<table>
<thead>
<tr>
<th>Title</th>
<th>Culturally based intervention for post traumatic stress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author(s)</td>
<td>Imura, Tomoko</td>
</tr>
<tr>
<td>Citation</td>
<td>Hitotsubashi journal of social studies, 38(1): 23-32</td>
</tr>
<tr>
<td>Issue Date</td>
<td>2006-07</td>
</tr>
<tr>
<td>Type</td>
<td>Departmental Bulletin Paper</td>
</tr>
<tr>
<td>Text Version</td>
<td>publisher</td>
</tr>
<tr>
<td>URL</td>
<td><a href="http://doi.org/10.15057/8267">http://doi.org/10.15057/8267</a></td>
</tr>
</tbody>
</table>
CULTURALLY BASED INTERVENTION FOR POST TRAUMATIC STRESS

Tomoko Imura

Introduction

An ongoing practice of workers in the mental health, psychotherapy and other related fields is to attempt to incorporate cultural dimensions into the application of psychotherapy. Tseng (1999) presented an overview of previous research and classified such into 5 broad perspectives: (i) cultural-embedded indigenous healing practices, (ii) cultural-influenced ‘unique’ psychotherapies, (iii) cultural elements in ‘mainstream’ therapies, (iv) the practice of psychotherapy in different societies, and (v) intercultural psychotherapy. This classification is based on both therapeutic origin and process and the cultural diversity of treatment and practice, and focuses on cultural minority groups in different societies. In addition to these perspectives, many researchers have studied indigenous mental illness, such as *Taijin-kyofusho*, which is a phobia caused by socio-cultural factors in Japan characterized by people worrying about the appraisal received from others. As demonstrated above, nowadays cultural perspectives cannot be ignored in the practice of psychotherapy. On the other hand, there are some mental health fields that do not seem to address cultural aspects of therapy in detail. One such is Post-traumatic Stress Disorder (PTSD), a disorder that in recent years has captured the minds and imaginations of people around the world. Once known as a psychological disorder associated with veterans of the Vietnam War, PTSD is now being considered in relation to many traumatic incidents, including experiences such as rape, abuse, disaster, accidents, and torture. However, it is rare to find the traumatic disorder research and/or its treatment discussed from a cultural perspective. Conceivably, this is partly a result of the standardization of intervention due to the necessity of being able to provide prompt care to victims. During the Hanshin-Awaji earthquake disaster in Japan, some foreign care teams came and intervened to prevent the spread of acute stress disorder. One such group that responded was the National Organization for Victim Assistance (NOVA), an American non-profit specialist group for mental health first aid (Shinfuku, 1996; Nishio, 1996). Although the team helped Japanese victims with cultural traits different from their own, reports of their activities unfortunately do not refer to efforts that may have been made to overcome such cultural challenges. PTSD intervention in such a disaster must also be considered from a cultural viewpoint. In other words, we must begin to raise increased discussion concerning the need for new approaches for dealing with disasters in foreign countries, for utilizing indigenous intervention to treat victims, and for departing from programs that apply uniform treatment regardless of the cultural setting. In this paper I will discuss the need to consider cultural perspective when providing PTSD intervention during a disaster.
Previous Intervention for Disaster PTSD

Since PTSD was first categorized in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition (DSM-III) in the early 1980’s, a number of case studies and research papers about PTSD have been presented. I have tentatively organized those which refer to cultural aspects into three categories: (a) the therapist with cultural competence, (b) PTSD therapeutic methods and (c) the intervention process and program.

(a) The therapist with cultural competence

Practice Guidelines from the International Society for Traumatic Stress Studies by Foa et al. (2000) clearly indicate that only an expert practitioner can conduct PTSD treatment. In my understanding, this principle indicates that the therapist should be well-trained in order to have obtained the special skills required to treat PTSD, be versed in the process that victims may undergo, and be able to organize a project aimed at helping them recover. The therapist is definitely expected to possess these skills and experiences. Over and above these minimum abilities, however, it is also arguable that a therapist should be able to incorporate cultural perspective into the treatment of PTSD and other mental illnesses. While not specifically an example of PTSD treatment, Levine & Matsuda (2003) presented an interesting case from Australia in this regard. In that case, a practitioner with a cultural background different from the client misdiagnosed and provided inappropriate treatment to the client. According to Foa (op. cit.), 80% of PTSD sufferers have at least one complication. Therefore, in many cases the therapist must be able to discern which symptom to place more emphasis on as well as the appropriate treatment and care for symptoms other than PTSD. Accordingly, cultural competence is also a necessary skill for the PTSD specialist.

(b) PTSD therapeutic methods

Nakajima & Kim (2004) grouped several PTSD treatments into four major categories as follows: (a) medication, (b) cognitive-behavioral therapy, (c) eye movement desensitization and reprocessing (EMDR) and (d) critical incidents stress debriefing (CISD). EMDR and CISD are peculiar to the treatment of PTSD. However, EMDR is still considered controversial in terms of its effects (ibid) and medication. Additionally, because EMDR is based on very scientific methods, it makes it difficult to take cultural perspective into account. As such, I will limit my consideration here to cognitive-behavioral therapy and CISD. Because CISD is a core factor in critical incident stress management (CISM), allow me to discuss both CISD and CISM as one set. In fact, there is ample room to argue that there is a need for cognitive-behavioral therapy and CISD/CISM to incorporate cultural perspective. First, cognitive-behavioral therapy is efficient on account of the element of exposure. It reveals what victims have experienced, how they have suffered, and what they have felt. In this process, it is significant that the therapist confirms how the experiences make sense in the survivor’s life. The particular meaning that any one survivor attaches to such experiences, however, will no doubt be culturally influenced. The PTSD of sexual abuse, for example, is defined with slightly different meaning depending on the survivor’s particular region and/or religion. Therefore, the therapist should be able to incorporate cultural understanding into her treatment. Second, turning now to CISD and CISM, these are the most common ways to utilize PTSD treatment
(Mitchell & Everly, 2001). Both are conducted by a specialist team with peer supporters. Although a standardized treatment like CISD can be extremely useful in providing PTSD care, its obvious drawback is its failure to consider cultural perspective. For instance, there are no instructional techniques within CISD guidelines specifically related to different cultures. In the case of catastrophes on a worldwide scale, it is certain that some teams would be dispatched from foreign countries. However, without culturally competent treatment, it is possible that sufferers might feel misunderstood and this could exacerbate their suffering. This does not necessarily mean that it is inefficient to send teams from different countries. I would suggest, instead, that with a few modifications the effectiveness of CISD in such situations could be greatly improved. Obviously, it is not going to be possible to predict just where a disaster is going to occur next. As such, it would be similarly impossible to try to incorporate information concerning each and every culture into such guidelines. What may be possible, however, is to formulate guidelines that help clinicians to incorporate cultural perspective on a case by case basis.

(c) The intervention process and care project

Once a catastrophe occurs, the particular government in that region immediately begins to formulate a plan to support victims that covers dimensions more extensive than CISM. Such a plan might include, for example, budget, duration, a range of treatment locations and a command system. An important job for practitioners is then to conduct their treatment activities in accordance with the short- and long-term outlooks of each of these government project guidelines. Although it should depend on a victim’s particular socio-cultural background, most projects tend simply to be imported from previous incidents. However, we can say with fair certainty that socio-cultural factors should be considered at the outset of every project. In the next section, I will discuss three interesting cases that draw implications in this regard, one where cultural aspects were considered and one where they were not. If we disregard social and cultural traits when establishing a response plan, sooner or later it is bound to fall short of expectations. Therefore, it is essential for socio-cultural perspectives to be considered at each stage in order to achieve the goals of the project.

Incorporating Cultural Perspectives into PTSD Intervention

The terrible tsunami disaster occurred near Sumatra at the end of 2004. The people in the area incurred awful damage and continue to suffer from distress to this day. Many countries and international organizations offered not only financial contributions, but also human resources. I will discuss three cases that reflect care practices with and without consideration of cultural perspectives.

(Case 1) A governmental project for tsunami survivors in Thailand

Immediately after the tsunami disaster occurred, the Department of Mental Health (DMH) organized a short-term active program, Project I, and a long-term support program, Project II. The objective of Project I was to establish an organization that delivered psycho-social and psychological services. Considering the timeline of one month, it seems that the main purpose of Project I was to prevent, as much as possible, victims with acute stress
disorder from developing full-blown PTSD. In terms of processes, the government outlined the following: (a) establish a mental health center (MHC) for the disaster, (b) set up a mental health personnel mobile team and committee to deliver psychological intervention to survivors, (c) set up rehabilitation programs to develop public education materials and training curriculum to transfer knowledge to personnel and volunteers, (d) transfer psychiatric mobile teams to assist traumatized individuals, and (e) have high ranking administrators of the DMH monitor and visit the area. In addition, target area, budget and structure of management were also determined. On the other hand, the purpose of the program shifted to more specific and deeper care in Project II. Some of the more specific objectives included providing tsunami victims with treatment closely matched to their psychological conditions and delivering traumatic education to individuals and the relevant network of support workers so that such people would be able to both prevent themselves from becoming victims and find the strength to cope with what they had already been through. Other significant steps included finalizing the various procedures to be followed, fixing the precise target areas, and increasing the budget. In other words, the government focus shifted to handling more extremely affected sufferers but a smaller number of victims overall. This process was supposedly an imported response from other countries that are more developed in the field of mental health care. In fact, the same kind of urgent project was developed following the Hanshin-Awaji earthquake in Japan and the September 11 terrorist attacks in the United States. However, it is questionable whether such a system can be so readily imported from different cultures. We can see from the following mental health center statistics that the two projects did not function effectively.

According to a summary report of the mental health services provided to tsunami victims by the MHC, 18,402 victims visited the center in 2005. The number of clients in January, the first month after the disaster, was only 10,477, which comprised 57.0% of the yearly total. The sum of the first three months totaled 88.2%. Meanwhile, the figures declined dramatically at the end of the year when only 62 people (0.3% of total) turned to the practical use of the service. Based on her own visit to the affected area, Imura (2006) reported on various aspects of this system including how some parts functioned well while others seemed ineffective. Although the figure increased to 248 (1.3%) visits in December due to the horror of the tragedy once again being brought back to sufferers during the one-year memorial month, this would still seem to be fewer uses than one would first expect. Based on observations made in the second case to be examined, it is my conclusion that this decline is not the result of an actual decrease in the number of sufferers, but is in fact derived from a failure to take into account the local traits of the Thai people. In general, Thai people receive indigenous counseling in their everyday lives as part of their religious tradition. Buddhists, which account for 95% of the Thai population, rarely hesitate to consult with Buddhist monks in the local community. Even people who underwent counseling from therapists at the MHC eventually returned to their own Buddhist consultants. As time passed, these sufferers likely realized that they had to start to rely on their own communities to deal with their grief. For one month following Project I, instead of the mobile team moving out, the practitioners settled down to provide counseling at a center that was located in an inaccessible location. In contrast to these specialists simply waiting in readiness, Buddhist monks began to visit individual communities more frequently than before. The abrupt decrease in the number of clients might therefore be explained by

1 http://www.dmh.go.th/english/
indigenous customs.

(Case 2) Therapy based on the local mindset in Thailand

Many internal and external groups headed for the suffering area to offer mental health care support after the tsunami catastrophe in 2004. The activity of a domestic professional team in Thailand provides a noteworthy example of culturally based counseling. Emavardhana et al. (2005) stated that they conducted counseling interventions based on crisis intervention theory and indigenous spiritual and cultural customs, which have long assisted people in recovering from catastrophic events. The team was composed of clinical psychologists, clinicians, practitioners at hospitals, and graduate students who had professional counseling experience. As the team felt that the interventions should be culturally relevant to the Thai population, this thus precluded automatically adopting treatment methods originating in Western societies. It is assumed that this belief was brought from their daily counseling practices (Emavardhana, 1997; Tori, 2006). The team explored and agreed upon culturally appropriate ways for Thai Buddhists to confront and eventually release their profound grief. Rather than avoiding the explicit mention of religious tenets, victims were encouraged to fully utilize revered rituals and meditative practices to release their sorrow and reestablish meaning in their lives. For example, victims gained various benefits from performing revered rituals such as pouring water upon sacred religious symbols, saying prayers, and meditating. In these processes, it is thought that the practitioners simply facilitated the re-cultivation of the nature of Thais and utilized the indigenous remediable power that each client already possessed. In their case report (Emavardhana et al., loc. cit.), this cultural based therapy yielded positive results in that survivors appeared to recover and in the end came to feel at ease. Although this discussion does not draw any comparison with the results of therapy of Western origin, it would be very evocative to keep this attempt in mind as we examine cultural based trauma symptom care.

(Case 3) Treatment by foreign specialists in Indonesia

In the same tsunami catastrophe a different kind of foreign support team conducted activities in another severely damaged area, Ache Indonesia. The team was established as a Japanese emergency and rescue team by school staff in Hyogo (EARTH) and was composed of PTSD specialists. After receiving a request from the Ministry of Education in Indonesia, Education International (EI) called on EARTH and sent the experienced team to schools in Ache. The team has accumulated knowledge and experiences gained through its activities during and after the Hanshin-Awaji earthquake in Japan. Mobilized in June of 2005, the team provided intensive treatment and education on traumatic stress to school teachers and other victims in the Ache area for 5 days. In this case, it deserves special mention that the Japanese mobile team successfully conducted crisis intervention work in a cultural setting quite different to theirs. During their activities, team members struggled with various aspects of Islamic society. One example from the team’s experience demonstrates how ineffective it is to try to adapt general mental health treatment to one’s setting. It is believed that one of the necessary steps in order to heal is to release our emotional energy by showing anger, irritation, agony,

2 This is based on the presentation by Prof. Yoshiki Tominaga at the society for stress management on 11th of Dec. 2005.
depression and sorrow. Nevertheless, the Japanese team noted that as a result of peoples’ religious beliefs, no one cried or expressed anger at their loss or grief. In fact, people of the Islamic faith in that region are not permitted to scream on any occasion. If the team had persisted in using the common style of treatment, they very likely would have been unsuccessful. To varying degrees, each member attempted to be conscious of the cultural and religious traits of their patients. As the relations between the treatment team and survivors grew closer, there came an occasion when one particular participant in a group therapy session began to relate how she controlled her deep feelings of mourning. While the method the victim used to control her grief was different than that common to the therapist’s culture, such an experience is evidence of a trans-cultural therapy overcoming the different cultural backgrounds of victims and clinicians. While this is too involved a subject to be dealt with here in detail, it is obvious that cultural perspective must be one of the vital factors considered when providing traumatic stress care in a disaster setting.

Discussion

As it has frequently been proposed as an intervention method for serious traumatic incidents (Bisson et al., 2000) and it was used in previous disasters as outlined in the above case studies, I would like to focus my attention on four therapeutic features of the psychological debriefing method (PD), or so called CISD. It is commonly explained that PD is a single-round, formularized method to prepare for the occurrence of emotion and to prevent critical traumatic stress disorder. Moreover, it is utilized not only as a combined and systematic group approach, but also as a stand-alone method for taking care of individuals. As Mitchell & Everly (loc. cit.) point out, there are 5 frequent procedural obstacles that one encounters with this intervention. Some of these are considered to be caused by cultural indifference. Obstinate abidance of guidelines without considering a particular client’s background causes the debriefing to malfunction.

Today, there are many occasions when we receive or send care teams in response to various kinds of disasters around the world. Therefore, it is necessary to consider the treatment from the standpoint of trans-cultural psychotherapy. I will discuss how to consider cultural perspectives at each stage. First, I would like to deal with the preparations necessary to mobilize a team. Whether the team is made up of foreign or domestic professionals, it should contain at least one local practitioner. The clinical director and senior team coordinator could be PTSD treatment professionals from abroad or other areas who are unfamiliar with the stricken area. However, local staff who usually handles the mental health needs of the area should participate in the team to provide relevant information to each side and to act as a buffer between them. It is advisable that an assistant team coordinator or a mental health specialist who is familiar with the disaster area takes on this role. The local team members play an important role in helping others on the team to understand victims’ socio-cultural backgrounds, to give effective debriefings, and to prevent misunderstandings during intervention. The team has to start to act in an unknown place as soon as they arrive. Accordingly, having brief and appropriate explanations from the local staff is the first step involved in the treatment of survivors. At this point we should remember that local practitioners also are sometimes victims. There is therefore a risk that local PTSD therapists could be hurt by
listening to a client’s episode. As a result, the local staff should take particular care. Interpreters also play significant roles in aiding overseas mobile teams. They not only interpret the words, but also communicate the emotion along with the survivor’s background. Such a role is both as important and difficult as the one played by general therapists. In principle, it is better that local specialists take on the responsibility of acting as interpreters as they are best able to relate a client’s reactions and attitudes toward the ongoing treatment. This clear feedback then allows dispatched specialists to concentrate on providing the most effective PTSD care possible.

Second, I would like to address the process of debriefing. The process of debriefing begins with the survivor talking about her general understanding of what she experienced. She then goes on to relate a deeper account of her thoughts, feelings and how she reacted to the event. The final stage of the process involves psychological education and the modification of illogical perceptions and inappropriate emotions. As mentioned above, the psychological debriefing for PTSD is a systematized process. At the introduction stage, the team is expected to introduce members, explain the purpose and intervention guidelines, to provide motivation, to relieve participants’ anxiety surrounding intervention, and to generally get to know each other. There is a significant danger that any one of these objectives can be interfered with by cultural factors. How people develop relationships with one another largely depends on socio-cultural factors. In one culture, people may start to talk with each other easily but fail to develop a close relationship. In another culture, a woman may not be allowed to talk to an unknown man, even if he happens to be a therapist. Accordingly, it is valuable if local staff can inform team members of such cultural characteristics in advance. Moreover, the more progress the session makes, the more attention to cultural aspects the therapist is required to pay. Even though victims can narrate what happened to them from a first-person perspective, because of deeply held defense mechanisms it is extremely difficult to lead them to describe their deeper and more overwhelming feelings. When the therapist is a cultural stranger to them, it is sometimes even worse. On the other hand, excessive speculation regarding cultural characteristics can also invite complex misunderstandings. When a survivor refuses to show emotion, there is a danger that a clinician might incorrectly attribute this to a client’s particular cultural background. Tseng (op. cit.) discusses the problem of placing too much emphasis on culture. It is essential that practitioners maintain cultural respect and yet at the same time do not become apprehensive in their treatment decisions. Team members must pay close attention to the level of venting of emotion and the timing of various expressions. In the event that such expression is delayed or survivors are unable to discuss their deeper emotions, it is necessary for clinicians to ask themselves whether they have been lax in their approach to cultural and religious factors.

After sharing their feelings, education on traumatic stress encourages victims to realize that the symptoms they are experiencing are normal. At this stage the practitioner facilitates the victim’s structuring of the skills to overcome the enormity of his or her stress and to readjust to new circumstances. Indisputably, socio-cultural respect is necessary when providing psychological education. Mitchell & Everly (loc. cit) suggest that the members pose such prudent questions to learners as the following. ‘What helped reduce your confusion and distress? What brought you even the slightest hope?’ ‘Do you think these experiences have taught you something useful for your future?’ Needless to say, team members are required to understand the cultural context within which such answers are given and therefore to accept
all answers. Eventually, the team conducts follow-up activities after the debriefing sessions. In general they follow up by going person to person, not within the group as a whole. It is important for each member to be careful of their words and actions because just after finishing long intensive sessions members tend to pay less attention to such. Team members should remember that they are still working within a victim’s cultural perspective. This means they still have to adapt to the client’s society which can be vastly different from their own. In the final stage of the process the team members take on the responsibility of compiling reports for the intervention as a whole. When producing reports, team members should note the cultural aspects that they became aware of during their work. This report generally contains the brief of the critical incident itself, themes that participants talked about, and a summery of indications that the intervening team gave to survivors during the process. From an intercultural point of view, how the team members evaluated the particular culture, which cultural aspects they took into the standardized debriefing, and how they felt during the session, should also be included. These efforts could prove enormously helpful in PTSD interventions in future disasters.

Treatment with regard to cultural context is indispensable for PTSD intervention as well as other mental health treatments. Psychological debriefing is regarded as a well-organized method for traumatic care. Meanwhile, Takahashi (2002) implies that it is necessary to develop it with regard to cultural perspectives. This certainly seems to be true because of the high probability that mobile specialists come from abroad. Socio-cultural respect on the part of practitioners promotes productive relationships between clients and clinicians. This relationship must be the basis of every psychological, mental health treatment. On this point, there should be no exceptions at all.

Conclusion

In the above I have discussed various PTSD care concepts with respect to cultural perspective. Without immediate and appropriate intervention, there is a real possibility that traumatic stress symptoms could be prolonged. We can address the immediateness concern by daily preparation for emergencies. However, it is difficult to manage the appropriateness of care concern because such depends on the particular situation and region. In such situations psychological practitioners can only rely on the local information, their accumulated knowledge, and what they acquire from direct experience in the field. Although my discussion in this paper focused on psychological debriefing as a kind of method for trauma care, I would like to refer to one other important socio-cultural aspect, that of the culture of medicine. Eguchi (2004) addressed the question of whether barriers to mental health treatment have been lowered in regard to trans-cultural psychiatry. There are various resistances to mental health treatment around the world. Such might be the result of social background or individual personalities. For example, Japanese people seem not to be open to undergoing mental health consultation and generally avoid going to see psychiatrists or other mental health clinicians. PTSD care specialists always recall a client’s receptivity to mental health care. It is clear that the concept of undergoing mental health therapy is received differently depending upon the particular country and culture involved. Both before and during PTSD therapy, it is worthwhile for PTSD specialists to understand the implications of mental health care in the victim’s
own country. Such an approach is yet another way of showing cultural respect. In conclusion, I suggest that a critical aspect of traumatic stress disorder intervention is the ability to approach such treatment with an awareness of cultural perspective. The future direction of this discussion will be one that details the various factors that interfere with such a socio-cultural approach and that examines various cases classified by region.

REFERENCES


Buddhist thought and applied psychology, Transcending the boundaries.