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TRAUMA ACROSS CULTURES: CULTURAL DIMENSIONS OF THE PHENOMENOLOGY OF POST-TRAUMATIC EXPERIENCES

abstract

In this paper, I enquire into the nature of the influence culture has on the experience of trauma. I begin with a brief elaboration of the dominant conceptualization of post-traumatic experiences: the diagnostic category of PTSD as it can be found in the DSM. Then, I scrutinize the nature and extent to which cultural factors may influence the phenomenology of the experience of certain events as traumatic and subsequent symptoms of post-traumatic stress. It seems that cultural circumstances alter the way in which trauma is experienced; it is not clear whether there is in fact a core pathology of PTSD, as the DSM assumes, or whether the structure of the experience of trauma is too multifaceted to be summarized in one diagnostic category. Finally, I show that phenomenological enquiry promises to identify the structural similarities that would justify the delineation of a distinct diagnostic category.

keywords

phenomenological psychopathology, post-traumatic experience, diagnostic categories, culture, DSM

Phenomenology and Mind, n. 18 - 2020, pp. 222-229
DOI: 10.17454/pam-1816
Web: http://www.rosenbergesellier.it/elenco-libri?aaidriv=14

ISSN 2280-7853 (print) - ISSN 2239-4028 (on line)

1. Introduction

The upcoming publication of the *Oxford Handbook of Phenomenological Psychopathology* highlights the significance of this research area in current academia. Phenomenology has become an important lens through which psychopathological experience is scrutinized, focusing on the first person perspective of the affected. However, phenomenological psychopathology has often been inattentive to cultural factors. I shall scrutinize cultural dimensions of the phenomenology of post-traumatic experiences, as the phenomenological literature on the latter is still relatively scarce and promises to yield interesting insights. I will enquire into the nature of the influence cultural factors have on the experience of trauma. I shall begin with a brief elaboration of the dominant conceptualization of post-traumatic experiences: the diagnostic category of Post-Traumatic Stress Disorder (PTSD) as it can be found in the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM). I will then scrutinize the nature and extent to which cultural factors may influence the phenomenology of the experience of certain events as traumatic and subsequent symptoms of post-traumatic stress. While the frequency of PTSD varies cross-culturally, it is not clear whether the structure of experience differs, too. Phenomenological psychopathology promises to be a valuable approach to further enquire into the nature of post-traumatic experience and the extent to which it is influenced by cultural context. Finally, I shall apply Sass's account of phenomenological implication to show that structural similarities can be found in the phenomenology of trauma across cultures.

2. Trauma in the DSM

The definition of PTSD that can be found in the DSM has become, since its inclusion in the third edition of the manual in 1980, one of the major ways in which post-traumatic experiences are conceptualized. The DSM is an immensely influential work. Its main goal is to provide a comprehensive register of mental disorders and their respective symptoms. It promises to be universally applicable by psychiatrists worldwide, in order to reliably diagnose psychopathologies. The handbook in general, as well as the PTSD category in specific, have been widely criticized for being inapt. Their validity and specifically their applicability to individuals from non-western[1] cultures have been challenged (Timimi, 2014). I will not, however, argue that PTSD is a mere fiction (Summerfield, 2001; 2004), or question

1 I am aware that "western" is far from being a unitary concept and dichotomizing into west/non-west is problematic. I shall only use this terminology when referring to other authors' work and in line with their argument.

the usefulness of the DSM (Frances, 2013; Parnas & Gallagher, 2015; Stolorow, 2018). What is of interest here is the extent to which cultural factors influence the experience of trauma and whether this challenges the DSM's assumption that the core psychopathology is equally applicable to individuals from all cultural backgrounds.

PTSD, according to the DSM, is diagnosed when an individual has experienced at least one traumatizing event and subsequently develops a range of symptoms of psychological distress. The DSM defines traumatic events as involving "actual or threatened death, serious injury, or sexual violence" (APA, 2013), such as exposure to war, torture, sexual violence, or natural catastrophes. These events are assumed to be traumatic in and of themselves and to provoke symptoms of post-traumatic stress in a large number of individuals exposed to them, directly or indirectly.[2] Symptoms of post-traumatic stress include, but are not limited to: intrusion of memories of the event such as flashbacks and nightmares; avoidance of stimuli associated with the event; negative alterations to cognition and mood, e.g. partial amnesia concerning the event, negative beliefs, loss of trust, *etc*.; and alterations in reactivity, e.g. heightened startle response (APA, 2013, pp. 271–272). A diagnosis of PTSD is made if these symptoms prevail for more than four weeks after the traumatizing event.

The DSM entry on PTSD, like many other of the pathologies, includes a section on Culture-Related Diagnostic Issues. It emphasizes that the risk of exposure to certain kinds of traumatic events and the subsequent onset and severity of PTSD may vary across different cultural groups. It furthermore acknowledges that the expression of symptoms may differ across cultures (APA, 2013, p. 278). It seems, however, that these cultural variations in the risk of exposure and the expression of symptoms which the PTSD category allows for do not apply to the experience of the core pathology, the structure of which is assumed to remain the same across cultures.

The DSM thus attempts to demonstrate its validity independent of the cultural background of psychiatrist or patient. As mentioned above, it has been widely criticized in this regard, not only concerning the PTSD category. In case of the latter, it remains unclear why and how an event that is supposedly traumatic in and of itself should lead to PTSD in some of the exposed individuals but not in others. Wells *et al.* point out that what is valid in one cultural context may not be valid in another. Symptoms might not carry the same significance in different cultures: hopelessness experienced by a healthy, young, upper-middle class individual has a very different significance than the hopelessness experienced by an individual in the grip of an oppressive system that denies all personal freedom (Wells *et al.*, 2015). Hassan *et al.* emphasize the importance of cultural competency in offering mental health and psychosocial support (MHPSS) to individuals from non-western cultural backgrounds. A failure to do so can result in misdiagnoses due to a misunderstanding of the ways in which distress is expressed, despite the DSM's warning. Consequently, the ill-informed intervention offered is likely to be unsuccessful or, in the worst case, do more harm than good (Hassan *et al.*, 2016; Timimi, 2014, p. 212).

The difficulty of applying the DSM's diagnostic categories to individuals from diverse cultural backgrounds is emphasized by the significant fluctuation of PTSD prevalence rates across countries. Differences in the expression of distress and the significance ascribed to experiences, as well as methodological variability, are only two possible explanations for

2 According to the WHO Surveys, up to 20% of trauma victims develop PTSD, depending on the type of exposure (Kessler *et al.*, 2017). Other factors may increase resilience or vulnerability, thus altering individual risk of developing PTSD. These can be of temperamental, environmental, or physiological/genetic nature, according to the DSM (APA, 2013, pp. 277–278).

rates ranging from 0.2% in metropolitan China to 3.5% in the United States (Hinton & Lewis-Fernández, 2011, p. 787). The question at hand is, however, not the cross-cultural variability in the *frequency* of PTSD, but the nature and extent to which cultural context influences the very structure of experience. In the following, I shall scrutinize whether it is likely that there are, in fact, cultural differences on a phenomenological level, i.e. whether traumatic events and post-traumatic experiences are in fact experienced in significantly different ways across cultures.[3]

3. Cultural Influence on the Experience of Trauma

Phenomenology offers an additional perspective on the question of cross-cultural applicability of the PTSD category. While cross-cultural differences in the experience of post-traumatic stress do not necessarily pose a problem for the validity of the diagnostic category, they might help to inform our understanding of the nature of the influence cultural circumstances have on the experience of trauma. In the following, I shall elaborate on the phenomenological differences in the experience of trauma across cultures before scrutinizing phenomenological similarities in part (4).

Phenomenological differences across cultural contexts can be determined in the experience of both the traumatic event and the subsequent psychological distress. Beyond the DSM, traumatic events are described as 'shocking', 'shattering', or 'rupturing', as being utterly incomprehensible (e.g. Brison, 2013; Herman, 1992). In phenomenological terms, one could say that trauma violently disrupts the individual's anticipations of what is experienced as possible: it inflicts upon the individual's horizon of possibilities ("*Erwartungshorizont*" (Husserl, 1966, p. 186)). Anticipation and the experience of possibilities have been thoroughly treated in phenomenological literature, from early phenomenologist Edmund Husserl to recent academic research (Fuchs, 2007; Husserl, 1931, 1966; Ratcliffe, 2018). From a phenomenological perspective, the individual is seen as an embodied and embedded subjectivity (Krueger, 2016). Their lifeworld, that is, the individual world of experience, involves corporeality, spatiality, temporality, and intersubjectivity, affordances and potentialities (e.g. Fuchs, 2017; Zahavi & Salice, 2017).[4] Experiencing some things as possible, given one's embeddedness in the life world, entails the experience of affordances: I can experience the light switch as being out of reach, but my pencil as within reach. This experience is pre-reflectively informed by my sense of corporeality, i.e. being embodied, and spatiality, i.e. being in a certain spatial relation to the light switch and pencil in question. In other words, I experience the light switch as not affording to be flicked, but the pencil as affording to be reached and, by extension, to be written with. If I were agraphic, the latter would not be the case. I would be, presumably painfully, aware of the lack of affordance the experience of the pencil would entail. Following a similar pattern, a close friend affords the possibility to be spoken to in a low voice about my insecurities and fears, while a stranger might be experienced as entirely impossible to address, e.g. due to a language barrier. The experience of affordances is not limited to what I can or cannot do, but also includes what other people and things can and cannot do. Moreover, the experience of affordances brings with it an experience of anticipations: I anticipate to feel the shape and mass of my pencil when reaching for it. This anticipation would be disappointed were my fingers to go right through what I thought to be my pencil but what turned out to be a very convincing image thereof. The entirety of my experience of affordances and anticipations is enclosed in a horizon of possibilities. To some degree, this horizon is shaped by

3 I use culture in the sense of context, including "all of the socially constructed aspects of life that shape neurodevelopment, everyday functioning, self-understanding, and experience in illness and health" (Kirmayer & Gómez-Carillo, 2019).

4 Due to the brevity of this paper, I shall only give a short overview of the respective theories. For a more detailed account of Husserl's phenomenology, cf. e.g. Dan Zahavi's *Husserl's Phenomenology* (Zahavi, 2003).

my social relations and, most importantly for the examination at hand, cultural context, as I will illustrate in the following.

Across cultural contexts, there is a difference in the phenomenology of what is experienced as normal and possible and what disrupts this horizon of possibilities.[5] An event such as a missile destroying a house may be experienced as utterly unimaginable in one context while being a daily occurrence in another. Seeing a lone house standing amongst the rubble of what used to be a neighborhood is likely to entail the experience of the possibility of the house's destruction, or even the anticipation thereof. Frequency does not make an event like this less disruptive; it does, however, influence the way in which it is experienced and the kind of distress the experience entails. An event that violently disrupts the individual's horizon of possibilities is likely to be experienced as rupturing and shocking, and thus traumatic, while a disruptive event that has become part of the individual's habitual life world is more likely to result in feelings of helplessness and depression. The 2006 war in Lebanon can serve as an illustration of this. The destruction of houses, subsequent displacement, serious injuries, and death of family members had already been a sad part of everyday life in Lebanon for 15 years, during the South Lebanon Conflict from 1985–2000. A study with 991 participants from south Lebanese villages conducted one year after the 2006 war found a prevalence rate for PTSD of 17.8%. Interestingly, half of these individuals that qualified for a diagnosis with PTSD - a total of 9% - was found to also meet criteria for Major Depressive Disorder (MDD).[6] Only 8.8% were diagnosed with PTSD alone (Farhood, *et al.*, 2016). This high prevalence rate of co-occurrent PTSD and MDD points to a different kind of experience: it appears that the horrendous events of the war were not merely experienced as shocking, but also as disillusioning. This example illustrates that the context in which an event occurs plays a significant role for how it is experienced by those affected by it.

Several authors claim that there are, furthermore, differences in the way in which the symptoms following potentially traumatic events are experienced; differences that are, at least in part, culturally informed. Not only the expression of mental disturbances and the significance ascribed to them varies, as I have pointed out earlier; there is some evidence for deviations in the phenomenology of psychological distress (Hassan *et al.*, 2016, p. 135; Kirmayer, 2012, p. 149; Lewis-Fernández *et al.*, 2010). Catastrophic cognitions, i.e. the catastrophic misinterpretation of sensations as aversive, dangerous, or more severe than they are, increases the experience of psychological distress (Clark, 1986, p. 462). Lewis-Fernández *et al.* point out that individuals are inclined to search for specific symptoms that are prevalent in their respective culture. Through attentional mechanisms and positive feedback mechanisms, these symptoms become enhanced. Thus, the cultural context influences the experience of distress, by emphasizing certain symptoms.[7] Furthermore, cultural particularities of grouping symptoms into clusters may lead to individuals experiencing the co-occurrence of symptoms that are supposed to belong to the same cluster as the distress experienced (Lewis-Fernández *et al.*, 2010, pp. 5–6).

Whether the experience of depression and post-traumatic stress is more closely linked in some cultures than in others must remain a matter of speculation for now. What can be said is that the high comorbidity of PTSD and MDD that was found in the Lebanese context and beyond poses the question of whether drawing a hard line between the two distinct diagnoses is

5 For a concise account of Normality in Husserl's Philosophy, cf. Zahavi, 2003, pp. 133–135.

6 Shalev *et al.* found that 44.5% of PTSD patients also met criteria for MDD at 1 month after trauma (Shalev *et al.*, 1998).

7 Catastrophic cognitions have been studied in regard to anxiety and panic attacks and would have to be specifically applied to the study of PTSD.

legitimate. It seems that cultural circumstances alter the way in which trauma is experienced; it is not clear, however, whether there is in fact a core pathology of PTSD, as the DSM assumes, or whether the structure of the experience of trauma is too multifaceted to be summarized in one diagnostic category. Further research in phenomenological psychopathology that pays close attention to the ways in which cultural circumstances may influence individuals' experience of disruptive events and subsequent psychological distress is needed. Phenomenology, which has the tools to scrutinize the very structure of experience, promises to yield interesting results and might grant insights as to why some events are experienced as traumatic, while others are not.

4. Phenomenological Implication

Despite the phenomenological differences in the experience of traumatic events and subsequent distress across cultures, there are also similarities in the structure of the experience of trauma. I have explicated above how the experience of an event as traumatic depends on the horizon of possibilities, shaped by the cultural context. A core pathology of PTSD would require significant similarities in the structure of experience across cultures. In other words, the relation between a traumatizing experience and the subsequent development of symptoms of post-traumatic stress would have to follow a pattern that is independent of cultural influence and universally applicable. Louis Sass's account of phenomenological implication, which he developed in regard to the study of schizophrenia, might also be applied to scrutinizing the structure of traumatic experiences. I shall give a brief account of the phenomenological implication that links the experience of a traumatizing event to the experience of post-traumatic stress, drawing on Sass's account.

Trauma is primarily understood as a diachronic relation between a cause (the traumatic event) and an effect (the symptoms of PTSD). I have shown above that both the cause and the effect can be experienced in different ways, influenced by cultural circumstances. Sass suggests that there are not only multiple kinds of diachronic, but also several synchronic relations at play (Sass, 2010; 2014). The experience of a symptom of post-traumatic stress is not only a direct consequence of the event that is experienced as traumatizing; it can furthermore be understood as standing in a more intricate relation to the event. The disruption of the individual's assumptions about what is possible and to be expected implies that the individual will no longer hold these assumptions.[8] An individual that never took them for granted would not experience an event that is contrary to these assumptions as disruptive or traumatic. To illustrate this: torture is said to imply a loss of trust.[9] That is, people hold assumptions about each other that involve a certain basic trust, a "habitual confidence" (Ratcliffe, Ruddell, & Smith, 2014) in people. When receiving a manual treatment from my physiotherapist, I assume that the pain inflicted is to my benefit and that I could ask them to stop anytime. My trust would be broken if, instead, they tied me down and increased the pain to extract valuable information from me. If I assumed from the start that they were going to torture me, the physical pain I experience would not be lessened (and my fear of physiotherapists merely confirmed); however, I would not experience the event as shocking or disruptive in the same way. The experience of losing trust only occurs if the event itself involves a breaking of my habitual patterns of trust, of what I conceive of as possible for someone to do to me. Who I trust and in which way depends on my cultural context. The relationship between having these expectations violently shaken and my subsequent psychological distress follows a

8 Assumptions, i.e. the things "...that one habitually presupposed, took for granted, and came to depend upon" (Ratcliffe, 2018 n.n.).

9 For a detailed phenomenological account of trust, cf. Ratcliffe, Ruddell, & Smith, 2014.

pattern that surfaces in the development of post-traumatic stress following events that are experienced as traumatizing across cultures.

5. Conclusion

The DSM offers a diagnostic category for post-traumatic stress, namely PTSD, that aims to be cross-culturally applicable, which is a matter of debate. An enquiry into the nature of cultural influence on the experience of trauma showed that the experience of events as traumatic is shaped by culturally-informed habitual patterns of anticipation and possibilities. Furthermore, the experience of subsequent symptoms of distress varies, influenced by cultural circumstances. A core pathology would require significant similarities in the structure of experience across cultures and it is not clear whether these are present. Phenomenological enquiry identified a structural similarity: phenomenological implication presents a link between the experience of an event as traumatic and the kind of subsequent psychological distress. Pursuing further phenomenologically informed research thus promises to shed light on further question: why are only some disturbing events experienced as traumatic? Why do they lead to the development of post-traumatic stress in some, but not all, individuals? And, is PTSD a cross-culturally applicable diagnostic category, if a distinct pathology at all? Further research is needed.

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