PART I

Introduction and Theoretical Background

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Introduction: Culture, Trauma, and PTSD

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Since the 1970s, the terms "trauma," "posttraumatic stress disorder" (or PTSD), and "trauma treatment" have become so much a part of everyday language in the United States that they seem to most Americans to name natural realities. Although the general public could hardly recite the criteria of the most recent American Psychiatric Association's *Diagnostic and Statistical Manual*—the DSM-5—the image of persons suffering intensive, recurrent memories or flashbacks of traumatic experiences they have suffered is now part of common understandings of human nature. The ideas that reliving such traumatic events through intrusive memories can reproduce the terror associated with events and lead to social withdrawal and impairment, that repressing and re-remembering such memories is possible, and that working through these memories in some form of psychotherapy can lead to improvement are now deeply embedded in popular American understandings of trauma, illness, and recovery. It was therefore provocative when in 1995 Allan Young wrote in the introduction to his classic book *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder*: "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 1995:5).

Among anthropologists and cultural critics of mainstream psychiatry, Young's position is now widely accepted. For many, it is linked to a broader critique of the universality of psychiatric diagnostic categories in general—and of the globalization of psychiatry. The more specific critique of PTSD and trauma treatment as the pathologization of normal forms of suffering—in settings of war and violence, for example—is for many particularly compelling. But while quoting Young on the "invention" of PTSD is common, it is less

common to attend to Young's rejection of the suggestion that his saying PTSD is a "historical product" means that it is "not real." "On the contrary," Young writes, "the reality of PTSD is confirmed empirically by its place in people's lives, by their experiences and convictions. . . . My job as an ethnographer of PTSD is not to deny its reality but to explain how it and its traumatic memory have been *made* real, to describe the mechanisms through which these phenomena penetrate people's lifeworlds, acquire facticity, and shape the self-knowledge of patients, clinicians, and researchers" (5–6). The program set forth by Young, of exploring the ways that traumatic memory is made real, penetrating people's lifeworlds and shaping self-knowledge, is in many ways more challenging than engaging in debates over the status of PTSD. And it is the subject of this book.

Culture and PTSD is an examination of the ways that PTSD—and trauma and trauma treatment more broadly—are made real in diverse, cross-cultural settings far from the clinics of the post–Vietnam War Veterans Administration in which Young did his research and twenty years removed from that work. The central chapters are ethnographic and historical, providing rich data about the local experiences of complex forms of violence and the deployment of psychiatric categories and psychosocial treatments in these settings. The chapters raise explicit questions about whether phenomena comparable to the DSM description of PTSD are to be found in other societies and at other times in history. And they raise explicit questions about particular diagnostic criteria. But the book is not organized as a debate over the ontological status of PTSD. The essays do not focus primarily on the question of whether PTSD is a real, universal disease, or whether, as psychiatrist Derek Summerfield (1999) claims, it should be considered a "pseudocondition." This book is rather an examination by anthropologists, psychiatrists, and psychologists about the fit between PTSD, as is represented in the current *Diagnostic and Statistical Manual* (DSM-5) and in clinical research, and local forms of illness experience. And it is an exploration of the deployment of trauma, PTSD, and trauma treatments in settings such as Navajo country in New Mexico and Oaxaca in Mexico, and settings of conflict and violence, including Haiti, Peru, and Aceh, Indonesia. While the book addresses classic questions about the historical and cross-cultural validity of the PTSD construct, its real focus is an examination of how individuals, families, and communities in very diverse cultural settings experience the effects of wars, brutal civil conflicts, and domestic violence, and on how communities,

clinicians, and public health specialists respond to individuals who experience prolonged suffering as a consequence.

Debates Framing the Book

This book is framed by two sets of contemporary debates. First, these chapters were written as revision of the American Psychiatric Association's *Diagnostic and Statistical Manual* and the preparation of the new manual, the DSM-5, was under way. The anxiety disorders committee took seriously questions of cultural validity, and critical reviews—such as Hinton and Lewis-Fernández's review (2011) of the cross-cultural validity of PTSD criteria—have played a role in the revision of the manual. Debates about specific symptom clusters and diagnostic criteria will be discussed below.

At the same time, narrow debates about the wording of diagnostic criteria were easier to address in the revision of the DSM than larger debates about the framing of the diagnostic manual. For PTSD, issues of narrowly defined categories versus more pervasive conditions have been long-standing concerns in both clinical work and research. PTSD in the psychiatric diagnostic system is defined as a response to a specific trauma event that produces particular clusters of symptoms. But how is this relevant to the more pervasive trauma, such as that resulting from years of child abuse or living in localities of ongoing insecurity and violence or long-term involvement as combatants or civilians, for clinicians and trauma researchers? For many, broader issues such as these are more important and far more difficult to respond to than the wording of specific criteria for PTSD and acute trauma diagnoses. In the current revision of the DSM, these broader issues were left unresolved—again. As the essays in this book show, the broader view of complex trauma is more relevant in many settings in which anthropologists and global mental health specialists work than the narrower view of PTSD represented in the DSM. This book contributes to an understanding of these more complex forms of trauma, their effects on lives in particular cultural settings, and the implications for trauma treatment and trauma research in cross-cultural settings.

The terms "complex trauma" and "complex PTSD" are used in this book and are part of ongoing debates. Both terms have a variety of meanings (Bryant 2010, 2012; de Jong et al. 2005; Herman 1992, 1993; Resick et al. 2012).

Complex trauma can refer to experiencing a severe trauma or multiple traumas over an extended period of time. Some define complex trauma as resulting from extended periods of child abuse, while others argue that complex PTSD may result from "a range of adult experiences, including war, civil conflict, torture, and other experiences involving pervasive loss of control over aversive consequences" (Bryant 2012:253). Complex trauma can refer to experiencing prolonged trauma while in a state of vulnerability, such as when young or when subject to multiple stresses. The term "complex PTSD" often refers to the clinical picture that may result from complex trauma, with complex trauma, as indicated above, said to result from many causes: the nature and severity of traumatic experience; duration of the trauma; age the trauma occurs and developmental effects; genetic vulnerability; or current levels of stress. The term also may refer specifically to the complexity of the clinical picture, including specific symptoms, in particular, somatization and emotion regulation difficulties, and comorbidity with other diagnosable conditions (major depressive disorder, other anxiety disorders such as panic disorder, and somatoform disorders, as well as personality disorders). Put more broadly, the complexity of the disorder may be related to social response and stigma associated with the traumatizing events (such as those experienced by many Vietnam vets) and to cultural interpretation of particular trauma-related symptoms. For example, as chapters in this book demonstrate, a culture that has catastrophic cognitions about somatic symptoms resulting from traumatic experience or PTSD may amplify the anxiety associated with traumatic memory and associated symptoms, resulting in more comorbidities among other effects.

Many of the chapters in this book address PTSD as understood in a broad perspective. The difference between PTSD as defined by DSM-5 and PTSD in a broader sense, that is, complex PTSD or trauma-related disorder, needs to be kept clear. This chapter and Chapter 1 use the term "posttraumatic stress syndrome" to indicate the wide set of symptoms that actually occur in a locality owing to trauma, from DSM-type PTSD symptoms to depression, generalized anxiety disorder, substance abuse, poor emotion regulation, or hyperreactivity to multiple triggers, among other symptoms in the "trauma symptom pool" (see Chapter 1). We also consider the term "posttraumatic stress syndrome" to include the local meaning of trauma symptoms (e.g., attribution of symptoms to local cultural syndromes), local consequences of having the symptoms (e.g., interpersonal and economic course), and ways of seeking treatment for symptoms. There are local "posttraumatic stress

syndromes"—a Cambodian one, a Haitian one—which will overlap but also differ radically. The term "posttraumatic stress syndrome" better conveys the sense of the lived, contextualized experience of trauma than does the narrower term "PTSD"; it better describes the lived experience of illness than does the disease concept PTSD (Eisenberg 1977; Kleinman et al. 1978). At the same time, we recognize that much of the literature that describes PTSD actually refers to conditions or clinical presentations that are more akin to complex forms of posttrauma conditions than to simple PTSD. (When the term "posttraumatic" is used, it must be remembered that often trauma is ongoing and continuing, not just one past event, and in addition, that there are multiple types of ongoing stress. Hence the term "complex trauma" is often used as is discussed in this chapter and in Chapter 1 [Hinton and Good]. We use the term "posttraumatic stress syndrome" with the assumption of this broader frame. Many chapters in this volume discuss these issues, such as that of Jenkins and Haas [Chapter 5] and James [Chapter 11].)

Nosologically oriented researchers seek to find symptoms that are unique to particular disorders in order to create DSM categories that are distinct or heterogeneous, reducing the presence of the same symptoms in multiple diagnostic categories, increasing differentiation of disorders, and improving differential diagnosis (Bryant 2012; Resick et al. 2012). This is true for PTSD and acute trauma diagnoses. But for clinicians, as well as researchers with interests beyond nosology, not only are features of responses to trauma that are unique to PTSD important, but the entire range of symptoms and disorders that result from diverse forms of traumatic experience have great importance for understanding and responding to these conditions, particularly in culturally diverse populations. This book brings special attention to this broader range of phenomena, what we refer to as the posttraumatic stress syndrome, that is, to a broader set of trauma symptoms and how these play out in different cultural and global contexts. Given the eruptions of episodic violence globally, high endemic violence in some societies and in particular settings in nearly every society, widespread sexual and domestic violence, and forms of extreme traumatic experience for which there is universal risk, both PTSD and posttraumatic stress syndrome are important public health issues globally. These are the focus of the studies in this volume.

If the revision of the *Diagnostic and Statistical Manual* served as one context for the essays in this book, debates about the legitimacy of focusing on trauma and trauma treatment in global humanitarian settings serve as a second critical context. Attention to trauma and trauma treatment in settings

of complex emergencies (e.g., IASC 2007), as well as debates about the legitimacy of psychosocial and mental health interventions in global humanitarian work, have become far more widespread and urgent than was the case when Young wrote about the making real of PTSD. Many, including anthropologists and cross-cultural psychiatrists, such as Arthur Kleinman, have strongly criticized the labeling of acute responses to traumatic violence as a mental disorder, arguing that this represents a pathologization and professionalization of normal forms of human suffering, a form of globalized medicalization of human responses to disaster and violence. Anthropologists interested in mental illnesses across cultures have also criticized the assumption—without adequate empirical research—that PTSD is a universally valid condition. These arguments have been elaborated by critics of humanitarianism and development, such as Derek Summerfield (1999:1449) who calls PTSD "a pseudocondition, a reframing of the understandable suffering of war as a technical problem to which short-term technical solutions like counseling are applicable." For Summerfield, the extension of notions of trauma and PTSD to non-Western societies may represent a form of psychological imperialism that "risks an unwitting perpetuation of the colonial status of the non-Western mind" (2000:422). Vanessa Pupavac (2001), Mark Duffield (2001), and others have linked the focus on trauma by humanitarian organizations to the pathologization of whole societies. The demand for "psycho-social interventions," they argue, serves as a "new form of international therapeutic governance" (Pupavac 2001:358) that contributes to the "mobile sovereignty" (Pandolfi 2008:263; cf. Fassin and Pandolfi 2010) of international aid organizations more than to the relief of suffering in the communities they intend to help.

These criticisms have been taken up by those who question the increasing role played by humanitarian organizations in settings of complex emergencies over the past several decades (see Good, Good, and Grayman [Chapter 12]). In her remarkable book about violence and reconciliation among the Quechua communities in Peru in the years following the end of the Shining Path era, Kimberly Theidon (2013) describes the significance of the "trauma industry" and its effects on how nongovernmental organizations framed their mental health missions, how the Truth and Reconciliation Commission coded data from the interviews conducted, and how the report described the long-term effects of the violence on those who had experienced and witnessed it. In the coding of interviews, a wide variety of deeply embodied descriptions of pain and suffering—embedded in what

Theidon calls "sensuous psychologies" (24–53)—were simply coded as "trauma." Theidon argues that this represented not only a globalization of trauma and PTSD as categories, shaping how international communities viewed the effects of violence, but that the dismissal of local Quechua terms represented a much deeper and long-standing view by urban, professional Peruvians of the indigenous communities as backward and incapable of abstract thought, a people whose complaints required translation into the modern language of trauma to be comprehensible. A history of colonialism and racism thus shaped the view of indigenous people and the need to code their experience in the reality-based, modern language of trauma and PTSD in order to devise mental health responses.

Many involved in the global mental health movement would agree that mental health and psychosocial interventions focused narrowly on trauma and trauma treatment are misplaced in postdisaster or postconflict settings. There is strong evidence that major disasters, conflicts, and violence increase the prevalence of mental health problems broadly, including the clusters of disorders associated with PTSD. Studies repeatedly show a "dose effect" linking levels of experiences of traumatic violence to risk for depression, anxiety disorders, and acute psychoses, as well as PTSD. And many of the settings in which humanitarian organizations work have extraordinarily limited mental health resources. Advocates for global mental health thus see humanitarian responses to disaster or violence as providing an opportunity to build mental health services more broadly. In this context, the critique of PTSD, trauma treatment, and psychosocial interventions often provide donor organizations with a rationale not only for not building effective responses to trauma-related conditions, but for refusing to invest in capacity building for mental health care more generally. The stakes are thus high in debates about how to think of trauma in settings of complex emergencies and what the most appropriate responses should be.

Given the massive scope of mental health problems in postdisaster and postconflict settings, are there empirically supported clinical and public health interventions that are effective? Is there evidence that providing mental health treatments for PTSD and other trauma-related mental health problems actually "jeopardizes local coping strategies," as suggested by Pupavac (2001)? What is the evidence for the effectiveness of purported "local coping strategies"?[1] And what, on the other hand, is the evidence for long-term effects of medical and psychosocial treatments for acute trauma and chronic, long-term forms of PTSD?

The essays in this book address questions that are central to the study of PTSD in cross-cultural perspectives, questions about what we can learn about PTSD and trauma-related mental health problems from cross-cultural research. But these questions are placed in the context of urgent questions about how to proceed, about whether the deployment of PTSD as a tool of identifying and responding to human trauma-related suffering is effective or actually creates new forms of victims and pernicious demands to demonstrate traumatic experience as a means of determining who is provided compensation and care.

Framing the cross-cultural study of PTSD in these terms—in technical diagnostic terms about the validity of particular symptom clusters across cultures, in relation to humanitarian work in resource limited settings, and in ethnographic terms concerning how PTSD is made real in diverse settings—is a reminder of significant changes since the writing of Young's *Harmony of Illusions*. Concerns about experiences of soldiers remain, but with traumatic brain injury now playing a new—or recurrent, given the similarities to the diagnosis of "shell shock"—role in discussions and treatment. Identifying and responding to PTSD is far more closely related to human rights activities than in the past and are closely linked to the moral imperative of the human rights movement. PTSD and trauma treatment play an important role in advocacy for increased investment in global mental health. Terms such as "historical trauma" (see Ball and O'Nell [Chapter 10]) place PTSD in a broader context of moral claims and the search for social and political forms of restitution. And debates about sexual violence and gender issues have taken an increasingly important place in global settings; these debates are often waged in terms of trauma, PTSD, and trauma treatment. These are all central issues in the essays in this book.

Historical Background

How have the terms "trauma" and "PTSD" come to be used to do such important cultural and moral work in American society and in global debates? Richard McNally argues in his essay in this book (Chapter 2) that although shell shock was commonly observed for soldiers in World War I and World War II, the cluster of symptoms now defined as PTSD are difficult to find in the records of medical treatments of soldiers in the great world wars. If this is the case, how did the current constellation of symptoms, meanings, and

practices now associated with PTSD come to be recognized, produced, and made the focus of a wide variety of treatment modalities and the site of an extraordinary body of scientific research, particularly in the neurosciences?

Young and Breslau (Chapter 3) argue that the current conceptualization of PTSD arose in direct response to the Vietnam War. Current ideas about trauma and PTSD emerged, they show, in response to problems suffered by Vietnam veterans. Following the Vietnam War the concept was introduced in the DSM-III and became a diagnostic category to explain the psychological wounds of war, which enabled access to benefits and helped shift the society's view of the soldier presenting with psychological distress from that of shirker or weakling to victim deserving support and remuneration (Fassin and Rechtman 2009). In previous wars, a psychological state was not a condition warranting recompense; rather, one needed to have a true *physical disorder* like "irritable heart" or "soldier's heart" to gain such benefits. Trauma—overexertion in the case of irritable or soldier's heart, or a shell blast in the case of shell shock in World War I—was then understood to have psychological effects, constituting a physiopsychology (Kugelmann 2009; Micale and Lerner 2001). In the Vietnam War, a psychological wound—PTSD—was cast as analogous to the inevitable effects of an overwhelming stressor, like a building that is physically stressed to the point of collapse. But such psychological disorders still carry stigma. This has contributed to the continual emergence of ambiguous, physiopsychological syndromes and promotions of categories such as Gulf War syndrome, a condition in which toxic exposures during war have given rise to multiple unexplained complaints, a kind of "toxic neurasthenia" (Jones and Wessely 2005; Kilshaw 2009).[2]

While exposure to combat and the experiences of Vietnam veterans returning to an America hostile to the war constitute one historical lineage of PTSD, there is a second lineage that has been equally important in determining the meanings trauma, PTSD, and trauma treatment have come to take on, particularly in the United States. It is impossible to discuss trauma treatment in this country without evoking issues of traumatized children, sexual abuse, incest and domestic violence, debates about false memories, and an enormous bureaucratic, therapeutic, and legal apparatus for managing claims of sexual predation. Brown, Scheflin, and Hammond (1998) provide an important history of this lineage of PTSD and the controversies it generated, as well as the empirical evidence associated with the false memory controversy. While the modern era of child abuse concerns can be traced back to the 1950s and the recognition by radiologists that skeletal lesions were parentally

inflicted, it was not until 1962 that C. Henry Kempe described the "battered child syndrome" and provided medical data about child abuse (Kempe et al. 1962). The recognition of child abuse led to dramatic change, and by 1966 every state except Hawaii had enacted statutes mandating physician reporting of child abuse (Brown et al. 1998:6). Child sexual abuse was the last frontier of recognition of and response to child abuse, and passage of the federal Child Abuse Prevention and Treatment Act in 1974 mandated reporting and evaluation of suspected child sexual abuse and the investigation and prosecution of offenders. These mandates came without clear guidelines for assessing allegations of sexual abuse, and child abuse investigations were highly idiosyncratic and often highly prejudicial. Brown et al. (1998) describe how the original goals of providing care for children were often subverted, and by the late 1970s and 1980s laws and procedures came increasingly to focus on finding fault and prosecuting offenders rather than providing care for those injured (Conte 1991). Many of the debates about legitimacy of identifying "perpetrators" resulted from an era of excessive and highly suggestive interviewing tactics, and the focus on sex offenders continues to garner far more legal and bureaucratic investment than attention to providing services for those needing care.

Childhood sexual abuse was the domain not only of pediatricians and child protection advocates, but of feminist researchers, scholars, and therapists as well. Armstrong (1994) argues that Western societies went through three eras: an Age of Denial (up to the 1970s), an Age of Validation (1970s to 1990), and an Age of Backlash (after 1990). Writings on father-daughter incest (Herman 1981), on hidden sexual abuse of children, and on rape and rape trauma emerged in the 1970s, with an increasing body of research supporting the recognition of the prevalence of sexual abuse. It was only in the 1980s that the sequelae of incest and sexual violence were recast in terms of PTSD (Brown et al. 1998).

The development of phase-specific trauma treatment played a critical role in bringing together these two cultural histories associated with PTSD—that associated with the Vietnam War and that associated with the recognition of sexual abuse, particularly of children. Mardi Horowitz's *Stress Response Syndromes* (1976) was critical both in framing trauma response in terms of alterations between intrusive reexperiencing and general numbing of responsiveness, and in the development of phase-oriented treatment of PTSD. While the growing consensus about the treatment of PTSD had its historical roots in Pierre Janet, who advocated treatment of trauma and dissociation

in stages including stabilization, memory processing, and rehabilitation (Brown et al. 1998:9; van der Kolk and van der Hart 1989), the years following Horowitz's book saw enormous development of the field of trauma treatment as a central modality in psychological services. Although memory processing has been a part of most trauma treatment from the initial days, consensus has developed concerning the dangers of rapid recall and abreaction methods. The early consensus on this issue pointed forward to evidence for the hazards of debriefing approaches, which has shaped guidelines for international psychosocial responses to trauma.

The emergence of a focus on dissociation and dissociative disorders, the fierce controversies about false memories, and the development of an enormous body of empirical research about the nature of traumatic memory are beyond the scope of this introduction. What becomes clear, however, in this brief schematic description of the cultural history of PTSD is that our understanding of trauma, PTSD, and trauma treatment today results from the remarkable convergence of efforts to understand and respond to experiences of war veterans, particularly Vietnam War veterans, and efforts to treat children and adults suffering the effects of childhood trauma and sexual abuse, as well as sexual violence into adulthood. It should be of little surprise that containing these diverse meanings in the DSM diagnoses of acute stress disorder and PTSD requires a remarkable act of simplification. And it should be of little surprise that such simplification would poorly serve clinicians treating a diverse array of trauma-related mental health disorders.

There is today an enormous literature associated with evidence-based practice guidelines for the treatment of PTSD (Foa et al. 2009 and Friedman et al. 2014 present reviews of the literature on the major treatment modalities; cf. Cukor et al. 2010 for a short review), as well as a significant body of work outlining the evidence for diverse modalities of treating complex traumatic stress disorders (see essays in Courtois and Ford 2009). Nearly all point to various forms of cognitive behavioral therapy as demonstrating effectiveness (Cahill et al. 2010), and psychopharmacologic treatment with antidepressant medications, particularly the SSRIs, has been shown to be effective, while the benzodiazepines have not (Friedman et al. 2009, 2014). Few studies have evaluated what forms of treatment are both feasible and effective in low resource settings in which large parts of the population have experienced severe and protracted violence (see Nakimuli-Mpungu et al. 2013 as one example).

Essays in this volume suggest that while phenomena quite similar to PTSD in North America and Europe are widely present across cultures, a narrow

focus on the validity of this construct may well obscure the limitations associated with recognizing and responding to PTSD as defined by current diagnostic manuals. They also raise the question of whether evidence-based treatments for PTSD can be effective as public health measures in dealing with trauma-related disorders in postconflict settings for societies or groups attempting to respond to historical trauma, or in locations of ongoing ontological insecurity and endemic violence. Trauma seemingly results in a complex array of effects that vary by cultural context—what we have described as posttraumatic stress syndromes. The PTSD cluster of symptoms is only one subset of symptoms associated with such syndromes. This volume is an exploration of the larger set of phenomena, of which PTSD is a part, a set of studies of how such phenomena are understood and responded to in diverse cultural-historical settings, and an examination of how the PTSD construct has been deployed to make PTSD real in very diverse social settings.

PTSD: Biology and Recovery

Trauma and PTSD have been the focus of an enormous body of research in the neurosciences and neuropsychology, particularly since the establishment of the National Center for PTSD in 1988 (see chapters in Kirmayer et al. 2007 for an important review of this work). Underlying contemporary research are classic studies of the fight-or-flight response to threatening events and classical conditioning models. Some studies continue to focus on embodied responses to fear and processes of fear extinction, with particular interest in fear extinction as a form of new learning rather than the extinction of memory (for summaries, see Barad and Cain 2007; Quirk et al. 2007). A body of research focuses on the processing, storage, and retrieval of traumatic memories, with particular interest in differences between processing of normal versus traumatic memories and between body memory and declarative memory. Traumatic memories are consistently characterized by "fragmentary and intense sensations and affects, often with little or no verbal narrative content" (van der Kolk et al. 2001:9). The amygdala has been shown to be particularly critical in the processing of traumatic memory (Ledoux 1996). Any reminder of the trauma is said to activate the amygdala, which results in a fight-or-flight type of response: palpitations, fear, shortness of breath. This is said to result in reexperiencing (or flashbacks) and in hyperreactivity to any trauma reminder. Other studies argue that trauma results in a hyperreactivity

to a range of cues (e.g., to noises, stresses, or worry itself), and that early adversity may even modify genes permanently toward that state (Bohacek et al. 2013; Heim et al. 2000; Mayer 2007).

Although studies of the processing of memory are critical to understanding basic neurobiological processes associated with PTSD, it is often difficult to determine why the majority of persons who suffer traumatic events—at a level meeting DSM criterion A for PTSD—*do not* develop PTSD. Most persons are highly resilient. Meta-analyses of epidemiological studies have found that only approximately 20 percent of persons who experience traumatic events develop PTSD (Yehuda and McFarlane 1995). Breslau and Kessler (2001) showed that while 75 percent of adult Americans suffer traumatic experience fulfilling DSM-IV criteria, only 12 percent actually develop PTSD. Shalev (2007) argues that while most persons suffer initial experiences characteristic of PTSD, most naturally recovery. He suggests, therefore, that PTSD be seen as a disorder of recovery, and that research should be focused on identifying processes that disrupt normal recovery rather than basic processes associated with response to trauma.

Cognitive-behavioral therapists argue that persons who develop chronic PTSD are characterized by particular patterns of dysfunctional cognitions about themselves and the world (Foa et al. 1999). Many have argued PTSD may represent a "pathological block to normal memory consolidation, resulting in trauma memories being retained in short-term storage, thereby allowing rapid and inappropriate triggering of recall" (Silove 2007:247). Van der Kolk (2007) argues that developmental issues are critical to risk for PTSD, and that "PTSD captures only a limited aspect of posttraumatic psychopathology, particularly in children" (226). He argues that when their primary "caregivers are emotionally absent, inconsistent, frustrating, violent, intrusive, or neglectful," individuals are at far greater risk for developing chronic PTSD. This includes children who develop what a task force of the National Child Traumatic Stress Network calls "developmental trauma disorder" in children, as well as what is described as "complex trauma" or "disorders of extreme stress not otherwise specified" (DESNOS) (Luxenberg, Spinazzola, Hidalgo et al. 2001; Luxenberg, Spinazzola, and van der Kolk 2001). But while neurobiological, cognitive, and developmental issues may be important in determining who is at heightened risk for failing to recover from traumatic experiences, current social and cultural factors—such as lack of social support, continued adversity, or inability to make sense of traumatic events—may be even more important (see, e.g., Brewin et al. 2000; Shalev 2007).

This book suggests that these issues need to be placed in social and cross-cultural context. On the one hand, chapters in this book show diverse ways in which traumatic experiences are understood, expressed, and made sense of. On the other hand, they suggest that trauma results in a broad arousal symptom pool—which includes the DSM symptoms but others as well—that forms a key part of the biological effects of severe trauma: hyperreactivity to stimuli and emotions, poor emotion regulation, sleep disorders like severe insomnia and sleep paralysis, multiple somatic complaints. (Those who advocate for complex PTSD as a DSM diagnosis argue in particular that symptoms of "emotion dysregulation" distinguish complex from usual PTSD [Bryant 2012].) These various symptoms may be induced by the nature and severity of the trauma and ongoing vulnerabilities, and the symptoms may be amplified by cultural ideas about the mind and body and about the meanings of particular symptoms. Ethnopsychologies and ethnophysiologies specific to given cultures and local cultural illness syndromes may lead to heightened attention to particular symptoms (hypersemiotized symptoms), as well as to "catastrophic cognitions," leading to bio-attentional looping that produces a certain trauma-based illness reality (cf. Hinton and Good 2009). Ethnopsychologies and ethnophysiologies give rise to certain ideas about redress and cure, to local therapeutic practices, and to certain trauma-based identities and self-narratives. And local religious and ritual traditions may be key in determining whether individuals are able to make sense of and recover from particular traumatic experiences, including both embodied and declarative memories of trauma. These and other analytic frames or contextualizations are discussed by Hinton and Good in Chapter 1 of this volume and are illustrated in all the book chapters.

PTSD in DSM-III, DSM-IV, and DSM-5

The formal definition and diagnostic criteria for PTSD have been debated and have undergone limited but significant changes within the *Diagnostic and Statistical Manual* since being introduced in DSM-III. The PTSD diagnosis was first introduced in 1980 in the *Diagnostic and Statistical Manual of Mental Disorder-III*, or DSM-III (American Psychiatric Association 1980). (On the history of the PTSD concept, see McNally [Chapter 2]; Young and Breslau [Chapter 3]; Ball and O'Nell [Chapter 11].) In DSM-III, PTSD was comprised

of three clusters of symptoms (American Psychiatric Association 1980). The first cluster consisted of reexperiencing symptoms, such as recollections and dreams of the event; the second of avoidance and numbing symptoms, such as avoidance of reminders, a sense of blunted emotion (viz., a restricted range of affect), and loss of interest in activities; and the third of hyperarousal symptoms such as startle and hypervigilance. The criteria were minimally changed in the next edition of the manual, DSM-IV (American Psychiatric Association, 1994), or in the DSM-IV-TR (American Psychiatric Association 2000), which is shown in Table I.1.

Table I.1. PTSD: DSM-IV-TR Criteria (309.81)

A. The person has been exposed to a traumatic event in which both of the following were present:
   (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
   (2) the person's response involved intense fear, helplessness, or horror. *Note:* In children, this may be expressed instead by disorganized or agitated behavior.

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:
   (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. *Note:* In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
   (2) recurrent distressing dreams of the event. *Note:* In children, there may be frightening dreams without recognizable content.
   (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). *Note:* In young children, trauma-specific reenactment may occur.
   (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
   (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
   (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma

(*continued*)

Table I.1. (continued)

(2) efforts to avoid activities, places, or people that arouse recollections of the trauma
(3) inability to recall an important aspect of the trauma
(4) markedly diminished interest or participation in significant activities
(5) feeling of detachment or estrangement from others
(6) restricted range of affect (e.g., unable to have loving feelings)
(7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by three (or more) of the following:

(1) difficulty falling or staying asleep
(2) irritability or outbursts of anger
(3) difficulty concentrating
(4) hypervigilance
(5) exaggerated startle response

E. Duration of the disturbance (symptoms in criteria B, C, and D) is more than one month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Source: *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., text revision [DSM-IV-TR], pp. 271–72. Copyright 2000. American Psychiatric Association. Reprinted with permission.

More significant changes were introduced in the criteria for PTSD in the recently published DSM-5 (American Psychiatric Association 2013) (see Table I.2) (for a discussion, see Friedman et al. 2011).[3] There was a narrowing of the numbing and avoidance cluster, making it solely an avoidance cluster, and the creation of a new cluster called "negative alterations in cognitions and mood associated with the traumatic event(s)," which includes the DSM-IV's numbing items[4] and two new items: a self- and other-blame item ("persistent, distorted cognitions about the cause or consequence of the traumatic event[s] that lead the individual to blame himself/herself or others") and an emotion-type item, namely, "persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame)." Also, in DSM-5, the wording of two of the DSM-IV numbing items has been changed (and as was indicated above, the new version of these two items, along with the other DSM-IV "numbing items," have been moved to the "negative alterations" cluster). The "restricted

Table I.2. PTSD: DSM-5 Criteria (309.81)

A. Exposure to actual or threatened death, serious injury, or sexual violation in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).
   Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
   Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
   Note: In children, there may be frightening dreams without recognizable content.
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)
   Note: In children, trauma-specific reenactment may occur in play.
4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by avoidance of one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

(*continued*)

Table I.2. (continued)

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
   1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
   2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
   3. Persistent, distorted cognitions about the cause or consequence of the traumatic event(s) that lead the individual to blame himself/herself or others.
   4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
   5. Markedly diminished interest or participation in significant activities.
   6. Feelings of detachment or estrangement from others.
   7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
   1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
   2. Reckless or self-destructive behavior.
   3. Hypervigilance.
   4. Exaggerated startle response.
   5. Problems with concentration.
   6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

F. Duration of the disturbance (criteria B, C, D, and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the direct physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Source: *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. [DSM-5], pp. 271–72. Copyright 2013. American Psychiatric Association. Reprinted with permission.

range of affect" item is now a "persistent inability to experience positive emotions," transforming the item from a numbing item to more of a depressive-type item, an anhedonia item. The "foreshortened sense of future" item is now a "persistent and exaggerated negative beliefs or expectations about oneself, others, or the world."[5] Thus, the new cluster that is named "negative alterations in cognitions and mood associated with the traumatic event(s)" contains a heterogeneous mix of items with many being depression-like items: the two reworded items; an amnesia item, which may well be a depressive item in that depression can give rise to a sense of mental slowing and poor memory; and the "pervasive negative state" item, with that negative state possibly being depression.[6]

In DSM-5, the arousal cluster is somewhat changed. In the cluster description, the term "reactivity" has been added to the term "arousal." Also, another criterion has been added: "reckless or self-destructive behavior." Anger is again in the arousal cluster, and anger is more emphasized in the overall DSM–5 criteria because another cluster, namely "negative alterations in cognitions and mood," has a persistent negative mood item, and this may be a state of anger.

There are ongoing debates about the symptom clusters in the PTSD criteria, the putative "dimensions of PTSD," and whether DSM-IV and DSM-5 PTSD leave out key dimensions or key symptoms (Armour et al. 2012; Elhai and Palmieri 2011). For example, some have suggested somatic symptoms to be a core dimension of PTSD, particularly in non-Western cultures, and that somatic symptoms should form another criterion in the arousal cluster or be another PTSD dimension (for a review, see Hinton and Lewis-Fernández 2011). Somatic symptoms, it is argued, may be prominent in certain groups for multiple reasons, including the severity of trauma and the cultural interpretation of symptoms (for a detailed discussion, see Hinton and Good [Chapter 1]). For example, somatic symptoms are caused by the arousal associated with PTSD, and in certain cultures those somatic symptoms are attributed to cultural syndromes: palpitations attributed to "weak heart" in the Cambodian case. Consequently, there is a hypervigilant surveying of the body for the symptoms associated with a syndrome, and catastrophic cognitions upon discovering them, with those catastrophic cognitions increasing arousal. Owing to these reasons, in certain cultures the arousal dimension will have within it many somatic symptoms that are associated with cultural syndromes, that is, there will be an arousal cluster of the typical PTSD arousal

symptoms along with somatic symptoms associated with various culture-specific syndromes.

A further cultural critique of DSM criteria holds that there are many trauma-related symptoms that are not in the DSM-IV and DSM-5 criteria that are a key part of the response to trauma (for an overview, see Hinton and Good [Chapter 1]). The current volume shows many examples of symptoms that occur in trauma-related disorders that are not in the DSM-5. For example, among Cambodian refugees, not only are somatic symptoms such as dizziness upon standing (orthostatic dizziness) central complaints, but also are multiple other non-DSM-5 PTSD symptoms such as sleep paralysis. As illustrated by the current volume, PTSD is just one of many disorders that result from trauma (for a review, see Hinton and Lewis-Fernández 2011). The core response to trauma includes not just the currently specified PTSD items and clusters, but also somatic symptoms, depression, bereavement, anxiety, and panic attacks, as well as acting out and substance abuse, raising questions about whether these are comorbid disorders or should be incorporated into a broader posttraumatic stress syndrome. Depending on the cultural group, certain of these other psychopathological dimensions may be more prominent. In addition, cultural syndromes like the Khmer "wind attacks" (*gaeut khyâl*)[7] or "heart weakness" (*khsaoy beh doung*) may be a core aspect of the trauma-related distress in a locality, creating a unique cluster of complaints and inflecting trauma-symptom presentation and meaning, producing a certain profile of DSM comorbidities (e.g., prominent panic attacks), resulting in certain kinds of symptom clustering, and profoundly altering the attempted treatments of symptoms and the course of recovery. Through these means, these syndromes and local understandings pattern trauma-related experiencing profoundly, forming certain sensuous psychologies (Theidon 2013), local embodied ontologies, that are linked to local healing traditions and the local ethnopsychology, ethnophysiology, and ethnospirituality, and these syndromes and local understandings result in a certain social and personal course of trauma-related experiencing.

Finally, as suggested throughout this Introduction, failure of the DSM-5 to address complex PTSD and to distinguish between initial symptoms associated with traumatic experience and long-term or chronic PTSD that results from an inability to recover, limit the value of PTSD as described in the DSM-5 for cross-cultural settings. Chapters in this volume provide evidence for the importance of understanding complex forms of posttrauma disorders, including those associated with pervasive childhood abuse and

trauma, and long-term trauma related to wars or civil conflicts. Such trauma creates complex symptom presentations and shapes multiple ontological domains (for an overview, see Hinton and Good [Chapter 1]). Chapters in this book address specific issues of validity of the PTSD construct, and some chapters provide evidence concerning specific symptom clusters. But the larger conversation with the DSM categories in this book concerns the broader issues of the relation between the DSM-5 categories and the larger posttraumatic stress syndromes observed in diverse cultural settings.

Book Themes and Questions

This volume examines the question of how trauma and PTSD come to be constituted and experienced in cross-cultural and historical contexts. These chapters suggest five overall themes critical to understanding trauma, PTSD, and trauma treatment, raising important questions and directions for future research.

First, what is the nature of local phenomenologies of posttrauma experiences and symptoms? Chapters in this volume demonstrate that culture has important influences on local illness vocabularies, understandings of how trauma affects mental and bodily experience (the local ethnopsychology and ethnophysiology), attention to particular symptoms, and practices aimed at reducing these symptoms. Assessing the validity of the PTSD construct and criteria across cultures requires not simply asking whether there are cases in which symptoms co-occur in the way described in the DSM, but how DSM-defined PTSD relates to local forms of illness experience.

Second, running throughout the book is a series of questions about the importance of "ontological security" in the very conceptualization of "post" traumatic stress disorders (cf. Green 1999; Hinton et al. 2009; James 2008). James, in her chapter on Haiti (Chapter 11), makes most explicit the importance of insecurity as a basic feature of social life that shapes experience. The issue of the "post" in PTSD is called into serious question in many of the settings in which anthropologists work. Security pertains to multiple domains that include safety, spiritual, existential, economic, and environment concerns. A key aspect of trauma can be seen as a sense of being under threat following a traumatic event, a feeling that a trauma may occur again. Ongoing or current threats to security will reverberate with this concern. This raises quite fundamental questions about whether it is meaningful to

diagnose PTSD in settings of continued insecurity, or whether the very concept assumes that trauma is in the past and individuals are currently living in settings of ontological security. Determining the nature of PTSD and PTSD symptoms in settings of security and settings of continued violence or economic insecurity is a critical issue for research.

Third, we have raised throughout this Introduction the issue of the adequacy of a concept of posttrauma disorders focused on relatively limited traumatic events and the importance of experiences of pervasive and complex trauma—in developmental contexts or in settings of long-term exposure to violence—in cross-cultural settings. The chapters in this book bring this issue into particularly sharp focus. While they do not suggest that phenomena represented by DSM criteria are absent or unimportant in cross-cultural settings, they do raise important questions about the relevance of more pervasive, complex forms of traumatic experience in a conceptualization of posttrauma disorders.

Fourth, although not the explicit focus of the chapters of this book, the authors demonstrate the critical importance of local social, cultural, and religious practices that contribute to recovery from trauma (or resilience or self-remission of symptoms). The chapters describe specific local strategies for making sense of disaster or violence, the failures of sense making, and diverse practices of resilience that contribute to recovery (on these processes, see also Hinton and Kirmayer 2013). They raise important questions about why these processes may be successful for some individuals and not for others, and more general comparative questions about how members of different societies achieve recovery and understand and respond to those who fail to recover.

Fifth, these chapters speak to the debates about the utility of the PTSD concept in humanitarian work and in local therapeutic environments. How has PTSD as a concept been deployed, how have trauma treatments been deployed, and how effective have they been? What therapeutic responses can be effective in settings with widespread experiences of violence and with limited mental health resources? Is the PTSD concept useful in the task of developing local mental health systems in settings with extremely few psychiatrists? Has it been deployed in ways that contribute to the development of mental health services capacity, or does a focus on trauma and PTSD reduce attention to broader strategies for developing mental health services? How does targeting DSM-defined PTSD affect the broader range of symptoms or disorders associated with trauma?

Finally, a number of the chapters provide important data for responding to questions about whether deployment of the concepts of trauma, PTSD, and trauma treatment produces "victims" and contributes to the pathologization of whole societies, or whether it provides mechanisms for effective response to social suffering. Do processes of identifying individuals who have experienced massive trauma and developed prolonged symptoms, advocated by many human rights groups, support the identification of perpetrators and provide effective means of compensation? Are these processes effective in identifying those who need medical and psychosocial interventions? Or does the deployment of concepts of PTSD lead to the struggle to produce "trauma portfolios," as James describes for Haiti (Chapter 11), thus engaging individuals in prolonged bureaucratic procedures requiring demonstration of continued suffering rather than providing genuine support that promotes recovery?

These are the broad issues that are raised by the chapters of this volume. Let us now turn to a close examination of the chapters.

Summary of Chapters

Part I: Introduction and Theoretical Background

This introductory chapter is intended to place the book in the context of the historical emergence of the PTSD concept, to indicate the importance of cross-cultural studies for understanding posttrauma disorders, and to situate the essays in this book in relation to critical debates that have arisen particularly in the past decade.

In Chapter 1, Hinton and Good describe three general models to use to assess the trauma survivor in a culturally sensitive manner: using eleven analytic perspectives, avoiding certain kinds of errors, and employing dynamic, multiplex models of how trauma-related distress is generated. The chapter outlines eleven analytic perspectives from which to examine the existential position of the trauma survivor, providing a framework that brings the chapters in the book into conversation with one another and showing how the chapters aim at a rich contextualization of trauma-related disorder in particular sociocultural and historical contexts. Based on the analysis of the eleven ontological dimensions, Chapter 1 describes some common errors made by clinicians and researchers when examining trauma in cross-cultural

perspective. The chapter also discusses multiplex models of the generation of trauma-related disorder, giving emphasis to the notion of complex trauma and the related concept of the "arousal complex" or "reactivity complex" (a much broader concept than "poor emotion regulation").

Part II: Historical Perspectives

The three chapters in this section examine PTSD in historical context. McNally gives an overview of several controversies about the PTSD construct, critiquing both the social constructivist view (that PTSD is the invention of a certain sociocultural group) and the acultural view (that PTSD as described in the DSM is an accurate mapping of trauma-related disorders, free of cultural context). He argues for the importance of open-ended queries about symptoms and notes the problem that when assessing PTSD symptoms in any context, diverse social and cultural factors influence the reporting of symptoms and bodily experience. McNally gives a historical view of PTSD, describing the emergence of PTSD in DSM-III in response to experiences in the Vietnam War: the new diagnosis served to validate the distress of Vietnam veterans and allowed a way of providing benefits. He notes that in the Vietnam War, many "psychiatric casualties" had no combat exposure and many had delayed onset. He points out that it was in this context that the concept of numbing emerged to explain delayed onset of PTSD symptoms: numbing was seemingly the first response followed by the development of PTSD symptoms.

McNally discusses the unique symptoms seen in each war setting. In the narratives collected by physicians in World War I, certain symptoms we call PTSD were not salient whereas others not now prominent took central stage: in the narrative of a WWI veteran with shell shock, flashbacks were not found but rather such symptoms as irritability, depressed mood, dreams about the war, and apparent sleep paralysis. But he notes this absence of flashback in the assessment narrative might have been a result of methods of questioning rather than true absence. Other than these issues of possible overinclusion, McNally points out the problem of category truncation—of trauma-related disorder having a wide range of symptoms not included in the DSM-IV PTSD category. McNally shows that many symptoms, including somatic symptoms, not in the DSM PTSD diagnostic criteria were seemingly common in past wars. And he shows that symptoms that were common in Vietnam veterans

are less emphasized in the current conceptualization of trauma's effects: guilt, which was a prominent part of the Vietnam War distress presentation (though now in DSM-5, self-blame is a criterion) and rage at society (though now in DSM-5, persistent negative emotional state is a criterion, which may include such a sense of persistent rage).

McNally examines possible definitions of PTSD, including the abnormal response to trauma no matter what the range of symptoms. He points to the problem of defining what constitutes a "trauma." There is a danger of "bracket creep" if what is considered a trauma is too broad, such as including under the rubric the experience of feeling helpless upon learning of threats: as an example of this kind of bracket creep, he notes that in one study that 4 percent of Americans were classified as having PTSD after 9/11 despite living far away, apparently by watching the event on television. McNally ponders the theoretical implications of considering that pulling a tooth can produce PTSD. For example, he asks whether in the West some cases of PTSD serve as an "idiom of distress" that is taken on for reasons analogous to Charcot's patients in the Salpêtrière enacting the steps of grand hysteria (Didi-Huberman and Charcot 2003; Haskell 2011), that is, a sort of final ethnobehavioral pathway to express distress that is provided by a society (Carr and Vitaliano 1985).

Young and Breslau also examine the historical origins of the PTSD concept and argue that it is a heterogeneous entity because the supposed cause (a trauma) is so variable and at times almost nonexistent, even imagined. They note that the definition of stressor has shifted: from being an objectively verifiable extreme threat in DSM-III to in DSM-IV being simply an event considered as threatening to oneself from the person's perspective or threatening to others when the event is witnessed. DSM-5 has a similar definition, though slightly narrowed (see McNally [Chapter 2]), for example, specifying that learning of a trauma can only qualify as a trauma if the event occurred to a close family member or a friend. Young and Breslau describe DSM's memory logic, in which a traumatic event (A) leads to a bad memory (B), and that memory leads to both of the following: constant arousal (C) and avoidance of anything that reminds the person of the trauma event as well as numbing (D). Young and Breslau review the problem of expanding what is considered causative of PTSD to the point that the presence of symptoms (C and D), leads to a search for any bad memories (B) that may explain the experiencing of those symptoms (C and D)—that is, a process of retrospective attribution. In respect to the heterogeneity issue, Young and Breslau

point out that the symptoms of major depression and generalized anxiety disorder (GAD) are similar to many of the symptoms in the PTSD criteria, and that often the person with PTSD will be given those two diagnoses.[8] It would also suggest that a person with GAD or major depression may notice that they have many of the PTSD symptoms and this then may give rise to the search for the cause in some trauma.

Young and Breslau note the potential large increase of PTSD diagnoses and hence the rate of meting out of disability benefits to veterans if the liberal definition of a stressor (criterion A) is used. They review cases from Charcot and discuss one that demonstrates the invention of memory. The man in question did not have trauma but vividly conjured it in mind in anticipatory fear to the point of insisting on having passed through the trauma; the case shows how conjuring to mind an imagined and feared event (a carriage rolling over the leg, a nearby bomb explosion) comes to be viewed as a true memory. In addition, Young and Breslau argue that someone reviewing past life events may come to view one of them as traumatic not only by such distortion but simply through emotion inflation—reconfiguring a past event as pathogen. Experiencing distress leads to a review of past events in search of those that caused current distress, and through *Nachträglichkeit*, the "pathogenic event" is found and imbued with a sense of harrowing power, of dark significance. A further mechanism encouraging retrospective discovery of a "pathogenic trauma" is self-narrative making. If finding the pathogen allows the person to cast current distress such as anger, depression, anxiety, or substance abuse as part of the narrative of a "hero," of a combat survivor, with invisible psychic wounds, then this process may be accelerated; in such a way, the person creates a new and preferable identity—and this choice may have important economic consequences. Private memory is central to self-fashioning and the narration of the self; through the PTSD diagnosis, the person is not a failure but a survivor, a war hero. Even in cases of true severe trauma, the master narratives of trauma's effect will strongly shape the experiencing of those with trauma.

Young and Breslau show the continual dance between textual definitions of disorder (DSM), prototypical cases (i.e., pure cases such as those that result from a severe trauma that seem to exemplify the illness characteristics and may serve as pure representatives of the kind[9]), and actual clinical populations. They refer to prototypes as cases where a severe traumatic event seemed to result in PTSD symptoms, and they state that clinical cases are much more complex entities. There is also the problem of autosuggestion and

malleable memory. Young and Breslau describe how each war seems to result in certain "assemblages" that constitute new forms of war-related distress and how those forms may enter society as the prototypical image of trauma. These assemblages will be influenced by current medical knowledge, institutional cultures, and popular attitudes. These assemblages result in unique trauma subjectivities. As they point out, somatic syndromes often took central place in such assemblages, in the associated trauma subjectivities: the prominence of gastrointestinal concerns and fears of peptic ulcers among soldiers in World War II. Or in the Gulf War, the fear of deadly chemical agents and contamination led to prominent somatic complaints. And following 9/11, the effect of viewing those events constituted a seeming new trauma assemblage that is referred to as "distant PTSD," as described by Young and Breslau.

Boehnlein and Hinton's chapter investigates the overlap of traumatic brain injury (TBI) and PTSD in historical perspective. They situate in historical context the present debates about whether the complaint of having TBI may sometimes serve as the new guise of a PTSD, what might be called "mimicked TBI"; this occurs when TBI is not present but TBI-like symptoms are enminded and embodied as a distress form, when TBI is not present but trauma-related symptoms lead to the diagnosis of TBI. Trauma-related symptoms such as PTSD overlap greatly with TBI symptoms: TBI symptoms include headache, dizziness, fatigue, insomnia, vision problems, sensitivity to light and sound, memory problems, difficulties with focus and concentration, impulsivity, depression, irritability, anxiety, and personality changes. As Boehnlein and Hinton discuss, several previous war syndromes and their symptoms—irritable heart in the Civil War, railroad spine in the late nineteenth century, and shell shock in WWI—were attributed to physical damage but were usually psychological in origin. For example, shell shock was thought to result from a concussive injury (from a blast); and shell shock was thought to bring about many of the symptoms that we now classify as PTSD symptoms, as well other symptoms. In the current episteme of war syndromes, TBI inflects the understanding of psychological trauma because it leads to a special scrutinizing for the presence of symptoms like headache, memory loss, and poor concentration among those with a history of head trauma (which includes being present in the zone of a bomb explosion)—soon these TBI-type symptoms may be more salient in all psychological trauma presentations. In the current episteme of war syndromes, there are several types of overlap between TBI and PTSD, creating a complex typology: pure

TBI, which act as paradigmatic cases in Young and Breslau's terminology, in which PTSD is not present and the person does not think him- or herself to have PTSD; pure PTSD, in which TBI is not present and the person does not think him- or herself to have TBI; co-occuring TBI and PTSD, in which the person self-labels trauma-related symptoms such as PTSD symptoms as TBI, with the presence of PTSD being ignored; and mimicked TBI in the absence of PTSD or any trauma-related psychological symptoms, in which the person has anxiety and/or depressive symptoms (e.g., anxiety, irritability, headache, poor concentration) from non-trauma-related causes and attributes those symptoms to TBI though TBI is not present.

Part III: Cross-Cultural Perspectives

Part III consists of eight chapters describing studies of trauma, trauma-related conditions, and trauma treatment in distinctive social and cultural contexts.

Jenkins and Haas detail how trauma plays out in a particular American subculture: the life experiences of adolescents in a community in New Mexico. They use the term "psychic trauma" rather than "PTSD"; the term "PTSD" conjures a certain circumscribed set of symptoms—such as trauma recall or anger—whereas the group they studied experienced adverse advents that have a far broader range of negative effects. And as they note, the PTSD criteria include certain symptoms that may not apply to other cultures—for example, numbing and avoidance in certain Latin American contexts—and do not include others that may be central in a locality. The authors call for an ethnography of traumas and stresses, and the effects on the local social world. They show how local traumas interact with local stressors to create a specific trauma ontology. The youth they studied in residential care grew up in situations marked by frequent traumas, by high levels of poverty, and by drug culture: the highest per capita rate of death by heroin overdose in America is found in rural New Mexico. Intergenerational legacies of structural violence are pervasive: parents often have psychological and substance abuse problems, making it difficult for them to provide protective parenting. Trauma by someone in the home shatters the bonds of social trust in profound and distinct ways. Rape is common. Self-cutting is frequent, seemingly used as a way to cope with negative affect or as a way to express a desperate need for help, a kind of idiom of distress and final ethnobehavioral pathway. Worsening matters, government services are being withdrawn.

The actions of those in these social worlds, according to Jenkins and Haas, are best viewed from the perspective of a "sociology of psychic trauma," analyzing how state structures and local realities combine to create crushing structural violence on the level of the family and the individual. There is the social course of trauma, the social embeddedness of trauma, in which trauma itself shapes social structures and interactions: ongoing stresses combine with frequent traumas to impact local life, and in turn, lead to more trauma—so go the vicious cycles. When seen through this optic, the illusion of human agency seems to dissolve. What becomes visible are crushing lines of structural violence, and how those forces play out on the national, state, local, and family level. As Jenkins and Haas's analysis highlights, there are various types of structural violence. There is the structural violence that a person experiences from living in contexts where violence is rampant, ranging from gang violence, crime, family-level violence (e.g., owing to anger generated by PTSD), to exposure to drug culture and all that it entails. Also, there is violence that comes to be perpetrated for structural reasons, such as when intergenerational problems and local stresses (e.g., economic issues) result in persons' perpetrating actual violence and abuses; that is, violence is seemingly generated by economic, social, and other conditions. And there is "structural violence" in the metaphoric sense: stresses (e.g., poverty) and deprivations (e.g., lack of education) that constitute a key aspect of endemic adversity. All these types of structural violence are present in the locality described by Jenkins and Haas, and the authors try to delineate all these lines of force that are the vectors of structural violence. Whereas Lewis (1959, 1966) describes a "culture of poverty," Jenkins and Haas detail a "culture of violence and stresses" ("culture of trauma and stresses") and they illustrate how these forces infiltrate and permeate the local social world. This is not to deny human agency but rather to point out the endemic structures that shape personhood, biology, and life experiences, to trace the lines of structural violence—and consider questions of agency. (The theme of structural violence is addressed in many chapters of the volume: see Hinton and Good [Chapter 1].)

In the next chapter, Duncan shows how the definition of the traumatic varies across cultures: in Oaxaca, whereas migration and other events are professionally framed as traumatic, not so domestic violence—it is just a "part of life." It is considered a man's right to hit his wife, and that his doing so in jealousy means he cares for her. Events that would elsewhere be seen as traumatic are not viewed as so in this context. But the conceptualization of the

traumatic and its effects are in flux. Duncan describes a location of high levels of trauma, and of high levels of stress, such as poverty and lack of potable water, and a location where campaigns about trauma and its effects have begun in the form of billboards and by other means and where therapeutic groups have become increasingly common in clinics. In one case that she describes, which involves a therapy group in a clinic, each woman is asked to describe a trauma and is told that not expressing it will lead to the trauma operating inside her like a pathogen, producing emotional distress. Campaigns against violence such as gender-based violence, high rates of such violence, and campaigns urging women to seek services for the effects of such violence: these all combine to lead many women to seek mental health services.

Through these campaigns and receiving services, a certain "trauma assemblage" results, to build on Young and Breslau's phrasing, the emergence of a new trauma subjectivity. Women are told that trauma results in certain symptoms, and they learn about the role of mental health professionals and about the supposed need for self-esteem and empowerment to recover from trauma's blow. Multiple means aim to educate women about psychological violence such as humiliations and insults, and about the need to get mental health care for sequelae of these events. Western-type PTSD and related ideas are taught in various ways in the goal of "sensitizing" (*sensibilización*). In this trauma assemblage, domestic abuse is not thought by local professional treaters to cause PTSD, but rather to result in anxiety and depression. As Duncan points out, this view is in contrast to surveys that show that as many as 20 percent of the women in Oaxaca have PTSD, and that intimate partner violence is a risk factor for PTSD. Though domestic violence does seemingly produce PTSD symptoms, Duncan hypothesizes that so diagnosing women might have negative consequences, in particular the medicalization of the problem: giving a pill to the woman who has suffered such violence rather than addressing the violence itself. But she argues that the expansion of the Euroamerican understanding of mental health in these settings is generative of novel social practices and self-understandings that are indeed empowering and that shine light on structural and routinized abuse and violence.

Pedersen and Kienzler put forward a general bio-psycho-social model of how distress and psychological disorders are produced among Quechua speakers in Peru. They advocate a model in which causality can occur at any of various levels, emphasizing current life problems and stresses. The authors review the literature showing that structural violence and disadvantage—poverty,

low socioeconomic class, lack of support—create particular vulnerabilities. And they review the literature on the impact of current stress and daily stressors on mental health as compared to the impact of traumatic events. In addition, the authors examine local meaning systems, analyzing the narratives of highland Quechua about their experience of violence and adversity to determine the local idioms of distress and ethnopsychology. The local ethnopsychology emphasizes how traumatic events along with current stress and worry worsen mental health. The authors present a semantic map of this local ethnopsychology's conceptualization of the effects of trauma and adversity (for a semantic map of this kind among Cambodian refugees, see Hinton and Good [Chapter 1]). For example, "worrying thoughts" (*pinsamientuwan*) are considered to possibly lead to insanity, and those persons who have passed through chronic adversity are thought to be highly vulnerable and are compared to a tattered cloth that rips easily or a friable piece of wood. The informants also speak of sadness (*llaki*) characterized by multiple somatic symptoms such as headache and stomach pain. *Llaki* are thought to be caused by *pinsamientuwan*. The authors present the results of a study showing how these idioms relate to DSM-type diagnoses and to functioning. In this way, the authors show how DSM disorders relate to local diagnostic labels (syndromes, idioms of distress, metaphors depicting vulnerability and disturbance) that form a network of syndromes constituting an ethnopsychology.

In the next chapter, Alcántara and Lewis-Fernández examine the conditional risk of PTSD among Latino patients as compared to other groups. By conditional risk they mean the relative risk in one group as compared to other groups of developing any of the following after a trauma: a PTSD diagnosis, certain types of PTSD symptoms, more severe PTSD symptoms, or more persistent PTSD. In determining conditional risk, differences in trauma exposure are eliminated as a factor. The authors review the conditional risk literature in respect to the Latino population and find evidence for higher conditional risk for certain disorders after trauma, such as rates of PTSD. They examine possible reasons for possible increased conditional risk among the Latino population: peritraumatic responses, cultural syndromes (e.g., *ataque de nervios*), expressive style, and uneven distribution of social disadvantage. For example, as other chapters in the book suggest, if panic attacks are more prominent in a cultural group owing to ongoing stress combined with catastrophic cognitions about somatic symptoms, then the panic attacks may result in higher levels of arousal symptoms and more severe and persistent PTSD. Or it may be that certain groups react to a trauma with different

coping styles—for example, derealization and dissociation—and this may influence course and symptomatology. It may be that a group has specific cultural syndromes that shape how the group reacts to trauma events and symptoms resulting from trauma: Latinos tend to use an "*ataque de nervios*" as a response to trauma, which will tend to guide distress in the direction of dissociation and panic attacks, and this in turn may predispose them to certain types of PTSD symptoms and to a certain recovery course. It may be that certain groups like Latinos have a different expressive style so that the relationship to symptoms is changed and so too the reporting of them. Or it may be that cultural values influence the experiencing of PTSD—among Latinos, fatalism may shape the sense of self upon being traumatized and influence the recovery course. And it may be that socioeconomic position, poverty, and discrimination, which are major issues in Latino communities, result in vulnerability, specific symptoms, and a certain recovery course.

Kohrt, Worthman, and Upadhaya present a biocultural approach to PTSD in terms of child experiences, pretrauma vulnerabilities, trauma event variables, and posttrauma variables. As an example of a pretrauma vulnerability, they review the literature that shows that there may be biological predisposition to a hyperreactivity to stressors among those with a short allele of the serotonin gene. They argue that certain cultural environments may lead to stressors and trauma that shape the local bio-ontology of trauma. They review the literature that experiencing stress prior to and following a trauma may impact greatly on its course. They also discuss other culture-determined vulnerabilities: certain cultures seem to be more protective toward women and children. Kohrt and his colleagues describe how the emotional impact of trauma may be shaped by local meanings. They review studies showing that arousal symptoms caused by trauma may be labeled as possession or panic, creating biolooping (or what might also be called bio-attentional looping), which amplifies certain symptoms and thereby shapes symptomatology (on biolooping, see Hinton and Good [Chapter 1]). And they discuss how certain locally specific variables may influence recovery, such as the degree of stress in the community and how a person's trauma is framed culturally by those in the community.

In their chapter, Ball and O'Nell examine "historical trauma" among Native American communities. The authors argue that the creation of PTSD in the DSM-III (the post-Vietnam syndrome) as a diagnosis for Vietnam veterans allowed members of that group to speak of their traumas and current stresses, and that before the diagnosis was recognized, that substance abuse,

anger, and other symptoms experienced by veterans were blamed on the veterans themselves rather than being attributed to past trauma and current adversity. According to the authors, Vietnam veterans were doubly victimized: by the original trauma and then by having their trauma-induced behaviors attributed to moral weakness. But Ball and O'Nell argue that the concept of historical trauma better describes the life situation of Native Americans than does PTSD. They consider the Native American situation to be one of complex PTSD that comes about as "a chronic reaction to genocide and oppression," and that the resulting symptoms and problems are broader than anxiety, depression, or PTSD because of the length of time that these traumas have lasted and because of other particularities of history that the authors depict in genograms.

Many chapters in this volume describe various types of adversity in lifeworlds marked by trauma, and Ball and O'Nell's chapter reveals how these lifeworlds of adversity may be complicated by historical trauma. The concept of historical trauma is much broader than PTSD—for example, it emphasizes vulnerability factors and not just trauma—and captures better the life situation of those in many Indian communities. In these communities, assessing for PTSD can be problematic; it leads to a neglect of other trauma-related problems such as substance abuse, depression, anomie, low self-esteem, and other key dimensions of psychopathology. Then PTSD acts as a reification of trauma's effects and hence prevents the scrutiny of other effects of trauma, which are broad and entail complex processes in time.

As one example of these complex processes in time, as described by Ball and O'Nell, there is cultural loss. Cultural loss can be seen as a trauma and as a vulnerability factor. The loss of traditional culture and healing ceremonies acts as a trauma, what might be called cultural loss trauma, with culture configured as the source of self-esteem, resilience, and recovery; and cultural loss may lead to vulnerability to trauma by causing anomie and a sense of loss of agency, to a sense of being unable to "cope," to the loss of recuperation-promoting ethnopsychologies, ethnospiritualities, practices, and rituals. Another key aspect of historical trauma is intergenerational trauma. As in other chapters of this volume, such as that of Jenkins and Haas (Chapter 5), intergenerational issues are revealed as keenly important; but here in Ball and O'Nell's chapter, intergenerational trauma is located within the context of historical trauma—though this type of analysis was also suggested by Jenkins and Haas's chapter, in which the two authors describe a locality of high levels of endemic substance abuse, trauma, mental illness, and

acting out behaviors that create self-perpetuating cycles of worsening through the generations.

According to the historical trauma perspective, one must examine how multiple traumas, losses, and stresses across time may create and shape life-worlds. Seen from this perspective, using exclusively the PTSD concept to examine the Native American situation is a medicalization that ignores not only the origin of the symptoms in socioeconomic forces such as poverty but also the origins in historical trauma. And seen from this perspective, the definition of trauma in the DSM-5 conceptualization (viz., criterion A) is too narrow, ignoring issues like cultural loss and historical trauma more generally. And from this perspective, in the PTSD criteria, criterion A should include not only traumas of an individual but of an individual's community through time. This historical trauma matrix includes traumas, vulnerability factors, stressors, social and cultural structures, intergenerational dynamics, cultural loss trauma, behaviors like self-cutting, and diagnostic disorders such as substance abuse—these all interact through time to form the historical trauma ontology.

In many Indian communities, historical trauma is now a prominent part of the local ethnopsychology, a concept well known by many. Ball and O'Nell report on studies of historical trauma based on operationalization of the concept into instruments. In a previous study, Ball and others found that many Native Americans thought about historical traumas on a daily basis and that it brought about rage and poor sleep among other effects: the study found that 72 percent of the members of a tribe had PTSD when assessed in reference to the termination of the tribe in the 1950s. The group also had extremely high levels of trauma and rates of PTSD. Out of this research, Ball and others decided to therapeutically use historical genograms that summarize the traumas endured by two tribes. A genogram shows trauma in the broader history of a tribe, and presents this information according to Native American values: traumas are depicted in a circle in relation to other important events in the tribe's cultural history, with the creation myth being placed at the beginning and time flowing in a counterclockwise direction.

Like several authors in this volume, Ball and O'Nell scrutinize the utility of the PTSD concept from the perspective of its ability to promote recovery. They argue that the historical trauma construct better captures the trauma ontology of Native Americans, and has greater therapeutic effects. This edited volume shows several instances of how new trauma subjectivities are formed through therapeutic ideas: in Oaxaca (Duncan [Chapter 6]), the

promoting of the notion of trauma and of the need for therapeutic processes like talking about the trauma and developing self-esteem and empowerment; and here in the case of Native Americans, there is the idea that recovery results from learning to view history through the lens of historical trauma. Acquiring a historical consciousness is healing among the Native American groups, according to Ball and O'Nell. The genograms help to put the self-image of trauma in the broader context of creation, ceremonies, and both negative and positive aspects of history. Healing is a cosmology making and self making, which are seen as closely related processes; healing from trauma involves a recontextualization of a trauma event—and related behaviors and symptoms—in a new explanatory frame and an attribution of dysfunctional behaviors and symptoms of those in the community to historical traumas. And as a further therapeutic process, healing involves using traditional ceremonies to help to redress the trauma of cultural loss. Healing is a reontologization, a remaking of the person according to the original cosmology, spiritual system, ethnopsychology, and system of therapeutics. This reontologization is said to undo cultural loss trauma, to increase a sense of agency, and to increase self- and group esteem.

James examines the social life of trauma in Haiti and argues that interventions aimed to treat PTSD are doomed to fail unless they take into account the Haitian understandings of personhood, embodiment, and trauma, and their lived experiencing of insecurity. According to James, there is a political economy of trauma in Haiti in which the PTSD construct is the source of supposed therapeutic competency and serves as the language of nongovernmental organizations (NGOs) and other interventions, but that PTSD has limited efficacy—it is a medicalization that obscures. This is particularly so in the Haitian context in which intervention organizations emerge for a day and then fade away, replaced by yet another NGO or other group. As an overarching analytic frame, James presents the idea of ontological insecurity—from poverty, to physical assault, to political insecurity, to assault by spirits—and the historical origins of that insecurity. This is a complementary analytic frame to that of historical trauma (see Hinton and Good [Chapter 1]). James argues that "treatment programs focusing on acute *individual* traumatic suffering will not be effective long-term unless *collective* security—political, economic, and social—is established and sustained in Haiti." This notion of insecurity can be expanded to encompass all ontological levels: from the physical to the spiritual (see Hinton and Good [Chapter 1]; see also Hinton et al. 2009).

Multiple local explanatory frames in Haiti are used to explicate trauma's occurrence and the meaning of the trauma event, to explicate PTSD and other trauma symptoms, and to attempt recovery, and these frames must be taken into account in interventions, according to James. There is, in a modernist, Western-influenced explanation, an examination of the effects of gender inequalities and of a predatory national state. There is an evangelical interpretation in which Haiti's individual and collective traumas are seen to result from involvement with *Vodou*, in particular the purported "diabolical pact" that Haitians made with Satan in 1791 to attain the powers required to overthrow French colonial forces. As another interpretive frame, there is an epistemology of the Vodou tradition that may identify the ultimate cause of affliction to be the failure to uphold kinship and other spiritual obligations or to be the result of the jealousy or malediction of others that results in sorcery. There are ideas about the fate of the dead: following past political events of violence, the inability to observe customary mortuary rites for those lost and presumed dead are among the most devastating experiences for Haitians and contribute to psychosocial trauma—ghosts and not just memories constitute part of the Haitian trauma ontology. This results in spiritual insecurity, in fears of ghost attack. To illustrate the key role of interpretive frames in processing trauma, particularly the ethnopsychology, ethnophysiology, and ethnospirituality frames, James presents cases. In one case, trauma results in psychosis, and seemingly the local ethnopsychology predisposes to a psychosis-like reaction to trauma; the ethnopsychology includes ideas about multiple and dislocatable selves, possession, and a dangerous heating of the head. Local therapeutic ideas shape the course of trauma treatment: if a man becomes agitated, a nurse may consider the man's head (*tèt*) to be hot (*cho*), and their ministrations may aim to reverse the flow of excess blood to the head that caused his outburst. Or as the cases also illustrate, in the traditional understandings of embodiment in Haiti, the condition of hot or bad blood, *move san*, could cause *endispozisyon* (indisposition)—spells of "falling out" or fainting and weakness—as well as other disordered states, seemingly resulting in these states being part of the local trauma ontology.

James argues for the importance of a genealogy of current ontological insecurity, a genealogy of a subjectivity marked by insecurity—a complementary optic to that of historical trauma. In respect to genealogy, whereas Foucault (1978) traces the historical emergence of a certain current sexuality, the formation of a certain sexual subjectivity, James traces the historical formation of the ontologically insecure subject. It is another take on

Heidegger's *Dasein*, but the insecure Dasein (Heidegger 1962)—being-there in which "there" is a place of profound threat, not just existential angst: being-there-in-danger. In her usage, *ensekirite* describes the experience of living at the nexus of multiple uncertainties—political, economic, environmental, interpersonal, physical, and spiritual. In Haiti, insecurities such as the threat of violence are ongoing—there is no "post" in the sense of PTSD. In such circumstances, hypervigilance would seem to be adaptive and appropriate to the ecological context. How is it to attempt to recover with a self that was formed in a past that was marked by multiple traumas and types of stress, with a self living under current threat of trauma and confronting multiple types of ongoing stress, and with a self that is anticipated to have such threats and stresses in the future? These three time perspectives—past horizon, current moment, and future horizon—shape the self. Does the Vodou cosmology of multiple exterior and interior selves in the individual—for example, the *gros bon ange* and the *petit bon ange* and the *lwa*—best convey this sense of a lived fractured history? On multiple levels, the Haitian ontology is marked by insecurities, and a genealogy of those insecurities is necessary to do justice to the actual workings of the trauma survivor's plight.

Good, Good, and Grayman describe the effects of trauma in post–Civil War Aceh based on over five years of work designing interventions in that locality. On an early visit they were traveling with a mobile clinic to a village and heard accounts of routinized, horrific trauma: of a man being hung from a rope like a goat and his head beaten, left for dead; and of a woman, along with her children, forced to watch her husband having his heart cut out. During the Acehnese conflict, there was also economic terror in the form of the destruction of home and livelihood. The authors review the literature claiming that psychological interventions in such settings are a sort of psychological imperialism, the imposition of an alien concept on the local populace in the name of humanitarian intervention—that PTSD is a pseudocondition. The authors respond that in their work they have found that many PTSD symptoms not only are present in the Acehnese context but are prominent, a key part of what matters to persons in the locality, a cause of great impairment, and an important treatment target. This suggests that the portrayal of PTSD as a pseudocondition risks to be a kind of orientalization (Said 1978), the positing of the other as an exotic radical "other" with this interpretation of radical otherness serving the supposed interpreter but not the group itself: the interpretive error leads to the group in question not receiving needed care. The orientalizer self-aggrandizes at the expense of the other. But Good

et al. do concur that the remainders of violence in Aceh are broader than PTSD and include acute psychosis, depression, and a wide range of anxiety disorders such as panic disorder, and that they include many somatic complaints like weakness, pain, stomach problems, and heart sensations. Panic attacks with multiple somatic symptoms are particularly prominent. (On somatic symptoms and panic among trauma survivors and the concept of the arousal complex, see also Hinton and Good [Chapter 1].) The authors conclude that a concept like complex trauma is needed to describe the broad range of symptoms that are a core part of the trauma survivor's experience, particularly in settings of ongoing ontological insecurity.

Conclusion

This edited book brings together a set of historical and ethnographic studies of trauma, trauma-related syndromes, PTSD, and trauma treatment in highly diverse settings. It examines how the phenomenology of responses to violence has varied historically, and it analyzes the emergence of PTSD and trauma treatment as contingent historical realities. In many cases, the authors describe PTSD and its uses in settings in which traumatic violence is or has been endemic, leading to complex forms of trauma-related suffering. The chapters examine the phenomenology of the remainders of violence in particular lifeworlds, raising questions about the cross-cultural validity of the PTSD construct. They focus in particular on the inadequacy of narrowly defined PTSD for settings in which insecurity and violence are pervasive. And the chapters describe how PTSD is made real in various settings—how PTSD has produced new ways of conceiving violence toward women in Oaxaca, how the construct has been used to organize care for a wide range of postconflict mental health problems in Aceh, Indonesia, and how PTSD serves as a mechanism for adjudicating who can receive compensation in Haiti. The book thus portrays PTSD in action, as a concept that produces a variety of effects as it is translated into practice.

The authors in this book demonstrate how a historically and culturally contextualized understanding of trauma survivors can help avoid dehumanization and interpretive violence. The goal is to advance a study of trauma survivors that does not distort the radical positionality that is one individual's experiencing of a trauma event. The goal is to examine trauma ontology in cross-cultural perspective, to determine experience-near categories of

understanding of trauma's effects in those localities. The goal is to explicate what is at stake for local actors and to be aware both of their being victims of vectors of force and of their being agents with a creative response to traumatic experience. Authors of the volume try to accomplish this by examining the category of PTSD and its application to local contexts, all the while investigating the broader effects of trauma and examining those effects from the perspective of multiple types of contextualization.

The book calls for a multifaceted view of evaluation and treatment that is developmental and ecological, one that takes into consideration the issue of treatment of current distress as well as public health approaches to prevention. There is much debate about which treatments may be effective for PTSD across cultures, and why.[10] The current volume describes the multiple ontological levels on which trauma makes a mark, the many paths that trauma effects take, and the ways that local responses to trauma shape the trajectory of trauma's effects as well. The book calls for an engaged anthropology in which contextualization informs treatment and the understanding of the effects of trauma. Contextualization leads to insights about culturally distinctive mechanisms that amplify or reduce symptoms, and contextualization also helps to address the following questions, which are a contextualization in respect to epistemology, episteme, and the biopolitics of power—the study of the consequences of a certain medical gaze. What is considered the object of treatment, who does the treatment apparatus empower and disempower, what are the consequences of the interventions for individuals and social groups, and what are the social and moral implications of those treatments—these are key issues that a socially engaged anthropology must address (Fassin and Pandolfi 2010; Fassin and Rechtman 2009).

Our goal is to show how a historical, multifaceted, development-informed contextualization may contribute to the debates about trauma, long-term suffering, and care. The chapters bear witness to suffering, suggest possible targets of humane care, and provide insights into how those treatments might be developed. The volume thus calls for an anthropologically informed contextualization of PTSD and posttraumatic stress syndromes and suggests ways in which this might be accomplished.

Notes

1. On the mechanisms of possible efficacy, see Hinton and Kirmayer (2013), which is the introduction to a special issue on this topic in *Transcultural Psychiatry*.

2. Speaking to this issue of stigma and its contestation, the Purple Heart can be given to those with traumatic brain injury and other physical injuries, but not to those who claim that combat led to PTSD. As we will see in what follows, traumatic brain injury is not uncommonly a PTSD-like syndrome that is taken on to avoid stigma associated with a PTSD diagnosis. The regulation barring those with PTSD from getting the Purple Heart is currently being contested by mental health advocacy groups.

3. Based partly on cross-cultural considerations (for a review, see Hinton and Lewis-Fernández 2011), some changes were made from DSM-IV to DSM-5 in the PTSD criteria. For one, the nightmare criterion has been changed so that it does not have to be an exact replaying of the trauma but rather just has to evoke a sense of terror and negative emotion reminiscent of the event. Second, in the section of the DSM-5 PTSD criteria labeled "negative alterations in cognitions and mood associated with the traumatic event," in the criterion "persistent and exaggerated negative beliefs or expectations about oneself, others, or the world," it is now stated that this includes ideas about bodily damage from the event, which is fairly common in cross-cultural contexts and in past historical periods (see Hinton and Good [Chapter 1] and Boehnlein and Hinton [Chapter 4]). And third, the numbing (restricted range of affect) item was altered so that it is now specified as an anhedonia, depressive-type item; as discussed in chapter 1, the numbing item is often difficult to apply cross-culturally because of translation difficulties.

4. Typically items C3-C7 in the DSM-IV are considered numbing items, though some of the items are clearly depressive symptoms, and so the items would be best considered as dysphoria and numbing items (Friedman et al. 2011).

5. This last item is strongly shaped by cultural ideas about how trauma can damage the mind or body, such as a Latino's fearing that fright may dislodge the soul or a Cambodian's belief that overwork will permanently deplete and damage the body.

6. Some consider the amnesia item to be a numbing or avoidance item, claiming that amnesia results from the attempt to not recall a negative event. But factor analyses show amnesia loading with depression items suggesting that it is a depressive-type item in many cases: It may result from a sort of mental lethargy, faulty concentration, a torpor (e.g., Armour et al. 2012; Elhai and Palmieri 2011).

7. For an overview, see Hinton and Good (Chapter 1) on wind attacks or *khyâl* attacks; see also www.khyalattacks.com (Devon E. Hinton, M.D., Ph.D.).

8. Generalized anxiety disorder and major depression are highly correlated and share symptoms such as poor concentration.

9. Analogously, Charcot's grand hysteria patients were the prototypical cases of disorder in the second half of the nineteenth century. Hence, what serves as a prototype may be a historical construction. In other cases, actual physical illnesses like brain injury may serve as the prototypical case of what might result and then are imitated and so also become forms of psychological distress (see the Boehnlein and Hinton chapter on TBI [Chapter 4]).

10. For example, recent studies suggest that treatments that target the biology of trauma (viz., pharmacology) or treatments focused on certain psychological aspects of the disorder (viz., cognitive behavioral therapy) are effective treatments for the DSM-defined symptoms of PTSD, and even culturally specific symptoms, such as somatic symptoms (Bass et al. 2013; Hinton et al. 2012).

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CHAPTER 1

The Culturally Sensitive Assessment of Trauma: Eleven Analytic Perspectives, a Typology of Errors, and the Multiplex Models of Distress Generation

Devon E. Hinton and Byron J. Good

In this chapter we present several forms of analysis that can be used to assess trauma and its effects in a culturally sensitive way. These analytic lenses demonstrate cross-cultural variation in DSM-5-defined posttraumatic stress disorder (PTSD) symptoms and trauma-related disorder more broadly. The chapter also serves to situate the theoretical contributions of the chapters in this volume. The first section presents the eleven-dimension analysis of the trauma survivor that can be used to examine in a multidimensional ecological way the ontology of the trauma survivor (on the call to contextualism, see Good 1977; Kirmayer et al. 2007). The second section presents a typology of errors (Kleinman 1988) that should be avoided in order to evaluate trauma in a culturally sensitive manner. Throughout the chapter and in a third and final section we present multiplex models to show how trauma symptoms are generated through biocultural mechanisms and how trauma results in particular episodes of distress.

Eleven Analytic Perspectives: The Multiaxial Analysis of the Trauma Survivor

As indicated in Figure 1.1, trauma survivors and their key complaints can be examined in terms of eleven ontological dimensions that create a certain trauma subjectivity.

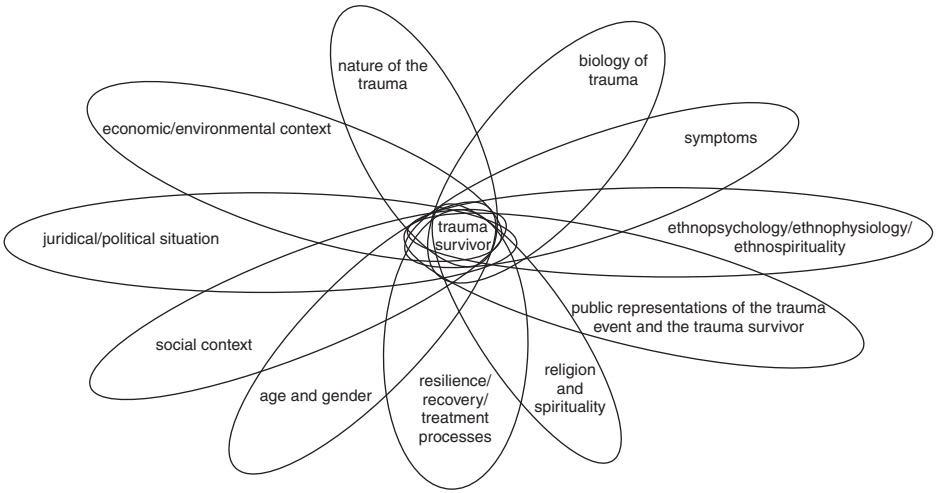

Figure 1.1. A multiaxial approach to the trauma survivor's ontology: Eleven analytic perspectives. The trauma survivor can be analyzed in terms of multiple ontological dimensions that range from biology to the justice situation.

The Type of Trauma and the Particularities of Effects

The term "trauma" is borrowed from the medical sciences, where it means a physical injury, and it is used to depict certain sorts of events that are deeply disturbing—to the point of causing permanent psychological harm, evidenced by perduring symptoms (McNally [Chapter 2]; Young and Breslau [Chapter 3]; see also Fassin and Rechtman 2009; Hollan 2013). The term "trauma" implies that some objectively verifiable damage has been sustained; the term "psychological trauma" suggests that whatever is upsetting to a certain degree is sufficient to traumatize and cause a long-lasting wound.[1]

There is great variability in the types of trauma, and the nature of the trauma event is a key part of every trauma survivor's subjectivity. Below we will discuss several classifications of trauma. Other types could also be identified. The trauma can be classified in the following ways, which are discussed in the rest of this section: the trauma can be classified by

- whether it is complex trauma;
- what are the trauma's general characteristics (e.g., physical assault, illness, observing a killing or a beating);

- whether it tends to induce strongly certain specific symptoms (e.g., anger or somatic symptoms) and how it does so;
- whether it has effects on the self-, interpersonal-, group-, and world-schema;
- whether it has intergenerational aspects;
- whether it occurs in the context of historical trauma;
- whether it is a social loss trauma (e.g., involves the death of a relative);
- whether it is a cultural loss trauma (e.g., involves the loss of cultural traditions);
- whether it is a ritual omission trauma (i.e., involves an inability to perform indicated rites);
- whether it is a social status loss trauma (i.e., involves a severe loss of social standing and status);
- whether it is an economic loss trauma (i.e., involves a severe loss of economic security); or
- whether it is episodic, endemic, or cohort in type.

In the trauma literature, one often finds the term "complex trauma," which may indicate either of the following or both (Bryant 2012; Friedman et al. 2011; Resick et al. 2012): a certain kind of trauma (viz., severe single trauma or repeated traumas) or trauma occurring during states of vulnerability (e.g., trauma at a particularly early age, trauma with genetic vulnerability, trauma with minimal social support, or trauma with ongoing stress). Of note, vulnerability factors said to result in complex PTSD are also recovery-inhibiting factors, like ongoing stress and broken social structures. Complex trauma is said to cause complex PTSD (Bryant 2012; Friedman et al. 2011; Resick et al. 2012), characterized by a recalibration of the nervous system to a state of hyperreactivity to a wide range of stimuli, such as to noises or visual reminders of the trauma, and by poor regulation of negative emotion, such as anger, and this hyperreactivity to stimuli and poor emotion regulation result in the frequent experiencing of symptoms such as anger, anxiety, and somatic symptoms (see Good and Hinton [Introduction]). Complex PTSD is described in many chapters in this volume (Jenkins and Haas [Chapter 5]; Duncan [Chapter 6]; Ball and O'Nell [Chapter 10]; Good, Good, and Grayman [Chapter 12]). As discussed throughout this volume, the exact nature of the traumas and vulnerability factors—and recovery inhibitors—needs to be carefully investigated.

On the most basic level, a trauma may be classified by the nature of the trauma event itself, such as torture, an illness, slave labor, starvation, or observing someone being beaten or killed. Each of these will have subtypes: torture will have subtypes depending on how it is perpetrated (Ursano and Rundell 1986). The type of trauma will result in specific effects and forms a key aspect of the local trauma ontology, and the ethnography of the trauma events and their classification is a key part of witnessing.

The type of trauma results in a specific trauma ontology in that it will tend to induce certain symptoms. Traumas can be classified and examined by the bodily and mental states they strongly induce, immediately in the event, and afterward. During the event certain emotions (e.g., anger) or specific symptoms (e.g., dizziness) may occur. Somatic symptoms are prominent in the trauma ontology of many cultural groups (for one review, see Hinton and Lewis-Fernández 2011): this is true of Cambodian survivors of the Pol Pot regime, and this was true of survivors of the Nazi concentration camps and other such internment settings, the term "concentration camp syndrome" being used after World War II to describe a cluster of symptoms found in those camp and internment survivors, one part of which was somatic symptoms (Bower 1994). This somatic symptom prominence in the trauma presentation seemingly results in part from the nature of the trauma that was experienced. Certain traumas strongly induce somatic symptoms, and so create a trauma ontology that includes prominent somatic symptoms along with frequent panic and arousal (Hinton et al. 2012, 2013b): this is because (1) experiencing the somatic symptoms for any reason leads to recall of past negative events encoded by those somatic symptoms, and then this recall of the somatic symptom-encoded negative events further evokes the somatic symptoms (both by somatic flashback and by the induction of arousal-inducing fear), creating vicious circles of worsening; or (2) the episode may begin by thinking of the trauma event, which then induces somatic symptoms by somatic flashback and by the induction of fear, also starting vicious circles of worsening.[2]

One can further classify and examine traumas from the perspective of the mechanism by which they cause somatic symptoms. For example, almost all Cambodian survivors of the Pol Pot period (1975–1979) experienced multiple events that brought about extreme somatic states. They had illness during the Pol Pot period that strongly induced symptoms: malaria, considered by them to be one of the worst traumas, in which the person had daily events of rigors (a feeling of extreme cold to the point of shaking along with panic-like

symptoms such as palpitations and dizziness) followed by a high temperature state, in which the person experienced strong palpitations, dizziness, tinnitus, headache, and sweating. Cambodians usually had starvation-induced edema alternating with extreme emaciation, accompanied by stomach cramps, bodily coldness, numbness, and other dysphoric somatic states. They had to do slave labor, often resulting in muscle soreness from carrying weights at the shoulder, exhaustion, dizziness, and syncope. They often saw corpses and mutilated bodies, inducing nausea and dizziness. They were often beaten, causing headache and other pains. And they often experienced fear, owing to all the traumas mentioned above, as well as others—being threatened by death, observing others killed, being constantly at risk of assault and death—with this fear resulting in muscle tension, palpitations, and other somatic symptoms.[3] All these traumas and somatic states mark the space-time (chronotope) of the Pol Pot period, constitute a somatic chronotope (Bahktin 1981) for the Cambodian refugee survivor, contributing to somatic symptoms being a prominent aspect of their trauma ontology. (Of note, somatic symptoms may be prominent in a group simply from the severity of the cumulative trauma load—e.g., multiple trauma events—rather from specific induction of somatic symptoms at the time of the trauma.)

Traumas can also be classified by the effect on self-, interpersonal-, group-, and world-schemas. Family-based violence—for example, parental abuse—may destroy bonds of trust (Jenkins and Haas [Chapter 5]), shaping interpersonal schemas, or the trauma, such as a genocide in which perpetrators are not punished, may result in a sense of a lack of justice and other effects that shape the world-schema (Foa et al. 1997, 1999). The trauma may also be an assault on self- and group-schemas, on self- and group-esteem, and the trauma may lead to stigmatization—both self-inflicted stigmatization and other-inflicted stigmatization. That is, certain types of traumas like rape or other acts of degradation may result in a sense of shame and in stigma, not just in trauma symptoms like poor concentration. The nature of the trauma that is recalled in memory will shape identity. When recalled to mind, the trauma memory may bring about a strong sense of anger or shame, among other emotions, may bring about a certain trauma-linked self-schema, or self-image (Foa et al. 1997, 1999): some traumas may be especially shaming and create what has been referred to as "humiliation memory" (Foa and Rothbaum 1998; Langer 1991) and these traumas may act as self-image violence.

Genocide and political terror may aim to create humiliation memory in the self- and/or group schema. In situations of genocide and political terror, perpetrators often purposefully use techniques to abuse and kill that will be the most upsetting in that cultural context; this increases terror and the sense of degradation and results in the recall of the trauma being extremely disturbing, a humiliation memory (Hagengimana and Hinton 2009; Hinton et al. 2013a, 2013c).[4] The perpetrators aim to create a negative self-image and a sense of shame for the targeted individual and that person's group more broadly, a kind of group-image violence, which may be perpetrated by symbolic violence. Such degrading imagery and experiences tend to create simultaneously a sense of rage and shame in the members of the targeted group. The tattoo of a number on the arm of the Jewish Holocaust survivor is an example of this kind of trauma, an attempt to impose an animal status on the other. Similarly, during the Rwandan genocide, the Hutu perpetrated violence against Tutsi guided by certain cultural schemas of what constitutes the abhorrent. The violence emphasized blocking imagery through the manner of killing, for example, impaling along the entire digestive tract, and through the manner of maiming, for example, truncating the breasts of women, castrating men, and cutting the person's Achilles tendon. This violence and the general rhetoric of the genocide seemingly attempted to represent the Tutsi in blocking imagery that resonated with other negative exemplars of blocking in the culture—for example, the witch was considered a blocking entity and was configured in such images[5]—and that contrasted with the positive exemplars of flow as health and prosperity in the Rwandan culture.

A trauma may be intergenerationally transmitted, and may have intergenerational effects. Trauma in one generation may be passed on to the next through multiple means: epigenetics; exposure to parental psychopathology, which may include anger and substance abuse; and parental downward economic and social mobility, which will create a certain life context for the child. Intergenerational trauma may play a key part in historical trauma. Historical trauma often refers to intergenerational trauma combined with other types of trauma as sustained by a group. Historical trauma refers to the fact that a traumatic event endured by an entire group—for example, a genocide that results in mass trauma in which local traditions are destroyed—may have effects through the generations by such means as impacting on social structures and the various sources of resilience and collective self-esteem,

leading potentially to multiple negative outcomes that range from substance abuse, to violence, to PTSD-like symptoms (Ball and O'Nell [Chapter 10]).

Social loss is another type of trauma. "Social loss trauma" refers to the loss of significant others owing to death or separation by distance, for example, after migration, immigration, or forced relocation. The term "bereavement trauma" may be used to refer to the death of a loved one, which may be even more upsetting if circumstances prevented performing culturally indicated death rituals.

Some use the term "cultural bereavement" (Eisenbruch 1991), or what might be called cultural-loss trauma, to refer to the loss of cultural traditions owing to their purposeful destruction or to the traumatized having moved to a location where those cultural institutions are not present: cultural loss may range from diminished access to spiritual traditions to inability to maintain food traditions and traditional diet. In some cases there may be public displays of destruction of aspects of a culture's identity such as the burning of temples—at the extreme, there may be cultural violence to the point of cultural genocide. (See Duncan [Chapter 6] on how migration is locally considered a trauma that brings about loss of social and cultural structures, and see Ball and O'Nell [Chapter 10] on cultural loss processes in historical and intergenerational trauma.)

The forced omission of indicated rituals may constitute a trauma, and complicate other traumas: what is considered to be dangerous and damaging about the trauma event may be that it made it impossible to do certain rituals, what might be called ritual omission violence. In these cases, inability to perform time-sensitive rituals is considered a key part of what is upsetting about the trauma event, what might also be called ritual omission trauma. As one example, Cambodians were unable to conduct postpartum rituals such as "steaming" in the Pol Pot period. If a woman does not perform these rituals, she fears the vessels in her body may become permanently disordered and thereby predispose her to frequent *khyâl* attacks,[6] that is, an upward surge in the body of blood and khyâl, a wind-like substance, that may cause various bodily disasters. As another example of ritual omission trauma, it is often impossible to perform mortuary rites in situations of mass violence. In many cultural contexts, not conducting burial or other mortuary ceremonies is thought to result in the deceased's not being reborn but rather becoming a ghost-like entity, and it is often thought that the deceased's restless spirit may attack the living—often in a nightmare, with a nightmare often

configured as the experiencing of the dreamer's wandering soul—and so may cause illness and even death (James [Chapter 11]; see also Hagengimana and Hinton 2009; Hinton et al. 2009a, 2013a, 2013c). These rebirth and attack concerns worsen bereavement and give rise to despair, guilt, and fear; and these concerns and cultural frames—along with the biology of trauma, which results in nightmares and sleep paralysis—seemingly lead to the encountering of the dead in nightmares and sometimes in sleep paralysis. Through these mechanisms, bereavement then becomes a key part of the trauma ontology of certain cultural groups such as Cambodians and Rwandans.

A trauma may involve a fall in social status and economic state. For example, in the Cambodian genocide and Chinese Cultural Revolution, there was a precipitous fall in social status and economic status of certain groups, who were often targeted for verbal abuse and various humiliations (Kleinman and Kleinman 1994). Or in Aceh, government forces often purposefully targeted economic resources of those considered to be rebellious (Good, Good, and Grayman [Chapter 12]).

A trauma may be further classified by degree of chronicity within a society. Several chapters document the repeated acts of violence that members of some societies and social classes confront, what might be called endemic trauma, that is, types of trauma frequently experienced by members of a society (Jenkins and Haas [Chapter 5]; Duncan [Chapter 6]), and cohort trauma, that is, a trauma like a genocide or 9/11 experienced by most in a society of a certain age (Pedersen and Kienzler [Chapter 7]; James [Chapter 11]; Good, Good, and Grayman [Chapter 12]). Episodic trauma is trauma that is not endemic or cohort in type, but much more sporadic, like a mugging in a wealthy suburb. As discussed in this and the following sections, there may be situations in which endemic trauma and cohort trauma co-occur in a situation of ongoing daily stressors such as poverty, resulting in what might be called a 1-2-3 punch of adversity. These might be called cultures of trauma and stress, of trauma and structural violence (Jenkins and Haas [Chapter 5]; Duncan [Chapter 6]; James [Chapter 11]).

Several chapters implicitly or explicitly invoke the concept of structural violence (Jenkins and Haas [Chapter 5]; Duncan [Chapter 6]; Ball and O'Nell [Chapter 10]). When using the term "structural violence," one should differentiate between the literal and metaphorical senses of the term. The term "structural violence" as usually defined suggests that endemic societal

problems like poverty are a kind of trauma. It may be clearer to use the term "structural insecurity" to refer to economic insecurity and some other key aspects of what is usually meant by the term "structural violence," and for trauma experienced by a group that is meant in the literal sense to use the terms "endemic traumas" (for recurring traumas that afflict a group, e.g., gun violence, crime, and sexual violence) and "cohort traumas" (for traumas experienced by an age cohort, e.g., a war, genocide, or a major act of terrorism like 9/11 in the United States).

Biology of Trauma

Another key ontological dimension of the trauma survivor is trauma's effects on the nervous, endocrine, and other biological systems, and the actual wounds on the body such as permanently deformed limbs from torture or scars from shrapnel or other injury. The inner and outer body may be marked by trauma, and as is explained below, the biological legacies of trauma range from changes to genes owing to epigenetic mechanisms, to amygdala hyperreactivity, to amygdala-based memories, to vagal-tone-caused poor emotion regulation, to brain-based generation of orthostatic dizziness and sleep paralysis, to biology-based predisposition to migraine with aura, to long-term biological effects of starvation, to bodily deformations. And the biological effects of trauma may be much worsened by current stressors like poverty and the threat of violence while living in crime-marked urban areas (Hinton and Lewis-Fernández 2011).

The neurobiology of trauma will produce a certain potential set of symptoms, what might be called a trauma symptom pool, with each symptom being interpreted according to the local cultural context, as is depicted in Figure 1.2. (On the call for a neuroanthropology of PTSD, see Pedersen and Kienzler [Chapter 7]; Kohrt, Worthman, and Upadhaya [Chapter 9]; see also Collura and Lende 2012; Finley 2012; Hinton and Kirmayer 2013.) Trauma-caused biological changes include decreased vagal tone that brings about poor ability to regulate emotion (Blechert et al. 2007; Hinton et al. 2009b). The trauma memory itself is registered in the amygdala (Ledoux 1996). A key aspect of trauma is a biology-generated emotional and somatic hyperreactivity in response to negative emotions and ruminative states like worry and in response to various external cues such as a noise or to any reminder of the trauma. This hyperreactivity is characterized by the rapid induction of

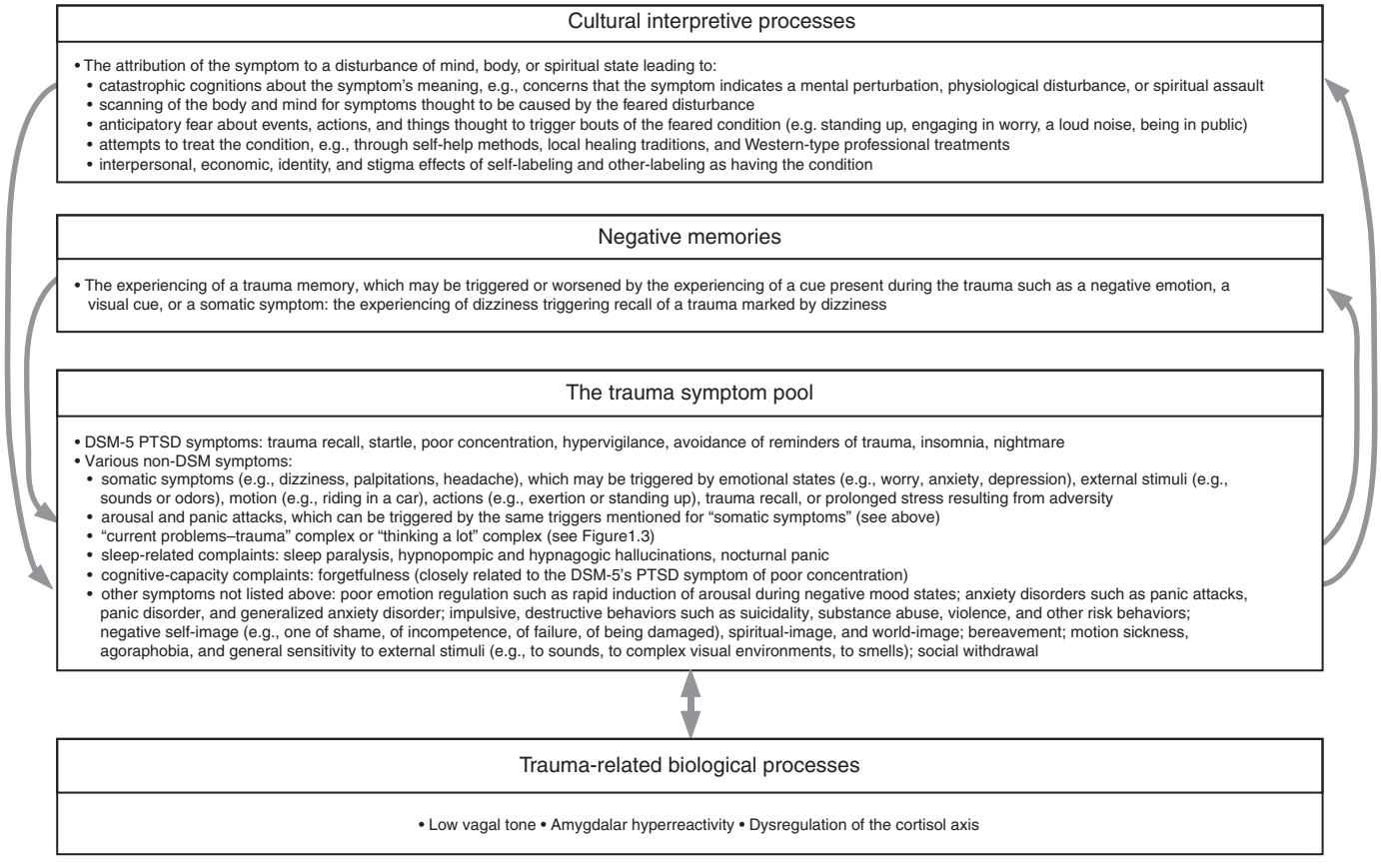

Figure 1.2. The multiplex trauma model: A biocultural model of cultural influences on trauma-related disorder. Feedback loops occur when cultural interpretive processes and negative memories increase arousal and distress and when cultural interpretive processes lead to bio-attentional looping such as surveying of the body for feared symptoms. The trauma symptom pool represents possible symptoms.

strong emotions and many somatic symptoms (Hinton et al. 2011). This hyperreactivity may begin in utero through intergenerational mechanisms: if a pregnant woman experiences trauma, it may cause certain shifts in the genes of the in utero child by epigenetic mechanisms, leading to hyperreactivity in many psychobiological respects, seemingly preparing the child for a hostile environment (Binder and Nemeroff 2010; Heim et al. 2000; Sherin and Nemeroff 2011; Yehuda and Bierer 2009).

The biology of trauma worsens the ability to handle current problems by several mechanisms, including by increasing reactivity (due to amygdalar reactivity) and diminishing psychological flexibility (due to amygdalar reactivity and diminished vagal tone). These coping difficulties predispose to the occurrence of distress episodes of the type depicted by the "current problems–trauma model" (Figure 1.3), this symptom complex forming one part of the trauma symptom pool. As shown in the model, when confronted by a problem, the trauma survivor may rapidly experience arousal that impairs the ability to consider other action options and compromises the ability to adjust to the situation. In addition, the mental and somatic symptoms induced by the distress experienced upon confronting the problem may give rise to catastrophic cognitions and may trigger trauma recall as well as negative memory more generally. Distress may rapidly escalate. The current problems–trauma model shows one aspect of the lifeworld of the traumatized person, a certain symptom complex: the frequent triggering by current life problems of severe episodes of distress through certain mechanisms, a multiplex model. Theorists increasingly advocate the need to show how specific PTSD symptoms and other symptoms interact in particular episodes (Borsboom and Cramer 2013; McNally 2012; van Os 2013), as this multiplex model does. Additionally, this multiplex model (Figure 1.3) demonstrates that trauma survivors don't simply have "symptoms," but experience certain symptom complexes, certain causal networks, which have a local trajectory.

The neurobiology of trauma may result in certain cross-cultural differences in symptomatology. Among Cambodian refugees, the biology of trauma conjoined with a seeming inborn predisposition plays a key role in producing orthostatic panic and sleep paralysis (Hinton et al. 2012). Orthostatic dizziness may result from trauma-caused impairment of the systolic blood pressure response to standing. Certain groups seem particularly prone to this effect, such as Cambodian refugees; and among Cambodian refugees, frequent orthostatic dizziness interacts with cultural syndromes to trigger panic on

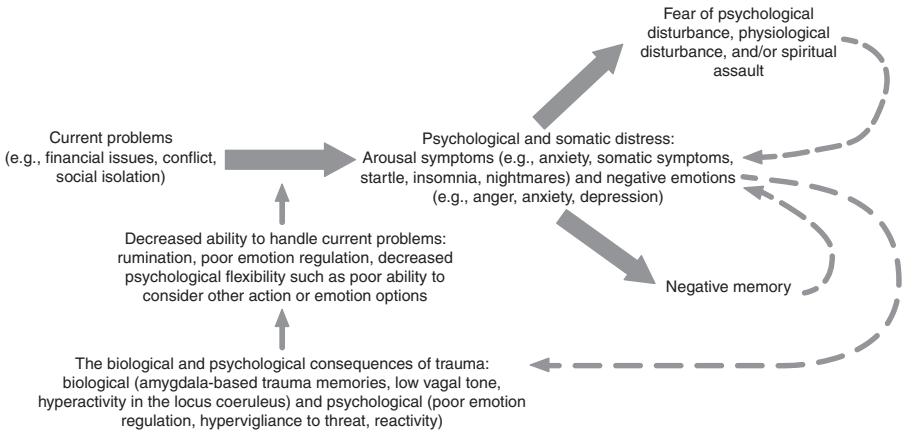

Figure 1.3. The "current problems–trauma" model. The model shows the key role of current problems in generating distress among traumatized populations, with problems meant in the broad sense ranging from current financial problems, concerns about personal safety, spiritual concerns (e.g., about the "rebirth" of a dead relative), to conflicts. Trauma will predispose to poor problem solving: rumination and the rapid induction of arousal. Once being confronted with a problem induces psychological and somatic distress, that distress may be interpreted as indicating the presence of a syndrome or some other disorder. Then bio-attentional looping may occur: fear of having a particular disorder (e.g., a cultural syndrome) will increase psychological and somatic distress, which in turn will worsen psychological and somatic distress, resulting in even more fear of having a disorder (e.g., a cultural syndrome), and so on. The figure also shows how psychological and somatic distress leads to the triggering of negative memory, which also leads to looping effects. As shown, in a feedback loop, psychological and somatic distress worsens the biological and psychological consequences of trauma; that in turn reduces the ability to handle current problems, which will lead to more psychological and somatic distress, and so on, in another vicious cycle.

standing, and too, the orthostatic dizziness brings about trauma recall, further worsening panic (e.g., fear of a khyâl attack; for a discussion of this syndrome, see the section below on ethnopsychology/ethnophysiology/ethnospirituality).

Sleep paralysis is a state of bodily paralysis conjoined with an inability to speak that occurs when falling asleep or awakening. Sleep paralysis is worsened by anxiety, and some groups have particularly high rates, such as Cambodian refugees, with the high rates seemingly resulting from a conjunction of anxiety and biological predisposition (Hinton et al. 2005a,b). Moreover, some groups, like Cambodian refugees, also have extremely

high rates of hypnagogic and hypnopompic hallucinations during sleep paralysis, which consists of seeing a shadow or other form approach and then descend upon one's body during sleep paralysis, often accompanied by extreme shortness of breath. And among Cambodian refugees, sleep paralysis and the accompanying hallucinations are given elaborate cultural meanings, and so result in sleep paralysis being a key part of their trauma ontology.

Certain Asian groups appear to have an elevated predisposition to motion sickness, which may indicate a biologically based enhanced tendency to experience dizziness more generally and to be conditioned to dizziness cues (Hinton and Good 2009). This tendency to motion sickness combined with conditionability to dizziness cues—along with a tendency to have impaired orthostatic adjustment—may explain in part why dizziness is so prominent in the distress presentations of many traumatized Asian groups. As another example of biologically driven somatic symptoms, we have found that Cambodian refugees frequently have headaches induced by distress, for example, by worry, and that the headaches are frequently accompanied by migraine-like visual auras such as scintillating scotomas or phosphenes (Sacks 1985) as well as multiple panic-like symptoms. This is part of the Cambodian reactivity complex. This again points to the existence of local biologies of trauma.

Symptom Dimension

There has been much debate as to whether DSM-5 PTSD and its symptoms are present in other cultures or whether it and its symptoms are a culturally specific experiencing applicable only to the West, a sort of Western cultural syndrome or idiom of distress (Summerfield 1999; Watters 2010; Young 1995). Recent research clearly shows that many aspects of the PTSD construct do indeed represent a cross-cultural psychobiological fact (Good, Good, and Grayman [Chapter 12]; for a recent review, see Hinton and Lewis-Fernández 2011) and that many of the symptoms listed in the PTSD criteria capture certain key aspects of the effect of trauma across cultures: unwanted recall of past trauma events, flashbacks, recurring nightmares, hypervigilance, startle, and anger. However, there are some symptoms in the PTSD criteria in DSM-IV-TR (APA 2000) that seem less prominent or even absent in other cultures following trauma, namely, "amnesia," "numbing," and "a feeling of detachment or estrangement from others," and several of these are difficult to translate and evaluate in another cultural context, specifically, the numbing and detachment

items (Hinton and Lewis-Fernández 2011).[7] In DSM-5, the numbing item has been replaced by a much more easily translated item, namely, an inability to experience pleasure, but the other problematic items have been retained.

The prominence of PTSD symptoms (and other symptoms) in a group's trauma ontology will vary. This variation results from the types of trauma commonly experienced, the local biology of trauma, and the various dimensions of the cultural meaning of symptoms. Let us take the case of the cultural meaning of the symptom. The symptom may be attributed to a local cultural syndrome (Hinton et al. 2012), and more generally, in each culture, certain PTSD symptoms may be considered especially indicative of a disturbance of psychology or physiology or of a comprised spiritual status such as a spiritual attack. For example, Cambodian refugees often attribute startle to a physiological problem such as heart weakness, and they usually attribute nightmares to be the actual negative experiencing of the dreamer's wandering soul such as encountering the dead and being attacked by hostile spirits (Hinton et al. 2009a).

As a major limitation of the PTSD approach, certain symptoms and psychopathological dimensions commonly found in other cultures that result from trauma are not listed in the PTSD criteria; the spectrum of trauma symptoms is much broader than PTSD as defined in the DSM (see McNally [Chapter 2]; Young and Breslau [Chapter 3]). Trauma survivors have a wide range of possible symptoms, what we have called the trauma symptom pool. If any of those symptoms are common in a certain group's trauma presentation, failing to assess those symptoms results in an underinclusion error, that is, in category truncation, and results in a lack of "content validity" (Keane et al. 1996).

As one example, somatic symptoms are not in the DSM-5 criteria for PTSD but are a common reaction to trauma in many cultural contexts: among traumatized Cambodians, dizziness and neck soreness are highly endorsed complaints (Hinton and Lewis-Fernández 2011; Jenkins 1996; Kirmayer 1996a; Mayer 2007). The reasons for certain somatic symptoms being so prominent in the trauma presentation of a certain group are multifactorial. They range from the nature of the trauma event; to the encoding of certain trauma memories in terms of somatic sensations; to great chronic arousal and frequent panic owing to a biological recalibration of the nervous system; to catastrophic cognitions about somatic symptoms such as attribution to certain cultural syndromes; to the symptoms being prominent in local metaphors used to express dysphoria, resulting in metaphor-guided somatization; to

the role of certain somatic symptoms as an idiom of distress in the culture in question (e.g., Good, Good, and Grayman [Chapter 12]; see also Hinton et al. 2012, 2013b). For example, among Cambodian refugees, a particular cultural syndrome is one reason dizziness and several other somatic symptoms are prominent: the syndrome referred to as "khyâl attacks" gives rise to multiple catastrophic cognitions about somatic symptoms, creating a hypervigilant surveying of the body for them, particularly for dizziness, in multiple situations said to trigger the khyâl attacks, such as engaging in worry or standing up.

Other than somatic symptoms, the following are some examples of symptoms and symptom complexes common in many traumatized populations but that are not in the DSM-5 criteria:

- Sleep paralysis is often a key symptom around which are centered an elaborate set of practices and beliefs (Hinton et al. 2005b).
- Substance abuse and acting out (externalizing) behaviors are also very common conditions among trauma victims but are not in the DSM PTSD criteria.
- Complicated bereavement is not in the PTSD criteria but is often a key issue, especially in situations of mass violence where brutal and widespread deaths occurred and where indicated rituals could not be performed.
- Cultural syndromes may constitute a key part of the local response to trauma (see the next section below on ethnopsychology/ethnophysiology/ethnospirituality) and result in trauma causing certain unique symptom clusters that relate to the cultural syndrome; these cultural syndromes, which are produced by the interaction of the biology of trauma and a set of expectations, among other variables, form a key part of the local presentation and experiencing of trauma.
- Multiple anxiety disorders, in particular panic disorder, panic attacks, and generalized anxiety disorder (GAD)-type worry, often co-occur with PTSD, and worsen one another (see also Good, Good, and Grayman [Chapter 12]).
- A general reactivity to worry and other negative emotional states is common in many traumatized groups, that is, the rapid induction of distress, arousal, and somatic symptoms.
- Frequent experiencing of the current problems–trauma complex (Figure 1.3), resulting in difficulties resolving problems, arousal,

and in much worsening of trauma-related disorder (Hinton et al. 2008, 2011).
- Frequent experiencing of the "thinking a lot" complex, that is, the hypercognizing complex, is common among traumatized groups (see the following section on ethnopsychology/ethnophysiology/ethnospirituality).

As indicated in this section and throughout this chapter and volume, the effects of trauma are broad, particularly when seen in cross-cultural perspective, and are much broader than the DSM-5 PTSD criteria. Hence our use of the terms "posttraumatic stress syndrome," or "trauma-related disorder" to indicate trauma symptoms in the broad sense. The particular symptom saliences and complaints typically found in trauma-related disorder in a certain group can be specified. In the Cambodian posttraumatic stress syndrome, prominent complaints include various somatic symptoms such as dizziness and migraine-type headache with aura; sleep paralysis; trauma recall; multiple somatic symptoms and panic triggered by many cues (e.g., standing up, encountering certain smells, engaging in worry, experiencing any strong emotion); bereavement and related practices; nightmares that are interpreted as the visitation by dead relatives; and syndromes such as khyâl attacks, heart weakness, and "thinking a lot," with the complaint of "thinking a lot" usually indicating the presence of—that is, episodes of—the "current problem–trauma" symptom complex, as shown in Figure 1.3 (Hinton et al. 2012, 2013b). The Cambodian posttraumatic stress syndrome, or trauma assemblage, also includes the local consequences of having the disorder (economic and interpersonal course) and ways of seeking treatment, for example, "coining" or meditation. In the Cambodian case, these complaints and symptoms, consequences, and ways of seeking recovery all also form key aspects of the life-world of trauma, of the biocultural ontology of trauma.[8]

The Meaning of the Trauma Event and Resulting Symptoms According to the Local Ethnopsychology/Ethnophysiology/Ethnospirituality

The local conceptualization of the nature of mental processes, bodily functioning, and the spiritual domain: all these will result in ideas about which symptoms will be caused by trauma, the meaning of those symptoms, and

how they should be treated. These understandings will amplify and even induce—through self-surveillance—certain symptoms following trauma. A key part of the trauma event memory is what the person thinks the trauma did to him or her, a key determinant of which is the syndrome that the person thinks to be caused by that trauma. There may result a certain trauma-based identity or self-schema, and there may result a certain spiritual-schema, such as the conceptualization of the spiritual status of those who died during a genocide. The syndromes that a group considers to be caused by a trauma event form a key part of the trauma meaning space, shape how trauma is enminded and embodied, and lead to particular ideas about the trauma's dangerousness, to a certain self-imagery of damage. Even if trauma-caused symptoms like startle and somatic distress are not linked in that cultural group to trauma, that is, the symptoms are not thought to be caused by trauma, those trauma-caused symptoms will be interpreted according to the local meaning systems. Consequently, the local ethnopsychology, ethnophysiology, and ethnospirituality will have a profound effect on the trajectory of trauma in a given context and on how the symptoms of trauma are experienced and treated and these understandings and actions will form a key component of the trauma ontology (Pedersen and Kienzler [Chapter 7]).

Experiencing trauma-related symptoms as "weak heart" in Cambodia will result in a very different trauma ontology than experiencing them as "PTSD" in the United States—different emphasized symptoms, different interpersonal effects, different identity effects, different ideas about the psychology and physiology generating symptoms, and different ways of attempting treatment (Hinton et al. 2002). The entirety of syndromes that are said to be caused by trauma in a culture along with all the syndromes to which trauma-caused symptoms are attributed might be called the network of trauma syndromes. This is illustrated in Figure 1.4 for Cambodian refugees (for the case of Quechua speakers in the Peruvian Andes, see Pedersen and Kienzler [Chapter 7, Figure 7.4]). More broadly, since Figure 1.4 also depicts ideas about the spiritual status of the dead and ideas about spiritual assault, it might be called the depiction of the spiritual and syndromic effects of trauma. As shown in Figure 1.4 and in Figure 7.4 in Pedersen and Kienzler (Chapter 7), often the syndromes and various idioms are thought to be interconnected in a causal network, and the network constitutes a local ethnotheory of trauma effects. These various syndromes—and the associated ethnopsychology, ethnophysiology, and ethnospirituality—are the matrix in which the trauma symptoms are interpreted.

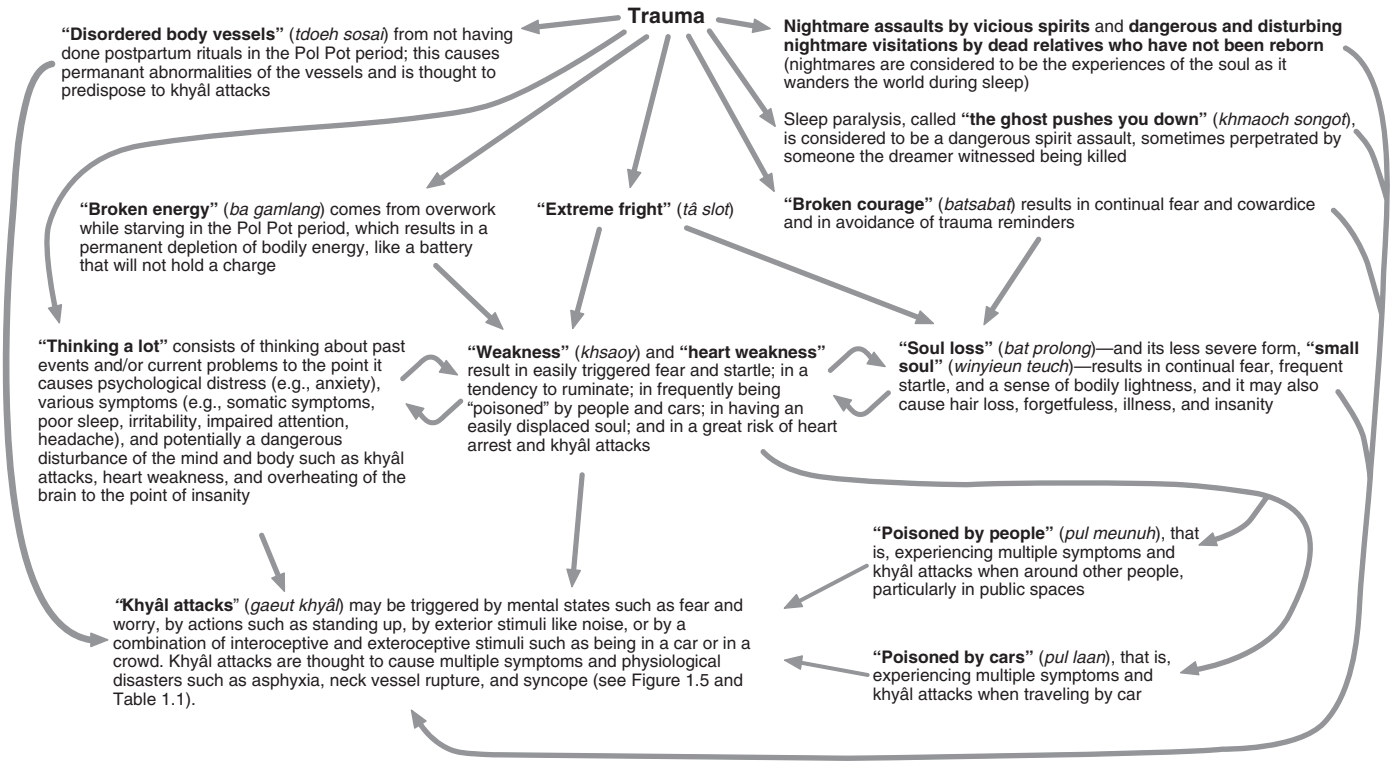

Figure 1.4. The trauma syndrome network among Cambodian refugees. This figure shows a syndrome network, a form of semantic network; moreover, it is a causal semantic network. The figure shows the causal network of closely related syndromes that shapes the Cambodian conceptualization of the effects of trauma. The figure depicts the processes of "circular causation" as conceptualized by Cambodians: "thinking a lot" causes weakness (e.g., it directly exhausts and impairs sleep and appetite), which then produces a predisposition to "thinking a lot," and so on. As another example, "soul loss" causes weakness, which then predisposes to soul loss, and so on.

In a particular cultural group, specific syndromes will be thought to be caused by trauma, such as PTSD in the United States or *susto* in certain Latin American countries. In other cultural contexts, what we in the United States would call a psychological trauma—seeing someone killed, being in a nearly fatal accident, being beaten—may not be considered permanently damaging with specific long-term symptoms. In the United States, bracket creep has resulted in increasingly minor events being considered traumatic and capable of causing the PTSD syndrome. The layperson's understanding results in PTSD serving for some as a sort of idiom of distress rather than a neurobiologically driven process (McNally [Chapter 2]; Young and Breslau [Chapter 3]): the person may label an event as traumatic and wonder about having PTSD, and then through self-surveillance come to take on the category's symptoms, even though most of the symptoms are due to anxiety and depression rather than to trauma. Whereas in the United States there is the idea that even minor trauma may produce PTSD, in some cultures, as in the Oaxacan (Duncan [Chapter 6]), the opposite seems to be the case: domestic abuse is not thought to cause PTSD. On the other hand, in Oaxaca events like humiliations or migration are increasingly considered to be traumatic and to induce PTSD and other disorders, with this new trauma ontology or episteme formed in large part by recent public awareness campaigns.

In many other cultural and historical contexts, events that in the modern West would be considered psychologically traumatizing are thought to cause psychological damage not because of their emotional impact but rather because of their directly damaging effects on the body; the bodily damage syndromes have psychological symptoms as secondary symptoms. These might be called physiopsychological syndromes, or somatopsychic trauma syndromes, in which DSM-type PTSD symptoms and other symptoms caused by the biology of psychological trauma are given a pathomechanic explanation involving initial damage to the body. Bodily damage explanations of the effects of trauma were very prominent in industrialized Western societies in the past (McNally [Chapter 2]; Young and Breslau [Chapter 3]; Boehnlein and Hinton [Chapter 4]), for instance, railroad spine in the nineteenth century in the United States. Or in some past wars, what was considered to cause PTSD-type symptoms like startle or constant fear were bodily damaging events (Kugelmann 2009): in the Civil War, exertions like carrying knapsacks were thought to damage the heart, or in World War I, exposures to blasts from bombs to damage the nervous system—and these bodily defects were

thought to cause what would now be considered anxiety and other psychological distress symptoms like startle or hypervigilance. In the ongoing wars in Iraq and Afghanistan, many are said to have traumatic brain injury (TBI), a disorder that has among its diagnostic criteria PTSD-like symptoms such as poor concentration and anger; but in a considerable number of cases the TBI-like symptoms seem to actually result from psychological traumas and daily stresses, from PTSD or general distress like anxiety and depression (Boehnlein and Hinton [Chapter 4]).

By way of contrast to these physiopsychological syndromes of trauma, current scientific theories of PTSD in the United States posit a psychosomatic-psychic causality (psychic event → brain changes → psychological symptoms), and this forms a common model in the lay psychology. According to this theory, a psychologically upsetting event is seared into the amygdala, and the amygdala and other brain structures will tend to cause all the psychological symptoms associated with trauma and the various reactivities such as startle (Ledoux 1996). This physiological model of trauma's effects is increasingly prominent in the Western imaginary of trauma, as found in representational spaces from talk shows to self-help books—plastic models of the amygdala held in the hand during explanations, the supposed location of trauma's central wound.

Cultural ideas shape the perceived dangerousness and specific effects of trauma, so that some types of trauma events may be locally interpreted as being more damaging than they would be in another cultural context. Cambodians consider that working while starving during the Pol Pot period had an especially debilitating effect on the body—that it made the body to be like a battery that cannot hold a charge—and so resulted in a permanent state of bodily weakness and heart weakness (*khsaoy beh doung*), with that heart weakness thought to result in PTSD-like symptoms such as startle, fear, and hypervigilance and in a predisposition to heart arrest and khyâl attacks. In terms of spiritual schemas, as discussed above, Cambodians and Rwandans consider that certain types of death as well as not performing indicated mortuary rituals may cause the deceased's spirit to enter a miserable state and to possibly become dangerous to the living. More generally, the inability to perform a ritual may lead to a sense of disorder in the mental, bodily, or spiritual realms, what we have referred to as ritual omission trauma. As another example of this, a Cambodian woman may believe that failure to do postpartum rituals during the Pol Pot period has damaged her vessels and predisposed

her to khyâl attacks, which may lead her to interpret trauma-related arousal from any trigger—like dizziness or palpitations that result from startle—as indicating the onset of a khyâl attack.

In the U.S. military, certain syndromes have shaped views about the dangerousness of war theater events. The Gulf War syndrome caused veterans of that conflict to fear that exposure to fumes might cause bodily harm and various symptoms, when in fact those symptoms resulted from anxiety and depression; as a result, veterans often came to reframe psychological distress as the Gulf War syndrome (Cohn et al. 2008; Jones and Wessely 2005; Kilshaw 2009). A veteran of the Iraqi war will expect that a trauma event involving explosions may bring about traumatic brain injury and those fears will cause him or her to be hypervigilant for amnesia, poor concentration, forgetfulness, headache, and certain other symptoms associated with TBI (Boehnlein and Hinton [Chapter 4]); consequently, among those having no actual brain trauma but who attribute psychological distress symptoms (e.g., those generated by PTSD and general anxiety and depression) to TBI, those psychological and somatic symptoms that have an equivalent in TBI will be emphasized (e.g., forgetfulness, poor concentration, headache), and there will be self-imagery of permanent damage. As these examples show, there is not just the trauma event itself but what the survivor thinks that the trauma did to him or her.[9]

The symptoms caused by trauma may be attributed to a syndrome that is not specifically caused by trauma according to the local understanding. That is, often the trauma-caused symptoms will be attributed to a cultural syndrome without trauma itself being perceived as the syndrome's cause. Much of the Cambodian experiencing of trauma-related experiencing plays out through the attribution of trauma-related symptoms to various syndromes, as indicated in Figure 1.4, and events of these syndromes in many cases will not be attributed to trauma:[10] startle and arousal-caused symptoms may be attributed to heart weakness, without trauma being thought to be the cause of the reactivity or symptoms. Or trauma symptoms may be attributed to spiritual assault rather than trauma. In several cultural contexts in Africa, the symptoms caused by trauma—from tinnitus to nightmare to sleep paralysis—are often thought to be brought about by spiritual assault and possession (see the next section on the religious/spiritual dimension).

Somatic symptoms are a key part of the presentation of trauma in many groups, and the interpretation of those somatic symptoms in terms of the

local ethnophysiology, ethnopsychology, and ethnospirituality—and related syndromes—will result in a specific trauma ontology (for one review, see Hinton and Lewis-Fernández 2011).[11] These attributions often lead to great concerns about imminent danger: if a Cambodian attributes arousal-caused somatic symptoms to "soul loss," heart weakness, or "thinking a lot" (see Figure 1.4), this will increase the perceived degree of dangerousness of those symptoms—and determine the indicated treatments. Let us examine in more detail a syndrome that greatly shapes the Cambodian experiencing of trauma-related somatic symptoms and that leads to severe catastrophic cognitions about those symptoms.

In the Cambodian context, trauma-caused arousal symptoms are often thought to be caused by a khyâl attack. Traumatized Cambodian refugees often have somatic symptoms brought about by various types of triggers: by triggers that are in the PTSD criteria such as trauma recall, anger, fear, nightmare, and sounds that startle, and by other types of triggers such as standing up, encountering certain smells, traveling in a car, entering complex visual and multisensorial environments (e.g., the mall or the temple), worry, and emotions such as sadness. The resulting arousal and somatic symptoms are often labeled as a khyâl attack, which leads to fears that the symptoms are produced by a dangerous dysregulation of khyâl, a wind-like substance said to flow alongside blood in the body (Figure 1.5, Table 1.1). Those catastrophic cognitions often lead to anxious self-surveying of the body for khyâl attack symptoms and the catastrophic cognitions lead to great fear upon seemingly discovering such a symptom. According to the Cambodian ethnophysiology, khyâl attack should be treated in certain ways, most often "coining," which entails pushing down the edge of a medication-dipped coin on the skin and dragging it outward such as down along the arms to help the flow of khyâl and its egress from the body (for a detailed description of khyâl attacks, including film footage of their traditional treatment, viz., coining, see www.khyalattack.com). The construct of khyâl attacks, in interaction with the biology of trauma, leads to the Cambodian trauma ontology prominently featuring bouts of arousal labeled as a khyâl attack: these bouts are triggered by what are considered typical triggers of khyâl attacks such as fright, worry, standing up, entering crowded spaces, and exertion, with the resulting arousal-caused somatic symptoms being labeled as khyâl attack symptoms, and with the sufferer of the bout attempting treatment in indicated ways, for example, by coining—and prevention by indicated means. (And

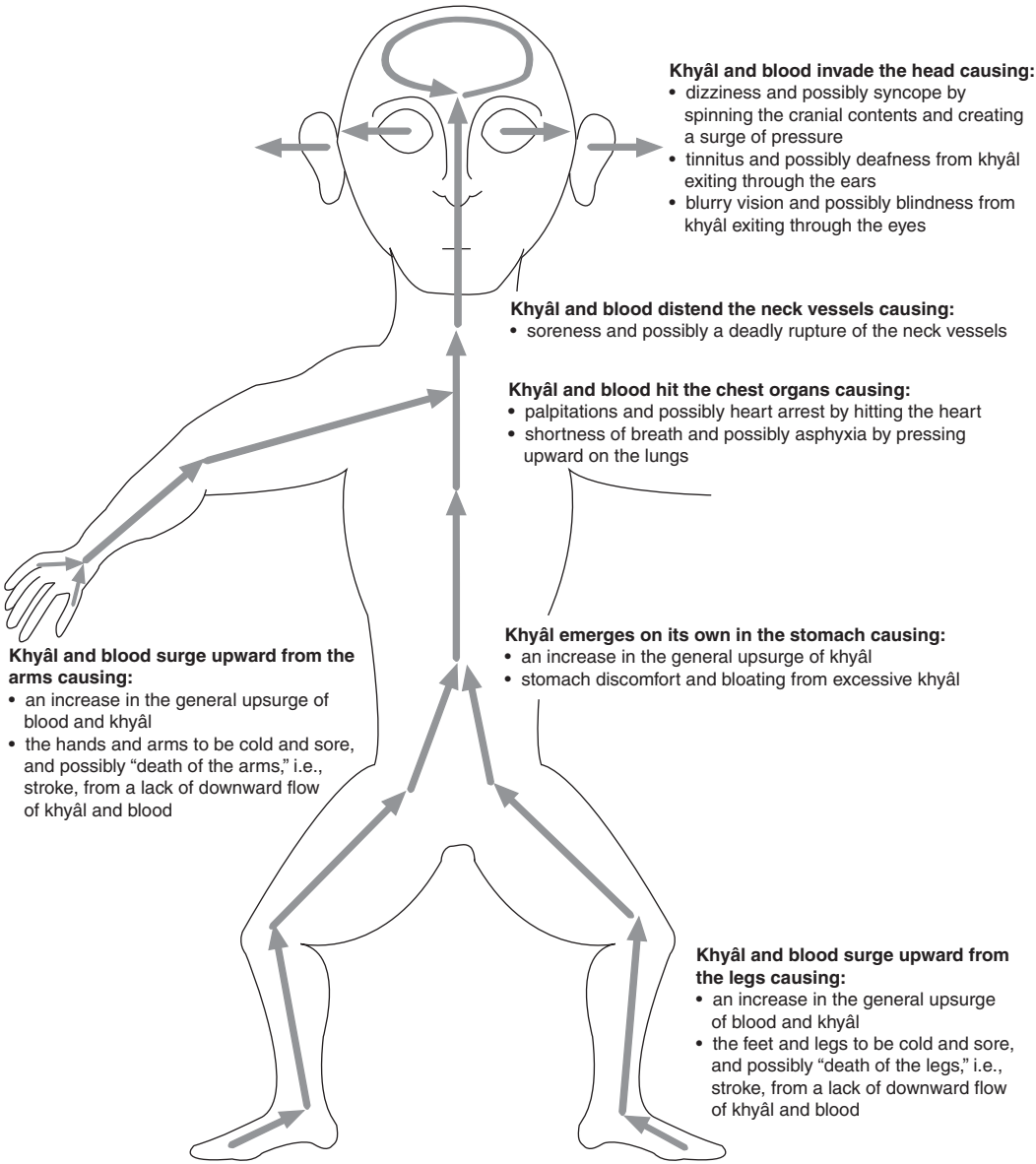

Figure 1.5. A khyâl attack: Ethnophysiology, symptoms, and associated disasters. The arrows represent the flow of khyâl and blood upward in the body during a khyâl attack. During the healthy state, khyâl and blood flow downward in the direction opposite to the arrows, with khyâl exiting the body through the hands and feet, through bodily pores, and down through the gastrointestinal tract, but during a khyâl attack, khyâl and blood surge upward in the body to cause the disasters outlined above.

Table 1.1. The Interpretation of Somatic Symptoms in Terms of a Khyâl Attack: Correlated Physiological State and Feared Consequence

Symptom	*Physiological state generating the symptom*	*Symptom-related fears (see Figure 1.5)*
Dizziness	A surge of khyâl and blood into the head	Syncope owing to khyâl and blood shooting into the cranium, and concerns that dizziness indicates the occurrence of a "khyâl attack" and associated bodily disasters, the most severe type of khyâl attack being called "khyâl overload"
Tinnitus	A pressure-like escape of khyâl from the ears; reflecting this, tinnitus is called "khyâl exits from the ears" (*khyâl ceuny taam treujieu*)	Deafness owing to khyâl shooting out of the ears, and concerns that tinnitus indicates the occurrence of a khyâl attack and associated bodily disasters
Blurry vision	A pressure-like escape of khyâl from the eyes	Blindness owing to khyâl shooting out the eyes, and concerns that blurry vision indicates the occurrence of a khyâl attack and associated bodily disasters
Headache	An upsurge of khyâl and blood into the head and its vessels	Syncope, and concerns that a headache (especially migraine-type headache with aura) indicates the occurrence of a khyâl attack and associated bodily disasters
Neck soreness	An upsurge of surge of khyâl and blood into the neck vessels	Bursting of the neck vessels, and concerns that neck soreness indicates the occurrence of a khyâl attack and associated bodily disasters
Nausea	An excessive accumulation of khyâl in the stomach and abdomen	Emesis that may "burst the gall bladder," and concerns that the khyâl may move up from the stomach to cause a khyâl attack and associated bodily disasters

(*continued*)

Table 1.1. (continued)

Symptom	*Physiological state generating the symptom*	*Symptom-related fears (see Figure 1.5)*
Palpitations	An upsurge of khyâl and blood that presses on the heart and interferes with its pumping; also, as part of a khyâl attack, there are blockages in the vessels in the limbs, so the heart must work furiously to pump blood and khyâl through the vessels, another cause of palpitations	Cardiac arrest, and concerns that palpitations indicate the occurrence of a khyâl attack and associated disasters
Shortness of breath	An upsurge of khyâl and blood that presses on the lungs and interferes with breathing	Asphyxia, and concerns that shortness of breath indicates the occurrence of a khyâl attack and khyâl overload and associated disasters
Soreness in the legs or arms	A blockage of the flow of khyâl and blood through the vessels in the limbs, particularly at the joints; reflecting this, "sore joints" are called "plugged vessels" (*cok sosai*) or "blocked khyâl" (*sla khyâl*)	"Death of the limbs" from a lack of outward flow along the limbs, and a surge of khyâl and blood upward in the body to cause various disasters
Cold hands or feet	A blockage of the flow of khyâl and blood through the vessels in the limbs	"Death of the limbs" from a lack of outward flow along the limbs, and a surge of khyâl and blood upward in the body to cause various disasters
Poor appetite	A direct effect of excessive bodily khyâl	Bodily weakness, including heart weakness, owing to poor appetite resulting in bodily depletion. Heart weakness results in disasters like heart arrest and produces khyâl attacks by causing poor circulation that results in plugs in the limbs

Table 1.1. (continued)

Symptom	*Physiological state generating the symptom*	*Symptom-related fears (see Figure 1.5)*
Energy depletion	Excessive bodily khyâl depletes energy directly; it also depletes energy indirectly as well by causing poor sleep and poor appetite	Bodily weakness, especially heart weakness, owing to bodily depletion. Heart weakness results in disasters like heart arrest and produces khyâl attacks by causing poor circulation that results in plugs in the limbs

too, dizziness and arousal present in panic attacks, such as those labeled as khyâl attacks, will often trigger trauma recall and negative memory more generally; see the multiplex models.)

A cultural syndrome that is prominent among the traumatized in many countries across the globe is "thinking a lot" (see Pedersen and Kienzler [Chapter 7]; see also Hinton et al. 2011, 2012, in press; Kaiser et al. 2014; Patel et al. 1995). "Thinking a lot" might also be called a hypercognizing syndrome, or a hypercognizing symptom complex. In many cultures, "thinking a lot" forms a local sociosomatic theory that links social distress to the experiencing of psychological and bodily distress (Kirmayer 2001; Kleinman and Becker 1998).[12] A bout often starts by "thinking a lot" about current problems, that is, by worrying about something (e.g., having money for rent, a child's truancy, health of relatives, or one's own health), but also may begin with other types of thoughts: depressive thoughts (e.g., thinking about past failures or those who have died), anger issues (e.g., thinking with anger about what a child has done), or trauma recall (e.g., recall of being beaten or doing slave labor while starving). Thus, what is "thought a lot" about is not only worry but also depressive and other types of cognitions, with all these types of thinking often coming one after the other in an escalating episode of distress. Among traumatized populations, "thinking a lot," whether it be worry, depressive thoughts, anger thoughts, or trauma recall, often induces mental and somatic symptoms, which then give rise to trauma associations, catastrophic cognitions, and certain ideas about treatment. For example, Cambodians consider that "thinking a lot" (*kut caraeun*) may bring about insanity and permanent forgetfulness through overheating the brain and may cause

death through the triggering of a serious khyâl attack; and Cambodians consider "coining" as a way of treating acute episodes and meditation as a way to prevent them.

There are several reasons why the "thinking a lot" syndrome is prominent among traumatized populations in countries having that idiom of distress. Trauma victims have a general tendency to engage in negative cognizing, with such episodes being labeled as "thinking a lot." Also, trauma victims often have many reasons to "think a lot," such as the trauma itself, having lost loved ones in a genocide, or being upset that the perpetrator has not been punished. As another reason for the prominence of "thinking a lot" syndromes in traumatized groups, "thinking a lot" syndromes often are centered on "thinking a lot" about a current problem, that is, worrying. Worry episodes, which will usually be labeled by the experiencer as "thinking a lot," are common and produce much distress among traumatized populations for the following reasons:

- Traumatized persons often live in difficult circumstances and so have multiple concerns that give rise to worry, and this worry will be labeled as "thinking a lot."
- Trauma results in a tendency to worry owing to trauma-caused hypervigilance to threat and difficulty in disengaging from negative states like worry.
- Trauma results in emotional and physiological reactivity to worry so that engaging in worry will lead to arousal and to multiple somatic symptoms such as palpitations, muscle tension, headache, and dizziness.
- Trauma increases catastrophic cognitions about the effects of worry and the induced mental and somatic symptoms owing to a general hypervigilance to threat.
- Many traumatized groups have catastrophic cognitions about the effects of worry: Cambodian refugees fear that worry-caused mental symptoms like poor concentration and forgetfulness will be permanent and lead to insanity and that worry-caused somatic symptoms like neck tension or dizziness indicate the onset of a khyâl attack.
- As we described above in the current problems–trauma complex (Figure 1.3), worry will result in bio-attentional looping processes and vicious cycles of worsening (on cultural syndromes, PTSD, and

looping, see Hinton and Lewis-Fernández 2011; Hinton et al. 2010; Kirmayer and Sartorius 2007). Thus, often a key part of trauma is not just the current problems–trauma complex but the hypercognizing-trauma complex, or "thinking a lot"–trauma complex, another key part of the trauma symptom pool.

Many chapters in this volume describe how cultural syndromes amplify and even induce the symptoms that are thought to be caused by the syndrome in question. Bio-attentional looping may occur as a result of a syndrome that shapes the experiencing of distress—for example, through the cultural syndrome amplifying and even inducing symptoms. See Figure 1.6 for a general model of how the cultural syndromes—including local lay understanding of a scientific syndrome—come to be enminded and embodied, become "forms of life" (Kishik 2008), lived ontologies. This model can be used for any of the syndromes discussed in this chapter, such as khyâl attacks.

To illustrate the processes in Figure 1.6, let us take the case of DSM-5-defined PTSD in those contexts where it is a diagnosis known by the local lay population. Increasingly as the DSM-defined PTSD construct has become known by laypersons in Western and non-Western cultural contexts, the understanding of the PTSD construct among professionals and laypersons in the society in question shapes the local trauma ontology. The Western concept of PTSD as understood in the particular cultural context in question shapes how trauma is experienced, how it is enminded and embodied, how it results in a certain social and economic course. PTSD as locally understood may come to be an idiom of distress as well—consequently, it may even be enacted during states of distress that are not produced by trauma. How does this induction and amplification of symptoms occur in the case of a cultural category or syndrome?

At the time of trauma, or at a later point, the person may experience upset and dysphoria and may wonder whether he or she has, or soon will have, any of the PTSD symptoms. If that person self-surveys for certain mental and physical symptoms such as jumpiness and hypervigilance or anger, then these symptoms may soon be discovered through a sort of attentional amplification; the symptoms may be induced by the expectation of their occurrence—the expectation of being in a state of hypervigilance, of reacting with startle to a noise, of responding to minor annoyance with anger, and of various triggers such as watching scenes of war evoking trauma memory. If that person keeps conjuring to mind a certain traumatic event, ruminates on it,

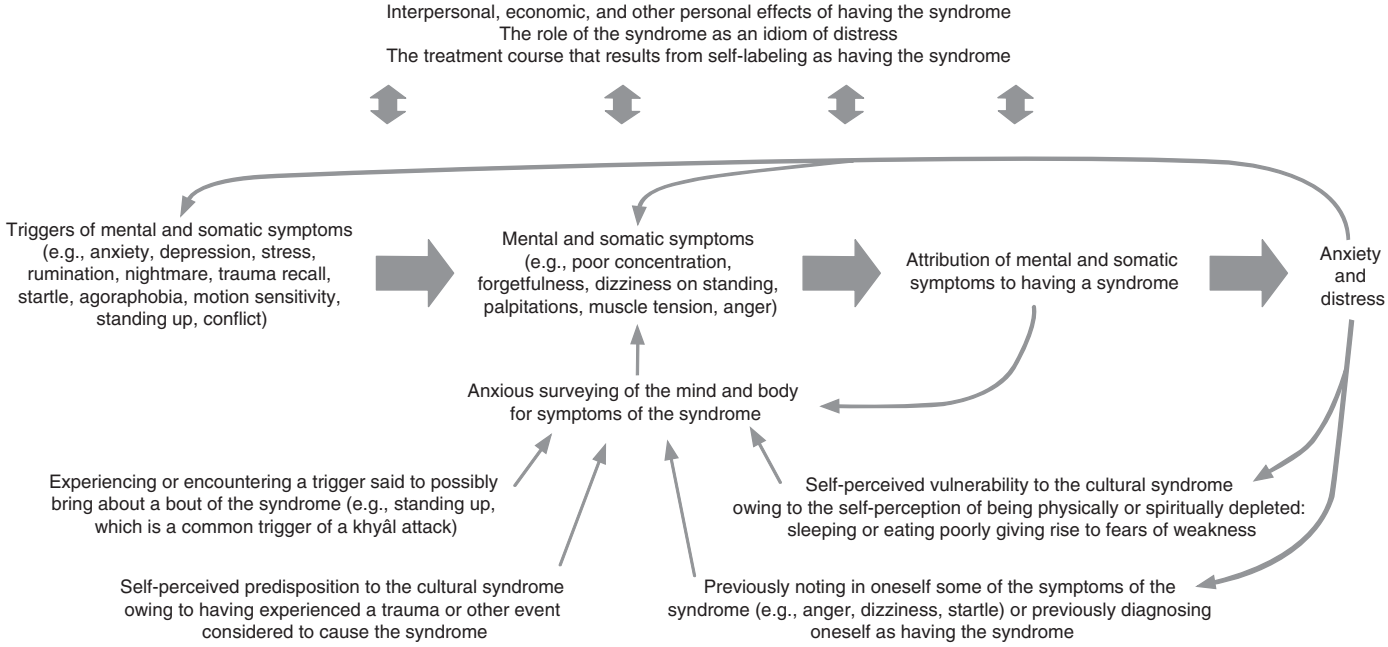

Figure 1.6. A multiplex model of the generation of a cultural syndrome. A trigger (e.g., anxiety, standing up, a conflict) brings about an initial symptom. Next, the attribution of a symptom to a syndrome will bring about more scrutinizing of the mind and body for syndrome-associated symptoms. This attribution often gives rise to catastrophic cognitions that then result in anxiety and distress, and that anxiety and distress may lead to more mental and somatic symptoms, which in turn creates more fear of having a syndrome. As indicated, hypervigilant surveying of the mind and body for symptoms results from several processes, such as experiencing a trigger that is known to cause a bout of the syndrome. This multiplex model is nested: it shows the importance of the reaction of the social network to the person having the syndrome and its symptoms as well as the economic effects and the effects of treatments that are self-administered, sought out, and received owing to labeling symptoms as a certain kind of disorder. Of note, in some cases a syndrome may not lead to anxiety and distress, but rather it may just serve as an explanatory frame for behaviors such as anger, even a justificatory frame, that is, a frame that excuses behaviors. But the rest of the model still applies.

continually views it with pained fear as being a pathogenic event that now explains all his or her woes and the tragic trajectory of life events, and if that person gives it a central piece in his or her life narrative, then the image may seem vivid and loom large in his or her mind. If the person hears others recounting such a narrative, and if the disorder and its symptoms are depicted in publically advertised medical literature, movies, TV, talk shows, and media, if having PTSD is seen as positively valenced, if having the disorder has positive economic effects (e.g., receiving monthly benefits), then the tendency to enmind and embody PTSD will be increased (McNally and Frueh 2013).

These same processes of culturally shaped bio-attentional looping will take place with all cultural syndromes attributed to trauma (for a description of how these issues play out among veterans of the Iraq war, see Finley 2011). To give the example of another contemporary war syndrome involving these types of processes, consider the case of "mimicked TBI" as a cultural distress syndrome, that is, the case of army personnel who have psychological distress without actual brain trauma but consider themselves to have traumatic brain injury (TBI). In such cases, a psychological syndrome masquerades as brain injury, and symptoms like poor concentration, poor memory, and poor anger control are sought out in self-surveillance, resulting in their amplification and induction, and those symptoms come to be framed in terms of a trauma ontology focused on that diagnosis. This model also applies to other war syndromes such as the Gulf War syndrome, in which olfactory sensitivity and other specific symptoms are emphasized (Cohn et al. 2008; Jones and Wessely 2005; Kilshaw 2009).

Religious/Spiritual Dimension

Religion and spirituality may be the main domain in which trauma events, trauma symptoms, and recovery play out (James [Chapter 11]). A religious frame may be used to comprehend violence and suffering as survivors seek explanations of why the trauma occurred, what the meanings of the symptoms are, and how the resulting suffering might be remedied. As indicated above, trauma-related symptoms like nightmares, somatic symptoms, and sleep paralysis may be shaped by and interpreted according to local religious ideas such as spiritual assault (Hinton et al. 2005a, 2009a): when a distressed Vietnamese survivor of trauma attributes somatic symptoms to the embodying of the wounds of the deceased through possession, or when a traumatized

individual from Guinea Bissau attributes tinnitus, palpitations, cold extremities, or racing thoughts to possession (de Jong and Reis 2010, 2013; Gustafsson 2009). Seen globally, trauma often plays out in a possession idiom (de Jong and Reis 2010; Igreja et al. 2010; Neuner et al. 2012; Reis 2013; van Duijl et al. 2010). Treatment of trauma-related symptoms may involve local religious traditions such as meditation and making merit in a Buddhist context or purification and possession rituals in certain animistic or shamanistic traditions (Gustafsson 2009; Hinton and Kirmayer, 2013; Nickerson and Hinton 2011; Reis 2013). Buddhism explains trauma and suffering in terms of karma; monks may also help people cope with their suffering by reciting scripture and by providing ritual objects and ceremonies thought to alleviate suffering.

Religious beliefs influence how a person deals with the death of others, memorializes and commemorates the dead, and imagines what happens to a person after death (Hinton et al. 2013c; Reis 2013). What is thought to occur after a person dies a certain kind of death, and what are the indicated rituals to ensure auspicious rebirth: these often have a profound effect on the meaning of a particular death. In many cultural contexts, the manner of death and the lack of death rituals may prevent the deceased from reaching the next spiritual level, may cause the deceased to become vengeful and dangerous rather than protective. Such beliefs may lead to bereavement causing more anxiety and fear than depression and to a sense of imminent assault and a lack of spiritual protection. For these reasons, mourning and issues of complicated bereavement, and trauma-related disorder more generally, may play out in an idiom of spirits—of attack by spirits, of placation of spirits, of making offerings and conducting ceremonies for spirits. Trauma-related disorder may be driven by bereavement issues such as when there is great concern that the deceased has not been reborn and when dreams of the deceased are deeply upsetting because they are considered to indicate the deceased is in a difficult spiritual place; in these ways, bereavement concerns and dreams may form a key part of local trauma ontology and a key cog in the generation of PTSD-like distress.

Public Representation of the Trauma Event and the Trauma Survivor

Every society will represent the trauma event and the trauma survivor in certain ways. These narratives of the event and the descriptions of the trauma

survivor will be found in a variety of domains that include public memorials, commemorative holidays and events, the visual arts, newspapers, books, television, state rhetorics, and public rituals. These representations shape how survivors view themselves and how they are viewed by others (Gustafsson 2009; Hagengimana and Hinton 2009; Hinton et al. 2013c; Kwon 2006, 2008; Perera 2001).

The survivor of certain kinds of trauma may be stigmatized in various ways, for example, as being somehow responsible for the event or being considered "polluted" afterward. The survivor's trauma symptoms may be said to result from weakness or malingering, or some other defect. In some cases, the trauma symptoms that seemingly relate to trauma—for example, substance abuse or self-cutting as a result of extreme distress following trauma—may not be recognized as resulting from a trauma, so that there is a blaming of the victim and a lack of awareness of the cause of disorder (Good and Hinton [Introduction]).[13] Trauma-type symptoms may be attributed to a combination of the trauma and "weakness," so that the condition is still stigmatizing (see Ball and O'Nell [Chapter 10] for a discussion of these issues as pertain to the veteran and Native American experience: the genogram and historical trauma as a compelling alternative public representation of the Native American trauma survivor).

The public representation of the trauma survivor will include the cultural syndromes associated with the trauma and its symptoms, both syndromes attributed to trauma and those not attributed to trauma but that are the common interpretations of trauma symptoms. These syndromes will create expectations about the individual that then take on a self-fulfilling role. Namely, these syndromes will create expectations about the individual in the form of symptoms, behaviors, and indicated interventions, and they will result in the person having a certain syndrome-based identity (Hollan 2004). To give some historical examples, three disorders were common PTSD-like presentations in World War I, and each was a radically different representation of the effects of war, and each created a radically different syndrome-based identity: shell shock was a war syndrome in which exposure to bombs seemingly "shattered" the nervous system, leading to certain stereotypical movements among other symptoms, and the disorder suggested cowardice; other guises of trauma-related disorder in that war were soldier's heart and neurasthenia, but these conditions were less stigmatizing (Jones and Wessely 2005; Kugelmann 2009). To take the example of a more recent war, the diagnosis of Gulf War syndrome was less stigmatizing than that of anxiety

or depression, and having the syndrome had different interpersonal, economic, and identity effects. In the public media representation of the Iraqi war, PTSD and TBI seem to be two highlighted disorders, with a conflation of constituting symptoms often occurring. In the case of public representation of both TBI and PTSD resulting from the Iraqi war, through newspaper media and such movies as the *The Hurt Locker* (Bigelow 2008), there are salientized a certain sensitivity of the nervous system, poor concentration, forgetfulness, and predisposition to anger.

Public representations are not static but continuously enacted and created in various settings including institutional ones. Take the case of an event the first author (Hinton) witnessed at the Vietnam War Memorial in Washington, D.C. When the first author visited that memorial, the guide, a Vietnam veteran, said that the tactile sense he experienced upon rubbing his finger across the names of the victims chiseled in marble had the power to evoke the sensory-scape of Vietnam: the sounds of planes, the smell of sulfurous bombs, and the image of bloody bodies. In this narrative there is an interaction of the space of remembering, the specificity of the memorial, the biology of trauma, and expectations about what passing through a trauma event will do to the individual. This veteran is producing at the space of the memorial a common public representation of the effects of the Vietnam War, according to which continued sensorial reliving in memory is a prominent aspect of that war's effects. The inner-seared image that is continually relived is like another memorial to the events, an inner badge. In certain war syndromes, anger or startle may play a similar role: icons of having endured an unutterable horror, of having carried the burden of a nation, of having made a supreme sacrifice.

Age and Gender Space

Age and gender influence trauma exposure, structural violence, stigmatization upon being traumatized, and ability to recover from trauma. There may be age- and gender-based vulnerabilities to encountering traumas and to its negative effects, and age and gender will influence the experiencing and trajectory of trauma-related disorder (Jenkins and Haas [Chapter 5]; Duncan [Chapter 6]). Early trauma predisposes to the development of a general reactivity and severe posttraumatic stress syndrome (Farmer 1997; Honwana

2006; Straker 1992; Suleiman 2006; Trawick 2007). Youth may be exposed to intergenerational trauma, such as having traumatized parents who exhibit mood extremes and have an impaired ability to nurture. Also, traumas such as spousal abuse and sexual violence may vary by gender, and gender may influence the stigmatization resulting from trauma: a rape victim being blamed for what occurred and being labeled as "polluted" (Coulter 2009). Also, age and gender may impact exposure to structural violence and the ability to recover after mass violence: in certain cultural contexts, a woman may have especially poor economic prospects after the death of a spouse during a genocide, and she may face cultural prohibitions against remarriage for women.

Social Dimension

Violence and its aftermath are situated in given social contexts, ones that may undergo significant transformation through trauma (Hobfoll 2012; Lischer 2005; Lubkemann 2008). Trauma survivors reside in a certain family and social structure, and it is there that trauma's main effects may be felt, and the trauma events themselves may emerge in the family itself in the form of spousal or child abuse (see Jenkins and Haas [Chapter 5]; Duncan [Chapter 6]). Trauma may shatter a family through the trauma-caused anger of the parent, spouse, or child or through trauma-caused silences and nonverbal behaviors (Argenti and Schramm 2010; Hinton et al. 2009c). On a group level, trauma may have its effects through the social interactions and social structures brought about by drug use, violence, and defeatism (Jenkins and Haas [Chapter 5]; see also Evans-Campbell 2008; Gone 2009). Trauma symptoms and syndromes are treated and reacted to at the level of family, creating a certain interpersonal course of trauma symptoms: Cambodian refugees often consider anxiety symptoms and panic attacks to be a khyâl attack—that is, a surge of khyâl and blood upward in the body that compresses the lungs, causing asphyxia, and hits the heart, causing palpitations (see Figure 1.5 and Table 1.1), among other disorders—and they often ask family members to treat the symptoms by coining and by other methods, including massage.

The intactness of the family and its manner of functioning will impact on resilience and current levels of stress. There may be a loss of relatives and

friends, for example, owing to a genocide or to living in a community marked by drug overdoses, violence, and poor medical care. There may be social abandonment as a result of parental separation, which is all too common in settings of poverty (Jenkins and Haas [Chapter 5]; James [Chapter 11]). A person displaced from a country or community owing to civil war or other reasons will lose the support of friends and others (Hinton et al. 2010). There may be loss of connection with deceased ancestors, a key issue in cultural groups that emphasize that the dead interact with the living; in those cultural contexts the social network includes not only the living but the dead.

Idioms of distress and the local sociosomatics are also an important aspect of the social dimension. Within a particular group, certain syndromes or somatic symptoms will be considered key idioms of distress, that is, typical complaints of those under great stress, and thus indicators of ongoing interpersonal and other social problems (Kirmayer 2001). The cultural syndrome of "thinking a lot" functions as an idiom of distress in many cultural contexts, with "thinking a lot" often centering on worry and problems with the social context: a conflict with a child or spouse. The complaint evokes a certain theory of sociosomatics, according to which social problems may cause mental distress and somatic symptoms, possibly even death or insanity (see Figure 1.3). Or many somatic symptoms will be understood by members of a social group on a metaphoric level. In the United States, a trauma victim's complaint of back pain may be understood by others as indicating the person to be "overburdened" in the metaphoric sense (Hinton and Lewis-Fernández 2010). Dizziness has multiple metaphoric resonances in the Cambodian context and is a key presentation of social distress (Hinton et al. 2012), as is the case in China (Kleinman and Kleinman 1994; Park 2009).

Economic-Environmental Context

Each person inhabits a certain economic and environmental space. The person's economic-environmental situation includes the safety of self and family members (e.g., the probability of assault), level of income, housing, and access to water and food. These issues impact on ontological security (Pedersen and Kienzler [Chapter 7]; James [Chapter 11]; see also Green 1999; Hinton et al. 2009a; Hobfoll 2012).[14] If concerns about these life domains are acute,

then this may intensify the effects of trauma by bringing about repeated activation of the autonomic nervous system and an emergency mode. This will worsen PTSD symptoms, for example, trauma recall, irritability, hypervigilance, and nightmare, and other symptoms as well, like sleep paralysis, somatic symptoms, and panic attacks (on such symptoms, see Cougle et al. 2010; Friedman and McEwen 2004; Hinton et al. 2005b); and then these symptoms—and others of the arousal complex[15]—may have reverberating effects on the other ontological levels such as that of the family. Additionally, those with fewer economic resources often have varying knowledge of, access to, and options for health care, resulting in health insecurity, with higher loads of health care burden—another stress and topic of worry. Above we provided a model of how worry, stress, and ontological insecurity worsen symptomatology, creating vicious circles of worsening (see Figure 1.3), a model of how current life stresses produce somatic symptoms and disorder. The economic dimension also drives which treatments are locally offered, be they pharmacologic interventions by firms, new paradigms of treatment produced by researchers who are funded by national agencies, or humanitarian interventions.

Juridical and Political Space

How the effects of trauma play out will be influenced by juridical and political issues. In the case of mass violence or acts of violence that are endemic in a society, whether perpetrators are punished may influence symptoms, in particular the degree of anger of survivors (see McNally [Chapter 2]; Ball and O'Nell [Chapter 10]). There is also the key issue of what compensation is given to the trauma survivor such as disability payments and whether asylum status will be granted (Fassin and Rechtman 2009). How these justice issues are handled will vary across societies. So too will the specific juridical processes by which this occurs, processes that produce a certain public representation of trauma survivors; for example, those persons having certain traumas and symptoms may obtain disability benefits and refugee status. These determination processes will involve institutional-based rules and dramas of adjudication, which shape public representations of the traumatized and lead to certain sets of traumas and symptoms as scripts that the trauma survivor may tend to enmind, embody, and enact—or at least emphasize among other

possible presentations. These scripts will shape the experiencing and presentation of the trauma survivor.

Resilience/Recovery/Treatment Dimension

The course of trauma-related disorder and its symptoms will be highly influenced by sources of resilience, recovery processes, and treatment sought and obtained for the condition (Collura and Lende 2012; Hinton and Kirmayer 2013). How the person attempts to deal with the trauma and to recover from its symptoms will vary greatly and will be profoundly influenced by cultural context (Ball and O'Nell [Chapter 10]; Good, Good, and Grayman [Chapter 12]). The trauma events and the resulting symptoms will lead the person to consider him- or herself to have some sort of disorder, which will result in certain treatments and attempts at recovery. The group may provide a source of resilience in various domains such as in ethnopsychology: in Cambodian Buddhism, many Buddhist-inspired idioms help to distance from negative affect ("you should stay far from your mood" [*niw chagnay pii arom*] or "you should change your attentional focus" [*gat ceut*]), and so too many proverbs such as "keeping yourself from getting excessively angry once will gain you a hundred days of happiness" (Nickerson and Hinton 2011). Public health announcements on television about the effects of trauma and about trauma-related symptoms may influence whether treatment is sought; self-help books or CDs may be used. Specialized mental health facilities may provide treatment, which may consist of receiving a selective serotonin reuptake inhibitor (SSRI), for example, Prozac, or receiving cognitive-behavioral therapy that involves the repeated discussion of the trauma event. Local healing traditions may be sought out for treatment of symptoms: Cambodian refugees may label somatic symptoms like dizziness and palpitations experienced upon trauma recall as a khyâl attack and ask a family member to do coining (Hinton et al. 2010), or a Cambodian may interpret a nightmare as a spiritual assault and consult with monks and perform religious rituals (Hinton et al. 2009a).

Each person is in a certain trauma-recovery space. How recovery plays out will depend in large part on the professional and lay syndromes that become frames of understanding and experiencing; those syndromes result in certain types of help seeking on the part of the individual and certain institutional-based interventions. In the cultural context, the trauma recovery

episteme, that is, the conceptualization of how treatment should occur for trauma-caused symptoms, will have both professional and lay versions, each of which will be heterogeneous as well, such as multiple professional subdivisions. The trauma-recovery apparatus (*dispositive*) is formed by the actual recovery processes that are available from the level of local ethnopsychology, to traditional healers, to medical treatment centers.

Ethnography should be done to determine how persons with psychological trauma tend to recover on their own (e.g., sources of resilience), where they tend to receive treatment, and how they typically present to get treatment (the gateway distress presentation), such as with a somatic complaint to the primary care physician or with spirit possession to a local healer. The trajectory of trauma symptomatology depends on the part of the trauma recovery apparatus the person is engaged in, which will have variable effects on that individual and that individual's familial and general existential situation. If the psychological trauma is labeled as PTSD and treated with a selective serotonin reuptake inhibitor (SSRI), for example, Paxil, and given by a particular person in the health care system, what are the effects (Jenkins 2011)? How is the treatment described to the person and what is the person's understanding of the given diagnosis and medication, and does this create a new explanatory frame that is a key part of the hybrid trauma ontology? Does the pharmacological treatment result in medicalization, that is, using pills to treat symptoms that ultimately result from current issues of stress such as lack of housing, without addressing that problem? And even if the economic-environmental origins, such as poor housing, are not addressed, does the medication help the person improve to the point of coping better and hence aid recovery (Good, Good, and Grayman [Chapter 12])? Or does the medication do no good? How much does ontological security—such as economic insecurity and ongoing threat of spousal abuse and other forms of violence—persist and make recovery impossible?

The global trauma industry alters local recovery processes through advertisement, clinical trials, efficacy claims, and the actual effects of medications and other treatments it offers (Pedersen and Kienzler [Chapter 7]; Good, Good, and Grayman [Chapter 12]). Governmental agencies fund certain types of research, resulting in the production of certain types of knowledge about trauma, and pharmacological companies will conduct studies and try to create markets for their products (Jenkins 2011). Therapy trial results may make their way into journals and physician trainings and ultimately daily practice. News outlets like the *New York Times* publish stories about

the struggles of particular war veterans and other trauma survivors, and about novel treatments and treatment trials. In international contexts, humanitarian agencies and others often follow the flow of money to conduct studies desired by national and international agencies, which will lead to certain types of interventions being implemented and certain ways of determining effectiveness. These various agencies—the pharmaceutical industry, foundations, national agencies—constitute another set of institutions, explanatory frames, and zones of trauma ontology production (Fassin and Pandolfi 2010; Fassin and Rechtman 2009).

A Typology of Errors

In this section we outline certain mistakes the researcher may make when studying trauma-related disorder in another cultural context.

Decontextualization Error

To fail to examine the situation of trauma victims and their key symptoms in terms of the eleven analytic dimensions is to commit an error of decontextualization.[16] Learning to contextualize trauma survivors and their complaints in respect to these eleven analytic dimensions is to acquire "contextual competency." Let us take an example of a symptom decontextualization. If the investigator ignores the ethnopsychology, ethnophysiology, and ethnospirituality according to which a presenting symptom—whether it be dizziness, startle, poor concentration, nightmare, or some other symptom—is understood by the experiencer, the investigator commits a decontextualization error, a semantic-type decontextualization.[17] Of note, the origins of symptoms in each of the ontological zones, as well as the effects in each of the zones, should also be assessed.

Medicalization Error

Medicalization is one type of decontextualization in which the clinician focuses on the patient's presenting complaint solely in terms of nosological

categories and the related putative biological origin.[18] The clinician considers symptoms only from the perspective of DSM categories, tracing the disorder from abnormalities of brain chemistry to psychological and somatic symptoms, and ignores other possible causes such as social conflict, poverty, and community violence—and the clinician neglects to consider the effects of symptoms in other ontological domains, such as how trauma-caused anger results in family level effects. To determine the dimensions omitted through such medicalization, the researcher can use the eleven-dimension analysis. It may not be possible to intervene in other dimensions, or at least not immediately, but all these levels should be examined, what might be called cultivating "places for listening" (Fassin 2012).

Neglect of the Interaction Across Ontological Levels

An intervention at any one of the ontological levels affects the others. Even a narrow medical intervention may have effects throughout the different levels. The biology of trauma produces certain symptoms that if addressed by medication may lead to improvement in other ontological dimensions (see Good, Good, and Grayman [Chapter 12]). If a pill such as a selective serotonin reuptake inhibitor (SSRI), for example, Paxil, helps a person to sleep better and be less irritable, then that individual may cope better with current life issues and have less interpersonal conflict.

Neglect of Ontological Security and Its Genealogy

This chapter and others in the book illustrate ontological security to be a key analytic dimension (see too Green 1999; Hinton et al. 2009a; Hobfoll 2012; James 2008). Ontological security ranges from bodily health to spiritual, financial, and personal safety. Trauma victims are very sensitive to issues of ontological security. After a trauma, the survivor will continue to have a sense of being under threat, to have the feeling that a trauma or some other dangerous event is about to occur; consequently, the survivor will have a hyperreactive response to a threat, for example, the rapid induction of strong

physiological arousal as well as recall of past traumas. Owing to being in this state, if the trauma survivor experiences actual current threats to security, those threats will greatly worsen trauma-related disorder through these multiplicative processes.

One way to assess ontological security is to profile current worry.[19] To do so, as a first step, the researcher should analyze the types and content of worry (Hinton et al. 2011). Next the researcher should try to construct causal models of the relationship of worry to PTSD and other aspects of trauma-related disorder, which can be based on the current problems–trauma model (see Figure 1.3): investigating such variables as symptoms induced by worry and catastrophic cognitions about those symptoms as well as determining how the symptoms are locally treated. Such multiplex models of worry (Figure 1.3) reveal a more complex and dynamic view of trauma-related disorder, situating it within the frame of ontological security.[20]

The genealogy of the current ontological security situation, its historical origins, should also be elucidated, as several chapters in this volume illustrate (Jenkins and Haas [Chapter 5]; Ball and O'Nell [Chapter 10]).[21] This includes the study of the intergenerational transmission of psychopathology, disadvantage, and suffering—what might be called micro-history as compared to macro-history. The dangers and difficulties in the local context—from stresses to traumas—may result from historical conditions of trauma and insecurity. The delineation of this genealogy may have a direct therapeutic effect for the population in question. By highlighting the dynamic origins of the current situation of ontological insecurity, genealogy gives insight into needed changes and how they may be brought about. When persons in these contexts become aware of this history and see themselves as partially the products of those forces, that historical consciousness may lead to a new sense of agency and self-esteem (Ball and O'Nell [Chapter 10]). Also, ways can be designed to attempt to address aspects of historical trauma, such as re-enculturing (e.g., revival of key cultural traditions) to address the loss of cultural traditions, thereby bringing a new group- and self-image and making available a new mode of being-in-the-world that may promote healing (see also Gone 2013; Hinton and Kirmayer 2013). (Though some have argued, such as Fassin and Rechtman 2009, that the belief in historical origins may give rise to a sense of profound victimhood and a justificatory frame for current dysfunction

that seemingly impedes recovery, particularly if economically or otherwise reinforced.)

Overinclusion Error

The investigator commits this sort of error upon assuming that a symptom that is part of psychological distress in one cultural context exists in another when in fact it is not present or minimally so. For example, in the DSM-IV PTSD category, one finds certain symptoms—amnesia for a trauma, estrangement and detachment from others, or numbing (and all these symptoms except "numbing" are found in the DSM-5 criteria)—that may not be present prominently in many other cultural contexts.[22] It is very difficult to translate to other languages the PTSD criterion of feeling of detachment or estrangement; the item suggests a sort of derealization or depersonalization that is part of a certain history of theorizing in the West about trauma's effects. Likewise, it is very difficult to translate the term "emotional numbing" to other languages; again, the idea of emotional numbing seems to arise from the particular history of trauma in the Western context guided by theories of the cause of trauma-related disorder (as noted above, numbing is a PTSD criterion in DSM-IV but not in DSM-5).[23] (The overinclusion error, and the following errors, for example, category truncation error and salience error, parse different types of "category errors" [Kleinman 1988].)

Category Truncation Error

When a researcher does not assess a symptom or syndrome that is a key part of a construct in a certain location, for example, a salient somatic symptom or an important cultural syndrome, we refer to this as a category truncation error. This type of error results in a lack of "content validity" in assessing trauma-related disorder in the locality (Hinton and Lewis-Fernández 2011), a truncation error. A prominent part of the trauma response in a locality may extend beyond PTSD symptoms, as indicated in Figure 1.2 in the box labeled "the trauma symptom pool"; for example, the trauma response may include somatic symptoms, cultural syndromes, panic attacks, panic disorder, uncontrollable worry, substance abuse, low self-esteem, complicated bereavement,

and disrupted family bonds (see McNally [Chapter 2]; Young and Breslau [Chapter 3]; Jenkins and Haas [Chapter 6]). The centrality of these other trauma-related symptoms can be examined by various means: factor analyses of the PTSD items along with these other trauma-related symptoms (e.g., somatic symptoms) may reveal that these other symptoms are the highest loading items in one-factor solutions (e.g., as we found for "thinking a lot" among Cambodian refugees; see Hinton et al. [in press]).

Salience Error

When assessing PTSD symptoms and trauma symptoms more generally, researchers often disregard differences in salience, namely, of frequency and intensity. We refer to this as a salience error. A difference in symptom salience may result from profound cultural differences, such as from any of the eleven dimensions discussed above (see Figure 1.1).[24] Ongoing threat and danger may lead to arousal symptoms like startle being prominent. Anger may be prominent owing to a perceived lack of justice, both in the sense of the perpetrator not being punished and the victim not receiving what he or she considers just—social security disability or citizenship (McNally [Chapter 2]). Many trauma symptoms will be more salient in a particular cultural context owing to their attribution to certain cultural syndromes and to their centrality in the local ethnopsychology, ethnophysiology, or ethnospirituality (for these issues, see also Pedersen and Kienzler [Chapter 7]; Alcántara and Lewis-Fernández [Chapter 8]): if a culture gives elaborate meaning to nightmares—such as considering them to indicate the spiritual status of the deceased—then nightmares may take on particular salience and become a key part of the trauma ontology in that context (Hinton et al. 2009a).

To avoid a salience error, the investigator should first examine the spectrum of responses to trauma in a locality because there is a wide range of possible symptoms other than DSM-5 symptoms as indicated in Figure 1.2 in the box labeled "trauma symptom pool"[25] (doing so also prevents a category truncation error). Next the investigator should determine whether any of these are especially salient aspects of trauma-related disorder in a particular context. For example, drug abuse or self-cutting may be highly salient symptoms in one context (Jenkins and Haas [Chapter 5]), and suicidality or depression in another. Once such saliences are discovered, the mechanisms causing those differences need to be examined (see below, the sections

"biocultural causal model" and "local causal model"): in the Cambodian case, examining why somatic symptoms, panic attacks, such as those triggered by standing up and by worry, and panic disorder are such prominent aspects of their trauma-related disorder.

Let us examine how a salience error can be committed in assessing somatic symptoms. From a cross-cultural perspective, somatic symptoms are prominent in trauma presentations, and certain somatic symptoms will be salient in a particular cultural context. Four types of salience errors can be made in respect to somatic symptoms. One error is not to assess somatic symptoms and note their salience in a group. Another error is not to assess subtypes, such as pain symptoms versus panic-type symptoms. Yet another error is to not assess the saliency of particular symptoms; as part of the assessment of the trauma response, not just somatic symptoms in general but specific somatic symptoms should be profiled, that is, not only rates and severity of aggregate symptoms but also rates and severity of individual symptoms. And finally, the frequency of types of particular subtypes of a symptom, such as dizziness that is triggered in particular ways, for example, by standing up, should be assessed (see the section "abstraction error"): in the Cambodian context, dizziness is a frequent and severe symptom, and so too dizziness on standing (Hinton et al. 2012, 2013b). To not assess individual salient symptoms is to commit an abstraction error (see the section "abstraction error"), that is, to commit the error of examining a broader category, when differences will only be found when examining particular items: this occurs if the investigator determines somatic symptoms as a whole, such as on a scale, and does not scrutinize individual symptoms such as dizziness.

Abstraction Error

Researchers commit this type of error when they examine a general class rather than its subunits, the concrete exemplars, for example, "somatic symptoms" rather than specific somatic symptoms. Individuals do not experience somatic symptoms but rather specific symptoms such as dizziness, and not just dizziness, but dizziness of a certain type—such as that having a certain quality (e.g., true vertigo or a sense of imbalance) and that having a certain trigger (e.g., standing up or fear)—and these are the true forms of actual experiencing, the units of actual phenomenological experiencing, the experience-near categories (Kleinman 1988). And an abstraction error is also committed

when a symptom like anger or dizziness is not contextualized in respect to the local semantic and causal networks. For example, there will be local terms for anger, often several types, each of which may have a slightly different meaning, different metaphors. There will be a certain ethnopsychology and ethnophysiology of anger. There will be certain common causes of anger in the cultural group. There will be certain ways of treating it. Likewise, a somatic symptom can be so examined, contextualizing it in its semantic networks—and causal networks (see the following two sections on "causal models"). In this way an abstraction error is avoided.

Not Assessing Biocultural Causal Models

Often researchers describe an idiom of distress or syndrome without exploring its semantic network (Good 1977), and often without showing how the idiom of distress or syndrome involves multiple interacting processes that may unfold in specific episodes as depicted in what we have called multiplex models (e.g., Figures 1.3 and 1.6). This might be called a semantic-type and a dynamism-type abstraction, and it is an abstraction from psycho- and biopathological processes that occur in time. Biocultural causal models show the interaction of various types of processes in time, such as triggers, cultural models, trauma associations, catastrophic cognitions, and somatic symptoms that are induced by arousal. The models reveal how idioms of distress and syndromes form dynamic networks and particular episodes that unfold in time. These multiplex models, for example, the current problems–trauma model (Figure 1.3), depict symptom complexes, causal networks, that are key aspects of trauma-related disorder in a locality. One needs to examine not just symptoms, but these causal networks.

Not Assessing Local Causal Models

The researcher needs to determine the local causal network models that articulate how a complaint is locally understood. To give an example, the symptom of worry can only be understood in the context of "thinking a lot," because this is the way that local populations often label events of worry. The model of the Cambodian conceptualization of "thinking a lot" is shown in Figure 1.7. This might be called a local causal network model of a syndrome

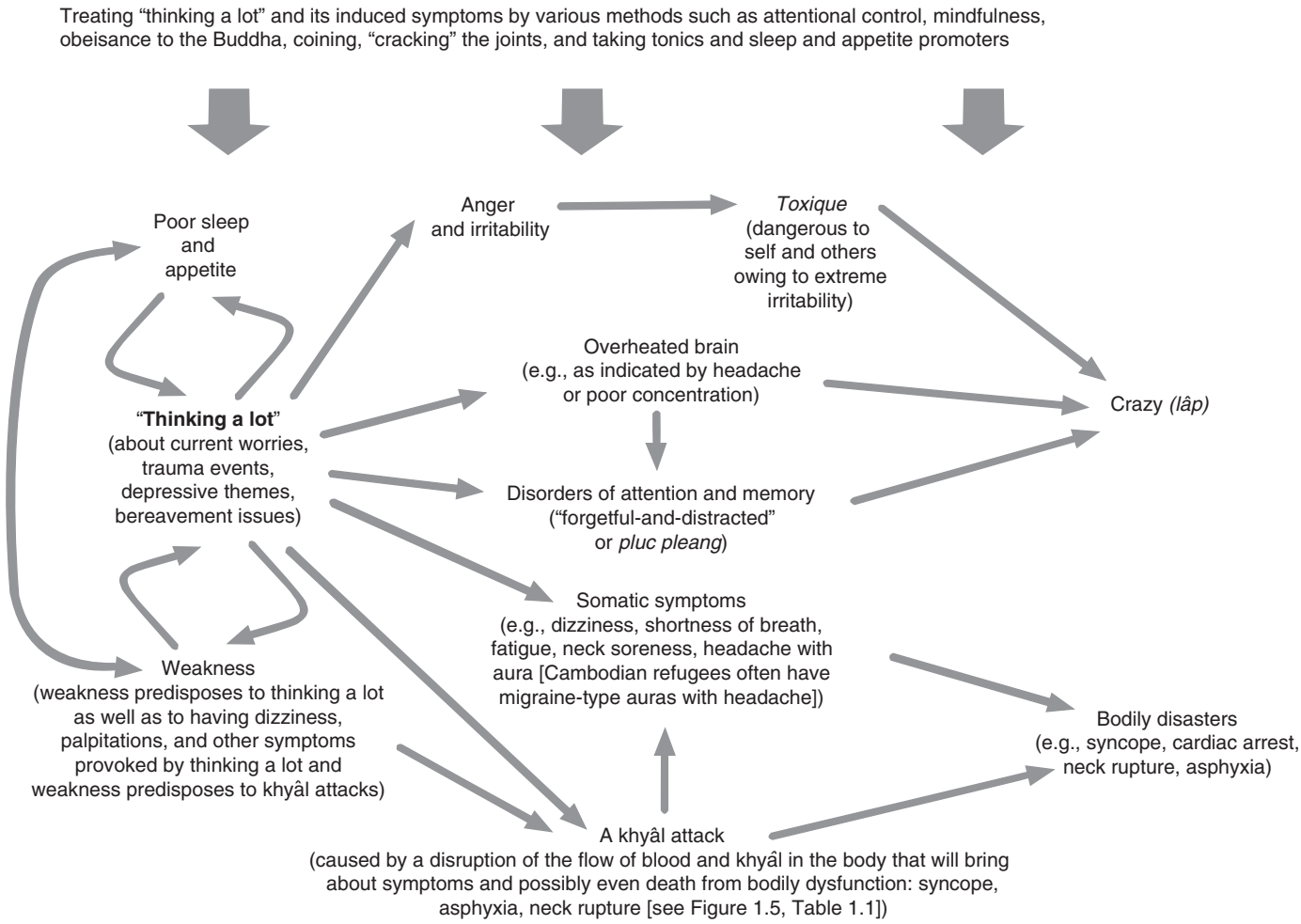

Figure 1.7. The Cambodian causal network model of how "thinking a lot" generates distress and how thinking a lot should be treated.

or idiom of distress, in that it shows the Cambodian conceptualization of what the syndrome or idiom of distress causes and what it is caused by, and how it is should be treated.[26] In turn, "thinking a lot" can be situated in the more general understanding of how syndromes occur (Figure 1.6), and local ideas about the effects of trauma (Figure 1.4; cf. Pedersen and Kienzler, Figure 7.4 [Chapter 7]). These kinds of models combine semantic network analysis and episode analysis in order to avoid both a semantic-type error and a dynamism error, both abstraction errors.

Multiplex Models of the Effects of Trauma

In this chapter, we presented dynamic biocultural models of how distress and cultural syndromes are generated in traumatized populations (see Figures 1.2, 1.3, and 1.6), as well as dynamic models showing how local populations consider different types of distress to be generated (see Figures 1.4 and 1.7). Elsewhere we have referred to these as multiplex models, which are characterized by bio-attentional looping that leads to vicious circles of worsening: attentional focus on feared symptoms amplifies them, what might be called attentional amplification, and the increased symptom leads to more fear, and fear itself activates the biology of anxiety that increases symptoms by mechanisms such as the activation of the autonomic nervous system—and increased symptoms and fear lead to more catastrophic cognitions about somatic symptoms and attentional scanning of the body for symptoms, and so on.[27]

The first multiplex model we presented (see Figure 1.2), the multiplex trauma model, is a cultural cognitive neuroscience model of trauma-related disorder. The model demonstrates how several trauma-related biological and psychological processes produce a certain potential trauma symptom pool (see too, Good, Good, and Grayman [Chapter 12]; see also Shorter 1992). Some symptoms may be especially amplified, and so set up vicious circles of worsening. This amplification occurs through bio-attentional looping, which results in large part from cultural processes, for example, the interpretation of anxiety symptoms in terms of the local ethnophysiology, ethnopsychology, and ethnospirituality. The biocultural multiplex models are nested (this nesting is shown most clearly in Figure 1.6) and so take into account the interpersonal and economic effects of the complaint, the role of the complaint as idiom of distress, and the resulting treatment course, all of which might be called socio-cultural pragmatics.

Thus, a biocultural multiplex model (e.g., Figures 1.2, 1.3, and 1.6) emphasizes multiple processes—bio-attentional looping, cultural interpretation of symptoms, trauma associations, socio-cultural pragmatics—and the importance of episode analysis, that is, the ethnography of particular distress episodes (Hinton et al. 2012). A biocultural multiplex model is a dynamic comorbidity model in that it assumes that among trauma victims often multiple psychopathological dimensions and types of symptoms—like worry, somatization, panic attacks, PTSD, depression, and panic disorder—will co-occur and worsen one another. Increasingly, the elucidation of these sorts of causal networks models is considered to be an important way to understand how psychopathology occurs (Borsboom and Cramer 2013; McNally 2012; van Os 2013). More generally, there needs to be a complex view of "symptoming," that is, the occurrence of a symptom as a dynamic event that involves multiple processes in interaction, and of "syndroming," likewise considered as a dynamic event. Our models try to capture symptom and syndrome as event.

In this chapter, we presented multiplex models that incorporated current psychobiological theories of psychopathology (see Figures 1.2, 1.3, and 1.6), and we presented local causal network models that articulate how the local population views distress to be generated (see Figures 1.4 and 1.7). That is, one type of multiplex model (a biocultural causal-network model) showed how general psychobiological processes could be hypothesized to interact with local idioms and syndromes to create a certain illness reality, whereas the other type of multiplex model (a local causal-network model) showed the local conceptualization of disorder. These two types of multiplex models, the general biocultural model and the local model, give key insights into how local biologies and local psychopathologies are formed. These two types of causal network models capture in a contextualized and dynamic way the key role of idioms of distress and syndromes (cultural concepts of distress) in local biocultural ontologies.

Conclusion

This chapter has provided three analytic optics—the eleven analytic perspectives, the typology of errors, and the multiplex models—to use in examining trauma-related disorder. These three types of analytic optics help to situate the chapters of this volume in theoretical context and suggest theoretical frameworks for the cross-cultural study of trauma-related disorders.

Through these three analytic optics, local trauma ontologies can be delineated, and the cross-cultural study of those ontologies advanced. Otherwise the performed analysis risks being decontextualized and abstracted, a sort of interpretive violence (Bibeau and Corin 1995; Nations 2008)—only the semblance of understanding the experiential space of the trauma survivor. Through these three analytic optics, the researcher becomes aware of key processes to target in interventions that seek to alleviate distress and build resilience of individuals and communities.

Notes

1. In addition to these metaphor issues, the term "psychological trauma" is problematic in that it suggests that trauma impacts only on the psychological domain, when clearly it has reverberating effects on multiple existential levels—the family, the society itself, spirituality (Jenkins and Haas [Chapter 5]; Ball and O'Nell [Chapter 10]; James [Chapter 11]).

2. Traumas that strongly induce certain somatic symptoms may create a trauma ontology that includes prominent somatic symptoms along with frequent panic and arousal (Hinton et al. 2012, 2013b). This is because whenever the somatic symptom is experienced it may trigger trauma recall, and whenever trauma recall occurs it may trigger the somatic symptom. In groups with traumas strongly paired to somatic symptoms, those somatic symptoms may evoke memories of past traumas and fear that involve particular events featuring that somatic sensation and possibly entire time periods encoded by that somatic sensation. In the latter case, the somatic symptom acts as a somatic chronotope evoker, a somatic marker of an entire time period. The term "chronotope" is taken from Bakhtin (1981), indicating a certain space-time. Jane Yager (2009) in her review of Karl Schlögel's *Moscow Dreams* (2008), a book on Moscow during the time of the Stalinist terror, describes Schlögel's use of the term "chronotope" in the following way, which is very close to the usage we intend here: "the Moscow of 1937 as a chronotope, a specific and inextricable bundle of time and space whose defining features are despotic arbitrariness, suddenness, shock, attack out of nowhere, disappearance and the blurring of the line between reality and phantasm." We argue that certain images and somatic symptoms have the power to evoke such a space-time, a specific chronotope.

3. Below we provide a more detailed typology of traumas based on how they induce somatic symptoms, providing Cambodian examples. Many Cambodian refugees, survivors of the Pol Pot genocide which occurred 1975–79, have had all these types of traumas, which explains in part why Cambodian refugees have such prominent somatic symptoms.

- *Fear-inducing events*. Somatic symptoms such as palpitations and sweating may result from the fear response during traumas—for example, when be-

ing beaten or threatened or when observing others being hit or killed—such as through autonomic arousal from activation of the sympathetic nervous system. Repeated severe fear was commonly experienced in the Pol Pot genocide. (The following traumas are almost all fear-inducing events as well as trauma events having other specific effects, so that they induce somatic symptoms both by a fear response and by specific effects, thus acting as a somatic symptom–inducer in two ways.)

- *Blow to the body and bodily injury.* Symptoms like headache and backache may result directly from being beaten. Such blows were common during the Pol Pot genocide, for example, punishments for perceived slowness in work. Scars and bodily shrapnel may even remain.
- *Illness*. Symptoms like nausea may result from illnesses such as cancer or malaria. In the Pol Pot period, Cambodian refugees often endured untreated illnesses that induced somatic symptoms: malarial illness was extremely common, usually lasting for months, and it produced almost daily rigors that featured palpitations, dizziness, and other symptoms—that is, malarial illness was a biology-induced event causing symptoms also found in a panic attack, a kind of malaria-caused panic attack.
- *Poisoning*. Various symptoms like nausea may result from poisoning. Cambodians often inadvertently consumed toxins when surreptitiously eating raw plants or uncooked meats in the Pol Pot period (e.g., certain kinds of roots must be cleaned a long time to rid them of toxins before eating, but often there was not time to do this for fear of being caught), and the toxins commonly would induce dizziness, nausea, palpitations, and other symptoms.
- *Starvation*. Weakness, dizziness, palpitations, and other symptoms may result from a lack of vitamins, protein, and calories. In the Pol Pot period, most Cambodian refugees experienced protein and calorie starvation, which caused weakness, severe edema, and palpitations on the slightest effort. These starvation effects were much worsened by beriberi from thiamine deficiency.
- *Slave labor.* A variety of symptoms, including palpitations, dizziness, weakness, and syncope may be experienced during slave labor, and particularly if doing this labor while starving. In the Pol Pot period, Cambodians were forced to do slave labor while starving: in the most typical form of labor, dam building, the laborer carried a basket heavy with dirt at each end of a pole that was balanced at the shoulder, which caused bodily soreness, particularly neck soreness, dizziness, and extreme exhaustion.
- *Viewing dismembered bodies, blood, and corpses, or consuming corpse-contaminated water.* Nausea, disgust, and other symptoms may result from encountering corpses, seeing severed limbs and blood, or consuming contaminated foodstuffs. In the Pol Pot period, Cambodians often came upon corpses in a state of decay, infested by maggots, and they often

inadvertently consumed water from sources containing corpses; and often they saw bombing victims who were eviscerated and whose limbs had been severed.

- *Near drowning.* Asphyxia may result from near drowning while traversing water or from torture methods. Cambodians are often unable to swim, and they have frequently experienced near drowning, particularly in the Pol Pot period when forced to work in deep water and to cross rivers; some were tortured by having their heads forced into water containers.

4. On "humiliated" memory, see Langer (1991), and also Kirmayer (1996b). As an example of humiliated memory, the person may recall being beaten or having to live without bathing, in filthy and tattered clothes, and with the body infested by vermin.

5. In addition to the manner of trauma acting as an assault on group self-esteem, the cultural encoding of the trauma events as "blocked flow" also contributed to the prominence of shortness of breath and gastrointestinal complaints among those Rwandans who survived the genocide, with these two somatic complaints each being a somaticized image of blockage, seemingly demonstrating the process of metaphor-guided somatization (Hagengimana and Hinton 2009).

6. On khyâl attacks, see below (viz., the section on ethnopsychology/ethnophysiology/ethnospirituality), and see also the DSM-5 (American Psychiatric Association 2013), in which khyâl attacks are one of the nine cultural concepts of distress.

7. These items may appear to be artificially elevated in surveys for several reasons. For one, an item that is poorly understood may be endorsed at the same level as the previously answered item, what might be called response perseveration. Second, misconstrual of meaning may lead to incorrect responses to an item. As an example, though amnesia does not seem to result commonly in other cultures following trauma, it may still be endorsed at a high rate owing to a lack of specification: the question about amnesia may be misconstrued as asking about poor memory in general, which is a common symptom of depression, that is, misconstrued as asking about poor memory in general rather than the memory of a particular trauma event. And third, there may be problems in translating a term that has no equivalency in another language. "Numbing" is a difficult term to translate and often must be rendered as an absence of pleasurable feelings as well as sad feelings. It would seem the use of the term "numbing" to describe an emotional state is a Western idiom of distress that poorly translates to many cultures; that is, the physical state of numbing cannot be used as a metaphor to describe an emotional state in many cultural contexts. Likewise detachment, a dissociation-type symptom, is difficult to translate and seemingly emerges from particularities of the U.S. context rather than a universal fact of biology.

8. Here we consider a syndrome as a "symptom" in the sense of an indicator of the presence of trauma-related disorder.

9. There are processes of *Nachträglichkeit* or *après-coup*, that is, afterwardness (Eickhoff 2006). If the person thinks that a trauma like torture has caused a symptom such

as back pain, then this produces a certain identity and relationship to the trauma event and shapes the survivor (Kirmayer 2008). The symptom may serve as self-identity and self-presentation and may impact on obtaining asylum and benefits. In terms of self-fashioning, metaphoric and other meanings come into play as well: back pain and imagery of burden. In such cases, how much the actual trauma event caused the symptom and how much the symptom resulted from processes of amplification—metaphoric resonance amplification and attentional amplification, for example—is hard to disentangle.

10. Some examples of these syndromes in the Cambodian context are the following (see also Figure 1.4):

- "Soul loss," a type of syndrome common in many cultures in various forms (Rubel et al. 1984), is considered by Cambodians to occur when a trauma or any fright displaces the soul; this leads to symptoms like startle and a general state of hypervigilant fear. Cambodians often attribute symptoms like startle, hypervigilance, poor concentration, forgetfulness, and avoidance of trauma reminders to the soul's not being secured in the body or being displaced from it. This soul "dislocation" is thought to be caused by a great fright such as upon being threatened with death by a Khmer Rouge soldier, seeing a ghost, hearing a sudden loud noise, or having a nightmare (Chhim 2012; Hinton et al. 2013b).
- "Heart weakness" is considered by Cambodians to cause startle, palpitations, irritability, excessive worry, and poor concentration, among other symptoms. It may be caused by a great fright, weakness itself (e.g., owing to poor sleep and appetite), or an inborn trait.
- "Thinking a lot" is considered by Cambodians to cause many symptoms that Western psychology would classify as trauma symptoms such as inability to distance from current problems and issues, irritability, insomnia, a reactivity to worry and other negative emotions, and "thinking a lot" is considered to bring about dangerous mental states and physical perturbations, such as permanent forgetfulness, insanity, and a dangerous weakness, as well as khyâl attacks. Cambodians believe that "thinking a lot" may be caused by many processes such as being weak, thinking about current life distress issues like poverty, or ruminating about losses or past traumas.
- Khyâl attacks are considered by Cambodians to be triggered by multiple causes such as standing up or fright, and those attacks are thought to result in physiological perturbations that bring about symptoms like dizziness, palpitations, and neck soreness as well as possibly death owing to syncope, heart arrest, neck vessel rupture, or other causes.

11. As emphasized in this chapter, a somatic symptom may have metaphoric resonances and a role as an idiom of distress as well, both of which contribute to the symptom's meaning.

12. "Thinking a lot" also involves other types of cognizing as well, such as cognizing about depressive themes such as being left by a wife for another man or being separated from relatives. These other types of negative cognizing may trigger many of the same processes as outlined for worry-type cognitions, such as the induction of multiple somatic symptoms. Additionally, "thinking a lot" may consist of other kinds of thoughts, such as thoughts of the past, another reason for the syndrome's commonality among trauma victims.

13. That is, it may be that individuals in a society have trauma symptoms that are not attributed to trauma, and the investigator must determine how those symptoms and persons are represented in a particular society.

14. Insecurity may also arise from a feeling of being in a vulnerable physical, psychological, or spiritual state, for example, of being at risk of assault by spirits. For a discussion of this type of insecurity, see the section on ethnopsychology/ethnophysiology/ethnospirituality and that on religion/spirituality.

15. This might also be called the reactivity–dysregulation complex, in that there is both reactivity to multiple triggers and poor ability to regulate the states of distress. The biological causation will be multiple, such as autonomic arousal and low vagal tone.

16. In medicine, these are referred to as "contextual errors" (Weiner et al. 2010).

17. As outlined in this chapter, there are many types of desemantization errors. Though not emphasized in this chapter, failing to consider metaphoric dimensions is another sort of semantic-type decontextualization of a symptom (Hinton et al. 2012).

18. Focusing on just one dimension is a myopia: attending only to the biological dimension is a simplistic "biologization" (cf. to the term "medicalization").

19. We presented a model that illustrated how worry generates trauma-related disorder (Figure 1.3). As Figure 1.3 illustrates, having experienced trauma in the past may result in worry having a far greater tendency to induce somatic symptoms and negative affective states (e.g., anxiety, depression, and panic), and this vulnerability may set up various looping processes. According to this biocultural model, past trauma results in the laying down of memory in the amygdala and biological shifts that may result in a state of rapidly induced arousal, increased reactivity to stress, and impaired ability to adapt. Engaging in worry may then set up various vicious circles that are depicted in Figure 1.3.

20. As we have discussed, "thinking a lot" is a common presentation of distress in many cultural contexts, and often the content of "thinking a lot" involves current concerns. The close relationship of ontological security to trauma-related symptoms is articulated in many ethnopsychologies, as shown in this chapter and in others in this volume (Pedersen and Kienzler [Chapter 7]). We have discussed the centrality of "thinking a lot" to trauma-related disorder among Cambodian refugees in this chapter, and noted that "thinking a lot" often begins upon thinking about current life problems (Figure 1.3). In order for Figure 1.3 to fully apply to "thinking a lot," it needs some modification. Besides beginning by thinking about current problems, the episodes

may commence upon thinking about depressive themes (e.g., separation and past failures), traumas, or anger issues. So in Figure 1.3, "Current Problems" would be replaced by "Negative Cognizing (e.g., thinking about current problems; separation from a loved one owing to death, distance, or break up; failures; conflicts; and/or past negative events)." Many of these kinds of thoughts are often present together bringing about escalating distress. "Thinking a lot" syndromes often articulate a local theory of the key relationship of current life distress to symptomatology, including trauma-related symptoms; the syndromes constitute a local theory of trauma somatics, of trauma sociosomatics, in which ontological security plays a key role.

21. On genealogy, see also Foucault (1978) and Fassin and Rechtman (2009).

22. Such overinclusion may not be detected for reasons of misassessment: if a person does not understand a questionnaire item, he or she may endorse having the same level of severity of that item as he or she had for the previous item, what we referred to above as a confusion-caused perseveration error, a form of response perseveration (see McNally [Chapter 2]). Then the item will seem to be prominent in a context when in fact it is not. See note 7 in this chapter for further discussion.

23. In the United States, the complaint of numbness by a trauma victim seemingly has metaphoric dimensions, a statement about an existential location. The idea that numbing is a key symptom of trauma also relates to a certain history of theorizing about pathophysiology: the opiate theory of numbing and PTSD (Glover 1993; van der Kolk et al. 1985). Here the scientific theory of pathophysiology seemingly shapes the theory of symptom profile.

24. The salience issue can be examined by techniques like latent variable analysis.

25. Some examples, grouped by type, are the following: DSM-type PTSD symptoms (e.g., anger and startle); somatic symptoms; behaviors (e.g., self-cutting, substance abuse, suicide gestures); psychopathology dimensions (e.g., worry, panic attacks); symptom complexes (e.g., the current problems–trauma complex); and diagnostic categories (e.g., panic disorder and major depression).

26. Figure 1.3 could be considered a biocultural multiplex model of one key aspect of the "thinking a lot" syndrome: that aspect of it focused on current concerns. Local network models consider only the local cultural model of disorder, whereas the biocultural multiplex models take into account the local conceptualization of disorder as well as current theories of biological and psychological processes.

27. The biolooping processes are more clearly shown in the biocultural models, but these same processes will also play a key role in local causal networks.

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