Re-visiting Traumatic Stress: Integrating Local Practices and Meanings in Explanatory Frameworks of Trauma

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By
Eliana Suarez

PhD Candidate, Factor-Inwentash Faculty of Social Work, University of Toronto
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COMPARATIVE PROGRAM ON HEALTH AND SOCIETY
Munk School of Global Affairs
University of Toronto
1 Devonshire Place
Toronto, Ontario, Canada M5S 3K7
Telephone: (416) 946-8891
Facsimile: (416) 946-8915
E-mail: cphs.munk@utoronto.ca
Website: www.utoronto.ca/cphs

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Eliana Suarez

Abstract

Although Post Traumatic Stress Disorder (PTSD) is only one of the identifiable responses to trauma, it has become the main focus of trauma research, writing, and clinical interventions. The unquestioned use worldwide of PTSD as a diagnostic category, however, presents the risk of pathologizing and/or oversimplifying human responses to traumatic events if local meanings and practices of trauma are marginalized from dominant explanatory frameworks of trauma. This paper goes beyond critiques of the current trauma paradigm and offers new theoretical tenets whereby multiple local contexts could be better incorporated into trauma discourse and practice. In doing so, this paper reviews the historical and theoretical context of leading explanatory frameworks of traumatic stress with an emphasis on cross-cultural settings. If a renewed trauma paradigm aims to have a renewed role in the global health arena, it should be informed locally and globally.

Eliana Suarez is a doctoral candidate at the Factor-Inwentash Faculty of Social Work of the University of Toronto. Eliana holds a Master’s Degree in Social Work from the University of Toronto, an Honours BA in Psychology from Trent University, and a BSC in Economics from the Universidad del Pacifico (Peru). Her research interests are the trans-cultural context of resilience and traumatic stress, global health disparities, and social perceptions of sexual violence. Eliana is completing her thesis: “Surviving the Sasachakuy Tiempu (Difficult Times): The Resilience of Quechua Women in the Aftermath of the Peruvian Armed Conflict.” Eliana may be reached at eliana.suarez@utoronto.ca

INTRODUCTION

For the past three decades, traumatic stress has been at the forefront of academic interest, research, and debate in a variety of fields such as psychiatry, psychology, public health, and peace-building, as well as among the lay public. The quest to identify common responses to different traumatic experiences, such as armed combat, sexual abuse, and natural disasters has also stimulated a renewed interest in the diagnosis of Post Traumatic Stress Disorder (PTSD) locally and globally. Although PTSD is only one of the identifiable responses to trauma, it has become the main focus of trauma research, writing, and clinical interventions (Kirmayer, Lemelson, and Barad 2007, 1). However, local meanings and practices of trauma from non-Western contexts are still highly marginalized from dominant explanatory frameworks of traumatic stress.

Interest in PTSD emerged when the diagnosis was included in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM III) in 1980. PTSD is categorized in the DSM IV-TR as an anxiety disorder, where its main characteristics are intrusiveness, avoidance, and over-arousal symptoms as a response to traumatic stress. It may be acute (i.e., lasting for less than three months) or chronic (i.e., lasting for longer periods, even years), and it usually presents as a comorbid condition with other DSM Axis I disorders such as depression (APA 2000). One consequence of the popularity of PTSD has been the exportation and inclusion of PTSD in international humanitarian programmes used in post-conflict or post-disaster contexts (Pedersen 2002, 175). Similarly there has been an increased use of PTSD tools (i.e., diagnosis and interventions) in the international standards of psychiatric care worldwide (Laungani, 2002, 128).

The unquestioned use worldwide of PTSD as a diagnostic category, however, presents the risk of pathologizing and/or oversimplifying human responses to traumatic events without examining or
considering the social context that encompasses those experiences and responses (Bracken 2001; 1073; Summerfield 2005, 50). Indeed, disparities in the prevalence of PTSD have been documented, often indicating lower incidences in non-Western than in Western countries² (Beckham et al. 1997, 379; Silove and Ekblad 2002, 401). These differences remain under-researched and have not been empirically confirmed or contrasted among case studies. Thus, the question arises as to why these differences exist? (Olff 2005) In efforts to answer this query, academics and practitioners have been split on two sides of the debate. One side of the debate has questioned the universal application of PTSD, highlighting the cross-cultural variations in the meaning of “trauma” (e.g., Bracken 2001, 1073; Laungani 2002, 127). The other side of the debate has focused on the cross-cultural variations in survival strategies in the aftermath of traumatic events (e.g., Hinton 2007, 433; Hobfoll et al. 2009, 138). Despite this, as Dei and colleagues (2008) indicate, local people and cultures (from the Global South) are often seen as sources of cross-cultural data, rather than as producers of knowledge. Conceptualizing and understanding trauma from a hegemonic view, while disregarding the experiences of traditionally “marginalized” segments of society in both non-Western and Western contexts is deeply troubling for the trauma field.

The purpose of this paper is to synthesize critiques of the current trauma paradigm in order to move beyond them and offer new theoretical tenets whereby multiple local contexts could be better incorporated into trauma discourse and practice. In doing so, this paper reviews the historical and theoretical context of PTSD as a leading explanatory framework of traumatic stress with an emphasis on cross-cultural settings.³ Based on this review, the final section identifies key tenets for a new conceptualization of trauma and argues for the necessary inclusion of global and local knowledge in the praxis and theory of trauma.

**HISTORICAL DEVELOPMENT OF PTSD AS THE CURRENT PARADIGM OF TRAUMA**

PTSD first appeared in the DSM-III (APA, 1980) to describe related terms, such as “post-Vietnam syndrome” or “delayed-stress syndrome” that were used to differentiate the delayed nature of the syndrome from acute reactions that characterized previous constructs (Jones and Wessely 2007, 164). Table 1 summarizes the historical development of the trauma paradigm and PTSD. Trauma syndromes before PTSD, were considered to be transient with good prognosis, and caused by individual predispositions. The PTSD diagnosis criteria include a necessary recognizable stressor – the key distinction between PTSD and the etiology of most psychiatric disorders. PTSD criteria include the external causality of the disorder, rather than individual biological or psychological factors (Stein, Seedat, Iversen, and Wessely, 2007, 139).

The new diagnosis of PTSD shifted the attention and responsibility from the soldier, in this case Vietnam veterans, to the nature of the war, and validated the “victim” role of the veterans, granting them a disability pension (Summerfield 2001, 95). These factors and the strong pressure of the anti-war movement made PTSD a politically driven diagnosis that quickly entered the psychiatric annals before there was epidemiological research to support its development.

The women’s rights movement was also influential in expanding the PTSD criteria to events not classified as “outside of the range of usual human experience” in the DSM IV (1998). The latter made it possible to categorize everyday violence against women such as wife abuse as potentially traumatic events and to include child sexual abuse in this same category (Burston 2005, 429). The last DSM-IV-TR further expanded the criteria of potentially traumatic events to include “not unusual events.” Although broadening the criteria of PTSD has made it easier to diagnose PTSD symptoms, it also has increased the overuse of the term PTSD as well as its misdiagnosis (Konner 2007, 300). In turn, the predictive validity of PTSD symptoms has been questioned. For instance, in a large sample (N= 832) from the UK adult general population, Mol and colleagues (2005, 494) found that PTSD scores were similarly high for individuals affected either by life events (e.g., burglary, relational problems) or by traumatic events (physical or sexual abuse, accidents, sudden death of loved one, war). In the context of these findings, it is not surprising that PTSD is considered a questionable diagnosis.

Several factors have contributed to the growing application of PTSD and the trauma response model. First, the emphasis on trauma has generated large amounts of scientific research in the decades, which demonstrates that PTSD is indeed characterized by specific psychobiological changes that differ from
normative stress responses (Stein et al. 2007, 139), confirming that PTSD does in fact exist (Konner 2007, 300). The scientific support to PTSD has also generated interdisciplinary acceptance of the diagnosis. Second, the trauma framework of PTSD has also gained popularity because it is reflective of social values and practices in Westernized societies. For example, the fact that trauma framework focuses on an individual-event dyad rather than on a group-event dyad is consistent with the core individualistic values assumed in modern and post-modern western societies (Bracken 2001, 734). PTSD has indeed become one of the most fashionable and “likeable” diagnoses in Western countries (Bracken 2001, 734). In turn, standardized responses to trauma have also diverted the attention from preventive measures and non-medical interventions (Stein et al., 2007, 139), and from identifying individuals and/or societies responsible for violence that can cause traumatic stress, (e.g., perpetrators of rape, wars) (Summerfield 2001, 95).

As suggested by Hacking’s (1998) analysis, the PTSD discourse and framework have also travelled extensively around the world and are widely used in humanitarian interventions. Despite the overall good intention of these interventions, critics indicate that they run the risk of harming victims if there is no knowledge or assessment of the socio-cultural context of the event (Pupavac 2001, 358). The recent critiques to PTSD have fostered the development of new models to understand trauma, as, for example, integrative models of biological, cultural and social components of traumatic stress (Kirmayer et al. 2007,

<table>
<thead>
<tr>
<th>Year/period</th>
<th>Trauma syndromes</th>
<th>Etiological criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1866-1914</td>
<td>“nervous shock”</td>
<td>Predisposition to mental disorder precipitated by frightening events stored in repressed memories</td>
</tr>
<tr>
<td></td>
<td>“traumatic neurosis”</td>
<td></td>
</tr>
<tr>
<td>1914-1945</td>
<td>“shell shock”</td>
<td>Predisposing individual conditions precipitated by exposure to combat</td>
</tr>
<tr>
<td></td>
<td>“war neurosis”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“exhaustion”</td>
<td></td>
</tr>
<tr>
<td>1952 DSM I</td>
<td>“gross stress reaction”</td>
<td>Vulnerability factors and exposure to combat or other extraordinary stressor</td>
</tr>
<tr>
<td>1966 DSM II</td>
<td>“adjustment disorder”</td>
<td>Vulnerability and fear of death, unwanted pregnancy, combat exposure as precipitating events</td>
</tr>
<tr>
<td>1974 (Burgess &amp; Holmstrom, 1974)</td>
<td>“rape trauma”</td>
<td>Recognize commonalities of symptoms presented by rape victims and war veterans</td>
</tr>
<tr>
<td>1980 DSM III</td>
<td>PTSD (Axis I Anxiety Disorder)</td>
<td>Requires the existence of a recognizable stressor that would evoke distress in almost anyone</td>
</tr>
<tr>
<td>1987 DSM III-R</td>
<td>PTSD</td>
<td>Traumatic stressor should be outside the range of usual human experience and would be markedly distressing to anyone</td>
</tr>
<tr>
<td>1998 DSM IV</td>
<td>PTSD</td>
<td>Traumatic event involves actual or threatened death or serious injury, or a threat to the physical integrity of self or other (i.e., events not outside the range of usual experiences)</td>
</tr>
<tr>
<td>2000 DSM IV-TR</td>
<td>PTSD</td>
<td>Include “not unusual events” e.g., learning about a serious accident experienced by a family member or close friend</td>
</tr>
</tbody>
</table>

Sources: Jones and Wissely (2007); Wilson (1997)
New diagnoses have been also proposed to explain long-term exposure to traumatic stress (see Table 1). Yet, local meanings of distress and healing from non-Western populations are rarely included in these new trauma models. Moreover, marginalized populations within Western countries (e.g., Aboriginals, ethnoracial minorities) are also excluded in these new conceptualizations of traumatic stress.

The development of PTSD demonstrates the interlinkages of medical and socio-political movements and discourses. PTSD went from being a specific combat-related psychopathology to a diagnostic condition related to a range of traumatic experiences among civilian populations. Extensive research in the psychobiology of traumatic stress has contributed to a questionable over-generalization of traumatic experiences that may have similar physical and psychological symptoms, but are contextually different.

**REVIEW OF THEORETICAL FRAMEWORKS AND RESEARCH ON TRAUMATIC STRESS**

Trauma theory is a concept used in the literature to describe the multiple concepts related to trauma and traumatic stress, such as responses and interventions to trauma. Over the past decades, trauma theory has moved from an analogy of physical wounds towards different models of physiological and psychological processes (Kirmayer et al. 2007, 2). In general, these models share a biomedical conceptualization of traumatic stress, whereby the presence of certain symptoms or behaviours provide evidence of a disorder. Traumatic stress, however, does not necessarily lead to PTSD or other mental disorders; in fact, extensive research indicates that the majority of cases resolve over time and do not create any lasting psychopathology (Bonnano 2008, 265; Kessler et al. 1995, 1048). Treatments for trauma-related disorders such as PTSD include specific pharmacological and/or therapeutic approaches (Bisson et al. 2007, 97) and contributors to trauma theory have mainly come from psychiatry, neuroscience, and psychology.

Trauma theory has been intimately connected with stress theory due to its emphasis on traumatic stress. The original conceptualization of stress by Selye (1976, 20), considered stress to be an adaptive response that, in small doses, could be positive because it produced better coping and/or functioning of the individual. Positive stress is referred to as “eustress,” whereas negative stress is known as “distress” and is associated with impaired functioning and well-being (Selye 1976, 25). In the context of traumatic stress, the dominant discourse has mainly focused on distress, thus undermining the role of “eustress” in traumatic experiences (Suedfeld 1997, 449).  

During the past decades the abundant contributions of neuroscientific research have been instrumental to the development of the current trauma paradigm. These contributions have demonstrated that the psychobiological processes of PTSD are in fact dissimilar from Seyle’s “normative stress response” and instead appear as a progressive sensitization of biological systems that create a hypersensitivity to different stimuli (Yehuda and McFarlane 1995, 1705). Despite this, several questions remain around the cause, duration, and most importantly, the socio-cultural meaning of responses to trauma.

The findings on the neurobiology of PTSD can be summarized as noradrenergic changes, neuroendocrine changes, and changes in the size and function of the hippocampus (Pedersen 2002, 175). The noradrenergic system has a key role in stress. It releases norepinephrine which prepares the individual for the “fight” and “flight” responses by focusing attention, elevating fear levels, and elevating the heart rate and blood pressure among other factors (Brenner 2007, 118). Persons with a PTSD diagnosis also show lower levels of the stress hormone cortisol than survivors of trauma without PTSD which creates changes in the size and function of the hippocampus (Villareal et al. 2002, 119). Impaired hippocampal activation in individuals with PTSD can affect diverse aspects of memory and visuospatial processes, as well as increase experiences of dissociation and flashbacks (Brenner 2007, 118). For individuals diagnosed with PTSD, therefore, traumatic stress produces distinct brain chemical changes and hormonal alterations that activate a series of physiological stress-related responses (Yehuda 2002, 123). However, further research is needed to clarify whether these alterations are present before the trauma exposure, are markers of a genetic predisposition, or develop because of reasons still unknown (Shalev 2007, 207).

Neuroscience and cognitive research have also been supporting the importance of “traumatic memory” as a distinctive clinical feature of PTSD: “the [PTSD] criteria require that the person remember and attribute his or her symptoms to the traumatic event” (Kirmayer et al., 2007, p. 7). Trauma theorists and researchers
indicate that the distress resulting from traumatic memories can be modified by psychotherapeutic techniques (e.g., Kubany et al. 2003, 3; Lee et al. 2003, 1071). However, Hull’s (2002, 102) systematic review on neuroimaging findings in PTSD identifies studies that show an increased activation of the amygdala after symptom stimuli, and decreased activity of the Broca area at the same time. The former may have an effect on emotional memory and the latter may explain the difficulty that persons diagnosed with PTSD have labelling their experiences and why some traumatic memories are “unspeakable” (Hull 2002, 102). These findings also account for the relative success of exposure and sensory-based treatments when compared with “talking therapies” (Hull 2002, 102). The notion of traumatic memory as a potential source of both distress and healing has also generated heated controversies around the usefulness, if any, of retrieving and healing traumatic memories.⁷ Another controversy in current trauma theory concerns the assumption that PTSD is a universally applicable human phenomenon. From one side, supporters of the universality of PTSD argue that PTSD symptoms are not culture specific and that the consequences of trauma follow similar dynamics cross-culturally (e.g., De Jong 2005, 361). On the other hand, opponents state that the experience of trauma is subjective and can vary considerably across time, culture, and space and that not all psychological distress associated with trauma should be called PTSD (e.g., Caple 2004, 127; Kagee 2004, 625; Stein et al. 2007, 139). Indeed, research demonstrates how the core physiological responses to trauma are usually translated into a diverse array of expressions depending on the socio-cultural context of the experience (Fernández, Zubieta and Páez 2000, 35). For example, in Cambodia, post-genocide trauma experiences are not understood through western terms such as “trauma,” but rather by words such as “suffering” and “hurt” (Hinton 2007, 433). Those expressions are connected with somatic symptoms such as headaches, sweating, and dizziness (Hinton, 2007). Similarly, there is no equivalent to the word “trauma” in Quechua, the language spoken in Peru by the indigenous population that was largely affected by the armed conflict of the 1980s. Instead, they talk about the “difficult times,” the “times of big sorrow and grief,” and “headaches” (Pedersen et al. 2008, 205).

Scholars have been also attempting to resolve this disjuncture by harmonizing different perspectives of individual and collective trauma (e.g., Abramowitz 2005, 2106; Kienzler 2008, 218). In response to this, new dimensional approaches to trauma are being developed, that integrate the biological, cultural, and clinical dimensions of trauma in the explanatory framework of trauma (e.g., Kirmayer et al. 2007, 451).⁸ However, even psychosocial frameworks that are more inclusive of the social context of trauma (e.g., those that consider social inequalities), still fail to examine the historical social relations of race, class, culture, and gender that influence the particular context where the traumatic experience and recovery processes occur.⁹ Therefore, although trauma theory has made significant contributions in understanding the physiological and psychosocial survival processes after traumatic stress, it has important limitations. The main limitation has been the failure to consider or include the socio-political context in the explanation of traumatic stress. For instance, trauma theory does not address the fact that traumatic stress and its effects are not equally distributed among populations (Kirmayer et al. 2007, 11). The rationale for the previous statement is simple. “Potentially traumatic events” (PTE) in the PTSD criteria are defined as life threatening events (APA, 2000), and it is known that violence occurs more often in environments such as poverty-stricken neighbourhoods or cities. Therefore, PTEs also occur more often in such contexts. For example Breslau and colleagues (2004, 113) found that inner city youth in the US have higher lifetime rates of occurrence of assaults than youth in middle-income neighbourhoods. Research in natural disaster zones also supports the importance of intersecting social identities as predictors of post-trauma distress. For instance, the onset and duration of PTSD in survivors of Hurricane Katrina was largely determined by gender, financial loss, post-disaster stressors, low social support, and post-disaster traumatic events such as being assaulted (Galea et al. 2008, 357). Another study on survivors of Katrina found that perceived racial discrimination during Katrina and financial stress after Katrina, were associated with PTSD-related symptoms with higher rates for Black female survivors (Chen et al. 2007, 257). In addition, Brewin and colleagues’ (2000, 748) meta-analysis, supports the relevance of the social context in trauma by indicating the absence of social support as a primary risk factor in developing PTSD.
This unbalanced distribution of events producing traumatic stress becomes more evident when observing the onset of mass violence in non-Western populations (Kleinman and Dejarlais, 1995). Population inequalities appear to produce unequal rates of intrastate violence which potentially increase the occurrence of PTEs for the populations of these states. Studies conducted within the Western context have also indicated that trauma can occur more often simply by belonging to certain minorities and/or disadvantaged groups such as low income women (Vogel and Marshall 2001, 569), Aboriginals (Duran and Duran, 1998), or Blacks and other ethno-racial minorities in North America (Neria et al. 2006, 467). Indeed, racism and discrimination have been indicated as risk factors for race-based traumatic stress (Carter 2007, 13). This unbalanced distribution of traumatic events and its aftermath indicate that most trauma is a targeted rather than a random occurrence, an issue that has been discussed very little in the trauma literature.

Trauma theory, therefore, explains the biopsychological processes of traumatic stress, but fails to contextualize the experience. I argue that the complexity of trauma makes it necessary to have a multi-framework of analysis. For instance, critical social theories, such as feminist theory, can complement trauma theory to contextualize trauma within the historical arrangements of social factors such as race, class, and gender. Similarly structural violence theory (Galtung 1990, 291) can explain the socio-cultural arrangements that legitimize violence, rendering some groups more vulnerable to violence and ultimately, to traumatic stress. Yet the knowledge and experiences of marginalized populations from Western and non-Western contexts are not being fully incorporated into the dominant discourse of trauma.

ALTERNATIVE FRAMEWORKS OF PTSD AND CURRENT TRAUMA PARADIGM

Previous sections have shown how the DSM categorization of PTSD has provoked tremendous research and interest in trauma diagnosis, but have also been accompanied by a growing number of critiques from different disciplines. Neuroscience, transcultural psychiatry, political science, and medical anthropology have all raised questions regarding the validity and utility of the DSM category. On the one hand, neuroscientists are concerned that the diagnostic category disguises the behavioural and brain mechanisms that underlie the biological response to trauma. Indeed, neuroscientist Bremner (2007,118) suggests that a broader category of PTSD that includes a broad spectrum of trauma-related disorders will better reflect the long-term changes in the brain as a consequence of traumatic stress, thus permitting us to observe stress responses. On the other hand, medical anthropologists argue that psychiatric categories such as PTSD are largely social constructions and that the current neurobiological knowledge pays minimal attention to the social and cultural processes of trauma responses (Kienzler 2008, 218). Of particular concern for anthropologists and critical scientists is the assumption of PTSD as timeless, universal and valid across cultures (Young 1995). Yet, much remains unknown about how the socio-cultural context can interact with neurobiological processes to produce responses to traumatic events and what this interaction implies for diagnosis and treatment.

Summerfield (2001, 95) argues that PTSD is a medicalizing and pathologizing view of human suffering. Furthermore, he questions the differences between PTSD and other comorbid DSM diagnoses and suggests that PTSD should not be treated as a separate diagnosis. Summerfield also argues that the trauma narrative is a product of Western globalized industry and that its unquestioned dissemination to other cultural contexts must be challenged. Bracken (2001, 733) also questions the universal validity of PTSD in cultures where other responses to trauma may be the norm (e.g., somatization or dissociation) and where central contextual issues (e.g., protracted conflicts) call for social reconstruction rather than individual therapy. Moreover, the focus on therapeutic interventions may distract valuable and scarce resources from addressing the structural causes of violence. Feminist theorists and liberation psychologists share the common elements of a “radical” critique to the trauma paradigm. In essence, they argue that the PTSD model is an inadequate model of trauma and instead propose a view of trauma as a concrete response to objective events (e.g., violence, oppression, natural disasters) where symptoms should be reframed as coping skills (Burstow 2003, 1293). Transcultural psychiatrists suggest that mainstream Western psychiatry decontextualizes and essentializes human problems by focusing on the individual, thus making it impossible to explain and treat trauma in cross-cultural contexts (Kirmayer et al. 2007, 471). However, they also propose that the trauma paradigm can be applied in non-Western contexts if it is integrated within the socio-political context of the experience and a multi-disciplinary, transcultural healing approach is used (Kirmayer et al. 2007, 472).
This brief review of some of the multidisciplinary critiques to the trauma paradigm offers valuable insights for the re-theorizing of a new explanatory framework of trauma. As suggested by medical anthropologist Kienzler (2008, 227), instead of proposing different and exclusionary alternatives, what is needed is a “division of labour” among the disciplines involved in the trauma field where contributions otherwise representing different interdisciplinary goals and methods are not considered opposite so much as complementary.

While there is abundant literature either supporting or critiquing PTSD or trauma theory, few alternative frameworks have been proposed. Some of the exceptions come from Latin American liberation psychology (Martin-Baró, 1994), from medical anthropology (Kleinman et al. 1997), post-colonial theorists (e.g., Gagné, 1998), radical feminist theory (e.g., Burstow 2003, 2005), and from revised psychosocial perspectives (e.g., Ager, et al, 2005). I discuss these in turn below.

Martin-Baró13 (1994) used a social model of trauma that conceptualizes mental health as a dimension of the relations between persons and groups rather than the individual mental state. In order to illustrate this, Martin-Baró described the dehumanizing context of war by emphasizing the importance of personal suffering and situating it within the family, the community, and the wider society, thereby characterizing the trauma as “psychosocial.” Furthermore, he situated the problems with political violence in the “traumatogenic” relationships of an oppressive system that creates the war context rather than the individuals involved. Therefore, trauma interventions or treatment should be directed to those socio-political forces that perpetuate oppression and political violence. As such, he is critical of the emphasis on individual therapy in the context of civil war and instead supports a psychosocial approach to rehabilitation. Alternatively to the trauma response framework and PTSD, medical anthropologists have developed the notion of social suffering. Kleinman and colleagues (1995) have indicated that there is no singular way to suffer as the perception and expression of pain is different even among individuals in the same community. Therefore, suffering intersects with gender, group ethnicity, religion, economic status, and other global processes that influence local realities. “Social suffering, results from what political, economic, and institutional power does to people and reciprocally from how these forms of power themselves influence response to social problems.”(Ibid,103). Conditions of social suffering usually involve different fields. For example, trauma, pain, and illness produced by violence are health matters, but are also political and cultural issues. Social suffering merges local and global issues and highlights micro-macro social interactions in the understanding of suffering and health as opposite dimensions (Pedersen 2002, 175).

Gagné (1998) presented an alternative trauma framework from a post-colonial perspective. In doing so, she examined First Nations people and the impact that colonialism and socio-political dependency had in creating trauma. Gagné went beyond the individualistic approach of trauma theory by integrating the historical, psychological and social dimensions of trauma. Gagné also used Einsebruch’s notion of “cultural bereavement” to examine the intergenerational effects that forced segregation had on an entire generation of Aboriginal children in residential schools in North America. In the post-colonial context of Gagné’s framework, the historical trauma of First Nations people is the result of the colonization process, which unfortunately is not yet a matter of the past. Gagné’s post-colonial theory of trauma is also applicable to indigenous populations worldwide and other groups. In addition, post-colonial theory sees the dominant trauma paradigm as a neo-colonial imposition that tends to silence or marginalize local meanings of mental health, in particular those of indigenous populations (Gagné 1998).

Feminist theorist Burstow (2003, 2005), among others, has delineated the foundation of a radical theory and applied it to an alternative trauma framework. In this framework “trauma is a concrete physical, cognitive, affective, and spiritual response by individuals and communities to events and situations that are objectively traumatizing” (2003, 1304). In other words, affected individuals or groups feel wounded or traumatized because they are indeed wounded. As such, PTSD symptoms are theorized as coping or survival skills that allow individuals to survive unbearable situations. Trauma is a concrete response to a traumatic event, which is also concrete and specific, and it happens to particular people for particular reasons. Therefore it is personal but also political (Burstow 2005, 429). The praxis of radical trauma reinforces the resilience of trauma survivors and addresses the collective nature of many trauma experiences.
Largely based on the notion of collective resilience, numerous psychosocial models have been proposed and implemented in trauma responses to large-scale disasters. While there is not agreement on any one single definition, psychosocial models are defined as those which explicitly recognize the link between social agency and mental health (Pupavac 2001, 358). This is accomplished through the use of medical and/or therapeutic interventions to promote social gains and/or social, cultural, or political interventions that promote health or psychological well-being. Psychosocial methods assume that there is an innate resilience among individuals and their ability to manage hardship. The aim of psychosocial approaches is to assist individuals and groups in rebuilding their human capacity, social ecology, and the cultural strengths of their community (Ager et al. 2005, 158). The psychosocial model is currently a popular, but also controversial discourse in humanitarian and development work (Pupavac 2001, 358).

While these alternatives frameworks to trauma theory make valuable contributions, I found some common limitations. First, they do not necessarily aim at building a body of theoretical knowledge. With the exception of Kleinman’s “social suffering” and Burstow’s “radical theory of trauma,” the other frameworks are mainly responses to the needs of particular social contexts or populations. Second, they do not attempt to build bridges among different theories or healing perspectives. In other words, they do not consider the “division of labour” proposed by Kienzler (2008, 227). Moreover, with the exception of Martin-Baró’s theory of social trauma, the local knowledge of non-Western contexts is not integrated into these frameworks.

INCORPORATING LOCAL AND GLOBAL KNOWLEDGE IN A NEW EXPLANATORY FRAMEWORK OF TRAUMA

My aim in this section is to develop some guiding principles for the foundation of a new explanatory framework of trauma. This new framework aims at building bridges between Western and non-Western traditions in trauma and to explicitly integrate local sources of knowledge. The proposed framework differs from current trauma theory because the latter is mainly informed by the multivariate paradigm, often without considering the symbolically meaningful relations among social actors or the specific historical context on which the variables are observed. Indeed, many of the critiques reviewed in this paper have identified this critical limitation of the PTSD model. Building on the review and analysis of previous sections, I will outline some of the guiding principles of a revised explanatory framework of traumatic stress. Unlike the previous alternative frameworks that have been proposed, I seek not only to build on previous critiques, but also to move beyond them by finding synergies among them and transforming them into the following guiding principles:

1. **Trauma is Defined as a Dimensional rather than a Categorical Construct.**

   A dimensional definition of trauma should be inclusive of all significant traumatic circumstances while avoiding trivializing experiences of trauma and suffering. Most importantly, in order to avoid a “category fallacy,” the voices and knowledge from non-Western populations have to be listened to and incorporated into this process. In addition, the absence of a unified version of non-Western voices or experiences also reinforces the multidimensional context of this framework. A good start is the definition of trauma as articulated by Laungani, an Indian scholar, as a “a state of physical and/or emotional shock, which may be a result of real, anticipated, imagined or forgotten experiences, or encounters. Trauma may occur at an individual level, a group level, and a cultural level” (Laungani 2002, 41). By using multivariate terms, the units for analysis can be individuals, but also families and communities. Thus, collective trauma is being explicitly incorporated into this dimensional framework. Another challenge is to transform the current “trauma language” emphasis on interventions that divert the attention from those responsible for traumatic events. I hope that continued interdisciplinary debate on the subject may generate a dimensional construction of trauma inclusive of all dimensions of the experience of trauma and human suffering.

2. **Trauma is Not a Random Occurrence.**

   The empirical evidence included in this paper indicates that membership in certain social groups makes people more vulnerable to traumatic events of a systemic nature. Indeed, structural violence theory explains how and why certain groups are more likely to be exposed to violence and in consequence to harmful and traumatic experiences (Farmer, 2003). This has largely been absent from the current trauma paradigm,
which is one of its major limitations. The Holocaust, genocides in places such as Guatemala, Cambodia, Rwanda, and Sudan, and the traumatic colonization of indigenous populations are disturbing examples of how violence is targeted and not random. The high prevalence worldwide of sexual violence towards women is another eloquent indicator of targeted violence. Indeed, this empirical review also demonstrates the need to include a gender analysis in a renewed trauma paradigm, as women are particularly susceptible to all types of violence and the detrimental effects of traumatic stress. Additionally, structural violence that is intrinsically connected to poverty, discrimination, and unequal access to health is also determined by historical dynamics of class, race, and gender, among other factors (Farmer 2003; Pedersen 2002). Although this principle is mainly applicable to human-made disaster or violent acts, the latest experiences of Hurricane Katrina and 9/11 also provide clear evidence of the absence of randomized occurrence of traumatic stress in the aftermath of traumatic exposure (Chen et al. 2008, 257; Galea et al. 2003, 514). Human rights violations are intimately connected with structural violence. Thus if these violations are not addressed in trauma work, the trauma field has the risk of becoming collusive with those practices.

3. Trauma Occurs in a Social Context and in Sequences.

The previous review indicates that the responses and consequences of trauma are determined by contextual factors and the time sequence of the experience. This principle is also inspired by Keilson’s (1992) model of sequential traumatization, which outlines the importance of the social context in generating traumatic sequences over different time periods. His research demonstrates that sequences shape the traumatic outcome more than the original event and/or experience. For example, social reactions in the aftermath of sexual assault (Ullman et al. 2007, 369), the socio-economic consequences of war, (Pedersen 2002, 175) and the nature of the asylum-seeking process for refugees, (Silove and Ekblad 2002, 401) demonstrate how the social context and the sequence of events influence the traumatic outcome. However, the dearth of longitudinal studies on trauma responses precludes further analysis on sequential traumatization. This strong connection with the social context reminds us that trauma is not a neutral experience, but a political one, as critical theorists have indicated (Burstow 2005; Keinzler 2008). The previous historical review illustrates that the development of the trauma paradigm was intimately connected with social movements such as anti-war and women’s rights movements. A current challenge for the trauma field is to revive this connection with global social movements and address the issues of social injustice that underlie most traumatic events.

4. Trauma and Resilience Are Bedfellows.

Simplistic views of trauma and resilience have denied the intimate and longstanding relationship between both of these human responses. A singular emphasis on trauma responses, which tends to present trauma as disabling, overlooks the fact that in most cases, the final outcome is resilience. Likewise, a narrow view of resilience tends to portray it as strength and as a normative response to trauma, thereby denying the risks and vulnerabilities that can co-occur after the traumatic experience (Stein et al. 2007, 139). The notion of “social suffering” (Kleinman et al., 1997) contributes to a new trauma framework in two ways. First, it allows for the inclusion of lived experiences of distress and suffering. Second, it accounts for the role of the pre-existing social order in creating the social problems that ultimately generate social suffering (Pedersen 2002, 175). A renewed trauma framework, however, also needs to explicitly include counteracting theories of survival – that is, how the social context can also foster resilience in the aftermath of trauma. Furthermore, stress theory illuminates how traumatic stress and “eustress”, or positive stress, have always been an underlying response to traumatic events (Konner 2007, 308). PTSD and the current trauma models have largely neglected this. This tenet also seeks to reflect the global occurrence of trauma and resilience and to integrate non-Western idioms and explanations of survival. Further research must examine the development of historical resilience in marginalized groups worldwide at the same time as examining intergenerational and historical trauma.

5. Trauma Is Both Universal and Localized.

Addressing trauma also entails contextualizing its multiple locations. Those locations compel us to look at those who are “traumatized” and how they are defined, perceived and located vis-à-vis the effects of trauma.
This approach is also congruent with the key role of the social context in traumatic responses. For this purpose, a critical and intersectional analysis of gender, age, culture, class, race, disability, historical and geographical location, and other social dimensions of the traumatic response is of utmost importance. That being said, there are core physiological responses to traumatic stress that appear to be universal and that need to be considered (Konner 2007, 319). There is a need to continue examining the psychobiological responses to trauma and how the social context may have influenced those responses. For example, the latest discovery of the “mirror neurons” demonstrates how neuroscience research helps to understand the environmental influences on social behaviours as empathy. In this respect, it is relevant to examine individual responses to trauma in a social context, and how “mirroring” other people may influence this. The same concept can be applied to resilience, whereby individuals influence and are also influenced by resilient families and communities, which is in agreement with contextualized resilience models.

The indiscriminate dissemination of the trauma paradigm to non-Western contexts calls for an assessment of the cross-cultural validity of trauma conceptions, instruments, responses, and most importantly, its underlying assumptions. The proposed framework will achieve this by integrating non-Western knowledge in explanations and interventions of traumatic stress. I understand local knowledge as the combination of individual narratives, but also as the local theoretical and practice developments from non-Western contexts.

In summary, these initial principles provide the basis of an alternative explanatory framework of traumatic stress that portrays trauma as a multidimensional experience of mostly targeted rather than random occurrence, which is situated within a social context and a temporal sequence. It also seeks to create stronger linkages and connections with resilience and with a strong primacy of local rather than universal features. In particular, these guidelines emphasize a critical analysis of trauma that integrates gender, race, class, and other social dimensions into the study of the differential occurrence of trauma. It also highlights the need to explicitly integrate local narratives and knowledge from non-Western contexts into the development of this framework.

**CONCLUSIONS**

With the growing criticisms surrounding PTSD and the current trauma paradigm, this is perhaps an appropriate moment to step back and reflect on alternative frameworks. The purpose of this paper was to develop the foundation of an alternative framework that synthesizes and builds upon dominant critiques. To do this, I have first examined the development of post-traumatic stress disorder from its historical antecedents to the current state of affairs. Second, I have presented an overview of the conceptual framework that guides the debate of the current trauma paradigm and an empirical review of its applications. The review highlights the limitations on the conceptual validity of PTSD, the inherent comorbidity of the diagnosis, the limited specificity of its etiological criteria, and its notable absence of cross-cultural validity. Third, I have reviewed and synthesized critiques and alternative frameworks of the current trauma paradigm. I conclude by highlighting my belief that although trauma work is prevalent, a trauma focus is less useful than a more holistic, interdisciplinary approach. In the final section, I have identified guiding principles for a dimensional conceptualization of trauma that centres on risk, resilience, and protective factors, and that highlights the importance of gender, culture, social structures, and social justice. This renewed conceptualization of trauma also includes Western contributions, e.g., feminist, anthropological, and transcultural psychiatric perspectives.

I argue that a key task for the future is to connect the trauma paradigm with larger global processes and movements of social transformation. In particular, I emphasize that the treatment of culture continues to be inadequate and superficial. Indeed, many trauma studies continue to treat culture as a variable rather than as constitutive. It is therefore necessary to include global and local knowledge in the praxis and theory of trauma. If a renewed trauma paradigm also aims at having a renewed role in the global health arena, it should be informed locally and globally.
Endnotes

1 This paper uses only the DSM’s definition of PTSD without reference to the International Classification of Disorders’ (ICD’s) definition of post traumatic disorder which is otherwise congruent for the most part with the DSM diagnostic criteria.

2 This paper will use the terms Western and non-Western countries as equivalent to other similar dichotomies (North (ern) vs. South (ern) countries and Developed vs. Developing). These categories are used to differentiate countries in the North Occidental hemisphere or Western countries who share similar socio-cultural backgrounds, the so-called occidental lifestyle, liberal political systems, and high income levels from countries in the Southern and Eastern hemispheres.

3 Since the focus is on the explanatory framework of traumatic stress, this paper will not include extensive details of therapeutic interventions unless it is indispensable for a particular discussion.

4 One example of the cultural impact of PTSD is what Satel and Sommers (2005, 48) refer to as the “trauma industry” or the extended number of trauma services, experts and on-line treatments that are available.

5 Hacking, a philosopher of science and author of “Mad travelers” (1998) has indicated that to develop a professional niche, psychiatry has taken elements of human responses to suffering that were originally found in socio-cultural activities and made them accessible only through highly privileged technical understanding.

6 One of the few exceptions to this has been the research on post-traumatic growth (PTG), which is defined as the positive consequences for survivors of traumatic stress (Tedeshi and Calhoum 1996, 455). With some exceptions (e.g., Hobfoll et al. 2009, 138), the scarcity of PTG research in non-Western countries limits its transferability as it is mostly reflective of a Western socio-cultural context.

7 For example, Elsaas (2001, 306) found that in a Peruvian community in the Andes highlands, “forgetting” the traumatic events that happened during a past armed conflict was often the mechanism used for traumatized individuals to recover.

8 Indeed, the Inter Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2007) emphasize the psychosocial issues that impact disaster and/or war-affected populations rather than the psychological trauma per se.

9 As Bennett (2007, 531) indicates, “before we can deal effectively with [the] environment, it is imperative to recognize race, class, and culture as factors in creating it.”

10 An analysis of armed conflicts between 1980 and 2005 in 146 countries confirmed that country poverty income, poor health and poor nutrition were significantly associated with the onset of armed conflicts (Pinstrup-Andersen and Shimokawa 2008, 513).

11 Kleinman’s (1997, 712) notion of “category fallacy” which occurs when it is assumed that a diagnostic category or other phenomenon has the same meaning across cultures, has been often applied to PTSD. This notion indicates that the presence of symptoms in a particular social context does not imply that these symptoms have the same meaning or importance than in other contexts.

12 In this context, Pupavac criticizes the intensified attention to the psychological state of war-affected populations paid by humanitarian responses in post-conflict areas, stating that “trauma is replacing hunger in the West’s conceptualization of wars and disasters in the South” (Pupavac 2001, 358).

13 Martin-Baró’s pioneering work on psychosocial trauma and political violence was tragically interrupted when he was killed in El Salvador in 1989.

14 Resilience is broadly defined here as an interactional process, which combines individual survival characteristics and the environment (Ungar 2008, 218). As such, it is important to consider the role of social relations, such as the cultural and power dynamics in an environment that could affect resilience capabilities (Fraser, Richman and Galinsky 1999, 131).

15 Mirror neurons are located in the pre-motor and parietal cells in the human brain. Those neurons are activated when there is action towards an objective and in situations where the action of others is being observed. This activation provides a neural mechanism for different social behaviours from imitation to empathy (Iacoboni and Dapretto 2006, 942).

16 Some examples of the latter are Martin-Baró’s (1989) social theory of trauma, and Chilean Cienfuegos’ and Monillas’s (1983) therapeutic testimony methods.
References


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