CHAPTER 17

Trauma in Cultural Perspective

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There is no solution to these problems, one must culture the
leadership.
—DINA EFDEL, KISAMA CAMP, KENYA, 1994

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Research on stress, trauma, and their interaction with health in psychology, physiology, and sociology has demonstrated that the impact of stress and trauma encompasses biological, psychological, social, and cultural phenomena. Recent research has alerted us to the self in the social context, as well as social support, that corrects the negative effects of stressful events (Csikszentmihalyi, 1991; Delongis, Coyne, Dakof, Folkman, & Lazarus, 1982; Rutter, Cooper, Schaeider, & Lazarus, 1981). Culture plays a key role in how individuals cope with stressful events and uplifting events can be expected. The interactions between an individual and his or her environment/community play a significant role in determining whether the person is able to cope with the potentially traumatizing experiences that set the stage for the development of PTSD. Thus, PTSD reflects the sociocultural environment in which it occurs.

Culture is a double-edged sword. Because of human beings' dependence on it, its loss becomes traumatic. The power of culture as a protector, sustainer, and security system is evident in studies where the degree of cultural assimilation is a key variable (Brown & Prude, 1981; Prude, Brown, Harris, & Dowland, 1981). In these studies, individuals who were strongly identified with cultural values benefited from increased social support; culture buffered them from the impact, and even the occurrence, of traumatic events. For socially less integrated individuals, stress had a strong negative impact on health and psychopathology. However, culture provides protection at a cost. Strong attachments to persons and lifestyles lead to a deeper sense of loss when the life of a cultural system becomes traumatic.

CULTURE, STRESS, AND TRAUMA

Culture may in many ways be viewed as a protective and supportive system of values, lifestyles, and knowledge, the disruption of which will have a deleterious effect on its members. During social and cultural upheavals, drastic changes occur in people's expectations, "the meaning of life," and communal values. Cultures, however, are powerfully resilient to the stresses of the environment and their environment. Culture is not the only buffer for members from the potentially profound impact of stressful experiences, it occurs by means of furnishing social support, providing identities in terms of norms and values, and supplying a shared vision of the future. Cultural stories, rituals, and legends highlighting the mastery of communal trauma, the relationship to the spiritual realm, and religion itself are important mechanisms that allow individuals to recognize their often catastrophic reactions to losses. Culture, as a source of knowledge and information, locates experience in a historical context and fosters community or discontinuous events.

Historically, culture is a health maintenance system whose function is to assure the adequate distribution of goods, as well as physical and social resources for maintaining social relationships and structure. In short, culture's function is the maintenance of an orderly progression through the life cycle (Whiting & Whiting, 1975). Culture provides a complex and flexible set of rules and values, as well as both practical and symbolic means to carry them out. Within the culturally prescribed social and community structure, life cycle roles and the emotional management of transitions from one role or relationship to another are facilitated and ordered (LeVine, 1975). It is in this context that personal life events, trauma, and illness will be mastered or not.

Provided that the individual does not interfere with the group's capacity to reproduce or remain viable in its niche, cultural social roles, shared values, and historical continuity will act as key stress managers. If the individual does not fit, social extrusion and stigmatization may result as a cultural defense reaction to the unwelcomed information or behavior. Culture is, however, geared toward providing the homeostatic processes that allow the group and the individual to survive under a wide range of stressful conditions. Shalev (Chapter 4, this volume) points out that when trauma strikes, this may not be the case. Trauma may be differentiated from stress at the cultural level in a parallel manner to what Shalev describes for the individual. Trauma, in contrast to stress, profoundly alters the basic structure not just of the individual, but of the cultural system as a whole. Society will never be the same again. Homeostatic mechanisms (e.g., rituals, social organization, and the economic system) no longer suffice to restore a sense of safety and belonging, and other forms of organization or lack of organization need to take their place. In analogy to PTSD at the individual level, a posttraumatic cultural reaction may be viewed as an abnormal response to an extraordinary event. To understand how culture is disrupted by trauma, we should first look at how cultures work under conditions of relatively normal stress.

WHEN THINGS GO RIGHT: HOW CULTURE PROTECTS INDIVIDUALS

The investigations into traditional societies carried out in anthropological research over the last 100 years constitute a good point of departure for illustrating the working ingredients of culture. Traditional cultural responses to stress are integrated within a frame of belief that holds that problems and illnesses, as well as their
The social function of linking an individual's experience of illness and trauma in complex ways, making it meaningful as a mode of action and identity within a larger social framework. A response to stress or danger also operationalizes society's capacity to support its members. In this model, illness and suffering are communication to the group, as well as profound personal experiences.

Indigenous social security systems are the means of the community response. Since in most societies the family/kin group is chiefly responsible for its members, the social security systems are based on filial piety and kin responsibility. After disaster strikes, the indigenous social security or filial (kin) system generally responds to emotional reactions and brings order to an individual's emotional reactions to life events. Depending on the particular culture, they facilitate the provision of help to dependents in various complex ways.

Cultures also create meaning systems that explain the causes of traumatic events as "fatalistic." "Fatalistic" cultures believe that traumatic events have external causes that must be continually faced during life; causes and consequences do not disappear. Rituals and symbolic places are necessary to reify and support group members during times of inevitable difficulty (Geertz, 1973). Traditional cultures assign causation either to gods or gods, leaders (voodoo), or ancestors (breaking of rituals or taboos). Such concepts of external causation have the social function of linking an individual's experience of illness and trauma directly to the larger society. In those settings, filial responsibility and dependence are evoked by the communication of suffering.

Rituals support the individual, repair rents in the social fabric, and reestablish the group. Individuals in traditional societies, then, not only lose their kin support network during social disruptions, they may also lose access to their cultural symbols and places, and this loss may limit their ability to mobilize healing resources. This stands in contrast to the West, where the prevailing idiom for illness experience is individual responsibility for one's own health. The "duty to be healthy" is a majorunderpinning of Western medicine, who is assessed individual health against outcomes, not against the right to be ill. All societies provide rules for emotional expression and illness behavior, ultimately facilitating interpersonal understanding and thereby working support or (when these rules are breached) rejection (deVries, 1995).

If a community remains intact after a traumatic disruption, the culture will make attempts to correct the effects of the traumatic experiences by employing accepted strategies or by developing new ones. Medical practitioners (or traditional healers) are key elements in such a response in most cultures; they are the guardians of the cultural concepts of dependence, family roles, consultation behaviors, and life cycle expectations. In traditional societies, the work of healers is based on the facts that the body cannot in any way be isolated from the mind, and the mind cannot be removed from its social context. This integration of body, mind, spirit, and culture is the result of the trauma that individuals grow up within a particular social context where cultural values and the meaning of health and disease are communicated from birth to death. Individuals, in turn, experience their physical and mental functioning in the context of a larger social and cultural frame of reference (Shweder & LeVine, 1985).

Every culture has its own medical system that embodies ideas of illness and health, as well as hope and the expectations for solutions. The medical system is deliberately intertwined with the group's ideas and feelings about the entire range of physical and social events possible or tolerable within the group. The medical system, then, plays a crucial role in shaping individuals' social world and experience (deVries, Laksen, & Berg, 1989). Cultures differ in their religious systems and social organizations, therefore, each provides its own particular interpretation of the causes and the experiences of physical and emotional suffering and trauma. Variations in these interpretations as to whether suffering can be cured, must be endured, or is a means of communicating are functions of cultural differences in the strategies for seeking solutions to suffering (Kleinman, 1988).

During massive upheavals, a culture may be incapable of doing its protective work and cannot adequately fulfill its functions of regulating emotions and of providing identity, support and resources. Such times call forth the best and the worst in men and women. The "up side" of the discontinuity is the possibility for change or the creation of new social forms; the "down side" is the regression to previous historical conditions and to primitive emotions and behaviors. In response to trauma, individuals and groups must help themselves. Glorious altruism and outrageous mendacity can therefore coexist.

CULTURAL ORGANIZATION OF GRIEF: CUSTOMS AND RESTITUTION

Cultures vary in the use of rituals and religion. The functions of rituals, for instance, may be to regulate, behavior, to maintain social relationships, and to provide guidance for action through social relationships. Cultures organize emotional expression in a manner appropriate to the established level of "person-
hood" of the sufferer; such expressions may range from stoical perseverance and withdrawal to Bambouyan, highly emotional acting out of grief or pain. Key emotions related to bereavement that receive special cultural attention are those related to anger and aggression, with the aims of reducing harm, facilitating resolution, and maintaining cultural production without interruption. Customs and rituals constitute a way of patterning behavior and providing organization during a chaotic period of transition, refining ongoing cultural values, and helping to cut the ties with what may never be again (Rosenblatt, Walsh, & Jacobs, 1976).

At the death of an important person in one's life, one generally experiences strong emotions and marked changes in behavior patterns. Among these emotions may be feelings labeled as sadness, anger, fear, anxiety, guilt, loneliness, and numbness. Behavior changes may include loss of appetite and weight loss, disruption of work activities, loss of interest, decrease in sociability, disrupted sleep, and disturbing dreams. These feelings and dispositional changes may result from many things, including uncertainty about what to do, loss of gratification, and disruption of familiar living patterns. The problems are greater when the loss is unexpected, is traumatic, or occurs at times of uncertainty, each of which aggravates the disruption of familiar patterns.

Grief rituals are designed to help bereaved people return to being able to make reasonable contributions in their social and work lives. In the West, we hold that grief should be "worked through." This includes acceptance of the loss; extinction of behaviors that are no longer adaptive; acquisition of new ways of dealing with others; and the amelioration of guilt, anger, and other disruptive emotions. Custom and ritual channel and facilitate the working-through process. Lindemann's (1944) description of the mourning process was helpful in alerting psychiatry to this process. However, today his description seems to reflect the diversity of outcomes in response to a range of grief reactions, including denial (Wortman & Silver, 1989). Wortman and Silver point out that loss is very often not worked through—a point made in a different way by the Dinka refugee quoted at the beginning of this chapter: "There is no solution to these problems. One must endure the hardship. Life is real, and trauma, despite the best efforts of cultures or individuals, cannot always be worked through; its effects remain. In traditional societies, however, customs can help by providing structure, a positive role for these times. They provide a grieving process for people who, left to their own devices, would not do so, and who thereby might be at risk for developing PTSD. Culture, with its customs and rituals, is thus a key participant in returning a person to normal functioning by helping the person from shock to grief, and ultimately to normalization or mourning is facilitated. In traditional societies, such as the Dinka, rituals provide the establishment of normalcy as well as to occur.

Custom, by causing people from social role obligations during the mourning period, decreases the amount of friction grief creates. It also facilitates and integrates dependence on members of a supportive group who help with ceremonies; this obligates the bereaved to those providing the support, with the expectation that the currently traumatized person will reciprocate in the future. Death customs are rites of passage and initiate a change in status for both the dead and the bereaved. As the dead person is ceremonially passed from the realm of the living to that of the dead, the bereaved person is passed from the state of mourner to the state of nonmourner. Deceased also empties the roles that have been occupied by the deceased. One thing that must be accomplished following a death is to refill the roles; this requires identifying persons to occupy them, recruiting them, and certifying their new positions. Customs and rituals then attempt to maintain social solidarity by regularizing potentially disruptive dispositions. Ceremonies following death will reinforce the remaining social ties, sort out who is in the group and who is not, and reinforce ties through shared work and ceremonially required cooperation. Eulogies are common around the world as forms of promoting solidarity and providing praise for the deceased; they also indirectly serve as a reward for those still living, who could be similarly praised at their own deaths (Rosenblatt et al., 1976).

In summary, cultural customs and rituals help individuals control their emotions, order their behavior, link the sufferers more intimately to the social group, and serve as symbols of continuity. Such processes of restitution, outlined in many ethnographic studies, are disrupted when cultures as a whole are traumatized. Similarly, variations in cultural custom influence individual grief reactions and the types of restitutions after traumatic events that are possible. The reaction to trauma varies a great deal from one place to another (de Vries, 1987b). When culture loses important aspects of its ability to function and becomes incapable of guiding grief reactions or to provide support, individuals are left unprotected and left to their own devices.

MEDICALIZATION: LEGITIMIZATION OF SUFFERING DUE TO STRESS AND TRAUMA

One formal social response to overwhelming stress is the expansion of the medical system itself, which legitimizes the reclamation of community resources. Digo medicine provides an example of an increase in the scope of the medical taxonomy to accommodate individual and communal stress (de Vries & de Vries, 1977). The Digo live on the East African coast; their territory is bordered to the west by the eastern extension of Mozambique. The two cultures, which previously had little contact, clashed in the 1960s-1970s because of drought and the subsequent expanded search by the Mutsa for grazing land. The Mutsa began raiding peripheral Digo homesteads for cattle and supplies, creating
panic and generalized anxiety throughout Digo land. The stress experienced by individuals and the group was often expressed in ritual "trance dances." In these dissociated states, individuals could experience and relive their anxiety and fear by abstracting and behaving like, or identifying with, the aggressor during the dance. Eventually, the traditional healer gave this specific stress response of anxiety, fear, and behaving like a Masai warrior a label, and incorporated it within the traditional healing rituals. The dances were then formalized and used to alleviate stress, as well as to accumulate resources for the protection of border communities from the Masai threat. Thus, personal fear and anxiety in reaction to community stress were labeled and transformed into an illness and a form of social communication, thereby securing attention and resources. Medicalizing the problem enabled the group not only to protect itself against the Masai, but to provide social support for individuals unable for both personal and social reasons to cope with this threat in their daily lives.

Similar to Digo medicine's economic response to social stress created by the Masai, 20th-century Tibetan medicine has undergone a transformation as a result of the Chinese-Tibetan cultural clash (Janes, 1995). The result of this violent collision of cultures is evident in modern Tibetan medicine's elaboration of the 'shang' epidemiological categories. Shang is a basic tenet of Tibetan medicine related to ordering the life course. During the upheaval, a new class of shang illnesses sprang up, symbolizing the rapid social economic and political changes confronting the Tibetans. The interaction of the Chinese state and Tibetan medicine also provided a new place for Tibetan medicine in the world. This new strength derived from its supportive local role in helping define the traumatic experience of the Tibetan people by means of shang. A solution to this cultural trauma demanded that Tibetan medicine both retain traditional ideas and incorporate the new reality of its changing world. This forced the modernization of Tibetan medicine, and resulted in an internationalization of its practice and ultimately in its acceptance by the Chinese state as a legitimate medical discipline. The current revitalization of Tibetan medicine can be attributed in part to its legitimization of the traumatic experiences of the Tibetans, which grew out of an internal demand by local and exiled Tibetan populations to resist domination (Janes, 1995).

The expansion of taxonomy not only facilitated adjuvants to stress but also the management of trauma. For example, it allowed the normalization of war trauma reactions in the United States following the war in Vietnam. Through medical labeling and legal action centered on the Agent Orange controversy, veterans were able to redescribe the social problems experienced upon their return to American society. The labeling of PTSD by the American Psychiatric Association in 1980 provided a context to accept the individual's suffering and legitimize the suffering of these reactions as they attempted to return to normal life. In all these societies—the Digo culture, Tibet, and the United States—stress experiences, though manifested at the individual level, were intrinsically tied to larger social issues. A society is constantly challenged and threatened, and it incorporates these group stresses. Its members' experiences and emotions need to be rendered meaningful and legitimated. Medicalization or labeling achieves this by expanding the medical taxonomy (deVries et al., 1982).

A medical label justifies and operationalizes social interventions and resource allocation. Culture, thus, may cast a necessary, protective human experience by means of its medical system. Human experience thus remains understandable and under control. The individual's suffering is legitimized, and society provides a way of tolerating disability in its members.

WHEN CULTURE FAILS

Culture is supposed to render life predictable. When the cultural defense mechanisms are lost, individuals are left on their own to achieve emotional control. Traumas that occur in the context of social upheavals, such as revolutions, civil wars, and uprisings, create profound discontinuity in the order and predictability that culture has brought to daily life and social situations. When this occurs, traditional systems break down and a conservative element often takes hold. Ethnicity, nationalism, tribalism, and fundamentalism become means of survival; all of these are regressive moves to release individuals behaviorally and ideologically from an intolerable complexity that cannot be managed or used in a more productive way. When culture as the identity giver fails, other models of identity formation and social group formation take its place. The roles and stasis that had previously organized the system may have no further meaning, as in Turnbull's (1972) classic study of the Ik—a nomadic tribe that, when pushed to the edge of the carrying capacity of its environment in East Africa, relinquished its hold on its traditional values and social structure. Age and family groupings, nurturing of the young, and respect for the old were no longer the underpinnings of the society. In cases such as that of the Ik, the homeostatic mechanisms of culture and behavior adapted to the normal stresses of life break down under the burden of trauma. At such times, new or no social forms take their place. The de novo creation of self-help groups is one very positive outcome (see below), but most often negative social forms appear (e.g., warfare, gangs, and brutal institutions of power). The aims of these are to forge order from confusion through violence and aggression, and in particular to deny anxiety and grief.

Today, we are only at the beginning of our understanding of the process of cultural disintegration, the shock it creates, and the individual and social attempts to come to terms with it. The new order these interrupted conditions often consists of negative identities derived from the old order (Erikson, 1965). Uprooting has profound impact on the identity of individuals—where do they belong, and where are they going? (Frankl, 1963). It would be naive to
attempt to discuss in precise detail the ramifications of trauma down from culture to the individual. Medicine and anthropology are still too stunned today by having opened their eyes to the reality of the effects of trauma on individuals and communities to make a definitive link.

When cultural protection and security fail, the individual's problems are proportional to the cultural disintegration. The avenues of vulnerability resulting from trauma follow the routes vacated by culture: Paranoia substitutes for trust; aggression replaces nurturance and support; identity confusion or a negative identity substitutes for a positive identity. Social bonding becomes a loss. Compounding these problems in most areas of the world is that at times the experienced losses or to defend themselves against expected additional losses. Compounding these problems in most areas of the world is that at times the experienced losses or to defend themselves against expected additional losses. Compounding these problems in most areas of the world is that at times the experienced losses or to defend themselves against expected additional losses. Compounding these problems in most areas of the world is that at times the experienced losses or to defend themselves against expected additional losses. Compounding these problems in most areas of the world is that at times the experienced losses or to defend themselves against expected additional losses.

Under a variety of conditions, therefore, culture may be inadequate to maintain individual support and social resources. Individual or group self-help strategies may then be required. Janzen (1982) describes how sufferers have been brought from the isolation of their sickness together with others with the same affliction, and have given one another mutual support to re-enter society. Indeed, even to become specialized healers of their affliction. Janzen refers to these self-help groups as "drums anonymous" (since drums are frequently employed in African versions of these groups), and describes the striking commonalities among such groups around the world. The gourd dance among the Native Americans of the southern plains is an example. It dates back to before the creation of reservations, when these groups were warrior societies. When the warriors put down their arms in the late 19th century and were placed on reservations, the gourd dance served as a means to work out their frustrations. At the end of the Vietnam War, when Native American veterans came home, they were again warriors who had turned in their weapons. They were sitting around in cities and towns not knowing what to do, drinking, often getting into trouble, and lacking a sense of orientation. The gourd dance, with its unique pulsating circular rhythm and the social activities surrounding it, re-emerged as a means of reestablishing orientation. Today, in the cities of the southern plains states and on the reservations, one finds active local gourd dance chapters. In these cases, veterans counsel one another on alcohol and other problems and dance together (Howard, 1976; Gephardt, 1977).

A common feature that makes a person eligible for belonging to a self-help group is that the affliction comes upon the individual rather suddenly and traumatically, as in a disaster. Despite this initial helplessness, in the group process the "sufferer" is gradually transformed into a healer; in these self-help groups, in striking contrast to orthodox professional medical models, evil is somehow converted into a virtue. Self-help groups emerge when permanent maintenance of help and resources is required and one-time solutions will not do. As in traditional settings (e.g., the Digo medical system), the suffering fully loses its alienness. The affliction is seen as a permanent characteristic that the sufferer cannot eliminate. Ongoing therapy is therefore necessary. The self-help group is a widespread, if not universal, mode of healing. The examples from the Euro-American tradition (e.g., Alcoholics Anonymous, Parents Anonymous, cardiac rehabilitation units) demonstrate that it is a viable and specific form of therapy for chronic afflictions and one that is of particular use when the given social system fails or is irrelevant (Janzen, 1982).

CONCLUSIONS

As I have described in this chapter, culture under normal conditions maintains an arsenal of approaches that can deal quite well with the challenges to its survival. Individuals are provided with identity, predictability, resources, and order. Grieving patterns, as well as the medical and social systems, provide the support required to deal with normal life events and stress. When these fail or do not support the person—as is the case with many displaced Third World residents, as well as with Vietnam veterans and many victims of familial sexual abuse—individuals are thrust back onto themselves. Trauma to some extent may be viewed as the product of a combination of the severity of the stress and the supportive capabilities of the environment. The age at which the trauma occurs, the social context, and the support and resources available will all influence the outcome. Many other chapters in this volume demonstrate that the individual will regress, fixate, or be thrown back to primitive defenses in order to manage trauma. At the group level, a collective response often takes hold—a historical regression to idealized familiar conditions, to a better and seemingly simpler time. Such a regression holds out the temptation of a new identity and the denial of pain and complexity.

In the other chapters of this volume, psychological and biological explanations are discussed. In this chapter, we have emphasized cultural aspects. The cultural and the individual level of explanations are different and may be best understood if applied at different points in time. Neither culture, psychology, nor biology explains the total pa...
ure over the period of time relevant for analysis—before, during, and after the trauma. The psychological and cultural explanations fit best at different stages of the trauma response. The psychological level of explanation of the trauma reaction is powerful in explaining immediate reactions to the trauma. The explanations of posttraumatic reactions have more to do with the process of recovery after the event. It is here that culture and social support become important explanatory paradigms. Culture cannot prevent calamity, nor can it blunt the immediate physical power of violence and the emotional shock of bereavement. It can only help to build up resilience before such events, or assist in providing validation, restitution, and rehabilitation afterward. Cultural processes such as social support and self-help groups are powerful forces for restituation, particularly when combined with formal cultural acceptance of the traumatic experience.

As care providers, we generally appear on the scene after a trauma has occurred. Culture at this point may be fully in place or may have been disrupted by the trauma. Whatever cultural structure remains should be employed to help victims manage the horror. After a traumatic event, rituals and customs that order emotions and create self-help opportunities must be facilitated. This provides individuals with a sense of identity and a locus of control that facilitates their taking adaptive action. The medical system should legitimize suffering by expanding definitions of formally recognized illness categories to encompass the experience of these individuals, such as the Digo, the Tibetans, and the American Psychiatric Association have done. The goal should be to bring order and continuity into the posttraumatic period to provide help with ordering emotional reactions, social relationships, and resources in response to the initial shock, recoil, denial, and anger. This will help defend against the conservative impulse and the psychopathological processes that may otherwise result in the formation of pathological liberation from trauma and repressive social bonding.

Rituals and the places required to carry them out should be incorporated in rehabilitative programs whenever possible. Following major social disruption, the reestablishment of symbolic places—church, mosque, trees for gathering under, schoolyards, special places for women and children to gather, and safe places for evening meetings—is an important goal. Symbolic places make viable the cultural and demographic distributions of a community, the range from young to old. This helps reestablish previously learned cultural rules and reinstate members of the community in role functions appropriate to their places in the life cycle. Symbolic places and the culturally prescribed behaviors within such places help reconstitute traditions of social relationships. These go along way toward facilitating more normal development and the essentials for adaptive action during times of disorganization and stress, whose regressive, primitive defenses such as projection, denial, and narzissistic survival strategies tend to prevail.

Everything should be done to keep the problem from becoming chronic. The “chronic stress” of trauma makes it possible for human beings, singly or in groups, to concretize delusions as reality. This is a well-described process among Russian intelligentsia under the repressive regime in the former Soviet Union (Shalamov, 1949), where the constant pressure of surveillance and mistrust created paranoid delusional states that became the norm for daily life. Such delusions may be necessary for survival and are extremely difficult to give up once they are no longer needed.

Two examples from Uganda are particularly instructive in terms of the continuation of this dissociative, delusional process in response to having become uprooted from one’s culture. Giel (1984) reports the story of a girl who, during the war in northern Uganda, was attacked in her local village by soldiers of the national army. Her father and brother, who under threat of death refused to rape her, were killed before her eyes. For 2 years, she was kept and abused by the soldiers as their “guerrilla girl.” Every night, she expected the lost of another soldier, she would wander in Ugandas, aimlessly searching for her family, detached from all around her, and often wishing she were dead. Another displaced Udugandian described by Giel (1984) is Peter, a somewhat suspicious young fellow who says he is 15 years old, but actually looks like a 3-year-old boy. He laughs and talks very little. For the last 3 years, he has accompanied the freedom fighters in northern Uganda and considers himself his only family. He states that he has no memory of his birthplace or school; he doesn’t know whether he had friends or whether he ever tended cattle. As the civil war draws to a close, there seems no way that this boy could ever find his way back to his home, nor does he have the social skills to fill a peacetime social role. These young people, uprooted from their cultures, cannot return to their past and seem to have little future: poignant symbols of acculturation.

In summary, when cultural patterns, identities, and relationships are lost, life becomes unpredictable. Under normal stressful conditions, a grieving process with the aim of leaving the old and adjusting to the new takes place. With trauma, however, other patterns are activated—conservative impulses (ethnicity, etc.) at the group level, and psychopathological reactions (depression, paranoia, and aggression) at the individual level. Culture helps protect against these processes. In its absence, loss, regression, and harm occur. The puzzle and paradox of both traumatic reactions and restitution provide a new challenge for understanding and action. The further study of the interplay of culture and trauma will help untangle the web of causal and protective factors that result in trauma’s being endured, succumbed to, or recovered from. This provides a unique opportunity for clarification and anti-pathological ethics—one that will help illuminate a dark, worldwide “field site” that really appears to be growing and endless.
REFERENCES


