The Importance of Culturally Minded Practice for International Psychiatry: A Review of the Anthropological Critique on the Cross-Cultural Validity of PTSD.

Word count: 3000

Harvard Manchester Referencing style

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I declare this work as my own with no conflict of interests.

Introduction

Since its appearance in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published in 1980, post-traumatic stress disorder (PTSD) as a medical diagnosis has been disseminated across the globe. Originally used to diagnose the behaviours attributed to mental suffering of American soldiers returning from the Vietnam war (also known as The Resistance War against America), PTSD has more recently been used to diagnose mental illness resulting from different traumatic experiences including childhood violence, rape, and gun violence (Moghimi, 2012; Nicolas et al., 2015). Also, over the past decades' the diagnosis of PTSD internationally and in refugee populations specifically has been immense, with the prevalence of PTSD being up to 32% in these groups (Blackmore et al., 2020). However, the widespread implementation of PTSD as a medical diagnosis has led many anthropologists to problematise its assumed universality within the international arena of global psychiatry. This essay aims to explore the anthropological critique on the cross-cultural validity of PTSD, not to deny the existence of a neurobiological substrate of trauma, but instead to make clear the saliency of a culturally minded approach to international mental health.

The Anthropological Critique

In 1995 Allan Young published his seminal book, *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder* that initiated an onslaught of anthropological critique on PTSD as a medical diagnosis. He argued, '*The disorder is not timeless, nor does it possess an intrinsic unity. Rather, it is glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated, and represented and by the various interests, institutions, and moral arguments that mobilized the efforts and resources.'*(Young, 1995, p5). Here Young is arguing, from the (cultural) relativist perspective, that PTSD can only be true from within the context in which it was determined. Without the socio-cultural particularism surrounding PTSD as a diagnosis, that the diagnosis is without meaning. It draws attention to the structural forces that influence its shape as a diagnosis, and also to the social fabric through which populations understand it. Psychiatrist Derek Summerfield illustrates this by his argument that the original construction of PTSD was done as a means to deflect societal blame from veterans for the US military's atrocities committed during the war in Vietnam (Summerfield, 2001). Upon their return to America, soldiers were being labelled as 'baby-killers' and 'psychopaths'

as well as being diagnosed with 'illegitimate disorders' such as substance abuse and anxiety disorders. In this way Summerfield and others have argued that PTSD was constructed in order to transform veterans from 'perpetrators' to 'traumatised individuals' and to deter attention from their personal histories to the objective traumatic nature of war.

Other partisan arguments include that PTSD has been as a tool in order to legitimise human inflicted atrocities and rights violations; In both Bosnia and South African men accused of politically inspired multiple murders have used a PTSD diagnosis as their defence (Summerfield, 2001) [1]. However, while the political arguments surrounding PTSD are compelling, they are mostly beyond the scope of this essay. Instead, the first section will review two of the leading anthropological criticisms of PTSD through a discussion on cultural idioms and the philosophical concept of personhood.

Section One: Universal Disease or Culturally Bound Syndrome?

Cultural idioms of distress represent an important anthropological critique on the cross-cultural validity of PTSD and demonstrates how PTSD cannot be viewed as inherently universal across cultures. Nichter (1981) defines an idiom of distress as '*an adaptive response or attempt to resolve a pathological situation in a culturally meaningful way'* (as cited in Kohrt et al, 2010, p325). He explains that in any given culture there are multiple ways in which people express their afflictions, and that these are heavily constituted by the cultural norms, ideas, and values of that society. Idioms of distress help to explain how different cultures somatise trauma differently, both as individuals and collectively as traumatised populations. As with colloquial dialect, these cultural idiosyncrasies of illness somatisation are often misunderstood by those who are not part of, or at least very familiar with, a given culture.

As well as somatic complaints, such as a sore neck, idioms of distress can present as other culturally significant experiences. In Kabul, Afghanistan, common complaints by conflict survivors include a type of nervous anger referred to as 'asabi' and a mental sensation of internal pressure called 'fishar-e-bala'; and refugee women in El Salvador often experience of intense heat in their bodies referred to as 'calorias' (Moghimi, 2012). The relativist criticism is that, given cultures present their experiences of illness in such a myriad of ways, the phenotypical architecture of diagnostic criteria cannot be disseminated across contexts.

[1] Interestingly, changes in DSM-V are reported as making malingering of PTSD, and, its utilisation as a defence in legal settings more accessible (Zoellner, 2013).

There are different classifications of stress idioms: psychological/somatic complains, eating disorders, illness syndromes, religiously involved idioms, and acting out behaviours such as alcohol excess and drug misuse. The strict relativist position would argue that PTSD itself represents a culturally bound illnesses, indiscernible from the western individualist epoch in which it was borne.

It is important to remember that for individuals within a given context, idioms of distress merely represent 'common sense' and are part of the unquestioned continuum of their reality. To illustrate this point, I will use Hinton and Lewis-Fernandez's (2010) explanation of lower back pain in the US context. This western idiom of distress, they explain, is the result of a complex set of interconnected cultural associations such as the trope 'back breaking labour' and 'more than I can bear'. Other associations, they continue, include links to lack of workplace, welfare and interpersonal support. In this way, professional and interpersonal afflictions may be experienced as pain in the lower back muscles through the process of somatisation. Then, it can be concluded that lower back pain is an example of a western idiom of distress, but it is unlikely that the 26% of US American adults suffering from this affliction will recognise it as such. Hopefully this example illustrates how firstly, cultural idioms become indiscernible from the daily order of any given context (for those within it) and secondly, how a deep understanding of that context is required for any valuable meaning to be achieved.

Idioms of distress and somatisation are made sense of through an individual's sense of self and person, which is known conceptually as *Personhood*. Personhood is a philosophical concept that describes how individuals and groups make sense of themselves and the world around them, or as put by Kirmayer (2007, p240), personhood is *'first of all a category in our system of knowledge that provides us with a specific style of explanation and attribution for action and experience'.*

Anthropology criticises the assumed universality of PTSD given it has been conceptualised using a specific western individualist (that of the self-embodied, rational, and atomistic man) understanding of personhood. Euro-American conceptualisations of personhood are built from western dualisms that transcends ontological, epistemological, and moral domains. Western dualistic form of thought, for example, understands ontologically the mind and body as distinctive essences; epistemologically symptoms as objective or subjective; and entails moral censure towards unforgiving wilful action vis-à-vis a physiological accident

deserving of sympathy. In this way, it is argued that PTSD becomes non-sensical when viewed through an alternative lens of personhood.

In most African cultures, for example, persons reach their full potential amidst the solidarity of their communities[2]. Personhood is understood as being embodied *within* the community and therefore it is only though this bond that the individual can discover their true selves; it is the community that allows for complete self-actualisation. In addition to this collectivism (or 'social' agency) Kpanake (2018) attributes differences between African and Western understandings of personhood using 'spiritual' and 'self' agency. Spiritual agency denotes the important role of cosmology insofar as—'given life is too tragic to pass alone'—gods, ancestors, divinities, and spirits are present and influence the life course. This is not to say that African cultures do not identify with words such as 'I' or 'me', just that the community is given primacy over the individual. Moreover, the 'I' and 'me' are understood to transcend the biological self, to enter the invisible and environmental self too. Such ecocentrism can have compelling implications for the understanding and diagnosis of PTSD. For example, an individual who understands themselves using an ecocentric conceptualisation of the person might be equally afflicted by an attack to their possessions as an individualistic person would be from a bodily attack. However, in this instance, the former would not meet the criteria for a diagnosis of PTSD.

Section Two: The Implications for International Psychiatry

Now that we have looked at some of the leading anthropological criticism of PTSD, this next section will discuss some on the implications these criticisms hold for International Psychiatry.

The category fallacy, coined by erudite psychiatrist Arthur Kleinman, describes how it is possible for PTSD to be diagnosed in people and populations where it is not really there. The category fallacy is mostly a consequence of PTSD's iterative diagnostic criterion (namely the DSM) than the concept itself, but the two are inextricably linked. Kleinman (1997) initially explained the category fallacy using the syndrome of depression by espousing that it represents a fraction of the entire field of depressive phenomena; *'it is a cultural category constructed by*

[2] Clearly African notions of self and personhood—given the huge heterogeneity of people, languages and culture residing on the continent— offer a much greater plurality for the understanding of personhood than the scope of this paragraph. However, my intention here is not to depict west/non-west conceptualisations using binarised essentialism, but simply to illustrate the potential implications of this difference.

western psychiatrists to yield a homogeneous group of patients. Per definition, it excludes most depressive phenomena, even in the west, because they fall outside its narrow boundaries' (Kleinman, 1997, p.3.). Thus, applying such categories in alternate cultures leads to a category fallacy because by definition it will find what is universal and it will systematically miss what does not fit its tight parameters.

The fallacy occurs given the diagnostic instrument will identify whether a symptom is present, but without determining its representative meaning for the illness experience of the patient. For example, one of the subdomains of criterion E (alterations in arousal and reactivity) in the DSM-V is hypervigilance. Hypervigilance is clearly a relevant symptom, in this case indicative of PTSD, for an individual recovering from the trauma of a road traffic accident in the UK. However, when that same symptom of hypervigilance is considered for a single mother escaping conflict with her children, it suddenly becomes less pathological. In this example, by removing the context of ontological security, hypervigilance is transformed from a symptom of disease to a necessary skill for survival.

Moving now away from the debate over validity, next we will assess some of the consequences of international psychiatry when primacy is not given to context. In order to consider these consequences we must remember that *'the belief in science and in the power of the international scientific community is so strong that it tends to marginalize local knowledge'*(Losi, 2000, p. 14).

Implementation of eurocentric diagnoses and therapeutic treatments can have the (borrowing Farmer 's (2013) term) 'unintended consequence' of undermining local healing practices and individual coping mechanisms. In Mozambique, Uganda, and Sierra Leone, cleansing rituals performed by traditional healers are used to help recovering child-soldiers make their transition back into society (Moghimi, 2012). Such traditional healers often hold a culturally sanctioned position and are ascribed authority to deal with the effects of trauma, which may be more amenable for an individual's reintegration and acceptance back into society. Similarly, in Uganda, rape survivors sometimes undergo a collective purification process to destigmatise the shame often bequeathed upon them from their communities (Moghimi, 2012). Disrupting these healing practices and the role of local healers has been shown to create strife in the short term, and in the longer term can undermine these coping mechanisms altogether (Hinton and Good, 2004). Moreover, it has been suggested that the more individuals are encouraged to adopt technocratic treatment, the less reliant they become on their own networks

and mechanisms to cope (Pupavac, 2002). This can become increasingly detrimental when international aid workers leave a given location and community (e.g. from an ebb in donor funding) leaving people sometimes ostracised from their communities and without the help they need.

Even when considered in isolation, the diagnosis of PTSD itself does not merely represent an arbitrary diagnosis with benign implications. Rather, a diagnosis of PTSD within the GMH discourse is too often associated with mutters of victimisation and vulnerability; labels which are known to be detrimental to the wellbeing of refugee and asylum-seeking people (Bauer-Amin, 2017).

In the UNICEF's Childhood Under Threat report, former UN Secretary General Kofi Annan declared that *'for nearly half of the two billion children in the real world, childhood is starkly and brutally different from the ideal we all aspire to.'*(Annan, 2005, Foreword) Similarly, a UNICEF Executive Director, on the subject of Kosovo refugees, speaks of *'the devastating, lasting psychological shock of what they have experienced'* (Bellami, 1999, as cited in Pupavac, 2002, p. 493). The speech content here can be problematised for different reasons. Kofi Annan's talk of an ideal childhood represents the sort of western paternalism that can be so damaging to the discourse of global mental health (GMH). Certainly, child refugees and other children living in LMIC's face problems that those in the HIC's might not, such as the conflict and political unrest described in the forward, but it is also true that these childhoods are often free from problems of western children, such as childhood obesity and self-harm. However, the aim here is not to problematise essentialist constructions of non-western children—Is it right for Koffi Annan to declare what an ideal childhood is?— nor do I wish to deny the abhorrent atrocities that these children suffer, but instead to question the accuracy and potential consequences of such fatalist rhetoric.

The anthropological perspective argues that there is nothing quintessential about traumatic experiences, and that overlooking people's resilience in these instances can undermine the intended beneficence of mental health aid. Skovdal (2012) expresses concern over the depiction of orphaned children with HIV as 'helpless victims' following their PTSD diagnosis. The concern is that the more children are reminded of this, the more it may shape how they feel about their situation and how this might then affect their engagement with treatment. The worry then is that, by hegemonising survivors of trauma using fatalist constructions of victimisation, the GMH discourse is encouraging individuals to embody victimhood. Similarly, it has been argued that the more society enforces a traumatic event as a

serious risk to mental health, the more likely it is it to turn out to be so. In this way, the current construction of PTSD by the GMH discourse has also been criticised for carrying a measure of self-fulfilling prophecy (Summerfield, 2001).

Section Three: An example of culture-centred research

The previous sections have brought to the fore some of the leading anthropological contentions surrounding PTSD as a medical diagnosis, and the potential problems these hold for international psychiatry. However, it worth emphasising that the above criticisms are not representative of the international psychiatric discourse as a whole. In fact, there have been multiple examples of excellent culturally sensitive and community-driven mental health research and intervention programmes (De Jong, Good, Hinton, Kirimayer, and Kleinman for example). Van Ommeren et al (2001), using their work with Bhutanese refugees, demonstrates an impressive piece of international psychological research. Their use of focus groups with the refugees exploring things like social problems in the camp, traditional healers, local knowledge, coping strategies, and community effects of the refugee crisis, enabled the team to embed culture and context at the centre of the diagnostic psychiatric interviews. Furthermore, by being aware of Kleinman's category fallacy, the team were motivated to undergo other qualitative research, a case-note survey and narrative study, in order to reveal over eighty idioms of distress. Compellingly, it is research like this, research that centres cultural relativist insight, that is best able to reveal the increasingly apparent biological component of the human trauma response.

Conclusion

Since the publication of Young's book (1995) there has been compelling neuroscientific evidence in support of a physiological substrate to PTSD. Nonetheless, this essay has hopefully demonstrated how such scientific advances will remain illusory to those they intend to benefit if culture and local particularisms are not considered in a meaningful way.

Section one explored cultural idioms and the philosophical construction of personhood to elucidate how the conceptualisation of PTSD can become lost across cultures; '*the problem is not one of a translation between language but a translation between worlds.'* (Summerfield, 2005, p. 76). It also touched on some of the political implications that can accompany a diagnosis of PTSD, which reminds us to always ask 'who' a given diagnosis is truly benefitting.

Section two drew upon Kleinman's 'category fallacy' to review some major limitations diagnostic manuals pose for international psychiatry. This is not to deny that diagnosing trauma using iterative tools like the DSM has benefits. The DSM creates a globally understood expression of human suffering, a means to galvanise funding, and a way to establish accountability. However, as also demonstrated by section two, reducing trauma in this way can too lead to the reification of human emotion, suffering, and experience. Moreover, in the absence of a sincere understanding of context, misinterpretation of trauma is inevitable, diagnosis can be fallacious, and treatment often lacks beneficence. Clearly, it can be concluded that a diagnosis of PTSD, as with all other psychiatric diagnoses, should never be uncritically disseminated internationally and that taxonomic tools should always be properly scrutinised and situated within the context they are being used.

We finished by pointing to some excellent examples of international psychiatric work and research. Unfortunately, this work remains mostly at the margins of GMH discourse with quantitative measures to population health being the status quo. Then, if we are to take seriously the mental suffering of people living across the globe—those who are constantly afflicted with the true and egregious costs of domination politics—current approaches must evolve to encompass the more nuanced ways people establish resilience and learn to recover when faced with trauma.

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