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(Editors)

Cultural Clinical Psychology and PTSD

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Library of Congress Cataloging in Publication information for the print version of this book is available via the LC Marc Database under the Library of Congress Control Number 2018952743

Library and Archives Canada Cataloguing in Publication
Cultural clinical psychology and PTSD / Andreas Maercker, Eva Heim, & Laurence J. Kirmayer (Eds.).

Includes bibliographical references.
Issued in print and electronic formats.
ISBN 978-0-88937-497-3 (softcover).--ISBN 978-1-61676-497-5 (PDF).--
ISBN 978-1-61334-497-2 (EPUB)

1. Post-traumatic stress disorder. 2. Traumatic incident reduction.
3. Cultural psychiatry. 4. Clinical psychology. 5. Ethnopsychology.
I. Maercker, Andreas, 1960-, editor II. Heim, Eva, editor III. Kirmayer, Laurence J., 1952-, editor

RC552.P67C84 2018 616.85'210651 C2018-904467-5
C2018-904468-3

PUBLISHING OFFICES
USA: Hogrefe Publishing Corporation, 7 Bulfinch Place, Suite 202, Boston, MA 02114
Phone (866) 823-4726, Fax (617) 354-6875; E-mail customerservice@hogrefe.com
EUROPE: Hogrefe Publishing GmbH, Merkelstr. 3, 37085 Göttingen, Germany
Phone +49 551 99950-0, Fax +49 551 99950-111; E-mail publishing@hogrefe.com

SALES & DISTRIBUTION
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OTHER OFFICES
CANADA: Hogrefe Publishing, 660 Eglinton Ave. East, Suite 119−514, Toronto, Ontario, M4G 2K2
SWITZERLAND: Hogrefe Publishing, Länggass-Strasse 76, 3012 Bern

Cover image: The cover image is a photo taken at Baddawi Refugee Camp, Lebanon and kindly provided by Wissam Kheir, PhD.

Format: PDF

ISBN 978-0-88937-497-3 (print) • ISBN 978-1-61676-497-5 (PDF) • ISBN 978-1-61334-497-2 (EPUB)

http://doi.org/10.1027/00497-000

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Preface

Andreas Maercker, Eva Heim, & Laurence J. Kirmayer

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

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

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

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

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

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

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

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

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

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

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

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

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

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1

Culturally Responsive Clinical Psychology and Psychiatry

An Ecosocial Approach

Laurence J. Kirmayer & Ana Gómez-Carrillo

Introduction

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

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

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

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

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

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

Locating Culture

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

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

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

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Cultural Psychology Is More Than Cross-Cultural Comparisons

Toward Cultural Dimensions in Traumatic Stress Research

Andreas Maercker

This chapter considers cultural dimensions to be a theory-guided framework within which to approach the wealth of psychological differences across diverse cultural groups. First, a few reflective statements will provide some background to the topic. This is followed by an overview of the current state of research on these dimensions in general, as well as in the area of posttraumatic stress disorder (PTSD) and prolonged grief disorder (PGD). The goal of this chapter is to encourage research which takes more of the so-called contextual factors into account when describing or analyzing posttrauma or postbereavement individuals, groups, or communities.

Background: Cross-, Inter-, Trans-Cultural Psychology, or just Cultural Psychology?

Are we dealing with one unified psychology for all humans? If not, how many culturally diverse psychologies do we need to consider? In any case, how can we best describe the abundance of psychological phenomena regarding sensing, thinking, feeling, and behaving, using a coherent methodology and concept? The scope of these questions is relatively new, as psychology with all its subdisciplines faces new challenges due to globalization and the increase in worldwide migration. From a practical perspective, it relates to the psychological health of migrants and refugees. The "Western," or "Global North" individual can no longer remain the archetypal individual to be investigated. Psychological research and application has lost its naïvety in describing assumptive human *universalities* and has even developed self-doubt about whether such a thing as "psychological universality" in the areas of cognition, emotion, motivation, and interpersonal or social regulation really exists.

Cultural psychology – which in recent times has gained increased attention – opposes this simplified view of "universalist" statements. Rather, it suggests considering the current state of conventional psychological subdisciplines as limited, as they do not systematically incorporate cultural dimensions to capture the vast wealth of differences.

Historically, the term *"cultural psychology"* was developed and consolidated in the middle of the 20th century. Several cultural psychologists laid the groundwork *avant la lettre*: Wilhelm Wundt in

his book series about cultural psychology, then called *Völkerpsychologie* (folk psychology) (Wundt, 1900–1920); Lev Vygotsky in the explication of cultural processes or dimensions in the developmental process (e.g., Vygotsky, 1929); and Carl G. Jung in his accounts of his worldwide journeys, as well as his texts on the *archetype* or the *collective unknown* (e.g., Jung, 1934–1954). Subsequent cultural psychology authors and schools of thought have had many other influences, particularly from Anglo-American cultural anthropology (including Boas, Mead, Benedict, and others), which played an important role following the end of colonization, subsequent to the end of World War II.

Mainstream modern psychology has had its difficulties with systematically including these theories and concepts into its disciplinary research. For epistemological reasons, *cultural psychology* often rejects quantitative research methods in favor of argumentative conclusions. In using this methodology, it has gained important insights into indigenous psychologies, the self as emergent phenomena, and more unusual states of consciousness, such as trance and possession.

However, cultural psychology's close relative *cross-cultural psychology* has received more acceptance and reception in mainstream psychology due to its application of quantitative methodology. Cross-cultural psychology is marked by a pragmatic point of departure. Research data from particular samples (e.g., Europeans, European Americans) are assessed for differences from samples from other ethnic origins (e.g., Asian, Asian Americans, and so forth). If differences are found, these are subsequently interpreted. Cross-cultural psychology applies, or sometimes rather develops, its own research methodology to make the necessary comparisons by following the highest methodological standards. However, cross-cultural psychology can also be regarded as very much nontheoretical, as it restrains itself from wider speculations on the human condition.

Nevertheless, both cultural psychology and cross-cultural psychology are still not widely accepted – for different reasons – in the major fields of psychology or psychological treatment. Given that there is still little co-operation between these two fields, this chapter proposes to create a discourse between them (see also Valsiner, 2007).

Cultural clinical psychology can make an important contribution by integrating theories and empirical evidence from different fields of research (i.e., clinical psychology, anthropology, sociology) to propose new theoretical frameworks concerning mental health and mental illness and its conditions across cultures. This includes both the description of clinical phenomena (i.e., symptoms) and possible explanations for these phenomena (i.e., the etiology of mental disorders), considering cultural and contextual factors besides individual dispositions or biographies (Chentsova-Dutton & Dzokoto, 2014, Kirmayer, Gómez-Carrillo, & Veissiere, 2017; Ryder et al., 2008; see also Kirmayer & Gómez-Carrillo, 2019; Chapter 1 in this volume).

As this book focuses on trauma-related disorders and particularly on PTSD, the remaining introductory statements will focus on these. Let's take an example from a classical cultural psychological question regarding PTSD: How does individual and collective perception consolidate the consequences of trauma? This question implies further questions: Which cultural, linguistic, and/or religious factors lead to a person labeling themselves as "I'm traumatized or I have PTSD"? – This is an entirely different approach to questioning than the traditional simplistic cross-cultural comparisons: Does the severity of PTSD main symptoms, such as re-experiences, avoidance, or sense of threat, vary in different ethnicities – for example, do Asian persons have more symptoms of avoidance?

These questions touch on the important distinction between *etic* and *emic* research approaches. These terms originate from anthropological field research and refer to the viewpoint of the observer: *etic* from the viewpoint of the Western scientific community (through the eyes of an outsider applying universal principles across cultures) and *emic* from within the cultural group (through the eyes of an insider). The emic approach generally equates to the indigenous one.

The next section begins by introducing not only the "classical" PTSD, but also the newly defined prolonged grief disorder, the latter being a newcomer to the trauma- and stress-related disorder category in current psychopathology.

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Principles and Evidence of Culture Sensitive Mental Health Approaches

Nadine Stammel

Expanding culturally diverse societies as well as increasing efforts to reduce the mental health treatment gap in low- and middle-income countries have made culturally sensitive mental health treatment more and more important in recent years (Barnett & Bivings, 2002). There are increasing scientific efforts to adapt empirically based interventions for members of non-Western societies. The claim to adapt treatment to the cultural background of the patients implies the assumption that evidence-based treatment approaches are usually developed for and empirically tested in Western societies and are not equally feasible and effective for patients with other (non-Western) cultural backgrounds.

The goal of culturally sensitive psychotherapy is to adapt the treatment to the needs of an individual in such a way that a positive therapeutic relationship can be formed, treatment processes are optimized, and therapy outcomes are improved (von Lersner & Kizilhan, 2017). Resnicow, Baranowski, Ahluwalia, and Braithwaite (1999, p. 11) define *cultural sensitivity* as the extent to which ethnic/cultural characteristics, experiences, norms, values, behavioral patterns and beliefs of a target population as well as the relevant historical, environmental and social forces are incorporated in the design, delivery and evaluation of targeted health materials and programs.

Culturally sensitive treatment can be achieved through cultural adaptations of evidence-based interventions (EBIs) and/or the cultural competence of the mental health professionals (Dinos, 2015). The focus of this chapter is on giving an overview of cultural adaptation of high-intensity interventions, while von Lersner (2019, Chapter 12 in this volume) will deal with culture-sensitive interventions in PTSD, and Heim, Harper Shehadeh, van't Hof, and Carswell (2019, Chapter 13 in this volume) will address cultural adaptations of scalable interventions.

Conceptualizations of Culture

Focusing on culturally sensitive mental health interventions makes it necessary to look more closely at the underlying understanding of the concept of culture. There are numerous different definitions of culture, which have changed over time (Baldwin, Faulkner, Hecht, & Lindsley, 2006). Already in the 1950s, Kroeber and Kluckhohn (1952) had collected 150 definitions of the term *culture*. Basically, *culture* refers to a learned meaning system that consists of concepts, beliefs, values, norms, symbols, and practices that are transmitted across generations (Ting-Toomey & Chung, 2005). The term *culture* includes two dimensions: a content-related as well as an extensional dimension (Welsch, 2010). Regarding its content, *culture* can be viewed as a general term for practices that people use to have a human-like life, such as everyday routines, forms of social

interactions, beliefs, norms, clothing, or cooking habits. The extensional dimension refers to the geographical, national, or ethnical extension of these practices that we usually have in mind when we speak about culture.

Unlike earlier conceptualizations however, culture is not understood anymore as a static, distinguishable, and rather isolated concept, being related to entire nations or ethnicities. Also, the current *Diagnostic and Statistical Manual of Mental Disorders,* fifth edition (DSM-5; American Psychiatric Association, 2013) acknowledges that a person's cultural background can have an impact on the experience and expression of psychological symptoms and disorders. Regarding the conceptualization of culture, in the DSM-5 it is stated that "cultures are open, dynamic systems that undergo continuous change over time; in the contemporary world, most individuals and groups are exposed to multiple cultures" (American Psychiatric Association, 2013, p. 749). According to current conceptualizations of culture, it is thus important not to restrict culture to the geographical dimension, nor to stereotype individuals based on their geographical origin or in terms of fixed cultural traits (see American Psychiatric Association, 2013).

Culture is thus a very complex and multidimensional concept. The cultural background of a person depends not only on the geographical origin of a person, but also on other factors, such as their educational level, age, gender, religion, or life circumstances (e.g., migration experiences). In other words, people sharing the same geographical origin do not necessarily share the same values, attitudes, practices, etc.; thus, they are no homogenous group. As Neuner and Elbert (2007) point out, we can find a wide diversity of attitudes, values, and habits in all regions in the world, and no country border or other artificial differentiation can account for differing cultural values. Peters even brings this to the point of summing up with "there is no national culture and identity that is a coherent system of beliefs or meanings. Culture is eclectic, syncretist, internally fragmented, a jumble of heterogeneous elements, not an organic whole at all" (Peters, 1997, p. 8).

The above-mentioned views are supported by different analyses conducted by Fischer and Schwartz (2011), who show that country differences accounted on average for only 4–22 % of the variance in self-rated values. They found this effect in representative and large data sets that had been collected in numerous countries. Ethnic groups also do not necessarily share the same explanatory models for mental illness. A study on causal beliefs of somatic and mental illness in Turkish immigrants in Melbourne found that the causes perceived by the participants were related to their level of education, acculturation, and their origin (rural/urban) (Minas, Klimidis, & Tuncer, 2007).

Thus, as Chao and Moon (2005, p. 1129) point out, "The classic use of the term culture as a 'grouping' mechanism for nation-states necessitates elaboration or extension to be applicable in a world that is becoming increasingly intertwined." To approach the complexity of culture at an individual level, Chao and Moon (2005) introduce a framework they refer to metaphorically as a "cultural mosaic." According to this framework, the individual's cultural identity consists of a combination of different "tiles" in the mosaic. While each tile is distinguishable, the cultural identity of a person is formed by the overall composition of tiles, which is different for each individual. According to Chao and Moon (2005), the individual's cultural mosaic comprises three categories, and thus the tiles, in turn, belong to three categories: (1) demographic (e.g., age, ethnicity, gender, race), (2) geographic (e.g., climate, regional/country), and (3) associative features of culture (e.g., family, religion, profession, politics). It would therefore not be feasible to adapt interventions solely to ethnic groups, but adaptations should also consider other characteristics of the members of the targeted group.

How to provide culturally sensitive care for clients with posttraumatic stress disorder (PTSD) and related disorders

This book, written and edited by leading experts from around the world, looks critically at how culture impacts on the way posttraumatic stress disorder (PTSD) and related disorders are diagnosed and treated. There have been important advances in clinical treatment and research on PTSD, partly as a result of researchers and clinicians increasingly taking into account how "culture matters."

For mental health professionals who strive to respond to the needs of people from diverse cultures who have experienced traumatic events, this book is invaluable. It presents recent research and and practical approaches on key topics, including:

- How culture shapes mental health and recovery
- How to integrate culture and context into PTSD theory
- How trauma-related distress is experienced and expressed in different cultures, reflecting local values, idioms, and metaphors
- How to integrate cultural dimensions into psychological interventions

Providing new theoretical insights as well as practical advice, it will be of interest to clinical psychologists, psychiatrists, and other health professionals, as well as researchers and students engaged with mental health issues, both globally and locally.

"The field of cultural clinical psychology takes an important stride forward with this carefully edited volume on the cultural shaping of posttraumatic stress disorder. An impressive group of experts combines rich theory with empirical and clinical examples from a wide range of contexts, embracing the complexity of the subject while pointing the way to potential solutions. This volume ought to be read by anyone working at the intersection of culture and mental health."
Andrew G. Ryder, PhD, Associate Professor of Psychology, Concordia University, Montreal, QC, Canada

"Comprehensive, evidence-based and practical. This terrific book brings together authors and topics from many different disciplines and fields of expertise to build a foundation for the cultural clinical psychology of trauma and its consequences. It is a must-read for those who work with traumatized patients, both in clinical and research settings."
Jianping Wang, PhD, MD, Professor of Psychology and Psychiatry at Beijing Normal University, China

"This text is an essential resource for traumatic stress professionals and others engaged in culturally-informed research, practice, and policy development in our increasingly diverse and multicultural society."
Diane Elmore Borbon, PhD, MPH, Immediate Past President of the International Society for Traumatic Stress Studies, Washington, DC, USA

Cultural Clinical Psychology and PTSD

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ISBN 978-0-88937-497-3