a means to assess hypothesis re self-concept and trauma put forward by previous authors; dependent.
Definition of culture:	Culture defined as having an emphasis on autonomy whereas interdependent culture defined as having a focus on social context.
Culture of interest; Specific boundaries set for the investigation (inclusion/exclusion criteria):	Independent cultures: Australian, Western European, New Zealand, American Interdependent cultures: Asian, African, Middle Eastern, Eastern European, South American No other criteria appear to have been set.
Cultural operational term used:	Nationality
Origin of study population: (include current country of residence for immigrant and refugee groups)	Originated from various countries but now living in Australia
Description of Cultural group(s) sampled: (include data on the culture of the practitioner if this available)	106 participants, grouped into independent and collectivist following completion of TST (researchers cultural leaning not clearly stated).
Method of sampling; Location from where the was sample obtained:	Convenient sampling from community via advertisements, Adult Migrant English Programs contacting ethnic organizations treatment centres from trauma survivors.
If the study has a control group and a comparison group, what description is given:	No control group was included
Type of trauma event(s) experienced by the sample:	General disasters, crime related trauma and physical/sexual trauma;
Is symptomatology self-reported by the sample, observed by the clinician, or both:	Participants self-reported symptoms through individual interviews;
Psychometric assessments used:	Post-traumatic Stress Diagnosis Scale (PDS), Trauma History Questionnaire (THQ), hsc-25, Twenty Statement Test (TST)
Comorbid conditions among participants:	None mentioned.
Culturally specific symptoms that are explored:	None.
Conclusion and recommendations for future studies:	This study is the first to show that trauma's impact on change in self-definition and personal identity is culturally specified

Article 14: Examination of the latent structure of DSM-5 posttraumatic stress disorder symptoms in Slovakia (2018) **Author(s): Ross et al.,** **Name of peer reviewed journal: Psychiatric Research**	
Data of Interest	**Information Provided**
Objectives of the study; Rationale for including culture as a variable:	Study aimed to comparing seven existing PTSD factor models in a sample of 754 trauma-exposed university students from Slovakia
Definition of culture:	No definition is provided, however a little context on Slovakian history is provided.
Culture of interest; Specific boundaries set for the investigation (inclusion/exclusion criteria):	Slovakian university students; no other criteria appears to have been set.
Cultural operational term used:	Nationality
Origin of study population: (include current country of residence for immigrant and refugee groups)	Slovakia
Description of Cultural group(s) sampled: (include data on the culture of the practitioner if this available)	754 participants, predominantly female (83.69%), with a mean age of 22.68 years
Method of sampling; Location from where the was sample obtained:	Purposive sampling; students were requested to participate via email.
If the study has a control group and a comparison group, what description is given:	No control group was included
Type of trauma event(s) experienced by the sample:	Traumas varied, however the most commonly cited trauma type was a vehicle collision. (n=139), this was followed by natural disasters (n=80), and physical assault (n=78).
Is symptomatology self-reported by the sample, observed by the clinician, or both:	Participants endorsed symptoms by means of various psychometric assessments
Psychometric assessments used:	Life events checklist for DSM-5 (LEC-5), PTSD checklist for DSM-5 (PCL-5), and Depression anxiety stress Scales-21 (DASS-21),
Comorbid conditions among participants:	None mentioned.
Culturally specific symptoms that are explored:	None.
Conclusion and recommendations for future studies:	Factors of the Anhedonia model also showed differential relationships with variables of anxiety and depression.

Article 15: Exploring trauma associated appraisals in trauma survivors from collectivistic culture (2016) **Author(s): Engelbrecht ,A. & Jobson, L**. **Name of peer reviewed journal: SpringerPlus**	
Data of Interest	**Information Provided**
Objectives of the study; Rationale for including culture as a variable:	Article aimed to qualitatively explore trauma appraisals and culture.; Culture included since little research exists on trauma appraisals and culture
Definition of culture:	Culture described as influencing how individuals think, feel and behave, interdependence versus independence categorisation employed to delineate participants.
Culture of interest; Specific boundaries set for the investigation (inclusion/exclusion criteria):	7 cultures: Indian, Jordan, Slovakian, Chinese, Sri Lankan, Vietnamese and Ethiopian; all participants were immigrants and refugees living in Britain for between 1 and 2 years
Cultural operational term used:	Nationality
Origin of study population: (include current country of residence for immigrant and refugee groups)	Originating from different countries but currently living in Britain (researchers' cultural leaning not stated).
Description of Cultural group(s) sampled:(include data on the culture of the practitioner if this available)	11 participants (male n = 8, female n = 3); 18 and older, could understand English. Culture of the authors not clearly stated.
Method of sampling; Location from where the was sample obtained:	Purposive sampling from the general community
If the study has a control group and a comparison group, what description is given:	No control group was included
Type of trauma event(s) experienced by the sample:	Road traffic accidents, witnessing death, injury/accident, persecution
Is symptomatology self-reported by the sample, observed by the clinician, or both:	Symptoms were reported in focus groups with community members and in 3 qualitative individual semi-structured interviews with mental health practitioners.
Psychometric assessments used:	Used Hofstede and Hofstede (2004) assessment to categorise participants as dependent/interdependent
Comorbid conditions among participants:	None mentioned.
Culturally specific symptoms that are explored:	None.
Conclusion and recommendations for future studies:	Findings show significance of group on each individual, other themes which emerged included the significance of social roles, and cultural appropriateness.

Article 16: Exploring the Mental Health Effects of Political Trauma With Newly Arrived Refugee (2015) **Author(s): Shannon et al.** **Name of peer reviewed journal: Qualitative Health Research**	
Data of Interest	**Information Provided**
Objectives of the study; Rationale for including culture as a variable:	Article aimed at increasing the knowledge of trauma related refugee experiences
Definition of culture:	No definition is provided; however context of each refugee group is provided.
Culture of interest; Specific boundaries set for the investigation (inclusion/exclusion criteria):	Culture of Somali, Bhutanese, Karen, Oromo and Somali refugees; no other criteria appear to have been set.
Cultural operational term used:	Nationality
Origin of study population: (include current country of residence for immigrant and refugee groups)	Originated from differing countries, however had resettled in U.S.
Description of Cultural group(s) sampled: (include data on the culture of the practitioner if this available)	Refugees 111 refugees were included (34 Bhutanese, three 23 Karen refugees, 27 Oromo refugees, 27 Somali refugees); 18-78 years old.
Method of sampling; Location from where the was sample obtained:	Conveniently sampled from a larger study
If the study has a control group and a comparison group, what description is given:	No control group was included
Type of trauma event(s) experienced by the sample:	Exposed to varying kinds of trauma.
Is symptomatology self-reported by the sample, observed by the clinician, or both:	Symptoms were reported by participants in focus group interviews.
Psychometric assessments used:	None.
Comorbid conditions among participants:	None mentioned.
Culturally specific symptoms that are explored:	"Culturally grounded words and concepts" distinctive to the refugee groups explored.
Conclusion and recommendations for future studies:	The results confirm current knowledge on cross-cultural symptoms recognition; refugees from each culture had substantial variation in how distress was expressed.

Article 17: Influence of memory theme and posttraumatic stress disorder on memory specificity in British and Iranian trauma survivors (2016) **Author(s): Jobson, L. & Cheraghi, S.** **Name of peer reviewed journal: Memory**	
Data of Interest	**Information Provided**
Objectives of the study; Rationale for including culture as a variable:	The study aimed to explore the influence of culture, memory theme and posttraumatic stress disorder (PTSD) on autobiographical memory
Definition of culture:	Western/individualist versus Eastern/collectivist notion of culture explained.
Culture of interest; Specific boundaries set for the investigation (inclusion/exclusion criteria):	38 British and 41 Iranians residing in the U.K.; no other criteria appears to have been set.
Cultural operational term used:	Nationality
Origin of study population: (include current country of residence for immigrant and refugee groups)	British participants were sampled on the basis of their nationality and Iranian participants were persons born in Iran that had immigrated to Britain.
Description of Cultural group(s) sampled:(include data on the culture of the practitioner if this available)	Study 1 comprised of Sri Lankan children of Sinhalese ethnicity; Study 2 comprised of children of Sri Lankan nationality
Method of sampling; Location from where the was sample obtained:	purposive sampling; recruited by means of advertisements and trauma contact centres
If the study has a control group and a comparison group, what description is given:	No control group was included
Type of trauma event(s) experienced by the sample:	Exposure to war- related and a natural disaster
Is symptomatology self-reported by the sample, observed by the clinician, or both:	Children self-reported symptoms through individual interviews;
Psychometric assessments used:	Autobiographical Memory Test (AMT, Trauma History Questionnaire (THQ), and Posttraumatic Diagnostic Scale (PDS)
Comorbid conditions among participants:	None mentioned.
Culturally specific symptoms that are explored:	None.
Conclusion and recommendations for future studies:	Results indicate that memory specificity may be correlated with PTSD symptoms. Researchers assert pan-culturally a broad-spectrum retrieval approach may be common to all PTSD suffers.

Article 18: The Interface of Psychic Trauma and Cultural Identity Within Arab American Groups (2008) **Author(s): Pharaon, N. A.** **Name of peer reviewed journal: Group**	
Data of Interest	**Information Provided**
Objectives of the study; Rationale for including culture as a variable:	Article investigated the interaction of trauma, groups , and culture in therapy groups in the Arab American community
Definition of culture:	No definition is provided
Culture of interest; Specific boundaries set for the investigation (inclusion/exclusion criteria):	Arab American culture; no other boundaries are given
Cultural operational term used:	Ethnicity
Origin of study population: (include current country of residence for immigrant and refugee groups)	Participants are Arab women originating from over 22 countries; currently residing in America
Description of Cultural group(s) sampled:(include data on the culture of the practitioner if this available)	Arab women of differing ethnicities; ages 20-50; researchers are an Arab and Muslim clinician.
Method of sampling; Location from where the was sample obtained:	Conveniently sampled from non-profit organisation in New York
If the study has a control group and a comparison group, what description is given:	No control group was included
Type of trauma event(s) experienced by the sample:	Domestic violence
Is symptomatology self-reported by the sample, observed by the clinician, or both:	Symptomology was primarily observed by clinician; practitioner identified women to be invited to join therapy group.
Psychometric assessments used:	None
Comorbid conditions among participants:	None mentioned.
Culturally specific symptoms that are explored:	None.
Conclusion and recommendations for future studies:	Therapy provided opportunity for Arab women to be empowered to better deal with domestic violence and the hostility they experienced from the American society in general.

Article 19: Contribution of shame and attribution style in developing PTSD among Japanese University women with negative sexual experiences (2007) **Author(s): Uji, M., Shikai, N., Shono, M. & Kitamur, T.** **Name of peer reviewed journal: Archives of Women's Mental Health**	
Data of Interest	**Information Provided**
Objectives of the study; Rationale for including culture as a variable:	Article investigated attribution style and shame among Japanese women exposed to sexual trauma
Definition of culture:	No definition is provided
Culture of interest; Specific boundaries set for the investigation (inclusion/exclusion criteria):	Japanese culture; no clear boundaries appear to have been set for the investigation
Cultural operational term used:	Nationality/ethnicity
Origin of study population: (include current country of residence for immigrant and refugee groups)	Participants were sourced from Japanese universities, cultural leaning of researchers not clearly stated
Description of Cultural group(s) sampled:(include data on the culture of the practitioner if this available)	532 female Japanese university students participated, 213 females were found to have experienced a negative sexual experience (NSE)
Method of sampling; Location from where the was sample obtained:	Purposive sampling from 5 universities
If the study has a control group and a comparison group, what description is given:	No control group was included
Type of trauma event(s) experienced by the sample:	Exposed to negative sexual experiences such as rape, touch, and displaying of genitalia among others.
Is symptomatology self-reported by the sample, observed by the clinician, or both:	Participants completed assessments anonymously
Psychometric assessments used:	Questionnaires on sexual victimisation, Abuse Attribution Inventory, Abuse Specific Shame questionnaire and Impact of Event Scale-Revised
Comorbid conditions among participants:	None mentioned.
Culturally specific symptoms that are explored:	None
Conclusion and recommendations for future studies:	The Japanese proclivity towards shame explained. The study found that PTSD symptoms are caused by shame, and this originates from cognitive attribution.

Article 20: PTSD Symptoms in Abused Latino Children (2004) **Author(s): Mennen, F. E.** **Name of peer reviewed journal: Child and Adolescent Social Work Journal**	
Data of Interest	**Information Provided**
Objectives of the study; Rationale for including culture as a variable:	Article investigated relationship between posttraumatic stress symptoms and abuse as well as demographics amongst Latino children. Researcher reports that understanding of this population is not at the same level as the knowledge on other cultural groups.
Definition of culture:	No definition is provided, however the researcher asserts that the term Latino is more preferred, despite the U.S. administration referring to this population as Hispanics.
Culture of interest; Specific boundaries set for the investigation (inclusion/exclusion criteria):	Inclusion criteria were: child had to have experienced abuse, had to be between the ages 6 and 12, had to be Latino, had to be capable to participate, and had to have received at least two months of treatment.
Cultural operational term used:	Geographical location, ethnicity
Origin of study population: (include current country of residence for immigrant and refugee groups)	The population in the study were Latino children living in the U.S. It is unclear if the children are citizens of the country or possibly migrants. The researcher asserts that Latino or Hispanic people are persons who have a lineage are from a Spanish speaking country.
Description of Cultural group(s) sampled:(include data on the culture of the practitioner if this available)	Cultural group is simply described as Latino children ages 6-12. 31 children were sampled, 20 girls and 11 boys. The culture of the practitioner is not stated in the article, however it is noted that Spanish bilingual researchers assisted in the assessment process.
Method of sampling; Location from where the was sample obtained:	Convenient sampling from a nearby mental health hospital and the child protection service. The precise details of were in the U.S. the study took place is not available.
If the study has a control group and a comparison group, what description is given:	It does not appear that a comparison group was included in the study, however the author states that he has written another article that compares Latino children with their counterpart from other race groups.
Type of trauma event(s) experienced by the sample:	Child abuse
Is symptomatology self-reported by the sample, observed by the clinician, or both:	Children and parents were assessed separately. Given that the study has to do with PTSD in this population it is unclear if the symptoms were recognised and as distressing to the children and their families who then approached the medical facility for assistance, or if the children were seeking medical assistance for another

	matter and then were diagnosed with PTSD by the treating professional
Psychometric assessments used:	PTSD Inventory; A Spanish version of the Children's Depression Inventory (CDI); A Spanish version of the Revised Children's Manifest Anxiety Scale (RCMAS); Spanish version of the Parent/guardians Child Behavior Checklist (CBCL); Child Dissociative Checklist (CDC); WISC-R with Spanish children norms.
Comorbid conditions among participants:	None mentioned.
Culturally specific symptoms that are explored:	None.
Conclusion and recommendations for future studies:	Results show Spanish speaking Latino children may experience more distress than non-Spanish speaking children. Overall, In Latino children were found to be highly distressed but low in symptom levels. This is similar to other studies.

Article 21: Observations on the Impact on Kenyans of the August 7, 1998 Bombing of the United States Embassy in Nairobi (2004) **Author(s): Thielman, S. B.** **Name of peer reviewed journal: Journal of Aggression, Maltreatment & Trauma**	
Data of Interest	**Information Provided**
Objectives of the study; Rationale for including culture as a variable:	Article aimed to explore the interpretations of Kenyan survivors of the embassy bombing in Nairobi.
Definition of culture:	No explicit definition for culture is provided however brief information about the ethnic and religious diversity is given.
Culture of interest; Specific boundaries set for the investigation (inclusion/exclusion criteria):	Kenyan nationals. No clear boundaries appear to be set: approximately 7000 people who were around the U.S embassy when the explosion occurred were treated. No exact criteria were used to qualify persons treated.
Cultural operational term used:	Nationality.
Origin of study population: (include current country of residence for immigrant and refugee groups)	Kenya, Nairobi.
Description of Cultural group(s) sampled: (include data on the culture of the practitioner if this available)	Survivors are simply described as Kenyan. The author is not Kenyan but many psychiatrists from South Africa, India and Europe were involved in treatment of survivors.
Method of sampling; Location from where the was sample obtained:	Mixed methods of reaching the effected population were employed. In some instances volunteer counsellors went out to debrief people. Psychoeducation was also provided through television media.
If the study has a control group and a comparison group, what description is given:	No control or comparison groups were included.
Type of trauma event(s) experienced by the sample:	Exposure to bomb blast (fatalities: 201 Kenyans, 12 U.S. diplomatic staff and 5000 people injured)
Is symptomatology self-reported by the sample, observed by the clinician, or both:	Symptoms were identified clinicians/volunteers and survivors. Once psycho-education on PTSD was provided more people sought psychological assistance to cope.
Psychometric assessments used:	No assessments were employed.
Comorbid conditions among participants:	Depression, psychosis and cognitive impairment resulting from head injuries.
Culturally specific symptoms that are explored:	None
Conclusion and recommendations for future studies:	Very little survivor's guilt was expressed and group was described as fatalistic. Strong opinion that event was an act from a high power (God/ Allah etc). Anger directed at terrorists and not towards deity. Guilt around personal actions taken during the time of the bombing. The role of Luck was also prominent.

Article 22: Posttraumatic stress disorder in African Americans: A two year follow-up study (2014) **Author(s): Pérez Benítez et al.** **Name of peer reviewed journal: Psychiatry Research**	
Data of Interest	**Information Provided**
Objectives of the study; Rationale for including culture as a variable:	The study was a two year longitudinal investigation that aimed to uncover the differences between African American with PTSD and anxiety and African Americans with only anxiety. Culture was included as researchers assert that little evidence of PTSD studies in different racial groups is available.
Definition of culture:	No definition is provided. Authors refer to African Americans as a racial group that is understudied.
Culture of interest; Specific boundaries set for the investigation (inclusion/exclusion criteria):	African Americans, no specifications were provided for what establishes an individual as African American in the study were given. Persons included had to be 18 or older, have a diagnosis of at least one of following index disorders: PTSD, panic disorder, panic disorder with agoraphobia, agoraphobia without history of panic disorder, generalized anxiety disorder, or social anxiety disorder. Participants were excluded if they had an organic brain syndrome, a history of schizophrenia, or psychosis at intake; information about the culture of the authors and interviewers was not provided.
Cultural operational term used:	Nationality and Race
Origin of study population: (include current country of residence for immigrant and refugee groups)	America
Description of Cultural group(s) sampled:(include data on the culture of the practitioner if this available)	Described only as African Americans; the culture of the researchers were not provided.
Method of sampling; Location from where the was sample obtained:	Participants were conveniently sampled from a larger longitudinal study on anxiety disorders.
If the study has a control group and a comparison group, what description is given:	The group diagnosed with PTSD and anxiety was compared to the group with only an anxiety diagnosis.
Type of trauma event(s) experienced by the sample:	Kinds of traumatic events varied, however the most commonly cited was an attack with a weapon. The least cited military combat.
Is symptomatology self-reported by the sample, observed by the clinician, or both:	Symptomology was reported by patients.
Psychometric assessments used:	Assessment included Structured Clinical Interview of DSM-IV Axis I Disorders, Non-Patient Version (SCID-

	NP); Trauma Assessment for Adults; Longitudinal Interval Follow-Up Evaluation-Upjohn (LIFE-UP); and the RAND-36-Item Health Survey.
Comorbid conditions among participants:	Comorbid conditions mentioned included MDD, substance abuse and social anxiety disorder amongst others.
Culturally specific symptoms that are explored:	None
Conclusion and recommendations for future studies:	The findings revealed higher chronicity and comorbidity among African Americans with PTSD. This was also coupled with low psychosocial functioning. Results show that more should be done to decrease barriers to treatment since this population is vulnerable to development of PTSD. This cultural/racial group also is exposed to more events that are likely to result in trauma (e.g. violence, accidents etc.).

Article 23: Study on victimization of crime: The trauma of crime victims in Japan (1998) **Author(s): Konishi, T.** **Name of peer reviewed journal: Psychiatry and Clinical Neurosciences**	
Data of Interest	**Information Provided**
Objectives of the study; Rationale for including culture as a variable:	The article aimed to investigate the cultural differences in physical and mental symptoms of posttraumatic stress.
Definition of culture:	No definition is provided, however a discussion of the Japanese cultural response to trauma is present.
Culture of interest; Specific boundaries set for the investigation (inclusion/exclusion criteria):	Japanese citizens, no clear boundaries are set for the population being studied.
Cultural operational term used:	Nationality and ethnicity
Origin of study population: (include current country of residence for immigrant and refugee groups)	Japan.
Description of Cultural group(s) sampled: (include data on the culture of the practitioner if this available)	Case 1: 18 year old female rape survivor; Case 2: grieving 48 year old mother. The researcher is a Japanese practitioner that works at a counselling centre for victims of assault.
Method of sampling; Location from where the was sample obtained:	Conveniently sampled from clients already being treated at the Counseling Service for Crime Victim Assistance (CSVA) offices
If the study has a control group and a comparison group, what description is given:	No control group is present in the study, however the findings of the researcher are contrasted with is already known about trauma survivors in the U.S.
Type of trauma event(s) experienced by the sample:	Sexual assault and unanticipated death of a close family member.
Is symptomatology self-reported by the sample, observed by the clinician, or both:	In case 1 the symptoms of distress were recognised by the women's family and was later diagnosed with ASD followed by PTSD. In case 2, the patient directly contacted the centre for assistance.
Psychometric assessments used:	No assessments were completed.
Comorbid conditions among participants:	No comorbid conditions are mentioned.
Culturally specific symptoms that are explored:	No culturally unique symptoms are discussed; however the cultural response to trauma in Japan is elucidated.
Conclusion and recommendations for future studies:	The author highlights several differences in survivor's response to a trauma that are different from U.S. culture. He notes that Japanese persons may struggle in verbalising the feelings, and are also unlikely to seek assistance for emotional distress. Japanese persons are also more likely to experience secondary victimisation other members of society.

Article 24: When combat prevents PTSD symptoms—results from a survey with former child soldiers in Northern Uganda (2012) **Author(s): Weierstall, R., Schalinski, I., Crombach, A., Hecker, T. & Elber, T** **Name of peer reviewed journal: Biomedical Central Psychiatry**	
Data of Interest	**Information Provided**
Objectives of the study; Rationale for including culture as a variable:	The study investigated the relationship between perpetrating violent acts and PTAD among Ugandan child soldiers.
Definition of culture:	No definition is provided
Culture of interest; Specific boundaries set for the investigation (inclusion/exclusion criteria):	Culture of Northern Uganda; no clear boundaries set by authors (no other information provided regarding distinctiveness of cultural cohort). To be included participants had to be male soldiers that spoke the Acholi language.
Cultural operational term used:	Geographical location, nationality, and language
Origin of study population: (include current country of residence for immigrant and refugee groups)	Northern Uganda. Participants were soured at camp for the internally displaced; however no information is given regarding their home-based location.
Description of Cultural group(s) sampled:(include data on the culture of the practitioner if this available)	Described as Ugandans aged 17-27 that had been abducted by the Lord Resistance Army (LRA).
Method of sampling; Location from where the was sample obtained:	Convenient sampling of persons in a camp of internally displaced people.
If the study has a control group and a comparison group, what description is given:	No non-abducted control group of soldiers was used to compare the findings.
Type of trauma event(s) experienced by the sample:	Exposure to war- related and non-war associated trauma
Is symptomatology self-reported by the sample, observed by the clinician, or both:	Symptomology was observed by the clinician. A survey was conducted among camp of displaced persons and counsellors approached persons they felt were appropriate.
Psychometric assessments used:	Appetite for Aggression Scale (AAS); Posttraumatic Diagnostic Scale (PDS)
Comorbid conditions among participants:	None mentioned.
Culturally specific symptoms that are explored:	None.
Conclusion and recommendations for future studies:	The study found that being exposed to high levels of violence increased participants appetite for aggression. An intensification of aggression may possibly make perpetrators more vulnerable to becoming traumatised.

Article 25: Stories of Trauma and Idioms of Distress: From Cultural Narratives to Clinical Assessment (2000) **Author(s): Rechtman, R.** **Name of peer reviewed journal: Transcultural Psychiatry**	
Data of Interest	**Information Provided**
Objectives of the study; Rationale for including culture as a variable:	The article aimed to investigate the influence of culture on the trauma experience of a Cambodian refugee living in France.
Definition of culture:	Culture is described as giving meaning to human experience. The manner in which cultural idioms of distress shape appraisals of trauma is also discussed.
Culture of interest; Specific boundaries set for the investigation (inclusion/exclusion criteria):	Cambodian culture. Women belong to the Khmer ethnic group. No other boundaries were set.
Cultural operational term used:	Nationality and ethnicity
Origin of study population: (include current country of residence for immigrant and refugee groups)	Cambodian refugee living in France
Description of Cultural group(s) sampled: (include data on the culture of the practitioner if this available)	A Khmer Cambodian women (the researcher's cultural leaning is not stated). Described as a 20-something year old Cambodian woman.
Method of sampling; Location from where the was sample obtained:	Convenient sampling by means of an outpatient program
If the study has a control group and a comparison group, what description is given:	No control group was included
Type of trauma event(s) experienced by the sample:	Exposure to war- related trauma
Is symptomatology self-reported by the sample, observed by the clinician, or both:	It is unclear if the patient sought assistance for her symptoms of if the features of PTSD were recognised in her by a treating professional.
Psychometric assessments used:	No assessments were employed
Comorbid conditions among participants:	None mentioned.
Culturally specific symptoms that are explored:	Aspects such as Khmoc are explored
Conclusion and recommendations for future studies:	The case study found that although the traumatised woman was experiencing symptoms that were distressing to her, the event she experienced did not meet DSM-IV criteria of being outside the range of human experience.

Article 26: PTSD of rape after IS ("Islamic State") captivity (2018) **Author(s): Kizilhan, J. I.** **Name of peer reviewed journal: Archives of Women's Mental Health**	
Data of Interest	**Information Provided**
Objectives of the study; Rationale for including culture as a variable:	The article aimed to investigate PTSDA prevalence among Yazidi women, and also look at predisposing factors.
Definition of culture:	No definition is provided
Culture of interest; Specific boundaries set for the investigation (inclusion/exclusion criteria):	Yazidi females from northern Iraq. No other boundaries appear to have been set.
Cultural operational term used:	Nationality and ethnicity
Origin of study population: (include current country of residence for immigrant and refugee groups)	Sinjar, Iraq; were residing in Germany at the time of the study.
Description of Cultural group(s) sampled:(include data on the culture of the practitioner if this available)	296 women aged 18-38, half were married prior to Islamic State attacks, and approximately 17% had become widowed as a result of the violence (no information about the researcher is given).
Method of sampling; Location from where the was sample obtained:	Convenient sampling by from a refugee facility.
If the study has a control group and a comparison group, what description is given:	No control group was included
Type of trauma event(s) experienced by the sample:	Were taken into captivity by the Islamic State, all of the women had endured rape.
Is symptomatology self-reported by the sample, observed by the clinician, or both:	It is unclear how women were chosen for the study. The total number of women in the facility was 1100.
Psychometric assessments used:	Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders (SCID) and the Event Scale, modified from Dyregrov et al. (2000)
Comorbid conditions among participants:	None mentioned.
Culturally specific symptoms that are explored:	None.
Conclusion and recommendations for future studies:	The study found that PTSD was prevalent in the sample. Rape and subsequent pregnancy was found to have a lasting impact on the women.

Article 27: Post-traumatic stress disorder in children and adolescents one year after a super-cyclone in Orissa, India: exploring cross-cultural validity and vulnerability factors (2007) **Author(s): Kar et al.** **Name of peer reviewed journal: Biomedical Central Psychiatry**	
Data of Interest	**Information Provided**
Objectives of the study; Rationale for including culture as a variable:	Article aimed to investigate trauma among children and adolescents in India.
Definition of culture:	No definition is provided
Culture of interest; Specific boundaries set for the investigation (inclusion/exclusion criteria):	Culture of Orissa Indians. No clear boundaries to have been set.
Cultural operational term used:	Geographical location and nationality.
Origin of study population: (include current country of residence for immigrant and refugee groups)	Orissa, India.
Description of Cultural group(s) sampled: (include data on the culture of the practitioner if this available)	447 children and adolescents, ages 7–17 years, the investigators were local psychiatrists in the area.
Method of sampling; Location from where the was sample obtained:	Purposive sampling from schools in different districts.
If the study has a control group and a comparison group, what description is given:	Participants were separated into exposure groups for comparison purposes. The groups were namely: high exposure areas (HEA) and low exposure areas (LEA).
Type of trauma event(s) experienced by the sample:	Exposure to a natural disaster
Is symptomatology self-reported by the sample, observed by the clinician, or both:	Whole classes from schools were selected to be interviewed. Clinicians that interviewed the participants observed the symptomology.
Psychometric assessments used:	An adapted questionnaire based from the International Classification of Mental and Behavioural Disorders, 10th revision: Diagnostic Criteria for Research (ICD-10DCR).
Comorbid conditions among participants:	None mentioned.
Culturally specific symptoms that are explored:	None.
Conclusion and recommendations for future studies:	The study found that not only is PTSD a useable construct in this population group but it is appears to presents with symptoms similar to other cultures.

Article 28: The structure of post-traumatic stress disorder and complex post-traumatic stress disorder amongst West Papuan refugees (2015) **Author(s): Tay et al.** **Name of peer reviewed journal: Biomendical Central Psychiatry**	
Data of Interest	**Information Provided**
Objectives of the study; Rationale for including culture as a variable:	The study aimed to investigate the validity of the PTSD and C-PTSD constructs amongst West Papuan refugees.
Definition of culture:	No definition is provided.
Culture of interest; Specific boundaries set for the investigation (inclusion/exclusion criteria):	West Papuan nationals; plenty history and context for this group is given (from historical challenges in their home country to their adjustment as refugees)
Cultural operational term used:	Nationality and ethnicity
Origin of study population: (include current country of residence for immigrant and refugee groups)	Originally from Western New Guinea, but now seeking refuge in Port Moresby, Papua New Guinea.
Description of Cultural group(s) sampled: (include data on the culture of the practitioner if this available)	230 West Papua nationals (men 137 and women 93); no information on the researchers is provided.
Method of sampling; Location from where the was sample obtained:	Purposive sampling from persons participating in a larger community study.
If the study has a control group and a comparison group, what description is given:	No control group was included
Type of trauma event(s) experienced by the sample:	Exposure to war- related and a natural disaster
Is symptomatology self-reported by the sample, observed by the clinician, or both:	Symptoms were identified by fellow refugees trained by qualified psychologists.
Psychometric assessments used:	Traumatic events (TEs) assessment, subscales of a measure resulting from the Adaptation and Development After Persecution and Trauma (ADAPT) model, and a culturally sensitive tool for PTSD measurement.
Comorbid conditions among participants:	None mentioned.
Culturally specific symptoms that are explored:	None.
Conclusion and recommendations for future studies:	Results indicated that the three core symptoms of PTSD (intrusions, hyper-arousal and avoidance) were valid amongst the population sampled, CPTSD symptoms however did not appear to form a cohesive constellation. The findings relating to PTSD were valid for the ICD-10 and 11, but the no supporting evidence was found for the DSM-IV and DSM-5 descriptions of the disorder.

Article 29: Short report: Influence of culture and trauma history on autobiographical memory specificity (2012) **Author(s): Humphries, C. & Jobson, L.** **Name of peer reviewed journal:**	
Data of Interest	**Information Provided**
Objectives of the study; Rationale for including culture as a variable:	The article investigated autobiographical memory among Chinese and British undergraduate students.
Definition of culture:	Distinction is made between individualistic and collectivist cultures are made.
Culture of interest; Specific boundaries set for the investigation (inclusion/exclusion criteria):	British and Chinese cultures; students were excluded if they had existing psychiatric diagnoses or conditions linked to reduced autobiographical memory ability.
Cultural operational term used:	Nationality
Origin of study population: (include current country of residence for immigrant and refugee groups)	
Description of Cultural group(s) sampled: (include data on the culture of the practitioner if this available)	64 students participated (37 British and 27 Chinese); the cultural leaning of the researchers are not stated.
Method of sampling; Location from where the was sample obtained:	Convenient sampling from the University of East Anglia.
If the study has a control group and a comparison group, what description is given:	To compare groups were split into high and low trauma exposure.
Type of trauma event(s) experienced by the sample:	Varying kinds of trauma
Is symptomatology self-reported by the sample, observed by the clinician, or both:	Symptoms were reported by participants to the researcher.
Psychometric assessments used:	Autobiographical Memory Test (AMT), Impact of Event Scale Revised, Hopkins Symptom Checklist - 25 (HSCL-25), Twenty Statement Test(TST), and Trauma History Questionnaire (THQ)
Comorbid conditions among participants:	None present
Culturally specific symptoms that are explored:	None.
Conclusion and recommendations for future studies:	The results of the study suggest that notwithstanding culture's influence on memory accuracy, trauma exposure appears to exert similar influence on autobiographical memory specificity.

Article 30: Individual and Collective Traumatic Memories: A Qualitative Study of Post-Traumatic Stress Disorder Symptoms in Two Latin American Localities (2001) **Author(s): Elsass. P.** **Name of peer reviewed journal: Transcultural Psychiatry**	
Data of Interest	**Information Provided**
Objectives of the study; Rationale for including culture as a variable:	Article investigated the PTSD diagnosis amongst persons from Peru and Columbia
Definition of culture:	No definition is provided
Culture of interest; Specific boundaries set for the investigation (inclusion/exclusion criteria):	In Peru persons from mixed Indian Peruvian origin and in Quechua-Indians were interviewed In Columbia Arhuaco-Indians and mixed Indian Peruvian people were interviewed. 4 psychologists and 3 anthropologists working in the area were also consulted.
Cultural operational term used:	Ethnicity and race
Origin of study population: (include current country of residence for immigrant and refugee groups)	Columbia and Peru
Description of Cultural group(s) sampled: (include data on the culture of the practitioner if this available)	8 persons were interviewed in Peru and 7 people spoke to the researcher. No other description of the participants is given apart from their ethnicity.
Method of sampling; Location from where the was sample obtained:	Conveniently sampled from different villages and location s in Peru and Columbia.
If the study has a control group and a comparison group, what description is given:	No control group was included, however the findings are compared to wat is known about trauma in Western nations.
Type of trauma event(s) experienced by the sample:	Exposure to war- related and a natural disaster
Is symptomatology self-reported by the sample, observed by the clinician, or both:	Participants self-reported symptoms to the research
Psychometric assessments used:	No assessments were conducted.
Comorbid conditions among participants:	None mentioned.
Culturally specific symptoms that are explored:	Cultural methods of healing are explored a well as the local conceptualisation of trauma related distress.
Conclusion and recommendations for future studies:	The findings from Peru showed that affected individuals had symptoms consistent with PTSD, however they also presented with other additional symptoms. In Columbia the persons interviewed did report some symptoms of PTSD, however their symptom patterns did not fit the usual syndrome.

Appendix E

Theme summary map

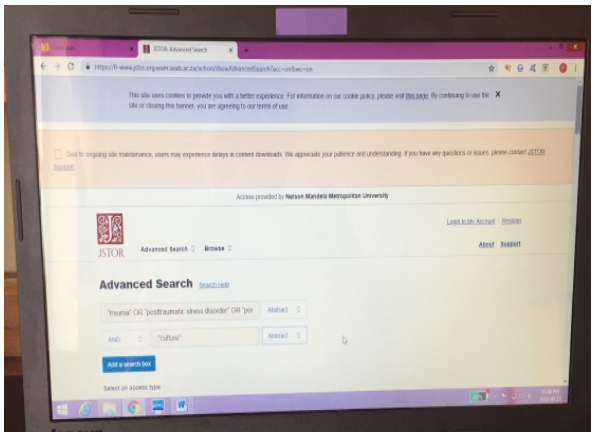
	Article																
Themes	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**
Culture																	
Definition for culture							X	X	X	X		X	X		X		X
Specific frame of culture for study	X		X	X	X		X	X	X	X	X		X	X	X	X	X
Rationale for manner of operationalization	X	X		X		X	X	X	X						X		
Trauma																	
Unique relationship between trauma experienced and culture of interest	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	
Symptomatology																	
cultural conceptualisations of distress					X	X										X	
Culturally unique expression of symptoms (culture bond syndrome)					X							X					
Cultural practices engaged in believed to ameliorate symptoms					X							X					

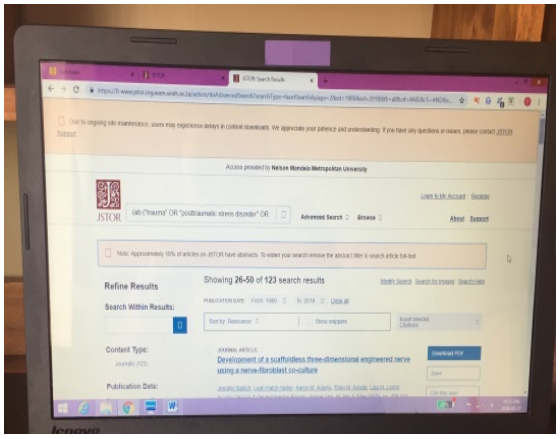
	Article													
Themes	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	
Culture														
Definition of culture												X		
Specific frame of culture for study	X		X	X	X	X	X	X	X	X	X	X	X	
Rationale for manner of operationalization		X	X		X									
Trauma														

Unique relationship between trauma experienced and culture of interest	X	X	X	X	X	X	X	X	X	X	X	X	X	
Symptomatology														
cultural conceptualisations of distress								X					X	
Culturally unique expression of symptoms (culture bond syndrome)								X						
Cultural practices engaged in believed to ameliorate symptoms								X					X	

Appendix F
Database Search Results

JSTOR





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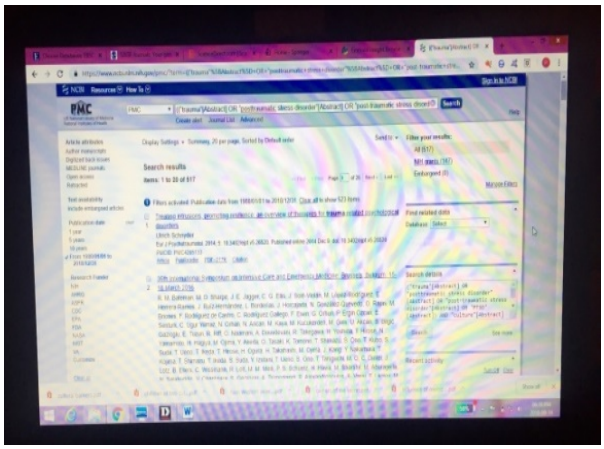

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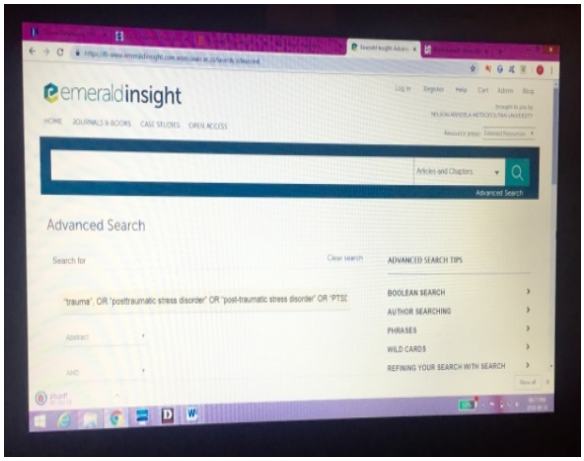

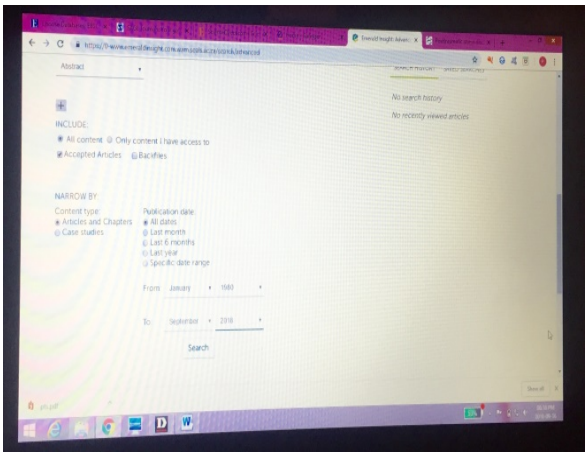

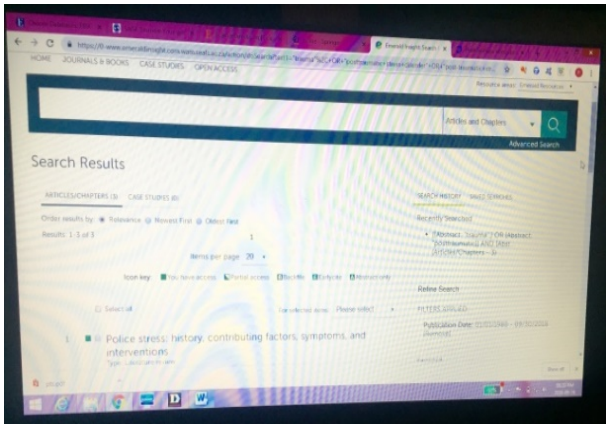
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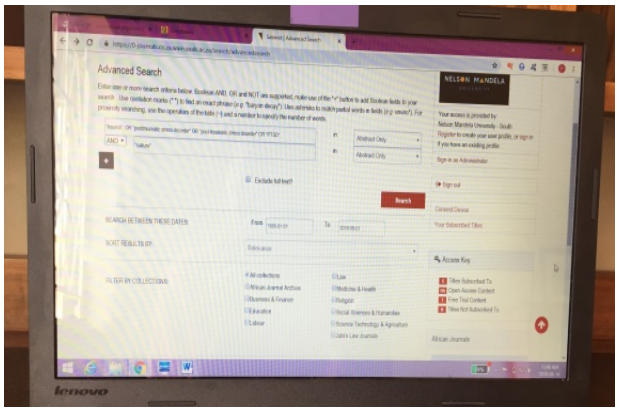
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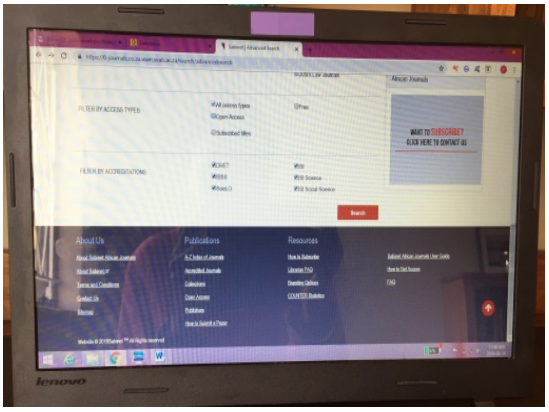
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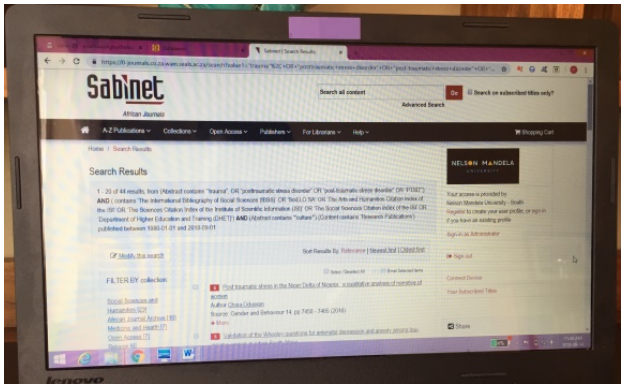
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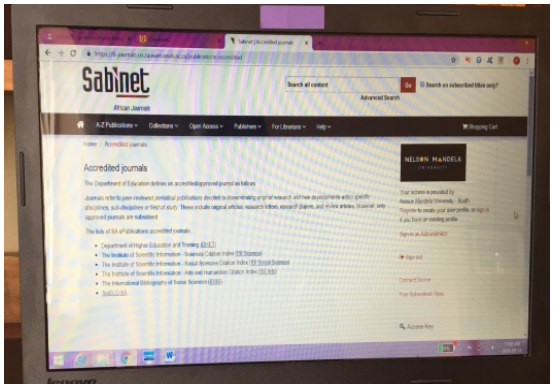
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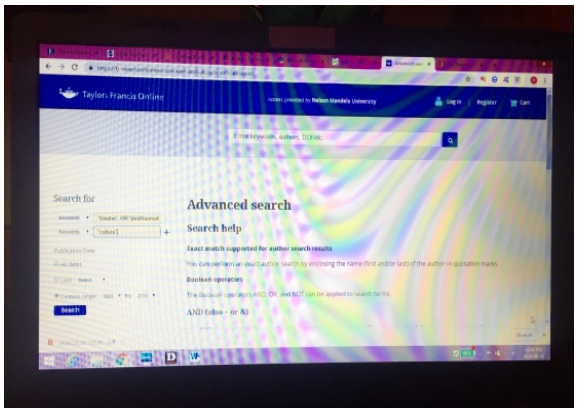

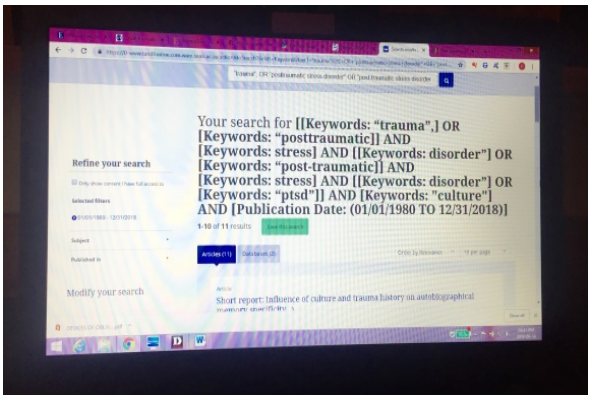

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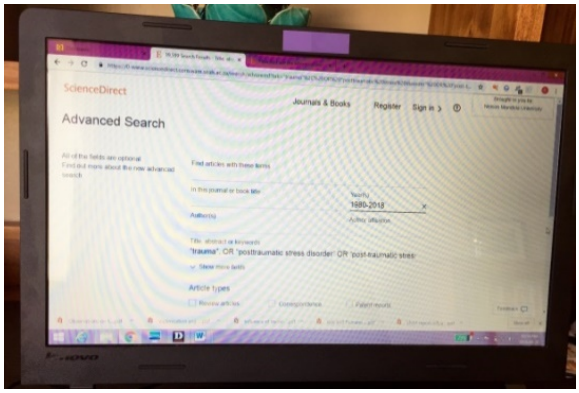

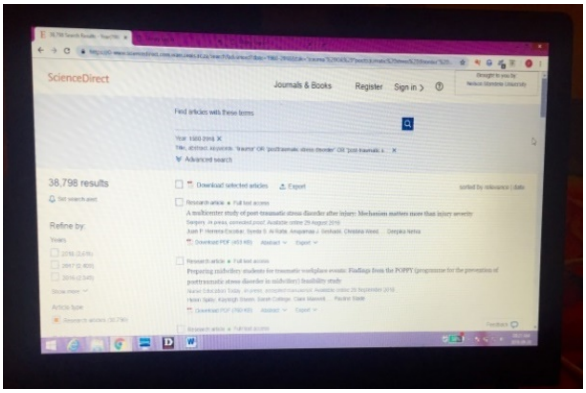

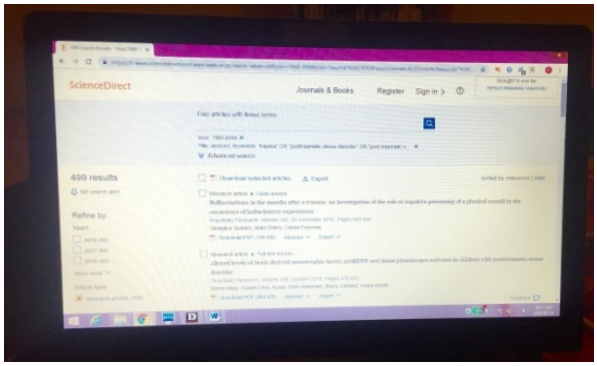

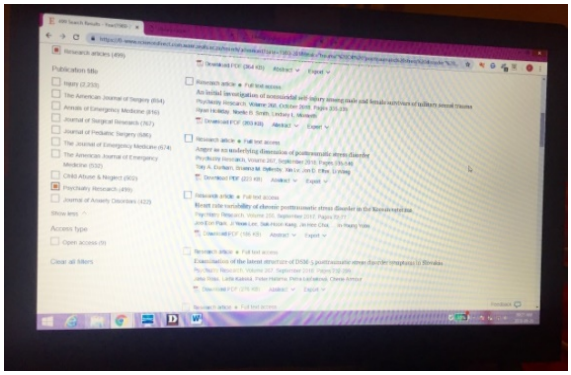

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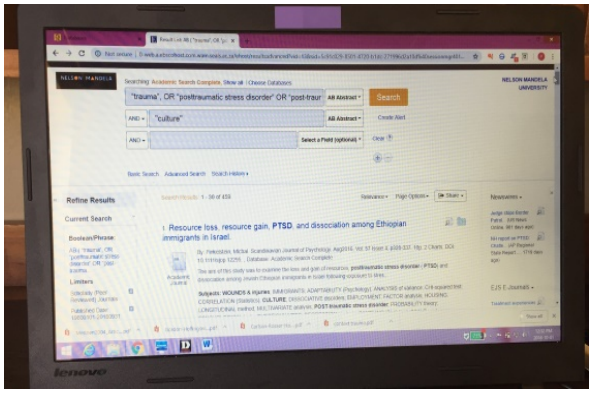

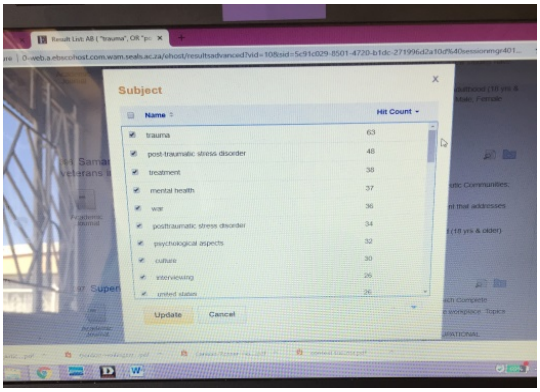

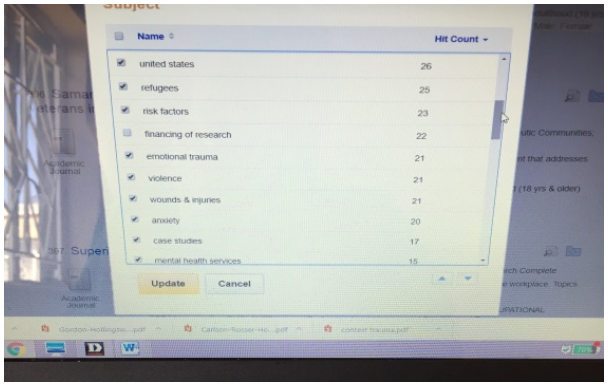

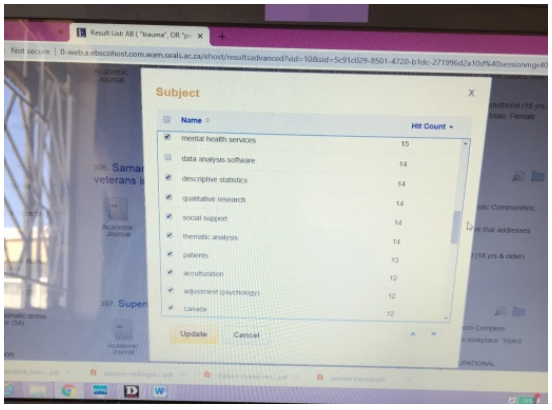

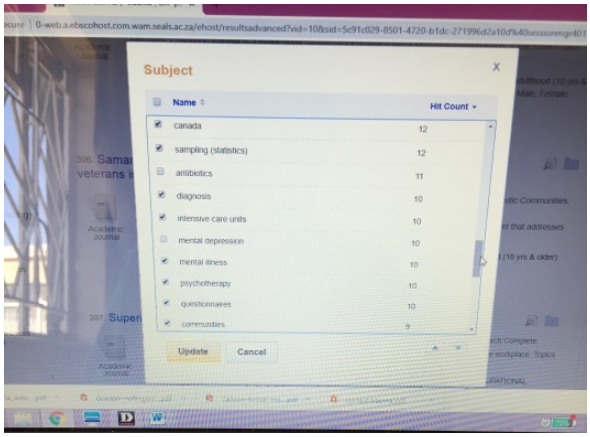

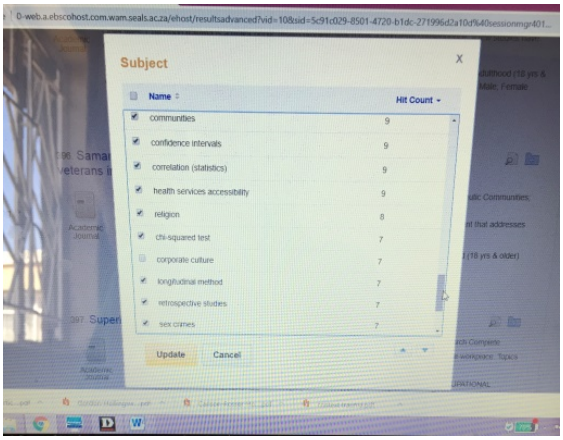

Subject headings selected: trauma, post traumatic stress disorder, treatment, mental health, war, posttraumatic stress, psychological aspects, culture, interviewing, united states, refugees, risk factors, emotional trauma, violence, wounds and injuries, anxiety, case studies, mental health services, descriptive statistics, qualitative research, social support, thematic analysis, patients, acculturation, adjustment, Canada, sampling, diagnosis, intensive care units, mental illness, psychotherapy, questionnaires, communities, confidence intervals, correlation, health services accessibility, religion, chi squared test, longitudinal method,retrospective studies, and sex crimes.

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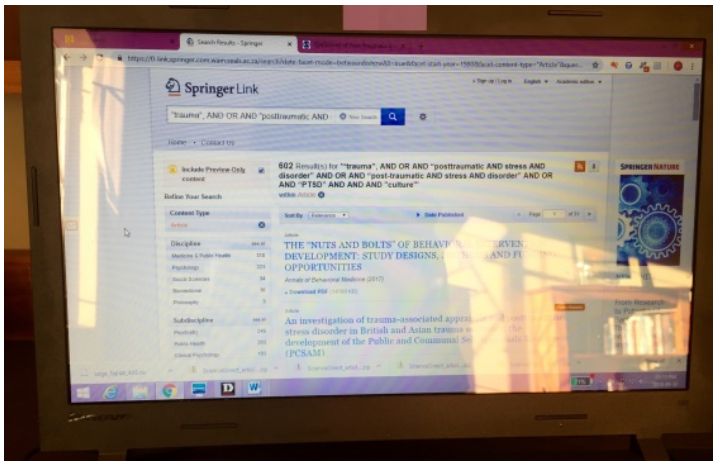

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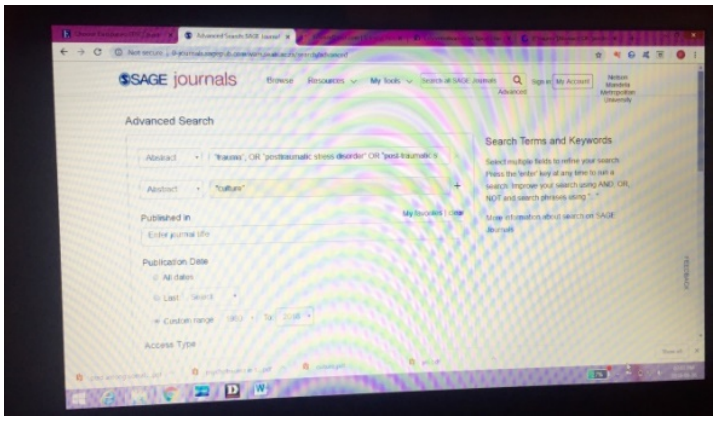

Appendix G
Theme Development and Coding

	Article Text of Prominence	Initial Succinct Label or Code	Grouped Similar Codes	Potential Themes	Final Themes
Article1	"reviews of the international literature, however, reveal that post-traumatic stress disorder (PTSD) responses in children are less studied than those of adults (16% as opposed to 70%), and populations in developing countries are less studied than those in industrialized countries "Sri Lankan communities might be more likely to engage with others rather than withdraw from them" "historical and sociopolitical circumstances of ethnic groups could shape the manifestations of their disaster responses, accentuating some types of symptoms and diminishing others" "arguments highlight the need for empirical evidence on potential cultural variations in the manifestation of PTSD among non-Western populations living in their home countries as well as those who might emigrate abroad" "All the participants were born after the war began in 1983 so they had never known life in peacetime." "predisaster PTSD data were nonexistent in the population studied" " community-based interventions explicitly acknowledge the shared nature of the problems, thereby preventing isolation and its iatrogenic consequences."	Prevalence differences in children and adults, as well as between industrialised and developing countries Differences for Sri Lankan pop. Historical and sociopolitics influence symptom expression More evidence needed in understudied groups Protracted war impact on children No baseline trauma information present amongst Sri-Lankans prior to this study Interventions take culture into consideration	Number of studies differs from adults to children and from cultural group to cultural group Context of illness presentation is important (historical or protracted trauma in the area, soci-political climate of war or oppression).	Cultural differences between research and participants	Researcher and participant differences

Article 2	"Before the 1950s Greenland was a closed country with little external cultural influence." "Non-Inuit people have poured into the country and have filled many of the well-paid jobs and influential positions available. In addition, the transition has brought about increased contact with the rest of the world." "Due to lingual or cultural differences, the researcher requested that the teachers for each class would assist in providing translations and/or explanations of questions from the students." "The above suggests that Greenlandic adolescents are not exposed to more PTEs on average than adolescents from other parts of the world, but that they are indeed more exposed to certain specific PTEs" "there is clear and compelling evidence that the long history of cultural oppression and marginalisation has contributed to the high levels of mental problems found in many Indigenous peoples." "It has been suggested that people in smaller towns are more vulnerable towards adverse life events."	Little influence from other cultures Increased engagement with non-Inuit people Linguistic differences during assessments with participants Certain kinds of trauma are more likely to result in PTSD (kind of trauma experienced by the culture being studied is important) History of oppression makes certain groups vulnerable Vulnerability of living in a small community	Evidence is lacking in understudied populations	Western PTSD model versus local concept of traumatic distress	Different expressions of distress

Article 3	" Nevertheless, the latent structure of PTSD is quite topical in that it continues to be debated in the extant literature." " Some have found that the proposed DSM-5 model of PTSD demonstrates a good fit (e.g., Elhai et al., 2012; Keane et al., 2014), whereas others have chosen to focus on and borrow from the previous dysphoric and dysphoric arousal models based on DSM-IV" " Thus, the first aim of this study was to assess the underlying substructure of PTSD, as described in DSM-5 after the Ya'an earthquake in a sample of Chinese adolescents by using a confirmatory factor analytic alternative models approach" " our second aim was to evaluate the external and discriminant validity of the optimal model identified in the first analysis by examining correlations between PTSD symptom factors and external measures of depression and anxiety" " Our results indicated that all six models were acceptable, but the seven-factor hybrid model provided the best fit to the data when compared to the other competing models" " The current study should also be interpreted in light of some limitations. First, instead of using clinician ratings, this study used self-report instruments to detect and diagnose PTSD"	Latent structure of PTSD has sparked much research Different models for PTSD have been proposed Many models proposed are tested across differing groups PTSD model also compared to MDD and Anxiety symptomology in specific groups All models proposed were a fit in a Chinese group Participants reported their symptoms as opposed to clinicians/ possibility of incorrect answering	History of certain cultural groups makes them vulnerable to PTSD	Differences in symptoms reported by population groups	The stigma of posttraumatic distress
Article 4	" Because of the absence of wars, natural disasters, or a culture of rape, the stressor trauma examined in our pilot study was domestic violence" " which lends to Ju/'hoansi domestic violence the distinctive and strong fear that such incidents could well end in death" " In the Ju/'hoan culture, aggression and violence after drinking are attributable, not to the individual, but to the state of drunkenness; "the fault is in the beer" "A few of the DSMIV concepts (e.g., psychic numbing) proved quite difficult to express in the Ju/'hoan language. However, through iterated give-and-take between translator" " The findings of this pilot study were that among the Kalahari assault victims, intrusive and arousal symptoms were universal, but only 35% of the sample met full criteria for PTSD because of the avoidance items that are typically assessed."	Domestic violence is most widespread trauma in this group Lack of medical personnel made this community fear consequences of violence Language difficulty in communicating PTSD diagnosis in this community Intrusive and arousal symptoms were found, but avoidance symptoms were less likely to be reported	Kinds of trauma more common in certain groups e.g. domestic violence in Brazil	Certain kinds of trauma more common among certain groups	

Article 5	" She attributed her worsening to a nightmare" " Many Cambodian refugees arrived traumatized and had trouble adjusting due to language problems, disrupted family and social networks, low status and, for a long time, the lack of culturally sensitive mental health resources" " we argue that to understand the key role of nightmares in the Khmer trauma ontology, one must explicate the Cambodian conception of personhood: multiple ''layers'' protect the self and produce ''ontological security'" " For a Cambodian refugee, a nightmare raises concerns that a protective layer of the self is defective, that forces that should protect one are not intact" "every patient had a panic attack after awakening from the most recent nightmare." " The clinician should determine the patient's trauma associations with the nightmare's content, the patient's understanding of the nightmare and what the patient has done as a result of the nightmare"	Apart from trauma experienced, refugees face adjustment challenges Cambodian concept of person as consisting of multiple layers important for understanding their experience of trauma Panic attacks were experienced by all participants Clinician should seek understanding and actions taken by patient	Adjustment of refugees and immigrants Ontological perspective of the self that influences interpretation of symptoms. E.g. nightmares in among the Cambodian pop.	Increased vulnerability in groups with history of protracted trauma (war/abuse)	
Article 6	" Dissociation is an important if less familiar and less studied posttraumatic symptom than PTSD or depression" " We see severe dissociation as a component of PTSD that could be conceptualized as cognitive avoidance" "We asked ten literate Cambodians (who were blind to all other aspects of the study) to rate each of the experiences on a scale from 0 to 100 in terms of how upsetting the experience would be to a Cambodian (with 100 being the most severe)." " Criteria of emotional detachment, restricted range of affect, and sense of a foreshortened future were not included as they were thought to translate poorly to Cambodian culture where overt affective expression is socially undesirable" " The subjects in this study showed high levels of the symptoms seen in other groups who have suffered traumatic experiences." " the Cambodian refugees we studied did show the same basic picture of symptoms that have been observed in survivors of trauma in the United States"	Dissociation has not been studied as in-depth as other PTSD symptoms Cambodians were consulted about what is traumatising for this community Symptom such as restricted affect, sense of foreshortened future and detachment were not included for this group Symptoms in this group were similar to what has been seen in the US	There are studies that have confirmed existence of PTSD in non-western groups	Ethnic, religious, language differences in cultural groups	

Article 7	" Europeans and Americans frequently provide self-revealing, self-focused memories of specific, personal events and tend to differ in the ratings of the phenomenological properties of their autobiographical memories when compared to those from Asian and Middle Eastern cultures, who instead tend to focus on collective activities, social interactions and significant others" " the individualistic non-PTSD group reported significantly higher recollection, language and fragmentation properties and significantly less rehearsal for both trauma and negative memories than did the collectivistic non-PTSD group." "Participants' tendency to express self-determination and autonomy in their memories was indexed using the autonomous-orientation variable." "Iranian immigrants had significantly less egocentric, autonomously oriented and specific memories than those in their host culture (Britain), but did not differ significantly from those in their culture of origin (Iran). In contrast to that predicted the phenomenological properties." "Iranian immigrants lead a bicultural life in that they adopt aspects of their new culture (phenomenological properties) while preserving values and practices (memory-content and specificity) from their home culture."	Individualistic persons share memories of the self that are more self-focussed Collectivist persons emphasise others. Individualistic persons had higher language, recollection, and fragmentation and lower rehearsal than collectivistic persons. Iranian participants had less ego-centric memories than British participants. Iranian immigrants had adopted aspects of the British culture.	Memory and culture may interact in how persons consolidate their autobiographical memories	Refugee and immigrant adjustment to new location	
Article 8	"Mental health is a subjective concept influenced by culture." "The western conceptualization of mental health and mental illness may not be universally applicable." "… Account for the uniqueness of the culture. As practitioners, an ethical diagnosis must include a cultural context that considers the whole field of a victim's relationship to the trauma." " The results suggest that mental health care, in the form of further assessment for chronic PTSD and specific interventions, is needed for at least half of the Galle population and about a quarter of the Kegalle population." "Prolonged PTSD can have later complications with detrimental effects for a collective society."	Mental health is subjective and influenced by culture Clinicians need to consider the patients context when diagnosing Results showed than more investigation is needed into chronic PTSD and appropriate interventions in the Kegalle community Prolonged PTSD impacts the collective group	Refugees avoid seeking assistance because of cultural concerns e.g. Arab women in America that don't seek assistance because of societal attitude towards Muslims; Japanese suffer secondary victimisation for sexual trauma	Consideration of accculturation	

Article 9	"Autobiographical memory is central to current understandings of posttraumatic stress disorder (PTSD)." "Paradoxically, this elevated involuntary access to memories of the trauma is often accompanied by compromised voluntary access to coherent accounts of what happened during traumatic experiences (Brewin, 2011). Thus, the phenomenological properties of trauma accounts often include being fragmented, temporally disorganized, and laden with sensory-perceptual features." "research has shown that individuals with PTSD have significant difficulties in providing specific autobiographical memories of everyday events (i.e., memories of discrete occasions that occurred at a particular time and place). Instead, PTSD sufferers tend to retrieve categoric overgeneral memories (OGMs; i.e., memories for collections of events; see Moore & Zoellner, 2007; Williams et al., 2007)." "These autobiographical-memory disruptions can be conceptualized within our Self-Memory System model…The SMS posits that a motivational hierarchy of goals (the working self) encodes and integrates memories into an autobiographical knowledge base—a hierarchically arranged database of memories with general summaries of broad categories of lifetime periods…Voluntary retrieval of specific event details requires navigating down this hierarchy. However, retrieval can also occur via direct, involuntary access to specific event representations in the memory hierarchy, thus bypassing the hierarchical search." " An OGM retrieval style may create less affect than the recollection of specific episodic memories, given that remaining at this level of more general information reduces the impact of retrieving potentially emotional material"	Symptoms can persist for long period following diagnosis Trauma results in increased access to memories, this also leads to fragmented recall of the trauma event Trauma results in everyday memories being impaired but general memories are intact Memories serve us by helping us organise our working self, witting retrieval of information can also trigger recall of specific events central to the working self Remaining at a general memory and not recalling the traumatic material reduces emotion around the event	Treatment is sought in accordance with beliefs. Religious practices Stigma around PTSD in some communities	Identity in countries with various religions and ethnicities Investigators eliciting reports of PTSD symptoms versus participants volunteering information regarding their distress	

Article 10	" Shame and guilt feelings related to the traumatic event and its consequences might also interfere with emotional processing of the trauma (La Bash & Papa, 2014), contributing to long-term consolidation and retention of PTSD" "Bedouin soldiers face tension between identification with the IDF and their mistrust toward the state, as it manifests in civil discrimination and neglect, and growing criticism by the general Arab public for their participation in military activities against Palestinians in the West Bank and Gaza." " the community's negative stigma toward mental health problems and the deep-seated fear of being labeled affect treatment utilization and are considered as some of the primary barriers to early identification and early intervention" "themes were revealed: (1) "'I wanted to be like everyone else'… (2) "Fluctuating between belonging and the experience of mental injury." " In the case of the Bedouin minority in the Israeli military, the Arab culture and Muslim faith potentially represent additional challenges due to the ongoing tensions and suspiciousness that characterize Jewish–Arab relations." "The "perceived self" is a mediating factor that allows for a culturally informed interpretation of the posttraumatic experience, as it relates conjointly to the society and culture as to the meaning derived from the personal narrative, relationship to others, cognitive structures, values, and beliefs" "The veterans expressed shame, mainly through describing reluctance to share their emotional experiences, due to criticism by others" "Alam's words seem to imply criticism of Bedouin soldiers who suffer from PTSD, suggesting that their distress is almost faked or unreal."	Feelings of shame and guilt interfere with how trauma event is processed Soldiers felt torn between their loyalty to the Israeli Defence Force and their distrust towards their state who are criticised for their activities against Palestine Stigma prevents veterns from seeking assistance Veterans volunteered to join the military yet they had lost trust in the Ministry of Defence The perceived self is includes interpretation of trauma event and other cultural/societal aspects Many veterans did not express their pain to family out of fear, and shame	Collectivist emphasis on impact of trauma on social roles Language challenges for researchers investigating remote cultural groups. Applicability of assessments used? e.g. Kalahari Bushmen study that translated assessment tools	Stigma of PTSD/ distress in some communities	
Article 11	"Victims of violent crimes have a high incidence of psychological problems, including posttraumatic stress disorder (PTSD) and depression" " Malaysian women reported staying in their abusive relationships longer than women in the US sample." "present study found that a majority of Malaysian women who experience partner abuse and seek help from a shelter, endorse posttrauma symptoms and meet self-report based criteria for posttraumatic stress disorder."	Violent crime survivors have high rate of PTSD, and MDD Malaysian women stay in abusive situations longer than US women			

Article 12	"Although there is some evidence of the posttraumatic stress disorder (PTSD) construct's cross cultural validity, trauma-related disorders may vary across cultures, and the same may be true for treatments that addresssuch conditions." "These approaches differ in various ways including the duration and number of sessions, as well as the number and diversity of interventions. However, they also have many commonalities, such as psychoeducation, imaginal exposure, cognitive restructuring, or meaning making." "But these cultures have access to Western cultures such that they influence one another and share some, although not all, basic assumptions. These common aspects allow successful dissemination of PE and other psychosocial treatments." "the great majority of traumatized refugees do not receive trauma-focused therapy, largely because cultural differences with regard to, for example, the way of establishing and maintaining a therapeutic relationship or basic ethical values such as trustworthiness and discreetness…" "She is Kisii by tribe, one of the 42 Kenyan ethnic groups, each with their own different indigenous cultures. These cultures dictate healing methodologies, practices, and rituals that govern mourning especially following traumatic death." "Interpersonal violence (including both community violence, and family and intimate partner violence) in Brazil is high." "Psychotherapy was no concept for her as she relied on traditional and religious ways of healing, including the use of local herbal extracts. Her interpretation of the incident was entirely religious, and she felt deeply ashamed as she perceived that various moral transgressions of herself as well as her community were responsible for the incident." " culture is not always right (Dyregrov et al., 2002). We need to beware of premature cultural stereotyping and false dichotomies such as Western versus nonWestern cultures or developed countries versus LMICs."	Trauma varies across cultures, treatments should be sensitive to this Despite the differences there is also similarities in treatment Cultures do not exist in isolation, the multiple societal elements that influence patients should be considered Refugees often do not receive treatments cause of cultural concerns e.g. trustworthiness, discreetness Kenyan patients may rely on ethnic and religious methods of healing Brazil experiences higher intimate partner violence A German patient sought herbal and religious means to heal from her trauma Stereotypes of West and non-West may not always serve us.	DSM use in America versus ICD use in Europe Many understudied populations		

Article 13	"Berntsen and Rubin (2006, 2007) posit that self-change occurs because memories of the trauma are highly accessible and easily evoked, and hence, the trauma event becomes perceived over time as 'a major causal agent'." " For Conway, any change in the conceptual self will be motivated by a drive for self-coherence." " A number of cross-cultural researchers have argued (Suh, 2000, 2002) and shown (Kanagawa, Cross, & Markus, 2001), however, that self-consistency needs are culturally variable." "In these cultures, promoting the self by means such as publicizing the individual's life story, personal identity, and uniqueness, mastery or lack of mastery are accepted, valued and culturally sanctioned (e.g. Wang, 2001). Summerfield (2004) posits that in such cultures the private self and individual emotion/vulnerability is emphasized following trauma. Therefore, the social role of trauma survivor/victim aligns with independent cultural expectations." " interdependent culture is associated with a sense of duty towards one's group, interdependence with others, a desire for social harmony, conformity to social norms, and roles and status defined within the group (Green et al., 2005; Sato, 2001). Discussing the individual's life story, personal identity, and uniqueness may be viewed as abnormal, immature, or arrogant, i.e. culturally inappropriate." "the findings are consistent with those of other studies that show trauma memory can become salient in self-conception and thus an important component of personal identity and self-definition in PTSD." "while a clinical awareness of the impact of trauma on identity and self-definition is important, awareness needs also consider cultural factors which moderate any impact."	Given that the trauma event is so easily remembered it becomes a major casual event over time Self-coherence is the primary goal of the individual; all change is motivated by this Self-coherence needs may be culturally variable Individualistic cultures that emphasis narrative of the self may be advantaged in that they give full expression to trauma emotion Collectivist culture does not place as much vale on individual personal experience Trauma memory becomes salient in self-definition Clinicians should remain aware of Influence of trauma on self-perception and cultural attitude towards this	Having many cultural influences. Israeli soldiers that are Muslim and live in a Jewish nation but fight who fight against Palestine. Differences in symptoms reported by cultural groups e.g. avoidance symptoms less likely to be reported by Bushmen participants		

Article 14	"Despite the large number of studies conducted in this area, with the majority pointing to the superiority of the Hybrid model, the consensus regarding the true latent structure of PTSD is yet to be reached." " the DSM is being used primarily in the US, whereas the Europe relies more heavily on the International Classification of Diseases (ICD), currently in its tenth edition." "Slovakia is a small country in Eastern Europe, which up until 1989 was under the communist rule. Mental health research in Slovakia has been limited, but there are reasons to believe that subtle cultural differences, perhaps ones linked to the Slovakian communist past, could affect the expression of mental illness." "Contrary to our hypothesis, the seven factor Hybrid model, which has garnered a lot of empirical support in the literature, did not fit the data in our study." " it is important that both clinicians and researchers do not ignore the fact that the more differentiated models of PTSD provide better fit."	The structure of the PTSD model has not been tested across cultural groups world wide Methods of diagnosis vary word wide (ICD vs DSM) Limited research done in Slovakia, has a different history to other countries Resuslts show seven factor model of PTSD is not appropriate for this pop. Different models of PTSD describe the expression of the disorder in different countries	Ethnic and religious diversity in small communities e.g. Kenya		
Article 15	"One's culture provides such a context, namely the context in which humans reside, from which they draw meaning, and determines whether particular explanations, appraisals and cognitions make sense." "people in different cultures have strikingly different understandings of the self" "trauma was predominantly thought of in terms of physical health while mental health or psychological health was not appraised to be of equal importance." ""if you're from a collectivistic culture then bonds are everything, so its [trauma] something which break the family, breaks relationships, breaks your bond to society" "Participants emphasized societal and cultural impact factors and endorsed the importance of social and cultural expectations and roles." "Participants placed emphasis on others and the group they felt they belonged to, and focused on the importance of their relationships with them." "members from collectivistic cultures appraised trauma as a predominantly physical stressor, while some did acknowledge psychological distress."	Context provides meaning and is the influences how appraisals are made The self is different in different cultures The collectivist participants interviewed viewed trauma as physical injury/ mental health was not as important Trauma reported as an aspect that breaks bonds between people The importance of the group was expressed Participants emphasised the social roles that were impacted by trauma (e.g. role as a father etc.) Some did acknowledge psychological impact of trauma	Expression of symptoms different among various groups Some cultures are not emotionally expressive. E.g. Japanese In Slovakia history of communism is mentioned		

Article 16	"Scholars have questioned the universality of Western concepts of mental health and the applicability of Western measures of PTSD and depression when applied to the assessment and treatment of vastly diverse refugee populations." "Although research into local idioms of distress has provided a deeper and more nuanced understanding of the mental health of some refugee populations, the general finding of mental health stigma in non-Western populations remains a perceived barrier to effective cross-cultural communication about mental health." " categories in common across all focus groups: (a) symptoms cannot be described separate from their political causes, (b) understanding degrees of "craziness," (c) too much thinking, (d) cognitive effects, (e) behavioral effects, (f) physical effects, and (g) emotional effects." "Concepts unique to each refugee group include words used to describe mental health and culturespecific symptoms and problems." " The greatest variability in culture-specific concepts and idioms was observed with regard to the emotional effects of war trauma. The most universal cognitive language used to describe the effects of war trauma was a category called "thinking too much."	PTSD's universal applicability has been questioned Stigma around mental health hinders further research on PTSD in many populations For all refugee groups: political context of trauma was important; the concept of a continuum of mental illness; rumination; cognitive impairments as a result of trauma; behavioural effects; physical effects and emotional effects Different words were used to describe mental health in each culture; culture specific problems also arose	Long term trauma, injustice of war and sexal victimisation may result in diminished symptom expression, or C-PTSD		

Article 17	"The self in autobiographical remembering is considered to be a psychological reality that is embedded not only in the brain and body but also in the socio-cultural context." "This cultural context influencesthecognitiveprocessesandresourcesutilisedinautobiographicalrememberingdifferentlyto that employed by individuals from Western cultural background." "There is some evidence to suggest that when asked about self in memories from childhood, participants often report are presentation of themselves from a photograph or a sort of stereotyped image. For more recent memories the images of the self in a memory are more frequently specific than generic." "The two cultural groups did not differ significantly in terms of trauma experience and trauma history." "This suggests that pan-culturally those with PTSD may engage in similar OGM avoidance strategies regardless of memory theme." "When considering specificity, those from Western cultures have been found to emphasise the retrieval of specific memories (i.e., remembering a personal event that occurred at a particular time and place and lasted less than one day)." "research has also demonstrated that reduced memory specificity is a cognitive bias associated with PTSD that occurs across cultures." "the British group provided significantly more personal-themed (as opposed to social-themed) memories than the Iranian group."	Autobiographical remembering is thought to be influenced by socio-cultural context Adults memory guides their present daily living Across cultures there may be similar over general memory avoidance strategy used by trauma survivors Western survivors are better able to remember with specificity Impaired memory ability may also be a feature of the disorder Groups being studied (British and Iranian) differed in terms of symptoms severity British recalled greater personal-themed memories, whereas Iranian survivors recalled more group centred memories	Much comorbidity plague African Americans diagnosed with PTSD.		
	"there are different sets of psychological phases that are likely to occur after." " These vary in length and intensity, depending on the victims vulnerability, type of disaster, severity of physical damage, and resources available." "The tragic events of 9/11 and their subsequent backlash, which continues to this day, have resulted in playing scapegoats and stereotyping, which has translated into collective blaming of the Arab American community, thus generating chronic fear and distrust among its members." " Arab Americans are one of the most diverse ethnic groups in the United States in their cultural and linguistic backgrounds, political and religious beliefs, family	different symptoms may be elicited at different times Type of event, vulnerability of survivor and resources available all pay a role 9/11 resulted in many Arab American women being stigmatised and stereotyped			

	structures and values, and acculturation to Western society." " In the Middle East, domestic violence is treated as a family issue and not as a serious public health threat or a politicolegal issue." "Culturally sensitive group leaders need to frame the therapeutic process within the cultural context when working with Arab American women."	Arab Americans are diverse, acculturation to their Western context should also be noted Domestic violence in this community is not openly spoken about Therapy should be tailored to the unique cultural needs of this group			
Article 19	"People attribute the cause of what has happened around them. Attribution is an individual appraisal of an event in terms of the causality." "In Japan, some researchers argued about shame in relation to help-seeking patterns, such as hesitation in seeking mental health services after the natural disaster (Goto et al, 2002) and young women's reluctance to consult physicians because of urinary incontinence (Hirai et al, 2002)." "The Japanese culture is characterized by the pervasiveness of shame feeling, which may be caused by the Japanese people's sensitivity to the shame." "cross-cultural differences make it impossible to discuss the role of the shame feeling in developing PTSD."	Attribution is related to causality. People generally look at their environment to make attributions In Japan shame inhibits victims from seeking assistance regarding traumatic sexual experience Cultural differences play a large role in development of shame and PTSD			
Article 20	"The term Latino is currently preferred, but the U.S. government continues to refer to those whose ancestors came from a Spanish speaking country as Hispanic." "Her discovery that ''normal'' children who experienced a traumatic event could have significant psychological distress led to the study of children's reactions to many traumatic situations …" "many abused Latino children are reacting to child abuse as a traumatic stressor and develop symptoms that are characteristic of PTSD." "This study lends support to the universality of traumatic reactions in abused children regardless of ethnicity." "Also important to the effective treatment of Latino children is the availability of bilingual therapists and the translation of effective interventions into Spanish."	Term Hispanic and Latino are not interchangeable Children that are abused over long periods of time may develop PTSD Latino children do in fact develop PTSD in response to sexual abuse Traumatic reactions among abused children may be universal Language is an important consideration in treatment			

Article 21	"Kenya is ethnically and religiously diverse. The country has more than 70 ethnic groups, although about 70% of the population belongs to one of five largest groups (East Africa Living Encyclopedia, n.d.). Approximately 7% of the population is Muslim…12% of the population are African traditional religionists, but the majority of Kenyans (79%) are Christian and belong to a variety of Christian denominations." "Fatalism tended to shape the clinical response of many of the victims. Among the many Kenyan survivors and rescuers with whom I had contact, expressions of survivor guilt were virtually non-existent." "On the other hand, Kenyans did sometimes express guilt about their own actions at the time of the bombing." "Although their methods of treatment used the western PTSD framework and counseling approaches as a starting point for dealing with problems, Kenyan mental health care providers adapted western knowledge to the local African situation."	Kenya is ethnically and religiously diverse Traumatised persons here were fatalistic (saw bombing as an act of God/Allah's will); no survivors guilt was expressed Some expressed regret for not acting to save more people Although western notion of PTSD was applied to this context, treatment tailored to local situation			
Article 22	"Overall, little is known about within-group clinical characteristics of PTSD in African Americans." "No demographic differences were found except that African Americans with PTSD were more likely to have physical and psychiatric disabilities than individuals without PTSD." "This study revealed high rates of chronicity among African Americans with PTSD, along with high rates of comorbidity and very low psychosocial functioning." " Overall, in comparison to non-Latino Whites, African Americans with PTSD have less consistent contact with medical professionals (Seng et al., 2005) and are less likely to receive treatment for PTSD."	Little info. Available about PTSD in African American community Those suffering from PTSD in this group were likely to have comorbidities such as low psychosocial functioning This group has less contact with professional and less likely to be treated			
Article 23	"my clinical experience indicates that the basic symptoms of trauma are common across cultures." " secondary victimization, exacerbating the mental condition of crime victims occurs more frequently in Japan than in other countries." "For many people who have led their lives without any contact with psychiatry, visiting a psychiatry clinic engenders a kind of stigmatization." "In Japan, individuals who suffer pain quietly and alone tend to receive respect from others." "Although subjective symptoms are the basis for the diagnosis of PTSD, Japanese people are not good at verbalizing their emotions. This makes it necessary to devise therapeutic methods tailored to Japanese people unfamiliar with verbalization."	Core symptoms of PTSD may be universal Secondary victimisation is high in Japan Japanese community still has lot of stigma around mental illness Remaining silent about challenges is praised Japanese do not easily verbalise their emotions.	Assessing differing PTSD models in different groups		

		Therapy should thus be sensitive to this			
Article 24	" Instrumental aggression has been linked to the secondary rewards, like the gain of social status." "as implied by the interplay of the two interactions and the group effect, those who reported an appetitive perception of aggression showed less trauma symptoms, whereby this effect was greater in participants of the abducted group." "Appetitive aggression was present at least to some degree in both the abducted and the non-abducted group, except that the extent was more substantial in the formerly abducted group." "results indicate "that violence breeds violence" not simply in the form of reactive aggressive acts but fosters appetitive aggression."	Aggression can come with secondary gain Persons that had an appetite for aggression had less trauma symptoms (esp. those previously abducted) Results demonstrated that violence breeds violence			
Article 25	"The rate of post-traumatic stress disorder (PTSD) in this population is probably one of the highest among Southeast Asian refugees, according to most epidemiological research." "in the case of long-term major traumatic events such as war and deportation, there is a close relationship between the individual's clinical history and the collective history of his or her group." "For groups, it is generally more important to constrict social relations during difficult periods than in normal times. Adversity reinforces the will of the group to maintain social cohesion, sometimes to the individual's disadvantage." "In Khmer for instance, the idea of the self is far from our conception. This highly hierarchical society does not give strong value to the individual." "This narrative is congruent with Cambodian culture and also with most ordinary stories of trauma." "The whole narrative reproduces the Cambodian expression of 'psychological' distress in bypassing the personal affect of the speaker." "Clinical practice cannot be satisfied with only a generic analysis of meaning that risks dissolving individual particularities in the name of an illusory collective identity."	Cambodian have higher prevalence of PTSD than other south east Asians w.r.t long term war exposure, an individual's clinical history will likely be similar to that of the collective Collectives typically reinforce their bonds amongst the group during difficulty Khmer ontological view of self as part of a system in which individual is not greater than the group Distress is expressed in a way that side-steps the individual Clinicians may cautiously challenge the collective identiy	Participants identifying their own symptoms versus clinicians observing PTSD in the group		
Article 26	"The Yazidis are a Kurdish minority group, distinguished in terms of religion rather than through ethnic or linguistic differences." "Allparticipantsshowedonthe15questionsoftheEventScale (Dyregrovetal.2000) that they had experienced some kind	Yazidis are subgroup of Kurds; have different religion Participants			

	of violence, had been exposed to threatening events, had been raped, or had lost family members during the IS attack or captivity." "The prevalence of PTSD was not associated with the site of the IS attack or the time of being held as a hostage." "The study indicates that rape is a powerful trauma that has resulted in different psychological disorders in all the women involved in the study."	experienced traumas of varying kinds Being held captive did not predict presence of severity of PTSD symptoms Results show that rape resulted PTSD AND other disorders in this group			
Article 27	"Current literature suggests that there are wide variations of prevalence figures for PTSD in children and adolescents after natural disasters." "Similarly studies more than one year following disasters also suggest variable prevalence figures." "All children exposed to disasters do not develop PTSD; some appear to have greater risk." "children may not report their psychological reactions to the trauma unless they are specifically asked about aspects of trauma." "The results suggest that post-traumatic symptoms and the syndrome in children and adolescents in this culture resembled those noted in western societies."	Research shows differing rate of PTSD in children and adolescents following natural disaster Prevalence after a year also differs Risk for PTSD differs Children may not report symptoms till they are asked Findings resemble western sample	Differentiating MDD and Anxiety from PTSD in understudied groups		
Article 28	"Concerns have been raised about the tendency for the PTSD category to be applied to persons exposed to an ever-widening range of common-day life experiences such as exposure to severe illness, accidents and severe work stresses." "Commentators also have raised questions about the validity of applying PTSD as a psychopathological entity across cultures." " In DSM-5, the avoidance and numbing constellations have been separated, generating a fourth domain of "persistent alterations in mood and cognition" "In contrast, both ICD-10 and the proposed ICD-11 criteria limit the definition of PTSD to three core symptom clusters, namely reexperiencing (or intrusions), avoidance, and hyper-arousal, the latter system including a reduced number of symptoms for each domain [14]." "A further area of complexity relates to the longstanding proposition that survivors of extreme traumas such as childhood sexual abuse, rape and torture are prone to experience a complex form of PTSD" "There is a small but growing body of evidence supporting the diagnostic criteria of C-PTSD amongst survivors of childhood abuse and sexual assault residing in high-income, largely Anglophone societies [16-20]. In contrast, there is a dearth of research into C-PTSD across cultures, and particularly amongst refugee populations exposed to traumas associated with severe human rights violations."	PTSD has been applied to various kinds of trauma across various cultures Disorder is presented differently in DSM and ICD Different models are also proposed for the disorder Longstanding trauma suggests C-PTSD however not enough evidence has been found Research also is needed to uncover diminishing PTSD in long term PTSD C-PTSD may be applicable to long term trauma exposure (e.g.			

	"There is growing evidence, however, that the sense of persisting injustice may be instrumental in generating and maintaining the PTSD reaction and related symptoms of distress [24-26]. It may be therefore that the sense of injustice distinguishes the unique constructs (negative evaluation of self and others, affect dysregulation, and interpersonal dysfunction) that putatively differentiate CPTSD from core PTSD." "our findings offer support for the construct validity of ICD-10 and ICD-11 definitions of PTSD in a transcultural population that has had limited contact with western psychiatric concepts or services. Our findings therefore pose a challenge to the assertion that the PTSD construct is culture-bound to western societies." "Given the specific experiences of the community in the settlements in Port Moresby, we cannot generalize the findings to West Papuan populations residing in the home country or further afield. Our index of PTSD was validated specifically amongst the West Papuan community in Port Moresby, a cultural distinct group with no exposure to western concepts of trauma."	abused children) Continued injustice may actually diminish symptoms Study findings can not always be applied to cultural groups with different characteristics This study validated the current PTSD model among the West Papuan refuges of this area			
Article 29	trauma survivors with higher levels of post-traumatic stress have reduced AMS compared to trauma survivors with lower levels of post-traumatic stress." "currently, most of our understanding regarding the development, maintenance and treatment of post-traumatic stress disorder (PTSD) is informed by research conducted in western societies." "analyses revealed a significant negative relationship between PTSD symptoms and AMS in the Chinese sample. However, the relationship between PTSD symptoms and AMS was not found to be significant for the British group" "there were no cultural differences in self-reported task difficulty and all participants had university Standard English language competency. Nevertheless differences in language ability might have influenced findings." "Theoretically the findings suggest that if a current goal of the ''working self'' (Conway, 2005) involves protecting the self from distressing memories, then regardless of culture, trauma survivors, especially those with PTSD symptoms, tend to retrieve general autobiographical memories."	Most of what is known re PTSD is from Western context PTSD research is mostly from the West Memory specificity and PTSD were linked for Chinese participants in this study The theory of the working self finds that all cultures retrieve their trauma memories as part of their autobiographical narrative	Sharing distress shameful in some cultures e.g. Japan and Israel solders in particular		
Article 30	"A growing body of literature from medical anthropologists indicates not only that differences in response to trauma are more numerous than are similarities, but that the features of PTSD identified in different cultural settings around the world do not have the same meaning to people in each setting" "Victims of violence from villages in Colombia and Peru illustrate different types of interaction between collective and individual traumatic memories."	Features of PTSD may mean different things in non-Western contexts For Columbian and Peruvian persons interviewed collective and			

	"there are differences between the two countries in the expression of traumatic memories, indicating the need for different guidelines for psychosocial work." " most subjects confirmed the presence of symptoms consistent with the PTSD criteria. However, they often included more than what is contained in the diagnostic criteria." "Concrete episodes of violence are also explained by referring to local myths and cosmology. One such example is the myth of El Naqak, the foreign conquistador." Treatment seems to consist instead mainly of 'forgetting.' People get drunk and buy tranquillizers over the counter in Peru. They themselves say that they want 'help to forget',that they 'wish to be in dreams without thoughts'" "In Colombia, many people have symptoms that they attribute to the Violencia. These symptoms are often consistent with the diagnostic criteria for PTSD. "Consistent with our findings, some studies have shown the significance of the social network for PTSD symptoms." "An important aspect of the loaded debate around PTSD has been the undermining of the concept of 'traumatic memory.' 'Traumatization' is widely used to denote a war-induced psychological condition but there is no consistent working definition of the term and it is often used in a figurative and journalistic way." "In Colombia, the individual, traumatic and pathogenic memory is a secret, repeated only in the therapeutic space between client and therapist. Collective traumatic memory, however, is more an act of will." "This study shows the importance of listening to both the individual and the collective aspects of memory."	individual memories may be different Different expressions may call for diverse treatment approaches Although PTSD symptoms could be found in Peruvians being interviewed, other symptoms were also described Belief systems influenced attribution of violence Forgetting seen as a helpful strategy Personal telling of ones trauma story is something that should occur in a counselling context, however the collective remembering is seen as a voluntary process	Interventions need to take context into consideration . For example, Kenyan mass bombing that relied on media to psycho-educate		