UNDERSTANDING TRAUMA IN GUATEMALA:

A CROSS-CULTURAL PERSPECTIVE

A DISSERTATION
SUBMITTED TO THE FACULTY
OF
THE GRADUATE SCHOOL OF APPLIED AND PROFESSIONAL PSYCHOLOGY
OF
RUTGERS,
THE STATE UNIVERSITY OF NEW JERSEY
BY
JEFFERY BUCHANAN BRAND
IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE
OF
DOCTOR OF PSYCHOLOGY

NEW BRUNSWICK, NEW JERSEY OCTOBER, 2015

APPROVED: _____
Monica Indart, Psy.D.

_____
Dan Fishman, Ph.D.

DEAN: _____
Stan Messer, Ph.D.

Copyright 2015 by Jeff Brand

Abstract

This study provides a qualitative analysis of how a sample of Guatemalan psychologists conceptualize and work with psychological trauma. Ten psychologists living and working in Guatemala completed semi-structured interviews developed by the researcher to investigate their conceptualization(s) and clinical experience of treating trauma. Participants also answered a brief demographic questionnaire about their clinical training and professional practice. Interviews were analyzed for themes, which were grouped into meta-themes around four main areas: re-experiencing memories, unformulated emotional distress, hyperarousal and loss of meaning/connection. Selected interviews were also analyzed holistically as "cases" to examine how the internal logic and assumptions of each perspective varied. Different conceptual models of trauma emerged, and given the diversity of ideas, it is not possible to talk about ideas of a "Guatemalan model" of trauma. While primary themes showed some similarities to occidental ideas, the research also reveals how different participants employ multiple different concepts, each with different organizing assumptions. This includes use of alternative therapies (i.e., energy-based therapies), spiritual elements, social psychologies and interpersonal perspectives. Established trauma concepts— such as PTSD— import their own organizing assumptions, which may or may not be consistent with the basic assumptions of different cultures. Participants' ideas showcase how trauma concepts can evolve to become more culturally syntonic with different worldviews. An original theoretical framework is proposed for analyzing trauma concepts cross culturally. While the study of trauma may recognize common themes or similarities, cultural sensitivity requires greater awareness of philosophical differences. While not mutually exclusive, the professional mandate to provide evidence-based treatments may potentially come into conflict with the equally important mandate to provide culturally sensitive

care. When it comes to treating trauma, pluralism in concepts proves indispensable if the field hopes to uphold its multicultural values.

Acknowledgements

Very often, a work upon completion can seem as if it stands alone. Certainly in the writing and the scholarship, one hopes that it has a coherence and an integrity that allows it to make its own contributions. In that way, it tends to focus on the outcome, even at the expense of knowing how it all came together.

Without exaggeration, I see this work as fruit off the vine of everything I have ever learned. Certainly, it would have never been possible without the formative influence of Chris Latiolais, who deserves the credit for what I understand about philosophy. Any misunderstandings in this arena are sorely my own, as he remains a remarkable and wiling teacher. As a clinician, I owe so much to my professors at GSAPP, my supervisors, and my former colleagues at Catherine Freer Wilderness Therapy Programs. Monica Indart was a stabilizing force for this project as my dissertation chair, and Dan Fishman contributed with his insightful comments. Don Morgan lent a spark through personal introductions and his timely encouragement. Perhaps one of the most indispensable people in this project was Maria del Pilar Grazioso and the Universidad del Valle de Guatemala, to whom I owe a great debt of gratitude. There are a great many other people who deserve to be mentioned (in alphabetical order): Andres Consoli, Nick Copeland, Angelina Snodgrass Godoy, Finn Kjaerulf, John Linstroth, Jimmy Reyna, Elizabeth Rohr, Celines Villalba and Erika Wassell— each of whom contributed in unique and important ways.

On a very personal level, I want to express my heartfelt thanks to all of the participants in this study who took the time to share their thoughts with me. You have taught me so much, and please know that I did my best to represent your words and thoughts with the same respect and admiration that I hold for each of you. I want to thank Dan Braman, Mariana Torres-Viso, and "the Council" for their support as colleagues and friends. To my family, I love you very much and I hope you take a feeling of pride in this effort,

knowing that it would never have come to be without your support both in my life and during this long, winding process.

I want to recognize the people of Guatemala who have suffered so much and yet still find strength and beauty in their lives— a testament to resilience that I hope is represented here.

And lastly, I dedicate this work to Kate, for all the reasons that you know and because there are so many things we will never know.

Table of Contents

Page

Abstract ii

Acknowledgments iv

Table of Contents v

List of Tables viii

Chapter

Introduction 1

I. History of Trauma & PTSD 16

History of PTSD 30

II. Research Review of PTSD 42

Review of Clinical Interventions 60

III. Constructive Criticism of the PTSD Diagnosis and Revisions to the DSM 5 74

Empirical Foundations 84

Heterogeneity 87

Dimensionality 93

IV. Paradigmatic Criticism of the PTSD Diagnosis and Trans-Cultural Psychiatry 99

V. Core Conceptual Assumptions of Trauma Concepts: A Theoretical Framework 121

Question of Reference 126

Question of Suffering 133

Question of Etiology 143

Question of Response 152

Interlocking Issues 158

VI. Implications of A Post-Modern Perspective on Trauma 162

VII. An Introduction to Guatemala, Its People and Its Cultures 184

VIII. Research Methods 215

Recruitment and Data Collection 214

Development of Research Methods 219

Data Analysis 221

IX. An Analysis of Themes 225

Sample Characteristics 225

Professional Practice 226

Trauma Concepts 234

Clinical Intervention 242

X. Analysis of "Cases": Examples of Diverse Trauma Concepts 251

Case 05 251

Case 03 258

Case 09 266

XI. An Integrated Analysis: Perspectives on Context & Development 279

XII. Discussion 293

Reviewing & Understanding the Results 293

Cross-Cultural Perspectives & Integrating Science 298

Hypotheses on Cross Cultural Practice 305

Alternative Explanations, Implications
& Anticipated Criticism 320

Limitations & Future Research 328

Conclusion 333

REFERENCES 341

APPENDICES 386

List of Tables

Table 1 DSM 5 Diagnostic Criteria for PTSD in Adults 81

Table 2 Comparison of Trauma Concepts 278

I. Introduction

On June 13, 2013, 14 men wearing plaid shirts, jeans, and cowboy boots stormed a police station in the small town of Salcajá in the western department of Quetzaltenango, Guatemala, where they executed eight police officers and abducted a ninth ("Ataque," 2013; "Narcotráfico," 2013). Partial remains of the kidnapped officer were later found in a river (Fausset, 2013). Salcajá is a quiet, textile-producing community along the Pan-American highway accustomed to being the backdrop for the occasional robbery or assault but is otherwise unfamiliar with murder ("Policías recibieron," 2013). The executions were swift with shots to the head, carried out by drug traffickers believed to be enacting revenge for the seizure of a cocaine shipment ("Narcotráfico," 2013). One month later, four men would be arrested for participating in the killings, two of them police officers themselves (Reuters, "Guatemala," 2013). Accusations would later surface against the captain of the station for having stolen money and drugs, thereby precipitating the attack from the cartel (Parkinson, 2013).

This massacre tells the story of tragedy on many levels for the individuals, families, and communities involved. To say that this event is trauma seems obvious, but what does it mean to say that? Part of what makes this killing such a tragedy in Guatemala is the way that it unmasks lies of safety and exposes the banality of danger. The town, relatively unassuming, had no expectations to be in the path of violence. Street crime can often be impulsive or opportunistic, but this is the naked, predatory power of well-armed organized crime. The charges of corruption sicken a vaguely nauseating sense of futility. With the killing *of* police, it cuts at the very thing that attempts to keep the community safe. With the killing *by* police, it bleeds out a feeling of trust and solidarity. That Guatemala would need to mourn such violence is neither uncommon

nor unexpected as the country is racked with one of the highest violence crime rates in Latin America (Reuters, "Guatemala," 2013).

This work is concerned with how we understand what is commonly described as psychological trauma. It presents original research with Guatemalan psychologists about how they attempt to understand and address trauma in their work. What might they say for the witnesses who saw the attack on the station? How would they make sense out of the families' traumatic grief? What would they do to care for a community that suddenly awakes to find waves on a rising tide of violence lapping at its doors? This killing introduces this work not only because it occurred at the time of data collection for this study, but because it can be seen as a bellwether for the state of violence in the country. The textures of fear, the sense of betrayal, the pervasive mistrust, the impotent rage, the futile wish to retreat, deny and avoid—as a tragedy, this massacre can be seen as much as a symptom as it can be seen as a cause, depending on how we understand the nature of trauma.

The primary way we think about trauma in the occidental field of mental health is post-traumatic stress disorder (PTSD). Throughout this work, I will argue that the concepts of trauma and PTSD are not synonymous, but I also argue that PTSD is the proverbial axis around which the field is organized. This is held in place by the institutional legitimacy conferred by hospitals and other treatment centers, insurance companies, the legal system, and other social service systems. Academia cements the diagnostic concept in place through both research and teaching. Funding for research has historically been tied to diagnoses, and treatment protocols have been predicated on the disorder and its symptoms. With the growing mandate for the use of "evidence-based practices", the diagnosis underlies the provision of care. Across diverse arenas

like psychology, medicine, social work, policing, public policy and so on, PTSD has become the *lingua franca* for talking about trauma (e.g., see Bonanno, Brewin, Kaniasty and La Greca, 2010; see also Lerner and Micale, 2001). If it does not define the discussion, it certainly guides it as its lodestar.

This work starts with the common sense idea that the way we think about a problem influences the way we go about trying to solve that problem. For psychologists in Guatemala, their attempts to understand trauma—perhaps that of the massacre in Salcajá—will focus their attention and shape their response. To look for the personal agonies of bereaved individuals may miss the curdling insecurities running through the community. To see trauma as a medical condition may overlook the socio-political aspects of a public betrayed by corruption. It may never notice the spiritual disorientation or the cultural echoes of past events. As this work will review, PTSD is a very good concept in some ways, but very problematic in others. To only look at trauma through this lens limits both the scope of our perspective and the depth of our understanding.

Perhaps not surprisingly, not everyone in the world thinks about trauma in the same ways, and different ideas lend themselves to different approaches to healing and recovery. This work attempts to explore the ideas and assumptions that guide our understanding of life's most awful events. It considers a wide array of ideas from psychology and psychiatry, but the sampling of concepts presented here serves the purpose of uncovering how different foundations shape and even predetermine our models for traumatic experience. A medical model, for example, presumes a certain type of understanding that is based on the physical body, but what happens if we think about trauma socially, culturally or spiritually rather than physiologically? If the

premises change, then the model's basic construct changes as well. Moreover, I argue that the assumptions we make about 'what is trauma' reflect cultural perspectives. They often work from the same templates as our worldviews in terms of beliefs about self/subjectivity, knowledge, reality, power, and so on.

This issue becomes particularly important in clinical practice, and it becomes extraordinarily important in clinical practice when working cross culturally. If a therapist thinks about trauma strictly as a state of neurobiological dysregulation while her client is convinced that it is a sickness of soul, then the therapist's ability to hear, respect, and engage with the client depends on navigating these differing concepts. What is different or similar in their perspectives? How do these differences shape the healing process? What can be learned from the different ways that people are thinking about the same experience?

I will argue in the broadest sense that the notion of psychological trauma—from its basic etymological root to our formulations today—is that of an explanatory metaphor that is used to describe a 'wound to the mind'. To say that something is "traumatic" invokes a narrative premise as an attempt to explain how something that happened has caused the suffering that followed from it. It attempts to tell us about how events in the past relate to the present. As an explanatory metaphor, the notion of "psychological trauma" can be formulated in different way —some of which may have scientific merit to describe effects on the body.

Psychiatry has invoked this metaphor in many different ways throughout its history and developed various theoretical models that provide a structure for the study and analysis of awful experience. In light of such an assortment of ideas and models, I will introduce a conceptual framework for organizing and understanding this landscape of different ideas. I suggest that

there are basic, core conceptual questions that any trauma concept must effectively address. These core questions effectively organize the assumptions of the model, which then allow it to have explanatory power in various contexts and cultures. This work will show how the assumptions of some trauma concepts exist in conflict with the cultural assumptions of different worldviews. When we can appreciate the philosophical foundations of a concept, we can begin to meaningfully appreciate its implications for therapy across cultures.

This work is not intended as a conventional review of the literature. It is not about exhausting the range of perspectives or cataloguing the diversity of trauma concepts. It employs various examples of different models that illustrate how different constructs selectively bring different features into focus. Each perspective attempts to make its own contributions, and does so by making different organizing assumptions about what trauma is. This enables us to formulate new ideas, but it also limits the range of what any concept might explain. As such, these frames of reference are both limiting and enabling when it comes to narrating our experience of catastrophe. A brain-based concept will look at trauma differently than a meaning-based concept, and both can be useful in understanding and treating distress.

It may be useful to the reader to state at the outset that this work takes a postmodern perspective and presents an explicit argument that PTSD is a social construct. This has been a contentious debate since the diagnosis was created, but this work attempts to deepen the discussion by showing how the current debates between relativity and universality are simplistic. Reading in the literature, there appears to be a tremendous amount of confusion surrounding what we mean when we say something is "real". Critics may often argue that PTSD is a social construct (e.g., Summerfield 2001), which is heard on the other side of the debate as a negation

of human suffering (e.g., Shalev, 2001)—as though the only way to validate the suffering of survivors as "real" depends on the materialist ontology of the medical sciences. This work will make an argument that "reality" itself is composed of both material and social ontologies that demonstrate how socially constructed meanings come together with empirical discoveries to give shape and form to the world. Our attempts to understand trauma through various theoretical constructs are exemplary indications of this dynamic.

The trauma concepts reviewed in this work are not natural kinds or 'things in and of themselves.' They are explanatory models that attempt to make the best use of knowledge and belief. The diagnosis of PTSD is inextricable from its underlying cultural assumptions, but that does not mean that it lacks scientific rigor. Recognizing that the suffering of the mind can have a physical impact on the body does not release the diagnosis from the weight of its assumptions. This is not merely an issue of how PTSD is operationalized, but rather it is a question of how psychological trauma is conceived and formulated. Over the course of this work, I will tease out the assumptions and consequences of a concept like PTSD in order to show how these contrast with different ideas—such as those in Guatemala.

This work is also interested in the way that different concepts can impact the way that providers approach people and treatment. Psychology values culturally sensitive care, but it also values science as a way to set the profession apart from other kinds of care taking. While not mutually exclusive, these values can come in conflict and create ethical dilemmas—the occurrence of which we have a responsibility to understand. Most clinicians emphasize the importance of culture in formulating a case, but practices of assessing and investigating cultural backgrounds lag behind (Arnault and Shimabukuro, 2012).

While it is rarely discussed, psychiatry and psychology have their own cultures replete with beliefs about truth, reality, the self, and how we know things (Littlewood, 1996). If the field does not understand the different ways that its theoretical and philosophical assumptions impact its concepts—and by extension, guide clinical practice—then it will not be able to be sensitive to the different cultural issues in clinical work. This lack of awareness will ultimately betray our multicultural values because we will be unable to recognize how the field's quiet assumptions conflict with those of the people it serves—even to the point of unwittingly propelling clinicians to impose their views and values in the course of therapy. There is also reason to suspect that being culturally mis-attuned may worsen a survivor's condition (Eisenbruch, de Jong, and van de Put 2004).

Ethically, there are equally important mandates in clinical work for evidence-based practices and for multicultural sensitivity (i.e., the APA ethics code and its guidelines for multicultural practice) (APA, 2010; APA Office of Ethnic and Minority Affairs, 1993). The extent to which we are prepared to stop and acknowledge the potential conflicts among these mandates is a testament to the field's willingness to examine its use of power as a social force. For example, this power can be used in opposition to legacies of imperialism and structural inequalities—or it can function as an extension of a neoliberal reiteration of the old order. In other words, psychological treatment can unwittingly become a force of cultural homogenization if it does not recognize its assumptions. It becomes a question of what informs our practice and how we engage with it (Summerfield, 1998).

In the case of understanding trauma, the work is to understand how different conceptual models are able to articulate a diverse range of insights into the suffering that follows from

catastrophe. Like all multicultural work—and like all clinical therapy—the ability to understand the other's experience depends on appreciating the strengths and limitations of one's own perspective in order to be able to exchange with others in meaningful ways. Failures in perspective will unavoidably lead to failures in meaningful exchanges. We might be careful, too, not to assume that our perspectives—academic or embodied—exist independently of time or context. I argue that without the philosophical literacy necessary to facilitate conceptual pluralism, the use of behavioral science will never live up to its values of cultural sensitivity.

The veritable dialogue of perspectives and concepts that I am promoting demands the utmost attention to diverse points of view. My point here is that while pluralism starts with the acknowledgement of different paradigms, negotiating within and between these views is itself a complex ethical process. For example, what significance should be afforded to spirituality when formulating a case? The secularist and the true believer may have different answers: the former may fold it in as one among many variables, while the latter may see it as the central organizing issue. When a survivor is convinced that his suffering comes from the loss of his soul, what type of solace will he find in a medical model? The answer may well depend on the fluency of the cultural exchange.

Negotiating these differences is largely a matter of social authority expressed in terms of who gets to set the terms of the discussion. When it comes to understanding trauma, whose explanatory model should we use—the clinician's or the survivor's? Different worldviews may have very different ideas. For example, the priorities of science are not necessarily the priorities of faith. What kind of common ground can they establish? If the goal here is to understand something about awful events, then we have to examine how it is that we came to look at trauma

in the ways that we do, namely PTSD and the biomedical model. This work will show how the assumptions and priorities of this model reflect a specific—and culturally based—perspective. This is in hopes of fostering an academic dialogue between this perspective and those that are more marginalized.

Cultural diversity holds up a proverbial mirror to examine how differences exist between peoples. Because so many factors play a part in shaping a trauma concept, it is important to look across contexts and cultures to appreciate their differences. This work looks at examples from Guatemala for three major reasons. First, Guatemala is home to extensive diversity. Because of the size and significance of the indigenous population, a distinctly non-Western European perspective infuses the society. It offers a way to examine not only cultural differences between a North American perspective and a *latino* experience, but also involving a culture that has entirely different historical and philosophical roots. Second, the prevalence of extreme and "potentially traumatic" events is staggering. The occurrence of violence—whether it is familial, political, urban, gendered, structural or historical—is routine. Moreover, natural disasters such as earthquakes, hurricanes, mudslides, volcanoes, and droughts are relatively common (e.g., Reuters "Central America," 2014; Reuters "Earthquake," 2014; Zabludovsky, 2012). Essentially, no corner of the society has gone untouched by repeated traumatic experiences. Lastly, there is a major shortfall in the psychology research literature with respect to Guatemala. There is very little written about professional practice and/or clinical populations in the country (Aguilar 1996).

This work is organized into two parts. The first half of the work provides a review of the current paradigm and develops a theoretical framework for analyzing trauma concepts. Chapter

One describes the history of psychological trauma and the development of PTSD. Chapter Two offers a general summary review of the PTSD research as well as a brief introduction to treatments for PTSD. In order to consider criticism of the concept, Chapter Three outlines common arguments that aim to revise and improve the PTSD diagnosis. Chapter Four describes criticism that questions the basic premises of the diagnosis and reject its foundational assumptions. In light of the research and criticism, Chapter Five offers an original framework for analyzing different trauma concepts by exploring their underlying assumptions. The final chapter in the first half describes the implications of understanding trauma concepts in this way and why pluralism is important for clinical work.

The second part of this work presents an original qualitative study, which offers both an illustration of how to employ the proposed framework of analysis as well as making an original contribution to the research literature. This qualitative study asks how a sample of Guatemalan psychologists conceptualize and work with trauma. It assumes that the extent to which they accept, reject and/or adapt the concept of PTSD can provide a useful perspective on the relative adequacy and utility of that construct for working with the populations they serve.

Chapter Seven introduces Guatemala, its history and its people in order to lay out a context for appreciating the sample's contributions. Chapter Eight reviews the methods used for research. In chapter Nine, the study analyzes data for common themes across the interviews, while Chapter Ten presents selected interviews as "cases" to illustrate how different concepts establish their own internal logic and organizing assumptions. Chapter Eleven examines how participants' thinking is evolving as it responds to common themes in the practice of psychology

today. In the work's final chapter, the findings are discussed to show how all these various concerns come together.

Cross cultural work can be both confusing and complicated, and language is important. Concepts are often codified in the words we use, and I try to take care when writing about these issues not let implicit language bias influence the discussion. Some basic explication may be useful: in this work, I attempt to use the word "trauma" to refer to the relationship between an awful or catastrophic event and the suffering that follows from it. Notably, I believe that the word trauma should refer to the relationship between the event and its consequences, and I would dispute the suggestion that that word can meaningfully refer to either an event or suffering in isolation. I use the word "traumatic" as a corresponding adjective, but do not use it to invoke specific concepts of "traumatic memory," PTSD, or other discrete formulations.

"Psychological trauma" has become the idiom through which psychology discusses terrible events and the misery they create, and I use that language here in broad, inclusive ways. This usage is left intentionally vague in order to facilitate a dialogue among different trauma concepts. In order to avoid a common muddling of terms (Lerner and Micale, 2001; McNally, 2009), I take pains to distinguish between the event and the outcome. When referring to the precipitant, I will use the phrase "traumatic event" or a close colloquial equivalent (e.g., "awful event"). In keeping with my desire to be inclusive, I often use the word "awful" to invoke the painful, subjective sense of suffering that survivors feel. In referring to the subsequent sequelae, I employ the term "trauma response," or else stay in keeping with the anthropology literature by using the word "distress" (Littlewood, 1990).

The phrases “potentially traumatic” and “potentially traumatic events” entered the clinical lexicon in large part due to the stipulations of criterion A1 in the PTSD diagnosis (APA, 1994). For reasons that will be discussed later, these phrases can prove confusing and problematic, and will be avoided in this text unless they allude to debates involving criterion A1. “Posttraumatic stress disorder” and “PTSD” will naturally refer to the diagnosis, specifically as it is articulated in the Diagnostic and Statistical Manual, 5th edition (APA, 2013), unless otherwise specified.

In talking about the individuals involved, I try to avoid words like “client” or “patient”. Both terms make assumptions about the relationship status conferred by the experience of suffering. The structure of roles in helping relationships varies across time and culture, and I try to avoid assuming any particular relationship among survivors and those who try to help them. Instead, when talking about individuals who have been through adverse events, I will use the term “survivor” or simply refer to them as “individuals” or “people”. The word “victim” is declined here because it connotes passivity in the face distress. Another foundational assumption of this work is that all individuals who are faced with traumatic stress make an effort to attend to their needs—even if that only means freezing in place. For some, these efforts bear little fruit or create new problems, but these reactions (symptoms included) embody the spirit and effort of the individual to respond.

Because perspective—and its implicit assumptions—features so heavily into this work, I believe it is important to acknowledge my own perspective as the author. I am a white, U.S. American, non-Hispanic man who learned Spanish as a second language in adulthood. I lived and worked with a non-governmental organization in Guatemala for approximately four months

in 2003-2004 and have traveled extensively in Latin America. My professional training is that of a clinical psychologist, and this work is written for largely for an audience of mental health professionals. Throughout this work, I often refer to "the field" of mental and behavioral health in recognition of the many different disciplines that contribute to contemporary clinical practice. Whereas the roots of therapy may have been seeded in psychiatry, current practice relies on an indispensable mix of psychiatrists, psychologists, social workers, nurse practitioners, art therapists, and many others. Readers are invited to think inclusively about "the field" and how different perspectives may fit together.

At times, I choose to use the first-person plural (e.g., "our work…" or, "we have a responsibility…") because I believe it would be conceptually inconsistent to question the assumptions of a paradigm or insist on recognizing ideas as embedded in cultural practice, without actively acknowledging my own perspective. I employ the plural form because I try to restrict such usage for speaking about widespread concerns and not just my own (e.g., professional ethical obligations). This should in no way be misconstrued to suggest that everyone in mental and behavioral health thinks alike. Quite the contrary, if this work does anything, it should underscore for the reader that the field remains a creative and diverse enterprise.

I believe that the questions raised in this work should be compelling for anyone interested in challenges of multicultural clinical practice and the integration of clinical orientations. It may be of interest not only to practitioners in Guatemala—who do not have the opportunity to consume much research literature directly about their work (Aguilar, 1996)—but also to clinicians and researchers in North America and beyond. Over 1 million Guatemalans are

believed to have immigrated to the United States since the 1960s (Grazioso, 2013), meaning that many U.S.-based clinicians may work directly with this population. Currently, as the humanitarian crisis in Guatemala and other Central American countries deepens (e.g., Robles, 2014), this demographic shift is only likely to increase. North American practitioners may benefit from hearing how their international colleagues approach trauma work with this population.

While this study focuses on Guatemala, it could easily turn its attention around the world and ask the same questions. International researchers and the global mental health community may find the practical and theoretical concerns of this work to be engaging. They may find the theoretical frameworks useful for analyzing and discussing different paradigms. It has bearing on the debate between anthropology and psychology, as well as relevance for thinking about nosologies and diagnoses. Anyone interested in broadening the discussion about trauma or considering counter-examples to the current paradigm may feel engaged by the topics discussed. Lastly, at a time when the galloping pace of research stretches our ability to integrate new findings, this work provides a useful philosophical framework for analyzing different ideas.

My argument—my overall argument—is in defense of pluralism. In clinical practice, there really is no substitute. In arguing to look beyond the biomedical model when understanding trauma, I am not attempting to negate the efforts of health science to construct a concept on empirical grounds. I am not attacking its assumptions or the evidence it amasses, but rather taking issue with the types of claims that can be made on the basis of these assumptions. Certainly the search for scientific grounding has led to an impressive body of research and innovation, but any process of inquiry is going to be grounded in a set of assumptions which

mark it as fundamentally perspectival. In many cases, we may not recognize these grounding assumptions because they are deeply rooted in a worldview. In other words, it may seem natural that we would start there, but the challenge is then to recognize how this embedded stance shapes what we come to understand later on.

This work will invite the reader to come at trauma in a new way—in a way that is not often talked about in the literature with a focus on philosophical assumptions. The study of trauma is at a crossroads where many scholars, policy makers and even national media are asking important and difficult questions about what we do and do not understand about the field (Rosen and Frueh, 2007). Perhaps the more ambitious hope of this work is to facilitate a broader conversation among the many different ways of making sense of the awful things in life. It enters directly into controversial debates with the hope of providing a useful framework for deepening conversations. It invites the reader to look first at the philosophical assumptions that govern the concept of PTSD in order to understand how they influence approaches to healing and recovery. The importance of these assumptions is true the world over, and it is especially true in places with an amazing wealth of diversity like Guatemala where violence lurks, the past haunts, and the present faces each day its own danger.

I. The History of Trauma & PTSD

So much has been written about trauma—not merely in the last 35 years, but in the course of humanity—that reviewing it alone could easily consume an entire career. Recovering from the agony of something awful is a central preoccupation of the human experience, and so discussing it here requires a judicious commitment to being concise. This discussion picks up with the 19th century when the nascent fields of psychiatry and psychology emerged as academic disciplines, but it is important to recognize that how far back the tap root runs.

Accounts from antiquity in Sumeria (Kinzie, 1996) and ancient Greece (Lasiuk and Hegadoren, 2006a), for example, describe distress born out of painful events. There is no question that hardship has always found a way to linger, but we should be careful in what we call it. It would be no more accurate to call these historical accounts "psychological trauma" or "posttraumatic stress disorder (PTSD)" than it would be to say that pre-Columbian Maya lived in Guatemala. The country we now know as 'Guatemala' took shape (at least politically) in 18th and 19th centuries, and as such its boundaries and frontiers only became meaningful once they were more widely recognized. The word "trauma" stems from the Greek word meaning '"to pierce" or "to wound" (Ray, 2008). The idea that distress could be described as a psychological trauma was first expressed by Hermann Oppenheim in 1889 (Holdorff and Dening, 2011). Prior to the late 19th century, trauma had been a surgical term in medicine.

If we hope to understand 'psychological trauma', then our investigation should begin at the point when the concept begins to take shape. In what will be a cornerstone of this review, I want to emphasize that the lineage of trauma concepts is far from unitary, but rather emerges from diverse traditions and practices (Symes, 1995). It branches out in many directions into a

variety of concepts. This includes not only the various explanatory models of PTSD, but also a wide array of theoretical frameworks and ideas—some of which we will touch on later. We inherit a legacy of efforts to understand suffering that comes down from many different perspectives. Our immediate concern rests with understanding how those traditions led to the development of PTSD, but we also have to appreciate the context of this intellectual history.

One of the earliest medical formulations of catastrophic distress was offered by Dr. Waller Lewis of the English postal service, who treated employees injured in railway accidents. The Industrial Revolution invited not only a zeitgeist of technological innovation, but also introduced new dangers. The field of medicine was undergoing a burgeoning specialization, and the field of psychiatry was a part of this new zeitgeist. Industrial accidents at high speeds (relatively speaking) were a novel source of risk. In 1861, Lewis explained the suffering he observed by describing a post-concussion syndrome or 'railway spine' (Lasiuk and Hegadoren, 1996a). Railway spine was further formulated and advanced by John Erichsen in 1867 who suggested that the sudden shock of a train wreck caused organic damage to the spinal cord. Sequelae were seen as neurological (Kinzie, 1996).

In contrast, Oppenheim advocated for a bio-psycho-physiological perspective. His theory of trauma neurosis assumed suffering was primarily psychological in origin. Invoking an as-yet unknown organic mechanism, he believed that the loss of memory was central to the disturbance. As a prominent German neurologist, Oppenheim's views received attention from his colleagues, but by the early 20th century, his ideas were roundly rejected. His concept believed that psychological trauma was 'functional' in ways that were not dissimilar to the concept of hysteria as put forward by the famous French neurologist Jean-Martin Charcot (Holdorff and Dening,

2011; Young, 1995, Chapter One). Like Lewis and Erichsen, Charcot also worked with working-class men who suffered in accidents (Kinzie, 1996). These men suffered from conversion symptoms such as paralysis or visual disturbances that were assumed to be traumatic in nature and to stem from a case of hysteria (Holdorff and Dening, 2011).

Medicine historically applied the term hysteria primarily to women (van der Kolk, 2007), and the assumption was that it would take catastrophe to induce it in men. Hysteria remained a vague concept that served as a proverbial junk drawer of psychological and psychosomatic symptoms (Lasiuk and Hegadoren, 2006a). Charcot nevertheless recognized the similarities, and suggested that its attribution in men could be attributed to an unknown flaw in the nervous system (Kinzie, 1996). Broadly speaking, European psychiatry regarded trauma as evidence of weakness of character (Holdorff and Dening 2011; Jones and Wessely, 2007). These were chauvinistic times, and the study of trauma followed suit in its understanding (Herman, 1992). Psychological explanations were heavily stigmatized (Holdorff and Dening, 2011).

On both sides of the English Channel, concepts of trauma raised important social and legal questions. Compensation for injury in accidents played a formative part of trauma concepts from their very inception (Young, 1995, Chapter One). A medical designation of trauma legitimated an experience of suffering (Summerfield, 2000). Moreover, it ascribed a causal explanation which could be leveraged as a form of social power in economic and legal arenas. No sooner did psychiatry formulate a “trauma neurosis” than it followed up with a concept of “compensation neurosis” in 1895 to explain the power of secondary gain (Kinzie, 1996; for a history describing secondary gain in trauma presentations, see Jones and Wessley, 2007).

It is beyond the scope of this review to provide a detailed chronological summary of trauma concepts or to explore them in depth, but it is worth mentioning some other concepts that came into play over time. An almost singular figure in the study of trauma is Pierre Janet. A student of Charcot, he pioneered the concept of dissociation and his work continues to guide clinical ideas today. One of his most important contributions included the concept of automatisms—splits between the conscious and subconscious processes (Lasiuk and Hegadoren, 2006a; Young, 1995). Ironically, dissociation remains a relatively unintegrated component of trauma response in many of the conceptual models in the field. In 1869, George Beard proposed the concept of neurasthenia to describe "nervous exhaustion" as a primary cause of symptoms (Kinzie, 1996). In the late 1800's, Emil Kraepelin's explanation was to name *schreckneurose* as a distinct type of disorder (Friedman, Resick and Keane, 2007), while Freudian views of neurosis gained prominence (Kinzie, 1996).

In a shift of historical significance, psychoanalytic views exemplified the importance of the dialectic between objective and subjective points of reference. Freud's original "seduction theory" recognized how childhood incest left indelible scars on the psychic development of the women he treated, but he later turned to his theory of infantile sexuality. In the latter, he discounted the veracity of the memories that his patients provided and instead chose to interpret them as fantasies constructed out of libidinal energy (Kinzie, 1996; Lamprecht and Sack, 2002). Instead of focusing on his patient's subjective narrative, Freud claimed that psychoanalysis provided a uniquely objective vantage point to explain their suffering.

This pivot in theory—from narrative accounts to observer's interpretations—led to a change of course in trauma treatments towards abreaction and catharsis. Whereas treatment had

once focused on integration of experience, this new affective focus shaped mainstream ideas for at least half a century (Kinzie, 1996; van der Kolk, 2007; Wilson, 1994). History should not forget that there were contemporary dissenting psychodynamic ideas, such as those offered by Sandor Ferenczi, but his work was roundly rebuked by the analytic establishment and it would be many years before subsequent generations would appreciate his work (Rohr, 2012).

Many of these early concepts shared an assumption of universality. In keeping with the Enlightenment's presumptions about an orderly universe (Chakraborty, 1991), early European psychiatry did not reflectively account for its cultural biases. Instead, it assumed *a priori* that its efforts to understand trauma would hold true regardless of person, place, or context. For example, a great conceit of psychodynamic theory assumes a universal process of human development—including the dangers posed by traumatic experience. Perhaps historically, this principled foundation may constitute a response to the anti-Semitic bias that early analysts faced at a time when psychoanalysis was being formulated. Universalist assumptions about development and distress may have rebutted the prejudice against Jews, even as it invalidated the integrity of other cultures (Littlewood, 1992). One of the legacies of our understanding of trauma is an insensitivity to non-European cultures' expressions of traumatic suffering.

In Freud's later writings, history conspired to challenge his thinking as he grappled with the horrors of World War I. Certainly, war threatened Europe again before he died, and his later writings offered some re-consideration of the role of external stressors. In opposition to Erichsen and other early European psychiatrists, he disavowed an organic basis for trauma response, but insisted that it serves a functional role in the psychodynamics of a wounded mind. While he never abandoned his emphasis on the intrapsychic origins of trauma, he came to believe in the

power of external stressors that could break through the defenses of the ego. The injury becomes disorienting, incapacitating, and disabling. The self, damaged and depleted, struggles symptomatically in a new stable (symptomatic) instability. This basic idea—that trauma is an experience of being overwhelmed and incapacitated—would become the nucleus of 20th century traumatology (Wilson, 1994).

Freud's later writings responded in part to the violence of WWI, but this inspiration was also in keeping with a longer lineage in the study of trauma. Military combat and the treatment of veterans provides much of what we know about the enduring effects of violence (Ray, 2008). The American Civil War produced accounts of somatic distress involving various cardiovascular and gastrointestinal problems, often subsumed under the Arthur Meyer's diagnosis of "soldier's heart". Jacob Mendez Da Costa, an army surgeon, regarded this condition as a biological response to the stress of battle (Lasiuk and Hegadoren, 2006a). This concept guided diagnoses during other wars such as the Crimean War and WWI. Most diagnoses in WWI consisted of neuroses such as neurasthenia and hysteria. In either case, symptom presentations included a variety of psychosomatic sequelae such as paralysis, contractions, disordered gait, tremors, shaking, lassitude, fatigue, weariness, headache, and nightmares (Ray, 2008). F.W. Mott documented the startle reflex for the first time and included head jerking, spasming, and reactivity (Kinzie, 1996).

New concepts emerged from WWI, as well. Charles Samuel Meyers coined the term "shell shock", which he attributed to blood vessels ruptured in the central nervous system by artillery explosions. Abram Kardiner extensively documented soldiers' symptoms and coined the term "war neurosis"—in part because of his opposition to the pejorative connotations of

‘hysteria’ (Lasiuk and Hegadoren, 2006a) He sought to understand symptoms as attempts to control anxiety in a more “reactive view” of psychiatry, all of which found a home in American clinical practice (Young, 1995, Chapter 3).

Psychiatry began to group hysteria and war neurosis together under the heading of psychic trauma, and a new consensus emerged about the limitations of human endurance. Clinicians realized that everyone has a breaking point, and explanations of trauma shifted towards environmental theories instead of characterological or biology accounts (Lasiuk and Hegadoren, 2006a). Here again, the same themes of psychology and physiology reemerge—this time in a historical moment of socio-political change (Lasiuk and Hegadoren, 2006b). The prospect of pathologizing a generation of men as having weak character or neurological defects stretched the credulity of the theory, and the field drew from various disciplines as it sought new explanations.

With the start of World War II, psychiatrists had no more consensus in their trauma concepts than they had at the outset of European psychiatry. Examples of terms used during the war include war neurosis, war fatigue, combat fatigue, acute exhaustion, old soldier’s syndrome (Ray, 2008), exhaustion neurosis, fright neurosis, transfer neurosis, asthenia, neurasthenia, and traumatic hysteria (Kinzie, 1996). The precipitating event itself was sometimes downplayed and explanations attributed greater emphasis to context (Ray, 2008). Again, the historical moment plays a compelling role in our understanding of trauma. In the face of massive global conflict, distress can seem more related to contextual chaos than to intrapsychic pathology. In many cases, certain theories of organic etiologies proved invalid (Kinzie, 1996), and the importance of social support was recognized for the first time (Lasiuk and Hegadoren, 2006a).

In a post-war world, understandings of trauma struggled to account for the atrocities of the Holocaust, and concentration camp survivors lived as testaments to the inadequacy of the field's conceptualizations (Kinzie, 1996). New research like that of Eric Lindemann (1944) introduced new ideas such as "pathological acute grief." Trauma no longer seemed merely about sudden disasters, but began to admit a profound sense of loss. In light of Hiroshima and the Cold War, Robert J. Lifton in 1967 pushed understandings of trauma in the atomic age with concepts of "psychic numbing" and "nuclearism" (Kinzie, 1996). Psychiatry began to consider trauma on a scale heretofore unimagined.

Historically speaking, psychoanalysis began a slow decline from preeminence in the 1960s (Lasiuk and Hegadoren, 2006a) and dimensional, biopsychosocial perspectives influenced by Adolf Meyer increasingly came to the fore (Wilson, 1993). In time, behaviorism and cognitive-behavioral theories became more prominent than psychodynamic or humanistic perspectives, and an eventual shift took place from dimensional to categorical thinking. The publication of the third edition of the Diagnostic and Statistical Manual marked a watershed moment in the history of modern psychiatry—in part because of its introduction of the diagnosis of posttraumatic stress disorder (APA, 1980). The advent of the 21st century, christened with the ashes of 9/11, finds trauma as a central preoccupation, seen with new eyes and sparking new research. Moreover, as a major socio-cultural and political event, 9/11 broke through stigmas and profoundly changed the way we talk about traumatization in a day and age of terrorism (Coates, 2003).

This historical review sketches the progression of ideas, but understanding how they developed requires us to appreciate the major themes and concerns that drove these debates. The

field began by looking at the suffering of individuals. Railway spine, trauma neurosis, and hysteria represent first forays into explaining what we now talk about as psychological trauma. While these concepts have fallen out of fashion, the thematic issues they raised continue to shape the field (Lasiuk and Hegadoren, 2006b).

One theme is the plurality of perspectives. Medical specialties such as neurology and psychiatry each offered their own explanations that drew upon their respective disciplines (Lamprecht and Sack, 2002). Psychology cast new light on the relationship between mind and body, while economic questions pushed the legal utility of the concept. Socio-economic trends like the Industrial Revolution ushered in new ways of life that helped define the experience of suffering. Socio-cultural expectations of gender inequality made their way into purportedly scientific concepts. In the long arc of intellectual history, the Enlightenment transformed the world and everything in it into a subject of analysis, and these intellectual trends would continue to shape the study of trauma into the 20th century (Wilson, 1993). Perhaps a point of singular importance is recognizing that from its inception, trauma has always been a combination of biological, psychological, social, cultural, economic, legal, and historical concerns.

A second major theme revolves around how to integrate these perspectives (Lerner and Micale, 2001). Is trauma response best understood as something biological (as suggested in railway spine), or is it psychological (as suggested by hysteria)? Is a trauma response a function of the environment (like a train wreck), or is it a reflection of the individual (who has a weakness of character)? Should our concepts be practical (for economic and legal purposes), or should they be clinical and adhere to a scientific standard? Another major theme considers the point of reference: Should trauma be understood objectively or subjectively? Further still, questions of

trauma must address the relationship between the mind and body (Lasiuk and Hegadoren, 2006b). Many of these perspectives can be set in opposition, but they can also represent false dichotomies. The way in which trauma concepts are formulated inevitably reflects the context, concerns and perspectives of their progenitors (Wilson, 1994).

In addition to these reoccurring themes, there are several historical trends worth noting in this history of trauma. The first is the cyclical quality of explanatory principles. Having recognized the multiplicity of perspectives, it is important to notice that different disciplines tend to hold greater sway during different historical periods. For example, medicine and neurology provided early explanations, but psychological formulations gained prominence soon thereafter. Concepts of stress first appeared in the literature in the 1950s and now provide a useful framework for understanding the impact of trauma on the body (Ray, 2008). In a resurgence of bio-medical influence, medical assessments of the "allostatic load" (Friedman, 2009) make it possible to talk anew about organic and physiological causes of trauma. After some movement towards dimensional, ecological and psychosocial concepts in the mid-20th century, the pendulum swung back towards a neurologically based conceptualization as we enter the 21st century.

Of course, none of these disciplines or perspectives ever entirely disappear from the debate. Where railway spine and shell shock fell short, new advances in science offer new insight into disruptions of the hypothalamic-pituitary-adrenal axis (Banks, 2002). Even as one discipline's perspective may gain prominence at any given time, new discoveries in different fields inevitably transform our understanding. In a major break from the philosophy of the Enlightenment, existentialism and post-modernism, for example, have exposed devastating

critiques of logical positivism and the Western notion of mind-body dualism (e.g. Bracken, Giller and Summerfield, 1995). Medical anthropology challenged ethnocentric assumptions and a new transcultural psychiatry questions many of the tenets of the field (Littlewood, 1990). The result is that in a day and age of global mental health, trauma concepts are being challenged on socio-cultural and political grounds (e.g., Breslau, 2004). Just as it was at the start of the 20th century, integrating the diversity of biological, psychological, social, cultural, economic, legal, and historical perspectives remains a difficult task.

A second trend in the study of trauma appears in the behavior of the academics themselves. As Judith Herman aptly notes, "The conflict between the will to deny horrible events and the will to proclaim them aloud is the central dialectic of psychological trauma" (Herman, 1992, pg. 1). Survivors often feel whipsawed between the urge to bury any whisper of a memory and a shout-it-from-the-rooftops sense of urgency to denounce what happened. Certainly, the helping professions have not escaped this conflict. The field of mental health alternated between an intense focus and abject neglect in the study of trauma (Herman, 1992, Chapter 1). Herman notes a two-fold sensibility in both the need to deny vulnerability and a squeamish confrontation with evil—even on the level of professional discourse (cited in Lasiuk and Hegadoren, 2006a). The last 35 years represent a sustained period of intense interest, having been preceded by relatively 20 years of marginalization (Lamprecht and Sack, 2002; Wilson, 1994). Not unlike common reactions to traumatic events, the field exhibits fascination followed by disbelief (van der Kolk, 2007).

Another parallel process appears in the varying degrees of integration and dis-integration that characterize approaches to trauma. Over the last 150 years, the field has waxed and waned

in its consensus. Early psychiatrists from Erichsen to Charcot, from Beard to Janet each went in distinctly different directions before psychoanalysis pulled together an agreement of sorts around concepts of hysteria and neurosis. By WWII, this framework reached a state of decadence that instigated a whole manner of new perspectives. Trauma work took place in "discrete pockets of knowledge" (Lasiuk and Hegadoren, 2006a) as clinicians proposed various syndromes for survivors of rape (e.g., Burgess and Holmstrom, 1974), of concentration camps (e.g., Grubrich-Simitis, 1981), and others. This occurred for many years before advocates coalesced around the PTSD diagnosis and won its inclusion in the DSM III (Wilson, 1994).

It remains to be seen whether ongoing debates over concepts like "complex PTSD," PTSD subtyping, and alternative trauma concepts will dissolve this consensus. Trauma survivors often feel fragmented or splintered in their memories and sense of self, and perhaps we need to recognize this congruence among the healing professions as well. These parallels rightly invite us to question about both the extent of trauma's impact and the extent to which it can perniciously infuse our shared experiences.

A fourth and final trend that should be considered is the importance of the survivors' perspectives. Psychiatry and psychology have not always responded well to the stories of suffering that patients have described. Freud's disbelief in formulating the theory of infantile sexuality offers an early example of professional invalidation. On the other hand, his student Ferenczi's commitment to his patients' narratives stands as counterpoint in the effort not to lose sight of their humanity. This alternating tendency between humanistic engagement and professional devaluation also echoes trauma processes of splitting and rigid identification.

Survivors' voices play another important role in terms of guiding and shaping the field. The tradition of the "wounded healer" has resonance in many cultures (Wilson, 2007), and despite the detached objectivity of the medical model, the presence of the survivors' voices continues to play an important part in Western behavioral health. As we will review momentarily, the creation of PTSD represented a victory for victim advocacy groups and Vietnam veterans—a coalition of social and political activists that profoundly changed the clinical formulation of the issues (Herman, 1992). Many times, those who know the most about trauma and recovery are those who suffer it most profoundly. They make vital contributions to the field by sharing and living out the promise of survival.

To review, our efforts to understand trauma have always been multifaceted and reflected the concerns of many different points of view. Trauma is not simply a "clinical" issue any more than it is legal, or cultural, or so on—and it never has been.

> History demonstrates psychiatry's embeddedness in social forces, possibly more so than any other branch of medicine. These cultural forces include the status of women and children, issues of compensation, availability of funding for particular scientific endeavors, forensic issues, and other economic and political processes. (van der Kolk, 2007, pp. 32)

It is historically inaccurate to say that trauma is a purely clinical concept, and there is a trend in the field is to recognize more ways in which these issues intersect rather than to separate and distill them. New domains—such as human rights and international development (e.g., Agger and Jensen, 1996; Steel, Steel, and Silove, 2009)—are helping to mold a 21st century perspective in addition to many of the familiar arenas of past eras. At different points in history, different thinkers advocated for the primacy of different explanations and reflected different historical

priorities, but each domain continues to offer new developments and ideas. No domain ever entirely disappears from the conversation. Often times the field's prevailing ideas have shifted according to the newest innovations and research discoveries. Even when there has been consensus, it has never reached conclusion.

This abbreviated history of trauma should not be confused with a history of PTSD, which we will consider in what follows. Instead, this history of trauma intends to showcase the complex array of ideas and perspectives that have informed the conceptualization of trauma. The diagnosis of PTSD represents only one construct comprising one chapter in a broader intellectual history that is attempting to make sense of human suffering. As it will be discussed throughout this work, PTSD does not represent the only trauma concept in the contemporary literature, and while its importance to the field is undeniable, the concept should not be thought of as unassailable.

A word or two about language: Because of the diversity of concepts and usage, "trauma" can balloon into a very broad term. When trauma is used too liberally, it begins to lose its meaning (McNally, 2009). Conversely, as the field has coalesced around the PTSD diagnosis, there appears to be some conflation of the terms. Trauma is sometimes used almost synonymously with PTSD (Pedersen, 2002; Summerfield, 2000). This is neither consistent with history nor the framework of the concept. It will be important moving forward to keep these terms clear and separate.

Other writers have criticized the somewhat careless usage of the word "trauma" (e.g., McNally, 2009; see also Lerner and Micale, 2001). By muddling the terminology, careless usage makes it unclear to what the word refers. In some cases, trauma is used to describe events and in

other cases to describe reactions to these events. As McNally (2009) writes, "In the language of behaviorism, it confounds the response with the stimulus. In the language of medicine, it confounds the host with the pathogen."

An important premise of this work asserts that the word trauma describes a particular type of relationship between an event and the suffering that follows from it. Specifically, it describes a causal relationship that assumes that the event produced the suffering in some way, and therefore the suffering is an expression of what happened. The word does not refer strictly to the event or its reaction, but rather to the relationship that characterizes this sequence of experiences. We will return to the question of etiology later in this work.

In tracing the origins of the concept of psychological trauma, Young (1995) provides an ethnographic account of the genesis of "traumatic memory". While suffering has always been universal to the human experience, the notion of "traumatic memory" as unprocessed and "hidden" memories—memories so disturbing that the individual herself does not know of their existence—was first articulated by European psychiatry in the late 19th century. Whereas this may now be commonly regarded as a "discovery," Young contends that the medicalization of memory reflects a particular cultural construct created by a combination of practices, technologies, institutions, etc. In other words, the notion of psychological trauma—and the idea of traumatic memory in particular—are historical artifacts.

History of PTSD

Hindsight can make an idea—especially what may be a good idea—seem like the natural conclusion of any course of events. The diagnosis of posttraumatic stress disorder appeared at a

portentous time in modern psychiatry. The publication of the DSM III in 1980 marked a turning point in the history of the field. Not only were the winds of change blowing through the clinical orientations, but the reformulation of the nosology would revolutionize both research and practice (Wilson, 1994). The diagnosis of PTSD provided a much needed diagnostic label for clinicians and academics alike (Lasiuk and Hegadoren, 2006a). It became the foundation of an expansive research paradigm. It legitimated the suffering of thousands as an issue in need of clinical attention. It created a framework for advancing new treatments and guiding intervention. It offered not only a way to describe illness, but also a way to describe recovery (Wilson, 1994). PTSD became the central organizing concept in psychiatry's understanding of trauma. In many ways, it was what the field had been waiting for.

In retrospect, the diagnosis can take on an air of inevitability—as though it represents a 'natural kind' or a found object (Haslam, 2002). Psychiatry's prior disposition to see trauma response as evidence of personal failings nowadays smacks of blaming the victim, and PTSD enabled a revision that focused more intently on the nature of the event. It was certainly not the first attempt at this, but the diagnosis nevertheless stands as an important iteration in the ongoing rebuttal of Freud's theory of infantile sexuality. In other words, PTSD represents an important statement in the psychiatric paradigm to acknowledge the power of external events to impact the mind-brain-body (Wilson, 1994). The diagnosis, its accompanying research paradigm, and its assumingly non-stigmatizing social currency offer a reconciliation of many different perspectives (Lasiuk and Hegadoren, 2006a). But PTSD is not a stable "finished product". The concept continues to evolve (Symes, 1995).

Posttraumatic stress disorder represents the confluence of two important streams of psychiatric history: that of trauma (which is discussed in the previous section of this chapter) and that of diagnosis. In order to understand the latter, it is important to appreciate the significance of the Diagnostic and Statistical Manual (DSM). It is published by the American Psychiatric Association and is typically compiled by preeminent figures in the field. As the handbook of recognized psychiatric disorders, the DSM provides an index of pathology and constitutes the single most important document in establishing the nosology. It plays a unique role in the mental health literature (Spiegel, 2005). Its first edition was published in 1952, had a heavily psychodynamic perspective, and under the category of "transient situational personality disorders," the manual included a diagnosis of "Gross Stress Reaction" (Wilson, 1994).

Gross Stress Reaction provided the first formalized trauma diagnosis in this new compendium, and it described an individual's struggle to adapt and cope. The concept drew heavily from Freud's ideas about overwhelming the defensive capacity of the ego. By definition, the diagnosis indicated that the symptom neurosis was something in passing, rather than rooted in character. Symptom reactions were expected to readily abate with time and treatment, and any persistence of symptoms indicated a dynamic developmental problem. The thinking was that "normal" people would naturally get better when the stressor was removed (Wilson, 1994). Criteria were intentionally left vague in order to allow for the summary inclusion of diverse stressors (Friedman, 2009). It did require "severe physical demands" or "extreme emotional stress," and in that way foreshadowed criteria to come (Wilson, 1994).

In 1968, the second edition of the DSM was published involving a variety of revisions, text edits, and diagnostic changes. In what is perhaps the most striking example of psychiatry's

historical capacity to neglect and deny the field of trauma (van der Kolk, 2007), the DSM-II does not contain a discrete trauma diagnosis. Gross stress reaction was eliminated without clear reason or substitution (Spitzer, First, and Wakefield, 2007). "Adjustment reaction to adult life" was its closest equivalent and took on the quality of a placeholder. There seemed to be recognition in the field that external events could be precipitants of distress. Moreover, some events were seen as more likely than others to provoke a crisis (Wilson, 1994), but diagnostically, the field turned away.

It would be twelve years until the publication of the DSM-III in 1980, and during that time the tide came in on a sea change of intellectual currents. Historically, the 20th century was reaping seeds it had sown. Clinicians struggled to make sense of the concentration camps and the profound changes that survivors underwent (Grubrich-Simitis, 1981). The women's rights movement began to assertively confront the silencing stigmas of rape and domestic violence (Herman, 1992). The Cold War, burning in Vietnam, sent home a generation of young men and women who were scarred inside and out (Summerfield, 2001). Each of these arenas formulated its own account of survivors' struggles, such as rape trauma syndrome, post-Vietnam syndrome, prisoner-of-war syndrome, battered women's syndrome, child abuse syndrome—among others (Friedman, Resick, Bryant, and Brewin, 2011).

Intellectually, the torch also passed. Even by the late 20th century, psychiatry was lacking the empirical bona fides befitting its pedigree as a medical science. Research never seemed to escape the gravitational pull of theory when it trafficked in terms of metapyschological constructs such as psychodynamic drive theory. Reliability in research—the cornerstone of any empirical project—was poor, and claims on validity were paid out from a the

writer's reputation of "expertise" (Spiegel, 2005). Epistemology is the branch of philosophy that justifies how we can know things, and in the epistemology of medical science, psychiatry could not claim to know much of anything.

From this positivist morass, the Feighner criteria emerged from the Department of Psychiatry at Washington University in St. Louis in 1972. At a time when psychoanalysts continued to guide most U.S. American departments, these faculty held closely to a data-oriented approach. A committee headed by John Feighner built on the research criteria of Eli Robins and Sam Guze in articulating a research framework for psychiatric disorders (Regier, Narrow, Kuhl, and Kupfer, 2009). The thrust of the project aimed at improving reliability and validity, and it was seen as a major necessary nomothetic course correction to the otherwise idiographic *status quo*. This criteria had three major impacts on the field: 1) it operationalized disorders according to standardized criteria sets; 2) it emphasized a biomedical focus on course outcome; and 3) it emphasized the empirical basis of diagnosis. In short, it attempted to bring the field in line with its aspirations as a empirical science (Kendler, Muñoz, and Murphy, 2010).

Robert Spitzer was a psychoanalyst working on faculty at Columbia University when the APA assigned him the task of spearheading the third revision of the DSM. Spitzer shared the sensibilities of the Feighner committee, and his interest in diagnosis and empirical data outlined a new approach to the manual. Diagnosis would minimize clinical orientations in favor of observable symptom presentations. The result was polythetic criteria sets that specified multiple forced-choice items. Clinicians indicated the presence or absence of a given symptom, which in combination could confirm the profile of a disorder (Spiegel, 2005).

The very nature of 'a disorder' blossomed into a new fruit of the field. Post-WWII, the field gravitated towards dimensional conceptions with Adolf Meyer as its champion. Concepts like neurosis or health were understood on a continuum without discrete cut-offs. A person might be less obsessive compared to a more neurotic counterpart, but it all spread out along the same continuum (Ghaemi, 2009). Such dimensional views are equally antithetical to a rigorous empirical paradigm because they interminably complicate inclusion/exclusion criteria. It is hard to make distinctions among groups if we are all 'a little bit' crazy.

Psychiatry also had a new player in town: psychotropic drugs. Medications like lithium, chlorpromazine, and imipramine promised new therapeutic potential, but their different indications gave clinicians pause. Each drug had beneficial effects but for different groups of people. The state of psychiatric diagnosis had no reliable means of discriminating who should take each drug, and that also prevented any fruitful research into therapeutic mechanisms of action, etiology, treatment outcomes, etc. New possibilities put new demands on the importance of diagnosis (Ghaemi, 2009).

Facing epistemological pressure, psychiatry devised a new solution. It jettisoned Meyerian dimensional considerations in favor of Neo-Kraepelinian views. Kraepelin had been a prominent German psychiatrist in the 19th century who proposed to model mental health on medicine. In medicine, the allopathic model of disease has proven to be a transformative paradigm that supports a rigorous platform for research and treatment. It assumes that every disease has a discrete physical cause, and moreover that the cause of each disease is unique to it alone (Albee, 1982). For example, tuberculosis is caused by tubercle bacillus, which only cause

that one disease. Influenza may share some symptoms, but it is a distinct disease with a distinct cause (Kendell and Jablensky, 2003)

For Kraepelin and his acolytes, mental health problems are analogous to disease-states. Major psychoses—schizophrenia, biopolar—are each assumed to have a distinct (physical, brain-based) cause, which is distinct from that of anxiety, or depression, or trauma. The taxonomist's task is to catalogue each of the discrete disorders of the mind in ways that can be clearly delineated. Once these disease-states are properly recognized, scientists can discern their causes. In a Neo-Kraepelinian model, a strict biological causation is disavowed; multi-factorial causes are recognized, but the discrete categories continue to be the operative premise in formulation. That is, the mind presents with distinct diseases, and moreover, the nosology dramatically expands beyond major psychoses by cataloguing all mental issues as disease/disorder states. One either has a clinical disorder, or one does not (Ghaemi, 2009).

For Spitzer and the DSM-III steering committee, the foundation for a revolution was set. Feigner's criteria provided the rationale and model for empirical research. A Neo-Kraepelinian model provided the conceptual framework for mental disorders. The next step was to determine classes of disorders and describe their constitutive criteria. This new perspective also offered an adroit political compromise (Ray, 2008). At a time when radical behaviorists, cognitive psychologists, existential humanists, family therapists and psychoanalysts wrestled over ideology, common ground in clinical formulations was hard to find. A nosology of observed criteria provided a through-line that could satisfy different perspectives in a way that avoided overt etiological assumptions (Ghaemi, 2009).

In an important philosophical footnote, the third DSM revision advanced a purportedly atheoretical stance between these orientations (Spiegel, 2005). Stated in these terms, this claim is a clear over-reach: the DSM advocates a decidedly biomedical framework that is Neo-Kraepelinian in outlook and tailored to an empirical paradigm. It makes assumptions about the existence of disease entities as an ontological substrate. It invites a Western set of beliefs about epistemology and a reformulation of mind-body dualism. To say that the DSM is free from theoretical assumptions is intellectually naive (Thakker and Ward, 1998). Nevertheless, it represented a point of convergence in a fractious field that provided a viable compromise at an important historical moment for several major schools of thought.

While Spitzer and the APA reworked the nosology, clinicians and victim advocates organized around the needs of survivors. In New York City, Chaim Shatan, Robert Lifton and colleagues began to join rap groups of Vietnam veterans and anti-war advocates. Disturbed by both the war and the shattered lives it sent home, they insisted that the disturbances they saw among veterans were unique and unlike previously catalogued war syndromes (Baldwin, Williams and Houts, 2004). This was a period of upheaval, however, and rape crisis advocates, therapists of concentration camps survivors, and the survivors themselves also lobbied to change the discourse (Friedman et. al., 2007).

Social and political pressure created a public need to redefine trauma concepts, and certainly in the case of veterans, the VA administration required a clinical diagnosis in order to compensate and treat soldiers (McNally, 2009). The political and bureaucratic challenges of tending to the wounds of war can be stark, and public figures like Senator Alan Cranston and VA director Max Cleland worked for years to offer trauma- and substance abuse services to veterans

before legislation came through in 1979—one year before the publication of the DSM-III (Baldwin, Williams and Houts, 2004). PTSD became "one of the few politically-driven psychiatric diagnoses" (Anthony, Pickren and Koerner, 2009) in the history of mental health.

The omission of a trauma diagnosis in the DSM II created a clinical vacuum that could simultaneously ignore and stigmatize the suffering of individuals. If trauma response was not in fact a disease category, then any truly clinical source of suffering must come from an intrapsychic cause. In the dialectic tension between the event and the individual, any omission of traumatic causes could implicate the character of the individual. In crafting the DSM revision, Spitzer and other data-oriented psychologists aimed to adhere to the research: they believed that diagnostic criteria should be informed by science. Unfortunately, a rigorous science base was in short supply (Lasiuk and Hegadoren, 2006b; Spiegel, 2005). Much of what formed the original diagnostic criteria was the product of expert consensus. For example, the original Feighner criteria drew on the work W.L. Cassidy who formulated a key criteria set for defining clinical depression. Stipulating six of 10 criteria fell back on clinical judgment because in Cassidy's estimation, "It sounded about right" (quoted in Kendler, Muñoz and Murphy, 2010).

The formulation of PTSD would follow the same path. The DSM committee pulled from diverse perspectives in the trauma literature, but the process of definition was more organic than empirical (Lasiuk and Hegadoren, 2006b). It is worth noting that the symptom profile of PTSD is not co-terminus with the various symptom complexes described in the history of trauma. There are many overlapping features, but differences remain (Bracken, 2001). Despite relying heavily on the work of Kardiner (van der Kolk, 2007), the committee omitted symptoms of historical note, such as headache, fatigue, loss of will, weakness, gastrointestinal distress, and

(later) personality change (Kinzie, 1996). As a result, the diagnosis took on the imprint of clinical judgment from a particular group of people working on a particular set of issues at a given moment in history. "You know, we made up that diagnosis. There are other things that could and should be in it," Frank Ochberg said in a 2014 interview (Fromm, 2014). Ochberg served on the committee that defined PTSD for the DSM III, and he served as the editor of the first published text for its treatment.

Curiously, over the course of constructing the DSM-III, separate working groups for PTSD and dissociative disorders came to believe that they were mapping the same conceptual terrain. The DSM steering committee tabled (and left unheeded) the unanimous recommendations of both committees to merge their work (van der Kolk, 2007). As a result, dissociation remained (ironically) split off and unintegrated into the framework of acute trauma response. PTSD was placed in the class of anxiety disorders because it was assumed that anxiety and fear represented the essential features of the disorder (McCabe, Swinson, and Jacobs, 2009). It should also be noted that the authors of the DSM-III did not presume that PTSD represented the only possible response to trauma (Jaranson et. al., 2001). Rather, the framers intended for it to satisfy the diagnostic needs of advocacy groups as far as the research could allow.

Structuring the concept was a key concern. The work of Mardi Horowitz played an important role by providing an organizing focus on the alternating dynamics of intrusion and avoidance. In Horowitz's work, the course of the disorder had some predictability, and the committee stipulated a three-cluster model of intrusion, avoidance, and changes in behavior and personality (Ray, 2008). The magnitude of the stressor took on an etiological role, and the notion

of pre-traumatic vulnerability was discounted. Individual differences among survivors were given less credence in understanding reactions.

In other words, in the DSM-III it was the event that mattered. The committee expected that a stressor that was "generally outside the range of human experience" would provoke PTSD in "almost everyone" (quoted in Lasiuk and Hegadoren, 2006b). As Freud had argued, trauma would overcome the adaptive capacity of the individual, and the committee believed that the unusual intensity of the event could reliably predict the type of reaction. Onset of the trauma response could be immediate or delayed, but the diagnosis reinforced the conventional wisdom that it has a systemic impact and affects multiple domains (Wilson, 1994). All in all, the diagnosis emphasized clinical expectations in weighing the impact of objective events that were considered iatrogenic of disorder by virtue of their extremity.

Since its introduction, the diagnosis of PTSD has undergone various revisions and has changed with each subsequent edition of the DSM. In 1987, the APA issued a "revision" (R) and published the DSM-III-R. This would be followed in 1994 by the publication of the fourth edition (DSM-IV), and again in 2000 with the fourth edition, text revision (DSM-IV-TR). The fifth and most recent edition was published in May, 2013 (DSM-5) (APA, 2013). Rather than studiously account for each variation, the review here is concerned with the way this diagnosis has evolved over time in response to the various demands and developments of the field. Specific changes in the criteria will be discussed later in conjunction with criticism of the diagnosis.

A fuller consideration of the theoretical implications of changing diagnostic criteria will follow later in this work. For now it may suffice to notice the way in which the DSM steering

committee assembled the definition around their basic assumptions about trauma. It is a diagnosis built out of a (Neo-Kraepelinian) nosology that is guided by a discipline (medicine), structured around an epistemology (empiricism). In other words, PTSD is a concept nested in theory, based on a belief system as part of a philosophy.

In the next section, a selected review of the literature provides an overview of PTSD and describes many of the current positions of the field. In keeping with the interdisciplinary history of trauma studies, perspectives from several different bodies of literature represent various contributions and conclusions from 35 years worth of research.

II. Research Review of PTSD

As a point of reference in appreciating the contributions of research, first consider an assumption that the framers built into the definition: The original PTSD diagnosis considered trauma to be rare. Because the early architects of the disorder attributed the etiology to the magnitude of the event, they generally assumed that it did not matter who suffered the experience. If something bad enough happened, the disorder would naturally follow. They believed that cases of pathological traumatic stress were unusual, and therefore they assumed that exposure to extreme events was uncommon (Keane, Marshall and Taft, 2006).

The DSM committee defined trauma to be consistent with this expectation—first by highlighting its extremity and later by restricting its range when considered on a stress continuum. When it proved problematic to define 'extremity,' the DSM-IV provided more explicit examples of potentially traumatic events (Rosen, 2004). Epidemiological research has found that exposure to this catalogue of events defies expectations, however. Grave events are common in the general population and even frequent in the lives of many. In the United States, for example, 50% of women and 60% of men will be exposed to potentially traumatic events throughout the course of their lifetimes (Blain, Galovski, and Robinson, 2010). Clearly, research has forced a reconsideration of not only the definition, but also of assumptions about etiology.

If the original diagnosis grossly underestimated exposure to extreme events, the original parameters did not necessarily misjudge the occurrence of PTSD trauma response. It remains true that the majority of people who face grave challenges will not meet criteria for the disorder. Rates of PTSD are comparatively low. Many people may exhibit symptoms in the immediate aftermath of an event, but these symptoms do not qualify for a diagnosis (Cahill and Potonski,

2005). As calculated from U.S. American national samples, an estimated 7-8% of the population will experience PTSD in their lifetime (Kessler, Sonnega, Bromet, Hughes and Nelson, 1995). This is not insignificant—PTSD is the fifth most common psychiatric diagnosis in the United States (Keane, Marshall and Taft, 2006)—but considering the rates of exposure, it indicates that resilience is the norm (Bonanno, 2004; Bonanno, et. al., 2010; Harvey, 2007).

Research indicates that not all events are equal in their risk of causing PTSD. Some events—like rape or combat, for example—may be statistically uncommon in occurrence but far more likely to provoke a disordered trauma response (Cahill and Pontonski, 2005). Interpersonal violence (e.g., rape, armed robbery) creates more susceptibility to PTSD than non-assaultive accidents (e.g., earthquakes, car accidents) (Blain, Galovski, and Robinson, 2010). A significant amount of the research points to a dose-response relationship in which the greater the severity of the event, the more traumatizing it is likely to be (Friedman, Resick, and Keane, 2007). While the intensity of the experience alone is not sufficient to induce a pathological response, conventional thinking believes that the gravity of the event in combination with an element of uncontrollability and unpredictability can combine to curdle our natural resilience (Keane, Marshall and Taft, 2006). This research is complicated, however, and factors unrelated to the event appear to contribute a significant amount to the development of the disorder (Rosen and Lilienfeld, 2008).

Severity is only one aspect, and several factors stand out in the literature as relevant to provoking a disordered response. The availability of social support and concurrent life stress have the largest effect sizes across studies (Cahill and Pontonski, 2005). Prior exposure to extreme stress and cumulative adversity pose risks for more negative outcomes (Keane, Marshall

and Taft, 2006). In more colloquial language, the research shows that when something bad happens, people who have more support and fewer problems tend to cope better, especially if they have not had to deal with a lot of awful things before or deal with bad things that have been piling up.

Curiously, demographic factors such as age and gender show some consistency across cultures (Keane, Marshall and Taft, 2006). Men are more likely than women to experience almost every type of traumatic event with the exception of rape and sexual assault (Blain, Galovski, and Robinson, 2010; Stein, Walker and Forde, 2000). Women are more likely than men to develop PTSD, however (approximately 10.4% vs. 5%, respectively) (Hegadoren, Lasiuk and Coupland, 2006). While the type of traumatic event may explain some of this gender discrepancy, there appears to be evidence that men are nevertheless more likely to experience interpersonal violence, categorically speaking (i.e., physical assault). As a general observation, women may be more susceptible to both acute and chronic PTSD, as well as showing associated factors such as peritraumatic dissociation. An array of factors (i.e., neurohormonal, social cognitive styles, coping styles) appear to be important in these findings (Blain, Galovski, and Robinson, 2010). Overall, gender plays a major role in shaping trauma response.

Age is another important demographic variable. Two facets are important: the individual's age at the time of the event, and the role that age plays in any changes to the trauma response over time. In some studies, age at the time of event shows more significance for men than women (Keane, Marshall and Taft, 2006), but the relationship between variables of age and distress is complex. The relationship between age and symptom presentation does not appear to be linear—positive or negative—but there does appear to be some reduction in symptoms over

time (Averill and Beck, 2000). Longitudinal studies vary, but they suggest that a diagnosis can be problematic years or even decades after its appearance (Friedman and Marsella, 1996). In some cases, longitudinal research has found an uptick in distress even 20 years after the initial stressor (Solomon and Mikulincer, 2006). Many adults who experienced trauma early in life will report an episodic course as life events may exacerbate or alleviate their symptoms. Different symptoms may also prove more or less salient at different points in time (Averill and Beck, 2000).

Research has also explored race and ethnicity in trauma, but studies paint an inconclusive picture. Studies among veterans, for example, document higher rates of PTSD among minority service members (i.e., highest among Hispanic and African American soldiers), but some of this variability can be explained by rates of combat exposure. When controlled for in multivariate equation modeling, race and ethnicity do not prove to be strong predictors of PTSD. Instead, race/ethnicity may act as a placeholder for other mediating variables such as social adversity, family stress, and limited access to resources (Keane, Marshall and Taft, 2006).

All in all, a large amount of trauma response may hinge on psychological factors. Cognitive indicators such as the extent of trauma processing, the degree of memory disorganization, the persistence of dissociation, emotional regulation style, and the negative interpretation of memory can all play a significant role (Amone-P'Olak, Gamefski and Kraaji, 2007; Keane, Marshall and Taft, 2006). In fact, some research points to a predominance of psychological factors in explaining the lion's share of the variance in symptom presentation. A tendency to catastrophize may prove predictive of later outcomes, and the meaning associated with the event influences distress—both in terms of valence and severity (Keane, Marshall and

Taft, 2006). A state of 'mental defeat' involving the perceived loss of autonomy, profound helplessness and a sense of rendering of oneself as an object can be characteristic (Ehlers, Maercker and Boos, 2000).

Understanding an individual's response to an extreme stressor depends on appreciating multiple different personal factors (for an early discussion, see Tyhurst, 1951). Some researchers have suggested that people differ in their "trauma thresholds"—a dimensional construct that describes the person's capacity to cope (Friedman and Marsella, 1996). An individual may cope effectively up to a certain point, but after that their reactions may become pathological. Such a threshold depends on different variables like age, gender, education, personal or family histories of trauma and psychiatric disorders; and other qualities (Cahill and Pontonski, 2005; Friedman, Resick, and Keane, 2007). Premorbid functioning seems particularly pertinent; it can be important to consider how the trauma 'lands' on the person. How well did they function before it happened (Averill and Beck, 2000)?

Peri-traumatic factors such as concurrent dissociation, intensity of emotion, and panic attacks have been linked to outcomes. Environmental and contextual factors weigh heavily in predicting trauma response (Booth-Kewley, Larson, Highfill-McRoy, Garland and Gaskin, 2010; Campbell, 2008; Keane, Marshall and Taft, 2006), while factors like social support in the event's aftermath have been shown to moderate responses (Friedman, et. al., 2007). Biology may also play a part in PTSD, but research indicates that genetic predisposition appears less significant than once thought. Studies of genetic markers appear inconclusive and inconsistent (Keane, Marshall and Taft, 2006). By and large, most disorders are now thought to reflect many different genetic and epigenetic factors (Hyman, 2010).

Brewin and Holmes (2003) review associated features of the disorder. In its characteristics, PTSD shows changes in memory with a bias towards recalling traumatic material. Remembering can seem contradictory at times with some cases evidencing amnestic gaps while others demonstrate excruciating detail. Research shows reductions in working memory capacity and indications of attentional bias. The negative interpretation of symptoms (i.e., self-criticism, self-blaming) can lead to worse outcomes.

> At present, it appears that what is most likely unique to PTSD, compared to other psychological disorders, are the unusual and inconsistent memory phenomena centered on the event itself and the recruiting of a variety of dissociative responses. In contrast, findings concerning other processes have much in common with results of research on depression and other anxiety disorders, with which PTSD is frequently comorbid. (Brewin and Holmes 2003)

One line of research that is commonly invoked to explain PTSD is that of animal models. These models offer new insights into both behavioral responses and the biology of fear. It goes hand in hand with a vast body of research into the anatomy, physiology, and neurology of the organism as it undergoes extreme stress. Kindling may explain how the organism can become hyper-sensitized to aversive events, and fear-potentiated startle response can also generalize to newly conditioned stimuli (Friedman and Marsella, 1996). Learned helplessness offers a concept from animal models to explain how symptom-like behaviors can arise in the face of an uncontrollable and painful stimuli (Friedman and Marsella, 1996). Faced with the repeated failure of the 'fight or flight' response, animals may develop physical immobilization as a conditioned response (van der Kolk, 2006). A similar experience of mental defeat is predictive of PTSD severity (Hegadoran, et. al., 2006).

Understanding trauma is often studied for its impact on the brain, and to understand the brain as a system requires some appreciation of its basic structure. The human brain works in modular fashion with different organelles that perform different tasks. In the broadest overview, the brain has a tripartite structure in which different regions managed different orders of functions (van der Kolk, 2006). As a rudimentary generalization, higher order tasks (e.g., executive functions, planning, creativity, language) occur in the prefrontal cortex, while gross motor functions (e.g., balance, respiration, swallowing) are controlled by the brain stem. A mid-brain region helps to manage affect, motivation, social functions and other responsive tasks. This mid-brain region also controls the "fight-flight-freeze" response that is so commonly evoked in the face of an acute stressor (Siegel, 2003).

Describing the architecture of the brain and its assorted functions is far beyond the scope of this work, but it has bearing on our understanding of trauma response and explanatory models of PTSD. (For a lucid and accessible explanation of the brain and its basic structures, see Siegel, 2003). A major research paradigm used to support the PTSD diagnosis calls on the principles of classical learning theory to describe the way in which trauma "rewires" the brain on a neural level. The amygdala is a group of nuclei in the mid-brain that play the operative role in the body's fear circuitry. When the individual encounters a grave threat, the brain forms and activates neural pathways to mobilize for a response to fight, flight or freeze (Banks, 2002; Debiec and LeDoux, 2009).

With exposure, the brain "learns" by altering synaptic pathways so that new events can be more quickly routed through the brain's circuitry. This includes associated stimuli that are linked in neural networks. Subsequent exposure to either the direct stimulus or any of its associated

stimuli activates these fear networks to mobilize in defense. In terms of learning theory, this process is called "generalization" and describes the branching networks that include chains of associated stimuli. The result is that any of these stimuli—whether directly related to the event or secondarily associated with it—can elicit a fear response from the body (Debiec and LeDoux, 2009).

Because the amygdala occupies a central location in the brain, it strategically receives input from both the prefrontal cortex as well as direct sensory input from the body. The latter route skirts the prefrontal cortex and acts faster, albeit more imprecisely. In an amazing testament to the evolutionary priority of survival, the body can physically react in fear before the prefrontal cortex (and the consciousness mind) even knows what is happening (Debiec and LeDoux, 2009). Clinically, this corresponds to the apparent "irrationality" of traumatic reactions by activating subcortical responses (van der Kolk, 2006). A disconnect may develop between an "implicit" memory (the fear memory) and its conscious memory (the memory of fear). The inaccurate attribution of meaning to stimuli breeds new fears and greater generalization of fear circuitry (Debiec and LeDoux, 2009).

Various findings support this focus on fear circuitry. Not only has research offered evidence of over-activation of the amygdala, but it corresponds with a failure of activation in parts of the prefrontal cortex (Neumeister, Henry and Krystal, 2007). Whereas in the case of brains untouched by traumatic stress, the prefrontal cortex is able to modify and integrate different urges, affects, and instincts. This flexibility is an acquired capacity learned over the course of development, but under stress we retain a tendency to revert to our most immediate urges even into adulthood (van der Kolk, 2006). Stress will naturally suppress the prefrontal

cortex—and even more so in crisis. In the aftermath of trauma, the 'thinking brain' shuts down, and the 'survival brain' takes over. The brain effectively redirects its resources away from deliberative thinking and towards coping with a perceived threat. Over time, this begins to shape and sculpt the capability of the brain to selectively respond. Because the brain is a 'use-dependent' organ, its development and structure reflect the patterns in its activation. Not unlike a muscle, the more it works in a particular way, the more it grows accordingly. In the case of young trauma victims, trauma can leave lasting impacts on the development of the brain (Ford, 2009).

Neuropsychological research has found evidence of impairment in executive functioning (e.g., working memory, attention, inhibition), albeit some of the differences may be subtle (Aupperle, Melrose, Stein and Paulus, 2012; Schweizer and Dalgleish, 2011). Extreme stress can produce changes in cerebral metabolites, hippocampal volume and cell proliferation. After trauma, the brain-body can "shift gears" and get stuck in a grinding cycle of stress-induced over-activation (Neumeister, et. al., 2007). As parts of the brain associated with strong emotions are activated, those parts of the brain that organize, integrate and express higher order thinking shut down (van der Kolk, 2006). Over activation of the stress-response system can lead to neurological downregulation of neuropeptide receptor sites. The prolonged stress-induced overactivation depletes the availability of neurotransmitters, which paradoxically may spur the upregulation of receptors in an attempt to restore homeostasis. The result is heightened physiological sensitivity, which then combines with stress-induced hypervigilance. The individual may seesaw between states of hypo- and hyper-arousal (Banks, 2002).

The diagnosis of PTSD is associated with neurobiological alterations in both the central and autonomic nervous systems (Friedman and Marsella, 1996). As the sympathetic and para-sympathetic nervous systems are affected, the individual struggles with modulating affect (van der Kolk, 2006). Two of the most prominent biological markers in the acute aftermath of trauma include low cortisol levels and an elevated resting heart rate—both of which implicate dysregulation in the hypothalamic-pituitary-adrenal (HPA) axis of the brain (Cahill and Pontonski, 2005). Other indicators involve skin conductance and startle eye blink (Southwick et. al., 2007). The intensity of this sort of biological response can predict the development of PTSD to a degree, but none of these biological factors—either alone or in combination—provide adequate means for diagnosing PTSD (Cahill and Pontonski, 2005).

The impact on the HPA axis amounts to one of many neural systems affected by extreme stress. The noradrenergic, serotenergic, and endogenous opioid system all show effects that appear unique to PTSD. Research has also documented changes involving neurotransmitters like dopamine and endogenous opioids (Southwick, et. al., 2007). To consider one example, the neurotransmitter serotonin is known to play a role in the regulation of sleep, and traumatic disruptions can occur in the diurnal sleep cycle (Gerrity and Solomon, 1996).

Serotonin is also associated with regulation of aggression, cardiovascular and respiratory activity, motor output, analgesia, anxiety, mood, and neuroendocrine activity—all of which are implicated in a PTSD trauma response. Extreme stress appears to cause decreased serotonin uptake, as well as exaggerated norepinephrine and noradrenergic activity. It is possible that the neurotransmitter GABA may decrease in some areas of the brain, but some of these findings have been inconsistent. These neurochemical irregularities may contribute to the hyper-

sensitization of the brain's systems, undercutting its ability to self-regulate or modulate its response (Southwick, et. al., 2007).

Overall, the research clearly indicates that individuals who have experienced trauma tend to have poorer physical and mental health (Hegadoran, et. al., 2006). The immune system plays an important role in the body's response to stress and trauma reactions, and trauma compromises its ability to function (Baker, et. al., 2012). The biological consequences of awful events can be extensive, and while much of the research has tried to identify areas of the body that are affected by trauma, it may be more interesting in the future to ask if there are parts of the brain-body that are not affected by trauma. There is still a lot that we do not know about PTSD and its impacts on the brain-body—including the heterogeneity of its impacts. For example, brain imaging research shows different neurological activation patterns among people facing acute arousal symptoms versus those for whom dissociative symptoms dominate (Hegadoran, et. al., 2006).

The recent amount of progress in these areas of research is astounding, and professionals in all fields have been challenged to keep pace with new discoveries. The formulation of PTSD draws heavily on this research, and in turn, this research is used to provide justification for the PTSD construct. Litz (2014) offers a concise and useful summary:

> The prevailing theory about why acute and chronic stress and trauma are harmful is the neoconditioning, fear-system-based, biological model of uncontrollable stress. This model is doctrine in the medical model of PTSD. The essential necessary precondition is exposure to life-threat trauma, which triggers an unconditioned "fight, flight, or freeze" response, initiating activity in the hypothalamic-pituitary-adrenal axis, the locus coreuleus and noradrenergic systems, and the neurocircuitry of the fear system. This hard-wired response to life threat is richly encoded in memory and conditioned to a variety of peri- and postevent stimuli. In this framework, PTSD is, in effect, the manifestation of traumatic Pavlovian conditioning and learning. (pp. 196)

Here we have the intersection of learning theory, neurobiology, and the PTSD construct. One of the questions we need to ask ourselves is, what are the implications of overlaying one theory atop of another?

Because this psychiatric and neurobiological material carries such weight in current perspectives, it is important to address it in this review, but this is tricky conceptual terrain. It demands caution to heed of how several different concepts do and do not overlap. Formulating trauma response in terms of PTSD invokes many different perspectives, and certainly no single perspective on trauma can provide a comprehensive view (Newman, 2001).

A central premise of this work is that trauma and PTSD are not synonymous terms. To use them in such a way is neither consistent with history nor with the current articulation of the concept. The DSM 5, for example, provides a whole class of diagnoses labeled "Traumatic- and Stress-Related Disorders" that recognize a clutch of categories above and beyond PTSD (APA, 2013). Trauma can have many consequences. Moreover, the way we understand those consequences pulls from many different ideas. The immediate point here is to recognize that our diagnostic system and our understanding of biological correlates have parallels but function as different frameworks. When it comes to animal models and studies of physiology, these lines of research fit well under the awning of trauma, and in some cases correspond well to PTSD. The danger lies in confusing and conflating these separate ideas, however.

Psychiatry ascribes to a biopsychosocial framework. This cannot be reduced to a biological substrate without disavowing the field's basic, stated assumptions about the mind-body problem. The same is true regarding a behavioral science of observation: we do not practice a "mindless psychiatry" (Ghaemi, 2009) that can be reduced to the analysis of objective

behavior patterns or molecular peptides. As a discipline, psychiatry still regards the life of the mind as important. The concept of PTSD is designed to span mind and body. It is defined by its criteria and the textual explication afforded in the manual—crafted historically on clinical judgment and now augmented by empirical research. Academics offer explanatory models around this concept in hopes of describing and explaining different dimensions of it. These explanatory models also ground the concept in other bodies of knowledge, which help to legitimate the idea. When we can see how a construct like PTSD corresponds to other bodies of research, we gain confidence in the integrity and accuracy of its definition. The literature remains very diverse, however, with many different models of trauma. Each tends to offer its own definitions, premises and organizing assumptions (Ghaemi, 2009; Hyman, 2010).

It can be seductive to think of PTSD strictly in terms of physiological reactivity, as though the disease-entity in the diagnosis is best articulated by changes in the brain-body. Cognitive and affective sequelae might then be considered as epiphenomenon of these material changes. Interpersonal or social problems reduce down to secondary consequences of the more primary disorder of self-regulatory mechanisms on a biological stage. But if we conflate PTSD with the study of anatomy, then we have effectively redefined the construct. Again, the construct is defined according to a multifaceted nosology and is delineated according to its criteria. Whereas Kraepelin postulated a discrete biological cause, the revisions of the Neo-Kraepelinian school moved towards a biopsychosocial model (Ghaemi, 2009). Misconstruing PTSD with anatomy would only mean that old theories die hard.

The same is true for learning theory. Friedman and Marsella (1996) write,

> Because the hallmark of PTSD is the response to a traumatic event, and because PTSD symptoms can be triggered by exposure to traumatic stimuli, no other psychiatric syndrome can be conceptualized in terms of classic learning theory as well as PTSD. (pp. 17)

But again, there is a danger here. Learning theory is an explanatory model that offers us an integrative framework for discussing PTSD symptomatology. But this same phenomenological set of symptoms can be approached by other conceptual models such as cognitive or psychodynamic theories. Learning theory is not the only way to look at this issue of trauma or the diagnosis of PTSD, and moreover, learning theory may offer perspectives and ideas that are not otherwise included in the PTSD construct. Or, it may struggle to explain some features (i.e., numbing) (Cahill and Foa, 2007). PTSD is not intrinsically defined by learning theory, even if learning theory offers a powerful explanatory framework.

If we allow learning theory to be seen as definitive of PTSD—or moreover, definitive of trauma—then we have bracketed the construct according to a particular explanatory model. Rather than testing the integrity of the construct, we have created a tautology. The definition would only include that which can be accommodated by learning theory and then organized into the diagnosis of PTSD. Learning theory would then explain PTSD by explaining itself. When we further conflate the terms trauma and PTSD, we introduce explanatory bias that potentially excludes or overlooks important dimensions that might be discussed as trauma. Trauma—as a concept—is not simply reducible to learning theory, even if learning theory can provide an explanatory model for trauma.

Appreciating this research without getting lost in it requires us to understand how different ideas may operate in concert and in parallel with the current PTSD construct. Unique

physiological profiles associated with the disorder do not provide incontrovertible evidence of the validity of the current construct, *per se.* These findings provide evidence of biological correlates that lend credence to the transformative power of the event, but it does not establish that these physiological features would not be better accounted for by other psychiatric or psychological concepts. Again, PTSD is not defined according to a biological constellation of features (Thakker and Ward, 1998), and features like heart rate or startle eye-blink are not diagnostic criteria. The concept of PTSD has to be evaluated on its own merits.

The same is true with respect to trauma. Recognizing how the brain-body reacts to extreme stress may offer a unique and objective vantage point on understanding the short- and long-term biological consequences of an event, but it does not encapsulate trauma as a concept. As we have discussed, the concept of trauma has always incorporated diverse perspectives from many different fields. Over-activation of the amygdala, for example, tells us nothing about how to negotiate the value propositions of economic liability or the moral terms of existential crisis. Trauma cannot be reduced to biology.

There are, after all, significant concerns in mapping neurobiological findings onto the disorder category of PTSD—even if this proved advantageous. Many studies have methodological issues including potential confounds. The extant literature frequently suffers from small sample sizes, limited population samples (i.e., mostly combat veterans), samples that are heterogenous in their use of medications, diagnostic comorbidity, limited generalizability, and a focus on chronic PTSD (as opposed to acute stress disorder, for example) (Southwick et. al., 2007). Potential confounds (i.e., comorbidity) and pertinent behaviors (e.g., tobacco use) are rarely controlled for in these studies. A significant portion of the early PTSD literature generally

lacks the methodological rigor to make truly sound, valid causal claims (Friedman & Marsella 1996; Marsella, et. al., 1992).

Even beyond any evaluation of methodology, the premise of incremental investigations may be misguided.

> Most studies in humans with trauma-related disorders have investigated one brain region or neurotransmitter system at a time. However, hormones, neurotransmitters, and neuropeptides are known to interact with one another in a complex fashion, so that alteration in one system affects the functioning in other systems. (Southwick et. al., 2007)

The brain's many regions are controlled simultaneously by multiple neurotransmitters, and the relationship between neurotransmitters and behaviors is equally complex. A behavior identified as a symptom may reflect multiple influences—a statement that is true across levels of analysis (i.e., neurologically, behaviorally, psychologically, etc.). The diversity of PTSD symptoms is unlikely to be explained by a singular set of interactions. It is more likely that each behavior will be explained by its own (relatively complicated) neurobiological processes.

Some perspectives in psychiatry have begun to explore how social relationships influence brain development. Assessing the nature of human interactions adds a new, qualitative, and (inter)subjective dimension to this research. It certainly adds to the complexity of the project, but also adds to the explanatory power of model. By drawing on the attachment paradigm, interpersonal neurobiology provides an empirical paradigm to investigate reciprocal dimensions in neurophysiology that reach beyond the brain-body as a closed system (Siegel, 2003). In other words, the theory offers a way of understanding how social relationships wire (and re-wire) the brain. This new paradigm offers a chance to examine the importance of age and upbringing. It allows our understanding trauma to go beyond fear circuitry and into more holistic and

developmental perspectives that are consistent with concepts like complex posttraumatic stress disorder (Ford, 2009).

Researching and modeling the neurobiological complexity of trauma poses an extraordinary challenge. Given the difficulty in accessing the central nervous system (practically, ethically) in humans (Southwick et. al., 2007), it would be premature to assume that answers to these questions are just over the horizon. Perhaps there is some temptation then to limit our study to those physiological changes which correlate to a narrow set of generalized conditioned stimuli. But that would not be the study of PTSD, and it certainly would not be the study of trauma. As van der Kolk (2007) writes,

> Although biological and treatment outcome research has made vast strides over the past quarter century, much remains to be learned about those issues, as well as about other complex posttraumatic phenomenon that have been repeatedly observed over the past 130 years but received relatively little attention at this point: automatic behaviors, dissociative states, problems with intimacy, focus, and attention; helplessness and persistent sense of victimization; as well as debilitating, ill-defined, and shifting somatic problems. (pp. 32)

If diagnostic frameworks prematurely narrow the focus of research, then perhaps the opposite can prove true for clinical work: the muddled demands of therapy can confuse what is and is not contained within the PTSD construct. Writing about the VA system, Litz writes,

> I believe that it is useful if not essential for clinicians, family members, the media, and veterans to be clear about PTSD as a clinical disorder, with a distinct set of causes, a course, and an approach to treatment. This might seem trivial and obvious, but I believe that in clinical practice, PTSD is overdiagnosed and overutilized in case conceptualization and in terms of explanatory labeling. There is also no doubt that in the culture, among family members, and among service members and veterans, PTSD is far too liberally applied and evoked to explain the diverse biological, psychological, behavioral, spiritual, and social consequences of warzone exposure. Why would clinicians be any less immune to this way of thinking? (Litz, 2014)

The danger is that when confronted with the panoply of traumatic symptoms—both included and excluded from the diagnostic criteria of PTSD—the temptation to lump it all together under the diagnosis misrepresents the concept. It confuses the boundaries of what the construct does and does not explain, making it possible to then explain everything (and nothing) at once.

In addition to the aforementioned findings, research into PTSD also reveals unusually high rates of comorbidity. In particular, rates are highest for major depressive disorder, panic disorder, alcohol abuse, and obsessive compulsive disorder (Friedman and Marsella, 1996). In men, alcohol abuse/dependence co-occurs most commonly, followed by depression, anxiety disorders, conduct disorder and other substance use issues. In women, depression and anxiety disorders are most frequent, followed by alcohol abuse/dependence (Jacobsen, Southwick and Kosten, 2001). Generally, such rates of comorbidity would suggest that something is askew in the nosology, but this is not a problem that is confined to PTSD. Co-morbidity/co-occurrence is a major concern in the nosology as a whole (Hyman, 2010), and the inextricable overlap in disorders undermines assumptions about discrete disease categories that the framers of the DSM-III had in mind. Framers of the DSM-5 made an intentional effort to include more dimensional measures (Regier, Narrow, Kuhl and Kupfer, 2009). What this means for understanding trauma and PTSD will be discussed later in conjunction with a review of common criticisms.

Research also established that PTSD in its present iteration is heterogeneous, varying across cases and cultures (Friedman and Marsella, 1996). As we will discuss later in this work, issues of culture and heterogeneity (among other concerns) raise important questions about the integrity of the construct. Research has gone a long way to strengthen the PTSD diagnosis, but it has also produced findings that could someday threaten to break apart the diagnostic category. In

general, research has found high rates of internal consistency. Predictions of expected correlations support the notion of construct validity, and its predictive validity has merit (Friedman, Resick, and Keane, 2007). It is fair to say that for many reasons—both empirical and practical—PTSD rightly commands a place in psychiatry. Despite having great currency, however, it has uncertain value and continues to evolve (Newman, 2001). It is likely to remain in this liminal state for some time (Ray, 2008; Symes, 1995). One of the goals of this work is to shed light on the theoretical issues that make us ask how a concept like PTSD can be both so well constructed and so much in flux at the same time.

In the next section, we will look briefly at how clinical practice has used the concept to treat trauma when seen through the lens of PTSD. Perhaps the major preoccupation of this work requires us to understand how the theoretical assumptions that underlie the concept ultimately play out in the process of treatment.

Review of Clinical Interventions

This discussion of the clinical literature is limited in scope and is only intended to provide a cursory overview of common practices. As a sampling of meta-analyses and annual reviews, it presents summary conclusions about the state of research in treatment. An important early caveat: this review only discusses the English language literature. Some of the authors cited here acknowledge this limitation in their own work (e.g., Bisson, et. al., 2007; Bradley, Green, Russ, Dutra and Westen, 2005), but it should be recognized that the findings discussed here run the risk of precluding important cross-cultural work or trends pioneered by non-English-speaking clinicians.

The treatment of PTSD relies on both psychopharmacology and psychotherapy. Among medications, selective serotonin reuptake inhibitors (SSRIs) are both the most frequently studied and the most efficacious. SSRIs show effects across symptom clusters and have fewer side effects than other drugs (Keane, Marshall and Taft, 2006). They may be particularly helpful with intrusive and depressive symptoms, but they tend not to confer lasting benefits (Van Etten and Taylor, 1998). In other words, they tend towards relapse upon discontinuation (Cahill, Pontoski and D'Olio, 2005). Other antidepressant medications—such as TCAs and MAOs—have some evidence of efficacy, but are rarely prescribed due to side effects, potential for toxicity, and/or necessary restrictions in diet and medication. Trazadone and nefazodone are often used as adjunctive treatments for symptoms like insomnia (Keane, Marshall and Taft, 2006). Mood stabilizers like carbamazepine show similar effects: they show some utility in diminishing symptoms, but gains are not maintained upon discontinuation (Van Etten and Taylor, 1998).

Other types of medications like anticonvulsants may be prescribed, especially in light of neurological hyper-sensitization and "kindling". Results are qualified and side effects can be an issue. Prazosin—an anti-adrenergic medication—has been prescribed to alleviate nightmares, improve sleep, and lessen other symptoms. Antipsychotics are generally not recommended and have not been subjected to extensive study. Atypical or second generation antipsychotics do have some usage for psychotic-like symptoms like paranoia, dissociation or intense anger. None of these classes of medications have the same efficacy or research base as SSRIs, however, and SSRIs only boast of modest effects (Keane, Marshall and Taft, 2006).

In general, the use of psychopharmaceutical medications does not have a strong standing in terms of demonstrated efficacy. In a 2007 review by the Institute of Medicine (IOM), it

concluded that there is insufficient evidence to make treatment policy conclusions for any of the aforementioned medications. It also declined to draw conclusions about the use of benzodiazepines or drugs such as naltrexone, cycloserine, or inositol (IOM, 2007). Van Etten and Taylor (1998) concluded in a meta-analysis that when medications were compared to psychotherapy, psychotherapy proved to be the preferred intervention. Dropout rates for therapy were lower than drug trials (14% vs. 32%, respectively). Therapy and medication both conferred more benefit than wait list or controls, but therapy posted better results in outcome. All in all, pharmacological treatments may be most helpful as adjuncts to psychotherapy (Bisson, et. al., 2007).

Contemporary approaches to psychotherapy defy blanket statements, and there is considerable diversity among clinical practices (Bisson, et. al., 2007). Individual therapy is most common, although group treatment (which is not discussed in this review) also occupies an important role (Sherman, 1998). This review gives brief consideration to major clinical perspectives. Behavioral therapies draw on learning theory and generally inform the paradigm of exposure-based treatments. These interventions rely on strategic re-exposure to frightening stimuli in controlled situations in order to extinguish learned associations. This de-sensitization can be understood on many levels from neurobiology (i.e., “re-wiring” synaptic networks) to cognitive processing (i.e., training explicit associations) (Marsella, et. al., 1992.). Targeted exposure de-conditions a fear-response while reducing hyperaousal and a perceived need for avoidance. Exposure may be rapid (e.g. flooding) or graduated (e.g., progressing from imaginal to *in vivo* exposure). Prolonged exposure (PE) represents a common and well-studied example (Foa and Rothbaum, 1998).

Many other orientations incorporate procedures that are analogous to exposure treatments. Cognitive therapies suggest that while the event may have been terrifying, the protracted experience of pathology hinges on the person's negative beliefs about the event. For example, a distorted belief that, "I should have done more to stop it," can lead to affective symptoms of guilt and recrimination. Ongoing distorted appraisals of risk effectively maintain the trauma response. Cognitive restructuring works on changing negative beliefs, and may involve "homework" that tests "experiments" about the accuracy of anticipated outcomes (Cahill, et. al., 2005). Traumatic experiences are also processed, meaning that they are subjected to repeated consideration and analysis in order to better integrate cognitive and affective aspects of the event (Briere and Scott, 2013c). Cognitive interventions are commonly paired with behavioral interventions, and trauma-focused cognitive-behavioral therapy (TF-CBT) represents a major approach to clinical practice (Bisson, et. al., 2007).

Another feature of cognitive treatments includes psychoeducation which may also be used in CBT or adjunctively with other treatments. Psychoeducation involves sharing clinical knowledge with trauma survivors so that they better understand their behaviors and reactions (Cahill, et. al., 2005). For example, psychoeducation may educate people about how fear circuitry works in the brain and how that relates to symptoms. Whereas survivors may have felt they were "going crazy", psychoeducation can help allay these fears. Psychoeducation typically should not be used as a stand-alone treatment, however. (Briere and Scott, 2013a).

Stress inoculation training (SIT) or other relaxation training treatments teach survivors to use techniques such as deep breathing, muscle relaxation, or "grounding" exercises to orient them to their senses. These techniques can help people to cope with lability in their mood or the

distress caused by intrusive imagery, among other things. By helping establish stability, these techniques help survivors to cope and to reengage with world. Often times, these approaches to treatment can lead to the development of on-going practices such as yoga or meditation (Briere and Scott, 2013b).

Eye-movement desensitization and reprocessing (EMDR) incorporates elements of cognitive processing along with a series of clinician-directed eye movements. Invoking an adaptive information processing model of the brain, EMDR proposes to help process disturbing experiences that "block" the natural "metabolization" of experience (Shapiro, 2007). This approach remains contentious in the field for many reasons—one of which relates to the fact that the method preceded the theory. While post-hoc explanations reference neurobiological states of dyssynchrony in brain functioning that can be "reset" or "rebalanced" by either eye-movements or bilateral stimulation (i.e., tones, tapping), questions remain about the extent to which it corresponds to current understandings of the brain (Keane, Marshall and Taft, 2006). Empirical findings in clinical studies have been inconsistent, and additional criticism argues that while the theory may work effectively, it may not do so for its stated reasons (Sherman, 1998).

Psychodynamic psychotherapy has a long tradition of different perspectives on trauma, making it difficult to adequately summarize here. Freud's first theory of seduction looked at caregivers' transgressions, but he revised to focus on intrapsychic conflict over unbidden desires. His formulations have little resemblance to current psychodynamic approaches, however. Sandor Ferenczi challenged these perspectives in the early 20th century and was initially shunned from the psychoanalytic community. His work was later reclaimed and re-valorized by later writers (Rohr, 2012). More recently, Boulanger (2007) and Stolorow (2007) have offered

examples of new perspectives on trauma in keeping with interpersonal, post-modern philosophies and contemporary schools of thought (Coates, 2003). As an umbrella statement, however, Gerrity and Solomon (1996) offer the following: "According to psychodynamic theory, traumatized individuals are faced with the task of integrating the traumatic event into their understanding of the meaning of life, self-concept, and world image" (93). Not only is this a cognitive challenge, but psychodynamic theories also look holistically at the individual's experience, which includes developmental, ecological and interpersonal perspectives (Schottenbauer, Glass, Arnkoff and Gray, 2008).

In the most general terms, trauma therapy works towards integration (Herman, 1992). Treatments often have common elements that involve "working through" the event and making sense of what happened. This may include re-appraising risks, facing fears, and finding meaning or purpose in the aftermath (Sherman, 1998). The literature boasts of many different models and theories, some of which have strong exposure elements. Examples include narrative exposure therapy [NET] (Neuner, Schauer, Klaschik, Karunakara, and Elbert 2004), testimony therapy (Cómite de Defensa, 1989; Weine, et. al., 1998), and the counting method (Johnson and Lubin, 2005).

Other treatments draw on diverse ideas and traditions. Hypnosis attempts to work directly with unconscious processes (Gafner and Benson, 2001) while mindfulness invites people to expand their awareness as means of practicing greater acceptance (Briere and Scott, 2013d). Sensorimotor therapy works with the body to understand the ways in which distress is expressed somatically (Ogden, Pain, Minton, and Fisher, 2005). Ecological approaches (Harvey, 1996; Harvey, 2007) understand the broader context of the survivor's life and build on their resources

in the community. Other research has involved yoga, improvisational theater, self-defense techniques (van der Kolk, 2006), music therapy, mother-child dyads, and a combination of acupuncture, chiropractic medicine and psychotherapy (Palic and Elklit, 2011).

Again, the purpose here is not to provide a comprehensive review or contrast the relative merits of each approach. This reviews intends only to showcase the current diversity and complexity of different ideas. At the very least, the field maintains a wide diversity in emphasis; for example, some practices are more focused on making meaning from the event while others focus on modulating arousal (van der Kolk, 2006). Just in the same way that different trauma theories formulate different conceptualizations of the problem, these formulations direct the focus of clinical intervention.

As research studies the virtues of different approaches, there remain important questions about the best way to measure treatment efficacy. Many studies track the reduction of symptoms and report on percentages of subjects who no longer meet criteria for the disorder. This may misrepresent residual or subsyndromal distress, however. It may also misrepresent changes registered between pre- and post-morbid functioning. An individual's optimal functioning may be a far cry from their post-traumatic functioning, and the full scope of a trauma's impact may not be captured by a catalogue of their symptoms (Gerrity and Solomon, 1996). Diagnostic criteria in and of themselves tell us little about post traumatic growth or resilience (Tummala-Narra, 2007).

Bradley, et. al. (2005) found that on average, of the patients who complete established treatments, 67% no longer meet criteria for PTSD. Comparable results were found by Sherman (1998), whose earlier meta-analysis indicated an expected improvement rate for 62% of those in

treatment. Sherman tabulated that 38% can expect to improve on their own, whereas Bradley pegged the recovery rate—independent of completing treatment—at 57%. Many of these individuals remain highly symptomatic, however (Bradley, et. al., 2005; Sherman, 1998). A common concern in interpreting the research, however, recognizes that patients who do not improve typically drop out of treatment. In light of these findings, an estimated 40-70% of clients may benefit—at least in the near term—from short-term, symptom-focused treatments (Bradley, et. al., 2005).

A large body of research has touted the efficacy of CBT treatments. CBT has proven effective with a wide range of adult populations (Cahill, et. al., 2005; McDonagh, et. al., 2005; Paunovic and Ost, 2001). Meta-analyses have established CBT, behavioral treatments and EMDR as efficacious in alleviating PTSD (Benish, Imel and Wampold, 2008; Bisson, et. al., 2007; Bradley, et. al., 2005; Sherman, 1998; Van Etten and Taylor, 1998). A large initial improvement in symptoms and a reduction in "case-ness" commonly follows treatment. (Bradley, et. al., 2005; Sherman, 1998). In a review of treatment for chronic PTSD, Bisson, et. al. (2007) found trauma-focused CBT and EMDR to be efficacious as compared to wait-list or usual care; the former also positively impacts depressive symptoms. They found that these treatments showed greater gains than supportive or non-directive treatments, leading them to argue that, "A course of trauma-focused psychological treatment should be offered to everyone with chronic PTSD" (Bisson, et. al., 2007). They are not alone in their position: Friedman, et. al. (2007) asserts that, "All clinical practice guidelines for PTSD identify CBT as the treatment of choice" and this is recognized in other national standards (National Institute for Clinical Excellence 2005).

Discriminating among treatments can pose challenges, however. Not everyone who undergoes these treatments is expected to benefit, and secondary or second-line treatments are possible, perhaps necessary (Bisson, et. al., 2007). Case studies support claims of efficacy for humanistic and psychodynamic models, but there is an insufficient research base for drawing conclusions (Bradley, et. al., 2005). It can be difficult to clearly discern what the research does or does not indicate. When Bisson, et. al. (2007) conducted their meta-analysis, they created composite groups to look at aggregate effects with statistical significance. Recognizing the amount of available research, they constituted both CBT and EDMR as separate categories. When they found insufficient numbers research studies to sufficiently constitute a separate arm for analysis for "other treatments," the authors grouped them into a third category of diverse practices. Ultimately, they concluded that these "other treatments" were less efficacious than CBT or EMDR, but they stopped short of drawing conclusions about their ineffectiveness (Bisson, et. al., 2007).

Benish, Imel and Wampold (2008) criticized this methodology on the grounds that it misrepresents different approaches to therapy. As constituted, the category of "other therapies" in Bisson et. al.'s meta-analysis represents a potpourri of techniques without an overarching rationale. It mixes bona fide treatments with control conditions that are not formulated as stand-alone therapies. In the language of logic, the category represents a 'straw man' and conclusions about the comparative (in)efficacy of treatments in the absence of research are premature. When Benish, Imel and Wampold conducted a meta-analysis that only compared the effects among bona fide therapies, they failed to find evidence of differences in terms of outcome or symptoms. They suggest that common factors may be at work.

Despite some claims about the superiority of CBT/exposure-base therapies, several meta-analyses continue to refute this position and found no reliable differences in outcomes over time (Benish, Imel, and Wampold, et. al., 2008; Bradley, et. al., 2005; Sherman, 1998; Van Etten and Taylor, 1998). In a summary of PTSD research, Cahill, Pontoski and D'Olio (2005) found little evidence of the superiority of CBT over control conditions and no evidence for the superiority of one treatment modality over another. Uncertainty remains about how some treatments work (Van Etten and Taylor, 1998) and guidelines for best practices offer only limited direction in cases of "treatment resistant" PTSD. Many traditional therapies for abuse, stress and combat are only effective in 50% of patients—many of whom have suffered many different kinds of physical and psychological injuries (Xenakis, 2014). In the case of CBT treatments, for example, half of patients achieve full remission of symptoms—leaving the other half of patients with partial or no remission (Friedman, et. al., 2007).

Not all treatments appear to impact symptoms in the same way, and making generalizations about treatment can be confounding. Evidence for behavioral treatments show greater efficacy in reducing positive symptoms (i.e., physiological arousal, nightmares, anger) in contrast to reducing negative symptoms (i.e., numbing, alienation, affective constriction) (Sherman, 1998). Combat-related symptoms show the least impact from treatment (Bradley, et. al., 2005).

Research criteria also complicate generalizability. The IOM (2007) cautions that the tendency only to report on treatment completion introduces a strong bias in favor of treatment efficacy. A positive relationship exists between exclusion criteria and favorable outcomes—meaning that the more narrow the selection criteria, the better that clinical protocols appear to

work. Clinical trials tend to exclude roughly 30% of referrals, which raises questions about generalizability (Bradley, et. al., 2005).

Many exclusion criteria screen out individuals suffering from other psychiatric disorders. By not attending to the problem of co-morbidity/co-occurrence, generalizability is reduced when in fact comorbidity is so common (Friedman and Marsella, 1996; IOM, 2007). Psychotic symptoms, for example, are often excluded in the study of trauma response despite increasingly recognized associations between trauma and psychosis (Bradley, et. al., 2005). Co-morbidity is often approached as though symptoms and/or disorders can be treated independently. For example, it as if intrusion and affect are separable and can be handled *a la carte*, as if adding modules onto treatment practices. This approach is not supported in the literature, but narrow inclusion criteria continue to be common research practice (Bradley, et. al., 2005).

Without unduly disparaging the progress of treatment research, it is important to recognize how its many weaknesses—e.g., high drop-out rates or weaknesses in handling missing data—can introduce significant bias. Research often does little to account for an individual's developmental or trauma history (Bradley, et. al., 2005), and few studies adequately incorporated gender-specific factors (Hegadoran, et. al., 2006). A lack of reporting about adverse effects in treatment raises particular concerns about drop-out rates (Bisson, et. al., 2007). Because no single measure can tell the whole story of a treatment, researchers should include multiple outcome measures. Moreover, no story is every summarized by a single point in time. The paucity of follow-up measures in most studies precludes any assumptions about lasting treatment effects. The existing longitudinal data often does not account or control for other

possible factors in recovery. Because treatments often share common techniques or factors, making causal claims is difficult (Bradley, et. al., 2005).

Aggregating findings can be difficult. For example, Benish, et. al., (2008) note that many meta-analyses on trauma incorporate research findings into statistical models that are underpowered to adequately assess for significant results. Bradley, et. al., (2005) have warned that not enough is written about bias in meta-analysis. This can translate into uncertainty in best practices. For example, the IOM (2007) found insufficient evidence to make policy conclusions about similarities or differences between veteran and civilian populations. In other words, there is not enough research to empirically conclude that veterans and civilians would equally benefit from the same treatment protocols. It also appears premature to scientifically conclude that different cohorts of veterans can all benefit the same things in therapy (IOM, 2007).

In general, it appears that short-term symptom-focused treatments are helpful for roughly two-thirds (67%) of the people who complete them, even if that means they still have symptoms. At least one-third (33%) will complete a treatment protocol and still meet criteria for PTSD, and 21% will drop out of treatment before completion (Cahill, et. al., 2005). It is harder to draw conclusions about the number of people who suffer PTSD but do not engage in therapy or whose cases are not studied in research because of complicated or co-morbid symptom presentations. The extant literature does not answer many questions about the relative efficacy of combined treatments (Van Etten and Taylor, 1998). For example, Foa, et. al. (2005) compared the efficacy of PE with and without cognitive re-structuring and found that while both are efficacious, the combination showed no added benefit. Understanding how different treatment techniques may complement one another will take time and research.

There is some evidence of improved efficacy of CBT and medication, but results are not conclusive. Medication appears to be more widely accessible to the general public than access to providers who follow manualized treatments (Cahill, et. al., 2005). Community-based clinicians may not follow protocols used in research for many different reasons. For example, in community-based populations, rates of co-morbidity can be as high as 83%, highlighting the different imperatives of research and practice (Bradley, et. al., 2005). Even proponents of evidenced-based practices acknowledge limitations. Foa, Hembree, and Rothbaum (2007) notably specify that, "prolonged exposure is a treatment for PTSD, not a treatment for trauma" (pp. 21). What we know about the treatment of PTSD has grown considerably, but a major gap remains, owing in no small part to both the limitations of research and the complexities of practice.

Some authors have pushed to look beyond a narrow view of "best practices" and recognize that easy prescriptions are hard to make (Xenakis, 2014). Unfortunately, according to an IOM report (2014), neither the VA administration nor the Department of Defense are well positioned to evaluate and monitor PTSD outcomes. Considering that these agencies represent two of the major N. American systems concerned with the treatment of trauma, this reflects the challenges of enhancing our approach to "best practices".

In light of drop-out rates, the number of people who are not helped by current treatments, and the knowledge gap around issues like co-morbidity, there are reasons to promote an inclusive approach to treatment. Benish, et. al., (2008) call for developing new and combined treatments, disseminating evidence-based practices, and conducting efficacy/efficiency tests in "real world" settings. Rather than stipulating a particular type of therapy, they suggest that optimizing

retention and participation in therapy may be the better course of action. Patient preference is also very important in light of dropout rates (Cahill, et. al., 2005), and more research is needed into understanding patient preference (e.g., Zoellner, Feeny, Cochran, and Pruitt, 2003).

The state of PTSD treatment is multifaceted and complex. It is characterized by both similarities and differences, and while it shows good effects for many cases, it exposes striking deficits for others. Despite common claims for the superiority of some treatments, there is little evidence to suggest that a definitive approach for treating PTSD has emerged. "Real world" challenges suggest that we need new and original ideas to contend with people's complex reactions. As Herman (2008) writes,

> The state of current knowledge should not be arbitrarily restricted to treatment outcome findings that can be demonstrated rigorously within the constraints of the very crude methodologies that have so far been developed. We are nowhere near to establishing a gold standard in trauma treatment.

Moreover, if research learns in fits and starts about treating PTSD, it remains to be seen everything we still do not know about treating trauma. Again, these are not synonymous terms. As we will discuss in the next section, there are many different criticisms of the PTSD construct. Several of these have influenced the latest revision in DSM-5, but many of them remain open issues for debate. These objections offer us our clearest point of entry into understanding the dynamic tension between theoretical assumptions and clinical practices.

III. Constructive Criticism of the PTSD Diagnosis and Revisions to the DSM 5

Few diagnoses are more controversial than PTSD (Spitzer, First and Wakefield, 2007), and its criticism takes many shapes. There are critiques that are largely technical in nature and address the relative merits of the research base. There are also critiques that object to the entire paradigm. Some of the criticism of PTSD can be understood as rebukes to the way that the field has generally approached trauma. Whereas some writers are aiming to improve to the diagnosis, others discount it entirely. Further still, there are writers who hope to reframe the debate in ways that help us understand what the diagnosis is and is not.

Given this range of ideas and interests, it can be helpful to introduce some organization when reviewing these ideas. This review starts with ideas that come from within the paradigm before shifting to criticisms that critique its assumptions. The debate has prompted criticism from not only clinical disciplines like psychology or psychiatry, but also from medical anthropology and the subfield of transcultural psychiatry. Because this encompasses multiple bodies of literature, I make no claim that the review offered here is comprehensive or exhaustive. Conceptually speaking, this review is intended to sketch the major criticisms and fault lines in the construct. While some effort has been made to differentiate arguments and ideas, the reader is invited to regard these distinctions for their practical utility. More often than not, one idea dovetails with the next in ways that make them difficult to separate conceptually, even if we can distinguish them discursively.

In some ways, we can think of the new edition of the DSM as a snapshot in the debate over trauma diagnosis. Long-standing disagreements in the study of trauma pushed and jostled to shape the latest revision, and the result reflects a combination of research, compromise and

cooperation (Reiger 2009). Examining the debates that shaped the DSM-5 provides an effective introduction to criticisms of the concept. In this chapter, we will review findings that produced changes in the DSM 5 as well as criticisms intended to improve the current paradigm. In the next chapter, we will consider arguments that challenge the contemporary approach to trauma.

In many ways, much of the criticism can trace back to the definition of 'trauma' (Friedman et. al. 2011). How broad should the definition be? What should it be based on? Should it be broadly inclusive or narrowly restrictive? These questions take aim at Criteria A, which have traditionally operationalized trauma in terms of the event. What kinds of events can cause a trauma reaction? And, what is our point of reference to understand the experience of those events? Should we understand them objectively or subjectively? The DSM III was vague in its definitions and made a misguided appeal to frequency as the distinguishing feature. The magnitude of the event was seen as pivotal in its definition, but establishing an independent assessment of magnitude proved difficult and impractical (Lasiuk and Hegadoren, 2006b).

DSM-IV introduced a two-part criteria that included both objective and subjective dimensions, largely with the hope of incorporating the uniquely personal reactions of the individual (Lasiuk and Hegadoren, 2006b).

> Expansion of the stressor criterion to include such subjective components opens the door for consideration of psychological, experiential, and ethnocultural factors that mediate emotional responses to stressful events. Such factors also include the individual's subjective response to the historical, social, and political context in which stressful events occur." (Friedman and Marsella, 1996, 15)

Criterion A2—which required that the event be experienced with fear, horror, or helplessness—was a nod to the complexity of personal experience.

Introducing subjectivity into the diagnosis proved to be one of the more contentious points in the development of PTSD. If these emotions are featured as part of the criteria, then they presumably constitute a central feature of the disorder or perhaps have a causative role (Weathers and Keane, 2007). This role is unclear, however. First of all, when do these feelings happen? Are these emotions assumed to be concurrent with event? In the immediate aftermath? What about in retrospect? Do these intense emotional experiences cause the trauma reaction? Are they signature features because they are believed to be predictive of the disorder? The language of the criteria does not clarify this relationship, and research has found that Criterion A2 is only weakly predictive of PTSD (Friedman et. al., 2011; Kilpatrick, Resnick and Acierno 2009) . Dropping Criterion A2 does not significantly alter prevalence rates (Friedman et. al., 2011).

Some writers have argued that the criteria only describes the usual context of the stressor without adding to its diagnostic precision (Brewin, Lanius, Novac, Schnyder and Galea, 2009). Training—such as in the case of combat soldiers or EMTs—can inhibit a fear response during the event, but not necessarily prevent the individual from later meeting criteria for PTSD (Kilpatrick, et. al., 2009). Some cases of traumatic brain injury (TBI) have shown that in spite of being knocked unconscious—and ostensibly lacking in a clear affective response—these individuals may go on to develop PTSD symptoms (Weathers and Keane, 2007). Other emotions, such as anger, shame, guilt, betrayal, and grief (Fromm, 2014; Resick and Miller, 2009)—in the absence of fear, horror, or helplessness—have been associated with a characteristic PTSD response (Weathers and Keane, 2007). These emotions may also play an important role in the maintenance of symptoms (Resick and Miller, 2009).

Over the years, several researchers have argued against Criterion A2, and as a result, it was removed from the diagnosis in DSM-5 (APA, 2013). Originally, the response to DSM-III forced a recognition of subjective elements, but the field has come full circle to eliminate subjective criteria. An operational approach to traumatic events now hinges on qualities like the magnitude, complexity, and uncontrollability that the individual experiences. This unfortunately does not afford an easy rubric for standardizing comparisons. By the same token, the need for a unified definition demands a degree of specificity (Weathers and Keane, 2007).

Specificity has typically been addressed in Criterion A1, which lists both general qualities and specific examples of "potentially traumatic events". The DSM-5 definition retained Criterion A1, but not without some dispute over its definition of trauma (Friedman et. al. 2011; Weathers and Keane, 2007). A major concern in the literature deals with the breadth of the definition. The DSM-IV expanded the criteria to include learning about traumatic events that happened to loved ones. Learning about—but not directly experiencing—extreme events began to be seen as traumatic, and this represents the first time the diagnosis moved beyond first-hand exposure (Rosen, 2004). Critics contend that this gradual expansion amounts to "bracket creep" (McNally, 2009) which weakens the integrity of the concept. In this line of thinking, it frustrates the search for biomarkers and moves the diagnosis away from its original rationale of describing the extreme events (McNally, 2009).

When we create a category that includes such diverse experiences as learning of a loved one's car accident along side of surviving a concentration camp, that certainly challenges the face validity of the concept (McNally, 2009). Using DSM-IV-TR criteria, some estimates suggest that 89.6% of the U.S. population has experienced a "potentially traumatic

event" (Kilpatrick, et. al., 2009). Given the relative rarity of developing PTSD, it would seem etiologically problematic to cast such a wide net in looking for potential causes of trauma (Friedman et. al., 2011). Some critics contend that unless the field establishes a clear threshold for the definition, it runs the risk of "trivializing" the suffering of the most wounded (Weathers and Keane, 2007). When it comes to the breadth of the concept, for what purpose is it being defined so broadly (Kilpatrick, et. al., 2009)?

If some critics have fought to narrow the scope of the definition (e.g., Spitzer, First and Wakefield 2007; Merskey and Piper, 2007), others have argued for the opposite and sought to make it more inclusive. Certainly some kinds of events—such as medical amputations (Cavanagh, Shin, Karamouz, Rauch, 2006) or intensive care procedures (Wake and Kitchiner, 2013)—may not have come to mind when the original diagnosis was framed, but these incidents provide good evidence of meeting the basic definition. There is empirical validation of indirect exposure as leading to trauma response (Friedman et. al., 2011), and some events that do not meet criteria—for example, divorce, collapse of adoption, financial problems, loss of cattle to disease—have demonstrated PTSD-like reactions (Gold, Marx, Soler-Baillo and Sloan, 2005; Mol et. al., 2005). It is important to acknowledge that as the boundaries of the PTSD trauma response are explored, methodological questions remain (Brewin et. al., 2009).

One problem with standardized descriptions of events is that they incorrectly assume that the capacity to cope is standard across a population. Two individuals may experience the same event in very different ways, which raises questions about how much the event itself truly matters. If we subscribe to the idea that the disorder can be summarized according to a distinct neurobiological profile, then there is grounds to argue that the cause is irrelevant (Brewin et. al.,

2009). Conversely, some writers contend that the experience of the event is the essence of the disorder. For example, a flashback "flashes back" to something specific that happened—not to something abstract. In terms of PTSD, one can only be traumatize by a specific event, and so the experience has to be thought of as necessary but not sufficient to the disorder (Friedman et. al., 2011). Here, are we more concerned with a biological profile, or an etiological process? These may or may not prove to be mutually exclusive—depending on how they are formulated.

In the DSM 5, concerns about inclusivity trumped concerns about "bracket creep" (McNally, 2009). The new edition expanded the range of potentially traumatic events to include exposure to aversive stimuli. The shift is subtle in that it focuses less on the event as an episode and more on the experience of stimuli that are gruesome or distressing in the extreme. The DSM 5 makes allowances for a heterogenous presentation of symptoms, but the core of the diagnosis remains the moment of crisis. The full criteria (for adults) can be see in Table 1. Criteria A now requires "exposure to actual or threatened death, serious injury, or sexual violence 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… (4) experiencing repeated or extreme exposure to aversive details of the traumatic event(s)" (APA, 2013).

Over the years, the language of diagnosis remained ambiguous and difficult to operationalize. For example, several phrases from the DSM-IV-TR such as "confronted with," "threat to physical integrity," or "inappropriate sexual experiences," defy easy or consistent definition (Friedman, 2009). Ambiguity notwithstanding, some features of the disorder have remained the same across iterations. Consistent with the previous edition, the text of PTSD in

the DSM 5 stipulates that, “The essential feature of a posttraumatic stress disorder (PTSD) is the development of characteristic symptoms following exposure to one or more traumatic events” (APA, 2013). This central thread runs through all of the editions of the DSM, and has been generally consistent even as the criteria has evolved (Kilpatrick, et. al., 2009).

Table 1: DSM 5 Diagnostic Criteria for PTSD in Adults (APA, 2013)

Diagnostic Criteria

Posttraumatic Stress Disorder 309.81 (F43.10)

· **Note:** The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see corresponding criteria below.

A. Exposure to actual or threatened death, serious injury, or sexual violence 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 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).

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 consequences 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 physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Specify whether:

§ **With dissociative symptoms:** The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:
   1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
   2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).
   § **Note:** To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Specify if:

§ **With delayed expression:** If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

While the core of the diagnosis has stayed the same, the structure of the disorder underwent significant revisions in DSM 5. Multiple analytic studies indicated that the a three-factor model of symptom clusters (intrusion, avoidance/numbing, and hyperarousal) was sub-optimal in accounting for the data. Some studies suggested that a two-factor model would work

better (Buckley, Blanchard and Hickling, 1998), but the predominance pointed towards a four-factor model of intrusive experience, avoidance, persistence of negative mood and cognition, and alterations in reactivity (Asmundson, et. al., 2000; Friedman et. al. 2011; Rasmussen, Smith & Keller, 2007). Notably, this incorporates elements of affective distress such as anhedonia or depressed mood.

The DSM 5 introduced a second major revision by re-classifying PTSD in the new category of Traumatic- and Stress-Related Disorders (APA, 2013). Previously, the manual regarded PTSD as an anxiety disorder because it was assumed that not unlike other phobic reactions, fear and anxiety were the primary emotions involved. Laboratory-based findings have not implicated anxiety, however, and studies show high rates of comorbidity with not only anxiety and mood disorders, but other diagnoses including eating disorders, substance use disorders, personality disorders, and somatoform disorders (Watson, 2009).

If many of these disorders disproportionately coincide, then it raises difficult questions about how to meaningfully distinguish them as separate disease processes delineated by "zones of rarity" (Kendell and Jablensky, 2003). A 'zone of rarity' constitutes a natural boundary in which case examples do not occur (or rarely occur), indicating that either such a kind does not exist or the variable in question is not continuous. In other words, a 'true' disorder should have a clear profile that does not blur or overlap with a variety of other disorders (Kendell and Jablensky, 2003). The problem of comorbidity creates a mishmash of overlapping symptoms (Brewin et. al., 2009), and PTSD appears to have a causal influence on many other disorders (Resick and Miller, 2009). The question becomes not only 'which category,' but if it should be its own category or even a category at all. The latest edition moved PTSD into a new category in

order to acknowledge the heterogeneity of trauma reactions, even though some overlap remains with anxiety, dissociative, and obsessive-compulsive disorders (APA, 2013).

Developmental considerations have historically been missing from the PTSD diagnosis, and the DSM 5 took steps towards a developmentally sensitive perspective. The diagnosis proved inadequate for working with very young children (Friedman et. al. 2011; Scheeringa, Peebles, Cook and Zeanah, 2001) and Pynoos et. al. (2009) argue that trauma in children requires a special appreciation of how different types of stressors (e.g., threat to caregiver) can have a unique salience. Developmental accomplishments (or deficits)—such as the ability to recognize and label emotions—impact the way that distress is experienced and expressed. Trauma can arrest development or cause regression, and the compounding effects of multiple traumatic events needs to be considered in light of development. The new edition included separate criteria for children under the age of six (APA, 2013).

The DSM committee also reviewed considerations for PTSD subtypes which may fit under the broad heading of the disorder. Proponents of the PTSD diagnosis continue to assert that it represents a universal category, modified in presentation by cultural idioms of distress and heterogenous symptom presentations (Friedman et. al., 2011). The DSM 5 elected to formalize two of these variations as dissociative subtypes, namely those of depersonalization and derealization (APA, 2013). The research into "complex PTSD" appeared to have "an uneven quality" (Friedman et. al., 2011), which prompted the committee to defer on the possibility that complex PTSD represents a subtype of the disorder. Subtyping includes the possibility of less severe forms, and different definitions of subsyndromal PTSD in the literature hampered any

ability to draw conclusions about milder expressions of the disorder. No changes were made in diagnostic criteria on this issue (Friedman et. al., 2011).

Overall, the new DSM 5 diagnosis provides a better actuarial account of symptom presentations thanks to its revised four-factor model. It incorporates affective distress, which had long been observed in the comorbidity/co-occurrence of depressive symptoms. This edition reclassifies trauma into its own category in order to acknowledge the unique and heterogenous qualities of such disorders. Developmental concerns and subtype variations attempt to offer more flexibility to account for the range of human suffering. There is strong concordance between the DSM-IV-TR and DSM 5 disorders, although more studies are needed as new populations are considered (Calhoun, et. al., 2012).

Despite these many concerns and thoughtful revisions, the DSM 5 did not end the debate about trauma studies, and several criticisms still stand out in the literature. Friedman, Keene, and Resick (2007) attempted to catalogue some of the common criticisms of PTSD, and their review is helpful here. Their commentary generally offered little exposition of the arguments in full, however, and before any rebuttal or response is possible, it is important to consider these positions more fully. Again, the purpose of this review is not necessarily to weigh in on these debates or find solutions to the dilemmas they pose. Rather, this review attempts to look more closely at the arguments in order to expose the different theoretical tensions that push and pull these ideas.

Empirical Foundations

One basic criticism of PTSD is familiar to all of the social sciences, namely that the concept lacks a scientific basis. In the case of PTSD, the idea that "verbal report is

unreliable" (Friedman, et. al. 2007) is an invocation of long-standing epistemological issues about the relative merits of social science research (e.g., see Bohman, 1993). Just because someone said something, how do we know it is true? Skepticism of verbal reports could be applied to all of psychiatry (Friedman, et. al., 2007), and short of abdicating the psychological and social dimensions in the biopsychosocial approach, there is little that can be done. Regarding the biological dimension of this approach, research into biomarker and genetic components is discussed in Chapter Two.

A comparable idea suggests that "traumatic memory is not valid" (Friedman, et. al., 2007) because physiological arousal can impact the process of encoding, storage and retrieval in memory. Research has established that memories can be lost and spontaneously retrieved, but not all memory—traumatic or otherwise—is accurate (International Society for Traumatic Stress Studies, 1997). Again, the epistemological suppositions of "science" and rigor of what constitutes evidence can be debated, even though it would seem unwarranted to completely invalidate the integrity of the entire intellectual project upon recognition that some of the "data" is unreliable.

An equally salient issue in the study of trauma looks beyond clinical questions to consider secondary gains. The symptoms of PTSD lend themselves to malingering and can be easily feigned. Rosen and Taylor (2007) point out that virtually none of the published research on PTSD attempts to rule out or assess for malingering. Not only is this a rarely considered confound, the authors suggest that the base rate of "pseudo-PTSD" is unknown and therefore unaccounted for in drawing conclusions. The authenticity of PTSD pathology remains difficult

if not impossible to independently assess, making it very difficult to conclude with certainty when distinguishing "real" cases from malingering.

The scientific bona fides of trauma research—as a field—are also compromised by shifting terminology. As previously discussed, the word "trauma" has been inconsistently used to describe both the event (stimulus) and the reaction (response) (McNally, 2009). Cohen (2001) has argued that a lack of specificity in terms is hardly unique in medicine, and while this may constitute a methodological and conceptual problem, it would not invalidate the subject of study. Again, it is a central premise of this work that the word "trauma" refers to the relationship that exists between an experience and the suffering that follows from it. As a clarification of terms, it is argued here that this relationship cannot simply be reduced to either the event or its associated suffering.

A major concern of scientific investigation depends on establishing the linear causality between the event as the traumatic stimulus and the symptomatic disorder that it induces. Causality represents a unique characteristic in the formulation of PTSD in light of the fact that the DSM eschews etiological positions on most disorders (Rosen and Taylor, 2007). McHugh and Treisman (2007) argues that much of the research falls victim to a *post hoc, ergo prompter hoc* fallacy. In other words, they believe that the field inappropriately attributes responses to awful events to the experience without appropriate justification. Summerfield (2001) questions the uni-factorial assumption that the event is singularly responsible for the perceived distress. Sometimes it is difficult to associate any particular consequence with a specific cause. For example, in the case of political refugees who have endured state violence, torture, displacement, and migration stress, drawing linear conclusions between events and outcomes is unclear if not

impossible (Thompson and McGorry, 1995). Significant research suggests that a wide array of non-specific genetic, developmental and environmental factors contribute substantially more to the development of PTSD than any event-based criteria (Rosen and Lilienfeld, 2008).

Whereas other disorders like depression or schizophrenia are regarded as having many contributing causes, the formulation of PTSD has historically claimed a clear, unitary progression from event to ailment. As previously discussed, the DSM III assumed that the magnitude of the event would stand alone, which is a stark contrast to the developmental and cultural considerations in the DSM 5. The need to appreciate complexity in causal claims is one criticism that has grown in prominence as evidenced by these revisions. The DSM 5 reflects an important change in the way that the diagnosis conceptualizes trauma.

Heterogeneity

Questions about the empirical basis of the disorder can have a close association with criticism about its heterogeneity. Whereas the former raise issues about knowledge claims, the latter takes issue with what is included when we talk about trauma. Several perspectives in the literature believe that the diagnosis provides limited coverage for describing trauma response (e.g., Coates, 2003; Herman, 1992a; Hegadoren, et. al., 2006, Palic and Elklit, 2011; Pedersen, 2002). As Hegadoren et. al., (2006) write, "Using PTSD as the sole index for interpersonal trauma has limited utility," particularly when accounting for the consequences of interpersonal violence.

"Complex PTSD" was originally proposed by Judith Herman (1992b), and this line of research spurred the creation of Disorders of Extreme Stress, Not Otherwise Specified (DESNOS) for field trials in conjunction with the DSM-IV. Though the concept had good

construct validity (Pedersen, 2002), the APA committee ultimately determined that this condition did not have an adequate research base to merit inclusion (Friedman et. al., 2011), but it remains a major area of study and investigation (Courtois and Ford, 2009). The latest edition of the International Classification of Disorders (ICD-10) does, however, include a diagnosis for 'Enduring Personality Change After Catastrophic Experience' modeled on the same research (Palic and Elklit, 2011).

Interest in looking beyond narrow definitions or diagnoses of trauma has a long history in the literature, as does looking at traumatic stress on a continuum (Herman, 1992b; see also Gilkerson, 1998; Scaer, 2005). Complex PTSD generally tries to formulate many of the areas of disturbance that PTSD does not include. Herman (1992a) describes three major areas of distress uniquely captured by complex PTSD in terms of symptom presentation, character change, and on-going relational vulnerability. Symptoms tend to be more diffuse, complex and tenaciously resistant to improvement. Survivors often have a greater number and variety of complaints that can be somatic, affective or dissociative.

Examples of somatic problems include insomnia, startle response, agitation, headache, gastrointestinal distress, chronic pain (i.e., stomach, back, pelvis), tremors, nausea, or a choking sensation. These types of symptoms proved nearly ubiquitous among concentration camp survivors, and they are common among refugees and victims of child abuse (Palic and Elklit, 2011; Herman, 1992a). In addition to the aforementioned symptoms, extreme forms of violence like torture have been associated with neurological symptoms such as vertigo, dizziness, seizures, and dysesthesias (Moreno and Grodin, 2002). Affectively, survivors of complex trauma may experience bitterness and depression along with a feeling of humiliated rage and self-hatred.

They may succumb to chronic suicidality as their anger moves back and forth between hate for the perpetrator and hate for themselves. Dissociation—common, for example, among victims of captivity like prisoners—may experience disturbances in sense of time, memory and concentration. When this merges with hyperarousal and depression, the difficulty concentrating can be pervasive and debilitating (Herman, 1992a).

The DSM 5 incorporates some of these features—particularly affective symptoms, and to a lesser degree dissociative phenomenon (APA, 2013)—but does not cover the same range. Complex PTSD also regards change in character as a signature component. Cases of complex trauma are typically thought to be precipitated by prolonged, repeated instances of interpersonal violence (such as abuse) that occur at the hands of a caregiver or authority and at a developmentally sensitive time (Herman, 1992b). Very few people can maintain an unfettered sense of the goodness in others when subjected to prolonged abuse, and survivors typically endure repeated events that undermine their sense of themselves. "All the structures of the self —the image of the body, the internalized images of others and the values and ideals that lend a sense of coherence and purpose—are invaded and systematically broken down" (Herman 1992a, pp 222).

Survivors may feel guilty, evil, fragmented, contaminated or robotic as they cope with a lost or injured sense of self. Wounded in relationships with others, they may find that future relationships resemble early abusive experiences and as a result, they are more likely to be hurt again (Herman, 1992a). The current nosology creates a bit of a puzzle in cobbling together diagnoses to cover the diverse presentation of these cases. A more piecemeal approach—often using diagnoses in addition to PTSD such as personality, somatoform, dissociative, anxiety, and

mood disorders—is possible, but that does not recognize the coherence and centrality of the traumatic experience and can be needlessly pathologizing (Herman, 1992b).

How do we understand the purpose of diagnoses? Are they short-hand aggregated lists of problems? Are they explanatory models? Bryant (2010) argues that any operational definition of complex PTSD should be based on observed qualities (e.g., affect dysregulation) rather than on types of experience (i.e., a history of child abuse). Even after assigning relevant diagnoses, however, how do we explain the occurrence of symptoms that are not accounted for by these disorders? As Hyman (2010) has pointed out, over-specificity in diagnostic criteria can unduly exclude cases that would otherwise warrant attention. There is reason to believe that "pure" cases of PTSD are in fact in the minority (Palic and Elklit, 2011). Trauma—however it is defined—has proven itself to cause all manner of different types of problems.

What makes trauma so heterogeneous? As PTSD is defined in the DSM-IV, two people could share a diagnosis without sharing a single symptom (Rosen and Lilienfeld, 2008). In fact with the DSM 5 revision, it is possible for four people to each carry the diagnosis all while sharing only two or three symptoms. When the concept becomes so heterogeneous, what are its unifying characteristics? What are the central qualities that its many permutations have in common? Defining the event also requires an adequate degree of differentiation from other disorders. Unfortunately, symptom descriptions can also overlap with diagnostic criteria for other disorders, making it hard to differentiate any sort of phenomenological signature. For example, both PTSD and depressive episodes share features of anhedonia and sleep disturbance (Rosen and Lilienfeld, 2008). When defining a trauma concept, is it better to be parsimonious

and only include unique symptoms? Or is it better to describe a common profile in abundant detail (Spitzer, et. al., 2007)?

One way to formulate this panoply of symptoms is through subtyping, but questions about subtyping are rife in the literature. There is some evidence of internalizing and externalizing subtypes of PTSD (Friedman, 2009), but this may only scratch the surface. For example, Kelley, Weathers, McDevitt-Murphy, Eakin and Flood (2009) conducted a study of three distinct types of trauma—sexual assaults, car accidents, and the unexpected death of a loved one—in a civilian population and found that different events were not only associated with different levels of risk and severity, but also different distress profiles. The research in subtyping has some methodological limitations (Kelley, et. al. 2009), and historical questions about a unique 'torture syndrome' or 'rape syndrome' (among others) have not always born fruit in finding qualitative differences (Basoglu, Jaranson, Mollica, & Kastrup 2001; Jaranson, 1998; Palic and Elklit, 2011; Silove, 1996).

Some research has attempted to explain differences in symptom presentation in terms of personality types. For example, Sellborn and Bagby (2009) conducted a study of military veterans and sexual assault survivors and analyzed their clinical issues through MMPI-2 personality clusters. They found three different personality types that correlated with different symptom presentations, confirming an accruing line of research by M.W. Miller and colleagues (cited in Sellborn and Bagby, 2009). If personality is consistently found to play a significant role in reactions to traumatic stress, then that raises interesting questions about the nature of PTSD. Does the criteria reflect a "pure" type that is then moderated by personality? Or, does the criteria merely represent what stress looks like for a particular group of people? Is a pathological

reaction to traumatic stress a distinct disease-entity with a recognizable core, or is it the result of a pathoplastic process that is shaped by other variables? At least as far as personality is concerned, research has produced mixed results. McDevitt-Murphy et. al., (2012) conducted a prospective study examining the same set of personality clusters and their results did not confirm earlier findings. It is not empirically clear if personality is a moderator, a mediator, or plays any significant role in the expression of a trauma response.

These different lines of research and investigation bring up important questions about how we label trauma responses. McHugh and Treisman (2007) critiqued the proliferation of PTSD qualifiers, including acute, chronic, delayed, complex, subdromal and masked variations. Generally speaking, the more diverse and flexible the parameters of a disorder become, the more it stretches its core features. Polythetic criteria sets offer flexibility, but as in the case of "bracket creep", they can also dilute the organizing premises of the category. There is a risk that its endless expansion would render the concept meaningless (Rosen, 2004).

In the case of diagnosing trauma, many writers contend that PTSD is inadequate to cover the range of human suffering. Diagnostically, does that warrant the recognition of new disorders —for example, a separate diagnosis of DESNOS? Or should these variations be subsumed under the heading of PTSD as subtypes? Do we need more labels, or do we need our label to fit more descriptions? For Ghaemi (2009), creating more labels amounts to "nosologmania" and the inappropriate creation of new pathologies. For McHugh and Treisman (2007), expanding the coverage of a label almost amounts to clinical gerrymandering which only serves to confuse and complicate a clinical approach.

This issue occupies an important place in debate, and it influences not only the consideration of PTSD, but the nosology overall. The DSM 5 notes in its approach to case formulation that,

> Although decades of scientific effort have gone into developing the diagnostic criteria… it is well recognized that this set of categorical diagnoses does not fully describe the full range of mental disorders that individuals experience and present to clinicians on a daily basis throughout the world. As noted previously in the introduction, the range of genetic/ environmental interactions over the course of human development affecting cognitive, emotional and behavioral function is virtually limitless. As a result, it is impossible to capture the full range of psychopathology in the categorical diagnostic categories that we are now using. (APA, 2013)

Admitting these limitations, what types of distinctions should we make? 'Delayed onset' PTSD has been found to be rare, but there is some empirical evidence to substantiate the fact that some people do not meet criteria until significantly after the event occurs (Bryant and Harvey, 2002). As we will discuss below, there are many different ways to understand this data. In the DSM 5, the criteria dropped the "acute" and "chronic" distinctions because research failed to meaningfully delineate them (APA, 2013; Bryant and Harvey, 2002), but "delayed" remains viable.

So while this latest revision changes the clinical qualifiers associated with the disorder, it does not necessarily unravel the mysteries of how traumatic reactions appear or evolve, or what is the best way to understand the heterogeneity of symptoms and problems.

Dimensionality

The basic aspiration in establishing a diagnosis is to clearly describe a unique disease category that is readily distinguished from other similar categories. Since Plato, theorists have aspired to 'carve nature at its joints' by recognizing "natural kinds" that—ontologically speaking

—exist independently of any objective analysis (Haslam, 2002). They are purportedly 'true' things that have discrete, objective qualities that meaningfully separate them from other kinds. Psychiatry's best efforts to do this as a medical science have come through the Neo-Kraepelinian approach, which along with the history of PTSD is discussed in chapter one.

PTSD is defined according to a set of criteria that allow for dichotomous decision-making about the presence or absence of the disorder. A rigid application of these ideas produces a stilted and clumsy approach to clinical work and is expressly discouraged by the DSM.

> It is not sufficient to simply check off the symptoms in the diagnostic criteria to make a mental disorder diagnosis. Although a systematic check for the presence of these criteria as they apply to each patient will assure a more reliable assessment, the relative severity and valence of individual criteria and their contribution to a diagnosis require clinical judgment. The symptoms in our diagnostic criteria are part of the relatively limited repertoire of human emotional responses to internal and external stresses that are generally maintained in a homeostatic balance without a disruption in normal functioning. (APA, 2013)

The expectation of the nosology requires the judicious application of these criteria as part of a clinical evaluation of multiple factors. In other words, the manual does not try to think for us.

What the manual does do, however, is assert the categorical integrity of the disorder. It acknowledges that there may be other disorders and categories; it acknowledges that the parameters of the disorders require clinical judgment, but the conceptual foundation of the nosology lies on its ability to traffic in disease entities. The nosology regards PTSD as a specific, unique and well-defined type of pathological disorder resulting from extreme stress, and it attempts to substantiate this view with research from different fields (APA, 2013).

What do we mean when we talk about "disorders"? The concept has spurred a rich and complex debate (e.g., Spitzer and Wakefield, 1999; Wakefield, 1992; Wakefield, 1999; Widiger

and Sankis, 2000) that unfortunately lies beyond the scope of this work. The concept of disorder is fundamentally categorical, however, and in the case of the biomedical model, it presumes that these categories have validity for understanding human suffering from all walks of life (Thakker and Ward, 1998). In the next chapter, we will discuss these universalist assumptions and the various critiques from psychology and anthropology. Immediately, however, it may be useful to tease apart the distinction between categorical and universalist ideas.

A categorical approach involves sorting people into discrete groups. A universalist approach assumes that a distinction will be valid in all cases. To approach disorders categorically does not preclude a relativistic stance. One could imagine describing disorders in categories that were explicitly contingent on historical and cultural circumstances. For example, these categories could be predicated on practical considerations such as insurance reimbursement or disability claims. Among other claims, PTSD provides a categorical approach to understanding trauma reactions because the diagnosis creates a threshold that stipulates the presence or absence of the disorder. Unfortunately, these thresholds create barriers that exclude sub-syndromal presentations that in the absence of clinical judgment, can create significant "epistemic blinders" (Hyman, 2010).

A compelling body of research has recently emerged that strongly rebuts the categorical assumptions of the PTSD diagnosis. By conducting taxonometric analyses of symptom response data, new studies consistently point towards a latent dimensional structure. For example, Forbes, Haslam, Williams and Creamer (2005) reviewed a large sample of military combat veterans and found that the data favored a dimensional structure over that of a taxon. The same results were

found in a separate study of male combat veterans (Ruscio, Ruscio and Keane, 2002), and in large samples of adolescents (Broman-Fulks, et. al., 2009) and women (Broman-Fulks 2006).

Bryant and Harvey (2002) studied delayed onset PTSD and found substantiating evidence that some individuals may meet criteria long after the precipitating event, but these findings also lend credence to a dimensional analysis. Many of the individuals in this study exhibited sub-syndromal levels of posttraumatic stress throughout the "latency" period before meeting full criteria. When trauma response is considered in terms of a continuum rather that a category, it becomes possible to imagine how individuals suffering distress may worsen or improve over time. It may take time before they meet diagnostic criteria, even if they have always suffered posttraumatic stress. When our concept of trauma becomes less dichotomous, it becomes more fluid.

The depth of these issues—again, not just for PTSD, but for the nosology as a scientific project—did not escape the DSM 5 steering committee, even as it sought not to lose the relative merits of the categorical approach. As Darrel Regier, Vice Chairman of the DSM 5 Task Force, and colleagues write,

> Mental disorder syndromes will eventually be redefined to reflect more useful diagnostic categories ("to carve nature at its joints") as well as dimensional discontinuities between disorders and clear thresholds between pathology and normality. However, our immediate task is to set a framework for an evolution of our diagnostic system that can advance our clinical practice and facilitate ongoing testing of the diagnostic criteria that are intended to be scientific hypotheses, rather than inerrant Biblical scripture. The single most important precondition for moving forward to improve the clinical and scientific utility of DSM-V will be the incorporation of simple dimensional measures for assessing syndromes within broad diagnostic categories and supraordinate dimensions that cross current diagnostic boundaries. Thus, we have decided that one, if not the major, difference between DSM-IV and DSM-V will be the more prominent use of dimensional measures in DSM-V. (Regier, et. al., 2009)

On the one hand, this is an affirmation of the dimensional qualities of distress as considered in psychiatric terms. On the other hand, it is a re-affirmation of the desire to eventually discern "natural kinds" that can provide an independent and objective framework for a universalist sensibility and a biomedical model.

As empirical and conceptual questions about categorization emerge, several authors have raised the importance of utility even if the validity of PTSD remains under consideration (Friedman, et. al., 2007; Ghaemi, 2009; Hyman, 2010; Kendell and Jablensky, 2003; Regier, et. al., 2009). While acknowledging that the concept is not perfect, these writers contend that it embodies a great deal of the field's present understanding of trauma. In other words, they assert that a prototypical category has value—even if there is no empirical basis for categorical distinctions. These categories have dramatically improved reliability but there is little to no evidence for the taxonomy's validity even if it remains supremely useful. Science as a whole lacks a clear definition of validity, and there are epistemological implications to any provisional definition (Kendell and Jablensky, 2003).

The criticisms raised in this chapter are not merely esoteric concerns. Thomas Insel, Director of the National Institute of Mental Health (NIMH) (2013), explained in an online post that the latest iteration of the DSM does not provide the necessary framework for advancing a psychiatric science of the brain or brain disease. Biomarkers for mental health conditions stand to be artificially constrained by working strictly from the standpoint of the DSM, and the NIMH is launching a Research Domain Criteria project in order guide its own research. For the NIMH, the 'psycho-' and 'social-' artificially constrain the 'bio-' considerations of the biopsychosocial model.

In this chapter, we have reviewed criticism of the PTSD construct that largely comes from within the paradigm. These commentaries raise difficult issues about the empirical foundations of the diagnosis, the validity of its claims, the heterogeneity of the disorder, and its latent dimensional structure. None of these critiques alone inherently dispute the diagnosis in terms of its basic merits. Each of these concerns can be addressed without disavowing many of the central organizing tenets or assumptions of the disorder.

In the next chapter, we review arguments and criticism from clinical and anthropological perspectives that question some of the foundational assumptions of the concept. To accept some or all of these criticisms fundamentally begins to change and/or break apart the paradigm on which traumatic stress studies have been built.

IV. Paradigmatic Criticism of the PTSD Diagnosis and Trans-Cultural Psychiatry

In this chapter, we review criticism of the PTSD construct that challenges the foundational assumptions of the diagnosis, and much of that criticism gains leverage from multicultural considerations. Hinton and Lewis-Fernandez (2011) reviewed the literature on the cross-cultural validity of PTSD and found that it demonstrated various types of validity. Overall, they conclude that the concept is strong, but they also noted a variety of areas of concern, notably the lack of established biomarkers, variability in symptoms, and the roles of context, subjectivity and interpretation with respect to onset and severity, among many other issues. They suggest that different experiences may mediate or moderate trauma reactions across cultures, and that the constellation of symptoms—particularly with respect to avoidance—may vary considerably as well. They argue for a need for more research into both mechanisms and diagnostic entities.

Many of these are familiar concerns. Marsella et. al (1992) noted that much of the early literature was compromised by methodological issues and created difficulties for drawing conclusions about the validity of the construct. Johnson and Thompson (2008) found a host of methodological issues in the literature on the treatment of refugees: small sample sizes, non-random sampling, increased reporting bias, retrospective analysis of notes, lack of control groups, language barriers, and high attrition rates. There is also so much heterogeneity in these groups—ethnicity, language, duration of events, types of events, number of events, etc.—that generalizability is severely limited. Jakobsen, Thorsesen, and Johansen (2011) discussed the ways in which common trauma screening measures in use with asylee/refugee populations appeared to have a high level of agreement, but in actuality misrepresented prevalence rates. For

some groups, they over-estimated the prevalence while under-estimating it for others. They report that 93% of published studies report the use of screening measures on the assumption of their validity, but research into validity studies is small.

Efforts to understand trauma cross-culturally have always been complicated—even to the point of debating what the proper means and methods of investigation should be (Littlewood, 1992a). Disease and distress concepts from different cultures are not necessarily congruent which makes it difficult to analyze them as if they were complementary units of study (Jenkins, 1988). Historically, the DSM-IV brought significant changes to the manual by introducing multicultural concerns (Arnault and Shimabukuro, 2012), but these changes nevertheless only reflected a modest portion of those that were recommended (Thakker and Ward, 1998). To some extent, the same is true in the publication of the DSM 5 (see Hinton and Lewis-Fernandez, 2011; APA, 2013).

Current diagnostic practice assumes that culture shapes the expression of distress, but such distress has recognizable roots in the basic disorder category (APA, 2013). In keeping with Kraepelin's original intentions, psychiatry largely maintains that diagnoses have a biological core that is moderated by cultural factors. Different features in these variations can be assessed in terms of basic psychiatric features or symptoms, which include biological, cognitive, affective and behavioral domains. These domains are privileged in formulating disease categories. In some circles, thinking outside of these domains may meet with dismissal or derision as an example of 'the Seligman Error,' named for an early case of cross-cultural diagnosis that dared to include spiritual elements in its formulation (Littlewood, 1990).

Thakker and Ward (1998) write that protagonists of the biomedical model claim "that mental disorders as defined in Western taxonomies will have similar, if not identical, manifestations in all cultures because they are the result of physiological dysfunction and human beings share a common physiology." But psychiatry historically lacks a theory to explain the interplay between biology and culture—or even a way to account for its own processes of investigation as a science. For example, the foundational step of operationalizing terms can be problematic when it comes to delineating what makes a condition "culture-bound". If culture moderates expression, where do we supposedly find unfettered access to the prototypical disorder category?

For example, Littlewood (1990) argues that *tabanka*, a depressive experience that occurs in Trinidad when a woman cuckolds her husband, could be operationalized along side Major Depressive Disorder. It could be treated as a universal disease category and comparatively evaluated the world over—but yet only one of these diagnoses is regarded as culturally bound. The same holds true in the way that we look at symptoms. For example, somatic symptoms in non-Western cultures are sometimes regarded as indirect expressions of emotions, but there is no scientific basis to assume that emotions are the primary form of experience or somehow developmentally superior. It may be the case that a Western experience of depressed feelings is an intellectualized experience of somatic sensations (Thakker and Ward, 1998).

Historically, the field has wrestled with questions about how to address 'what's wrong' without getting caught up in 'what's different'. The "old transcultural psychiatry" (Kleinman, 1977) relied on the presumption of objectivity and looked epidemiologically for its categories across cultures. It assumed that distress categories are universal, but people may express them

differently. Anthropology spurred a major pivot, however, and the "new transcultural psychiatry" (also called "cross-cultural psychiatry") attempts to consider not only the way in which culture molds our expression of distress, but the very foundations of how we understand what distress is (Kleinman, 1977). This should not be confused with the anti-psychiatry movement of the 1960s, which focused on issues of social control (Littlewood, 1991). Instead, the 'new transcultural psychiatry' attends to the ways that cultural beliefs infuse clinical practices. It involves a recognition of the inevitability of our limitations for completely stepping out of our perspective or claiming a truly objective view (Littlewood, 1990).

It is considered well established in the anthropology literature that culture mediates the experience and expression of emotion, and as such the pathoplasticity of trauma reactions (such as PTSD) may or may not suggest a unitary disease-entity (Jenkins, 1996). Again, the question is how to account for heterogeneity: how similar do two things have to be before we can say they are the same thing (Littlewood, 1990)? For example, is it our assumption that a largely somatic trauma reaction is actually a cultural variant of PTSD? Or do we assume that in some cultures, "potentially traumatic events" predominantly may cause somatoform disorders (but less so, cause PTSD)?

Two approaches can characterize the study of distress and psychopathology across cultures: a clinical approach with universalist assumptions, and anthropology's normative approach that considers the relativity of social and cultural factors (Pederson, 2002). In the previous chapter, we established that categorical approaches are not synonymous with universalist approaches. It may also be worth noting that universalist assumptions need not necessarily be medical, and medical assumptions need not necessarily be universal (Thakker and

Ward, 1998). The biomedical model—employing universalist medical categories—remains the defining paradigm, however, and much of the criticism directed from the new transcultural psychiatry attempts to lay bear its assumptions and articulate alternatives.

Perhaps the first major criticism of anthropology is psychiatry's inattention to the problems of translation, and this is most noticeable in its claims of universality. In a foundational paper, Kleinman (1977) identified what he called the "category fallacy" of contemporary psychiatry. Simply identifying a constellation of symptoms that occur in various contexts does not establish that these represent the same diagnostic entity. By way of a simplistic analogy, if one identifies tigers as big predators with tails and teeth, then simply finding more big predators with tails and teeth does not logically prove that you have found more tigers. It terms of medicine, for example, tuberculosis could not be identified simply on the basis of symptoms like cough and sputum (Kendell and Jablensky, 2003); the same is true with respect to PTSD and its various symptom clusters (Hinton and Lewis-Fernandez, 2011). Simply because symptom clusters have been found across cultures does not conclusively validate the concept or incontrovertibly prove its assumptions. Some may question whether or not social factors alone could produce such comparable findings (e.g., Devilly, 2001), but speculation is hardly a basis for psychiatric science.

In brief, the universalist assumptions of PTSD are these: the disorder is universal, timeless and cross-culturally valid. It has always existed in the form we now recognize, and would continue to exist even if it was never diagnosed, studied, or treated (Kienzler, 2008). Research presents it as though it was "discovered" as a found object. Most of the research validating the concept has been based on Western samples, and this has been recognized as a

limitation (Marsella, et. al. 1992). In recent years, research efforts directed more energy towards sampling diverse populations with varied backgrounds (Hinton and Lewis-Fernández 2011), and the grounds for universalist claims are in debate (Bracken, 2001).

One of the problems with claiming the disorder is timeless is that it is a largely speculative assertion. While historical descriptions by Shakespeare or Charles Dickens, for example, may provide case studies, this hardly represents a basis for such a sweeping conclusion (Jones et. al., 2003). There have been various attempts to look through medical records and historical documents to find evidence of symptoms (Friedman, 2009), but given the heterogeneity of trauma reactions, a tally of symptoms in hand-picked cases across thousands of years hardly substitutes for epidemiological research.

Jones et. al. (2003) attempted to ground this claim in empirical data by combing through a sample of medical records for British veterans dating back to the Boer War (late 19th century). They compared the detailed annual medical documentation gathered to determine pension benefits to assess for contemporary symptoms of PTSD with a particular focus on the occurrence of flashbacks. Flashbacks are considered to be a unique and signatory symptom of PTSD, but these authors found it virtually absent in veterans before World War II. Veterans of the Persian Gulf War were statistically more likely to present with flashbacks than previous generations of veterans. Contemporary ideas of PTSD attempt to make allowances for cross-cultural differences in symptoms that vary on a common core, but if the core features are themselves culturally and historically determined, then the disorder category would collapse as a timeless phenomenon. Again, it is hard to draw definitive conclusions when the possibilities for definitive research are so few and far between.

Cross-cultural research often relies on self-report of symptoms, which faces major challenges in translation. On methodological grounds, Kienzler (2008) raises questions about the common assumption that the subjects understand the research in the same way as the investigators. Hermeneutically, it is hard to draw valid conclusions from an exchange of information if there is no shared basis of meaning. In other words, when a subject reports or describes an experience, the decision to interpret that phenomenon as a "symptom" of some kind of distress reflects the assumption of a particular set of value-propositions. What is 'abnormal' depends on the priorities of a particular definition.

> A physical sensation or emotion is labeled a 'symptom' when it is a sign of an abnormal state, disturbance, illness or pathology. Because of the influence of cultural models on the development of perception and interpretation, all of these analyses are cultural interpretations, and are based on experience by the self and others within one's family and reference group. (Arnault and Shimabukuro, 2011)

Noticeably, what research may regard as a symptom (e.g., disturbing dreams) may not have distress value for the subject as something that needs treatment. Moreover, a questionnaire methodology does not invite the full range of cognitive or affective symptoms—or any of the other consequences that might be regarded as ailments. For example, if research does not ask about spiritual or supernatural "symptoms" because they are considered outside of the purview of psychiatry, then it may truncate the local understanding of experience. When working from a circumscribed set of symptoms, it precludes consideration of distinguishing features that might set concepts apart. Research findings may then be subject to confirmation bias (Bracken, Giller and Summerfield, 1995).

Translation as a hermeneutic issue—a shared framework of meaning, for example—can often be regarded as a hinderance in psychiatry and a hurdle to collecting data. At times, psychiatric research can exhibit a tendency to over-emphasize similarities as proof of universality at the expense of divergent evidence. As a research imperative, however, cross-cultural validity must have equal weight with reliability, including a clear effort to operationalize culture as a variable. This includes reflexive investigations of psychiatry's "culture" and its philosophical assumptions in the biomedical model (Kleinman, 1987).

> The biomedical view of clinical reality, held by modern health professionals in developing as well as developed countries, assumes that biologic concerns are more basic, "real," clinically significant, and interesting than psychologic or sociocultural issues… Treatment oriented within this view emphasizes a technical "fix" rather than psychosocial management. It is less concerned with "meaning" than other forms of clinical care. It deals with the patient as a machine. Contrary to the usual belief of health professionals, this biomedical viewpoint is *both* culture-specific and value-laden: it is based upon particular Western explanatory models and value-orientations, which in turn provide a very special paradigm for how patients are regarded and treated. [emphasis original] (Kleinman, Eisenberg and Good, 1978)

Culture is not merely something "out there" to be found among the indigenous and other language groups. Rather, psychiatry imports its own assumptions and beliefs in every diagnosis it investigates (Kleinman, 1987). This is perhaps the second major criticism of anthropology: the medical model forecloses on the level of analysis and the focus of inquiry when it comes to understanding trauma. It begins with a pre-established set of assumptions about 'what trauma is.'

Thomas Insel, Director of NIMH (2013), makes the model explicit: "Mental disorders are biological disorders involving brain circuits that implicate specific domains of cognition, emotion, or behavior." Perhaps to state the obvious: all human experience (diseased or

otherwise) has biological correlates (Damasio, 1994), and the notion of mental health as a matter of brain disease or dysregulation reflects the belief that biology is the primary mover of experience. Diagnosing disorders amounts to identifying problematic dysfunctions in the brain's systems (Wakefield, 1999). In the case of trauma, the assumption is that neurological processes can definitively explain traumatic reactions. Greater science in the search for the "holy grail" (Clark, 2001) of biomarkers may revise current concepts, but the model presumes that in its final formulation, the 'true' nature of human distress will be explained by neurology. This basic physiological focus also justifies the universalist assumptions for talking about the species.

The medical model of trauma has elicited criticism from many different quarters, many with overlapping objections. For some, they object to the notion of pathology. In the wake of awful events, distress was once regarded as a part of life, and to redefine life's travails in terms of disorder runs a risk of obscuring a natural response (McHugh and Treisman, 2007). This criticism is not entirely clear, however. Even making allowances for the low prevalence rates of PTSD following exposure, it is not clear how this position would differentiate between obvious gradations in severity. In part, the notion of pathology is an attempt to make such a distinction. A medical model does, however, forego the conclusion that such distress could be anything other than a diagnosis (Kleinman, 1995). In other words, the medical model assumes that a given profile of distress is pathological no matter the circumstances.

Other objections to pathology question whether trauma reactions are not better conceived of as adaptations. For example, following an experience of torture, many of the "abnormal" features that indicate that 'something is wrong' may in fact have served adaptive functions at the time (Gerrity, Keane, and Tuma, 2001; Silove, 1996). For example, dissociation may have

provided a way to avoid overwhelming pain. By objecting to pathology, these writers contend that a trauma reaction can be better understood as a normal response to an abnormal situation. Friedman, et. al. (2007) dispute this line of thinking because so often, resilience is the norm. To assume that a trauma reaction is "normal" when in fact the majority have a very different "normal" reaction seems inconsistent. In favor of pathology, the argument might acknowledge the reaction could have been adaptive at the time, but an inability to change the behavior may be disordered.

Assuming there is in fact something "disordered" in trauma response, several writers rebut the pejorative associations attached to "pathology" (e.g., Friedman, et. al., 2007; Spiegel and Vermetten, 2007). Shalev (2001) advocates that there should be no shame in mental health diagnoses. Spiegel and Vermetten (2007) defend medicalization as removing the moral judgment that has historically stigmatized trauma reactions. These authors suggest that the purported objectivity of the medical perspective should be a source of comfort. By decontextualizing the trauma response, the medical model essentializes features of distress.

As a professional discourse, medicine organizes categories and observations independently of any meaning associated with the event (Kienzler, 2008). It decouples awful events from any social meaning they may have. In this view, what matters is the arousal of fear circuitry and the implications that has for the organic function of the brain. In treating trauma as a neurological condition, the subjective sense of what made the event awful is diminished. The narrative meaning of the event becomes peripheral. What originated as a lived experience with social dimensions shrinks to an intrapsychic neurological phenomenon. The medical model does not regard symptoms as having any inherent meaning or communicative value separate or

distinct from their physiological basis. Distress has no meaning apart from its signal value as criteria for the disorder (James and Prillentenskey, 2002).

The medical model treats the individual independently of context, but this overlooks the way in which social dimensions of intersubjectivity are biologically expressed and 'written' on the body (Kleinman, 1995). "While the physiology of stress reactions may be reducible to a universal sequence of events, this is clearly not true of cognitions and emotions" (Bracken, et. al., 1995). Interpersonal experience—from personal relationships to politics—is also embodied. Meaning always emerges from shared experiences, and to treat trauma as a medical problem depends on treating a social dynamic as an individual pathology. It assumes "violence as an event that can be studied outside of its particular context because of its putative universal effects on individuals" (Kleinman, 1995).

There are ways in which a medical frame impedes the discussion about what factors are relevant or have bearing on traumatic events (Pederson, 2002). For example, the collapse of one's house in a mud slide may seem like a straightforward natural disaster, relatively independent of social factors and amenable to biological assessments of fear and risk. The poverty that forced the individual to live in a precariously perched shantytown, however, invests the experience with new layers of meaning—and by extension, shapes the experience of the event. The social and the biological are not so easily disentangled (Kleinman, 1995).

This constitutes anthropology's third major criticisms of PTSD: the focus of inquiry exclusively attends to the individual instead of recognizing a broader, more dynamic process. The idea of disorder stands as something independent and objective, as opposed to an expression of the person's (inter)subjectivity. Anthropology would say that the person's experience of

suffering emerges from a dialogical exchange between the individual and their social world. Medicine, however, looks at the individual as a relatively closed system. By virtue of its objective stance, a diagnosis stands as a monologue rather than as part of a dialogue. It invalidates reciprocal exchange because it claims to have an independent status by virtue of its knowledge base. In this view, medicalization weakens and/or denies the moral significance of suffering: "The very idea of post-traumatic stress as a disorder invalidates the moral and political meaning of suffering" (Kleinman and Kleinman, 1991).

Ironically and paradoxically, this view is not entirely out of step with those who would suggest that a diagnosis alleviates stigma and offers social sanctuary in the authority of medicine (e.g. Shalev, 2001; Spiegel and Vermetten, 2007). A formal diagnosis can offer a new social currency, namely the 'sick role' which legitimates needs. The diagnosis stands as a record of injury which can "objectively" validate claims of injustice. In other words, it identifies victims (and by extension, perpetrators), which allows the diagnosis to be used to arbitrate political and moral questions. The status of having a diagnosis appeals to a 'higher' authority, namely the objectivity of medical science (Summerfield, 2001). An extension of anthropology's criticism argues that a biomedical approach can serve in a pacifying and/or oppressive role by sanitizing injustices. For example, suffering no longer finds its roots in moral indignity and mistreatment, but rather in the activation of the HPA axis.

While a formal diagnosis may change the social perception of distress, it may well be factually wrong to suggest that it reduces stigma. Research has shown that while the general public in the United States increasingly view mental health issues as biological diseases, stigma against mental illness has increased (e.g., Corrigan and Watson, 2004; Read, Haslam, Sayce and

Davies, 2006). More research is needed, but assuming that a formal diagnosis defends survivors from socio-cultural pressure does not appear to be true. It appears to be exacerbating the problem in some ways. The medical model would suggest that social attitudes are irrelevant to the science of discovery, but they also illustrate the complexity of understanding suffering.

The aforementioned concerns show how psychiatry, as a medical science, remains embedded in social and political dimensions among others domains of life (McHugh and Treisman, 2007). This invites anthropology's fourth major criticism of PTSD, namely the relativity of its knowledge claims. Psychiatric knowledge is built on foundational philosophical beliefs about knowledge, selfhood and reality. It subscribes to a positivist empirical epistemology in service of studying the individual as its basic unity of analysis (Bracken, et. al., 1995). It has historically understood the self in terms of mind-body dualism such that the boundaries between "self" and "world" are delineated by the physical body. The presumed primacy of the body favors "naturalistic explanations" (involving physical processes) over "personalistic explanations" (employing human characteristics like meaning, goals, or motivations). The physical is often used to provide explanations for the psychological (Littlewood, 1990), and the psychological is often used to explain the spiritual (James and Prillentensky, 2001).

Psychiatry understands the mind analogously as a kind of squishy computer (Bracken, 2001), and each person—as an autonomous actor—can be understood individualistically. The essence of identity and selfhood are presumed to function independently of any relational or social context. The study of psychopathology is then limited to the brain-body, the autonomous mind, and their conjoint history (Littlewood, 1990). By extension, psychiatry approaches trauma

in the same ways. "Current thinking about trauma is guided by an individualist and positivist agenda. It is based on separation of an 'inner' mind from an 'outside' world which is reflected in the mind in the form of representations" (Bracken, 2001). Psychiatry attempts to study the damage to the mind and this 'true' self, often by reducing its terms to the physiological sequelae of the body. Trauma is seen as a purely internal or intraspychic phenomenon (Bracken, et. al., 1995). "The psychiatric sciences have sought to convert human misery and pain into technical problems that can be understood in standardized ways and are amenable to technical intervention by experts" (Summerfield, 2001).

The medical model adheres to the same standards of empiricism that govern medicine, and proponents assert the superiority of such a rigorously scientific approach. Among its strongest proponents, they consider clinical practice based on its evidence as "the only legitimate and acceptable form" (McFall, 1991) of psychological practice. Some efforts to work and think holistically have emerged in the literature, but despite integrative frameworks for practice based on the biopsychosocial approach, there is (empirical) evidence that psychiatrists continue to apply mind-body dualistic thinking in their work (Miresco and Kirmayer, 2006).

It is worth noting that some of anthropology's most pointed critiques come from a social constructivist perspective (Litva, 2001).

> Critical social sciences insist that knowledge production is never neutral, that there is no such thing as 'mere fact' and that scholars and researchers themselves are inevitably linked to a particular social group and are working within a given social and cultural context. (Pedersen, 2002)

Social constructivists would argue that realizing the limits of objectivity and the impingements of context do not necessarily render the whole intellectual enterprise as useless. As Bracken, et.

al., (1995) write, "Our argument is not that the concept of PTSD… be abandoned, but rather that [its] limitations be recognized, and [its] use in non-Western situations approached with caution." Navigating these concerns requires understanding something about the cultural framework of psychiatry.

Since the Enlightenment, the Western episteme has seen human nature as universal (Chakraborty 1991). Medicine in modernity sees itself as independent of culture, and because psychiatry in particular follows suit to claim the mantle of medical science, it does not consider the possibility of its work as a cultural product of any kind (Bracken, Giller and Summerfield, 1997). It is interesting to look back on the history of medicine and trace its roots through colonial and imperial standards tinged with racism (Littlewood, 1996). The basic assumption, however, is that these missteps reflect the corruption of science, and that the epistemology of 'pure' science is above culture or perspective.

In the context of psychiatry, the 'reality' of disease has historically been indexed to Western norms. As modern sensibilities changed our views on pluralism, the notion of "cultural idioms of distress" provided new ways to account for differences. From a social constructivist perspective, all disorders are culture bound (Littlewood, 1996), and not all cultures formulate disorders, distress or even reality in the same ways (Chakraborty, 1991). The postmodern critique takes issue with the basic epistemological assumptions of modern medicine.

> What the postmodern mind is aware of is that there are problems in human and social life with no good solutions, twisted trajectories that cannot be straightened up, ambivalences that are more than linguistic blunders yelling to be corrected, doubts which cannot be legislated out of existence, moral agonies which no reason-dictated recipes can soothe, let alone cure (Bauman, 1993: 245). (Bracken, et. al., 1997)

In a field like psychiatry, this makes 'translation' from one distress idiom to another problematic if we assume that the basic foundations of "disorder" remain constant.

The anthropology literature makes a distinction between 'disease' and 'illness' that illustrates important dimensions of this debate. Disease refers to abnormalities in structure and function of the organs and organism; illness refers to the experiences of distress and discontinuity in role performance—all of which may shift over time (Eisenberg 1977; Kleinman, Eisenberg and Good, 1978; Littlewood, 1990). One might genuinely experience physiological consequences from trauma, but the experience of suffering reflects a distinct process of illness. A diagnosis of disease has a particular social currency, which in turn shapes the illness experience. All beliefs—including those about disease—are culture bound (Eisenberg, 1977).

This is particularly important in trying to understand a self-reflexive, complex cybernetic system like the mind-brain-body. There is no pure "disease" experience, as though we might know what would happen if distress somehow unfolded in a vacuum. "The oversimplified framing of sociocultural processes as merely epiphenomenon to mental disorders eclipses their constitutive role, resulting in essentialism, reductionism, and ethnocentrism" (Alarcón, et. al., 2009). The organism's disease response is inevitably and inextricably cultural, rendering the distinction between biological and cultural processes as somewhat arbitrary (Kienzler, 2008). In other words, there is no basis to assert that these are natural disease kinds because neither the biology nor culture can definitively claim to be primary. This is a chicken-and-the-egg type of regress. For constructivists, diagnoses are pragmatic distinctions made in service of understanding how to help other people.

As Cushman (1995) writes,

> Nothing has cured the human race and nothing is about to. Mental ills don't work that way; they are not universal, they are local. Every era has a particular configuration of self, illness, healer, technology; they are a kind of cultural package. They are interrelated, intertwined, interpenetrating. So when we study a particular illness, we are also studying the conditions that shape and define that illness, and the sociopolitical impact of those who are responsible for healing it. (pp: 2)

Psychology—in all its efforts to describe and treat illness—is inseparable from the culture in which it is conceived and practiced (Littlewood, 1987; Poyrazli and Thompson, 2013).

One of the most elaborated and oft-cited critiques of trauma is Alan Young's (1995) ethnographic analysis of PTSD, *A Harmony of Illusions*. He argues that the notion of "traumatic memory" as something so odious and unbearable that it has to be hidden from the conscious self functions as an analogy to explain the broader pattern of traumatic stress response. He does not dispute the distress of those who have suffered awful events but he argues that the "discovery" of traumatic memory—which forms the basis of PTSD—was in reality an idea invented to afford explanatory power for approaching experiences of suffering. Not to be confused with implicit or procedural memory, traumatic memory was proposed as a unique type of memory that is unconsciously removed from consciousness. Because it serves a narrative and organizing function, the concept of traumatic memory remains a cultural artifact and a product of history. Neurobiology may afford new explanations for unconscious trauma response in terms of subcortical processes. This is an example of an old insight paired with new science, but the idea of a "hidden" response becomes merely allegorical whereas it once enjoyed a different status (Young, 1995; see also Scaer, 2005). Some recent research into the coherence of trauma memories has also raised questions about old assumptions, finding that disordered traumatic

narratives do not significantly lack in coherence when compared to non-disordered narratives (Rubin, 2011).

Changing formulations of traumatic memory offer a useful example of how different cultural and philosophical beliefs come together in interlocking ways to shape our understanding. Consider again psychiatry's foundational assumptions about the self, epistemic knowledge, and the nature of reality. The medical model is the product of an array of ideas about health and healing. We could not think of psychopathology in terms of disorders if we did not delineate the self as relatively independent and autonomous. There is a reason why we do not diagnose relationships because the notion of a disease-entity depends on a proverbial host, a relatively closed system that brackets the boundaries of what incurs the disorder. Moreover, neurobiology's explanatory power is contingent on mind-body dualism because the presumption that the body has ontological primacy allows us to explain psychological issues in terms of physiological states.

The empiricism of the science is not in question when it comes to documenting the physiological process. The *implications* of that empirical science, however, remain a matter of cultural significance. What does this information tell us? How does it shape our understanding of reality? The value of this information in terms of its ability to assert truth claims is contingent on how it is integrated into a broader culturally-based framework of meaning. A neurological process may not speak to the challenges of soul loss, as we will discuss in chapter five. Secondly, what we know about dysregulation in brain states does not explain much of anything about the illness experience. The disorder category selectively ignores the very embodied, very physiological ways in which socio-cultural context shapes the organism in an ongoing, dialogical

process between self and world (James and Prillentensky, 2001). In order to propose a universalist medical model, we have to first assume that the self exists as a distinct, discrete, and relatively independent unit of analysis that is not otherwise continually reshaped by a social milieu. In the case of trauma, identifying a causal process can only be accomplished in a closed system in which the factors that condition the response are clearly identified.

It may go without saying that not everyone—either in or outside of the field of mental health—thinks about these issues in this way. It is also the case that many times, patients and providers within the same culture may think about issues of health in very different ways (Lauber, Nordt, Falcato and Rossler, 2003; Lewis, 1995). Western assumptions about agency and subjectivity are not shared around the world, and the non-Western self is often delineated in very different ways (Littlewood, 1990). Other cultures do not prioritize or focus on intrapsychic phenomenon in the same ways (Bracken, et. al. 1995). The separation of somatic, psychological, and cultural dimensions of experience is problematic and reflects cultural assumptions about the best way to approach, understand, and even constitute reality (Bracken, et. al. 1995; James and Prillentensky, 2001). This leads to our own assumptions about healing—and specifically therapy—that may or may not be appropriate in other settings (Bracken, et. al. 1995).

When we think about trauma as the loss of shared frames of meaning, for example, it changes the way we work to rebuild social worlds. Such perspective cannot be adequately conceptualized when formulating distress as a matter of individual functioning (Bracken, 2001). Many of these issues remain salient in the debate over our nosology. In its section on "Cultural Issues," the latest edition of the DSM explains,

> Mental disorders are defined in relation to cultural, social, and familial norms and values. Culture provides interpretive frameworks that shape the experience and expression of the symptoms, signs, and behaviors that are criteria for diagnosis. Culture is transmitted, revised, and recreated within the family and other social systems and institutions. Diagnostic assessment must therefore consider whether an individual's experiences, symptoms, and behaviors differ from sociocultural norms and lead to difficulties in adaptation in the cultures of origin and in specific social or familial contexts. (APA, 2013)

Notably, while this position acknowledges some of the challenges of cross-cultural work, the basic philosophical paradigm remains unchanged. For example, categorical assumptions are still central to the act of diagnosing which fundamentally splits "normality" from "abnormality".

> The boundaries between normality and pathology vary across cultures for specific types of behaviors. Thresholds of tolerance for specific symptoms or behaviors differ across cultures, social settings, and families. Hence, the level at which an experience becomes problematic or pathological will differ. The judgment that a given behavior is abnormal and requires clinical attention depends on cultural norms that are internalized by the individual and applied by others around them, including family members and clinicians. (APA, 2013)

Friedman, et. al., (2007) have attempted to defend PTSD as a "legitimate diagnosis" and rebut claims that it is a "culture-bound European American syndrome" by emphasizing the causal linearity drawn from the event to clinical abnormalities. They cite research conducted on many levels, the practical viability of the model, its ability to unify strands of knowledge from different fields, and its corroborating evidence from brain imaging studies. They assert that, "There can no longer be any doubt about the legitimacy of PTSD as a diagnosis" (Friedman, et. al., 2007). They call for the end to the debate between psychiatry and anthropology, but this is possible only once one accepts the philosophical assumptions of psychiatry. That is, concluding the debate is only possible once you accept a particular cultural frame.

The contributions of empirical science and the study of the brain-body afford new information about a particular disease concept, but that disease concept does not represent a natural kind. Rather, it exists in a state of dynamic tension within a cultural reality that defines the illness experience—all of which has bearing on the empirical state of neurobiology. The philosophical and cultural assumptions of Western psychiatry are embedded in the concept in a way that cannot be ontologically disentangled. It is important to realize that for the most part, anthropology's criticisms of traumatology cannot be resolved with more empirical research. To some extent, issues of translation and category fallacy can be incorporated into research paradigms in ways that will yield more reliable data. But social constructivism's objections to the medical model and the limitations of perspective are not methodological problems; they are philosophical questions that shed light on basic assumptions that make a particular type of inquiry possible. Every culture has its own ideas about what constitutes reality, which involves making assumptions about both what that reality is and what is the best way to understand it. As part of the contemporary Western world, psychiatry is no different.

In this chapter, we have discussed how critiques both from within psychology and from transcultural psychiatry reveal the limitations of the PTSD concept. The challenges of translation across frames of meaning, the presumptions of the medical model, and the cultural foundations of these concepts all reflect complex theoretical assumptions. As part of our effort to understand human suffering, psychiatry's limitations do not inherently negate its contributions. Rather, these limitations can guide us in a judicious dialogical process of understanding. Derek Summerfield (2001), one of the most outspoken critics of the PTSD construct, reminds us of the spirit of this debate: "As a category post-traumatic stress disorder

can support some weight, and I am saying we should debate how much this is, but it cannot support the tower block that has been erected on it."

In the next chapter, I will introduce a framework for discussing and analyzing trauma concepts. This quasi-structuralist model identifies four core conceptual questions that necessarily appear in any trauma concept. By recognizing the theoretical diversity that different trauma concepts use in answering these questions, it becomes possible to recognize how different philosophies come to influence our understanding and treatment of trauma. It also becomes possible to start a comparative dialogue across concepts that has the potential to enrich this diversity without attempting to simplify it or ignore it.

V. Core Conceptual Assumptions of Trauma Concepts: A Theoretical Framework

We can think of any idea or concept as an attempt to answer a question, or perhaps a series of questions. The more clearly we can elaborate on the nature of those questions, the easier it is to explore and examine the idea.

Psychiatry borrowed the term 'trauma' from medicine. The etymology comes from ancient Greek as a surgical term, where it referred to wounds and injuries suffered by soldiers when their armor was pierced (Newman, 2001; Ray, 2008). Trading on the metaphor of psychological defenses, psychiatry appropriated the word to describe injuries and/or damage to the mind inflicted by the proverbial slings and arrows of an external world. As we reviewed in Chapter One, the idea of psychological trauma has engendered a range of concepts and formulations reflecting a variety of disciplines and domains. Perhaps most notably, the idea of 'traumatic memory' as a distinct type of 'hidden' memory holds a certain sway on formulations of the concept (Young, 1995b).

The heart and soul of the concept, however, remains the metaphor of an inflicted injury (Baldwin, et. al., 2004). Its power is not in its identification of a natural kind or 'a thing,' but rather in the explanatory power of the analogy. Any concept of trauma makes a central causal claim by identifying what happened and then what happened as a result. As mentioned in the introduction, it is a central premise of this work that the word trauma describes a relationship between an experience and the suffering that follows from it. To be plainspoken, any notion of trauma fundamentally asserts that, 'This caused that suffering.' It identifies 'this' (the event) as having an etiological role in a creating a particular ('that') type of distress or pathology ('suffering').

The concept of trauma is intrinsically retrospective because it attempts to explain sources of distress through narrative propositions. It looks backwards to tell a story about what happened. Prospective and predictive research is as much an effort to impose some semblance of order and predictability on reality—not coincidentally in moments of chaos and crisis. This is a perfectly valid scientific project, but it also invites philosophical and anthropological questions about the nature of reality and the relativity of our worldview. To speak of 'potentially traumatic events' forecasts possible outcomes, but it does not describe the lasting experience of an event. 'Potentially traumatic events' are possibilities, not narratives of lived experience, and so on the grounds of the premise here, it makes no sense to talk about an event as a 'trauma' in the absence of a particular type of suffering.

I argue that the narrative structure of psychological trauma and the metaphor of injury constitute the unifying features of all trauma concepts. When these are absent, we are no longer looking at a concept of trauma, but instead an alternative proposition about psychiatry, or the mind, or experience, etc. Historically, for example, trauma was diagnostically distinguished from phobia in part because of the causal narrative involved (McNally and Saigh, 1993). Working across settings, one of the primary demands of cross cultural work depends on the translation of narrative concepts of causal suffering. Other cultures may not language their ideas in terms of 'wounds' and 'defenses', but every culture tells familiar stories about how bad times can change us and lead to painful and even sudden losses in life. As an idea, trauma attempts to answer some basic questions about our experience of acute hardship. The metaphor of injury offers a degree of explanatory power by providing a framework for thinking about these issues in

complementary ways. The range of trauma concepts can be analyzed in terms of the different ways that they answer these core questions.

I am proposing that there are in fact four core conceptual questions that constitute the central preoccupations of any trauma concept: the question of reference, the question of response, the question of etiology, and the question of suffering. This chapter is devoted to explaining this model of analysis and considering examples in the literature.

This model of analysis is quasi-structuralist in nature. It is structuralist in that it purports to offer a universally applicable frame of inquiry for examining trauma concepts across cultures. It assumes that trauma concepts inherently reflect the issues raised by these four questions and that the term 'trauma' otherwise becomes meaningless—or at least fundamentally incommensurable—in their absence. As I will argue, I believe that these core questions are 'interlocking' which means that while each can be answered independently, they mutually influence one another such that the implications of any one issue can only be understood in light of the others. The result is that these core questions exist in a state of dynamic conceptual tension that allow the concept to cohere in a particular way.

This model is 'quasi' structuralist in that I make no assumption that these questions necessarily have to be delineated in this way. I present them in terms of four key concerns, but there may be other ways to frame them that are more useful or intuitive. While I refer to them as 'core questions', I do not believe that there is one "correct" way to answer—or even to ask—each question. Rather, I refer to them as questions because they constitute sets of defining concerns. I do believe that the concerns at issue are inescapable. Because they are multifaceted

and interpenetrating, I make no assumption that the model I am proposing 'carves the theory at its joints.'

Some readers might object to my distinctions as either unduly simplifying or complicating different facets of each issue. I invite these criticisms, but ultimately I have chosen to present this material in this way because I believe it offers a coherent and comprehensive way to approach the complexity of these philosophical issues. In short and in the spirit of anthropology, I suggest that this model is 'useful to think with'. When reviewing each of these questions, the operative thing to have in mind is, "What issues does this question raise? What does it challenge us to think about?"

A few important theoretical considerations: First, these questions are not dichotomous. They do not have prescribed answers or represent forced choices. There is a range of possible responses—in the case of some questions, a relatively infinite array of possibilities—for addressing each question. In all, this suggests that there is effectively no limit on the number of different types of trauma concepts that we might hypothetically propose.

Secondly, these are not empirical questions. The core questions that I propose cannot be answered by empirical research. Rather, these questions help to set the frame for research. They are not answered *with* data, but rather they determine *what is salient* about the data. They organize the basic explanatory model. Answers to these core questions reflect the basic philosophical and epistemological assumptions that govern a trauma concept. This is not to say in any way that new research or scientific findings cannot force reconsiderations of basic assumptions. New discoveries about the brain-body, for example, can challenge old ideas about symptoms. Evidence of dimensionality can change diagnostic labels. Heterogeneity may change

criteria sets. But rather than providing conclusive answers to the core questions, new research forces us to make sense of investigative findings.

The core questions speak to this process of making meaning from knowledge. When we are unaware of our assumptions, knowledge appears to have an intrinsic meaning that can seem self-evident. But as is so often the case in cross cultural or interdisciplinary work, we find that different assumptions lead us to different conclusions about the same questions. In other words, we develop different ideas about the same issues. As it should be clear from the preceding reviews of history, research, and criticism, trauma concepts are deeply embedded in the worldviews of their progenitors. There is no way to disentangle the concept of PTSD from its core assumptions, which are themselves rooted in a particular discipline of study as part of a particular culture in a particular moment in history.

Cultural context does not predetermine our answers to the core questions, however. For example, positivists and social constructivists hold fundamentally different positions about knowledge, reality, power, and self/subjectivity—even though they both emerge from the Western episteme. Nor does the discipline or type of inquiry dictate the explanatory frame. For example, the literature of psychology is full of ideas about what constitutes trauma—many of which are quite distinct from PTSD. As we examine each of the four questions, much of what we will consider involves examples from the literature of how writers in the field have put forward different ideas about what trauma 'is' and how best to understand it. These writers effectively answer the questions I am proposing in different and illustrative ways. While the introduction of this analytical model is my attempt to organize this literature and shed light on these debates, it would be inappropriate to assume that any of the writers or theories cited here

conducted their work with these distinctions in mind. Any mistakes or confusions in the presentation of these ideas is solely my responsibility.

To some extent, the discussion of each question depends on artificial constraints. They are not presented here in any intrinsic order, but as a matter of preference. Each question offers its own vantage on the overarching concept, and while we will review them one by one, discussing examples for important concerns will inevitably invoke answers to the other questions. Again, the coherence of any trauma concept summarily depends on the interplay of all of the issues discussed here.

Question of Reference

For all the confusion and conflict that pervade traumatic experiences, what is the best point of reference for trying to understand what happened? Almost by nature if not definition, the subjective experience is disorganized and overwhelming. Is it better to step back and get some distance in order to look objectively at what happened? Or does this lose touch with something vital about the experience? Does objective impartiality overlook something about the essence of trauma? Can we develop an adequate understanding of trauma without a first-person appraisal of what the event means? Do we need to know something about why this event mattered? Or can trauma be understood strictly on the basis of objective criteria?

The question of reference is not simply a matter of what is salient, but also of understanding what is salient to whom. For example, the focus of inquiry for a neurobiologist—as a scaffold of ideas—may stand in contrast to that of human rights advocate, each of whom may argue for different understandings of trauma in part because they emphasize the importance

of different perspectives. The issue of subjectivity and objectivity is central to the construction of meaning and the latent organization of the explanatory model.

Before elaborating further on different ways of handling this question, we need to clarify more about what is meant by subjectivity and objectivity. There are in fact two different debates here, and it may be beneficial to tease them apart before moving forward. One debate is about the perspective that gives rise to the narrative: Should we understand trauma through the eyes of the person who lived it, or through the observer? Is our understanding constructed from the lived phenomenology of the experience or from observations and analysis that we can make about an experience that someone had? The other debate here is about the epistemological status of subjective and objective reports. What constitutes evidence? What type of data deserve the imprimatur of science? This debate feeds into criticism about the veracity of memory and self-report, and by extension calls into question the empirical basis of the field.

My intention in raising the question of reference is to concentrate on the former and defer the latter. Following the latter debate would lead us back into discussions about the legitimacy of putting 'science' into 'social science'. It would also invite a much broader philosophical debate about epistemology, definitions of knowledge, and what constitutes adequate criteria for making truth claims. It may be worth noting that all of these philosophical issues have deep cultural roots, but let it suffice to say that while epistemology plays an important role in shaping our paradigm(s), this debate is beyond the scope of this work.

So in matters of reference, the question invites a focus on the 'who' and 'how' of narrative accounts. How are different perspectives accounted for in establishing the narrative? For example, when a woman who was raped describes the worst part of her experience as the

defense attorney's cross examination, how do we incorporate that subjective experience into our understanding of trauma (see Campbell, 2008; in the case of torture, see Martinez and Fabri, 1991)? Different explanatory models may emphasize different foci of inquiry or levels of analysis for different reasons. A biological model faces different practical, conceptual and empirical demands than a socio-legal perspective, but both have purchase on this issue.

Perhaps my main point here is that there are different yet equally valid ways to make sense of subjective and objective features, and it would be presumptuous to suggest that one way is somehow more 'true' or more representative of 'the real trauma' than the others. As we will discuss over the course of this chapter, the interlocking nature of core questions often mutually reinforce our implicit conclusions about what we believe is the 'proper' way to understand things. But if we make allowances for the different issues raised by these questions, then we have to recognize the integrity and complexity of different narratives.

To speak simply in terms of subjective and objective positions belies the range of possible approaches to the question of reference. It is not simply dichotomous. There are at least four possible positions: exclusively subjective, exclusively objective, an amalgam of both, or a relational perspective in which an understanding about the experience is regarded as the product of shared meanings. The question of reference can also be multi-dimensional, which is to say that different parts of the explanatory model may draw from multiple and/or different sources.

The latest revisions to the DSM showcase this issue in exemplary fashion. In the DSM-IV, PTSD had both subjective and objective reference points for defining the event. The inclusion of criterion A2 stipulated that "fear, horror or helplessness" played a part in defining the event as traumatic. This criteria was included as an attempt to compensate for the limitations

of a relatively objective account proposed in the DSM III. The DSM-IV tried to balance the emphasis between subjective and objective features. As we reviewed in chapter three, however, substantial criticism and empirical shortcomings prompted its removal. It proved too difficult to operationalize subjective features in ways that meaningfully contributed to the concept. So while the challenges of operationalizing subjective dimensions may prove impractical, this hardly gives any ground to claim that a definitive conclusion can be reached about the relative contributions of subjective or objective perspectives. It does not conclusively answer the question of reference. Instead, it consolidates findings to be consistent with the range of ideas that make up the concept.

The controversy about criteria A illustrates different ways to approach the question of reference. PTSD also showcases how points of reference can be incorporated into different parts of an explanatory model. In the current diagnostic classification, subjective phenomenon (i.e., affective symptoms and internal states) are not ignored. Subjective phenomenon are objectively documented in criteria sets as part of the trauma response. In terms of defining trauma as PTSD, the meaning or personal narrative of the experience is irrelevant. The phenomenology is actuarial. (It might be helpful to take a moment to distinguish between the hermeneutic and psychiatric usage of the word 'phenomenology'. In hermeneutics, phenomenology refers to the lived, embodied experience of the individual. It invokes a holistic sense of being-in-the-world—seamless, existential, in some ways ineffable. This is not to be confused with psychiatric phenomenology in which features of experience—i.e., mood, cognition—are documented, catalogued and assessed as states.)

The question of reference not only has a high profile in the current literature, but it has been prominent since psychiatry took up the metaphor of trauma. For example, Freud himself dabbled with different answers to this question. His original seduction theory emphasized the objectivity of a real experience and by virtue of its own unbearable truth, became repressed in the unconscious. Fleshing out the unique psychodynamics of the individual's experience offered a way to account for the subjectivity of experience. Nevertheless, it remained a largely objective frame of reference for understanding violation because it was concerned with a subjective response to real events that occurred in the world. The event itself had stature as being awful. His subsequent abdication of these ideas introduced an more subjective account in the theory of infantile sexuality. The solipsism of infantile fantasy separated out the (un)conscious narrative from actual events in the world. While Freud continued to believe in the purportedly objective science of drive theory, he became almost exclusively focused on the intrapsychic subjectivity of the individual.

Some historical ideas such as railway spine or shell shock offer medicalized accounts that clearly privilege objective perspectives. Their medical hypotheses did not prove true, but their point of reference is the same as that of neurological dysregulation. Interestingly, when trauma concepts are formulated strictly in terms of neurobiology, the subjective dimension becomes secondary but does not disappear entirely. As we discussed in Chapter Three, some critics contend that trauma should be formulated simply in terms of its neurological profile. This is the equivalent of objectivity or bust. In such a formulation, any event that is sufficiently salient to the individual to trigger the necessary biological response can be considered traumatic. In such a concept, the objective register of trauma definitions contends with subjective concerns by

recognizing the radical relativity of salient stimuli. Subjectively, whatever "freaks you out" can be trauma as long as it meets objective criteria.

Another way in which the question of reference emerges in the literature involves the debate between idiographic and nomothetic frames. Should we organize our understanding of trauma around individual experiences, or should we focus on classifications and categories? Is it biological or biographical? Narrative or actuarial? Some critics contend that the PTSD diagnosis has set back our understanding of trauma because it distances psychological practice from a historical tendency to work idiographically (McHugh and Treisman, 2007), but as we discussed in Chapter One, this may be true only for particular moments of history. Different ideas rise and fall in prominence. In anthropology, this issue has some resonance with the emic/etic debate: What happens when we try to understand an experience as an outsider as opposed to thinking about it in the terms used by the participants? Should we understand what happened in terms that are experience-near or experience-distant?

The question of reference has important implications for the type of inquiry we hope to conduct. It is important to recognize how answering this question in different ways can expand (or diminish) different sets of concerns. When answered in certain ways, it makes certain types of investigation possible by directing our focus. Certain types of analysis are more amenable to research from a particular point of reference. For example, if we want to work with neurobiology, then that dictates objectivity. If we want to do phenomenology, then we have to be (inter)subjectively concerned. Implicit in any trauma concept is a presumption of what we want to understand about an experience.

For some writers, a central dimension of their criticism hinges on the way in which our reference point brackets our potential for understanding trauma. Bracken, et. al., (1995) argues that the assumption that events can be described objectively and retain their meaning misunderstands the subjective and cultural context of the experience. He argues that we cannot understand the range of an individual's response without understanding the associated meaning that the event has. These sorts of biographical concerns must be embedded in social, economic, and historical contexts (Kienzler, 2008). The experience of distress—as reported by the individual—may (or may not) be consistent with a diagnostic approach (Bracken, et. al., 1995). A strictly objective stance may offer a unique insight, but it also precludes hermeneutics, which then precludes our consideration of how we construct meaning.

In another example, Eisenbruch (1984a) argues that traumatic loss needs to be understood in reference to the "Assumptive World" of the individual through which meaning and self-in-relation are established. For example, in the case of an asylee, the loss of culture/place can cause a profound sense of loss akin to grief and bereavement. When one's world has fallen away, it is as though part of oneself has fallen away as well. Eisenbruch describes feeling "in limbo" living in a "ghost reality" (Eisenbruch, 1984a). This bereavement may be expressed in diverse ways that are "traumatic" in their own right. To suggest that (objective) universalist explanations can describe such a loss misses the diversity of human experience—and in terms of the question of reference, completely misses the subjective sense of being-in-the-world. Eisenbruch's emphasis on subjective reference fundamentally changes how we account for trauma compared with other more objective accounts.

As we have seen in these examples, there are many ways in which different trauma concepts attempt to establish a point of reference. Each of them grapple with objective and subjective dimensions in different ways. As van der Kolk & McFarlane (1996) write,

> The critical element that makes an event traumatic is the subjective assessment by victims of how threatened or helpless they feel. So, although the reality of extraordinary events is at the core of PTSD, the meaning that victims attach to these events is as fundamental as the trauma itself. (6)

In working with any concept of trauma, it is important to recognize that it invokes a particular frame of reference, and regardless of how rigorous, comprehensive, or exhaustive this perspective may attempt to be, it does not invalidate the integrity of other perspectives to define, describe, or explain the same experience.

Question of Suffering

When someone is in great distress, every culture tells a story that attempts to explain how they came to suffer so much. Every tradition offers different kinds of stories to explain what happened and why, giving birth to different explanatory systems. The comparative work of looking across nosologies involves some effort to understand—or possibly even reconcile—the different ideas they offer. As we discussed in chapter four, one of anthropology's primary critiques of psychiatry exposes the category fallacy of wrongly assuming that a constellation of feelings and behaviors can establish the cross-cultural validity of a diagnosis. Without the delicate hermeneutic work of translation, we remain unaware of our assumptions about the nature of suffering.

If the basic idea of trauma assumes a psychological wound, then the question of suffering asks, "What does it mean to be wounded?" How do we understand what suffering is? How is

suffering related to the way we see ourselves and the world? For example, should we understand suffering as a punishment of some kind? Does suffering have meaning? Or is suffering meaningless as a value proposition—the impartial product of circumstantial factors? Is it medical? The assumptions that we make about what suffering 'is'—and what is the self that suffers—shape the way we understand what it means to suffer.

In explaining the experience of suffering, every culture makes its own assumptions about what makes for an adequate story. Cultures provide explanatory frameworks for organizing and structuring experiences of distress. For example, some may appeal to divinity while others look closely at the science of the body. The notion of traumatic stress appeals to a biopsychosocial framework that integrates scientific propositions about distress and suffering. From a clinical point of view, it can seem foreign to look at distress in any terms other than diagnosis. Historically, as we discussed in chapter one, there have been other ways of conceptualizing suffering. Psychodynamic theory traditionally looked at psychological problems on a neurotic to psychotic continuum—a dimensional perspective that also informed Meyerian systems in the mid-20th century. These ideas have regained some credence in discussions for the DSM 5, but the prevailing paradigm remains a categorical approach.

As we have discussed throughout this work, psychiatry follows medicine in subscribing to an allopathic disease model that is based on Neo-Kraepelinian disorder categories. Suffering is formulated in terms of disorders that constitute distinct types that can be separated by category and class. Disorders are defined according to criteria sets which are comprised of symptom clusters. Symptoms provide the basic unit of analysis in structuring and analyzing the experience of distress. Each symptom can be considered as an independent feature, and some

symptoms may constitute features of multiple disorders (e.g., negative mood may be present in both depression and PTSD).

One characteristic of the medical model is that each symptom is treated as a value-neutral proposition, which is to say that its signal value stands in relation to its diagnostic feature. In contrast, psychodynamic theory has historically considered symptoms as symbolic communications. The medical model assumes that associated features of distress and suffering should stand in isolation, although increasingly these symptoms are treated as epiphenomenon of physiological dysregulation. For example, hyperarousal need not be regarded as an expression of existential dislocation and insecurity, but instead formulated as learned association in which kindling precipitates the over-generalization of a conditioned fear response. Because symptoms are regarded as value-neutral and diagnoses claim the mantle of medical science, a PTSD diagnosis is often held up as non-stigmatizing and value-free.

The medical model depends on the concept of pathology as a state of disorder. Because the idea of "disorder" carries so much weight, it may be useful to quote the DSM 5 at length in clarifying the concept.

> A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above… Until incontrovertible etiological or pathophysiological mechanisms are identified to fully validate specific disorders or disorder spectra, the most important standard for the DSM-5 disorder criteria will be their clinical utility for the assessment of clinical course and

> treatment response of individuals grouped by a given set of diagnostic criteria. (APA, 2013)

Pathology fundamentally distinguishes a state of abnormal condition or development, and any discussion of a reaction as 'normal' and 'abnormal' depends on beliefs about healthy development or healthy states of being—the way it 'would be' if something bad had not happened. In a very basic sense, disorder assumes that there is an order that has been disrupted. It invokes a value system—not merely in terms of stigma as a social reaction, but in terms of a (social) order that is implicit in the idea (Wakefield, 1992). This is also explicitly acknowledged in the DSM 5.

> Mental disorders are defined in relation to cultural, social, and familial norms and values. Culture provides interpretive frameworks that shape the experience and expression of the symptoms, signs, and behaviors that are criteria for diagnosis. Culture is transmitted, revised, and recreated within the family and other social systems and institutions. Diagnostic assessment must therefore consider whether an individual's experiences, symptoms, and behaviors differ from sociocultural norms and lead to difficulties in adaptation in the cultures of origin and in specific social or familial contexts. (APA, 2013)

In other words, suffering (if not "pathology") is always contextual. It emerges from and describes a worldview.

To summarize in the view of psychiatry, the way to understand suffering is through disorders in the allopathic disease model, which determines that each disorder has a distinct cause. The primary disorder of trauma is PTSD, which is caused by exposure to a qualifying event (Criteria A) and the over activation of physiological response in a pathonomic process of learned associations. Observation of features can formulate distress in terms of symptoms, which are value-neutral propositions and can be understood acontextually. That is, the

communicative value recognized in symptoms is that they may be possible markers of disorder. The medical model views the body as primary, and symptoms can be explained as epiphenomenon of neurobiological and physiological processes. Overall, it keeps closely to a dualistic framework in which the mind and the body can be approached through a biopsychosocial framework.

As we discussed in chapter one, the medical model and the concept of PTSD are deeply embedded in a worldview, replete with philosophical assumptions about epistemology, selfhood, and ontology. As the limitations of a categorical approach to diagnosis come more into focus (as discussed in chapter four), there is a need even within our paradigm to look beyond our current concepts of suffering. The universalist (read as: acontextual) assumptions of the model pose a variety of theoretical and empirical challenges. As van der Kolk and McFarlane (1996) write,

> When people are traumatized, the choice of defenses is influenced by developmental stage, temperamental and contextual factors. Hence, the diagnosis of PTSD alone never fully captures the totality of people's suffering and the spectrum of adaptations that they engage in… The core issue is the inability to integrate the reality of particular experiences, and the resulting repetitive replaying of the trauma in images, behaviors, feelings, physiological states, and interpersonal relationships. Thus, in dealing with traumatized people, it is critical to examine where they have become "stuck" and around which specific traumatic event(s) they have built their secondary psychic elaborations. (7)

As with many of the issues encountered in this work, it is beyond the scope of this inquiry to fully describe or elaborate alternatives to the medical model, but it may be illustrative to take some time to consider how suffering is understood in another culture. Only by recognizing the radical variability in ideas can we appreciate how concepts of suffering shape our understanding of trauma. For an example, we turn to the Maya, who are the indigenous

people of Guatemala. I offer a fuller introduction to the Maya and Guatemala in chapter seven, but here the focus is limited to exploring how suffering is understood in this culture.

A brief note: to speak of 'the Maya' is like talking about 'the Scandinavians'. The Maya are indigenous people who originally lived in Central America from Chiapas, Mexico down to what is now Honduras in the pre-Colombian era (Wearne, 1994). The Maya are comprised of several major ethnic groups and speak 22 different languages (Grazioso, Keller, Swazo and Consoli, 2013), which makes it hard to offer generalities without oversimplifying nuance and difference. Historical factors have recently forced greater development of an 'indigenous identity,' and so "while common use of the term 'Maya' might be new, the unity of 'Maya' culture is not completely fabricated" (Metz, 2006, p. 11). Many of the studies cited here drew from research on groups in Chiapas and with refugees in Mexico from the central highlands of Guatemala.

The basic Mayan conception of health is based largely on a humoral system in which elements of the body exist in balance. Two major polarities of strength-weakness and hot-cold are in some measure syntonic and co-terminus—and the world is understood in terms of these innate qualities. For example, all plants, foods, and medicines are classified according to qualities of hot, cold or *fresco* (meaning cool or fresh). A health body exists in a state of equilibrium, and illness is a state of imbalance (Cosminsky, 1977). Health and distress are understood holistically, and properties of hot-cold are not limited to physical concerns. Psychiatric concerns are not considered as separate or distinct (Fabrega and Manning, 1973). These qualities are mapped onto metaphorical-ideological levels in which emotions and social interactions are imbued with warmth or cold. For example, authority, power, and maturity are all

considered ‘warm’ or having heat. Health depends on the presence of ‘vital warmth’ and cold is considered pathogenic (Groark, 2005). The expression of negative emotions (e.g., anger) is considered detrimental to the social order (Woodrick, 1995), and its associated disturbance can also be both pathogenic and contagious (Fabrega and Manning, 1973).

In terms of the question of suffering, we have to understand the way in which distress reflects the broader worldview. Illness reflects a state of imbalance not merely in the body, but of one’s relationship with the natural order. This has social and spiritual dimensions. Mayan concepts of the self recognized three dimensions of existence: the waking self, the essential soul, and an animal co-essence (Groark, 2009). What it means to be a person involves all three, and the animal co-essence—called a *nagual*—represents a key node in linking the material and spiritual worlds (Gossen, 1994). The waking self—in some ways what a Western perspective might think of as ‘the self’—is a largely passive figure before the forces of nature. Volition and personal ambition—insofar as psychiatry might understand autonomous agency—is seen as a transgression. One’s birth establishes one’s place and destiny in the natural order—synchronically across the worldly and the divine—and living ‘the right way’ involves living in balance according to one’s position in the natural order (Gossen, 1994; Groark, 2009). The self, the soul and the natural order must all live in harmonious balance, and these ideas offer their own nosology of illness (Asociación Médicos Descalzos, 2012).

Suffering and distress in the Maya worldview present themselves in two main types of illness experience: spirit loss and *awas*. Human *awas* amount to “an inherent malformation of the victim’s constitution” (Wilson, 1995, p. 124); mountain *awas* occur as a result *tzuultaq’* which involve transgression against the moral code and natural order. All aspects of one’s

lifestyle—religious ceremonies, farming, pregnancy, etc.—are implicated in maintaining a proper sense of the harmonious balance characteristic of health. Transgression may result in constitutional malformations (such as when the parents' violations are visited upon their children) or spirit-loss. Spirit loss can occur when an individual gets too close to a 'hot' feature, such as part of a mountain, or a fall can cause a person to "lose a tight grip on his or her spirit" (Wilson, 1995, p. 144), at which point it may be taken by a spirit or deity. A deity may also take one's soul as a punishment for living improperly. Fright and witchcraft can also produce soul loss (Wilson, 1995).

In terms of understanding trauma, a concept like soul loss can seem tempting for comparisons to a medical concept like PTSD, but these are incongruent ideas. If we presume to think about psychological trauma as a wound to the mind, then there is already a hermeneutic challenge because the dualisms of Western psychiatry that make such an organizing metaphor possible do not exist in the Maya worldview. Metaphorically, what is being wounded? Is it the waking self? For the Maya, illness experience is understood holistically, involving social and spiritual dimensions. Is it the animal co-essence? The Maya believe that what happens to the *nagual* affects the individual—and vice versa—and so the death of one portends the death of the other. Is it the soul that is wounded? In working with Maya women who survived a long and protracted civil war, Arias (2009) notes they talk about *txitzi'n* which is a "deep pain". "The term signifies not only physical suffering but also 'a wounded soul,' conceptualizing an image in which a part of the subject is dead" (Arias, 2009). It is a traumatic suffering—one not defined by fearfulness, but by a struggle to find a new sense of meaning in life. A tripartite self does not

readily lend itself in the same way to talking about the disease/disorder categories used in psychiatry, and the concept of trauma requires considerable hermeneutic effort.

Another hermeneutic challenge in talking about "trauma" cross culturally reflects its implicit assumptions about selfhood. For example, Paul Kockelman (2011) writes about the interrelations among the construction of self, affect, and ontology among the ethnic Q'eqchi' Maya. In other words, he examines how our understanding of being a person is wrapped up with our understanding of the world around us. Emotion tells the story of how the self stands in relation to the world, making affect, ontology, and selfhood inseparable—much like different sides of a die. In an occidental worldview, the self is typically seen as distinct and separable from its relationships or context. The self includes the inner world of the mind and the physical body (Kockelman, 2011), and it becomes possible to talk about a 'true self' separate from outside influences. Thinking about psychological trauma, we talk about injuries to this separate self.

For the Q'eqchi' Maya, the self extends beyond the physical body because selfhood is not demarcated in the same ways. For example, there are ways in which the boundaries that delineate a woman's selfhood overlap with the chickens she tends, such that she and her chickens are reflective and representative of the other. It is believed that a woman's choices—the firewood she gathers, the way she sleeps at night, the way she handles the wash, etc.—have bearing on the brooding hen and the chicks being hatched. Pathology in the chicks indicates her own transgressions against traditions and practices. This syncretic self experience has standing in social relations (i.e., her children may be jealous of the flock). Threats to the chicks (i.e., from a chicken hawk) can be experienced as a threat to self. Men have a relatively similar relationship to the corn they plant. This is part of a wider set of beliefs about animals (i.e., wild vs.

domesticated) and the natural world. It is part of a larger cosmology in which the very ontology of what 'is' stands in the balance—and must be in harmonious balance lest consequences arise (Kockelman, 2011).

In thinking about trauma, the idea of a 'wound to the mind' tells a story about how the individual self was wounded. Can witnessing the killing of one's animals be a traumatic wound to the self? What about learning that one's crops had been burned (Summerfield, 1998)? These events do not meet criteria as a "potentially traumatic event" for PTSD. Moreover, suggesting that domestic animals and crops could be culturally equivalent to "loved ones" misrepresents the ontology of their worldview. As Beristain, Paez and González (2000) write, "Indigenous thought is more holistic and analogical, and so many western analytic categories cannot be found." It would be reductionistic and ethnocentric to assume that a Western ontology tells more of "the truth" about 'what really is', or that a medical model contained a more parsimonious explanation of suffering than an indigenous perspective.

The Mayan concept of suffering rejects the dualism of Western psychiatry (Fabrega and Manning, 1973). Whereas the medical model typically does not regard a symptom of illness as valid unless it correlates with evidence of biological change (Farias, 1992; Grubrich-Simitis, 1981), the spiritual and social dimensions of suffering radically change the basic assumptions about the illness experience. What the medical model might describe as cognitive sequelae of brain dysregulation might be seen by the Maya as punishments for transgression. What psychiatry believes to be psychological symptoms, carries metaphysical implications for the Maya. If Western disciplines emphasize the value-neutral objectivity of physiological processes in formulating distress, the Maya emphasize the moral, relational consequences of a imbalance

with the natural order. "The structure of the diagnostic exploration determines the characterization of the present pathology" [my translation] (Farias, 1992). This is true whether we think about categorical disorders, dimensional neuroticism, or spiritual imbalance.

Question of Etiology

Trauma concepts implicitly assume not only a wound, but a narrative sequence of cause and effect. Trauma tells the story of how an event caused suffering to happen, which assumes not only a type of relationship (i.e., causation), but also the presence of separate features with different roles in that relationship (Young, 1995b). There has to be a clear separation of the cause from the effect. The very idea of causality rests on the assumption of a binary of active and passive. Explaining a cause depends on describing how one element is active in operating on another. The effect reflects the passive transformation brought about by the cause.

When the cause and effect become muddled, it becomes impossible to determine the active and passive features of the exchange. Without a clear distinction between the agent and its consequences, we cannot make causal claims, which makes defining cause and effect the central preoccupation of any etiological question. Certainly, there are processes in which a cause produces a change, which then becomes a cause of its own. This type of exchange can be elaborated in reciprocal and reflexive ways, but even these dynamic exchanges represent a fluidity that transcends the basics of active and passive. The importance of cleaving a distinction between cause and effect remains unchanged.

The other side of the etiological coin is the issue of the mechanism: having defined the cause and the effect, we need to understand how it is that the active cause is producing the passive results of the effect. What is the mechanism by which this happens? The mechanism

attempts to explain how the cause spans the cleavage in order to produce the effect. In other words, the mechanism is what affords connectivity and coherence to explain continuity in the change. In the case of trauma, the mechanism explains how the event produces suffering.

The question of etiology asks a two-part question: How does the concept define the event? And, what does it understand as the mechanism? In the question of etiology, I direct our attention to understanding the active elements of causation. As we will discuss shortly, I address our understanding of the passive effects in the question of response.

How we define what constitutes the event involves bracketing the experience. Life is lived in an unbroken stream that we narrate in terms of events and episodes. The way in which we distinguish these episodes reflects our own complex assumptions about reality, time, the self, and other basic qualities about existence. When we identify an "event," we bracket a portion of our lived experience as having clear temporal dimensions: events necessarily have a narrative structure of beginning, middle, and ending. Causality fundamentally assumes a linear sequence of events that start and stop. In the case of trauma, how we define the traumatic event plays an important role in selectively identifying causal elements in the narrative of suffering.

Trauma has been described by some as a disorder of time in which the present only repeats the past, the past is interminable, and the future does not exist (e.g., Stolorow, 2007). By its narrative structure, the metaphor of a psychological wound narrates a sequence, and concepts of trauma inherently introduce an element of structure to an experience that can seem timeless. Definitions of trauma can be seen as conceptual containers—as veritable pockets that envelope experience as an event. By virtue of beginnings and endings (read as: temporality), the concept

cleaves the cause and effect in ways that allow us to talk about the impact. In other words, definitions circumscribe experience in ways that allow us to narrate associations.

As a point of illustration, consider the familiar misery of trauma survivors—namely, the painful process of weaving a meaningful story from what happened. Trauma narratives have a tendency to struggle with defining the event in healthy ways. Survivors may agonize on a fixated constriction of the cause: think of the motorist who agonizes over glancing at a text message that led to an accident. Here, this limited and singular detail may twist with obsessive preoccupation as the cause is defined with the tightest, choking constriction. Alternately, survivors may wallow in a global attribution of cause: "This keeps happening because I'm completely unloveable!" In this case, the event has no brackets or boundaries; the cause rolls endlessly through their experience leading to the present.

The same can be true in understanding the effect. Survivors may feel devastated by an effect that defines too much of experience: think of the mother who cannot forgive herself in the wake of her child's death because her parting words were in anger. In the suffering of her narrative, the rich complexity of her relationship with her child is reduced to a single interaction. When she tells her story, the death that follows an argument (read as: cause) results in what feels like the annihilation of what they shared. She feels the effect as if one moment swallows the past, present, and future. As another example, people may feel unmoored by an effect that engulfs them: imagine the Vietnam veteran who sees his entire life as laid to waste by his combat experience in the jungle. Here, the effect is endless and the narrative has no conclusion.

Part of what therapy does is to help clients to integrate traumatic experiences into their lives by helping them define what happened within a broader narrative. As clinicians, we define

trauma, too. It is important that we be cognizant of the way that we introduce these definitions in our work. Practically, one way to think about therapy is that it is an invitation to our clients to join us by holding their stories in the pockets of definitions—either our own or the ones we help them to create.

In telling a story about what happened, every trauma concept selectively "pulls out" the event from its context and history as a way to illustrate the narrative. Trauma concepts have to define what is and is not part of the event. They make assumptions about what is relevant in order to separate the event from its context. What matters? What is foreground and what is background? Without these distinction, the nature of the event gets lost in the context. Otherwise, the alternative would be to say that all of time and history led up to this moment as the cause, and all of life across time hereafter is the effect. While maybe this spiritually unfolds some of life's mysteries, existentially it betrays our natural understanding of the world and is also scientifically useless. Causality is fundamentally episodic. In other words, causes and effects have to have beginnings and endings. What is considered "relevant" deals in a limited number of details.

So, what defines the event? This is not an empirical question. It is not as though there is only one way or one "proper" way to define an event. Telling a story about 'what happened' invites all manner of ideas. A narrative is rooted in a worldview as we have seen in the question of suffering, and it hinges on perspective as we have seen in the question of reference.

The concept of PTSD makes for an interesting example in answering the question of etiology because diagnostically it eschews a formal etiological theory. As we discussed in chapter two, the concept of PTSD leans heavily on learning theory and neurobiology, but it does

not specifically stipulate the causal mechanism in its formulation. This invites a range of theories and ideas, and in some ways it represents one of the major inspirations for the evolution of the concept. Cahill and Foa (2007) note that the psychology literature provides several examples to explain the acting mechanism(s): conditioning theory, schema theory, emotional processing theory, cognitive theory, dual representation theory, among others. They share common assumptions about associations between stimuli and fear response that demonstrate discrepancies between actual and perceived danger. They all involve some degree of cognitive appraisal and link sequelae with disruption and dysregulation. In other words, they point towards an understanding of the mechanism.

None of these theories can provide a full or satisfactory account of numbing symptoms, and none of them provide a key to unlock epidemiological questions of who develops PTSD and why (Cahill and Foa, 2007). Magnitude, frequency, predictability and controllability all purportedly work in concert to leverage the experience as the mechanism. Writing about the similarities and differences between emotion processing theory, dual representation theory and Ehler's and Clark's cognitive model, Brewin and Holmes (2003) discuss the operative factor of memory. "The most important areas where they differ is their accounts of how trauma impacts on memory, the process whereby changes are brought about in memory [through treatment], and how these changes are related to recovery." Across theories, PTSD roots the question of etiology in its formulation of the event—namely the creation of a memory.

Teasing apart the creation of memory from what "really" happened is its own complicated, convoluted philosophical debate that we will have to set aside here. Perhaps this introduces an inextricably subjective dimension in understanding trauma, but the construction of

the disorder stipulates objective features. PTSD defines the event in terms of Criteria A, bracketing those events capable of producing the memories that will serve as the mechanism of the disorder. As we also reviewed in chapter one, this definition was originally vague in DSM III and revised to offer greater specificity in subsequent editions. In both DSM IV and DSM 5, the definitions were expanded in order to broaden what can be defined as a "potentially traumatic event." While trauma concepts are fundamentally retrospective in explaining the relationship between cause and effect, the need to operationalize the construct forces a standardize definition of events that can be "pulled out" of their context in objective ways according to their pre-determined proximal features.

For some of these "potentially traumatic events"—e.g., car accident—it may seem relatively straightforward to discern when they begin and end. Other events—e.g., war trauma—may be harder to pinpoint in terms of beginnings and endings. But this is part of what is at issue in "pulling out" an event from its context. Imagine again our Vietnam veteran experiencing combat in the jungle. When does "the event" begin? Does it start with gun fire? Does it start when his platoon hears reports of enemy movements in their sector? Or does the event begin when they enter the jungle? Or when his division is deployed to Vietnam? The emphasis in PTSD is in recognizing the immediate proximal stress (read as: the event) that precipitates the over-activation of a fear response (read as: the mechanism). As we reviewed in Chapters three and four, however, many critics object to the lack of developmental, contextual, and historical considerations in PTSD. Defining the event in this way is much broader and more inclusive than the predetermined proximal features of PTSD.

Complex PTSD offers a prime example of that challenges that come with defining the event. To review from chapter three, complex PTSD involves prolonged, repeated instances of interpersonal violence. For example, imagine the woman who endures domestic violence. She is raped by her husband when he comes home from work and he proceeds to push, slap, and threaten her over the course of the evening before he eventually passes out from drinking. This occurs several times a week over the course of a year. What is the event? Is the rape a separate event from the physical and verbal abuse? When each incident of physical violence is separated by a chronic state of threat, should we understand this threat as foreground or background? Should we think of this 'threat to physical integrity' as an event of its own, or should we see it as the context in which other "traumatic" events occur?

With a concept like complex PTSD, 'what happened' is not simply episodic as a singular event. The "cause" can only be circumscribed to encompass a sustained episode of one's life—a period of time in which singular attributions to discrete events are either not possible or not reflective of the same complex causal dynamic. The most important point here is to recognize how concepts like PTSD and complex PTSD fundamentally differ in terms of how they delineate what constitutes "the event," and by extension, understand the mechanism and trauma response each in different ways.

A similar criticism is commonly offered in the literature on massive state violence: for many war trauma survivors, they endure a protracted crisis of armed conflict or even genocide. The trauma, for example, might not be confined to the bombing of their city, but rather emerges from the terror of indiscriminate violence over a long period of time. In this line of thinking, it makes little sense to suggest that the individual is suffering from "post-" traumatic stress after a

bombing when the event (read as: the war) is not even over (Hernández-Wolfe, 2013; Richman, 1998). Bracken, et. al. (1995) argue that community and place setting fundamentally shape trauma response, which means that these elements are not merely background to the event, but rather active, causal features. He argues that social, political, and cultural issues should be seen as central in defining trauma.

It is hard to overstate the implications of how different formulations of "the event" as the cause can change our understanding of trauma. Because it defines the event in broad terms, a concept like complex PTSD invites a much more developmentally and contextually informed understanding of causality. In PTSD, the event is described objectively in standardize ways to recognize the impact of the proximal event. The "potentially traumatic events" constitute active components in the causal relationship while the individual is passively affected. The literature describes "exposure" (as in, "exposure to potentially traumatic events") without regard to the agency of the individual. Again, causality depends on establishing active and passive roles, and some critics reject the idea of seeing people as passive in their own survival—especially in the case of complicated interpersonal and socio-political events (e.g., Summerfield, 2000; Watters, 2001). "Psychological trauma is not akin to physical trauma: people do not passively register the impact of external forces (unlike, say, a leg hit by a bullet), but engage with them in active, problem-solving and social ways (Summerfield, 2000)."

From the "beginning" of the event (however this beginning is defined), the individual is an active respondent, creating a complex dynamic which is equally contingent on the context, meaning, and personal history of the individual. Delineating nomothetic principles of causality is predicated on overlooking what chaos theory would describe as the sensitive dependence of

the system (Lorenz, 1993). A partial accounting may be possible through identifying moderating, mediating and protective factors, but this actuarial approach does not fully recognize the fluid cybernetic complexity of human agency.

In the concept of PTSD, the notion of "potentially traumatic events" foreshortens a consideration of the meaning associated with these events because of the way in which the definition of the event is "pulled out" from its context. Perhaps the most important point here is that the cut points used to define the event and to cleave the separation between cause and effect are necessarily theory-driven if not arbitrary. This does not undermine causal investigations *per se*, but it does insist on recognizing the perspectival foundations of causal claims. The place for empiricism comes in terms of recognizing that once we have cleaved cause from effect and "pulled out" events from context, we need to depend on research to trace out the correlations and consequences of these ideas.

So far, we have considered how different trauma concepts define the event by identifying the cause. We can also consider how different concepts may build around a different understanding of the mechanism. Robert Stolorow (2007) offers a relational psychodynamic perspective in existential terms. Whereas meaning in life emerges from the "embeddedness" of day-to-day life, trauma jars people out of the immersed, engaged experience of being connected with others. Normally, meaning and emotion are 'held' in the shared, pre-ontological experiences that give rise to a sense of self and identity. In trauma, the loss of this natural attunement and reciprocity becomes intolerable precisely because there is no felt sense that it can be shared. Stolorow writes, "Trauma is constituted in an intersubjective context in which severe

emotional pain cannot find a relational home in which it can be held. In such a context, painful affect states become unendurable—that is, traumatic" (p. 10).

Rather than formulating the mechanism of trauma in Cartesian terms—namely those elements which overwhelm the mind-brain-body—this trauma concept hinges on the existential terms that co-create meaning and identity. The basic mechanism is the lived experience of being unbearably alone, which in turn radically reshapes the way in which we define the causal event. A similar perspective can be found in the attachment literature. As Susan Coates (2003) writes,

> The tendency to supplement our knowledge of the psychological experience of trauma with neurophysiological data, which have been so clarifying in terms of understanding some of the effects of trauma, particularly on memory, only strengthens this tendency to think of the traumatized person in isolation: that is, we think about the hormonal and other changes occurring within the *individual* organism. But what defines trauma in the first place, what changes a challenge into stress and stress into a genuine trauma, may in part be derived from the fact that it is undergone alone. Facing a dangerous situation with others is quite different from facing a dangerous situation alone. And the memory of terrible events can be made more tolerable when shared with others. (p. 3)

Here, the way we define trauma comes center stage. It is a process of pulling out what we recognize as the event from life's context and articulating what we narratively understand to be the means by which it causes distress.

Question of Response

The question of response connects closely to the question of etiology in that it addresses the flip side of causality, namely the effects. What constitutes a trauma response? To foreshadow our discussion of how the four core questions interlock, let it suffice to say that a cause cannot be defined independently of the effect. When a concept articulates the cause and/or its mechanism(s), it intrinsically implicates the effect. There is no reason, however, why

concepts must be built out starting from the cause to the effect, or on the basis of a particular mechanism. One can work 'forwards' by designating what constitutes the event and studying what responses follow from it. Or, one can work 'backwards' by stipulating what constitutes a response and then empirically go in search of causes. Much of the debate over PTSD criteria reflects an iterative process of back and forth as the breadth of the concept shifts over time, largely in response to changing definitions of cause and effect.

The question of response also connects closely with the question of suffering. Whereas the question of suffering asks, "What does it mean to be wounded?" the question of response asks, "What kind of wound is this?" In other words, the question of response is concerned with the unique suffering of trauma. How do we know when a trauma has occurred? What are we looking for? What tell us that this is trauma?

The way in which a concept defines trauma response (and its causes) has a great deal of impact on how we study it. The current definition of PTSD derives in part from symptom criteria that lend themselves to behavioral research. The field's epistemology and beliefs about what make for good science craft the concept according to the empirical needs of the investigation. Studying overt signs of hyperarousal affords much greater technical precision than studying personality change or existential dislocation. What is included in any particular trauma concept reflects the parameters of the inquiry. For example, if soul loss defines trauma response, the inquiry will necessarily have spiritual parameters.

In the DSM 5, PTSD describes trauma response according to four symptom clusters (Criteria B, C, D, and E) in conjunction with requirements for duration (Criteria F), distress/ impairment (Criteria G) and differential diagnosis (Criteria H). Specifically, clusters outline

possible presentations including five symptoms of intrusion (Criteria B), two symptoms of avoidance (Criteria C), seven symptoms of negative alterations in mood/cognition (Criteria D), and six possible symptoms of arousal and reactivity (Criteria E). A diagnosis requires at least one symptom from both clusters B and C, two symptoms from both D and E, and consistency with Criteria F, G, and H. A diagnosis can further specify the presence of dissociative symptoms and/or delayed expression. Criteria vary somewhat for use with children under age six (APA, 2013).

As we reviewed in Chapter Three, considerable research went into reformulating the constellation of symptom clusters in order to better reflect the data that had been collected. This represents an improvement in the factor structure of the diagnosis because it provides a more efficient account of the effects as they have been defined. We also reviewed research showing that indirect exposure to events could produce a characteristic PTSD trauma response, and the expansion of Criteria A also matched research findings to new "potentially traumatic events," thereby establishing new associations between events (as causes) and their effects. Revisions to the DSM 5 adjusted both causes (i.e., Criteria A) and effects (Criteria B-E) (APA, 2013).

Some critics have argued that disorder criteria fail to distinguish PTSD from other diagnoses because so many symptoms are widely shared among psychiatric populations (Spitzer, et. al., 2007). If trauma reactions are unique to trauma, then what explains how they can be so common across experiences? For example, Gold et. al. (2005) looked at the responses of 454 undergraduates for their relative distress associated with traumatic stress versus "life stress". Traumatic stress referred to symptom presentations following events that met Criteria A1, while "life stress" described "trauma-incongruent" events that did not meet criteria as "potentially

traumatic." In contrast to their hypothesis, they found that significantly more people in the "life stress" group met criteria for PTSD than those in the trauma group. Key events under "life stress" included the not-unexpected death of a loved one and/or serious illness, among several others.

The same surprising results have been replicated in other studies (Bodkin, Pope, Detke and Hudson, 2007; Long et. al. 2008; Mol et. al. 2005). There may be good reasons to be tenuous in drawing conclusions: for example, Boals and Schuettler (2009) failed to replicate Gold et. al.'s findings; but these studies nevertheless provide growing evidence of how characteristic trauma responses do not match up with etiological assumptions about the PTSD construct. Additional research has illustrated how criteria A1 is contingent on subjective interpretations as to what qualifies as a "potentially traumatic event"—thereby straining causal assumptions about how to define the event and its operative mechanism of action (van Hooff, MacFarlane, Baur, Abraham and Barnes, 2009). Increasing evidence suggests that Criteria A1 (and formerly A2) cannot effectively screen which qualifying events may precipitate a characteristic response (Bedard-Gilligan and Zoellner, 2008). In other words, we assume that people respond to trauma in a particular way, but it seems they respond that same way to a good number of other "non-traumatic" things as well.

Accounting for these findings raises a variety of questions about a variety of concerns. Certainly, there are a range of methodological issues (e.g., the use of retrospective self-report measures, the generalizability of findings, etc.) that could lead to greater empirical clarity. Subsequent studies may well refute these findings as aberrations or explain them with moderating or mediating factors. The theoretical issues, however, invite a consideration of our

basic definitions. As defined in the DSM-IV-TR, this profile of trauma response does not always appear to correspond well with its definitions of traumatic events. Whether or not this merits a revision to definitions of event (i.e., Criteria A) or revisions of trauma response (Criteria B, C, D, E, F, and G) is unclear and largely dependent on theoretical considerations.

The same relative considerations apply when we look at taxonometric studies. If we reconsider the dimensional structure of PTSD, then we are looking at how to conceptualize a particular type of effect. If we assume that particular types of features are the hallmarks of a trauma response, we can better understand how they hold together conceptually, but this is built on the prior assumptions of these features as representative. Categorization has an empirical dimension, but that research exists on the foundation of an *a priori* assumption of its constitutive qualities.

Even while factor analysis, taxonometric studies, and epidemiological studies can map out dimensions of a construct, these studies do not definitively answer the question of response because they work within definitions of cause and effect. Factor analytic studies help us organize chosen data sets, but they cannot validate the selection those data sets as the intrinsic variables of interest. Empirical research cannot tell us what to study independently of theory. It cannot tell us how broad or narrow our definitions should be. Prior to the creation of PTSD, the various trauma concepts such as hysteria, neurosis, railway spine, shell shock, etc., all defined trauma partly as a matter of its effects. One possible way to read this history would be to assume that each was inaccurately sketching the contours of a natural kind. This work has shown such position to be problematic and untenable. Another way to read this history, however, is to recognize that the each concept afforded its own definition of trauma response that was further

elaborated from a given perspective in relation to the causal mechanism(s) associated with a concept of suffering.

Shifting a concept's understanding of trauma response—albeit sometimes at the expense of familiar units of analysis—can open new frameworks of understanding. Ghislaine Boulanger (2007) conceptualizes trauma psychodynamically with a developmental sensibility, noting that the effects of extreme events are different for adults than for children. In the case of massive adult-onset trauma, she describes "the collapse of the self" (p. 29) in which the psychic structures of adult identity integration are destroyed or flattened. In other words, the experience proves so overwhelming that the balance of drives and desires, object relations, etc., are so devastated that they are no longer able to make sense of the self in relation to external events, shared meanings, or the social context. The result is a "loss of the self as interpreter of experience" (p. 125) which renders perspective on oneself in a narrative capacity impossible. In other words, it feels impossible to arrive at a meaningful story about 'what happened to me'.

As Boulanger writes, her formulation of trauma is "not intended to describe a syndrome *per se*" (p. 80) and so she answers the question of response not with a reconstitution of symptom clusters, but with a theory that operates as an entirely different type of analysis. As expected, her understanding of the event is equally complex:

> There is no single cause, but rather a complex neurological, cognitive, and affective response to the environmental event… In this way, I am attempting to capture the process by which an individual comes to experience radical and long-lasting discontinuity with his previous sense of self. (Boulanger, 2007, p. 79)

Her understanding of trauma response precludes a discussion of suffering, reference, or etiology such as that employed by the PTSD construct.

> Indeed, there is always a relationship between the survivor's psychodynamics, the psychological impact of the traumatic event itself, the psychological consequences and meaning that event assumes, and current symptoms. To overlook any of these variables and their interaction with one another is to fail the patient. (Boulanger, 2007, p. 4)

Traditionally as a wound to the mind, trauma has focused attention on individuals, but psychology has increasing begun to conceptualize it on different levels of analysis. The Salvadorian psychologist Ignácio Martín Baró (Anckerman, et. al., 2005) may be the foremost figure in this area. He describes the way in which oppressive systems not only impact individuals, but profoundly affect the social and community context. They violate and destroy the very context in which singular "potentially traumatic events" may occur. The trauma is not contained to the proverbial foreground, but poisons the background. In other words, the society itself is traumatized, and it is only coherent to talk about trauma on a collective level. Several other writers have offered trauma concepts that are comparable, including that of "historical trauma" (Yellow Horse Brave Heart, 2011) and a culture's "chosen trauma" (Volkan, 2001).

Interlocking Issues

Appreciating the complexity of any trauma concept depends on understanding how the core questions buttress one another. For example, addressing the question of etiology will directly shape the answer to the question of response—all of which assumes a particular vantage point in the question of reference as part of framework for suffering. No one question is primary, but each necessarily carries ramifications for the others. The more explicit and delineated the answer is to one core question, the more calcified and predetermined the answers to other questions become. For example, if we insist that a concept must be understood in strictly objective terms, then that curtails the range of possibilities we have for understanding the

mechanism, trauma response, and even the definition of suffering. Also, while these core questions are strictly concerned with philosophical issues, the answers that we elect demand investigative examination. For example, when a concept affords a particular understanding of causality, it opens up possibilities for a research paradigm. It is the composite of these *a priori* assumptions that make the parameters of research possible.

The evolution of PTSD offers some insight into shifting philosophical frames in the study of trauma. In many ways, the concept has ostensibly remained the same, but that also belies changes in the basic theoretical structure of the idea. As a question of reference, what began with a vaguely defined objective standard for defining trauma then temporarily took on subjective features before its latest revision. The original definition of symptoms were selected from an array of documented sequelae to provide a foundation of what constitutes a trauma response, but these have been expanded and revised over time. Some have been dropped (e.g., survivor's guilt) while others added (e.g., negative mood), and all the while revised in clusters and structure. In understanding etiology, epidemiological work has spurred greater inclusion in attributions of the event. A broad base of theory now describes the mechanism(s). Allopathic inspiration for the disease model has faced important challenges, and a categorical formulation of disorders has been questioned by both biomedical research and psychology alike. In summary, the diagnosis retained a similar sensibility as to what trauma 'is', but that consistency required significant evolution in its latent conceptual structure.

The value and integrity of a concept depends on the coherence it demonstrates in balancing the tension among these various core questions. For example, a concept that proves incoherent in its ideas of etiology and response—or in the research that emerges from its

paradigm—would not be intelligible because it would not provide a consistent explanatory model for understanding experiences of trauma. Again, the DSM 5 provides a useful case study largely because the revisions consolidate findings that strengthen the concept: it employed a new factor analysis to strength its formulation of response in order to be consistent with research data. It mitigated tension between empirical questions about both subjective criteria (Criterion A2) and its etiological position *vis a vis* learning theory and physiology. It expanded causal criteria (Criteria A) to show greater consistency with evidence based on symptom clusters, which adheres to its medical model and the presumptive primacy of the brain-body.

Tensions still exist in the concept, however. Numbing symptoms are not fully accounted for in etiological models, and despite efforts to revise our understanding of mechanisms and "potentially traumatic events," uncertainty remains about what is qualitatively different about traumatic stress versus life stress. The heterogeneity of possible symptoms and the apparent dimensionality of PTSD raise questions about templates for trauma response and the categorical framework used to understand suffering. In debates over heterogeneity, does the exclusion of somatization, dissociation and personality change artificially constrain our understanding of response? Do subjective meanings feature into the narrative structure and/or definition of what constitutes a symptom? The DSM 5 does not escape these tensions—in essence because they are always there in one form or another. I believe that the different criticisms and debates surrounding the PTSD diagnosis can all be understood as either the results of different core assumptions about trauma or empirical arguments about the research paradigm that the concept affords.

In this chapter, I have introduced what I believe to be the four core theoretical questions that underlie any trauma concept. These questions reflect a particular way of approaching the philosophical tensions that exist in elaborating any concept of trauma as a veritable 'wound to the mind'. This organizing metaphor inherently relies on a narrative structure that allows us to make causal claims about events and their consequences. Any narrative constructed to explain these issues must wrestle with the range of possibilities in terms of point of reference, and it must locate itself within a particular concept of suffering that will inevitably reflect cultural and historical concerns. All of these concerns are interlocking and interpenetrating in ways that reflect the complexity of formulating what people fundamentally experience as an overwhelming crisis.

PTSD is one type of clinical discourse. As we will discuss in the next chapter, it may or may not be best suited—or even suitable—to discuss the range of awful and extreme human experiences. I will argue that a concept can be simultaneously reliable and valid, and still relatively meaningless. Trauma concepts reflect many different disciplines and domains, and what makes a concept meaningful lies in its relevance to the explanatory discourse in a given context. This proves to be of tremendous importance in the context of cross cultural studies and global mental health. There is no substitute for pluralism when approaching the therapeutic encounter.

VI. Implications of a Post-Modern Perspective on Trauma

Generally, one of the strengths of the PTSD construct has been its ability to weave together various strands of knowledge into a centralized—if not unifying—concept (Friedman, Resick, Bryant, and Brewin, 2011). This represents a particular type of clinical discourse, however, but it hardly amounts to the range of experiences commonly considered in the psychological literature on trauma. For example in writing about the impact of torture, Silove (1999) argues that the focus on trauma in terms of safety precludes our appreciation of the depth and range of the experience. In other words, the construct artificially constrains what we understand as the impact of trauma (see also Bonanno and Mancini, 2008). He writes that human experience can be broadly formulated under five "core adaptive systems" (Silove, 1999): safety, attachment, justice, identity-role, and existential meaning-making. Helplessness is often considered as a defining feature of traumatic stress, and whereas PTSD has greatly enhanced our understanding of fear-based threats to safety, it spares little attention for trauma's impact on these other areas of function.

An emphasis on pluralism foregoes the idea that trauma can be summarized into a singular concept. It advocates for multiple concepts, each of which may make different assumptions about what constitutes an event and how an experience might be understood. These various ideas may or may not allow for easy comparisons because pluralism invites us to approach things form different directions. Depending on how one answers the core conceptual questions, each construct may frame different types of narratives about the experience—and in so doing, elucidate unique features and impacts.

For example, the concept of moral injury is rooted in experiences that are truly awful and extreme. Shay (2014) notes two uses of the term: moral injury constitutes an event that deeply violates one's moral principles that is either perpetrated by the individual or constitutes a betrayal by someone of authority in a high stakes situation. Unlike the characteristics of fear response, in moral injury the individual faces shame, guilt, demoralization and loss of self-esteem (Litz, 2014). Not unlike complex PTSD, it deteriorates character, renders an inability to trust, and damages attachment. Moral injury relies on a fundamentally ecological perspective because it invokes the relational and contextual history of actors and events (Shay, 2014). (For a first-person account, see Yandell, 2015.)

These experiences are "traumatic" but are poorly described by the PTSD diagnosis. According to Litz, et. al., (2009), providers working with veterans frequently (mis)diagnose PTSD for a host of reasons—in part because the narrow formulation of trauma does not meet the needs of the clinical encounter. It calls for a different set of basic assumptions. In advocating for the concept of moral injury, Litz et. al., (2009) comment, "We are not arguing for a new diagnostic category, per se, nor do we want to medicalize or pathologize the moral and ethical distress that service members and veterans may experience." Proponents of moral injury see the importance of pluralism in trauma concepts. "We are doing a disservice to our service members and veterans if we fail to conceptualize and address the lasting psychological, biological, spiritual, behavioral, and social impact of perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectations, that is, moral injury" (Litz et. al., 2009).

Development of the moral injury construct offers a variation on the core questions of trauma concepts—driven by a perceived "need to broaden the discourse about what is injurious in war" (Litz, 2014). Rather than a preoccupation with safety, moral injury describes the loss of trust. Rather than a focus on life threat, it describes trauma in terms of an affront to values and morals—which constitutes an etiological position. The question of response recognizes re-experiencing and avoidance along side relational features, but notes the relative absence of hyperarousal (Shay, 2014). Its reference is intrinsically more subjective because it demands a hermeneutic appreciation of the individual's morals and values. As a matter of suffering, it looks foremost at the idiopathic crisis of identity and alienation rather than nomothetic classification of pathological disorder (for an introductory review of moral injury, see Maguen and Litz, 2012).

Some readers might argue that while moral injury is undoubtedly awful, it does not constitute "trauma" because it does not map onto fear circuitry, but therein lies the point: trauma is not synonymous with PTSD, and fear circuitry only reflects the core assumptions of a particular discourse. As Litz (2014) writes, "The PTSD syndrome is derived from the questionable and often ill-fitting assumption that trauma is exclusively life-threat-based and symptoms are the downstream systemic results of high fear and fear conditioning." As 'an wound to the mind', trauma has never been exclusively defined by one perspective.

> To put these issues in context, consider this thought experiment: What might promote a service member's healing and recovery from a single life-threat incident, such as a sniper attack when no one was hurt (high threat)? Contrast this with a service member who is plagued by the aftermath of an explosion that killed her best friend, whose death she witnessed (traumatic loss). Contrast that with a service member who is haunted by an incident in which he acted out of rage due to a mortar attack that killed his friend the day before (he was not present when that happened) by killing an unarmed civilian man who was agitated during a house search (moral injury related to perpetration). Compare that with the experience of a service member who is angry and demoralized by a betrayal of a

> trusted leader whose ruthless and capricious decision led to the unnecessary deaths of civilians. Does the fear-conditioning model fit any case but the first? (Litz, 2014)

The point is not to argue about what the "right" way to understand trauma is or to propose a new set of contours for the PTSD concept. This is not a dispute about diagnostic criteria or the breadth of inclusion. More importantly, this is not about proposing the discovery of a new disorder—as though moral injury were a discrete universal disease. Rather, moral injury represents an example of a new trauma concept that provides an alternative for generating narratives to explain the suffering that follows from awful events.

It may be important to remind ourselves at this point that trauma is not a 'thing'—a natural kind there to be discovered. It is a broad explanatory metaphor woven into a worldview. Psychiatry has worked the idea of trauma into different concepts at different times, offering different explanatory models for describing and understanding lived experience. This has been accompanied by empirical science that leaves little question that life experience is 'written on the body' in objective ways that document how the mind shapes the brain. In the Western dualism of mind and body, there is important reciprocity: the mind can only take those shapes that the brain allows, but the mind in turn can shape the brain in many different ways. By the same token, we can recognize that our lived experience is truly embodied in that the science of medicine uncovers basic material conditions of our lives. For the Western episteme, trauma offers a unique bridge for tracing the unbroken continuum between mind and body (Mucci, 2013), and a concept like PTSD may afford us an explanatory model for integrating some of these ideas. But a model is not the same as a 'thing'.

Understanding trauma requires us to understand what it is and what it is not. Appealing to neurobiology can only ever tell one part of the story. However comprehensive the accounting, the material sciences do not explain all of live experience. They explain the embodied experience in terms of the organism as one level of analysis, but biology does not describe the totality of humanity. Genes could not tell us about identity even if they do correlate with temperament. The prefrontal cortex cannot tell us about ethics and virtue even if it does play the central role in executive functioning. The capacities of the brain cannot tell us how it will be used. Or should be used.

Mapping the material ontology of what is "really" happening in the body cannot then dictate the socially constructed terms of self and subjectivity. Knowledge of what happens to the biological organism does not define the meaning of experience, nor does it even suggest anything about the scope of what we may try to understand. Medical science is one type of knowledge that comes out of a particular type of discourse. This information does not float in a vacuum, but rather is inextricably melded to a worldview. We may muddle discoveries about disease into categories of disorders or knead them into philosophies of science, but the explanatory models we generate are always a mixture of social and material ontologies. Any basis to claim that one is somehow "more real" than the other reveals the value propositions laden in the argument. Social and material claims are distinct, but never wholly separable. The types of knowledge claims we can make differ according to their material or social foundations, but this reflects different ways of knowing rather than a unique or superior vantage on "the Truth".

The psychological literature on trauma hosts a robust—if not full-throated—debate on whether or not PTSD is a social construction (e.g., Summerfield, 2001). Arguments wrestle with

its universality and its suitability for working with diverse groups (e.g., Blackwell, 2005; Bracken, Giller and Summerfield, 1997). Unfortunately, this debate is terribly convoluted because it confuses many of the different types of claims that are being made. As we discussed throughout this work, psychological trauma, PTSD, and the biology of stress are not interchangeable. Moreover, universality, categorical approaches, and biomedical models are not synonymous either. The conflation of these terms represents the particular historical meld of ideas that come together in the diagnosis of PTSD. When we consider the way in which core conceptual questions are answered in order to elaborate the construct, we can recognize the basic philosophical assumptions that set the stage for research. Under the analysis here, there can be no question that PTSD is a social construct. It is impossible to disentangle it from the cultural and historical conditions that produced it because the coherence of the construct depends on the core assumptions that it makes.

In the literature, an oft repeated (and somewhat tiresome) rider tags along with almost any argument that attempts to describe the social dimensions of trauma diagnosis. The rider beseeches the reader not to confuse the stated concerns about cultural relativity with a negation of survivors' suffering. Perhaps this is an offshoot of the historical concerns about malingering discussed in Chapter One, but the need to insert this provision illustrates how ineffectively the literature is communicating about these underlying philosophical issues. Appealing to material ontologies to substantiate suffering reflects the values and priorities of biomedical empiricism, but recognizing the reality of social constructions (or the social construction of reality) does not negate the experience of suffering. It should be clear that in this analysis, the key question is not, "Is this suffering real?" but rather, "How do we understand the ways in which this suffering is

real?" PTSD is not a natural kind, but that does not mean that people are not genuinely suffering.

When we articulate a concept of trauma, we are attempting to explain and describe something about our lived experience by discerning features and dimensions thereof—which includes not just the body, but the sum total of our existence. We are starting with pre-ontological experience—holistic, embodied, historical—and discerning qualities we presume will enable us to organize and explain features about self, reality, etc. If trauma is an exemplar *par excellence* for bridging mind and body, it is equally ripe for illustrating how such fundamental ideas about ontology, epistemology and selfhood are culturally and historically rooted. As Bracken (1998) writes,

> Because psychiatry understands itself as scientific and thus culturally neutral, it fails to grasp the cultural specificity of its concepts and interventions. Because, in general, psychiatry lacks a critical understanding of its own origins, it fails to see that the realm of the psyche is a constructed realm and not simply 'how the world is'. Psychiatry thus assumes that the models it produces are universally applicable and valid… My argument is not that the Western discourse on trauma is fallacious or mistaken, but that it makes sense only in the context of a particular cultural and moral framework. (55)

Concepts of trauma are not 'real things', but rather part of the story we tell about what is real—a story that includes observations of our own bodies.

By the same token, practically speaking the validity of PTSD may be as trustworthy as any other coherent concept that we might develop (criticism in chapters three and four notwithstanding). That is, the core questions do not have "correct" answers. There is no "true" set of assumptions. There is no "right way" to understand trauma—or any other human experience. Any foundational set of assumptions that we might make then affords us a particular

vantage point on understanding experience. PTSD's rigorous research basis then affords its coherence and clarity, which in turn allow for its scientific integrity. PTSD consolidates information about trauma into a unit of analysis that can be subjected to a scientific process, but that does not mean that it is necessarily "more real" or "true" than other concepts. It merely allows us to approach the experience with a particular understanding—an understanding that can be subjected to further types of analysis. If we chose to value these analysis over other ways of knowing, then that is a function of our beliefs and values—not an intrinsic indication of our superior knowledge about reality.

An important postmodern idea in making sense of this debate is that a concept can be reliable and valid, and still relatively meaningless—which is to say, it lacks explanatory power (Gergen, 2001). How can something be both valid and meaningless? A concept becomes "meaningful" because it conveys something important. To claim that something is 'meaningful' is indexed to truth claims, which are themselves fundamentally perspectival. To say that PTSD is "valid" indicates that it accords with what we understand to be true about reality, but our understanding of reality never emerges free and clear of history or perspective. And so, for example, PTSD may be psychometrically reliable and scientifically valid when measured in Guatemalan populations. This does not mean, however, that it guarantees any useful contributions to explaining a Mayan experience of suffering, for example, *because the basic assumptions of the construct do not align with those of the broader worldview*.

It is unfortunate that empirical practices do not look beyond validity more often. As Kendall and Jablensky (2003) write, "There is no single, agreed upon meaning of validity in science, although it is generally accepted that the concept addresses 'the nature of reality'." If

we understand trauma as an explanatory metaphor, then the conceptual validity of any particular construct is not a testament to some presupposed objectivity of the mind. Rather, the concept's validity is a testament to its empirical integrity and coherence. The scientific method is a means of investigation, not an ontological thesis. Simply because a construct withstands the rigors of science does not mean that it has provided the only valid way to understand a phenomenon. Ideas become meaningful when they work within a worldview to make sense of experience. When we apply ideas cross-culturally, this explanatory contribution is not assured. In other words, a concept can demonstrate scientific merit without providing explanatory insight into an experience. It may still be valid—even if it does not have much value.

These issues matter. They are no more esoteric than the feelings of survivors in treatment. A trauma concept represents a narrative discourse that not only defines and describes experience, but it represents an expression of social power. Trauma concepts inevitably and invariably raise questions about who has the power and authority to define experience. For example, some writers believe that it is wrong to talk about trauma in terms of pathology, especially in the case of torture (e.g., Viñar, 2005) or domestic violence (e.g., Gondolf, 1998). 'Trauma as diagnosis' arguably focuses our attention on the victim's "disorder" rather than the perpetration of interpersonal violence. It arguably implies that a complex moral and/or ideological struggle can be reduced to a medical status (Gorman, 2001).

Some torture survivors object to terms like "patient," "client" or "victim" (Gerrity, et. al., 2001) because it implies that their suffering can be separated from the transgressions they suffered. They argue that a medical discourse is no longer appropriate because the heinousness of the act ethically demands that our understanding of trauma rest first and foremost on the

violation of human rights (for a fuller consideration of human rights and PTSD, see Agger and Jensen, 1996; or also Steel, Steel and Silove, 2009). Psychometric measurement may be reliable and valid, but it does not hold the same *meaning* because in a human rights perspective, the basic assumptions about suffering shift from a clinical perspective into a political domain. While the adequacy of the PTSD concept is strained, the validity is not. It is simply that the concept ceases to be helpful for understanding this aspect of our reality. As we discussed in chapter one, trauma has always been more than a clinical concept, and the discourse about experience and reality reflects that in different ways.

When the medical establishment (via univeralism, the mantle of science, etc.) asserts the "truth" of the PTSD concept, it invites a parallel relational process of struggling with survivors for the power to control the narrative and define suffering (Summerfield, 1999). Not incidentally, this is partly why survivors are so integral to directing the study, history, and treatment of trauma. Here again, we see the question of reference: is trauma defined by the observer or by the survivor? By the same token, survivors are no more in a position to demean the perspective of science than science can demean that of survivors. There is nothing scientifically invalid about studying PTSD in torture survivors, but it may or may not be useful for understanding the complexity of their experience. Some people may long for the information and authority of a medical perspective, whereas for others it may feel invalidating. In other words, when it comes to the narrative about what happened, PTSD may or may not contribute much to survivors rebuilding their lives, even if it contributes something important to behavioral research.

The utility of an idea hinges on the assumptions we make about how best to understand the experience, and those assumptions reflect an array of cultural and life experiences. The same is true with respect to non-Western populations. Psychiatry may study PTSD in indigenous populations, but it should not assume to know much about their experience simply because it did so. Conventional approaches to therapy may inform work with non-Western populations (e.g., d'Ardenne, Capuzzo, Ruaro and Priebe, 2005), but the field should be wary of prescribing an occidental perspective.

There is nothing inherently invalidating about an etic perspective, even if it affords a different reading than the emic alternative. Far from being somehow intrinsically inappropriate, this is the fruitful source of any cross-cultural exchange. We may find and/or create meaning in the exchange of ideas in which different understandings of trauma are used to broaden, deepen or transform existing perspectives, but it is ethnocentric to assume that a given concept will have explanatory power regardless of the assumptions we make about the world. To frame this exchange in the most basic humanistic terms, "we" might understand what happened "this" way. "They" might understand it "that" way. Maybe "we" could learn something from how "they" understand it, and vice versa—such that all of us benefit from thinking about how to make sense out of what happened. In the case of trauma, these new meanings may be what help us move forward.

Again, there is nothing about a human rights discourse that invalidates a medical discourse. They offer different frames of reference that are useful for understanding different aspects of experience. One of the pitfalls in this work comes with wrongly assuming that one discourse is somehow "more true" than another—as though somehow medicine (or the law, or

developmental theory, or survivors themselves, etc.) can tell us "what trauma really is." As a question of reference, some readers may see this as good reason to emphasize a dialogical approach—to be inclusive in the discussion of trauma. Others might want to prioritize an objective point of view as a way to structure or manage the array of voices and ideas. Others may decide that at the end of the proverbial day, it is the individual whose (subjective) perspective matters most. As an explanatory metaphor, trauma is narrative. Sometimes it is a scientific narrative, but not all the time.

As we discussed in the last chapter, the integrity of a concept hinges on its ability to reconcile tensions among core conceptual issues. This includes examining the evidence generated in its worldview. What constitutes evidence is a function of the epistemology in play. For example, the empirical positivism of Western medicine is based on a philosophy of science, but the Mayan worldview has no expectation that data-driven research can or should substantiate one's intrinsic spiritual connection to the natural world. What constitutes evidence of trauma in medicine necessarily invokes neuroscience, whereas evidence among the Maya is a spiritual awareness of imbalance in the natural order. One approach is empirical and the other is hermeneutic. The decision to privilege one above the other is a value proposition about what is important about reality.

PTSD makes a particular set of assumptions in order to understand a particular type of experience in a particular way. After making allowances for emic/etic distinctions, PTSD can be universally applied but is not universally instructive. In the same way that different clinical orientations value different traits (James and Prillentensky, 2001) and make different philosophical assumptions (Waterman, 2013), different cultures offer different understandings of

reality that make "validity" a relative construct. Basic dialectical classifications (i.e., normal-abnormal, health-disease) pervade clinical concepts and infuse the therapeutic encounter. These organizing assumptions may or may not be concordant with survivors' experiences (Blackwell, 2005). Illness experience is cultural, and the *meaning* of any symptom is local (James and Prillentensky, 2001). All of these factors create a tremendous need in mental health to recognize the importance of conceptual pluralism if there is a hope of respecting diversity in the consulting room.

This emphasis on pluralism has to invite not only "idioms of distress" that appear as cultural syndromes, but the wholesale recognition of different philosophies and concepts. This is not about encouraging the proliferation of new disorders or diagnoses; it is a call to look outside of mainstream assumptions. Good cross cultural work requires what I refer to as the basic "philosophical literacy" to understand the assumptions that shape clinical practice. As discussed in the question of suffering, not all "idioms of distress" make the same organizing assumptions about distress and the illness experience. In Latin America, for example, there is a long tradition of looking beyond the radical individualism of a Euro/North American perspective (Hernández-Wolfe, 2013). More socio-centric traditions that formulate trauma from relational and macro social perspectives defy the argument that trauma can be adequately described on an individual level (i.e., Suárez-Orozco and Robben, 2000). The same is true for questioning whether resilience can be understood outside of sociopolitical resistance (Hernández-Wolfe, 2013).

Jenkins (1991, 1996) has written about the widespread political violence in El Salvador and the importance of "political ethos" as a central feature in understanding the impact of trauma. "Political ethos" amounts to "the culturally standardized organization of feeling and

sentiment pertaining to the social domains of power and interest" (Jenkins, 1991). Emotion is not merely generated out of individual experience, but rather crafted by social context which has the power to bend or influence the hedonic quality of (inter)personal experience (see also von Peter, 2008). Actions of the government and other social institutions shape and re-shape perceptions, and under the extreme conditions of civil war and militarization, the role of the state plays a major role in the construction of affect (Jenkins, 1991).

> The idea of political ethos is useful here because it incorporates social domains of power and interest into a culturally standardized organization of feeling and sentiment. The political-emotional atmosphere of El Salvador is one of generalized specific conditions of terror and has serious mental health consequences for those whose daily experience is so constructed. (Jenkins, 1991, pp. 171)

In other words, the apparatus of the state wittingly induces feelings of fear and insecurity, and understanding any individual's emotional response becomes inextricable from the public construction of affect.

This climate of terror frequently causes *nervios* which is a common illness experience throughout Latin America characterized by fear, anxiety, anger, somatic complaints, tremulousness, and *calor* (literally: heat). Without the hermeneutic work of anthropology, one might readily conflate this with psychiatric ideas of trauma pathology, but *nervios* makes fundamentally different assumptions about the four core questions. The illness experience of *nervios* in the wake of state violence takes up hermeneutic concerns in interpreting the climate of terror. Causality defines the event in terms of socio-historical context rather than individual events (or events in the lives of individuals). Trauma response is diverse in terms of types of symptoms and distress. The question of suffering goes well beyond medical disorders. *Nervios*

is not just an intrapsychic experience of disorder or psychosomatic dysregulation; it is regarded as inextricable from embodiment in a cultural context. This represents a fundamental disjoint not unlike the distinction between a one-person psychology that recognizes disorders and a two-person psychology that describes tensions in relationships. (Perhaps in the case of *nervios*, the discussion should be about a "multi-person psychology").

To regard this merely as an "idiom of distress" overstates the validity of the basic assumptions in psychiatry. In the case of *nervios* in El Salvador, traumatization happens not by the direct experience of torture or the knowledge of torture to a loved one (per DSM criteria), but by living in a situation where torture happens (Jenkins, 1991). In other words, torture need not threaten an individual or the ones they love (per DSM criteria), but rather it subsumes the community in a precarious state in which violence is unbridled. Kleinman (1995) points out that in low intensity warfare, the "aesthetics of violence" in which all manner of brutality is possible —think of public executions or of leaving the dead bodies of subversives to rot on the street— inflicts a social trauma on the population that can be hard to measure (see also Pedersen, 2002).

While that experience of trauma may not conform to current psychiatric definitions, it is nevertheless an extension of the distress and crisis provoked by the trauma of violence. Whereas the diagnosis would bracket our understanding of trauma according to a particular type of distress, a more socially situated definition follows the ripples and consequences of a particular experience of violence. A concept of trauma based on disorder centers on the individual's experience according to symptoms. A concept of trauma based on relationships centers on interpersonal violence according to the effects of power on shared meanings. By these terms,

Jenkins (1996) argues that PTSD is not well suited to describe her sample Salvadoran refugees. The concept may not be invalid, but she suggests it may not be as useful.

Zur (1996) comes to similar conclusions in studying trauma and PTSD in the case of war widows among the Quiché Maya in Guatemala. She discusses many of the same criticisms reviewed in this work, and her work takes pains to offer an ethnographic perspective on questions of agency and cultural beliefs about spirits of the dead. Her analysis shows how basic assumptions about self and reality come in contrast with the core assumptions of PTSD. While she does not disavow the concept out right, she emphasizes its limitations and the parameters of psychiatric science:

> Rather than continuing the search for the physiological universals of PTSD in other cultures, I suggest that at least including an anthropological approach—which entails looking at how people make sense of their worlds through their own concepts—would lead to better understanding of how unprecedented stressful events are explained and dealt with by people experiencing them. This would achieve meaningful and useful (experience-near) understanding of the effects of war and atrocity rather than the distorted image produced by the application of an individualized (experience-distant) schema based on Western cultural concepts. (Zur, 1996)

There are many illness experiences among the Maya of Guatemala such as *sentimentos* (Woodrick 1995), *susto* (Wilson, 1995), *muchkej*, or *chawaj* (Warner, 2007)—all of which are locally treated in culturally syntonic, holistic ways that would be at odds with a medical model (Gossen, 1994; Wilson, 1995). If psychology has a goal of understanding and helping, it may be necessary to rethink how to approach these experiences.

> The emphasis of research and analysis should thus be shifted away from questions of whether these disease entities are 'the same' or 'different' across cultures—or 'right' or 'wrong' in particular contexts—to that of how people make sense of life events. (von Peter, 2008)

Pluralistic thinking has many defenders, not the least of which involves a rejection of parochial frames of mind. If clinical practice elects to attend only to those conditions recognized as disorders, then it runs a tremendous risk of overlooking the very real and very deep distress of those people it is trying to help (Palic and Elklit, 2011; Ryder, Yang and Heine, 2002; Thakker and Ward, 2001).

By the same token, understanding trauma only in terms of PTSD may mislead us into thinking of resilience in parochial terms as well (Tummala-Nara, 2008), thereby missing many of the ways that people stay strong and/or recover from traumatic events. Emic concepts taken from local cultures may naturally afford a syntonic framework for narrating experience and confronting the relative ineffability of crisis. In other words, a local perspective may be more helpful for describing that which seems beyond words—which in the case of trauma may be particularly important (Sturm, Baubet and Moro, 2007). Clinical psychology is traditionally underrepresented in cross-cultural psychology and vice versa (Ryder, et. al., 2002). James and Prillentensky (2001) have argued for the idea of "practice literacy" as a way to appreciate the interplay between reflection, research, and practical clinical/social action. Tribe (2007) has written about the importance of recognizing "health pluralism" to describe the overlapping layers of beliefs about health and healing.

It is important to recognize the limitations of psychiatry without devaluing it (Pedersen, 2002). More over, the same can be said for Western approaches to research. Once core assumptions in trauma concepts are articulated, they can be subjected to rigorous study from a variety of perspectives. Some (but not all) of these concepts can be formulated in ways amenable to empirical research. For example, Steel, et. al., (2009) performed a large systematic

review and meta-regression to examine prevalence rates for depression and PTSD among refugee populations. In keeping with concerns about cross cultural validity, they found that significant methodological issues accounted for between 13-25% of variance in rates of disorders. Moreover, as the first study to include a society-wide index of terror, they found a modest correlation between the social climate and the mental health of the population—lending one example of Western evidence to socio-centric concepts of trauma rooted in non-Western cultures.

As the concept of PTSD gains global prominence as a discourse capable of shaping policy and humanitarian aid (Breslau, 2004; Steel, et. al., 2009; von Peter, 2008), it is important to look for clarity in the assumptions that shape this discourse. The criticism reviewed in this work in Chapter Six has challenged the unrecognized cultural assumptions of Western psychiatry. This criticism is warranted to check the preeminence of medicine's authority, but it should not be taken as an invitation to cast it aside. Anthropology, transcultural psychiatry and hermeneutic psychology make unique contributions, but do not have grounds to dictate clinical practice (Littlewood, 2002; Martin and Sugarman, 2001; Rechtman, 2000). What is called for is a dialogical exchange of ideas across levels of analysis that is collaborative and constructive, albeit prepared to admit the inevitable fallibility of perspective (Martin and Sugarman, 2001).

It may seem to some readers that the ideas I am proposing are inconsistent, as though there is a certain sleight of hand that tries to have it both ways. The analysis I present tries very modestly to admit its limitations and acknowledge what it does not know, including what it does not know about 'knowing.' It takes a very post-modern position that questions the very basic epistemologies and ontologies of different worldviews that make trauma concepts possible. At the same time, it defends the integrity of empiricism and the project of science as one possible

means to know the world, as valid as any other. What may seem like sleight of hand comes from the confusion about what it means to say that something is "real".

Outlining the full range of these philosophical issues remains beyond the scope of this project, but it is important to acknowledge that this criticism raises important issues and challenging philosophical questions (for a brief introduction, see Baldwin, Williams, and Hout, 2004). Rather than trying to resolve this tension, my hope is to name it for what it is. Essentially, people from all walks of life make different assumptions about the world as well as what it means to know it. This should be the starting point of our conversations. (In the context of the emic-etic debate, see Silove and Kinzie, 2001).

Perhaps what I am seeking most here is a sort synthesis that helps to frame the debate in constructive terms. Instead of wrestling with claims about natural kinds and philosophical absolutes, I choose to highlight converging questions. The four core conceptual questions represent common concerns that hang together in a balance that any perspective must try to strike in its own way. This tactic of abstraction—a retreat from the particulars of any trauma definition—makes its own assumptions about core questions in the name of finding a common ground, particularly as it hinges on the translation (literal and conceptual) of the word "trauma" across languages and cultures. The centerpiece of my analysis is the narrative quality of metaphor, which is not particularly controversial from a historical or etymological perspective. This position asks the reader to accept the conceptual framework implicit in these questions as the defining dimensions of 'trauma' *per* se. Maybe not unlike other concepts in psychology such as a locus of control or desire for achievement, the operationalization of "trauma" may be idiosyncratic across cultures even if the basic abstraction proves universal (Diaz-Loving, 1998).

I am inviting the reader to share in the open conceits of four questions precisely because it allows us to take stock of the more binding conceits that come from answering them. I am arguing that the answers to these questions represent articles of faith. They are taken *a priori* and are not negotiated independently but rather in concert with one another and as part of a broader worldview. They are beholden to the same trappings and failings that may befall the individual's larger project—be that ethnocentrism, inconsistency, or incompatibility with new findings about the world. This is not so much a resolution of epistemology's greatest challenges so much as a practical concession. The point is that this work on trauma concepts takes aim at the pragmatic demands of bringing theory to practice.

I hope to acknowledge the pragmatism of this perspective, although I realize that may seem unsatisfying for some critics. Positivism suffers critiques for its rigidity, but radical post-modernism can be equally unflinching (e.g. Gergen, 1997). Clinicians may recognize a parallel process in which trauma survivors feel a fragile vulnerability that can steer them towards rigidity in their thinking. Perhaps as a matter of course correction, we might invite a certain healthy amount of existential angst back into our philosophy. The hermeneutic circle remains unbroken, but perhaps there is still room in the ring for good therapy. I see what I am proposing as consistent with the dialogical sensibilities of a contemporary Continental tradition in philosophy. While it is beyond the scope of this work to outline these foundations or review these ideas, let it suffice to say that the limitations inherent in any given perspective do not preclude meaningful exchange across difference (Kogler, 1999). In a hermeneutically based psychology, we are beholden to processes of interpretation and reinterpretation (see Martin and Sugarman, 2001).

There has never been an unproblematic philosophy, and we have no reasons to believe that we will find one soon. Not knowing 'the true way' to think about something can feel unsettling, but perhaps it is that same vulnerability that facilitates the very human challenge of reaching out across differences to provide support in the face of something awful. Just as we recognize that the weight of theory presses down upon clinical practice, we might also expect theory to feel the anguish and uncertainty of accounting for trauma. If you juggle different models, then there is always the risk that something might get dropped. But this juggling also allows us to keep alive different ideas and to benefit from different points of view. Arguably, it is the only ethical approach to multiculturalism, and this includes recognizing the integrity of bringing the scientific method to bear on experience. Again, each set of concepts makes its own assumptions, and making allowance for that requires us to tolerate the ambiguity of difference in every step of the way, both in theory and in practice.

Whereas the first part of this work has reviewed the literature and provided an in-depth analysis of how to interpret these findings, the focus now shifts to the cultural demands on good clinical practice. Far from being merely a philosophical argument, these concerns about four core questions have direct bearing on the practice of psychotherapy. Working across differences means trafficking in different—and at times seemingly incommensurate—ideas. Bracken, Giller and Summerfield (1995) write:

> While empirical studies will no doubt shed some light on these questions [about the cross-cultural relevance of PTSD], conceptual analysis is also needed so that the results of such studies can be properly interpreted… There is a need for psychiatrists, other medical personnel and lay groups working with such communities to develop an appropriate understanding of the impact of such trauma. The relevance or otherwise of the concept of PTSD to such situations needs to be properly delineated. Approaches to

treatment and rehabilitation will in many ways depend on how we respond to these issues.

Clinical fields need to try to understand the direct experience of these differences. In studying Mayan experiences of distress, Cosminsky (1977) found that the way we conduct research—i.e., survey versus case study—yields different types of data that significantly influence the types of conclusions we make and the possible models of illness experience we construct. Sensitivity to methodology and approach are signature features of transcultural psychiatry, all of which must hew closely to the qualitative concerns of local experience (Littlewood, 1980).

In Part II of this work, I offer an example of how such research can be conducted and the importance it has for understanding the clinical encounter. I present a qualitative analysis of how Guatemalan psychologists conceptualize and work with trauma. For reasons that I will discuss, the extent to which they accept, reject and/or adapt the PTSD construct functions as a testament to what they feel about the relative adequacy of the diagnosis to frame an understanding of the trauma in their culture and society.

VII. An Introduction to Guatemala, Its People and Its Cultures

This chapter attempts to introduce Guatemala, its people and its cultures. Because this work is concerned with the different ways that people understand awful events, it is important to take a somewhat ethnographic approach. This work builds towards asking important questions about the adequacy of Western psychiatric concepts for understanding trauma in the face of radical differences. Only by having a robust understanding of context and experience can we appreciate the various ways that different trauma concepts attempt to organize and structure the lives we lead. When we can appreciate the nuances of local narratives, we can see how different concepts frame experience in different ways. We can also start to recognize how theoretical assumptions can be either in concert or in contrast to local assumptions.

As with any history, this account is incomplete. It represent my best attempt to balance the ethnographic emphasis on detail and specificity with the practical concerns of a research investigation. To abbreviate the long history of state violence in Guatemala with a summary comment about human rights abuses prematurely assumes that the details of this history are not significant. I chose to insist on a detailed account because I believe that is consistent with the broad project of looking across cultures, disciplines, and ideas. Just as a case study in therapy would not be complete if it only gave an inventory of symptoms, a study of a country and its attempts at healing would not be complete without a fuller account of the ways it has suffered.

In no way should this record be seen as an attempt to present the country in a negative light, but rather I hope that any reflection of its tragedy can shed light on the humanity and resilience of its people. I acknowledge that this history reflects my estimation of important historical events and I have attempted to select for those items that may be of greatest

psychological and sociological concern. I hope that this chapter will spark the readers' own ideas about how social history is written and interwoven with trauma history.

Guatemala is one of seven Central American countries. With a population of 14.3 million (Grazioso, et. al., 2013), it is the most populous country in the region (Godoy-Paiz, Toner and Vidal, 2011) and the largest in area, covering approximately 43,000 square miles. It is a country that is multilingual, multiethnic and multicultural in which 24 languages are spoken. Guatemala has the largest indigenous population of any of the Central American countries, and pre-Columbian cultures infuse much of the society. Demographically, 60% of the country identifies as *ladino*, 39.5% as indigenous, and 0.5% as Garífuna. In the broadest sense, the term "*ladino*" refers to individuals who speak Spanish as their primary language and identify as non-indigenous and/or claim mixed ancestry. "Indigenous" refers primarily to the Maya, while the Garífuna are individuals of mixed descent from Africans and Caribbean Amerindians. Another non-Maya indigenous group, the Xinca, are also present, but make up a fraction of the population (Grazioso, et. al., 2013).

Race, ethnicity and identity are complicated: "The concept of ethnic identity in Guatemala may not be the same as in other countries in Latin America or the United States" (Grazioso, et. al., 2013). In some respects, the differences between *ladinos* and the Maya can be considered as a matter of degree (Wearne, 1994). Descriptively, *ladinos* are a sociocultural Spanish-speaking group who live and dress according to customs largely derived from Spanish origins, but have become interwoven with indigenous practices. The meaning of the term "*ladino*" has changed over time. At various points, it referred to an intermediary group between the white elite and the indigenous population (Menjivar, 2011).

Perhaps not unlike "whiteness" in relation to minorities in the United States, the word *ladino* has an ambiguity that always implies a 'separation from' or a 'negation of' the minority (Menjivar, 2011). Many indigenous Maya who no longer live in villages or by traditional customs now identify as *ladino* (Grazioso, et. al., 2013), implying that ethnic identity is melded to a way of life. It is less a matter of biological heritage than a socio-economic classification. "Ladinization" refers to the acculturation of the Maya to the politically dominant culture, and has occurred to varying degrees across parts of the country and even across genders. Men tend to be more "ladino-ized" than women (Wearne, 1994). "Ladino-ized" groups, such as those in eastern Guatemala, continue to have complex syncretic traditions which are easy to misrepresent with generalities (Metz, 2006). Many Maya hide or reveal different sides of their identity—partly as a means of cultural survival and in political necessity (Wearne, 1994).

Most *ladinos* are poor, but the controlling class in Guatemala is *ladino* or of European descent (Menjivar, 2011). In fact, most of Guatemalans are poor regardless of identity. Fifty-eight percent of the population lives in poverty, and 16% live in extreme poverty. The indigenous account for 58% of the poor, and 72% of the extreme poor, leading to strong correlations between inequality and racial/ethnic disparity. Gender discrimination was recently outlawed, but Guatemala remains a male-dominated society with inadequate protections for women. Catholicism remains the predominant religion, but not unlike ethnic identity, Mayan beliefs infuse these practices in a syncretic faith that reaches across many demographic groups. In the last few decades, Protestant evangelical churches gained considerable popularity (Grazioso, et. al., 2013). The country's literacy rate (in Spanish) is estimated at 69.1% (Jacob, et. al., 2007).

Guatemala is a young, fast growing country: as of 2007, 44% of its population was under the age of 15. The capital, Guatemala City, is the largest city in the country with 3.1 million people, mostly *ladino* (Grazioso, et. al., 2013) and ringed by *colonias* which are poor neighborhoods often consisting of squatter settlements (Godoy-Paiz, et. al., 2011; Goldín and Rosenbaum, 2009). These shantytowns reflect the fact that Guatemala has the most unequal land distribution in all of Latin America (Beristain, Paez, and González, 2000). Access to services is difficult for the poor regardless of where they live, but vast differences between urban and rural life exist. The majority of the indigenous live in rural communities with limited access to social services, education, economic opportunities or infrastructure (Grazioso, et. al., 2013).

Land disparities have great consequences, and land ownership for subsistence farming is central to Maya culture. Maya creation beliefs tell the story of men made from corn, and the *milpa*—one's plot of corn—represents a cornerstone of cultural identity and has religious significance for this group (Beristain, et. al., 2000; Wearne, 1994). To lose one's land means losing an ability to care for one's family, and thus being displaced from the community in search of basic needs. Separation from one's village constitutes the loss of identity and of one's connection to one's ancestors. Most Maya will identify first and foremost by their village, and then by language, and then (if at all) as Guatemalan. As we will discuss shortly, a "pan-Maya" movement towards ethnic identity uniting indigenous language- and cultural groups emerged only in the last few decades as a means of survival, both literally and culturally (Beristain, et. al., 2000; Wearne, 1994).

There is comparatively very little ethnographic research on the *ladino* majority (Metz, 2006). Maya culture is notably socio-centric with less emphasis on materialism or individualism

than *ladino* culture. "Respect, responsibility, honesty and hard work are the indigenous values that have been woven into a code from which there is, by tradition, little individual or communal deviation" (Wearne, 8). Harmonious relationships—among all things, human and natural—constitutes the basis of moral order because all things point towards being a part of something greater than oneself. In that way, the culture is deeply and fundamentally spiritual.

> Mayan culture has an all-pervading sense of the religious, the magical and the supernatural. Animals and nature are related to humankind, they command love and respect and are personifications of good and of ancestors' souls. Some, but not all, of the mayan ethnic groups believe in animal alter egos, usually called *nagual*… Violence directed towards land and animals also implies inflicting symbolic wounds to the earth and god and potentially to souls and co-essences. (Beristain, et. al., 2000)

The indigenous typically eschew conflict and the open expression of volatile emotions such as anger. Stoicism in the face of suffering is important, and while it may appear as subjugated or submissive, their enduring perseverance represents an important source of strength. "If we see the Maya culture as plural and localized rather than generic and monolithic and the ladino state as weak and coercive rather than strong and hegemonic, we have the key to Maya survival" (Wearne, 1994).

Talk of Maya survival is not exaggeration. The Spanish conquest began in 1523, and the subsequent 500 years tell a consistent story of violence, discrimination, assimilation and exclusion (Consolí, Tzaquitzal, and González, 2013). The clash of cultures has been a centerpiece throughout the nation's history. The country gained its independence from Spain in 1821, but its social structure remains largely unchanged from colonial times with a wealthy land-owning and professional class dominating virtually all areas of society. Goldman (1999) writes,

> Two separate, gravely ceremonious, phantasmagoria-prone cultures, Spanish Catholic and Mayan pagan, shape the country's national character along with centuries of cruelty and isolation. In 1885, a Nicaraguan political exile and writer, Enrique Guzmán, described the country as a vicious police state, filled with so many government informers that 'even the drunks are discrete'—an observation that has never ceased to be quoted because it has never stopped seeming true.

Historically, repeated efforts to ladino-ize the Maya have come through the Catholic Church and economic policy. The indigenous, however, have repeatedly demonstrated an ability to co-opt acculturating influences and use them to reinforce existing elements of their cultural identity. For example, the unique and customary *traje* (clothing/dress) of these communities began as a colonial imposition, but now remains a source of pride and identity (Wearne, 1994).

For the better part of two centuries, land policy forced major seasonal migration as the indigenous sought work on coastal plantations where they faced atrocious conditions (Beristain, et. al., 2000; Davis,1998). It was not until the mid-20th century that the country managed to shift from a system of relatively feudal patronage to a modern capitalist economy. Local communities gained greater empowerment through political openings, and new avenues for social change came through a somewhat unexpectedly responsive effort of the Church called Catholic Action. For many, it seemed possible for the first time that change could come through politics. Reactionary state repression—including the massacre of an indigenous uprising—loomed over these changes, however (Wearne, 1994). In 1954, Jacobo Arbenz democratically won the presidency, but after confronting US-based multinational corporations and attempting to institute a series of land reforms, the US CIA overthrew his government on the pretense that it supported Communist activity in the Americas. Guatemala entered the Cold War, and the narrow political openings for change began to close (Davis, 1998; Esparza, 2005; Wearne, 1994).

As a country in the mid-20th century, Guatemala found itself at a crossroads driven by many different external and internal forces. A growing population strained the old economic order, and new technology (i.e., radios) and infrastructure (i.e., roads) facilitated change. A wealthy *ladino* society hewed closely to tradition and sought to conserve a social order that long benefited them. Capitalist pressures created new demands, but Cold War allegiances offered ready-made allies when it came to fighting social change. Progressive social movements—whether in the form of leftist politics or the liberation theology of Vatican II—brought new ideas to Maya communities, poor *ladinos*, and disenfranchised urban professionals. *Costumbristas*—older, conservatives among the Maya—remained mistrustful of these new promises. All in all, tension rose across all segments society and historical inequalities came increasingly to the forefront in new and volatile ways (Davis, 1998).

The year 1962 marked the bellicose beginning of what would be known as the *conflicto armado*,a 36-year civil war that consumed several generations (Esparza, 2005). Because this work is concerned with understanding and recovering from trauma, it is important to take time to bear witness to the scope of this conflict's horror and atrocities. It would unduly overlook the depth and complexity of the current psychosocial needs if we did not attempt to appreciate the protracted violence exposed in this conflict. It would also fail to convey the ways in which historical and structural violence have festered into the now common street violence of everyday life. Some attempt must be made to connect the current socio-political instability with the legacy of violence in Guatemala. In the *conflicto armado*, what started as a revolutionary political campaign eventually elicited genocidal state violence with the goal of decimating Maya culture (Esparza, 2005).

In the 1960s and 70s, the guerrilla forces remained modest in size and much of the state's violence targeted *ladino* peasants, union organizers, protest leaders, students, politicians and revolutionaries (Menjivar, 2011). Between 1966 and 1970, 10,000 or more people were killed by the Guatemalan military in pursuit of an estimate 350 guerrillas (Wearne, 1994). The Guatemalan military consisted of a *ladino* officer core who commanded cadres of conscripted indigenous soldiers, often deployed to serve in regions with different languages and cultural traditions (Wilson, 1995). Violence spurred the creation of new opposition groups and labor union activity, and several different revolutionary forces attempted to build relationships within Mayan communities before beginning their military campaigns. Eventually, the various guerrilla movements joined forces under the banner of the *Unidad Revolucionaria Nacional Guatemalteca* (URNG).

As the military increasingly used kidnappings, killings and massacres to intimidate its opposition, the political crisis deepened. Response to the conflict varied across Maya communities, and the *ladino*-led guerrilla forces struggled to unify support among the Maya. For some, the conflict awoke cultural stirrings of resistance that stretched back to the Spanish conquest, but for many Maya communities joining the guerrillas became a pragmatic decision. The military's generalized violence made neutrality too dangerous and they turned to the URNG for protection (Davis, 1988; Wearne, 1994).

On February 4, 1976, a major earthquake shook the country, killing 21,000 people—many of whom died when their adobe homes built on the precarious hillsides of their *colonias* collapsed. On February 6, an additional 1,500 people were killed in aftershocks that brought down weakened buildings (Levenson, 2002). An additional 77,000 were injured and over 1

million were left homeless (Wearne, 1994). As a point of comparison, after 14 years of the *conflicto armado*, 25,000 people had been killed in political violence. The quake created a social, political and humanitarian crisis that further polarized the society and the politics intensified (Levenson, 2002). It reshaped social dynamics, and two sides emerged: on the left, unions, cooperatives and the radical liberation church solidified in their opposition. On the right, the land-owning elite, the military, protestant sects, and the U.S. counter-insurgency became more closely aligned. This conflict would quickly go on to engulf all aspects of society (Wearne, 1994).

The *conflicto armado* would continue to escalate, but it is also important to recognize all the different ways that society was convulsing. An active labor movement led strikes and protests against working conditions and low wages. The elite worked to politically disenfranchise elements of society and political assassinations were common. Increasing violence spilled into communities to settle old scores among local landowners and workers (Wearne, 1994; Wilson, 1995).

In 1981, the conflict metastasized as the military introduced new counter-insurgency strategies that brought previously unimaginable levels of violence. Whereas state violence had previously pushed the Maya to align with the guerrillas, the state's new strategy intended to destroy the indigenous base of support—largely through genocidal violence (Wilson, 1995). Defense Minister General Mejía Victores is reported as saying, "We must get rid of the words 'indigenous' and 'Indian'" (Wearne, 1994), through either assimilation or extermination. The military assumed control of the government, and sought to advance a "state of permanent counterinsurgency" (Wearne, 1994). "Most observers are in agreement that the purpose of the

Guatemalan army's counterinsurgency campaign was as much to teach the Indian population a psychological lesson as to wipe out the guerrilla movement that, at its height, had probably no more than 3,500 trained people in arms." (Davis, 1998, p. 24)

The army developed a step-wise strategy that planned to destroy the institutions of civil and indigenous society before replacing them with militarized institutions. Human rights violations became ubiquitous (Esparza, 2005). The military targeted Maya communities regardless of political or revolutionary activity and with little regard for distinctions between civilians and combatants (Godoy, 2002). It killed a generation of indigenous leaders, Catholic catechists, union leaders, and others in positions of authority or responsibility. Many of the elders in communities who were most knowledgeable of cultural traditions died early. Massacres in villages were common (Wilson, 1995). "Simply living in a certain village could be a death sentence as the army set about waging war on the civilian population rather than the guerrillas themselves" (Wearne, 1994, p. 23).

Land became a key target in the conflict (Wearne, 1994), and the unique cultural agony of displacement demands witness. For indigenous cultures so rooted to the religious significance of their ancestral lands, this separation creates an existential stress. Every village has a unique relationship not merely to the natural world, but to the specific mountains and streams that nestle and support their village. For many communities, prayers are offered to the spirits living in each mountain, not unlike unique people with whom the community has an ancestral relationship (Wilson, 1995).

Other military tactics included widespread rape, "disappearances" (including the abduction of children), poisoning of food and water supplies, burning homes, razing villages,

burning crops, killing animals/livestock, and forced migration (Aron, Corne, Fursland and Zelwer, 1991; Godoy, 2002; Menjivar, 2011). Many communities fled their homes to hide in the mountains or the slums of the capital. They escaped to refugee camps in Mexico or migrated to the United States (Davis, 1988; Farias, 1994; Wilson, 1995). It is estimated that at least 150,000 people fled to Mexico, 200,000 to the United States, and unknown numbers of people retreated to the jungles to avoid the military (Farias, 1994). Many villages fled together as communities, often without possessions and practically starving in exodus (Light, 1992). The conflict did not effect all corners of the country equally, but for many, it was a time when the violence affected anything and everything that mattered.

Violence in the highlands was particularly unrelenting. As many as 80% of the villages in the highland department of Quiché were abandoned during the worst of the violence (Wilson, 1995). In one example of the pervasive terror that the conflict created,

> People were frightened, and they buried anything that might associate them with the guerrillas in the eyes of the army: their prayer books, because the army had accused the Catholic priests in the area of being Communists; their metal hoes, because the army had accused the peasants of using their hoes to help the guerrillas dig up and destroy the only road leading into the area from the provincial capital; and even their *huipiles* (long white embroidered smocks worn by the Indian women) and the *capixchays* (black, sheep's wool, sleeveless jackets worn by the Indian men) because the army felt—at least in [the early 1980s]—that all the Kanjobal Indians had cooperated with the guerrillas and therefore should be castigated or killed. (Davis, 1988, p. 25)

For so many in these communities, much of what they knew was gone, only to be replaced with military control. "Model villages" and re-education camps frequently attempted to indoctrinate the displaced by blaming the indigenous for their suffering. By appropriating Maya beliefs of sin against a natural order, the military blamed them for their hardship. Their

suffering, it was suggested, was evidence of transgression (Wilson, 1995). In addition to deliberately inducing shame and guilt, the military sowed seeds of disorganization: camps, villages and even the deployment of army units exploited diversity to undermine resistance (Adams, 1988; Wilson, 1995).

> Whether carried out by guile or simply through ignorance of the significance of local communities, it is the same technique of conquest that the Spaniards used over much of the New World in the sixteenth century. The colonial policy of establishing *reducciones* and *congregaciones* (bringing together dispersed populations) was for precisely the same purpose and helped achieve the conquerors' goals of dividing local communities. The colonial policy of forced labor of Indians, a practice that had finally been put aside after the 1944 revolution, was reinstituted by the army in the Ixcán and in roadwork elsewhere. (Adams, 1988, p. 290)

The year 1981 introduced a particularly pernicious tactic of what were called *Patrullas de Auto-defensa Civil* (PACs) [Civil Self-Defense Patrols]. Although the army claimed that it was voluntary, various forms of coercive violence were used to pressure participation. The PACs recruited boys and men of all ages to spend one day every eight to 15 days protecting roads and inhabitants from guerrillas forces. Dissenters could be forced into the military or punished in other ways while favors were granted to those who cooperated (Davis, 1988; Esparza, 2005). Elizabeth Rohr (2009), narrates the following story told to her by a taxi driver:

> He began to talk about his brother, who, during the war had been ordered to participate in training for soldiers in the reserve army. The young men were asked to bring along a lot of food and their dogs. After a long walk through the woods, the soldiers finally arrived at a clearing where they were to stay for the night. They were told to empty their rucksacks, and put all the food in the middle of a circle. They had barely finished, when one of the officers lit a fire, and threw all of the food into the flames. The soldiers were aghast, not knowing what to do. Noticing their anxiety, the officer explained that this was part of the training, and that they now had to learn how to survive in the mountains without food in order to be able to fight against the guerrillas. Then he explained that they did not need to worry because they still had their dogs, which they could kill, roast, and eat. The soldiers stared at the officer in disbelief, and some of them started to weep, but their despair was

> met with contempt and laughter. When a few soldiers finally began to kill, roast, and eat their dogs, the others could not bear the sight, nor the smell of burning dog meat, and ran into the woods to vomit, and hide their shame, disgust, and tears. The brother of the driver tried to resist his hunger a few days, but when he could live no longer on roots and berries, he surrendered as well. 'This was the way they brutalized and dehumanized a whole generation of young men,' surmised the driver. 'They turned them into animals before they were sent out to kill in the war.'

The bitter irony of these "self-defense" patrols was the way the military leveraged them into becoming perpetrators of human rights abuses. Sometimes, the military directed them as frontline defenses in fighting and searching for guerrillas forces (often with little equipment) (Esparza, 2005; Wearne, 1994; Wilson, 1995). More commonly, PACs served as vectors for war propaganda and the recruitment of spies. For some, the PACs were welcome because they introduced some measure of structure and authority, even while in many cases they were used to settle local vendettas (Davis, 1988).

If military violence physically destroyed communities, then militarization tore them apart socially. It orchestrated impossible choices, pitting neighbors against one another. PACs acted in public executions, either directly or by being forced to identify their neighbors who would then be executed. They participated in human rights abuses like murder, rape, forced disappearances and looting. It is certainly not the case that everyone involved in the PACs was involved in atrocities, but the threat loomed. For the men, they faced torturous positions of participating in the PACs with its incumbent risks and dangers, or else seeing suffering befall themselves and/or their families (Davis, 1988; Esparza, 2005).

By mid-1984, over 900,000 men (approximately 1/10 the population) participated in the PACs (Wearne, 1994). Not only did they involve the general public in committing state violence,

this obligation also began to undermine the rural economy through its significant (unpaid) demands on time and energy. Power in these communities increasingly consolidated in the hands of local PAC commanders, who acted as an assimilating force and an omnipresent face of the military (Davis, 1988; Esparza, 2005).

> In 1985, there was virtually no judicial system in the rural Indian communities, and most disputes were settled through arbitrary acts of violence by local civil patrol commanders, members of rival civil patrol units, or, in the final instance, local or regional army commanders. (Davis, 1988, p. 29)

The capricious nature of justice erased any semblance of civil legal order, which meant there was no meaningful distinction between guilt and innocence. The threat of retribution became constant and violence was chronic (Zur, 1994).

It is hard to suggest that anyone in Guatemala was prepared for the level of violence inflicted by the military. The guerrillas had difficulty adapting and countering the government's tactics, and retreated. The brutalized indigenous communities felt betrayed and abandoned, and fissures developed among factions of the revolutionary movement. The same survival instinct that turned the Maya to the guerrillas turned them back to the military (Wearne, 1994), but the Maya's historical mistrust of both groups blamed them both for disrupting traditional ways of life (Davis, 1988). Militarily, the revolutionary movement had been defeated. In 1986, a civilian government re-emerged—fragile and weak—before a state still bearing the scars of militarization. Formal peace accords were established and concluded in 1996 (Little, 2009b).

The basic structural inequalities that started the war remained relatively unchanged from the 1960s (Little, 2009b; Wearne, 1994). The peace accords proved largely a political disappointment because of the impunity they sanctioned for the perpetrators of unchecked

violence, but an angry and energized civil society fought to create enough space for a dynamic truth and reconciliation process. Conditions of the peace accords mandated immunity for crimes except for those in the case of genocide, torture, and forced disappearances (Grandin, 2000; Isaacs, 2010). While the military limited the scope of its judicial authority, the *Comisión de Esclaracimiento Histórico* (CEH) (Commission for Historical Clarification) provided extensive documentation of both the war's brutality and the historical injustices at its root. Aided by an effort of the Catholic Church called the *Recuperación de Memoria Histórica* (REMHI) (Recuperation of Historical Memory), the CEH documented over 7,300 testimonies testifying to the human rights abuses of the war. The guerrilla movement participated relatively openly in the process, but the military remained guarded behind a strategy of obstruction (Isaacs, 2010).

When it was published in 1999, the CEH report was extensive. Over 200,000 people had been killed or disappeared. Over 600 massacres were committed. Over 600 villages had been razed. Human rights violations were widespread, and the CEH determined that the government bore responsibility for 93% of the abuses (Grandin, 2000; Isaacs, 2010). Eighteen percent of human rights abuses were committed by the PACs. Unfortunately, this report failed to generate national consensus as different sides disputed its veracity. In 2000, the government acknowledged that it perpetrated human rights violations (Welsh, 2000) after having initially received the report without comment (Isaacs, 2010). Accountability went missing and violence remained common. In the years since the report, there have been over 1,300 attacks against those who testified and/or demanded accountability. Effectively, exposing the truth laid bare injustices that threaten the attempts at reconciliation (Isaacs, 2010).

In the nearly 20 years since the signing of the peace accords, Guatemala has not escaped the violence and insecurity that was endemic during the conflict. Ongoing efforts at reconciliation have unearthed—literally and figuratively—painful memories. For example, the exhumation of mass graves taxes the professionals who do the work, the families of the deceased and the society as a whole, pressing them to confront this past (Foxen, 2010; Iraheta Monroy, 2003). For the thousands of refugees displaced by the war, life in exile was characterized by a the threat of violence, lack of basic resources, disruption of communities and social order, and a lack of basic human services (see Farias, 1994; Light, 1992; Melville and Lykes, 1992; Miller, 1996; Rousseau, Morales and Foxen, 2001; Sabin, Cardozo, Nackerud, Kaiser and Varese, 2003; Urrutia 1987; and Warner, 2007). Coming home proved to be its own crucible often facing threats from the military and hostility from locals. In one instance in 1995, returning refugees were massacred by the military. Repatriation created its own fears (Rousseau, et. al., 2001).

Returning raised another question: return to what? Repatriating did not necessarily mean returning to one's ancestral village, as some villages had been razed in the conflict. Other people returned to find their lands confiscated by others, often at the encouragement of the military (Rousseau, et. al., 2001). With the loss of a generation of leaders and the devastation of social institutions, cornerstones of civil society were lost or thrown into disarray (Fernandez Garcia, 2004).

The assault on indigenous culture alienated and marginalized some people from their traditions, but it had a paradoxical effect for others.

> The capacity of the indigenous Mayans to withstand mass murder and displacement in the 1980s was founded on a similar sense of history, the knowledge accumulated through

> having weathered attempts over five hundred years to eliminate, diminish or change them as a people. (Summerfield, 1998)

For example, in the case of Q'eqchi villages that fled into the mountains and jungles, their faith became a primary source of resilience and resistance:

> As they had done during the sixteenth-century battles against the Spaniards, Q'eqchi's turned to their mountain spirits for guidance and protection. These refugees reported praying often to the *tzuultaq'as* and God to shield them from adversity. They petitioned mountain spirits for the right to pass through their domain with each new mountain they crossed. For these refugee groups, the *tzuultaq'as* took on the role of guardian angel, guiding people through the forest and out of danger. (Wilson, 1995, p. 227)

For all the tumult during the conflict, it effectively changed the continuities of social context. "War, whatever its other results, often accelerates the incorporation of indigenous communities into the national society… The hope that a remote mountain village could just avoid and ignore the state and be left alone was shattered forever" (Wilson, 1995, p 257). Because the conflict targeted the indigenous for their identity, it effectively spurred the development of a new ethnic "pan-Maya" identity. Having seen their language and ethnic differences exploited in their oppression, the Maya increasingly participated in a broader movement for indigenous rights (Beristain, et. al., 2000; Smith and Offit, 2010).

After so many years of assault and subversion, civic institutions have met with both progress and failure in re-establishing legitimacy. Unfortunately, progress may not always produce ample results even if it can be recognized as progress. For example, all aspects of the legal system remain weak and ineffectual (Smith and Offit, 2010)—which may not be surprising given so many years in which violence was the primary force of government control. Despite the work of the CEH and the stipulations of the peace accords, only a handful of high-profile

prosecutions have occurred. General Efraín Ríos Montt came to power in a *coup d'etat* in 1982 and presided for 17-months over what was considered to be the bloodiest period of the war. In a sign of the burgeoning strength of a rights-based civil society (and its challenges), he was charged in a Guatemalan court and convicted of genocide in 2013—only to have his sentence thrown out 10 days later on a technicality and a re-trial ordered. The prosecutor who was instrumental in bringing his case to court was subsequently forced to step down from her position (Ruiz-Goiriena, 2014). A second major prosecution of ex-President Alfonso Portillo in a U.S. court on charges of money laundering resulted in conviction and imprisonment (Reuters, 2014).

Just as there has been impunity for war crimes, impunity for legal crimes remains the norm (Human Rights Watch, 2012). The PACs continue to wield extra-judicial power in many communities (Martinez, 2003). In addition to its use of repressive tactics (Human Rights Watch, 2012), the police force also shows evidence of corruption and involvement in criminal activity (Smith and Offit, 2010). Human Rights Watch (2012) describes the judiciary as "largely incapable of controlling violence" and notes that the odds of conviction for murder stand at less than 5% (as of 2010). Guatemala has one of the highest murder and violent crime rates in the Western hemisphere—most of it concentrated in the capital (Godoy-Paiz, et. al., 2011; Rosenthal 2013)—and politically motivated killings continue to occur (e.g., Associated Press "Gunman", 2013; Associated Press "Prosecutor", 2012). There is effectively no witness protection program and intimidation of the judicial system is common (Human Rights Watch, 2012).

Organized violence continues unabated in different forms. In 2010, the government declared a state of siege in response to criminal activity by Mexican drug cartels (Human Rights

Watch, 2012). In the absence of a clear sense of community and stable families, many people have turned to gangs for kinship, support and protection (Burrell, 2009). There are an estimated 90 gangs operating in Guatemala City alone (Goldín and Rosenbaum, 2009) involving over 100,000 youth and using tactics familiar to the *conflicto armado*: kidnappings, extortion and gun violence (Burrell, 2009). Perhaps not unlike the militarization of society during the war, civil society has responded to this violence with a proliferation of (illicit) firearms and private security forces (Aguilar, 1996; Rosenthal, 2013).

The "new" violence (Smith and Offit, 2009) of post-conflict Guatemala disproportionately affects women—both Maya and *ladina* (Menjivar, 2011). In addition to high rates of sexual violence such as rape, many women endure domestic violence and battering (Human Rights Watch, 2012; Radan, 2007). Public agencies have little ability to respond or protect women (Goldín and Rosenbaum, 2009), but strong work by survivors' organizations like the Fundación Norma Cruz have played important roles for advocacy (Human Rights Watch, 2012) and showcase the depth of resilience (Radan, 2007). These examples of overt and episodic violence belie the way in which violence becomes normalized and commonplace as a routine event in daily life (Menjivar, 2011; Radan, 2007). It becomes a natural extension of the *conflicto armado's* "culture of fear" (Davis, 1988). Whereas violence during the war had been concentrated in certain areas of society, the post-conflict violence is diffuse—both less concentrated and more pernicious (Little, 2009b).

Given the range of violence and the extent of the judicial inefficacy, mistrust in the legal system pushes many people to look outside of it (Human Rights Watch, 2012). Lynchings have increased considerably since the end of the conflict: in the first five years after the signing of the

peace accords, local communities committed 421 lynchings, mostly by gun shot or immolation. Cynicism about the system encourages support for vigilante justice among some villages (Godoy, 2002). Here again, in the aftermath of such widespread political violence, group aggression facilitates acts of individual aggression by serving a disinhibiting role: violence becomes a common language (Fernandez Garcia, 2004). As in the cases of street violence and gender violence, retributive aggression is part of how this post-conflict society enacts new forms of violence that are commensurate with levels of violence during the conflict. Chronic structural inequalities—such as limited access to education, healthcare and economic opportunities—can make these conditions seem both 'natural' and insurmountable (Menjivar, 2011; Smith and Offit, 2010).

For many people, time and adversity eroded the relief and optimism that came with the end of the conflict. For example, a generational divide characterizes some communities. Apolitical, disillusioned youth feel split off from their parents who lost or sacrificed everything for their way of life (e.g., Foxen, 2010; Rousseau, 2005; Smith and Offit, 2009). Significant progress has been made in reforming legal and judicial systems (Human Rights Watch, 2012), but the day-to-day adversity of the present can seem unbearable. Approximately 1 million Guatemalans have immigrated over the years to the United States, with between 6,000 and 12,000 leaving annually (Grazioso, et. al., 2013).

Broad efforts involving legions of dedicated professionals (e.g., Rohr, 2009; Rohr, 2012), activists (e.g., Light, 1992), and many others try to sustain their efforts for change in the face of frustration and disillusionment (Burrell, 2009; Copeland, 2011; Martinez, 2003). The general public now widely supports a platform of indigenous rights, but it remains to be seen if this will

translate into structural change (Hale, 2006; Little, 2009a). New policies support ethnic and cultural diversity, and new education policies value cultural traditions and languages (Consoli, et. al., 2013). For some, the present-day uncertainty colors their memories of the past, making excesses (i.e., PACs) seem necessary or justifiable in the name of security (e.g., Remijnse, 2001). For others, pessimism about repatriation and the prospects of change (see Rousseau, et. al., 2001; Rousseau, de la Aldea, Rojas and Foxen, 2005) feed into the familiar politics of patronage and clientelism (Copeland, 2011). Sometimes, the idea of something better can feel too far out of reach.

What does this mean in terms of working with trauma? How does one begin to care for individuals under such circumstances? Even making an assessment of needs can be difficult. Psychiatric epidemiology tends to assume the worst and would predict widespread psychiatric disorders (Summerfield, 1999), but as discussed in chapter two, resilience in the face of trauma is normative (Harvey, 2007). Certainly, both Maya and *ladinos* alike have shown incredible resilience (i.e., Radan, 2007). There is very little epidemiological research (at least in the English language literature) about Guatemala and very little psychological research conducted in the country (Aguilar, 1996). Grazioso, Keller, Swazo, and Consolí (2013) describe a 2009 national survey of adults (18-65) in which 25% reported a mental illness consistent with a psychiatric diagnosis. Of those, only 2.3% sought care from a mental health professional. "Most significant for the counseling profession is the fact that the country is currently living out one of the most violent periods of its history" (Grazioso, et. al., 2013). When there are so many crises and awful events in the present, attending to the past can seem almost extraneous.

As with any history or legacy of trauma, it can be devastating to even speak of what happened, and Guatemala—for its people and society—is no exception (e.g., Rohr, 2012). As Lira (1998) writes in her experience of working with human rights workers, the context becomes central to her understanding.

> How many things can one not talk about in Guatemala? I tried to understand what was going on, but the newspapers gave very little idea. The television was the same… Television itself seemed like a good way to create exactly the kind of confusion that would make sure that nothing ever changed… Superficially, the human rights issue seemed to be the most important subject in the public arena, given the exhaustive media coverage… What it actually generated was a sense of banality; people became weary and uninterested… Yet in Guatemala, I was impressed by people's sense that these crimes had been committed with impunity, that the threat is ever-present. Fear is palpable, despondency as well as hope, and the impact of the violence is deeply personal… Fear lies behind every conversation, like something woven into the fabric of society, something one must live with… Fear becomes a chronic response to a situation that is constantly threatening, and where there seems to be no boundaries. Arbitrariness is 'normal', even in a context that is supposedly democratic. (p. 138)

A common expression in Guatemala is, "*Saber*," which means literally "to know," and implies, "How should I know?" (Isaacs, 2010).

Nearly twenty years after the signing of the peace accords, the specific events of the war are not its first legacy. Nearly half of the country was not born when the accords were signed and far fewer still during the worst of the genocidal violence (Grazioso, et. al., 2013). But the past is too complicated to just forget. In some cases, state violence remains an open wound:

> Relatives of the disappeared who never saw their loved ones again live with the torment of not knowing if these relatives were in fact killed. Rosita, whom I interviewed in the Altiplano, would cry whenever she tried to explain what it meant to have had her husband disappear fourteen years earlier. On one occasion, she told me, 'I live wondering, will he come back one day? How about for our daughter's fifteen-year celebration? Every Christmas, every New Year's, every birthday, I wonder if he will come back. Sometimes I almost go crazy. Why did they [government army] not return his body to me? Why such cruelty? I think my torture will last all my life.' Filita, on the other hand, explained that

> her father was killed right in front of her and her siblings rather than having been disappeared and noted that this had been a consolation to the family because at least they could give him a proper burial. Only in the brutality of Guatemala's reign of terror could the killing of a father in front of his children serve as a consolation. (Menjivar, 2011, p 38)

Certainly for some, the conflict never leaves them, but for others the legacy comes in terms of what it left them without: family, stability, security, innocence, tradition, closure, and so on. But for all its painful legacies, speaking about the past can also carry very serious risks and fear of reprisal (Rohr 2012). The past has not passed, but it cannot be made present.

Research suggests that in generalizing about post-conflict societies, rates of PTSD prevalence may range between 13 and 25%, although this research often suffers from major methodological issues. For example, prevalence rates of PTSD across conflicts are reported as anywhere between 0% and 99% (Steel, et. al., 2009). In a survey of Guatemalan refugees who fled to Mexico, Sabin, Cardozo, Nackerud, Kaiser, and Varese (2003) found PTSD rates of 11.8% in addition to high rates of anxiety (54%) and depression (39%). A later study of repatriated refugees found PTSD rates of 8.9%, also with elevated rates of anxiety (17.3%) and depression (47.8%) (Sabin, Sabin, Kim, Vergara and Varese 2006). Regardless of diagnostic profile, many families in Guatemala struggle with cycles of domestic violence, alcoholism, and family disintegration (Godoy-Paiz, et. al., 2011; Goldín and Rosenbaum, 2009; Radan, 2007).

Research on Central American immigrants and refugees documents high rates of exposure to political violence, torture, sexual violence, and other "potentially traumatic events." Many reported fleeing political violence and/or structural violence (i.e., poverty and a lack of economic opportunity), and they showed elevated rates of post traumatic stress, depression and anxiety (Aron, et. al., 1991; Cervantes, Snyder, and Padilla 1989; Eisenman, Gelberg, Liu, and

Shapiro 2003). Asner-Self and Marotta (2005) suggest that this population shows diffuse symptoms such as mistrust, confusion, and isolating tendencies—all of which can be comparable with US-born subjects who experienced prolonged trauma or abuse (Asner-Self and Marotta, 2005).

Questions remain about how much of this distress can be explained by the refugee experience and immigration stress (Asner-Self and Marotta, 2005; Gafner and Benson, 2001). Displaced populations endure diverse accumulating stressors (Porter and Haslam, 2005), and causal conclusions are hard to come by in such cases (Silove and Kinzie, 2001). In general, good evidence points to the increasing prevalence of mental disorders following armed conflict (e.g., de Jong, Komproe and van Ommeren, 2003; Murthy and Lakshminarayana, 2006), but there have been mixed or discrepant findings (e.g., Jones, Woolven, Durodie, and Wessely, 2004; Silove and Kinzie, 2001). Because individual experiences of war vary so widely, speaking of 'war trauma' may be too broad of a term (see Basoglu, Jaranson, Mollica, and Kastrup, 2001; Johnson and Thompson, 2008; Priebe et. al., 2010; Weine et. al., 1995).

> War affected populations are often exposed to multiple traumas, either simultaneously or in rapid succession, thus making it difficult or impossible to disentangle the consequences of any single trauma. The emphasis on a wide range of traumas may also reflect the reality of the multiple experiences of war-affected populations. (Silove and Kinzie, 2001, p. 164)

Individuals may have multiple experiences (e.g., torture, combat, sexual assault) or play multiple roles (e.g., aggressor, victim, refugee) (Silove and Kinzie, 2001).

Several generations of children grew up during the *conflicto armado* either in Guatemala or in exile. 'Low intensity warfare,' which characterized much of the long-running conflict,

disproportionately affects civilian populations. Children may suffer direct effects (i.e., being killed, maimed, burned, suffering fragmentation injuries) or indirect effects (i.e., malnutrition, famine, family disruption/separation, displaced persons, disruption of services/education) (Goldson, 1996). How well children cope often reflects a wide range of variables: age/ developmental level, intellectual level, type of incident, level of exposure, degree of loss, prior trauma, parent/community reactions, level of parent/community support, psychosocial context, parental separation, temperament/sensitivity, and media exposure, among others (Walton, Nuttall and Nutall, 1997; Fremont, 2004; Allwood, Bell-Dolan, and Hussain, 2002; McCloseky, Southwick, Fernández-Esquer, and Locke, 1995).

In light of the danger in Guatemala during the conflict, it may not be surprising that some of the available research from this time describes refugee children. Melville and Lykes (1992) offer both a quantitative and qualitative look into Maya children's experiences in Guatemalan villages and orphanages, Mexican refugee camps, and the poor neighborhoods of Mexico City. Generally, they documented greater fear among those in Guatemala along with generalized uncertainty about the future for all kids. While working as part of an international team, Lykes (1994) found high levels of insecurity, aggressiveness, anxiety, fear, psychosomatic problems, and difficulty sustaining relationships. Miller (1996), however, found very little evidence of PTSD trauma reactions or psychopathology in 2nd-generation Maya children living in refugee camps—in spite of significant stressors. The mother's health positively correlated with the child's mental health, and Miller emphasized the importance of community and traditional practices as psychosocial buffers for distress. There is no reason to assume that all children were negatively affected by the conflict (Summerfield, 2010).

It may be obvious to note that not everyone (individually or demographically) is affected by war trauma the same way (Porter and Haslam, 2005), and it is hard to draw conclusions about the well-being of someone simply on the basis of war history or displacement (Orley, 1994). For example, despite considerable differences in the prevalence of "potentially traumatic events," the reported rates of suicide are approximately five times *lower* in Guatemala than they are in the United States (2.3 vs. 10.3, respectively, per 100,000 people) (Jacob, et. al., 2007). All in all and despite the ferocity of the violence, it is hard to make assumptions about how the civilian population fared during the war or what types of issues they may be facing now.

Methodological issues of cross-cultural research are also important (Asner-Self and Marotta, 2005; Miller, 1996) as trauma reactions in this population may not be well captured by PTSD symptom clusters (Lopez, Boccellari, and Hall, 1988). Local of expressions of *nervios* and "heaviness of heart" (Godoy-Paiz, et. al., 2011; Radan, 2007) are common illness experiences even as trauma histories are under-reported (Radan, 2007). "There is a risk that a preoccupation with only a few diagnoses, especially PTSD, may lead to a neglect of other possible psychiatric disorders that may have their roots in trauma exposure" (Silove and Kinze, 2001, p 168). Practitioners in Guatemala report an increase in the prevalence of disorders and the range of needs (e.g., Consoli, et. al., 2013).

The national response to the psychosocial needs of the public is minimal. In 2006, the government allocated less than 1% of the public health budget for mental health, and approximately 90% of that 1% was directed to the national mental health hospital in Guatemala City. In November, 2012, the Inter-American Commission on Human Rights took action against

this hospital on allegations that patients suffered abuses, were denied medical care, and were sexually trafficked by criminal gangs (Archibold, 2012).

Access to mental healthcare historically belongs to the wealthy (Davis and Chinchilla, 1975), although more recently some services are available through hospitals, university clinics and other private clinics. Salaries for clinicians are modest and there is a limited range of professional opportunities; health insurances do not cover mental health issues (Aguilar, 1996). In Guatemala, there are 0.54 psychiatrists and 0.04 psychiatric nurses per 100,000 people (by comparison, there are 13.7 psychiatrists and 6.5 psychiatric nurses per 100,000 people in the United States) (Jacob, et. al., 2007).

First-world ideas about mental health have limited social currency in Guatemala. *Asistencialismo*—which can be common—is the phenomenon in which helping professionals fail to assess or address the felt needs of individuals or communities. Instead of responding to needs identified by these individuals, helping professions offer them services they do not need or want (Consoli, et. al., 2006). When it comes to "mental health issues," many people look for solace from shamans, religious leaders, midwives, and community leaders. Western counseling and psychological practice does not exist much outside of the capital for either Maya or rural *ladino* communities (Grazioso, et. al., 2013). Many local languages literally do not have words for "counseling" or "psychology," and attempts to provide services in indigenous languages faces challenges even on a basic linguistic level (Consolí, et. al., 2006).

The practice of psychology remains underdeveloped and unorganized (Aguilar, 1996). During the *conflicto armado,* many intellectuals who were not killed fled and only some of them returned (Aguilar, 1996). There are no licensing requirements for professionals (Grazioso, et. al.,

2013), and the standard of practice is based on five years of collegiate study, practicum hours, a graduate exam and the presentation of a research thesis. Many students do not formally complete their degrees, however, by choosing not to finish their theses and instead begin clinical practice without it (Aguilar, 1996). "[Psychology is] considered, in reality, more a profession than a science," (Aguilar, 1996) and very few of professional fixtures (i.e., journals, conferences, licensing boards) exist (Consoli, et. al., 2006). "Guatemalan psychologists are more interested in exercising their profession than in forming a professional association that could eventually interfere with their income-generating activities" (Aguilar, 1996).

Concerted efforts to professionalize the field continue. Recently, an ethics code was adopted and steps are moving towards a certification process (Grazioso, et. al., 2013). There are six psychology training programs in addition to counseling programs in the country (Aguilar, 1996), many of which are in the process of encouraging locally developed curriculums (Consolí, et. al., 2006). While psychotherapy historically drew on psychodynamic theory, diverse orientations (e.g., social-contextual, cognitive, systemic, existential) are also influential. Integrative approaches are common (Grazioso, et. al., 2013). There is a conspicuous absence of social and cultural psychology, however. As Aguilar (1996) writes,

> Social psychology is possibly the most neglected and least developed of all areas of psychology in Guatemala… It is curious, and an interesting phenomenon, that in a country that lives in a climate of insecurity of near anarchy, so convulsant from social events from delinquency (assaults, robberies, kidnappings, assassinations), ethnicity (racism, discrimination) and politics; and that looks for an internal peace-making process and a solution to the armed conflict between the army and the guerrillas, that the Government of the Republic does not include psychologists in their team of National Reconciliation, that tries to achieve its peace agreements. Nor are social psychologists studying, analyzing, or proposing anything in that respect. In reality, in Guatemala there are sociologists, anthropologists, and politicians, but not social psychologists.

Clinical practice is difficult to assess in Guatemala. In the English-language literature, there is virtually no research on common practices or what Guatemalan clinicians do when conducting therapy. Many of the published articles that describe therapeutic approaches are written by North American or European psychologists who work collaboratively with local clinicians and/or technical assistance from foreign governments and aid agencies (e.g., Rohr, 2009; Berliner, Dominguez, Kjaerulf and Mikkelsen, 2006). The Catholic Church has also supported some clinical efforts (e.g., Rohr, 2006).

Therapeutic interventions may be best described as diverse. Some common occidental interventions may be less familiar (e.g. group therapy) (see Rohr, 2009), and local counselors may use innovative approaches that go beyond talk therapy, such as expressive arts, play therapy, drama, crafts, narrative story telling and role playing (Grazioso, et. al., 2013). Non-traditional or less contemporary therapeutic techniques (e.g., creative workshops and the arts, hypnosis, dance/ movement therapy, games/sports) are also documented (see Iglesias and Iglesias, 2006; Ley and Barrio, 2013; Lykes, 1994; Miller and Billings, 1994). Spirituality is often entwined in mental health treatment (Grazioso, et. al., 2013). Some literature describes the integration of local practices such as massage, herbal tea and spiritual rituals (Beristain, et. al., 2000; Beristain and Paez, 1999; Rohr, 2006).

Perhaps the best example to showcase integrative practices among various healing traditions in Guatemala is presented by Consolí, Tzaquitzal and González (2013). They present a case study of work by María de los Ángeles Hernández Tzaquitzal, a *curandera* in her Mayan community who also has training in Western counseling. She incorporates a wide range traditions of Catholic customs and *biosalud* (bio-health) involving energy points, prayer, and

rituals (e.g., lighting of candles, visiting graves) with Western techniques such as writing letters and the empty chair technique (Consolí, et. al., 2013).

The literature also presents several examples of community-based interventions. Some of these efforts reflect international efforts that draw on community psychology and the seminal work of Latin American psychologists like Ignacio Martín-Baró (see Anckermann, et. al., 2005; Berliner, et. al., 2006; Lykes, Blanche, and Hamber 2003). Other community approaches describe local efforts that blur the boundaries between therapy and social action (see Margolis and Valadez, 2008; Lira, 1998). Comas-Díaz, Lykes and Alarcón (1998) have argued in support of Martín-Baró about the necessity of a "psychology of liberation" that challenges the current intra-psychic paradigm, and emphasizes the importance of "accompanying" people in need of services.

In many ways, the practice of psychology in Guatemala can offer a microcosm of the broader culture: it provides a Western approach to understanding people and fostering health in what is a diverse and complicated mix of ideas and practices. Only a small segment of society may have access to therapy as it is practiced in the First World. Social, cultural, economic, political, spiritual, and historical concerns shape the way that professionals work and that people pursue healing. The heavy legacy of trauma weighs on both people's present needs and their concerns from the past—all of which may inform clinicians' approaches to understanding trauma. It remains to be seen how the unique and syncretic mix of cultures and beliefs shape the way practitioners attempt to help the people they serve in Guatemala. This work attempts to study how clinicians here think about their work with trauma.

VIII. Research Methods

This study offers a qualitative analysis of the way that a sample of Guatemalan psychologists conceptualize and work with trauma. As we have discussed throughout this work, there are many different ways of conceptualizing those experiences that we commonly consider to constitute psychological injuries. Perhaps not surprisingly, not everyone in the world thinks about awful things in the same ways. Given its unique cultural, historical, and clinical circumstances, Guatemala is home to an impressive array of socio-cultural diversity. This study suggests that the extent to which Guatemalan psychologists accept, reject and/or adapt a construct like PTSD may function as a testament to the extent to which they find the concept adequate and/or useful when thinking about trauma in the populations that they serve.

Guatemala presents significant differences (culturally, socio-economically, etc.) from U.S./Canadian and European cultures in which much of the research on PTSD is conducted (Hinton and Lewis-Fernández, 2011). This wide array of differences maximizes potential for finding meaningful differences among concepts, which is appropriate for this type of exploratory qualitative study (Morse and Richards, 2002). Also, because of the paucity of research and information about clinical work in Guatemala (Aguilar, 1996; Grazioso, et. al., 2013), the use of qualitative measures is appropriate for gathering preliminary data that may inform future research (Morse and Richards, 2002).

Recruitment and Data Collection

This sample sought to recruit practicing psychologists who identify as Guatemalan and have practiced in Guatemala for at least five years. Study criteria stipulated that participants

work in the field of psychology and spend at least a portion of their professional time working with survivors of trauma. No specific requirements were placed on the participants in terms of the types of trauma they work with or the portion of their work it consumed. All subjects were required to be over 18 years of age and speak fluent Spanish. Exclusion criteria for participants sought to limit counselors who do not hold a *licenciatura* degree or above, do not identify as Guatemalan, do not work with trauma survivors, do not speak Spanish, and do not work full-time in Guatemala.

The study intended to select for self-identified Guatemalans in order to reflect local, culturally informed clinical perspectives. These individuals may have pursued training in other countries and/or lived abroad at different points in their lives, but in their individual and family backgrounds they identify as Guatemalan. This condition reflects the fact that many individuals with advanced degrees may have chosen to pursue educational opportunities abroad. One participant identified as "Guatemalan" after living and working for many years in the country, but reported growing up in a different Central American country. The decision was made to include this participant in light of their well-established connections to the country.

The original design of this study intended to select for clinicians with master's or doctorate degrees in psychology. A master's degree represents the basic standard of practice in the United States, which has a well-established system for clinical care. Because mental health services and delivery systems are still developing in Guatemala and in keeping with local standards of practice, a decision was made to include those who studied on the level of *licenciatura* on up to those with doctorate degrees. The professional standard was emphasized in order to ensure familiarity with the ways in which trauma is currently conceptualized in Western

mental health. It establishes familiarity with the model, which in turn helps to identify which participants have chosen to remain close to or deviate from conventional ideas. Such a contrast could help to illustrate how these practitioners adapt their clinical work in response to the clients they see.

A lower bound of five years was set in place in order to make sure that participants have had ample opportunity to work and practice in the country. Professionals with ample work history are presumed more likely to be in a position to have worked with a variety of identified populations and draw their reflections from wider personal experiences, rather than responding with what they have learned in their formal training.

No stipulations were placed on the types of trauma cases because this study aims to engage clinicians in their thinking about psychological trauma in general. Because one of the primary criticism of PTSD is that it artificially limits our understanding of the range of trauma responses, this study directs its emphasis into a qualitative consideration of practicing psychologists' range of ideas and observations. A specific focus on one type of trauma could preclude valuable insight into cultural or contextual factors.

Language limitations are set for the following reasons: Spanish is the official language in Guatemala and the dominant language in the professional world. Because of historical and cultural realities in the country, it is not feasible that a clinician with a post-secondary education would be unable to speak Spanish. The principle investigator in this study also had no ability or resources to conduct interviews in any of the Mayan languages.

Participants were recruited through a convenience network sample. Initially the primary investigator began by contacting professional colleagues who had published research about

Guatemala in various fields (anthropology, psychology, etc.). These colleagues were then able to assist in locating participants who meet the study criteria. Then, they were first contacted over email by the primary investigator. All of the informational materials were in Spanish as prepared by the primary investigator and reviewed by a native-Spanish speaking clinician. The primary investigator, who learned Spanish as an adult, was formally assessed for Spanish proficiency prior to the start of the project and his language fluency was found sufficient for completing this project.

As participants became familiar with the study, they were asked to share information about the study with any colleagues who may be eligible to participate. Participants were alerted up front that this study offers no compensation for participation. Psychologists who express interest were informed about the nature of the study and the types of issues it aims to explore. Subjects were then selected on the basis of inclusion/exclusion criteria, as confirmed by the primary investigator. None of the participants contacted were determined to be ineligible, and the study included a total of 10 participants.

After indicating their interest, participants were contacted by the primary investigator with consent information, which they were able to sign, scan, and return via email. In order to accommodate any limitations in access to technology, participants had the option of postponing consent procedures until the in-person interview. No data collection took place prior to obtaining a copy of the completed consent form.

The first step in data collection following consent involved completion of the Initial Questionnaire (see Appendix 1) which consists primarily of demographic information. In some

cases, this was administered over email prior to the interview and in other cases it occurred immediately prior to or after the interview.

An in-person interview was scheduled with the participant. Interviews were conducted during the summer of 2013 when the primary investigator traveled to Guatemala. At the beginning of each in-person interview, the primary investigator briefly reviewed the consent form and reminded the subject that all participation is voluntary and carries no compensation. Interviews followed a semi-structured format (see Appendix 2) that was developed by the primary investigator for the purposes of this study. All of the interviews were conducted in Spanish by the primary investigator.

Participants were directed to select a location for the interview in which they would feel comfortable talking about clinical concepts in a quiet location in which they were unlikely to be interrupted. All of the interviews took place in these professionals' personal offices and/or place of business. Participants were reminded at the outset of the interview that this was a study of clinical concepts—not clinical cases—and while some case material was offered as examples of ideas and practices, careful consideration made sure not to violate any ethical or legal parameters about inappropriate disclosure of identifying information.

Interviews were audio-recorded and later transcribed. Transcription was conducted either by the primary investigator or an approved professional transcription service. The shortest interview lasted 45 minutes and the longest reached 106 minutes, with an average of 90 minutes.

All research materials were kept in a secure location and redacted of any identifying information—organized by a code known only to the primary investigator—throughout the completion of the study. This study was submitted for approval to the institutional review boards

(IRB) of both Rutgers, The State University of New Jersey, and la Universidad del Valle in Guatemala City, Guatemala.

Development of Research Materials

Both the initial questionnaire and the semi-structured interview represent original research materials developed by the primary investigator for the purposes of this study. They were designed to reflect the concerns and considerations of a pragmatic approach to qualitative research (see Fishman, 2005) by providing a robust account of the ecological and contextual features of professional practice. The questionnaire and the interview format were intended to serve different purposes and gather different types of information germane to the present project.

An extensive review of the literature (concerning both trauma concepts and Guatemala) was underway prior to the construction of the research materials. The theoretical framework of core conceptual questions described in Part I began to emerge as questions of reference, suffering, etiology and response provided a framework for organizing debates in the trauma literature. It became of primary interest to investigate participants' ways of effectively answering these questions, but in keeping with grounded theory (Strauss and Corbin, 1990; see below), it was also important to allow for participants' responses to take shape in concert with the theory. Rather than organizing the interviews to reflect the questions as an *a priori* framework, the materials allowed for the research to field test the idea core questions. The research materials were then organized by areas of common concern in professional practice and research, thereby allowing for subsequent analysis of the data to determine whether or not the core questions could be answered even when not specifically inquired.

The initial questionnaire (see Appendix 1) intended to make efficient use of participants' time by asking direct questions about demographic and professional matters. In keeping with the post-modern perspective of this work, it is assumed that individual perspectives matter. It became important to closely identify the sample. It inquired about age and professional experience (i.e., years of experience, clinical orientation, training, treatment modalities, etc.). It also assessed for issues of context (i.e., work setting, clinical resources, location), population (i.e., range of clinical issues, populations served, etc.) and cultural issues (i.e., language proficiency, use of interpreters, etc.).

The semi-structured interview (see Appendix 2) was designed to elicit a broad range of ideas without presupposing what participants may or may not include in their thinking about trauma. The review of the trauma literature forecast a diversity of ideas across levels of analysis and drawing from multiple points of view. The semi-structured interview format was intended to invite participants to comment on common areas of clinical research and practice (e.g., access to treatment, treatment planning, resilience and recovery). This included concerns across levels of analysis (i.e., psychological, sociological, cultural issues, etc.) and of particular significance in Guatemala (e.g., trauma and culture). Participants could then endorse an answer or decline depending on the relevance to their thinking about trauma. For example, participants were asked, "In treatment, how often do you talk about social issues like poverty, political violence, cultural discrimination, etc.?" Participants were free to either elaborate on an answer or to decline the practice.

Data Analysis

The primary goal of data analysis in this study aimed to examine commonalities and differences across conceptualizations of trauma. It sought to identify assumptions and organizing ideas in the thinking of these psychologists in order to describe their concepts for and experiences of working with trauma survivors. A three-part analysis was conducted in order more fully represent the complexity of their thinking. The foundational approach to data analysis reflected grounded theory as outlined by Strauss and Corbin (1990). Secondarily, a "case-based" investigation inspired by Fishman's pragmatic case study design (Fishman, 2005) allows for appreciating the complexity and nuance of selected interviews. Lastly, an integrated consideration emerges from examining how participants understand their context. Here, each of these analyses is introduced.

The first round of analysis draws out themes across concepts using grounded theory. Grounded theory examines issues of "process and[/or] change over time" (Morse & Richards, 2002, pg 54). Underlying this type of analysis is the assumption that theory can be grounded in the data and constructed around themes (Morse & Richards, 2002). Rather than having the theory predetermine the organization and structure of the data, there is an interplay between the basic material and the frameworks proposed to explain it. The primary goal of data analysis will be to "determine the categories, relationships and assumptions that inform [participants'] view[s] of the world in general and the topic in particular" (McCracken, 1988).

Analysis in grounded theory takes place in three sequential phases. These three phases include: open coding, axial coding and selective coding (Strauss & Corbin, 1990). As the first phase of data analysis, open coding involves scrutinizing the data for similarities and differences.

The researcher reviews each transcript for both micro- and macro-level themes. Micro-level themes are extracted by analyzing each transcript line by line. Macro-level themes are derived from examining each transcript as a whole. Through open-coding, more general categories are extracted from the transcripts in order to categorize transcript data into smaller subsets of data. Data across transcripts are then collapsed into these more general categories and coding labels are often taken directly from the language used by participants themselves (Morse & Richards, 2002). Related categories are then grouped into sub-categories of a larger group or are placed along a continuum.

Axial coding represents the next phase of data analysis in grounded theory (Strauss and Corbin, 1990). In this stage, the goal is to understand the causal relationships between various categories that have been identified—as well the main phenomenon, condition and consequences of said categories. Thus in this stage, the relationships between the categories and subcategories identified in phase one (open-coding) are explored and identified. Axial coding ultimately helps the researcher to understand patterns that present themselves in a given model (Strauss & Corbin, 1990).

Selective coding makes up the final step in an analysis with grounded theory (Strauss & Corbin, 1990). In this last phase, categories identified through the prior two phases of analysis are collapsed further so as to form the primary or core categories of the theoretical model. These categories are then connected through a model that makes up the actual "grounded" theory (i.e. the theory that is grounded in the data itself). In addition, the researcher in this final stage attempts to further refine and validate any connections between categories previously identified (Stauss & Corbin, 1990). In this study, grounded theory is used to conduct a "horizontal"

analysis that cuts across each of the interviews to find common themes. Major topic areas are explored and considered in depth in order to illustrate common features and ideas.

In the second round of analysis, this study supplements this approach with a "vertical" analysis of separate interviews in which participants' responses can be considered as a "case" analyzed for its own internal coherence. As Fishman (2005) writes, "The pragmatic paradigm [of research] argues that actual cases—in all their multi systemic complexity and contextual embeddedness—should be one of the crucial units of study in applied and professional psychology." By considering the complexity of each case, it encourages a greater understanding of the interplay of different organizing assumptions. For example, rather than assuming that a theme of "social instability" that is present across the interviews has the same valence for each participant, the case-by-case analysis encourages an understanding of how different trauma concepts may integrate and respond to such an issue. This type of analysis recognizes that the meaning or significance of any "fact" only takes shape when it is indexed to a broader framework of ideas (Fishman, 2005).

In presenting a "vertical" review of cases, we will review three separate interviews that provide unique examples of distinct trauma concepts. This work argues that four core questions (the questions of reference, suffering, etiology and response) characterize trauma concepts such that the answers form implicit and foundational assumptions of each idea. Each case will be analyzed to review primary themes and identify basic responses to the four core questions. "Cases" were chosen to illustrate how different answers to these questions lead to profoundly different theories—each with their own complexity. This analysis also begin to illustrate how different questions hang together as interlocking issues that can be molded into distinct but

nevertheless coherent ideas. The framework presented in Part I becomes a useful tool to compare and contrast different explanatory models.

The final round of analysis returns to the "horizontal" thematic investigation of grounded theory, but pays particular attention to embedded and contextual concerns of a "vertical" review of cases. Interviews are analyzed to discuss common themes that emerge as participants describe the context in which they work. The third round of analysis allows us to understand something about how the various ecological levels of analysis influence the development of trauma concepts. This includes an understanding of the current socio-cultural, historical and professional climates of contemporary Guatemala. It also reviews participants' ideas about what is needed in the training of young professionals—which implicates how participants' concepts of trauma are evolving. The overall results of this research and its various rounds of analysis should illustrate how different trauma concepts reflect the contours of a wide range of psychological and cultural concerns.

IX. An Analysis of Themes

Sample Characteristics

This study assures the anonymity of its participants. Given the comparatively small community of mental health professionals living and working in Guatemala, some descriptive data in the sample is left intentionally vague. Nine of the 10 initial questionnaires were returned, and sample characteristics are taken from the available information. In general, it is difficult to draw conclusions about how representative this sample may be (Aguilar, 1996).

The average age of the sample was 51.7 with an age range between early 30s and upper 60s. On average, participants had 19 years of work experience with a range between less than 10 and more than 35 years. The most common professional setting was private practice. Nine participants described either currently working or have worked in private practice, and only two were not currently working at least part time in private practice. A large portion of the sample had professional involvements with universities (i.e., teaching, research, administration) which almost undoubtedly over-represents university affiliation in this study. Four participants described experiences of working in agencies (i.e., NGOs, public sector agencies, etc.).

Given standards of practice in Guatemala, the study sample appears over represented in practitioners with advanced degrees. At the time of the study, two participants had either *licenciatura* or were pending the defense of a thesis. One reported a *licenciatura superior* and five reported *maestría.* Two participants reported doctorate degrees or were pending graduation. All the participants completed part of their training in Guatemala; four participants described training experiences abroad—two of which reported earning degrees abroad. When asked about specialties, six participants (of nine) mentioned trauma as an area of focus or additional training.

At the time of the study, all participants lived and worked in the capital Guatemala City, but half the sample (5 of 10) described at least some experience of working in other regions of the country.

Professional Practice

Data from the interviews was complex and nuanced as participants talked freely about their conceptual foundations in addition to clinical vignettes and challenges in their work. The primary focus of this research involves understanding how different trauma concepts are constructed and the effect this framework has on clinical practice. An important dimension to recognize, however, is the way that settings and circumstances can exert pressure on the clinical demands of therapeutic practice. Situations can shape assumptions about trauma, making it important to appreciate the circumstances of professional practice as part of this inquiry into theoretical constructs. The material in this chapter has been organized into three main lines of inquiry: professional practice, trauma concepts, and clinical interventions.

Access to mental health services appears rare in Guatemala. A sizable portion of the sample (7/10) agreed with the premise that the majority of people in Guatemala do not have access and are not familiar with the process of therapy.

> 01: "In our case, it's within reach of very few. On a public level, it's rare, and on a private level, it's very expensive."
>
> 02: "Yes, from my point of view I believe that the reality is that there is little access to mental health services, psychological and psychiatric, and that effectively also a lot of taboo is at work around soliciting mental health services."

Common barriers include lack of funding/resources, the inadequacy of the mental health system and social stigma.

05: "[When I completed my training] people were more closed and less disposed to look for help because there's a connotation that if you look for help because something happened to you, it's to say that you're crazy or you're weak. So there's a very strong belief in weakness that sometimes people don't want, they don't want to transcend… It was a stigma. Now at times it's becoming a question of class. It's that, "I have a psychologist." So you're starting to see a difference."

06: "The majority of people don't have access and if I can raise it in the following way, perhaps they have access but they don't have information to be able to reach those services. But when they go to a health service and they've complained about something bothering them, many times the social workers tell them they could perhaps go to a psychologist, or a psychiatry provider. But it never seems that they have information about mental health services. But yes, there's an institute in Guatemala. In the city there's a mental health center that people go to there. Maybe it's more difficult in the interior of the country."

07: "I believe that [most people don't have access and aren't familiar with therapy], yes… I believe that the basic needs are poorly covered. So, mental health isn't kept in mind, which is important. But the people, more so the majority of Guatemalans who are lacking resources, they don't have it. Nor are they familiar with that, right?"

Among those who disagreed with the premise, they were careful not to imply widespread availability, but rather suggested that this was a time of change.

04: "I believe that we've been working more on the level of psychology with the fact that, for example, there's a college of psychologists among the universities, they have careers [*carrera*] and they're giving support [*servicio*] to psychology careers. I think they've done work not only on an urban level, but also on the level of the interior, of the departments in where now there is more knowledge of what is a psychologist. And moreover, there's access even though it's psychological attention in a social center or university where the students do practicums [*prácticas*], and I think that has opened a lot of space for [psychological] attention. We still lack a lot; that doesn't mean that it's there for everyone. But there is a process of opening up."

05: "Look, I think that specifically, perhaps there is little information about what supportive services [*servicios de ayuda*] are, and I work also with Mayan women, for example, and I see how these women in different parts of the country are organized to bring information to their—to groups that approach them. And with that, I believe that they are opening frontiers for more and more people to look for help and are very

> receptive to what you can give them. So within that idea, I think that it's changing. I can't say absolutely that they know because I see groups that work on different socio-cultural and socio-economic levels and that are having an impact. So I think it's shifting, it's evolving."

Over the last five years, seven (of 9) respondents noted an increase in the utilization of therapy services and greater acceptance of the therapeutic process. Four (of 9) described an increase in the number of women coming to treatment to address domestic violence, and two (of 9) noted that more men have started coming to therapy.

All of the participants indicated that they speak Spanish in their work, but three (of 10) indicated that they work (or have worked) with translators at times. All of the participants indicated that they work with *ladinos.* A significant amount of the sample (7 of 10) mentioned either currently working or having previously worked with indigenous and/or *garifuna* people. Two mentioned working with international foreigners.

All participants (10) described working with adults, while 8 (of 9) said they work with adolescents as well. Six (of 9) respondents said they work with children under the age of 13. Only one respondent indicated that they did not work with men. Seven (of 9) respondents indicated that they work with both homosexuals and heterosexuals.

Seven (of 9) respondents said they work with upper or upper-middle class clients. Eight (of 9) respondents said they work with middle class clients, while all participants (10 of 10) indicated that they either work or have worked in some capacity with poor, low SES clients. Therapy clients were often referred by other clients, with additional referrals coming from professional associations (i.e., universities, agencies) and directories/phone listings.

All of the respondents indicated that they work or have worked with Catholics. Five (of 10) participants indicated that they work with evangelical Christians, and three participants (of 10) indicated that they work with clients who believe in the Mayan cosmovision.

Generally, participants described ambivalence and receptivity in equal measure, but the basic theme they sounded was that different populations held different attitudes. For example, the geographic divide between urban and rural communities is substantial.

> 04: "I always ask where are they from because sometimes they come from some hamlet that's far away… Much farther than to come to the capital for us; it takes them two hours to go from the village to arrive at the session. So that also makes them think that they're not going to come back and the economic part of it is huge. They think that the expense is enough and they don't come back, regardless of the problems they have."

Perhaps the most significant feature cited was related to economic inequality, and was not simply related to ease of access. Several participants described differences in attitude and engagement when working with different social classes.

> 02: "I've noticed that there is considerably less resistance in people who come from lower social positions. They probably come with considerably more desire to talk and to say what's there, as a process of catharsis in telling. Meanwhile clients of higher social classes, I find that there is a little more resistance, more of an attitude, like an attitude of… 'I'm only going to show you one part,' right?… It takes more time to strengthen the alliance with a person of a higher social class than a person of a lower social class who probably comes more centered on the urge to resolve things, but also may not have clear what they want to resolve."

> 08: "The sector of the population that I work with is a population that is of a middle- or upper-middle class socio-economic level. So it's real and possible that they can invest in a therapy process… The attitude is like hoping that a therapist has the solution for the problem they bring, right? But I've seen that it's almost the last tool, when the situation has reached a point where they're in collapse most of the time, right?"

In part, these class issues can be expressed in the differing attitudes associated with the settings where people are seen. A private clinic can garner a different reaction than a public agency or a university clinic.

> 06: "In my experience, I've seen that when a type of intervention is proposed with a mental health program or trauma intervention [through an institution like a social service agency]… [i]t seems good and they accept it… In private practice the person comes convinced or at least believes that the cause of their problems is psychological or emotional. In institutions, they come there because they're sent by judges or by other institutions of the State, and so sometimes part of the institutions' programs involve mental health, psychology or assessment."

> 07: "Well, overall—I'm talking about people I saw [working in a nonprofit organization]—a lot of resistance, a lot of reservations. So, so many times we had to change the names of workshops so that people, on reading them, didn't identify that it was mental health… And I also think that the reservations that they have are because the ignorance is presumptuous. They don't know. They're not familiar with it."

> 10: "I think that it has been a very, very gradual process. I think that the interventions that are done in Guatemala are elitist, not on a community level. On a community level, more multicultural aspects are used, like shamans and those types of counselors, but those same community leaders have started in some ways to look for information about counseling or what is psychology. So I think that it has been an interactive process between what the community wants and what counselors have been able to give."

Regardless of the population, trust in the emerging field of mental health can seem precarious because mistrust can be so pervasive.

> 02: I think that as Guatemalan society really is small, and that people of the upper class, many times they come to a private consultation. I believe that there are a lot of problems in relation to confidentiality. Ah, that probably here the circles are really small… People don't trust that you could tell something [confidentially], that information could get out.

> 04: They don't understand confidentiality because they don't live it. They don't know what it is to keep a secret, and there's a saying in Guatemala that I don't know if you've heard it, but, "Small village, huge hell." [Laughs]

These and similar comments were made in eight interviews. Eight participants also described premature terminations—in part due to encountering external obstacles to treatment—as characteristic of their most difficult cases.

When asked about differences they observed among ethnicities, two participants deferred as they reported working primarily with *ladino* populations, but the other participants noted differences among ethnicities. No clear consensus emerged about signature characteristics.

Three participants described the importance of symbolism in working with the Maya population. Several other themes were mentioned two or three times, including the importance of educational background, cultural expectations about health and healing, and the value of rational explanations. Four participants reported that they made few or minimal variations in their work with survivors on the basis of cultural/ethnic background, and several emphasized a sense of common humanity in spite of cultural differences. Just as navigating diversity can be nuanced and complicated, so too were some participants' answers. They reflected both cultural sensitivity and a common foundation of practice.

> 04: "Look, we're all human beings, but in keeping with the experiences that we've come through, I think that's the measure. It's like with the pain threshold is how I try to think about it. There is a trauma threshold. There are people that have a very high threshold and the trauma can be great and the person doesn't feel it so much. There are people who have a very low one, and then the trauma can be a small thing but it gets magnified. So then, I think that the trauma threshold in ethnic groups, for example, that were really exposed to the armed conflict, I think that that made them more resistant, more resilient… It's like the wind comes but it doesn't blow down [*bota*] the tree because it's stronger. So, yes, I believe that here depending on the ethnic group principally on the exposure and moreover if you belong to an ethnic group, you are exposed to bigger lack of [social] acceptance, to discrimination. And all of that makes you stronger, I think. It's like, for example, some times you see it in homosexuals. The homosexual boys sometimes are stronger for facing certain things because they have had to face society. Something that is personal for them, from their way of life. So in that, I think it makes a difference, right?"

> [Omitted]: "Let's see, in approach it's different, especially with indigenous groups, groups of women, with men. Especially with men as I'm a woman. Yeah, it has to have a change, a special care. In the message itself, in the objective, I want to achieve the same objective with indigenous women, *ladina* women… At the end, the intention or the objective is to generate security in themselves or to development self-knowledge so that they feel empowered. That is the same with all the women, but in terms of ethnicity, I have to intervene so that it's well received… I believe that if you only saw it from the outside, one would think that they're very different. Yeah, Mayans can be more reserved and less expressive. And the ladinos can be more expressive… but within, I think that we're all the same."

Some participants suggested that the Maya are less expressive, while others found *ladinos* to be more guarded. Two reported that they saw no differences in the *level* of engagement, but seven described differences in the *type* of engagement. For example:

> 06: "At the moment, I have seen that both have an openness and a willingness to work and collaborate, but it's their language, their way of expressing [themselves]—it's distinct. But there's no rejection. They've never said, 'I don't want to.'"

Notably, five participants suggested that indigenous Maya were less receptive to traditional clinical frameworks. As a question of crossing culture, psychology's place as a western tradition cannot be overstated, which is also difficult to distinguish from the current socio-cultural context.

> 05: "I'll tell you, not necessarily in practice, but in observations that I've made from the practice of some colleagues… including my colleagues who told me about having difficulty making connections between indigenous and ladino therapists. Some times [the therapists] didn't intervene the same way that they did when they worked with their indigenous groups. So eventually, they divided and shifted up and the *ladinos* worked with the *ladinos* and the indigenous worked with the indigenous."

> 08: "Another is that ethnically there are few indigenous psychologists, right? So they go to their religious pastor, to the father at the church, to their elders rather than to a mental health professional… Really, for example, "psychology" doesn't have a translation in Kaqchiquel; they just say it in Spanish because it doesn't have a translation."

> 09: "Through the compensation program, this was in the time of [inaudible], I think. I don't remember. They contracted psychologists to do therapy in the countryside. Absurd! Absurd! The people didn't even get involved, but it was because [the psychologists] wanted to come from a traditional framework."

Four participants described noticing differences among the Maya in post-disaster interventions. For example:

> [Omitted]: "We asked [the leadership committees from the community], what did the community say about us? And the community said that we were a group of women that didn't have anything to do in our homes and that we came to bother them… It's not that they were a group of ungrateful people but I feel that we didn't approach them from where we should have come from, and for that reason people didn't understand."

Asked about a "typical" case of trauma in their work (without stipulations regarding "typical" or "trauma"), participants most frequently answered with either sexual abuse or interpersonal violence (both 4 of 10). The range of clinical work varied considerably, however. Throughout the interviews, participants were asked to talk about cases of trauma and/or give examples from their work. Many different types of events were mentioned repeatedly. Seven participants talked about both interpersonal violence (including coercive control) and rape/sexual assault. Each of the following were mentioned in five interviews: childhood sexual abuse, physical abuse/neglect, kidnapping (often in conjunction with rape or extortion), traumatic grief, and criminal activity (i.e, robbery, assault). Four participants talked about natural disasters (i.e., eruptions, hurricanes). Other events that were mentioned repeatedly but less frequently included accidents, political violence, home intrusion, and relationship issues.

The psychologists in this study described their populations as facing a range of traumatic experiences that differ in quality, danger and severity. These populations are equally diverse in

their backgrounds and ethnicities, all of which can appear in the therapeutic process. There was a high degree of agreement that trauma has layered consequences across levels of analysis—ranging from the individual to the community—which may present in many ways.

Trauma Concepts

Formulations of trauma concepts were gathered during the interviews through a mix of direct questions and case examples as participants were able to both explain and illustrate their ideas. Typically, an invitation to share de-identified case material would provide follow-up to a theoretical question. Detailed accounts of three interviews follow in the next chapter (i.e., 03, 05, 09).

Three major themes emerged about trauma reflecting (1) intense or chronic adversity, (2) dysfunction and impairment, and (3) subjective experiences of distress. It was common for participants to weave these themes together in their comments.

Nine of the psychologists in this study describe dysfunction as a matter of physiological sequelae, impairment in daily life and/or enduring difficulties over time. Six participants talked about trauma in reference to the personal meanings associated with the experience. Five specifically mentioned pain/adversity that exceeded one's capacity to cope (and/or the avoidance of it).

More specifically, participants were asked to share what they understand as the "central characteristics" of trauma. Notably, there was no clear consensus. While different themes can be identified in the data, these ideas are often interwoven but rarely overlap in completely congruent ways. Some participants emphasized the re-experiencing of intense adversity.

01: “The concept of trauma is a derivation or a consequence of an event that has been so intense that it has exceeded the window of tolerance that human beings have to fight against events in life. And that, whether it’s for the intensity or the continuity, and the chronicity of the presence of the stressor, it terrorizes the brain functionally so that as a consequence, there’s a series of dysfunctions in different areas of life… The characteristics are in the first place the presence of an event to which the majority of people would be terrified a lot, after that is the repetition of that event through thoughts, ideas, “flashbacks”, and... that make one feel as though the same situation was happening again.”

10: “I would say that it’s an adverse event marked in time; it’s not chronic, but rather it is in this moment. It’s acute, I would say that it has the ability to take a person out of their comfort zone and because if it wasn’t that, it would be uniquely an adverse event, but trauma has, like, more intensity. It’s intense.”

Others focused on unmanageable, unformulated emotional distress.

02: “When I see that there is dissonance between the event that objectively, well, was an impactful [*fuerte*] event… that also makes me realize about that level of dissociation—what in the first place can be a first level of dissociation. They have completely dissociated their emotions or they have completely split off daily functioning from what happened. And it’s normal, right? It’s normal. [The client] has continued to live and so in one way it’s served her. In the context of trauma, I assume it’s completely adaptive. It’s what happens, that there’s avoidance.”

08: “As a situation of pain and suffering, that has an impact on an emotional and cognitive level… on the events of the person, that you have sequelae in situations of the person’s real life… I would think that on the first level, like a sensation of malaise without being able to assign it to an event. In particular, a lot of difficulty recognizing emotions, confusing a lot of sadness and anger… So it’s like one doesn’t recognize or validate how I’m feeling, but constantly a sense of malaise comes out… There is a denial, a non-recognition to validate what I feel and recognizing what I feel and distinguishing it.”

Some descriptions indexed these ideas to hyper-arousal and physiological dysregulation.

07: “Well, [at the nonprofit organization] it would be more physical symptoms, right? Hair loss, for example. Skin rash. I’m talking about gastritis, poor digestion, tremors, sweats, not having good sleep… They weren’t hungry—[that’s] on a physical level, right? I think that when it starts, they don’t sleep well, they don’t eat well. They are very emaciated. And later, the kids start to have more emotional symptoms, right? They cry all the time; whatever thing that may happen affects me on an emotional level. Their

> thoughts, on a cognitive level, aren't conventional or normal. They start to have thoughts that don't help them move forward. Their thoughts are distorted."

The loss of meaning and social connection was also common. It may be worth noting that these ideas need not be thought of as mutually exclusive, but they do reflect different foci. For example:

> 06: "Well, we always come from the concept of Freud that we have to be in a situation that one can't manage, and so it's so strong that we feel incapable of resolving it, and that I don't have the mechanisms to move forward. And so it develops what the DSM-IV say is a post-traumatic stress. Well, that is one part, but I believe that that is part. But… I worked a lot with the concepts of Stolorow… an existential psychoanalytic focus, and it was a lot of what was traumatic [for the survivors in this example]… it's that there wasn't anyone there for them to be heard… So my concept of trauma is first that it's a situation so intense that they can't manage it but more than that, what is traumatic for me, the thing that's traumatic is the fact in itself of feeling isolated, abandoned, not wanted and not supported—that is what they don't forget. That's what they constantly can't forget. So it constantly repeats, and they constantly react [*comentan*], and that's traumatic. It's not so much the fact [that this experience happened]… but that if the people who say that they love me do those things, what can I hope for from others? So they see the world that way. They have a conception of the world of that kind and they don't trust anyone, and later they start to manifest a bunch of behaviors that fit within some of the clusters of the DSM-IV, right?… She has an internal world in which there isn't hope and there isn't confidence."

Participants also shared their views about what determines when something can be said to be a "trauma". This is in contrast to when something may be considered stressful but does not warrant the distinction of being called "traumatic". Notably, two participants declined any such distinction, suggesting that stress and trauma exist on a continuum without any substantive categorical distinctions.

Echoed in the quotes above, several participants suggested that trauma was experience-dependent and that subjective considerations made the primary difference. Intensity depends on the personal reaction that one has regardless of any objective criteria.

> 01: "What happens is that it depends on the reaction of the person because the same event one person can assimilate and another person no… The difference is in the reaction of the person, not in the event itself."
>
> 02: "The definition of what is traumatic is completely subjective… I have in mind all the diagnostic frames of the DSM—or the ICD 10, which I use more in reality. And well, I go to that. I start by analyzing and looking and observing how is this person's daily life. How do they sleep? What are they avoiding? How are they functioning? Because that's what gives me a sense of their discomfort, subjectively. When it's simply a stressor, also I look in relation to their levels of avoidance, of re-experiencing and emotional dysregulation that they are managing, right? So, those are the signs that I identify when, really, it's a trauma.""
>
> 10: "It's a very relative concept…"

For others, objective considerations played a role such as the level of impairment or the inability to cope effectively. The presence of diagnostic criteria was mentioned in some interviews—such as impairment—but others included a range of concerns that went beyond Criteria A.

> 06: "I think that it's when the person can't… manage to resolve that situation. They don't manage to get over and it's constantly present in their life in such a way that it impedes having global psychological well-being. I feel that that's traumatic. To be thinking about it constantly, to feel uncomfortable, to have that constantly present in one's life. That it can't be put aside and what appears later between the symptoms of the DSM-IV… [It's distinguished by] the consequences that it has in the emotional life of the person and on a cognitive level, too."
>
> 10: "Time or the moment, because I can have an adverse event—a car crash—and it doesn't necessarily take me out of my comfort zone because the insurance is in charge… It's not an absolute loss. When something so absolute is lost like a family member, a part of your body, a financial situation, for example… I also believe that the trauma in itself doesn't cause the problem. I have had people that have lived through similar traumas but

> with people who have more [internal and external] resources, the work isn't the same… There are people that the traumas they've had aren't so much and they have incredible post-traumatic stress because of the lack of resources and their vulnerability in life."

Overall, the majority of interviews provided mixed accounts of subjective and objective features that did not clearly distinguish parameters for defining trauma. In other words, the interview data did not yield clear boundaries in many descriptions of trauma concepts.

There was general consensus that some level of distress is "normal" following an awful event. Frequently mentioned factors used to identify abnormal reactions included time elapsed (5), intensity of symptoms (5), and non-normative reactions (4). Four participants talked about substance use as a maladaptive coping response, while other interviews linked trauma to interpersonal violence (3), avoidance behavior (3) and high risk behaviors (e.g. unprotected sex) (3).

Participant responses showcased complexity and nuance which were reflective of many different ideas and positions. Depending on the types of assumptions that one makes, these positions could be complementary or even contradictory. It is not possible to review these positions in aggregate to determine distinct theoretical positions. For example, a participant who states that s/he does not frequently use the diagnosis of PTSD—but is familiar with it and describes diagnostic criteria in case examples—does not *ipso facto* endorse the complimentary position that this nosological category is inadequate. A psychologist may not rely on the diagnosis for any one of a number of reasons, and the interview data does not provide a basis for offering clinical generalities about the array of ideas and assumptions that these psychologists make.

It is possible, however, to show how the diversity of comments supports a spectrum of attitudes about the value and merit of the nosological construct. In staying true to the data, it is important to recognize that the following reflects the expressly stated comments of the participants. The following does not make assumptions about ideas that these psychologists *may* hold. Rather, it only presents findings of their specifically stated ideas. Review of the data began by considering statements about how much each participant believes him- or herself to be influenced by the PTSD construct. This assortment of comments was then analyzed for themes which resulted in identifying the following attitudes. Notably, some participants made different types of comments throughout the interview that support a nuanced view or at least ambivalence about the PTSD construct.

Only one person stated that they believe that PTSD is definitive of their understanding of trauma.

> 07: "All the symptoms of post-traumatic stress rightly have, or for me are symptoms of trauma…"

Five participants made comments to the effect that the diagnosis directs their focus in treatment and influences how they engage with survivors. For example:

> 04: "I believe that the formulation of the case first indicates for me… what I have to focus on to work with the person. Because I believe that the most important is that they have results in a way as quickly as possible, that they feel trusting that this process is going to work and that it's not something else… And later, it influences how I engage with the therapeutic alliance because I feel that for me it's—I know that it's one of the most important things in the therapeutic process. So I see that it helps me to see how I'm going to engage with the therapeutic alliance. And I always focus on the motive for the consultation, and to support what I have to support, and not go off on a tangent."

Seven participants made comments to suggest that psychologists need to look beyond diagnoses like PTSD and develop idiographic case formulations. Some of these comments point to significant limitations that have the potential to interfere with treatment and/or recovery.

> 08: "I tend more towards counseling and positive mental health than towards pathology… I feel that the [DSM] criteria are very general, where sometimes the particularlity of the case is lost and isn't clarified, and other processes that run in parallel aren't included… I think that the DSM is an instrument, but it shouldn't be the only one, right?"

> 10: "Well, it depends because if the client has focused on that [the particulars of the event] —because I feel that one has to evaluate if the trauma is isolated from the life the client. But if the client is entangled with that, let's say in their life, then I can't separate it [the diagnosis] out [as a discrete event]."

To summarize across all of the interviews, the greatest number of comments were consistent with the idea that "PTSD is a practical clinical concept that has value in terms of assessment as a clinical heuristic." Several comments also supported the possibility that, "PTSD is a concept that is problematic and/or has limited utility." Comments supporting the idea that "PTSD represents a discrete disorder that is optimal for describing a universal response to trauma," were rare.

Ideas about health, healing and recovery were as diverse as ideas about trauma, although it was typically discussed in holistic terms as opposed to symptom alleviation. Six participants commented on returning to daily life, whereas five described resolving negative memories and finding a greater sense of meaning. Sometimes this involved personal growth.

> 01: "[Recovery] is coming back to trusting. Because regularly after a trauma, there is an existential crisis. The world is not safe. And to have overcome it is… we continue, we continue with life. I am alive, and I can continue forward with the problems of everyday [life]. That [moment] has passed."

02: "I see it that to recover from a trauma is to be able to achieve, well, to know what happened happened and put it in the past. To create some distance between the past and the present. I find health is also that there were learnings of that, new forms of being able to see reality from what happened."

04: "I have a holistic concept because I understand that mental health is a state of total well-being of the person. Also, it has to do with physical health, with the state of their relationships, with sustaining the family. The truth is that nothing is perfect. It doesn't have to be perfect but a problem can come along and we can take care of it even though it takes time to take care of it… [Recovering from trauma depends on an ability to] find a normal life, to enter into everyday-ness [*cotidianidad*] and to keep on managing it."

08: "I think that we are still thinking of psychological health as the absence of pathology, not as a concept of well-being… I have psychological health if I'm not ill, but it's not seen from the other side that psychological health is enjoying different dimensions of well-being… I would think that first it's affective, personal, family, spiritual, physical. It's a well-being that's integrated where it's not only that I'm well in my body but rather with all of my body that allows me to interact with others… I would think that [trauma recovery] has various phases. First, it's to know and to talk about what happened for however painful it may be; to give it space. I think that it's not to deny it but instead identify it. The next step would be knowing that it's in the past, so to give it its space in the past. After identifying it, well, those resource and what the trauma made possible; and next, to decide what I'm going to do with that, what I want for myself, what steps I have to have to be able to achieve that space that I want—freely chosen, not because my therapist convinced me."

Overall, the sample tended towards ideas about intense adversity, dysfunction and loss of meaning. Rather than sharing any central feature, participants' concepts of trauma were built around various ideas about re-experiencing, unformulated distress, hyper-arousal, and an existential loss of meaning and connection. A mix of subjective and objective qualities were common in their thinking. Attitudes towards PTSD typically varied from seeing it as a heuristic tool to viewing it with skepticism. Recovery from trauma is more consistently seen as a holistic process, rather than a matter of symptom alleviation.

Clinical Intervention

In describing their clinical practice, participants drew from a wide variety of influences. Psychologists mentioned by name (listed alphabetically) included Gioconda Batres, Aaron Beck, John Bowlby, Sandor Ferenczi, Edna Foa, Victor Frankel (twice), Sigmund Freud, Judith Herman (twice), Salvador Minuchin, Carl Rogers, Francis Shapiro, Robert Stolorow, and Bessel Van der Kolk. Six participants referenced EMDR, and notably, five participants described alternative, energy-based interventions (e.g., AIT, EFT, Theta Healing). Non-traditional healing practices appeared to have a burgeoning currency. For example:

> 08: "I've gone out a lot from traditional schools of psychology and I've entered a little into the alternative, because every time I'm more convinced that in a society like ours—given that by the fifth or sixth session patients start to stop coming—our processes should be in short therapies, right?"

Seven (of 9) participants described themselves as "integrative" in their clinical orientations, while the remaining two (of 9) described pluralistic perspectives (e.g., "psychodynamic/existential/cognitive"). In terms of diagnosis, eight (of 9) respondents made some reference to using the DSM, while one preferred the ICD-10.

Nine (of 10) respondents indicated that they regularly do individual therapy, while seven (of 10) respondents described experience with group-based interventions. Two respondents said they work with couples and three work with families. Most treatments reportedly last less than six months (7 of 9), while two (of 9) said therapy continues for six months to a year. Six (of 9) indicated that decisions regarding duration are made on a case-by-case basis.

When asked about additional resources available for psychiatric care, some respondents mentioned hospitals (5) and/or additional family members (5). Three (of 9) referred to medical

facilities, while two (of 9) mentioned support groups. All in all, there was little report or description of a mental health system that is comparable to the "continuum of care" that is familiar in the First World.

In beginning therapy and building confidence, all participants emphasized a process of orienting people to the work. For some, it meant encouraging the therapeutic alliance (7), providing psycho-education (6) or managing expectations (6)—including at times an exploration of motives for therapy.

None of the participants endorsed adhering to manualized approaches to therapy. One participant explained that a manualized approach informs the basis of some treatments, but also emphasized using clinical judgment to deviate from the protocol. In general and for most participants, they took an idiographic approach and their attention focused on alleviating symptoms in context of a therapeutic relationship. In six interviews, a holistic focus on the individual—including an understanding of the subjective meanings associated with the event—played a prominent role in guiding treatment. The nature of the distress and facilitation of therapy as a process were also referenced.

> 01: "What's the most important? Many times, it's not the nucleus of the memory. Many times it's the edges that the event has… I don't go directly to when they did this or that. I go, 'How is it coming out in your studies? How is it in your work? How is it in your relationships?' And go making little steps, little advances, that go increasing [the clients'] self-confidence in themselves. And when there's a good relationship, then it's decided… It's well established, then yes, it's time that we work with the memory."

> 02: "I make [a decision about what to focus on] with the person. For that, for me the issue of educating them about trauma or the provoked symptomatology is really important… So, I identify the triggers and… I explain to them what it is that's happened to them… I give a lot of information so that she's going to understand, maybe because I want to direct her. However, I can say that the majority of times I concentrate on a lot of stabilization at the beginning."

06: “Well, let’s say if I don’t use a cognitive-behavioral focus, we talk about the event, the people, and I focus it on how it relates to the relational links… Sometimes [Bowlby’s theory of attachment] explains a lot—why do these difficult situations keep going on? Why does [the person] look for certain types of dysfunctional relationships? And so I focus on the relationships that they’ve had, toward the interpretations they make of the events and how they interpret it.”

07: “I focus on the symptom that is causing the most bother, that’s the most uncomfortable or they’re handling the worst, but I think that we can never do just that. We are a whole. For example, if their physical symptoms, like not sleeping… Not sleeping creates a situation for the person that’s very, very difficult to manage. So I concentrate on how we’re going to make it so that they sleep, but not just that. I believe that one always has to take everything else into account.”

08: “Even though let’s say I’ve read a lot about trauma and victimology, all the theoretical aspects that can support that and explain how it functions, what characteristics and all—well that can sound very empirical, but I try to put a lot on my instinct in working [with people]… I try not to mark things according to the theory, but rather that the theory helps me understand better, but going back to the particularities as soon as there is something that the theory itself isn’t able to explain. Later, perhaps, I give attention to the symptoms that the person tells me about, that are going to be the complaint, but I focus more on empowering how to make it that the person gets resources little by little.”

Generally, participants indicated that they attempt to maintain a respectful clinical neutrality towards their clients’ beliefs. In most cases, participants indicated that they did not attempt to change or influence any beliefs, except in some cases or circumstances such as domestic violence. There was some discussion of how these beliefs can be enlisted to support the therapy, often providing motivation, support, and consolation. The most significant cultural factor was religion/spirituality, and eight participants reported the importance of considering belief systems when planning interventions. Some spoke explicitly about valuing the use of traditional and/or religious healing practices in their work.

01: "For example in Guatemala, we have many people with magical thoughts… of possession, beliefs in saints, in… herbs, incense, candles… It's part of the imaginary and of a cultural question. So when it emerges in therapy, I use it—I don't challenge it. Nor do I say that I don't believe in that. The work—I give back what the client uses positively."

02: "The differences are that I find that indigenous groups have much more acceptance of treatments that are at their base—that are [inaudible] of energy. Right? So that their protocols and those ways of approaching traumatic events go much more in tune with their worldview. They have much more acceptance [of energy work]… I find it almost natural with everything that has to do with more symbolic processes—as more symbolic, more of work with mediums, those types of things. While the *ladinos*, or the *mestizos*, or the *criollos* that are in this country—I find more resistance to energy work… They like to understand more, perhaps it's the side of reason. Some things are allowed in their religious beliefs, right? People who are more Westernized, let's say. As such they believe also that to… work with energy, with other techniques comes in conflict with their religious beliefs."

07: "Not all the people are open to [energy work], but when they are open to that, especially those here, it's a change—like whoom! I think that it has a lot to do with the connection with the beliefs that the person has within them. Because I don't know if it really works or not, that is… I can do it; I have the book… It's done like… sometimes—and I'm sincere, I see it like… like it was magic! But they believe it. So it works. I don't know how to explain it… When people believe it, it's like spirituality. If you believe that God has performed a miracle for you, he's performed a miracle… But they believe and I say, "Wow!" Right? But I don't know if so; I leave it be… Yeah, it's nothing psychological. This is more like "healing"—salvations. They're a little alternative."

10: "In trauma, spiritual/religious support helps a lot. Now, there's a lot of Christians in Guatemala and so they have used a lot of psychological conceptualization in their preaching. What they say has a lot of cognitive psychology… With Christians, trauma talks a lot about… the love of God for all the things and there's a design for things. It talks a lot about the meaning that one has a to give it. And for me, that's marvelous because it's what I work with here. It's just that they put it to a higher power and that's very beneficial for some people because it leaves it to God."

Other factors discussed less frequently included socio-economic factors (i.e., education, social class), language, and cultural expectations. For example, when considering different interventions:

06: "Ah, culturally, not so much as with education and training. I've found a focus that has to do with dialogue. Narration is more accessible for all groups and different ethnic groups than one who's oriented towards a behavioral focus like what they teach us a lot of the time—what's been taught to us, the model of Beck and company. But I feel that one could use some of these ideas that they have with respect to these things, the cognitive distortions that they generalize and the personification—these types of things they do. But the approach to [the clients'] experience of the situation, I think that a more open focus or a psychodynamically oriented one is more what gives space for them to express themselves better. Because the other is going to cure that, the complaints [*molestias*]. And there are forms of believing and thinking that are distinct. In North American Anglo-Saxon culture, all the cognitive models assume that everyone has the capacity of intellectual understanding to make certain changes but in their culture it's distinct, influenced by the mother, and the family comes in. That's not to say that if it's rational —"Don't give a damn!" That doesn't happen. In the family, the connections are very strong and it becomes something else… It's another way of life. It's not city-dweller [*citadina*] or indigenous—it's another thing, right? So they express themselves in another way and one has to respect that… In contrast, the other models are interventions to fix symptoms when the situation is very serious and it's so intense that yes, they need it. But sometimes there are problems in life that the person brings with them—an effect of their social condition, of the war, poverty. And so that also is traumatic for them in the sense that there's a loss. For the most I can do, I can accept that thing. So there, it's listening, understanding and perhaps resorting to other models like community psychology. It's a different community focus."

Participants were asked to think about ecological factors in two different ways. First, they were asked to describe how they attend to the types of insecurity created by social problems such as endemic urban violence or extreme poverty. Because the treatment of trauma so often depends on stability, it was a premise of this work that social instability could have bearing on the process of recovery. Second, participants were asked about how frequently they talk about social issues in their work. In the event of the former, the overwhelming emphasis (eight of 10 interviews) involved accepting limitations and adjusting to social realities.

02: "If the person is insecure, well, there are some moments, some things that I can manage and some that I can't. It's also that acceptance of that… I can't tell you what's going to come out of it and that, in this country, it's never going to happen again. I can't assure you of that. I can't assure you that the police are going to respond because our police don't respond. Those are the uncertainties with which we live. However, if I promote a lot that stability can be maintained by finding things that one likes to do or being connected with a social support network, to situations in which yes, to be with others and to be well—I strengthen that there are a lot of things to be able to feel better like exercise, nutrition. But moreover, all the positive things the person brings. In the middle of chaos, I can't reinforce you're always going to be bad off. There are always situations here and we learn to move ourselves in sectors. 'I can go here, but I can't go there, okay!' And we have to work with the frustration that produces in us."

04: "I think that the most important thing in the course of therapy is to teach the client to find their resources to resolve [issues] and keep on living… I can't change the situation of security—of insecurity that there is in this country, but then what things am I going to do? [In a previous example, a woman was assaulted and raped when she walked to the bus stop on the way to work. After recovering, she then moved to a new home in a new neighborhood.] Like the woman that changed her house, she went to a place where it was safer, where she didn't have to walk to go out and look for the bus, a place where there isn't protection. So to do these types of things. I don't know, it's another way of learning to live… because the truth is that I can't change things that happen. What a shame! I'm sorry that they couldn't grow up in another environment but so what can they do to grow up in the best one possible? The world has change. Here in Guatemala, there are guard houses [*garitas*] on all sides with police looking out [*cuidan*]… There's more fear and more preventive measures [*prevención*]. So it's another way to live to protect oneself in situations that can then be traumatic."

05: "And I see it like that for my clients. Now, what is it that I'm going to do? I'm going to go looking for [a] way I'm going to go about helping myself to find one, but there's no control here. Anywhere you can—anything can happen to you. But also, you're free to choose where you want to be as well. So for example, if they assault you—you're going in a car and they assault you at a stoplight—and now you don't want to go out, that's not adaptive. But there is a reality that they can assault you, but so then, what can I do? I can resolve my inability to adapt because then I don't want to go out of my house. One phobia brings another, and that brings another, and suddenly you have generalized anxiety and multiple phobias, all starting from one event and depending on your strength. But, what do you do? As a therapist and as part of the people who live here… you also have to have a sense of life here."

07: "I don't have confidence in the authorities [like the police or the courts.] That's normal here in Guatemala… but I think that it's adaptive… But I don't avoid [going out],

or it's that it doesn't stop me from going to take a chance with it, at night, or alone, or whatever."

These ideas were often interwoven (in seven interviews) with concerns for empowering individuals such as self-care, accessing resources, and re-establishing connections.

01: "It's like a woman who is having unprotected sex. I tell her she has to use protection. In this country, the educational conditions are so low, we can't work like when one works with a young university student… I ask if she's going to the doctor, if she's caring for herself… Because I believe that it's not [inaudible] of psychologists… It's not only to see what happens in the psyche of the person. Rather, it has to do with daily life also, and with the assumption of reality in which the person is immersed. This is a poor country and with little education."

06: "Okay, the attitudes that they take towards, let's say, the attitudes that they take towards poverty, justice and corruption: what attitudes? What does it provoke for them? It provokes anger, so what can they do with that? So what one has to remember there are their resources to be able to overcome a negative or unproductive attitude towards something—well, that transforms it, whether it's working with other people, doing self-help groups among themselves but that they get out of it."

08: If you work your plan, your structure can change. I try so that those types of situations—poverty, violence, economic and cultural conditions—don't revicitimize my patients. Because it could be very easy to enter into a discourse of 'yes, you don't have access; conditions were poor," because then it's coming back to say you're a victim of society and also of many factors. It's to say, yes, we are subjected to those factors or conditions, but you don't want that? What do you have to do?"

Notably, while so many participants emphasized an idiographic approach to case formulation as part of an ecological perspective, very few participants endorsed directly addressing social issues in their work. Responses tended to cluster into three attitudes. In the first, five participants indicated that they do not talk about social issues with any frequency.

04: "Well, I don't think very often."

05: "Only if it's part of the person's problem. On the contrary, it's not something that I talk about… If it's part of the problem, yes, we deal with that, but if it's not part of the problem, we don't address it."

06: "No, very little. That is, they can relate and comment on them so what is the perception they have, how they interpret it, how it should be. And they are very clear what should be with the political situation, the social situation, corruption… there, no. I, so, I just hear about it. I don't give my opinion."

08: "I don't introduce them. I feel that they come out. I deal with them only if the patient feels they are important. I don't say to them, 'Look, that is violence, you're boss is…' I don't do that. If I start to see that it's a recurring problem for the patient, then within the process I say, 'Well, we've talked about that but I see that lately this has happened. Do you want that we talk about this new theme?' So they say yes or no, and we work on it… Perhaps it's not conscious, but I'm not very macro, nor very family-level, as a neighboring unit, let's say, but I don't go very macro with social questions."

Social issues are discussed only as introduced by the client and deference is shown as to what role it plays in the discussion. This contrasts with a somewhat more multidimensional perspective in which social themes like domestic violence or crime are discussed. Three participants indicated that they may introduce these themes. For example:

01: It's like I said before, that perspective on differences, on injustices, on marginalization, on gender, for example. I bring it and I say it—if it's possible, I present statistics. I say, "This happens and that's like that."

02: I believe that I always get into that. I believe that that part always goes with knowing the meaning. When I told you about knowing what it means [to the person that an event happened], it was about what do they believe has happened? Because respective to Guatemala, we have a very complicated political situation and… violent. Well, but, but I'm not going to strengthen [the idea], 'Yes, we're all fine.'"

The third position takes a social perspective that understands contemporary issues as integral to recovery. This minority position (2 participants) not only frequently engages with

social issues, but argues that addressing the impact of broader cultural issues is integral to health and healing. For example:

> 09: "In any case, it's not going to resolve itself. I can isolate myself in my house, but that means the trauma is expressed in the loss of my social links, of my social life. I think that that is the major damage that I understand that our society has today. That is, this situation that gets stronger with each passing day. And getting into the increasingly isolated communities of the interior, one starts to see these types of things."

For the psychologists in this study, their work with trauma survivors draws on a diverse range of influences and incorporates an array of practices. Essentially the entire sample self-described as integrative or pluralistic in their thinking, which opens the door to a variety of non-traditional healing practices and religious/spiritual beliefs. Idiographic formulations and ecological perspectives constitute the operative factors in guiding many of the different approaches. In general, alleviating symptoms and distress in the context of a therapeutic relationship garnered the greatest amount of attention. This is done against a backdrop of social insecurity which is most frequently met with a mix of acknowledging limitations and promoting individual empowerment through access to internal and external resources. The sample was divided over what role psychologists should play in addressing social issues in their work.

X. Analysis of "Cases": Examples of Diverse Trauma Concepts

This chapter presents the results of interviews with three psychologists who participated in the study. These examples were chosen to showcase differences and offer some illustration of the range, depth and complexity of current thinking about trauma in Guatemala. It is important to review individual "cases" because this study makes no assumptions about what—if any—features of trauma concepts psychologists may share. This presentation reflects their views as organized through the framework of the four core questions outlined in this work: the question of reference, the question of suffering, the question of etiology and the question of response. Every effort has been made to allow each of the participant's to speak for him- or herself.

A note about confidentiality: Some of the potentially identifying details have been changed or intentionally omitted. Because the community of mental health professionals in Guatemala is small and closely knit, this work attempts to err on the side of caution in protecting the identities of participants.

Case 05

Approaches to treatment can reflect trauma concepts by the way they formulate cases and prioritize interventions. Case 05 offers an example of how clinical practice can adjust or build on existing frameworks by revising the assumptions of the core conceptual questions. It is presented first because mainstream North American practitioners may readily recognize differences without eclipsing similarities. While consistent with many aspects of a PTSD diagnosis, it expands on how we understand the individual's experience. Case 05 prioritizes idiographic formulations that shift away from explicit risks based on life-threat events and

towards a framework based on the availability of resources to counter stress. Its understanding of suffering shows less concern with disorders and more with dysfunction. Response may still follow in diagnostic footsteps, but the range of reactions is best understood in terms of effective and ineffective coping.

Case 05 keeps with EMDR's theory on information processing:

> I consider trauma as an event, a situation, a life experience in some way that has generated blocks in the person in their capacity to process information they're getting.
>
> Really if there's a trauma, there's a trauma—and that on the level of the nervous system is very, very clear. It's generating, perhaps, the fears… The fear is going to be there… Or it's what in essence forms the trauma that we have as humans. I think that includes that there are people who in the face of events that are totally traumatizing for others [because of how they perceive them] aren't traumatizing for them in the same ways as for others.

There is an objective reference in considering neurobiology, but it also takes heed of subjective considerations when trying to make comparisons. Unlike PTSD with its stipulations for Criteria A, traumatic events are not framed objectively by the type of event or external objective characteristics, but through the experience of the individual. What may not seem particularly difficult in some cases (i.e., for some people) can prove staggering for others. As an event, the trauma is indexed to the subjective experience of (a) stressor(s), and there is no distinction made between traumatic stress and life stress.

> From my orientation, for example, with the concepts of trauma and EMDR, I would think that including an acute stressor is a trauma in a lessor proportion… Depending on the person… because if a person definitely cannot handle it, it's generating a series of symptoms and behaviors that are disrupting the life of the person… [Constant exposure to low-intensity aversive experiences] is not a big trauma, perhaps, but it's a trauma perhaps that has bigger implications than, for example, 'I was raped and I almost died, where I was in danger for my life.' We can't say that one is less than the other because suddenly the emotional/psychological damage of this—the disabling of one's ability to handle a

> situation that, perhaps, yes one might manage… So I see it as all of this, as this continuum in managing trauma and the conceptualization of trauma.

Stress and trauma are variations of degree, and external attempts at defining the event are only taken as valid as their understanding of the individual experience of distress as reflected in neurobiology. Symptoms can serve as a guide for exploring the underlying blockages, but the organizing imperative pulls for looking at how effectively the person copes.

> Well, in general [trauma is when] the person is living in their past. So it's a person—well, if you refer to the DSM-IV, we could definitely look there for the characteristics. From my perspective and my experience—which is what I think you want—it's a person that lives in their past. He or she is full of beliefs from what they lived through, full of negative, irrational beliefs. Their present generally triggers [*le dispara*] that painful past. So they don't enjoy [things]. There is an absence of the capacity for joy. There's a lot of difficulty with connecting with their own resources… The person easily can lose energy from constantly fighting to keep themselves alive in the a world that's dangerous, that is threatening; where she feels invalidated, disempowered, without the ability to resolve [the experience of what happened] and evidently goes about generating a series of factors or clinical conditions that worsen the situation.

Notably, Case 05 may use diagnostic concepts to organize features of trauma response, but the focus of the trauma concept remains on the ability to deal with stress and trauma.

> I'm not a person that works much with diagnoses. Generally, for example I work with a formulation of the case and I establish what are the priorities for this client and really I see if these are relevant priorities. I do it with the client and in service of that.
>
> It's not that I put aside everything that has to do with clinical diagnosis, but that I use it obviously. If I see that the person presents with dysthymia or major depression, my approach is going to be different in working with the trauma that's presenting now. But also the trauma itself gives you that information because you're seeing what way the person is handling the situation, how she's fighting. And if in reality she falls into a depression [*llegó a una depresión*], it's… that the person feels absolutely, totally disempowered before these events… And so we work [with the depression] and that's where I'm saying that I start with the relationship. I start with the little things that could be beneficial.

In this respect, diagnosis serves as partial proxy for the failure to marshal resources. Understanding suffering looks at the extent to which one is overwhelmed, and trauma as a matter of degree is indexed to normal human development. In other words, part of what defines trauma as traumatic is that it is not normal to always be overwhelmed.

> Well, I think that the person brings [their distress] and what I do is to show them what is normal in the function of human development…
>
> It's not normal that a person lives suffering, even though including there are people that believe that that is normal. Because when we talk on what level of suffering you have and we establish a scale, for example, that goes from 0 to 10, where 10 is the worst, worst, the worst that you could imagine and 0 is nothing. There are people that say in the process of, when we go about working through and doing the reprocessing and the desensitization, there are times that you ask them the scale and they say, "No, I already came down. I'm good already, I'm calm." And you ask, where on the scale? "No, I'm fine." Yes, but where on the scale? Later, after I've explained to them the scale, [they say] "8" and you say to them, "You think that an 8 is fine?" But they were at 10 and even with what you've said, they say, "I'm at 14." And the scale is limited to 10. So there has been a risk of dissociation, so, but you try to teach them. "No, what you're dealing with is huge! Its very painful and look, you've been able to do it." So there isn't a resource but there is a little vision of what is reality. And what I am living and where I can get to.
>
> [With trauma] there is something that they're not handling, but it can be that when it's consolidated, after a certain amount of time, generally we talk about a lapse from when it's consolidated in memory, more or less a lapse of a three months or so. That also is a time factor that we consider

The lack of coping resources (or their ineffective use) becomes a tax on the individual's ability to function. Conversely, health and recovery involves the recognition and successful use of resources.

> Well, for me, recuperation is when you start to make sense of your life, when you start to find that life's worth living, when you start to have values or to value yourself and what you do. And you start to look for what to do, what you do well, and what you do well for others… When I see that they are capable of seeing all that caused the trauma as an opportunity, as a source of resources, but not just as a something devastating, like a

> shadow, like something that laid me low, that voided me, that annihilated me, that made me prefer death to that. So when I person is capable of seeing that dimension that the situation has and to realize all that she has and so there's a greater connection with her resilience.

If trauma appears as an inability to manage the challenges of stress, then treatment focuses on the access and utilization of resources. The challenge and art of the process requires an appreciation of how best to install and mobilize these resources.

> So I explain to them more or less the principles of trauma and I start to work now. If they are very vulnerable people, generally I start with resources, I start with building confidence, with forming the relationship, with making a connection with them, with the fact that they realize that healing comes from them. I go about offering resources as a means of accompanying them.
>
> If I consider that the person—because of the level of anxiety that they bring, the level of depression that they bring—she needs psychiatric help, I definitely refer them… And that's also something that gives you a lot, or that is, the tools that one has are those clinical studies.
>
> I begin at the least with what the person brings… I say, Look, you're going to get your objectives following your own process. I can't help you any more than that, but if you believe that another person exists who can do that, remember that you are always free [to go]. But remember also what's rich and respecting the process… So, generally, one goes to opening up other things… Now, if it's a person with multiple traumas [*politraumatizada*] for example, with a lot of fear, sometimes I only work the relationship more and start from there.
>
> What influences me [in complex trauma] is perhaps, that I go more slowly depending on the resources that the client has. We look at ourselves more, or that is, it's more for, what I'd say, a person has right now… So we start to work more in the here and now, depending on the situation to offer resources or to help to establish a secure situation inside, at least stability with me… It's the frequency with which we can see [each other], the availability that I have with those people: where they can call me at whatever hour in a moment that they need [me] and they know that I'm there. We offer resources that can be there and later we start to divide the elephant into little pieces.

The clinical focus on resources and the idiographic emphasis assume a cross-cultural framework because it validates the unique ways in which different elements may be resources for

different people. It may incorporate different practices (i.e., energy work) and draw from local beliefs (i.e., spiritual or magical elements), although the difficulty in accessing resources may be related to the trauma experience.

> Look, as to the disposition [of treatment] there isn't a difference [among cultures], because they are people that have come to me and including, are totally open to what you give them. If you give them magic, they do magic. *Ladinos* are a little more, more distrustful, more closed. There are times that they say to you, "Where is the book?" … So they look for a bibliography… So at times your work turns into a bibliographic fight and I don't like to work like that. I'm not here to convince you that what I'm giving you is going to help or not help, but try it—and my sense of ethics [*capacidad ética*] is here. I'm very clear who you are and who I am and your rights, and all that… I say to my clients, "Look, I see a lot of mistrust in you. Is it that there is something that you are thinking about in relation to my work, or what are you thinking in regards to what's happening here. Because if you're going through life living like that, obviously it's one block or another. How about if we work with your mistrust? What if we work with that?" Because for me those are the most difficult patients.

Question of Reference:

The question of reference in Case 05 is primarily concerned with the idiographic experience of the individual. It offers objective considerations (i.e., neurobiology) to explain the indications and impacts of trauma, but in the context of subjective sensibilities about what is or is not distressing. The nature of trauma requires an appreciation of the stress the individual perceives, which can only be fully appreciated in terms of the meanings and ideas associated with (an) event(s).

Question of Suffering:

Case 05 is not particularly concerned with diagnosis because while it can be said to provide a map of distress symptoms, it does not summarize the experience of the individual client. In other words, nosology commands less meaning because of the idiographic emphasis.

This is less a matter of disavowal than a question of explanatory power. It is not about disregarding diagnosis in favor of another nosology, but rather a matter of privileging the continuum (of traumatic stress) over the (diagnostic) category. It also places the individual (in their particularity) before the disorder (as a generality). The priority in understanding suffering lies in case formulation. Suffering signals a lack of resources to cope with stress or challenges, big or small. It indicates dysregulation and an inability to function relative to an abnormal state of distress as compared to normative human development. For the individual, it is associated with the loss of values and meaning that may suggest inactivity or inadequate activity in the face of distress and crisis.

Question of Etiology:

In keeping with EMDR, trauma effects the individual by preventing the processing of information processing. Memory and stimuli cannot be analyzed or integrated either cognitively or affectively, forcing the individual to struggle repeatedly with the experience. It is not merely life-threat based, but rather based on the experience of intense stress which may (or may not) be associated with fear. On a continuum, stress moves in a matter of degrees towards trauma, making it difficult to articulate discrete causes. Causes may not be cleanly circumscribed as events, but rather aggregated in the experience of cumulative stress. In other words, it need not be that divorce, or grief, or street violence against neighbors act as causative events *per se*, but rather the accumulating sense of distress and insecurity threaten a feeling that one can no longer manage in one's environment. Hypothetically, even common events such as the loss of a job at the same time as the birth of a baby might supersede an individual's ability to cope with stress.

Identifying a cause depends on understanding the way in which a particular individual experiences a particular set of stressors in a particular context at a particular time. The intense feeling of being overwhelmed acts as the mechanism which can be ascribed broadly to set of causes and/or a narrative, contextual description.

Question of Response:

Trauma response shares many of the signature formulations of a diagnostic concept, but what constitutes a trauma response may span different diagnoses. It may involve cue-based associations, anhedonia, and interpersonal qualities like mistrust. More broadly, trauma response involves the struggle of the individual to deal with the drain of energy and attention that comes from being consumed by a situation when one lacks the resources to cope with stress. This may presumably be expressed in many ways, including those summarized by other types of diagnoses. This represents a general state of 'living in the past' as though one is unable to overcome a particular moment, resulting in the prolonged state of invalidation and disempowerment.

Case 03

If PTSD as a concept prioritizes the clear operational boundaries of the disorder, then Case 03 embraces depth and mystery. This participant's concept invokes a variety of metaphysical beliefs about human subjectivity and spiritual ontology. It depends on an understanding of the human mind encompassed by the idea of a 'psyche' which holistically describes the interplay between mind, body, and spirit. Case 03 draws heavily on "energy psychology" which blends beliefs about meridians, energy points, and chakras. These "power

therapies" (Devilly, 2005) are sometimes seen as including EMDR, and Case 03 also uses language that is consistent with some EMDR concepts. Trauma is understood as a wound to the psyche and by extension, to totality of the individual as a human being. As a case, this account provides the clearest example from this study of how spiritual beliefs may impact trauma concepts.

> Trauma means a wound, a rupture [*falla*] you're having on the emotional level. So I work with that, with that type of problem. And what we are going to look for are your wound and the implications that they have in your actual life.

Psychic wounds involve unintegrated experiences that become lodged in the psyche at various levels. These experiences may be both extreme or mundane, but they constitute the unprocessed or unabsorbed moments of life.

> I believe the concept of trauma is an experience or the accumulation of extremely painful experiences that are frozen… that are dormant—one could say frozen in very deep layers of the psyche. Some are on the most surface level, but trauma—I see it as an experience that we all as live with as human beings, and that hides in the deep parts of the unconscious [*el inconciente*] and 'that which is unconscious' [*lo inconciente*]… That causes distinct types of behavior that won't allow you to have a healthy type of relationship.

Because trauma stemming from many different layers of the psyche may be expressed in many different ways, the concept begins to describe much if not all of life's distress. Effectively, there is no difference between life stress and traumatic stress, only a matter of degree.

> I always feel that a stress is going to take you to trauma… It's like a call [to another layer of the psyche]; a stressor is like a call of something profound that you are living, right? But on the whole you always find actions, flaws, you encounter pains… that are sometimes conscious and sometimes they are, like I said, frozen.

Trauma conceptualization then involves understanding how the injury may be expressed in the psyche across various levels. The depth and range of the work depends on the individual.

> The surface would come up as being what the patient carries now, as what cognitive-behavioral [treatments] treat. 'I can't stop smoking,' or 'I can't separate from this person who I don't feel good with.' It could be what is on the surface, like a recent trauma. What they're carrying. But when you being to explore the layers, you find every time things that you never imagined…
>
> Well, you carry the thread through the symptoms, right? They go telling you… that I'm having nightmares, intrusive ideas, I don't sleep, I don't want to go out, my life has changed, I don't want to go out with my friends; I spend all of my time avoiding remembering what I went through… And when people tell you that, the frame is clear. It becomes clear and you learn to read the symptomatology… But in reality, when you explore more there, you realize that there is always something, there is something more there and you don't know what it is…
>
> So then, it's also the person who defines what type of treatment she wants [to address different levels of psychic material] and from that base I start to identify more predominant symptomatology and that's what I focus on… despite that I see other things that are in the background [of the psyche].

Understanding individual experiences of trauma fundamentally extend beyond the individual to include an expansive view on time, space and relationships. For example, the individual's life does not bind or constrain the lived experience of time or the collective unconscious. Trauma may be developmental or even involve past lives.

> The unconscious [*el inconciente*] guards recent traumatic memories from this life. 'That which is unconscious' [*lo inconciente*] guards traumatic memories from this life, from the lives of ancestors, from the life of the people, but also of your experience as a human being in your universality [*en tu universal*].

An individual's experience needs to be understood not only in terms of their biography, but also as part and parcel of historical experience. In the case of Guatemala, that demands an awareness

of the historical violence and the clash of cultures. Working with this historical and ancestral material may address parts that are denied, buried or avoided.

> So, it's like seeing what assures you that you are a Mayan descendent, that even though you have copper color, that even though you are white—In the Guatemalan people, everyone, there isn't anyone that escapes the Mayan blood… Even though you want to deny your Mayan identity, in all Guatemalans runs Mayan blood, be it that you have blue eyes or coppery brown skin, we all have the blood of our ancestors.

In that respect, this shared history and common ancestry is a shared trauma that touches everyone in the depths of their psyche.

> Because despite… that we lived through the bloodiest conquest, the bloodiest conquest came to our people. It wasn't Mexico. It wasn't Colombia. The bloodiest came here and from there it was unleashed [*se desprende*] because Don Pedro de Alvarado was terrible, terrible. And from there it unleashed a category of trauma that is historical trauma.

Because of personal-social interdependence, the fluidity of experience can also express suffering in systems of reproductive violence. In other words, past trauma in the psyche can recapitulate violence or conflict in other realms. Because this view is more holistic and non-linear, causal claims in this conceptualization are largely subjective and otherwise weak- to nonexistent by empirical standards.

It is equally important to note that this conceptualization of trauma is fundamentally pluralistic in its use of theoretical models. It employs both subjective and objective perspectives, both idiographic and nomothetic frames. It does not discount a Western psychiatric nosology, but clearly integrates different ideas and expands on these foundations.

> So energy therapists, we need to know psychopathology; we need to have all the theoretical baggage because it helps you understand the psyche and what displaces the psyche, how the psyche is manifested—but those are judgments we leave behind. For example, the interpretations of psychoanalysis, that the analyst makes—they are not valid

> in the work that I do because each person goes through making their own interpretations. It's a little complicated because it breaks the paradigm of traditional psychotherapy.

Fully cognizant of moving between paradigms, this perspective employs both nosological and phenomenological sensibilities as it answers the question of reference. Moreover, it challenges several other basic assumptions about talk therapy, the therapeutic relationship, and the scope of health and healing. In the case of social issues, healing from a milieu of violence is both intra-psychic and broadly universal. It is something that is dealt with "all of the time":

> I was telling you that in working with trauma, the changes come about very quickly, in a way when you are having contact with the energy centers, the strongest part of the trauma is experienced in all of those centers… It's like pulling the deepest root—the information that is most charged with emotion, those that were frozen. So, the person experiences [the traumatic event] with all of their strength, but when you… revive it, you could say, it kills the mosquito, which you could talk about in terms of abreaction. The abreaction appears in all of that part. And as you go deeper, the person is giving answers to their own center. And that's why I say that the therapist interacts, never interprets because the information comes from the patient or client, and that's beautiful—this work—because you as therapist, excuse me for saying this, but if you work from words, you are mediating through a series of beliefs, through all the theories, through a series of ways of knowing the psyche, of interpreting the psyche. But those are your beliefs, not the beliefs of the client… So in that respect, with respect to the question of social issues, when the changes occur rapidly it's saying that… [it's] because the changes come from their center… [And when dealing with social issues] it's that your vision of what you're living changes… You reach an understanding of the reasons why you live in such a confusing country like this, why it falls to you to live in Guatemala and not in the United States or Canada, or in Spain or in some part or environment where respect for human rights is maintained. So it's not that social problems are not important, it's that your view on what happens overall changes.

In the overall formulation of this concept, such a move introduces greater breadth of perspective, but also limits the extent to which it can be formulated in terms of a single model. In other words, looking at trauma in more than one way depends on integrating more than one understanding.

> [My colleagues] know my work well but they don't understand how I can be in many moments very theoretical but in my practice, it's like a bunch of non-scientific elements… like the use of, like the use of incense… So when you work with all that, people think that's metaphysical and it breaks with the positivistic paradigms… But when people come here, they find a lot of calm and peace… So, it lets people see that this is scientific also, that those things that the people know are also truths, and truths that are verifiable, measurable and people experience substantial changes in little time.

The process of therapy itself is equally a blend of traditions.

> Well, I always follow the parameters that mark the work of psycho-trauma. Or that is, I always follow the steps from the perspective that I have that is the recuperation of security and confidence. I work a lot from Judith Herman['s perspective] and in that work I use all the techniques of stabilization… In some cases, I follow the steps and in those, yes, I am very methodical. Those cases are very delicate and I should treat them with finesse and give them the tools necessary. And to work that first layer that is going to permit later to enter the trauma memories. But yes, I take my time.
>
> I'm flexible because I never know what is going to pull the network of traumatic memories. I never know.

In terms of cultural differences, however, Case 03 did not indicate a need to adjust or change the approach to treatment on the basis because it showed congruence with local beliefs.

> Well, from the model that I work with… this model rescues [*rescata*] the culture; it rescues it, recovers it, and locates it in a privileged position because it is like native people had their own ways of resolving, for example, post traumatic stress in the communities here. They called it *susto*… The model rescues for example, the fact that working with energy centers, the Mayan communities work with 13 energy points. And when you explain that to the Mayan women, it's so fascinating to see them feel re-valued for their culture because the Mayan shamans work with the centers and do a lot of rituals that we work with too from energy psychology,. We work with emptying the trauma, and they work with emptying negative energies. So there is a rescuing of the culture that's interesting.

The restoration and recovery of culture can be seen as part of a broader recovery from trauma.

> I believe that psychological health comes when you connect with the source of joy and well-being, and psychological health comes when you know who you are and when you know who you are is because you have already explored all the superficial layers and deep layers of trauma. Psychological health is to laugh and cry; it's to connect with positive

> and negative emotions that make you human. That's something psychological, but also knowing your personal history and that of your ancestors, of course, because you are not only you.

Question of Reference:

This conceptualization relies on the multiplicity of perspectives that reach across paradigms. In the overall formulation of this concept, such a move introduces greater breadth of perspective, but also limits the extent to which it can be formulated in terms of a single model. In other words, looking at trauma in more than one way depends on integrating more than one understanding. Objectively, surface level distress can be described pathologically and cultural norms enable an evaluation of what is 'normal' or not. Both of these assessments take the viewpoint of the disengaged, third-party observer, and lend an element of objectivity. On the other hand, with greater psychic depth comes greater intrinsic complexity. Such complexity demands a more idiographic sensibility which invokes the individual's intuitive self-awareness. The therapist's interpretations are discounted because they do not—or even could not—fully channel the subjective totality of the other's psyche. Answers 'come from within' because the resolution (presumably 'thawing' and 'absorbing' the 'frozen' traumatic experience) depends on the person's unique ability to re-position themselves before their own historicity. Working at greater depth demands greater subjectivity.

Question of Suffering:

Suffering is framed in terms of individual experience, but that individual experience is regarded as channeling social and historical injury. Different layers of the psyche reflect different facets of self-experience that may or may not be acknowledged by other psychological

traditions. Whereas suffering results from unresolved and unintegrated experience, healing and recovery marshal the energy that re-vitalizes connection. In this view, addressing suffering may tend first to a superficial level and the alleviation of symptoms, but greater healing takes place as one moves deeper into the unconscious and 'that which is unconscious'. Engaging in the long, winding process of self-exploration affords both greater connection to oneself as well as a recognition of oneself as part of something greater. In that respect, the suffering of trauma is seen as a legacy of ruptures or wounds.

Question of Etiology:

Etiology is attributed to the 'freezing' of experience. The nature of the event is indeterminate because the trauma may stem from discrete episodes or accumulating stressors, varying in duration and distinguished by the meaning associated with them. They can have temporal precedence in this life or in previous lives, and they may reflect injuries to ancestors in ways that are transmuted across generations. The event is not defined in terms of distinct episodes or moments, but rather it is the aggregate of suffering that proves most important in terms of defining the event. The "event" can be conceived as broadly as the individual standing before history. This makes delineating direct and linear causal associations problematic if not impossible.

The mechanism by which trauma is induced depends on the pathogenic "freezing" of experience. This freezing implies an inability by the individual to integrate the experience such that the otherwise 'not-fluid' quality prevents its absorption into the totality of one's experience. Just as the mind, body and spirit merge inseparably with a broader sense of life and history, these

‘frozen’ experiences suggest a disjoint. Distress becomes unmanageable. The direct link between the experience and unhealthy behaviors is not articulated, and again, linear causal claims cannot always be made in this conceptualization.

Question of Response:

Trauma response is understood as a holistic reaction of the individual that may be expressed in different ways across “layers” of the psyche. The “surface” presents the cognitive, affective and behavioral dimensions commonly recognized in clinical psychology, while layers of greater depth reflect spiritual and socio-historical dimensions. Outwardly and on the surface, these experiences may present in terms of disorders and in congruent formulations as those described in the DSM. Psychopathology is understood as a taxonomy of distress in the psyche’s outer layers. It is important to note that trauma response from ‘deeper’ layers may or may not take the form of a Post Traumatic Stress Disorder; it may outwardly present in vary different ways or unexpected ways, but that does not mean that such a response is not a function of trauma. Assessing trauma reactions and distinguishing a normal from an abnormal response typically involves gauging the surface response as either culturally normative and/or consistent with diagnostic criteria for pathology. Assessing trauma on deeper levels requires the individual’s burgeoning self-awareness of inner experience and connections to history and society.

Case 09

The concept of PTSD explains trauma as an intra-psychic disorder that stems from an injury incurred by the individual, but in Case 09, trauma does not happen ‘to’ the individual.

Rather, trauma occurs in their interpersonal world. The injurious damage of psychological trauma is not formulated in terms of an injury to the mind, but rather in the loss of shared meaning that is enacted in social connections. Trauma is the profound violation of these connections and meanings. The incumbent loss of social bonds provokes suffering experienced as grief, alienation, and isolation that hinder the individual's ability to engage meaningfully in daily life. In other words, trauma undermines the shared meanings that organize our lives. For the individual, (s)he suffers distress and disempowerment in a struggle to regain a common sense of understanding, recognition and justice. For communities, trauma involves the collapse or conflict of its shared meanings, norms and expectations.

The perspective in Case 09 comes from an individual working within a community-based organization, and speaks of the collective efforts they undertake. This case epitomizes the way in which a socio-historical focus can impact a trauma concept.

First and foremost, understanding what is lost in trauma depends on a foundational sense of well-being:

> From this perspective alone, mental health is an effort to build and re-build relationships between people that are healthy, productive and constructive. Mental health is a fundamentally social state, since no one makes or breaks their mental health between four walls. It's undone in the family, or at work, or in school. So the effort to work with mental health, for us in this program or in others that we have, happens fundamentally by contributing to the recovery and re-establishment of healthy relationships. To recover relationships where humanized values, where those values rather, are practiced again: solidarity, respect, a shared dream, to work on shared goals. In the end, all those values that in the logic of actual societies are like they're secondary… So the concept for us that we use here, because that includes the clinic, the efforts of individual attention, goes about recovering those relational values… Because as I was saying to you, there is no psychology that's not social.

Because this concept is rooted in the interpersonal, it has a uniquely socio-centric focus that attends not only to individuals and their primary relationships (i.e., family), but also those of communities and society. Understanding trauma as a social force requires the broadest aperture: it invites history as a centerpiece and looks at trauma in cultural terms. In light of the country's long history, trauma has to be understood as a social and historical phenomenon. It is evident not only in the lives of individuals, but in relationship patterns and national character. It informs political trends and social institutions. Case 09 is exceptionally clear and explicit in formulating trauma on this level.

> So violence has been a huge component and that violence has been of multiple kinds, in different forms. In my understanding, it has created in Guatemalans a syndrome… [A] psychosocial traumatic [syndrome], that is a little how I define it, and what is expressed with this syndrome? Some indicators or symptoms are, for example, 1)—and this is seen in almost all parts of the society—1) is the inability more and more to be able to reason, but rather we resort very quickly to the instinctive question of responding, and the most common instinctive part is violence. There is a car crash in the street and instead of discussing it and reasoning out how it should be, they take out pistols and they kill each other, right? That's to say, the inability for rational exercise is a very powerful indicator in the society today, derived from recurrent, permanent traumatic experiences. Another indicator of the syndrome is how Guatemalans increasingly believe less in institutions of the state. And that has a traumatic effect even more powerful by the fact that we need referents for identity. The human being needs a state, that umbrella that we were talking about before, but to ask any citizen, what state institutions do you believe in? In the Congress? No. In the police? No. In the judicial system? No. It's that there's a fragmented identity—dissociated, we could say. Another indicator of the syndrome—something that before there was much more of—today we have less ability to react collectively and organize ourselves to solve problems together. Today, it's whoever can save themselves. Nowadays, it's everyone looking to save themselves, so it's "While it's not happening to me, it doesn't matter or I'll go in my house with high walls and I'll put up wire there. I'll put in vicious dogs inside," searching for individual solutions instead of social solutions… The violence has taken us for each his own, is individualized in Guatemala. In the capital a lot, there a bunch of *colonias* [neighborhoods] that have put a guard post and walls… Supposedly, that's a solution to the violence and insecurity, but it's not certain. That's false, but it's a tendency of this process of recurring social trauma. And finally, I would say, the other expression of this traumatic process, is the mood state of Guatemalans in general. We're a pretty closed off people, pretty introverted. A people

> with a mood state in some ways depressed, with a fatalistic sense of life. Our future perspectives are all black; all of them are black and in general, we've created a kind of shell, which is like a kind of defensive desensitization. In order not to suffer, we've created a shell; we haven't emotionally attached. We worry less about others, for the pain of others, that is. We're inward focused… It's like we put a salsa group, a salsa music group, and your buddies are there, everyone applauding and the people from Guatemala there watching… In other countries, they dance and enjoy it. No, here we are waiting in expectation; there's a mindset of a lot of fear. So, yes I think that there's very traumatized collective situation that is deepening, right? Because the answers to that situation again are of a social character and they aren't giving these answers… The human being cannot be permanently suffering before reality, we adapt. That desensitizing of ourselves, we adapt, but that adaptation to traumatizing conditions has a cost, and that cost is a cost of dehumanization which is… well marked nowadays in all social areas.

This is a social psychology perspective on trauma that looks well beyond the frame of clinical psychology. Trauma is formulated on a different level of analysis and with a different focus of inquiry. Instead of individuals, it examines communities. In lieu of disorders, it studies social dynamics.

> We have a mix between a strength of psychological attention and political work. There is a very strong link—we would say that is almost political psychology to put it that way—in where these events have had the possibility of being present in people's lives, but they haven't blocked their life, their development of life… To us, we're not so interested in the description of trauma that you have to find in full form [*en puro tubo*], as the possibility, the strength that there is in the family to push through and to recover what can be seen in the trauma. But above all to face it again in life and [address past trauma], and obviously in the dynamic of their community and whatnot.

Psychological intervention hinges on social organization.

> The process of being with them, it has been a process of healing, right? Of linking with the institution, but [moreover] the link between each other, because the strategy and our logic is a process of meeting between the families, no? That's to say, if a family is alone in their village, crying and suffering the trauma… the strategy has been to link them to others [who are facing similar issues]."
>
> The process is that we go to the villages, through the local committees, and there [are families struggling with past trauma in the community]. So we look for them, we link up with them, we carry their case and we offer them strength, let's say, of accompanying

> them [in addressing what happened], which isn't going to be brief… From there, individual attention is given to the family; a moment comes when they feel strong enough to be incorporated into the collective… So that sets them in action; it's a part of a permanent dynamic.

Contrary to some conventional wisdom (or even some clinical sensibilities), Case 09 makes no effort to 'leave the past behind.' An intentional effort is made to end the proverbial haunting by keeping these issues alive in the empowerment of communities.

> Of course, because to forget in this case isn't the therapeutic strategy. Forgetting once and for all doesn't happen. It hasn't happened in 30 years [since the armed conflict]… [What happened] doesn't get put in a box of forgetting. It's better that the work be more conscious and healthy, that pain translated into effort to know [what happened] because it mobilizes in an effort to recuperate the sense of being alive.

Some of the collective effort described in Case 09 involves directly addressing issues related to war trauma and the felt needs of the community. It may also involve experiential workshops and group processes with symbolic and process elements.

> [The therapeutic value of the experiential exercises] could have to do with the capacity to strengthen this concept that I mentioned to you before: returning life to the people, that control of their lives passes because they are moved to talk, because they are moved to cry —which is something that they hadn't done. So fundamentally, in this therapeutic process it moves along directed by strengthening human capability to situate oneself in a better way in front of life despite [what happened]. And as those were collective exercises, they had a very powerful impact on a lot of people.

One of the sensibilities that this formulation holds up as particularly important is the localized power of relationships. It does not presume that trauma recovery depends on imported technologies, even if it recognizes that fractures in communities may need help in negotiating solutions. The foundation of recovery remains the negotiation and re-negotiation of shared values and meaningful exchange.

> Indigenous communities have historically also had the capacity in the midst of these traumatic processes, beyond this concept of resilience, right? Historically in this country, to be able to rebuild oneself and maintain a sense of logic in one's life despite [it all]

This resilience builds on the existing worldview and calls on the historical capacities of a people and a culture to endure and thrive. For example, religion and spirituality has a unique place in Guatemala.

> There are symbolisms with respect to the magical, let's say, the religiousness of the Mayas, that one has to transfer into the magical religiousness of the Catholics and the evangelicals, right? Actually, when we do activities [like experiential workshops], there is always an ecumenical part, that's to say, because that has never been a conflict within the program. Because we are not unified by religion. We are [dealing with what happened in the war]. That's what unites us… So, it seems to me that, with those symbolic differences, it doesn't change a lot. The focus on trauma and on human suffering is the same. It's the same.

The focus on how trauma violates shared meaning redirects the focus of intervention. Not only does it reach for socio-cultural practices like religion for a source of strength, it reaches beyond individualized solutions. Whereas many participants in the sample focus on empowering individuals, case 09 focuses on empowering families and communities. When the parameters of the trauma definition are broad enough to include social dynamics, targeting individuals one by one becomes reductionistic and misguided. This is particularly significant when working with a collectivist culture.

> The origin of trauma is social. From there, we could accomplish nothing by going to offer therapy to people on an individual basis if we don't connect them. Because the people connect; they know that the origin of their trauma is in the social state and that in some way, the solutions and the answers are social, that individually one's seen, yes, but we can't disconnect the wider content because it's where it makes sense in the lives of the people. So… in difference from other efforts that have gone most to the psychological exclusively and haven't lasted at all… we have managed to maintain our efforts because

> that part of attending to the psychological, the human, the mental health or whatever we want to call it, has had a strong link with the felt needs of the community.
>
> I would say that we have had cases [of families involved]—very, just very few—where we have had to make an individualized effort. They have been exceptional. For the rest, it's been a collective effort, but I think that there is our therapeutic interest because if we are successful in helping the families be the protagonists in their lives… in their efforts for recuperation, there wasn't a lot to do [on an individual level].

Here again, the injury that defines trauma in this conceptualization comes through the communicative power of violence. The violence that occurs in the relationship and in the community negates the shared meanings that organize identities, families and communities as validating and valorizing. On a macro-social scale, the trauma of the war communicates the hate and rejection of the political state in committing human rights violations against its people.

> For the family to feel that the State, that their State is indifferent, let's say, to their pain, is one of the things that is always most affecting because apart from them being indifferent, they have many times blocked [the families'] efforts [to address grievances]… In [a prior government administration], this program was attacked in the countryside. There was an intention to destroy our program. So the family comes to feel this. It has been that famous shade or umbrella of what is the state, and its citizens feel protected, right? For the state, veiled by the state—it hasn't happened, and that creates a lot of obstacles. For us, it has been difficult because there is information that if the state, the government, or the army provided information, there would be a lot of cases that we could have resolved, but we have always bumped into that with what we have and the families with that door closed.

Efforts by Case 09 and the associated program in and of themselves represent actions addressing trauma. The commitment aligns with their pain and confers support and solidarity that enacts the same social process of joining and supporting that it facilitates among its families.

> One of the characteristics of this program, because our work for the most part is community-based, the majority of our work doesn't start from people coming to the institution, but rather that we go to the communities… So, the confidence, let's say, in the people, in the families, is born in the beginning in that they came to us in looking for them

> in terms of [their felt needs]. And we're looking for them not because they have trauma, or that is, we don't go towards the trauma, but rather this process of accompaniment… Because of that, the program [has]… a very deep relationship of trust with the people and the communities, because 1) like I mentioned before, we accompany and… 2) because over time, the families have been finding… a reparation of their pain…
>
> That is something very important, the confidence. That we're going to be there independently of however many years it takes… In this country, abandonment has been historical. There are a lot of people that come to offer things. They're there for a little bit of time and they leave, or they come to collect information and never come back with that information. So the concrete and quotidian link with the families is one of the most important resources of the confidence that you mentioned…
>
> The institutions [like family] are what's important; the families as they are passed off to the margins and all, here they are and the therapeutic effort was directed at that also, to strengthen the self, the ego. But it's the self that isn't disconnected from the collective self. So that was giving a lot of strength to the families… [In spite of the fact that their precipitating concerns may never be fully resolved,] it's incredible how the families keep being active parts [of the program] and propose ideas. Or that is, there you have achieved a process of recuperation because whatever has been said, "No, they didn't find anything, and well, I want to be here."

That is the transformation: the redress of trauma. By focusing on the reparation of relationships on a community level, it becomes possible for the pain and isolation that each individual felt in the wake of trauma to recover and reconstitute a life that regains meaning, purpose and direction.

> Because of [what happened in the community], I'd say, there were a lot [of people] that had decided, "I'm not going to be a part of organizations in the community." Now they come back to do so. They are a part of the school committee, or the improvements committee, of the water committee. So we make it a point for the human recuperation from the trauma caused by [what happened]… We've had a reunion and whatnot, but we make it a point to contribute to the civic value, that gives an aggregate value, as a human, right? Now you're not a estranged person, nor marginal, and that has achieved a lot.

Question of Reference:

The point of reference in Case 09 is not merely subjective or objective (thereby connoting a singular perspective), but it is dialogical in recognizing the different experiences and ramifications of social disruption. If one hopes to understand an individual's response to an event, then it becomes incumbent to develop a subjective appreciation of what it means to them in their social context. By the same token, however, the range of perspectives in any social context offers many vantage points for bearing witness to others' suffering. Perhaps unique to this trauma concept, the dialogical quality of social realities depends on the recognition of multiple points of view, both subjective and objective. This is in contrast to a diagnostic assessment which relies on an objective perspective to define the event and its subsequent suffering. It is also in contrast to a strictly subjective perspective in which a narrative presents a unique account of personal meanings. The perspective in Case 09 assumes *a priori* that multiple perspectives are relevant to the experience. By extension, the recovery from or resolution of trauma typically depends on developing shared understandings that restore personal narratives (a subjective sense of meaning) within a common understanding (a relatively objective sensibility —objective in the sense of independent of the individual). This fits within a broader understanding of psychology as a social field. The push towards mental health demands a public stance on fostering healthy conditions for exchange and reciprocity ("political psychology").

Question of Suffering:

Suffering emerges out of the isolation, alienation and loss associated with the violation of human rights and the loss of social bonds. This sense of pain is not indexed according to

psychiatric symptoms or catalogued according to diagnostic criteria. Here, pain remains the acute reality of social terms in which it seems as if meaning cannot be recovered. This is not merely confined to cognitive terms of negative beliefs about the self, the world, or the future. The suffering is experienced as a blockage in human development in which the individual feels unable and/or unwilling to face the implications of social violation. It is rooted in the experience of being disempowered from one's own life and the loss of agency to engage meaningfully in relationships that matter. There is no assumption that it can be neatly encapsulated in terms of a disorder because the pain is understood qualitatively and contextually. This perspective does not understand suffering to be separable from its social reality or as capable of being described as an independent disease entity. Even though it remains deeply socially embedded, the experience of pain that stems from human rights violations has a universal quality because it renders comparable experiences of disempowerment and alienation.

Question of Etiology:

The cause of trauma occurs in the loss or disruption of relational bonds. It occurs when the meaningful framework that upholds an individual's interpersonal world is assaulted and/or damaged. Just as a cup becomes useful because of the space it contains, the shared frameworks of social engagement sustain reservoirs of meaning. In this perspective, trauma occurs when those shared frameworks are broken in some way and the meaning that they held is lost.

Such a loss of meaning may occur through any number of events, for example death, betrayal, or rejection. In particular, this view described war- and community-related traumas and the violation of human rights. In those terms, the nature of the event occurs in principle—

namely the human rights violation—and the mechanism becomes the loss of social bonds. It may be worth noting that a definition of the event in terms of principle (i.e., human rights) provides an objective stance from which to describe the range of consequences for the interpersonal world of the individuals involved. In other words, talking about the event as a human rights violation becomes a summary statement of the trauma. For the individuals who suffer, however, they need not frame their trauma in these terms. The operative causal factor is the meta-communication of the transgressor: 'I negate you. Your humanity is disregarded.' Any sense of reciprocity—any recognition of dignity, value, respect—that the survivor may have known in that shared framework is invalidated. In this perspective, that loss of meaning is the trauma. The event is what signals the invalidation, and the mechanism is the loss of social bonds.

This perspective does not directly articulate a linear causal link between the mechanisms of trauma and any associated sequelae. Associated distress among individuals is understood in terms of the individual's response to the loss of social bonds. Moreover, this understanding of trauma can be understood as simultaneously operating on multiple levels of analysis. It can occur between individuals, within or between families, in or between organizations, or even in or between communities. For example, when the State commits violence against its people, that impacts the shared framework of meaning in which all of its members participate. The narrative and historical assault on these relationships reflects ongoing trauma on a collective level. In this respect, the event is the betrayal of the State in its charter to protect the people. The mechanism is the loss of those social bonds through which people find identity and safety in their affiliation

with the State. In this perspective, the event (and its mechanism) does not simply occur *in* a social context. Rather, the event is defined *in terms of* that social context.

Question of Response:

This trauma concept shifts the basic level of analysis. Whereas PTSD's formulates trauma on the level of the individual, Case 09 formulates trauma on the level of relationships and communities. The consequences can be witnessed on multiple levels of analysis (e.g., individuals, groups, communities), but this concept cannot be condensed simply into the way an individual responds. In understanding the individual, trauma is appreciated in terms of the person's reaction to the loss of social bonds. This response reflects at least three things: their personal experience of their suffering, their attempts to cope (effectively or ineffectively), and the changes in their understanding of their interpersonal world. This perspective does not employ the idea of PTSD and does not seek to explain individuals' presentations in terms of psychiatric sequelae. In this way of thinking, the source of 'what is wrong' turns from an internal locus of injury to look outwardly at the 'damage' in the social environment. The trauma response—what indicates that a trauma has occurred—is not defined in terms of symptoms of grief and alienation, but rather it hinges on the loss of shared meaning and the disruption of social bonds.

Table 2: Comparison of Trauma Concepts

	PTSD (DSM 5)	Case 05	Case 03	Case 09
Question of Reference	The point of reference is primarily objective. Criteria A1 stipulates qualifying events which can be assessed according to independent features. There are some subjective dimensions in interpreting criteria and the reporting of symptoms, but the diagnosis prioritizes objective qualities that seek to minimize subjective appraisal.	There is a combination of both subjective and objective points of reference: Whatever the individual subjectively experiences as extremely distressing may be considered as traumatic, but its impacts are considered in the presumption of brain-based impacts. It does not require the objective assessment of such impacts to consider an event traumatic.	There is a combination of both subjective and objective points of reference: Trauma can be seen objectively as having common features that may be described diagnostically, but nature of trauma's impacts must be understood subjectively as the individual describes his or her intrapsychic experience. There is no assumption that unconscious material could be assessed objectively.	The point of reference for trauma is dialogical and pluralistic. It requires a consideration of how a subjective sense of meaning stands in relation to shared meanings that are agreed upon as independent. It attempts to understand how multiple perspectives relate to one another. It does not assume an objective reference point capable of superseding personal and interpersonal experience.
Question of Suffering	Suffering is understood as the consequence of psychiatric disorders that result in difficulty with cognitive, behavioral and affective regulation. These disorders represent discrete types of maladies that are universal in applicability and based on biomedical formulations of harmful dysfunction.	Suffering is understood in terms of the individual's inability to function or cope with stress. Suffering can—but does not necessarily—indicate a category of disorder, *per se*, but rather it signals the challenges of this particular individual to marshal resources in response.	Suffering is understood in terms of the individual's distress or disorders, but the full extent of suffering involves recognizing the implications of social and historical injuries. Suffering is not merely an individual phenomenon, but a legacy of collective experience.	Suffering is understood is terms of how the individual struggles to make sense of violations of shared meanings. Suffering depends on the individual in context, and recognizing how disempowerment in social relationships engenders traumatic feelings of alienation.
Question of Etiology	Causality is not directly specified as the DSM does not take an etiological position other than stipulating exposure to a "potentially traumatic event". Several theories exist, and much of the supporting research literature focuses on the dysregulation of fear circuitry in which the brain is no longer able to re-establish homeostatic balance. The mechanism is in debate.	Causality is multiply determined. The accumulation of stress from events *in the life of the individual*—or from events in combination—create the conditions of trauma, rather than any singular event or type of event. The mechanism involves the physiological effects on the body. Linear causal claims may be difficult.	Causality is multiply determined. The accumulation of stress from events *in the life of the individual and across social history* create the conditions for trauma. The 'frozen' and unintegrated experiences in life persist in the unconscious and 'that which is unconscious', and the mechanism remains indeterminate. Linear causal claims are not possible.	Causality is attributed to feelings of isolation and alienation. The mechanism involves the loss of relational bonds. The shared framework of meaning is disrupted, and the resulting invalidation makes the relationship feel estranged. This concept does not articulate a direct link between causes/mechanisms and symptomatic suffering.
Question of Response	Trauma response is stipulated in terms of diagnostic criteria. Sufficient symptoms of re-experiencing, avoidance, negative alterations in cognition and mood, and hyperarousal must be present and impairing with adequate duration and proper exclusionary criteria (i.e., not caused by a medical condition or substance use).	Trauma response is best characterized by a loss of energy and resources to cope with stress. This may result in a variety of symptoms or responses, including both characteristics of post-traumatic stress and other psychiatric symptoms. Responses to trauma may be diverse.	Trauma response is multifaceted. The underlying intrapsychic injury is unintegrated, but this may outwardly be expressed in a number of different ways that defy easy categorization. The trauma response is then an amalgam of personal factors and may be highly diverse.	Trauma response is understood in terms of the multi-level consequences that come from disrupted relationships. The concept takes an interpersonal focus instead of an intrapsychic focus. It is equally a 'wound to the mind' as it is also a 'wound to the relationship'. Trauma response may be diverse.

XI. An Integrated Analysis: Perspectives On Context and Development

A thematic analysis of the data (such as Chapter 9) offers a snapshot of important ideas that are common across interviews. A case analysis (such as Chapter 10) illustrates the layers of complexity in individual ideas as they reflect these themes. What remains to be seen is how to integrate the thematic and case analyses. In other words, how do individual participants respond to the common themes and challenges in the field? What concerns do participants have when they think about the work that is being done in Guatemala? Because this work is concerned about the intersections of theory and practice in the treatment of trauma, it says a lot about the movement of ideas when we can understand where individuals are going in their thinking. It provides a window into how their assumptions may be evolving because it implicates what types of issues are most salient.

As we discussed in chapter nine, there are many different challenges facing the professional practice of psychology in Guatemala today—whether in terms of professional organization, theoretical conceptualization, or multiculturalism. If the state of psychology leaves something to be desired, what exactly do participants want to see happen when it comes to psychology's professional response to trauma? What do they believe that young psychologists need to know in order to do good work with survivors in the future? Their answers point to issues that may be going un- or under-addressed, and this reflects assumptions about what is most important for the field to advance. For example, if participants call for more neurobiology, then that might suggest a burgeoning influence of a medical, brain-based model. If participants call for more socio-cultural perspectives, then that might suggest more ecological and

interpersonal influences. This line of questioning suggests currents as to how the field of trauma may be moving in Guatemala—or possibly what is being unduly left behind.

Before looking directly at participants' responses to the question of training, it may also be useful to further contextualize their ideas. In a very literal way, the setting of the interviews tells something of the context. Many of the interviews took place in private offices that were in buildings behind high walls topped with broken glass or razor wire. Some of the interviews took place in gated communities policed by private security guards who monitor car traffic in and out of the neighborhood. This is in fact common in Guatemala City. The norm for security is considerably higher than in developed countries, and many businesses pay for private security equipped with body armor and shotguns. Making observations of armed guards during the course of this research, some of their placements may fit with First World expectations (e.g., government offices, banks, major corporations), but others become surprising (e.g., pharmacies, gas stations, car dealerships) to the point of incredulity (e.g., pastry shops, clothing stores, home renovation supplies). For psychologists, thinking about recovery also means thinking about the threats of on-going trauma.

Participants were also asked about socio-cultural dimensions of violence and how trauma is seen in Guatemalan society. Every psychologist in the study talked about widespread effects of traumatization on a collective level. The most common reaction portrayed a cultural trauma response, which can include a process of desensitization and normalization of violence. Violence can be ongoing and structural. For example, Case 09 provided the most extensive formulation which is described in the next chapter, but several other participants described what they saw as the social impact of massive traumatization.

02: "I can tell you that I see it as symptoms of re-experiencing, hyper vigilance, avoidance —the classics of stress in a person—I see on a collective level. I see it in the symptomatology on the personal level and I see it on the collective level. I see it in the silence. I see it in one of the universities that doesn't talk about domestic violence. And they don't talk about the war. 'The conflict is already over. It's gone.' Sure. It's passed because we signed an [peace] agreement, but we are talking about the most superficial aspect of that. We haven't talk about the histories of the women here… The murder of men, the killing of babies. Of the abortions, the obligatory abortions that an abortion company did. It's to say that the country has a very sad history and nevertheless, it avoids talking about those issues for reconciliation."

03: "[Looking at trauma] is avoided by any means. It's annulled, it's made invisible. It's better not to think about the implications that it brings to be exposed daily to experiences of trauma… We live in fear. We live wrapped in fear because the system wants us to live that way. If they instill fear in us, we can't defend ourselves so all the means of communication [i.e., the newspapers] and all of the experiences [*practicas*] are plagued with situations of horror, of panic, and of fear. So people become accustomed to living in that way, that it's normalized. It's normal that we live that… The norm is that [trauma] happens to you, but you don't see the trauma. You don't see the implications of the events… We live this alexithymia daily as a defense mechanism, or that is it's better not to feel. Why are you going to feel? For what? So alexithymia and dissociation are very impregnated in the Guatemalan identity."

04: "I think [trauma is seen]… more as inevitable, regrettable but something that's interesting is that many people in the country live with trauma. They have PTSD, they have panic attacks, they have anxiety, they have depression, they have addictions provoked [by events]—a product of that as a way to drown their sorrows—but they don't look for help. There are a lot of people who don't look for help, but we're making changes."

06: "Yes, with the violence that exists today it's normal that one is traumatized. It's normal for one to be traumatized. So an acceptance exists…"

07: "Guatemalan society has suffered so much. I think that it has a lot of repercussions in the way we express ourselves, in the way that we are able to say freely what we believe, that we don't want to suffer. The whole political level. I think that the trauma was so big that it keeps silence because whatever we did, it brought an answer of (smack!) and silence. The repercussions were so strong… I think that is regrettable in our society because it's affected a lot. We're a society that doesn't talk and also, I think we're a society—on all levels—they're starting to see, and I think it's a little—what we need… We're waterproof… But waterproof metaphorically… The violence, the historical war that

we lived through. I don't know if waterproof is the word, but it's emotionally waterproof. Like, here nothing happens; it's how we grow up. Not only the ladinos, but the indigenous, too… There's nothing to do [about the prevalence of trauma]."

08: "First of all, we're a society that is still sunk in a culture of silence. So to talk about trauma in public spaces isn't real. One doesn't talk about trauma in social situations, in meetings, in… It's in the newspapers and all of what happened in the 80's, the armed conflict, the guerrillas. We're a culture that doesn't speak out loud about problems. So I think that trauma has been minimized, it's been made invisible. There is, like, a false positivism, I would say, thinking in two or three little nice things life has changed, right? In Guatemala, that happens a lot in the political campaigns. The parties give out food, agricultural things, houses—I don't know. Past [inaudible] politicians those villages aren't seen, aren't visited, and don't figure in. So I think that our society is really accustomed to the exchange that I complain about what happened, they give me something, and I stop complaining. We forget. It's said that we have no historical memory. The problems that Guatemalans have had for the last 80 years have been the same because we don't ever get out of those conditions. I would think that trauma is seen as something that happened, but one has to keep moving forward by your own means. I don't see any state institution concern itself to bring attention to rehabilitating sequelae of trauma, to say nothing of its prevention. Health prevention, still is a theme that is talked about in books we read, but I don't think it's put into action in our country, right? Our state budget for mental health is ridiculous. We are talking about [inaudible] general hospital which are some of biggest in the country, if there's a budgeted clinical psychologist it's a lot. So if I have an appointment with a psychologist, it will be once and if I'm lucky, the next year."

10: "I'm worrying that we're getting accustomed. For example, you see that we read newspapers that they lynched someone. The first lynching and they say, "Oh! Look! How they got that guy!?" Now, you flip past the page because it's just—or it's, we're getting used to it. So, yeah, I can tell you that there's a process of adapting to trauma and that something that traumatizes us has to be something gross. It's that, we've had hurricanes, landslides, ash rained from volcanos. There's poverty; there's bloody murders. They kill who you can't imagine that they'd kill! There are lynchings. They burn [people]. The truth is very difficult… In Guatemala, it's in a way adapting—normalizing all of this. There's a process of normalization, is what I want to say."

Several participants (such as 02, 03 and 08 above) link the current violence and cultural condition to long-standing legacies of overt and structural violence. Socially, it becomes difficult to distinguish and describe collective impacts outside of cultural or historical frames.

09: "Guatemalan society, speaking in general, is a traumatized society. That I think everyone has clear, more than anything because of the fact as a society that historically has developed based on violence, the violence of the conquest in 1524 has been the great instrument, let's say, of social control. And it's molded the psychology—here I'm clear on that, that what's molded the Guatemalan psychology is violence. And it's not just the violence of the armed conflict and nothing else; here we have always had violence. If one reads for example, something about the 297 years that the colony lasted, the colonial kingdom after the conquest was terrible. It's really terrible."

Despite legacies of suffering that shaped social patterns, culture also remained one of the central features of resilience: religion/spirituality and family/social support were each mentioned as a primary source of strength by eight participants. Personal qualities and routines can also be useful.

04: "One can have nothing and keep going and then not need the help of anyone even though one's been through a trauma… I think that one thing that helps a lot in this country is that people are religious, they believe in God. That alone helps a lot. Their personal strengths, that is, 'I can reach it, I'm capable of doing it…' and if you're supporting someone else to give them an example, too, the person can be capable of being resilient because they adapt. The capacity to adapt, too."

05: "Sometimes I use spirituality a lot, like a great strength, and I talk about spirituality. I don't talk about religion. More than anything… and later, I base it on what the person brings because sometimes family is a source… But I don't assume that the family is a resource. It depends on the client, right? But I use a lot. The daily tasks of every day life for the person as a resource and as a source of—well, talking about resources, and as I see that it's maintained the person and it's helped them move forward."

08: "Faith, faith in God. To have a person to fight for: a child, a mother. Love is always directed towards someone external, right?… But, generally, a resource or something that comes out a lot in resilience is, 'Yes, I'm going to do it for my son; I'm going to do it for my little sister. I'm going to do it for my mom, as a reason to fight for someone…' The first is faith. We are a people who maybe aren't very practicing, or if practicing, it's more of an issue of faith in God independently of whatever one's professed religion."

10: "I think that fundamentally support in the community and in the family, support in the primary and secondary social system. Another is definitely one's upbringing because I

> believe that resilience has to do with all the resources—or it's, that capacity to struggle with adversity because it can be that the trauma wasn't the first adversity that [the person] had and from one's life one's developed strengths."

Three participants emphasized a need to look at survival, strength and recovery in broader terms than the concept of resilience. For example:

> 04: "I don't really like the word 'resilient' because even though it deals with a form of coping and at the same time, a form of resolution as it were. I think what a human being does is more profound than just saying 'resilient', right?"

Several participants volunteered comments during their interviews about the practice of psychology in Guatemala that have the potential to color an interpretation of their training prerogatives. (In the interest of maintaining confidentiality, much of this material is left intentionally vague.) All of the participants mentioned having the experience of working with either non-governmental agencies or professional organizations; some members noted that they previously held leadership roles within them. For some participants, these affiliations and mentors in schooling have been both enormously rewarding and supportive. One participant commented,

> I have a lot of people who have opened a lot of doors for me since I was young, since the beginning of my career… My teachers, I think that they have been great presences for me, that they have marked my personal and professional life where they emphasized for me ethics, not to neglect what's moral.

These personal connections form a lineage as mentors shape and influence their students, but as a field, psychology continues to struggle to establish itself in professional terms and to meet its own aspirations. One participant described it this way:

> Perhaps you know a little about the history of psychology in Guatemala because we're lacking a lot. We need to build a lot. Or that is, psychologists in Guatemala, we have a lot of gaps of all kinds… With so many limitations… here, they graduate in pathology and are placed in clinics and they haven't had the experience of psychotherapy themselves… Guatemalans are falling in with pseudo-professionals. I say "pseudo" because in reality they have not carried through the whole process. We haven't carried through… Or that is, it hasn't been said to those graduating from *licenciatura*, 'You have to enter into prolonged training and a supervision of cases.'

Another participant was critical of the current standards of practice.

> There's a lot of bad practices, and I would think that there's a lot of disinformation from the other side about what a psychologist should be. If we take that together that as a culture we don't talk about things, I feel that if our own were more demanding, maybe our union would be less mediocre. Sometimes I'm very critical and it bothers me a lot when, for example, people take things lightly.

There are challenges in advancing professionalization.

> I try to read and educate myself about what I have time for, but I think that I eat and sleep psychology… But the truth is that it's a difficult job. I don't know about how the [level of] organization is where you're from, but here it's very difficult to organize. We are very individualized, so it's frustrating, because the *Colegio* [*de Psicólogos*] exists—well, now it's obligatory, but the association [*Asociación Guatemalteca de Psicología*] is whoever wants to be there. There's very little collective consciousness [of the profession]… I have bumped into a lot of people—not a lot; I don't want to say that, but some of my patients have told me that they have gone to three or four therapists before, and… their experiences haven't met their expectations. Guatemala is very small, so there there aren't secrets. You know who is a member [of the *Colegio de Psicología*] and who isn't; who is a charlatan, who is only interested in the economic part; who [inaudible] ethical process.

It raises important questions about the role of psychologists in the field of mental health and society at large. How does a profession face up to a societal challenge? How does one balance the desire to answer a calling while making a living? What is the proper place for psychology in addressing trauma? These are not easy questions to answer, but several participants spontaneously reflected on these issues:

> Sometimes the role of the psychologist is difficult in our context. Sometimes we can't follow up like we want because the same people are not interested in you following up with them. So sometimes the role of the psychologist is that occasionally we have to wait for the person to come back to ask for our help—because one looks for them and tries to get close, looking for the person to resume the process. One tells them it would be good that you resume, that you finish—but many times one can't do more.
>
> And to see the suffering—and that really our tools and resources as psychologists, we can't [stop the causes of suffering]. We can do [something], knowing that it is for this moment, for the next hour. And nothing more. Nothing more.
>
> Look, I'm really accustomed to working in a poor country because it's not just the clients. Here, the country is poor, and I'm accustomed to working with a very rich elite. Very rich. So, I'm very accustomed to those contrasts. So what I do is that I have a range of prices in which they pay me more; they pay for those who pay less. Without knowing it, right? And so it evens out because I also want to feel ok because I live from this and I can't do it for free… I think that's a good model for my clients of how to struggle with needs, right? Of how to struggle to be resilient in a poor country because psychology in Guatemala is very poorly paid. Very poorly paid. We earn very little and on the other hand, if we're not [working for low fees], there's no income. And the University pays dreadfully, or that is, the classes pay dreadfully. It's not a profession that is—you have to give a lot and get little. So there's a clear empathy with the people because you know perfectly what they're going through.

Not surprisingly, the demands of this situation spur different ideas and different reactions. Social unrest has disrupted standards and traditions—whether dislodging psychoanalysis in therapy or disturbing traditional healing practices. The social crisis created by the *conflicto armado* has not only impacted the experience of trauma, but also notions of healing, as these participants describe:

> In some way, the war—the war permitted that they came in with all these proposals, that EMDR came in, that energy psychotherapy came in, that AIT [introduced by Asha Clinton] came in… That exposure therapy came in, that I believe more of the cognitive-behaviorists use—because the psychotherapy or the energy psychotherapies almost never use that.

> So imagine, it's like an opening because there are a lot of therapists that are training in AIT and it's totally out of the ordinary… It has very fast results in very little time—very little time… They aren't like painful abreactions… It's like a very fast process of connection and recuperation… but's like very gentle, very supportive [*acompañadora*] so the person doesn't necessarily feel confronted with too many things… This is a magical people, as well… This 'taps therapy' and EFT—which stands for Energy Freedom Technique—are more popular, but also many psychologists are looking to train themselves in it here in Guatemala… So I'm talking about basically what is influencing a lot of therapists in Guatemala… I use it… Sometimes I use [these tools] with patients including those that have come with a psychotic diagnosis from the United States, and that in reality have bipolar disorder. And they use their medication but I give them therapies that are for them, that they can self-regulate and really it works for them.

The cultural issues are also inescapable. After characterizing an approach to therapy, one participant noted,

> As you are doing work with Guatemalans, one thing that is important that you don't lose sight of is that we are a multicultural country and that the diversity there is per square meter is significant. So I think that it's important that what I can tell you about my experience can be very different than what [other therapists would tell you]."

With such diversity, the context of historical oppression and inequality are equally salient. A participant described an experience of teaching about indigenous healing practices and encountering student biases.

> And at some point, someone questioned that, saying, "What are the Indians going to know about mental health?" Because we're also a racist society. "How is that going to come into the academy, this academy of Freud or the greatest thinkers?" So our academia is very backward, and I think that this country needs psychologists… Sometimes, I say to some of [my students], "Go for yourself out to the countryside and see how many psychologists there are in the villages. There isn't a one, and see how they take care of their mental health problems!" Of course they attend to them! Yes, that's part of life. It's part of our dynamic human composition and subjectivity as they call it. Of course they take care of [their mental health]! Why not? In a richness like ours, with 22 different ethnic groups, with ancestral cultures and all, why not go deeper in that? And saying, "This could work for me and this couldn't work for me."

All in all, the question of training must be understood to speak to the professional crossroads of contemporary Guatemala. Hardship and trauma may be widespread, but it is not entirely clear what should be done or who should do it. Cultural issues are fundamental, but it is not entirely clear how to accommodate and respect these differences. The question of training and development speaks to the identified needs of psychology as a reflection of basic assumptions about what trauma entails. Faced with the challenge of the moment, different concepts will look to respond in different ways.

The interview prompted participants about what clinicians need to learn in order to do good therapy with trauma survivors. None of the participants advocated for closer adherence to manualized treatments or specific treatment orientations. Only a few were even mentioned by name. The trend was towards greater clinical integration, not greater fidelity to a model. Notably, none of the participants commented about or insisted on producing research as part of this process. In the broadest terms, their comments reflected concerns about clinical practice, multi-faceted perspectives (e.g., theory and formulation), and professional growth.

Clinical practice reflected some concern for clinical skills, such as techniques for containment or symptom management.

> 02: I believe that they have to learn how to identify a lot of how it shows up in a person who has been through a trauma. How it looks… I believe that it's hard to see the symptomatology… How it is that they see it, where they see the discomfort. I believe that's hard.

> 05: I think that before anything, it's to clarify the concepts of trauma that they have. It's like learning better what it is that's happening there. And after that, as I see it, with the psychologists that I've worked with and who I've taught… I see a great hunger for finding resources that will allow them to address the different needs of the person, right? So it's the information—good information—and it's also the use of resources [practica de

> recursos], such as including resources for relaxation, breathing, energy resources, kinesiology—which is impacting a bunch of therapies now.

Much more common in terms of clinical practice, however, was an emphasis on theory and case formulation. In particular, the power and importance of ecological perspectives and social psychology became a familiar refrain.

> 10: [New psychologists in training] only want techniques. They only want to know, 'how to do this'. They don't have a deep [understanding of] theory… I'm more hoping that they study more, that the can do a more integrative analysis of the data.

> 06: Oh, well, first good clinical and social training… I think that all of psychology is psychosocial even though I work individually and I have clinical concepts… So, good clinical training means understanding the other variables that influence the person like the economy, sociology, history, violence and all the other things that clinicians don't take into account much… It's not only the mind. There are external things that affect us like family, day-to-day work… So [inaudible] that training has to be important in our surroundings, in our environments—information about history, the history we've lived, right? Because we're born Guatemalans, different from Mexicans, or Salvadorans…

This includes multi-faceted perspectives stressing the importance of historical factors, cultural sensitivity, and interdisciplinary perspectives.

> 01: For example, my students, I teach them this perspective. That's to say, it's doing a sensitive therapy. Culturally sensitive. I do a sensitive therapy in general, sensitive to differences. Many of my students haven't had contact with poverty. In this country, people are hungry! This country, if you go around in a van, they can assault you! One suffers anxiety! One has post-traumatic stress from the situation. They are heroes to be able to adapt under these circumstances.

> 03: I believe that the most important thing is to activate historical memory… That they know their history; the historical memory so that they know what this country has lived through, that they know the mistakes that we have lived with… If you understand where you come from, the rest is going to come to make sense.

> 07: Anthropology is vital. For me, the courses I took in anthropology, they fascinated me. Maybe because I am focusing more on the work that I have done outside of private practice. That's another culture, it's another thing that for me, it's very important… I

> think that that makes it so that's certainly important, opening me up to how each person is without losing the objective of therapy, right? In that way, I think that also—we had community psychology that I also loved because it's work outside of the practice… I think that cognitive psychology—well, all of it, logotherapy, for example, for trauma, to me is very important… But I said that in the end, the work with trauma is going to be the same—to be able to come back and integrate everything about the event into the whole person. And probably even though the way is different, the base is the same.

In part, the demand for ecological perspectives comes in response to what many participants feel is missing. Judging from participants' critiques, the indifference and/or insensitivity to socio-cultural factors appears to be common both among the public and within mental health.

> 06: I also have patients, people with a lot of money like those that were kidnapped and all, and they complain that they don't have to give anything to other people—but that [disadvantaged people] have to learn to fish… The thing is to see if there are fish in the river! [inaudible] What are they going to fish for if there aren't fish?! So I feel that, yes, one has to have an understanding of the social in order to understand the emotional suffering or the psychology of the person. It's not just the super-ego, right?

> 09: [Guatemala needs] human resources or psychologists who can respond better to a reality that is extremely rich, to work with it, but just extremely rich. But we're not prepared for that. So on one side it seems that it's a limitation for the students, and if there were better content in the anthropological training—because prejudice sometimes doesn't allow us to understand a range of virtues that there can be in this whole way of understanding and facing life.

For many of the participants, if their comments did not speak directly to the complexity of learning to do the work, they continued to hint at the challenges of dealing with some many issues. Criticisms of the field often pointed at both the hubris and the indifference that could sometimes appear in over-confidence. The need for humility was another training element, which included a willingness to acknowledge and explore one's limitations.

04: I believe humility before knowledge because I see that now there isn't that humility in knowing. You have a pair of courses and you think that you know it all… or you graduate and you don't think you need to keep developing yourself… I think that everyone has to focus on themselves to be a therapist. So one goes about focusing, one goes about polishing his or her development in keeping with what one can and what one wants to dedicate him- or herself to. Because one can't be a know-it-all [todólogo]. You can't do everything… So I think that is one thing that's important: [knowing] where I want to focus myself… and what I don't know. I have to refer to someone who knows.

08: I think that the training of the therapist is vital. In one measure, we're lacking specialization on the master's level… We need as psychologists to do a little of everything. To run groups, to do couples work, to do family work, adolescents, to work with adults. The universities have made us think that when we graduate licenciatura that we can work with everything, from different populations to different pathologies… So, I feel that sometimes we have done interventions with good intentions but negating basic principles because we don't know them… I think that to me has allowed me to put limits and sometimes including to say no to situations where I'd like to work, by recognizing that I'm not competent for that. That's like a blow to the ego, knowing that I have no idea how to do something… I think that as a reality of this country, we have to take on different challenges in mental health… I've learned to refer and I've learned to know up to what point, and to talk to the patient and be able to orient them with someone who can work through the process. But I think that it's working the professional ego, and it's better to do less but do it well.

09: I think that the challenge, let's say, in terms of training and improving of human resources is one of the greatest challenges of psychology for this country, which it's not assuming [the challenge], right?… Because I feel that our universities as training institutions for human resources are in a purely academic world between four walls and they aren't linked to a reality where there's so much they could give and they could learn.

06: I have a psychodynamic clinical orientation, but with time one starts to use different approaches. Different approaches and ways of approaching problems that can be integrated in a useful and creative way. That is, 'it's more that way and there isn't another way'—that's not so! One has to break away from that [way of thinking]. The circumstances, the environment requires a lot of things and it's what one has to work with. I think that in the training of psychologists is important to know that and I believe that also it come from experience and time. It can be scary to do things, and now with time one has less fear about trying something new and seeing how it works even though it's common sense that tells you that it's something important.

The criticism and redirection of the field—at least for many participants—comes back to basic priorities.

> 09: In the end, the point of this profession is the people, whatever it is. It's the people. If the people don't go, they don't go. If the people don't want it, they don't want it. If the people don't understand, they don't understand. And here in Guatemala, that principle is very impoverished, or that is, the academy still doesn't enter into that.

And so we return to the question of how do these psychologists attempt to understand trauma in ways that help them enter into the suffering of the people they serve.

XII. Discussion

I. Reviewing and Understanding the Results

This study produced a variety of ideas that show complexity and nuance in thinking about psychological trauma. Participants in this study serve ethnically and culturally diverse populations from across socio-economic classes, and these psychologists approach them with different ideas about the nature of their work. While all of the participants professionally recognized and described what they saw as trauma, they differed in terms of what they identified as traumatic. They put forward ideas with important similarities and differences about central characteristics and the scope of what is included. For example, cases 05 and 03 both frame trauma largely as intrapsychic, but the former sees it more as a brain-based phenomenon, while the latter is concerned with experiences that become lodged in the unconscious. Different still, case 09 understands trauma as interpersonal by definition. The data generally does not support any consistent or universal set of assumptions about trauma, and so in that regard, we cannot speak of a "Guatemalan model" even if we can identify similarities.

When discussing trauma, participants generally commented on the three areas of intense/ chronic adversity, dysfunction/impairment, and subjective distress. The re-experiencing of memories, unformulated distress, hyper-arousal, and an existential loss of meaning/connection constituted the primary elements of trauma concepts. The sample also sought to understand events from different points of view. While the sample generally agreed that the impact of traumatic events is much broader than simply what happens to individuals, they differed in how they understand these impacts. All of them felt that context was important. Some described the normalization of trauma symptomatology across a population, while others described macro-

social changes as a result of collective traumatization. The sample tended to base clinical considerations on idiographic case formulations and ecological perspectives rather than diagnoses or a medical model. The role for psychologists in promoting health and recovery—in individuals and society—remained a point of divergence. Notably, many participants reflected a mixed view that included a need to address issues of context and environment even in individual treatments. Overall when it comes to issues of treatment, the sample appears focused on general factors such as establishing relationships, empowering clients, and promoting healthy coping resources—all of which are consistent with mainstream occidental approaches.

Many of these ideas about trauma can be consistent or complementary with the DSM formulation, albeit sometimes in older editions (e.g., Case 01: "the majority of people would be terrified" corresponds to the DSM-III original formulation). Some of the trauma characteristics that participants offered—such as appetite disturbance or somatic symptoms—are more consistent with the textual explication of "Associated Features" (APA, 2013). In some cases, practitioners seem to use clinical judgment in applying the PTSD diagnosis in ways that are consistent with the DSM's guidance about working cross culturally. This involves the judicious assessment of symptoms, accounting for cultural variations, etc., as part of recognizing the disorder category.

In other cases, it seems like practitioners take complicated (if not contradictory) stances towards the PTSD construct—using it, finding it limited, drawing on other ideas, or discarding it entirely. Various features go beyond the PTSD diagnosis, such as interpreting symptoms as a result of feeling traumatically alone (case 06). Rare examples (case 09) decline to use the concept. The sample also reveals similar ambivalence for the concept in the practice of therapy.

Many practices are consistent with techniques in empirically established treatments, including those for complex trauma. Examples might include a range of interventions from grounding techniques to working through stages of recovery. At the same time—and even setting aside the obvious differences of non-traditional or alternative therapies—some practices reported in this study are not conceived for or intended to address the basic etiological premises of the diagnosis. In case 06, the use of groups, for example, aims to foster connectedness without any explicit focus on de-conditioning memories or examining cognitive appraisals of threat.

From this study, there is clear evidence that some psychologists in Guatemala find the concept of PTSD useful and informative as it organizes important dimensions of their work. For many of them, it guides their thinking and influences their treatment. At the same time, however, many participants also clearly draw on influences and ideas that run counter to basic assumptions contained in the concept. For example, the emphasis on relationships and spirituality are not included in the diagnostic construct. This study did not provide any evidence to suggest that the concept of PTSD can suffice in describing what participants understand about trauma. Perhaps this is not surprising, given that the same is true for occidental mental health. Again, trauma and PTSD are not synonymous even in mainstream psychiatry. As the review in the first half of this work shows, the field offers many different ways to understand trauma. Nevertheless, many of the influences exhibited by these participants are outside of the mainstream of Western-based approaches. Based on the evidence presented in this study, there is good reason to argue that psychologists in Guatemala are exploring alternative frameworks for understanding trauma that are based on cultural considerations.

The psychologists interviewed in this study appear to encounter limitations in established concepts. For the most part, these psychologists do not appear to be abandoning or ignoring mainstream constructs like PTSD, but neither do they appear to be limiting themselves to its parameters. In order to respond to their populations, these psychologists appear to be revising not only traditional clinical practice, but the concepts themselves. In other words, the scientific merit of a western psychiatric concept like PTSD does not necessarily and universally guarantee its value will be the same across all settings and contexts. The assumptions that inform the PTSD construct may seem difficult to assimilate into the worldviews these psychologists encounter. Also, it may not reflect their own culturally informed beliefs. Perhaps it may best summarize the data to suggest that these psychologists are brokering understandings of trauma in the borderlands between different cultures, traditions, perspectives, and disciplines.

The full range of this complexity is not well represented merely by looking at the data thematically. A cross section of the interviews reveals many nonspecific factors like unconditional positive regard. It also presents recurrent themes such as social instability, inequality, a lack of access to services, the prevalence of violence, and the importance of spirituality. While these stand out as important factors, a focal analysis of cases is required to illustrate the unique ways that these factors are woven into participants' perspectives. For example, while virtually all of the participants emphasized the importance of being aware of socio-cultural dimensions, there are significant conceptual differences between a psychiatric review of biopsychosocial factors—as variables in the case of an individual—and a social psychologist's view of co-constructed experiences—as the foundation of interpersonal meaning.

Both views cluster around a theme of social factors, but their foci and structure offer different ways of understanding trauma.

In this work, I argue that the task of organizing a narrative of suffering invokes four core conceptual questions: the questions of reference, suffering, etiology and response. The question of reference considers what is the appropriate vantage point? Should we take an objective point of view so as to avoid the overwhelming subjective experience, or do we lose something vital in the process? Do we need some combination of both, or should our understanding be dialogical? The question of etiology organizes the narrative of what has happened: what defines the event (as a matter of what is salient about what happened) and what is the mechanism that caused it to have the effects that it did? The remaining questions look at consequences. The question of suffering asks, "What does it mean (for the mind/soul/ relationship, etc.) to be wounded?" whereas the question of response asks, "What type of wound is this?" In the case of the former, it speaks to our broader understanding of humanity and existence, whereas the latter distinguishes what makes traumatic suffering unique from other types of suffering.

It is important to also remember that these concepts are interlocking. While none of these questions should be considered as intrinsically more important that the others, they each shape and influence the possibilities for answering one another. Coherent, valid concepts must arrive at a balance in organizing assumptions, and this requires a consideration of both values and information. The result is that trauma concepts grow and evolve through a multifaceted process of assimilating and accommodating new perspectives and information against pre-existing assumptions.

I suggest that the evolution of trauma concepts can be traced through the shifting answers to the core questions. The discourse that traces its roots from railway spine through shellshock and hysteria reflects a muddle combination of theoretical assumptions and imperfect investigations. As science and its tools have improved, new vantages have opened up, but the themes and trends of history tell recurring stories: explanatory models based on exogenous and endogenous factors, biology and psychology, the intra- and inter-personal factors. The various historical concepts attempted to reconcile core assumptions around the ideas and evidence of the times. I believe the framework of core questions can also provide a means of analyzing and organizing the various criticism of PTSD and traumatology. Whereas

constructive criticism supports the general integrity of PTSD's assumptions in order to improve the diagnosis, the paradigmatic criticism rejects core assumptions in favor of reformulating our basic understanding of trauma. These various approaches strive for different things in their understanding of trauma. The test of any concept lies in its ability to reconcile its various core assumptions with each other and within a broader worldview.

As the research in this study shows, a framework of core questions provides a viable means of understanding and differentiating trauma concepts in a sample of Guatemalan psychologists. It complements and deepens our understanding of their work above and beyond a thematic comparison of their ideas. It enables us to distinguish unique features in their thinking, and it creates an opportunity to study cross-cultural differences in greater depth. Also, as we will discuss below, it allows us to recognize when trauma concepts are more or less congruent with broader cultural assumptions.

II. Cross-Cultural Perspectives and Integrating Science

Cross-cultural exchanges can seem tangled and complex, forcing many questions about theory and practice. In this work, I have argued for the importance of valuing different assumptions in trauma concepts. I strongly argue that conceptual pluralism is the foundation for good cross-cultural practice. Nevertheless, this does not invite any and all things to claim the mantle of science. Many participants talked about their use of energy therapies (or "power therapies" as they are sometimes called, which include things like Emotional Freedom Technique (EFT), Thought Field Therapy (TFT), Tapas Accupressure Technique (TAT), etc.). Reviews of the literature have identified these practices as empirically unfounded with characteristics of pseudoscience (Devilly, 2005; McNally, 2001). Only EMDR—which has neurology-based hypotheses but is often included as a "power therapy"—has been extensively subjected to empirical study and has good support for its efficacy. Explanations of its mechanisms still remain controversial (McNally, 2001).

An important anthropological point to recognize is that the energy therapies cited here are not formulated in terms of indigenous Mayan practices. They may have some overlap and similarity, but these "treatments" are also etic explanations that originate in North American alternative healing ideas. As it seems in Guatemala, alternative approaches have an appeal. Half of the sample described use of alternative models, and several mentioned the growing popularity of these ideas. If massive contemporary trauma, neoliberalism, and 21st Century technology have upset the traditional social order, the new normal may invite taking up outside influences that reformulate old ideas. The trappings and language of a scientific modern world may compel a certain legitimacy, even when the empirical questions remain unsettled. For some people, they may not be familiar with the research. For others, the empirical *bona fides* may seem less important when they experience meaningful results.

The popularity of energy therapies may represent yet another syncretic attempt at reconciling beliefs, this time blending magical spiritualism with the socio-political authority of Western science in the liminal spaces between Maya, *ladino*, and U.S. American culture. In Guatemala, there is a long history of survival in which the oppressed adopt the practices of the dominant group but imbue them with different layers of meaning. For example, Nobel prize winner and Maya activist Rigoberta Menchú (1984) writes about the place of Catholicism among the Maya:

> By accepting the Catholic religion, we didn't accept a condition, or abandon our culture. It was more like another way of expressing ourselves. If everyone believes in this medium, it's just another medium of expression… For instance, the Bible tells us that there were kings who beat Christ. We drew a parallel with our king, Tecún Umán, who was defeated and persecuted by the Spaniards, and we take that as our own reality. In this way we adjusted to the Catholic religion and our duties as Christians, and made it part of our culture. As I said, it's just another way of expressing ourselves. It's not the only,

> immutable way of keeping our ancestors' intermediaries alive… We just have to memorize the prayers they tell us to use and add them to our own. (80)

In this example, the authority of the Catholic church did not change the fundamental beliefs and assumptions of her people, but rather they draped themselves in its practices as a way of maintaining their worldview in a rapidly changing world. As new syncretic practices, energy psychologies may continue to speak to the underlying assumptions about trauma and recovery, but do so with the airs of occidental behavioral science. Whereas the staunch positivism of psychiatric science may disavow the more mystical qualities of religion and spirituality, these alternative therapies may claim the imprimatur of science while still inviting old articles of faith. Historical notions of trauma and recovery may be reimagined in the mix of cultures, but many of the core assumptions may remain the same. To paraphrase an expression, it may be old magic in new bottles.

There is nothing about cultural sensitivity that should expect for pseudoscience to be defended as empirically legitimate. Bad science is still bad science, regardless of whose ideas it champions. But cultural sensitivity does require that we listen for the ways that science and faith come together as part of a worldview. Nothing in this work should be construed to suggest that these alternative therapies have (or should have) scientific standing on par with mainstream psychiatry. Instead, several points deserve to be made: The first point is to realize that science makes its own assumptions as part of establishing its methods of investigation, which in the practice of its epistemology amounts to its own set of beliefs. By virtue of its critical and self-reflexive examination, science makes unique contributions to our understanding of the world, but these do not legitimate the presumptive superiority of its assumptions.

The second point is to realize that the beliefs of science are interwoven and largely inextricable from the broader, cultural beliefs about the world. Science and faith go hand in hand, even as each gives a different perspective on the world. The third point requires recognizing that when awful events happen, they typically dislodge and disrupt the lived experience of being-in-the-world, and as such, the concepts which guide our understanding of trauma and recovery are themselves part of restoring and re-establishing a worldview. In a complex cultural practice like therapy, we have to recognize the potential for differences to invoke new ideas and support new practices. Equally, we need to find ways to talk about cultural practices without succumbing to the false claims of pseudoscience.

As we discussed in Chapter Six, some types of trauma concepts are more amenable to scientific study than others. For example, one of the common criticisms of psychodynamic therapies is that their abiding theoretical framework is not reducible empirical analysis of component features. Psychosexual energy does not establish a clear unit of analysis for measuring sexual energy in any form. Object-relations theory does not provide a specific way to operationalize an introject. Narratives in the relational school do not readily lend themselves to being assessed quantitatively. We might empirically observe a process of change—noting changes in mood or patterns of behavior, for example, that follow from psychodynamic therapy—and thereby empirically establish the efficacy of a process, but the theory itself is an extrapolation that does not lend itself to closer scientific analysis. Contemporary thinking moved away from Freud's notion of psychosexual energy not because we were unable to find a biomarker for sexual energy, but because the framework elaborating concepts began to shift. Theoretical frameworks and their concepts always have an interpretive, assumptive element.

These theories can never be empirical or scientific in the same ways that neuropsychology, for example, might be because they employ different types of ontologies to map psychosocial and physical realities.

In terms of trauma concepts, psychodynamic perspectives (e.g., Boulanger, 2007; Schottenbauer, Glass, Arnkoff and Gray, 2008; Stolorow, 2007) offer different ways of thinking about what might be the collapse of self-concept and relational disruption—all of which can be very useful for understanding the survivor's lived phenomenology. But the process of investigating, for example, the ways in which restored ego functioning allows for greater mentalization after a complex trauma, is not the same as investigating the ways that coritsol corrodes the HPA axis. The direct observation of material conditions allows for a fine-grained scientific study of mechanism and its processes. The broad study of patterns allows for only a more general consideration of science because the unit of analysis is itself a complex theoretical construct. Both can be useful, depending on the other types of epistemological assumptions one choses to make. Some schools of thought in psychology—the radical behaviorism of B.F. Skinner, for example—disavowed the latter entirely, rejecting even common concepts like personality because they felt that any departure from the unit of scientific analysis was a misrepresentation of the process of inquiry. But this only reflects one possible set of beliefs about the role of science in psychology. In the case of the energy therapies, they make a variety of assumptions about the nature of existence and the human mind/soul which are not readily observable, and as a result are not conducive to a particular method of inquiry.

Part of what is so significant about the creation of PTSD is that it provides a unit of analysis that enables us to more closely explore facets of trauma in empirical ways. Complex

PTSD, for example, is in many ways a broader concept which poses different challenges in terms of defining the event and operationalizing elements for component analysis. It remains a useful frame for empirical study, but the parameters are different than those sketched by PTSD. Perhaps not unlike psychodynamic theory, the energy psychologies are not amenable to a fine-grained scientific study or a component analysis. They are largely based on Chinese meridians which purport to describe channels of energy in the body (Devilly, 2005). The basic unit of analysis and active mechanisms are unclear. Until these theories elaborate on presumptive physical mechanisms and material features, their scientific study—in keeping with a method of inquiry—is limited to correlating outcomes, which may or may not have a basis in the theory they propose. In general, theory serves to select for and guide the integration of information. To look at three example—neuropsychology, psychodynamic theory, and energy therapies—all make different organizing assumptions—some of which hew more closely to an empirical scientific process than others. Whatever theoretical architecture we chose to inhabit is partly a reflection of the organizing assumptions we make about what it means to know reality.

Some research in this area tries to add heft to empirical claims by looking at hallmarks of medical science. For example in a California-based study, Church, Yount and Brooks (2012) looked at changes in both cortisol levels and symptoms of psychological distress after a 45-minute session of Emotional Freedom Technique (EFT). Control arms of the study included supportive interviews and a non-treatment group. Results showed a significant decrease for the EFT group in both psychological symptoms of distress and cortisol levels when compared to the other conditions. Of the many possible issues in research methodology here, we might pause to focus on the implications of a physiological measure. To put it simply, the use of a biomarker

from medical science does not substantiate the theory. It may suggest a correlation that can be used to raise interesting questions, but it does not establish causality and it certainly does not root the data in a metapsychology of indeterminate forces. Biological variables do not prove the validity of social ontologies. This same basic rhetorical rebuttal was used in Chapter four to temper claims about the universalist, categorical assumptions of the medical model.

Again, there is not a strong scientific basis for incorporating energy psychotherapies into clinical practice, but there may be a basis in faith and spirituality. The use of these practices is not driven by science, but it may be culturally syntonic in legitimating ways. Ethical principles of multiculturalism demand that we respect the power of spirituality in the context of individual cases and cultures. For mainstream occidental mental health, the use of energy therapies is disreputable, but not all cultures value a fine-grained positivism in the same ways that mainstream occidental medicine does. They do not all share psychiatry's faith that empiricism will provide answers that can cure what ails them. Mental health is not the same as physical health because while the material conditions of the body lend themselves in a particular way to objective science, teasing out the layers of meaning braided through different worldviews requires different sensibilities and sensitivities. Introducing elements into clinical practice on false pretenses, such as pseudoscience, is unethical. Introducing spiritually resonant practices may be culturally appropriate in certain situations. Introducing scientific techniques may also be appropriate, provided we understand how the assumptions of science meet the assumptions of faith.

While these issues may seem far afield from mainstream of mental health, the field is already dealing with these issues in the treatment of torture and refugees.

> Talk therapy is not the only form of treatment that has proved useful. Some survivors use traditional medicines such as natural remedies prepared by 'folk' healers. Other favor techniques such as body work, massage, aroma and sound therapy, special breathing and relaxation exercises, or the ancient spiritual tradition of shamanism. (Gerrity, et. al., 2001, pp. 29)

III. Hypotheses On Cross Cultural Practices

This type of cross-cultural work is inevitably very complicated if it is to avoid bias. How do we make sense out of the great array of ideas in this sample? This first half of this work provides a framework for navigating different assumptions in various concepts, but is there also a way to investigate the factors that shape these differences? Many of the clinicians in this study show divergence from mainstream models of treatment, and one way to understand this is to see them as the development of adaptations. The exploratory, qualitative nature of this study provides a basis for generating hypotheses about some of the many factors that influence this adaptive process.

One idea to keep in mind at this point is the important difference between the conceptualization of an idea and the actualization of its operation. A theory of trauma may offer insightful descriptions of traumatic sequelae without any preordained conclusions about how to respond. By way of analogy, we can say that cake consists of milk, eggs, flour and butter (among other things), but that may not tell us much about baking. In psychology, if we recognize intrusive thoughts as symptomatic of trauma, this does not tell us what to do. Should we challenge them cognitively? Should we mindfully accept them? Should we interpret them as unconscious communications? Responding in treatment extends the concept of trauma into our

assumptions about practice. The practice of a theory constitutes a creative act that requires thoughtful engagement.

In fact, the actualization of treatment interventions may be one of the great sources of evolution in trauma concepts. For example, EMDR and prolonged exposure are both treatments that are predicated on PTSD but offer different hypotheses, particularly in terms of traumatic mechanisms. Research into active components of each treatment can invite re-considerations of how we define trauma. Moreover, one treatment can have multiple impacts on diverse things. Again, in the case of prolonged exposure, the model assumes that the therapy "works" on many different features of the disorder simultaneously (Brewin and Holmes, 2003). Perhaps the most important point to consider here is that moving from a concept to an actualized practice is itself a complex creative act, involving assumptions and inspirations. There is no reason to assume that either of these processes—either conceptualization or actualization—are not influenced by contextual factors including both socio-cultural and idiosyncratic dimensions.

III(a). Conceptual Maps and Models

I propose a hypothesis for navigating the complexity of conceptualization and actualization in clinical practice. This proposal builds on the work of Williams and Healy (2001) who distinguished between an "explanatory model" and an "explanatory map". Their work, which focused on understanding patients' beliefs about depression in the United Kingdom, found that many people concurrently held a range of ideas to explain what was wrong. Rather than finding that participants held discrete, stable explanations, their ideas about depression shifted. The authors argue "that the concept of 'explanatory model' is too fixed to fully convey the fluid status of beliefs among this patient group. The concept of an 'explanatory map' is suggested as a

replacement" (Williams and Healy, 2001). Essentially, they suggest that their patient group understands depression through a "map of possibilities" (Williams and Healy, 2001).

Based on the data in my interview sample, I suggest that most of the participants can best be described as using "explanatory maps" to understand trauma. While much of the research literature reflects the use of explanatory models, it may be the case that clinicians tend to use explanatory maps in order to respond flexibly to the people they serve. In this study, it appears that their concepts of trauma are not always simple, singular or clear. They appear to use many different ideas and shift back and forth in their core assumptions as they respond idiographically to different concerns.

I see my use of the terms "maps" and "models" as consistent with those proposed by Williams and Healy (2001), but it may beneficial to further clarify my use of these terms. Both represent metaphors that provide useful insight into the way that complex issues are understood. As I am proposing, a "model" provides a stable set of assumptions which is coherent and explicitly stated. Models operationalize variables that can be proverbially engineered to fit together not unlike parts of a machine. Models inherently value consistency, coherence, stability, verifiability, and parsimony as they generate propositions that can be clearly identified and tested. A "map," on the other hand, admits a range of assumptions to create a veritable landscape of ideas. It may involve different "avenues of thought" (Williams and Healy, 2001) featuring different combinations of assumptions. It creates space for internal contradictions and discrepancies as it values complexity, nuance, utility, flexibility and sensitivity. A map generates narrative threads that integrate multiple points of view.

The use of maps versus models may reflect the needs and priorities of different tasks. Academic inquiry constructs theoretical models as basic building blocks of empirical work that make it possible to test propositions, measure change, and replicate findings. Maps, however, may allow clinicians to move between models, reflecting the value of taking different perspectives when working with survivors. In thinking about their training, many clinicians will recognize a "tool belt" sensibility in which learning about different models invites 'putting more tools on the belt,' all of which can be flexibly applied. A map proverbially sketches out the clinical judgment that goes into the selective application of different 'tools'. Maps may be pragmatic for making sense of experience and formulating a case to accommodate different points of view. They may allow clinicians to remain oriented as they enter another person's phenomenology.

The sample of psychologists in this study appear to predominantly use maps to guide treatment as opposed to following the protocols of specific treatment models. In some cases, however (case 09, for example), they appear to be developing new or distinct models. In this study, thinking about the data in terms of participants' use of trauma "maps" can account for not only the continued use of the PTSD concept, but also the shifting complexity that draws on non-traditional ideas. A distinction between maps and models also provides a framework for understanding how to traffic back and forth between different assumptions, such as those that separate cultures or psychological concepts. Future studies of this idea would expect to find models in research that work with basic assumptions that are explicit, stable and falsifiable. Studies of maps and clinical perspectives would expect to find them as more ambiguous, nuanced, and interpretive.

Some ethnographic research already presents similar results in which fundamentally different ideas co-exist when cultures overlap. Joshua Breslau (2000) writes about the consequences of the Kobe earthquake in 1995 as a seminal moment in Japanese psychiatry. In an unprecedented way, it ushered in a new prominence for the PTSD construct and transformed the role of psychiatry in society. Notably, traditional ideas still maintained a popular currency even as Western ideas about trauma came to the fore. Breslau describes these "seemingly contradictory tendencies" in which,

> On the one hand, this view of psychopathology recognizes the role of events in the social world as sources of suffering and illness. It seems to offer an understanding of mental illness that would acknowledge contingency on cultural differences and situational circumstances. At the same time, however, it is based on a specific causal pathway that directs clinical formulations from event to symptom. (2000)

In other words, Breslau's descriptions report how Japanese psychiatrists navigate the same complex issues of working cross-culturally. As practitioners from a non-Western culture, they judiciously make use of new ideas in service of tending to the suffering they see. This does not entail an abdication of their foundational cultural assumptions about suffering or trauma, but rather it "maps" a new landscape of understanding.

Consideration of different explanatory models is not uncommon in psychology (e.g., Lewis, 1995; Karasz, 2005; Kleinman, 1978). In order to foster a shared perspective, many people have written about how to socialize clients through psychoeducation or even to assess for "mental health literacy" in communities (Lauber, Nordt, Falcato and Rossler, 2003). If psychology is not new to looking at how its ideas impact the people it serves, the field seems less attuned to the way it is *impacted by* the people it serves. It is beyond the scope of this research to

speculate about all the different factors that may contribute to the development of an explanatory map, but this study does offer a basis to make various hypotheses about how cross-cultural factors may impact psychological concepts of trauma.

III(b). Spirituality in the Adaptation of Concepts

I propose that psychologists with Western training who tend to work cross-culturally are more likely to adapt concepts of trauma in order to blend them with the worldviews with which they work. In other words, when assumptions do not line up, psychologists are more likely to become fluid in their thinking, either by working integratively or articulating new concepts altogether. It may also be the case that the greater the discrepancy between local understandings and occidental models, the more difficulty it could become to reconcile these ideas. As gaps widen between clinical and cultural assumptions, it creates greater and greater challenges for integration. This may tend to reinforce a split between separate healing traditions.

For example, in light of this study, I argue that the incorporation of spiritual and/or energy-based work by several participants reflects a syncretic attempt at blending the assumptions of behavioral science with the spiritual mysticism in Guatemalan culture. Spiritual, political and historical factors in Guatemala may pull for broadening the discourse on trauma beyond intrapsychic features, which may in turn spur the use of interpersonal/communal theories (such as case 09) or transcendent ideas about the unconscious (such as case 03). Because occidental and indigenous views have such wide discrepancies in their assumptions, the need for these psychologists to adapt concepts becomes more pressing. At the same time, however, because these differences are so stark, it may also reinforce the maintenance of separate healing traditions such as those practiced by shamans and other traditional or religious healers. It may be

the case that psychology and shamanism coexist in Guatemala because the challenges of caring for the brain, the mind and the soul are too far apart to be treated by any single practice. The various assumptions about 'what trauma is' may reinforce this division.

Given the frequency with which spirituality and religion were cited as sources of resilience, it seems hard to understate their importance in Guatemala. Spirituality takes on a different cast in the light of different trauma concepts, and the topic also illustrates the importance of pluralism in trauma concepts. From the standpoint of psychiatric science, spirituality amounts to a network of beliefs that may influence affective states. For example, if people believe in a loving God, they may feel safer. A cognitivist perspective appreciates spirituality as a protective factor in trauma because of its ability to moderate and mediate the interpretation of events (Cheung, 1994; Johnson and Thompson, 2008). But to approach spirituality as a cognitive component in a biopsychosocial formulation does not offer the same explanatory frame as social psychology when it comes to appreciating the centrality of spiritual transcendence. When spirituality is understood as a unifying sense of meaning among people (rather than as an individual's beliefs), it changes how we understand what is at risk in trauma.

When facing violence on such a massive scale as chronic armed conflict or genocide, the human environment may seem bereft of caring, responsive figures. From a social psychology perspective, it is not merely the cognitive interpretation of events, but rather the total loss of reciprocity. The seeming impossibility of finding empathy or having the power to change one's circumstances can render a profound sense of being desperately helpless and alone. Whereas people naturally develop a sense of themselves through their relationships with others, the survivor cannot help but endure an invalidation of their subjective experience. Devastation of

intersubjectivity creates a parallel process of internalized devastation (for a brilliant discussion of how experiencing genocidal violence can destroy inner worlds, see Laub and Auerhahn, 1989).

In the face of massive violence and the loss of one's social world, it is easy to lose any semblance of oneself or meaning in the world. The spiritual organization of one's universe may be one of the only stable, enduring sources of meaning and organization still available (See Frankel, 1959/1992). A sense of spiritual transcendence—to know one's suffering as part of something greater than oneself—may be one of the primary ways of retaining a stabilizing sense of connection and hope in the face of otherwise insurmountable brutality and trauma. In the cold of isolation, spirituality offers the warmth of community in the clarifying light of meaning. This transcendence may be as part of the naturalistic Mayan worldview, the magico-religiosity of syncretic Catholicism, or the fervor of evangelical Protestantism, but in each case, it remains faith that transcends a suffering that otherwise engulfs everything in the survivor's world. Family and community ties may play a similar role.

In Guatemala, violence of all kinds has been endemic since the Conquest, and this violence has shaped the culture and its people. This was especially true during the *conflicto armado* when the army intentionally targeted civil society and Maya culture. Violence and suffering become the norm. Menchú (1984) writes in her autobiography about birthing ceremonies among her people and the way in which new children are welcomed into the world:

> The neighbors bring another animal, and there's a big lunch in the new baby's house for all the community. This is to celebrate his integration 'in the universe', as our parents used to say… Then, the parents tell the baby of the suffering of the family he will be joining. With great feeling, they express their sorrow at bringing the child into the world to suffer. To us, suffering is our fate, and the child must be introduced to the sorrows and hardship, but he must learn that despite his suffering, he will be respectful and live

> through his pain. The child is then entrusted with the responsibility of the community and told to abide by its rules. (pg. 12)

Spirituality, as it is suggested here, is not merely a coping belief for individuals; it is a central pillar in the cultural and psychological survival of an entire population. In countless ways and across history, the poisoning sense of helplessness and isolation caused by recurrent trauma may find some antidote in a religious if not magical faith. In other words, the psychological survival of an individual in the face of massive social destruction may depend in part on staying connected to the historical means by which a culture survives. When uprooted from the grounding sense of culture's meaning and connection, the mind will likely die. Alienation from these tap roots of cultural survival may further undermine the resilience and resistance of the individual (See Summerfield, 1998).

Presumably in every society, the historical and cultural narrative holds the collective wisdom of how we heal, whether codified in science or given up to faith. For psychiatry, it may seem untenable and inadmissible to consider spiritual interventions (such as energy work) which may lack an empirical basis—lacking a basis as either clinical interventions or even simply as properties of physics. Western psychiatry's adherence to naturalistic science—to the exclusion of the phantasmagorical—is consistent with its own beliefs, but not those of many people in Guatemala. I argue that the failure to listen and hear these different explanations of trauma (as cultural concepts) deprives the therapeutic encounter of the very sense of (cultural) integration and continuity called for in healing and reparation. This is the historical rhythm that tells the story of recovery, a call and response of suffering and transcendence, of pain and endurance, of spirit and flesh. It is like the cultural hymn that survivors sing to know that they are not alone

and that all is not lost. Only by allowing ourselves to understand trauma in many ways does it become possible to recognize these culturally derived sources of strength, resilience and resistance.

Stated plainly, the depth of spirituality in Guatemala may reflect the principle means of recovering from the depth of trauma endured. Clinical adherence to only that which is supported by a psychiatric science could be culturally dystonic and potentially alienating from one of the primary sources of strength and resilience in the lives of survivors. Psychiatric science may prefer to view these spiritual beliefs as secondary to evidenced-based practices or as merely components in a broader formulation, but this runs risks of willful ignorance and ethnocentrism.

As many of the participants in this study clearly state, they are not unaware of being caught between traditions, and I believe that regardless of any explicit intentions, their work represents an attempt to creatively integrate these different views. Their work is pluralistic and integrative in the most basic cultural sense. The second hypothesis that I want to propose for understanding the adaptation of trauma concepts is to argue that across concepts of health and healing, the most successful cases of recovery will show a greater integration of beliefs about both trauma and health in ways that are culturally congruent for the survivor. That is, survivors who show the best outcomes will understand their traumatic experiences in ways that fit with their wider cultural beliefs. Whether or not survivors understand their trauma according to "evidence-based practices" or current research will have less benefit for their recovery if this perspective is not well integrated into their broader cultural assumptions about self, ontology, etc.

This hypothesis should be evaluated holistically. It is not enough to consider changes in symptom presentation or diagnostic criteria because this would predicate recovery on psychiatric

terms. For example, if treatment produces a reduction in symptoms of hyperarousal but increases estrangement from one's cultural identity, then there is grounds to debate the terms and conditions of what constitutes recovery. In perhaps more technical terms, if one of the overarching goals of trauma work is greater psychological integration, then the incorporation of etic ideas must be congruent and/or complementary to emic explanations—or else there is a risk that the "treatment" of a "disordered" intra-psychic sense of dis-integration could become a disjoint between self and world. What may solve one problem could contribute to the creation of another. I am suggesting that recoveries showing greater integration of cultural beliefs will show the best outcomes overall and over time.

III(c). Local Perspectives and the Need for Cultural Congruence

It may be accepted as a premise of cross-cultural work that local perspectives need to be incorporated into clinical practices for the good of improving clinical outcomes (i.e., Wilson, 2007). Trauma has a way of leaving survivors speechless and unable to put their pain into words. Emic concepts may help put the ineffability of awful events into forms that can be cathartically expressed (Sturm, 2007). This is not merely an issue for Guatemala. For example, in writing about the treatment of trauma survivors in Sri Lanka, Tribe (2007) has argued in favor of "health pluralism" in which "a multi-layered or diverse range of explanatory health beliefs" best suits the mix of healing traditions. To overlook—or worse yet, exclude—cultural understandings may deprive individuals of the frameworks of meaning that would be most amenable to describing their particular experience of suffering and survival.

If Guatemalan clinicians are using (primarily) Western concepts that are expressly formulated in materialist (biological) and cognitivist terms, it may prove useful in some arenas.

But several in the sample described working on psychosocial interventions with communities in the interior of the country. Many talked about working with service or non-governmental organizations, and one participant talked about how the lack of healthcare professionals often forces psychologists into opportunities for which they have limited training—such as group work or working with communities. I argue that trauma concepts that are formulated around materialist or cognitivist pathology may not be well suited to provide a coherent framework for addressing trauma on different levels of analysis or in different modalities, such as when observing traumatic reactions on the level of groups, organizations or communities. The demands of recovery may be better served by different ideas—and perhaps the most natural place to look for these insights is in the local understanding.

This hypothesis predicts that the use of psychological constructs (such as PTSD) that weaken or disregard an individual's identification with a culture of origin is likely to have less positive outcomes when well-being is assessed globally, holistically and over time. In other words, this work argues that ignoring cultural conceptions of trauma is potentially detrimental to the recovery process. In the case of Guatemala, this requires spiritual and communal considerations. It also predicts that the use of etic concepts in ways that can be assimilated or regarded as congruent with existing cultural constructions can be beneficial either independently or in concert with local practices. To be clear, I am *not* suggesting that mainstream psychiatric treatments cannot be helpful for non-Western populations, but rather I am suggesting that this process involves hidden risks which are rarely considered. I am predicting that when we help people to understand the awful things that they have been through in terms of how they already see the world, they will tend to do better. This perspective is opposed to a biomedical

perspective that sees a "technology" of intervention that can be universally prescribed with equal effect across populations and issues.

III(d). The Impact of Social Instability

The previous two hypotheses—the pressures to adapt concepts and the need for local conceptualizations—have focused on how cultural elements may prove central to the conceptualization of trauma and the actualization of therapy. Additionally, I argue that Guatemala's social instability is equally influential: cultures and societies in which prolonged and/or massive traumatization is either on-going or historically salient are more likely to make different assumptions about 'what trauma is' than cultures that have been relatively stable and/or dominant. The scale of widespread trauma may pull for assumptions that speak to interpersonal, historical or cultural formulations as a way to understand the scope of what has happened. I am not predicting specific formulations (i.e., specific political psychologies), but rather suggesting that the occurrence of widespread trauma will more likely be associated with interpersonal/ communal conceptualizations. Such ideas may necessarily take a political stance—calling for changes in their communities—but I am not predicting what stances would be prioritized in terms of healing. Further ethnographic research of different cultures beset by trauma could refute or corroborate these ideas.

The psychology literature already provides theories about cultural trauma (i.e., Volkan, 2001), including that of the indigenous throughout the Americas (Yellowhorse Braveheart, Chase, Elkins and Altschul, 2011). In this study, all of the participants described seeing the consequences of massive, widespread trauma throughout society, and all could recognize ways in which their work with people is influenced by social issues and contextual insecurity. Whereas

much of the conventional wisdom about treating trauma says that the first step is establishing safety, this becomes much more complicated when the world around you is unsafe. Perhaps the broader theoretical argument here suggests that the assumptions of a particular model may reflect the context in which it was 'engineered'.

Not unlike tools or machines, theoretical models can be limited by context. The premises of a given model are indexed to according to the conditions that make their identification possible. By way of analogy, there is no reason to assume that just because a thermometer and a submarine both work underwater that they will also both work in the desert. When it comes to theoretical constructs, the issue is one of explanatory power. In psychology, for example, hypervigilance (as a model of autonomic dysregulation) may translate across contexts more readily than PTSD (as a model of trauma). We have to recognize that the assumptions that structure the model may be out of place in a different setting. In Guatemala, adhering to criteria for a fear-based disorder may not make sense when widespread legacies of violence have created a general climate of fear. All of this speaks to our understanding of suffering and our chosen level of analysis.

When people grow up surrounded by legacies of violence, they may not realize how their actions contribute—either interpersonally or culturally—to the perpetuation of the social climate. For individuals, it may become natural to emphasize agency and empowerment—to resist a feeling of victimization, to not acquiesce to living in fear, to connect to resources, and to build support networks. Combating despair on an individual and even interpersonal level may not address trauma on collective levels. For example, moving one's family into an armed, gated community may ameliorate feelings of insecurity, but the retrenchment may also underscore the

community's lack of shared interests. Self-interest and survival may undercut the collective strengths capable of pushing back the shadows and fears of annihilation. For individuals in traumatized communities, recovery may demand a thoughtful consideration of how to situate oneself before these multilevel events. It requires cognizance of self in context—an awareness that may be best facilitated by different types of trauma concepts.

III(e). Common Themes Across Concepts

In advocating for pluralism, I also want to offer a hypothesis for unifying themes. Trauma concepts will show variations in their core organizing assumptions, but certain themes provide a unifying commonality when we talk about awful events. In the same way that I argue that trauma is fundamentally an explanatory metaphor organized around core assumptions, trauma concepts may also be recognizable on the basis of certain dialectics: vulnerability and safety, fragmentation and integration, dysregulation and balance, violation and security, rigidity and flexibility, instability and stability, inadequacy and mastery, disconnection and connection, alienation and belonging; and loss of meaning and meaning or purpose. For example, fragmentation on an individual level may mean incomplete memories, whereas on a community level it may manifest as the development of competing factions. In both, these divisions hold back functioning well—whether as individuals or a group. Different themes or dialectics may be more salient in different concepts, just as some may be more or less abstract. I suggest that trauma will present recognizable similarities across many levels of analysis and in the many different ways it is conceived. This hypothesis could be tested with a more extensive review of trauma concepts, both in the literature and in ethnographic study of diverse cultures.

IV. Alternative Explanations, Implications and Anticipated Criticism

The hypotheses offered here are intended to help organize and understand the data gathered in this study. I argue that the non-adherence to mainstream occidental trauma concepts is the result of a nuanced and creative process of cultural synthesis that reflects the organizing assumptions of different ideas. There are, of course, other possible explanations, such as seeing this non-adherence as the result of inadequate training, the under-development of professional practice in Guatemala, or even a lack of conviction on the part of participants. I consider each of these to be unlikely.

To suggest that participants in this study are poorly trained or lack professional development is highly implausible. This sample is likely biased to over-represent university affiliation, which means that on the whole these participants are reliably as well-versed as any other practitioner in the country. Six (of 9) participants indicated that trauma was a clinical specialty, and their recommendations for training future providers reiterate divergent themes and concerns. A significant number of participants alluded to professional organizations and affiliations to which they belong, which may also over-represent the level of engagement in professional associations. Working conditions (e.g., wages, public image) for mental health providers in Guatemala can be difficult, making it unlikely that many practitioners would stay in the field if they did not believe in its mission and its values. Overall, there is no basis in the data to assume that these psychologists lack conviction, training, or professional legitimacy. This work has also shown that within the English-language literature, there are a wide range of ideas about trauma. If deviating from an established concept is somehow regarded as an intellectual misstep, then the same argument must apply to a good portion of the discipline. It would run the

risk of ethnocentrism to assume that deviating from a largely North American model somehow constitutes an act of ignorance or a lack of professional rigor.

This work proposes various hypotheses about understanding cross cultural differences, but it also raises serious ethical issues about the proper place of culture in clinical practice. Just as many Guatemalan psychologists are actively working to further professionalize their field, it may be helpful to ask questions about what types of standards and expectations can support a fledging behavioral science in a culture with such diversity. To illustrate a point, imagine a strident commitment to the medical model that insisted on a Western positivist epistemology (e.g., McFall, 1991). Without conceptual pluralism, psychological practice would unwittingly run the risk of recapitulating the same historical struggle that has always bedeviled Guatemala—the cultural dominance of a occidental worldview over an indigenous way of life.

A Euro-Western trauma concept may seem foreign or incongruent when describing local or indigenous understandings of suffering. To have these ideas predominate in the practice of therapy runs the risk of alienating people who experience their pain in very different ways. Therapy is already somewhat marginal and arguably under-utilized in Guatemala; many people do not have access to clinical care. To imagine a therapy bounded by a parochial approach to trauma concepts could either contribute to its continued marginalization or else impose the therapist's ideas onto the client's experience as clinicians "colonize" new professional territory. In other words, people who are suffering might feel discouraged from availing themselves of mental health treatment if therapists only think about trauma in occidental terms. This work provides evidence that the Guatemalan psychologists are wisely avoiding such an approach.

Attempting to treat PTSD without considering other trauma concepts may prove yet one more example of *asistencialismo* (Consolí, et. al., 2006), offering services that people do not want or cannot use. Alternately, the therapist's insistence on PTSD as a trauma model might overlook the beliefs and assumptions that shape a person's worldview. In order to engage in therapy, the person might put aside their own basic assumptions in order to assume those of the therapist. This asks people to momentarily suspend their natural intuitions about healing which may not help them explain their experience in their own terms. Moreover, it may distance the person from the natural well-springs of resilience that are found in any culture. In a place like Guatemala where the importance of historical betrayal and exploitation cannot be overstated, the therapist's willingness to listen and engage with the client's assumptions may signal their willingness to bear witness to the many faces of trauma.

The assumption that "evidenced based practices" can serve globally as a default across settings and contexts—in an attempt to provide ethical and culturally sensitive treatment—is called into question by the ideas presented here. In a treatment that is guided by ethical considerations, efficacy and effectiveness for symptom reduction are not the only concerns. To practice in this way ignores the challenges of working through the various cultural assumptions that organize these practices. Western-trained clinicians should not feel obligated to abandon their training or their perspectives on trauma, but neither should they assume the superiority of their ideas. Reviews of research in this work have not only showcased a variety of empirical and conceptual concerns that should caution providers to have humility about the integrity of their ideas, but this assortment of research also demonstrates the cultural foundations of concepts like

PTSD. It is arrogant to assume that the strengths of one perspective should allow it to disregard and ignore the virtues of another.

Roland Littlewood (1992) has raised the important question of how universal is therapy?

> The way the whole process [of therapy] hangs together, and thus its power, remains however at the level of interpretive rather than empirical study. To say that in general 'therapy works' is a question of the same order as asking whether marriage, or religion, or democracy 'works'; of making higher order assumptions in which self, others, and problem are articulated within an overarching system of meaning which encompasses what it is to be human. (54)

In an era of globalization for mental health, so much of the discussion focuses on the proliferation of Western approaches to treatment (e.g., Jacob, et. al., 2007) that it may overlook the important differences in culture and context that refute the paradigm (for a critique, see Ganesan, 2006). Without dismissing the drive to provide care and support cross-culturally, there are different ways for psychologists to contribute internationally. For example, recognizing the importance of local trauma concepts is an invitation for local clinical scientists to do qualitative and quantitative work that can help us to understand how to integrate mainstream concepts like PTSD with local concepts. By sharing and exchanging ideas, Guatemala might develop its own traditions of healing trauma that are different from traditions developed in the United States, or Kyrgyzstan, or South Africa and so on (Fernando, 2004). So while concepts like PTSD that claim a universal mantle may contribute to recovery processes, there would be no assumption that this construct could substitute for the peculiar and historical challenges of each culture as they integrate these new ideas.

There is a danger in reviewing this material to look at these findings as "exotic" as though they were somehow unrelated or disconnected from the realities of North American or

European populations. Cross-cultural issues are not unique to Guatemala, and while the Maya may seem "worlds away" from First World concerns, the issues in this work are familiar the world over. In the United States, for example, research has established that ethnic minorities utilize mental health services at lower rates than Caucasians even after controlling for access and availability (Padgett, Patrick, Burns and Schlesinger, 1994). The implication is that cultural questions estrange some groups in the USA from traditional therapies. Spirituality and conceptualizations of mental health are equally salient: for example, approximately half of evangelical Christians in the United States believe that psychological disorders can be cured with prayer alone. They are more likely to see a minister for help than talk to a therapist (Hoffman, 2014)—and so while Mayan shamanism may seem foreign, the clinical alienation of those in need on the basis of spiritual assumptions remains as salient as ever even in North America.

The same is true with respect to violence. In the United States, for example, who could argue that decades of street violence have not profoundly shaped poor urban communities? Endemic violence is present in the United States, even if rates of exposure are not as widespread or pervasive as in Guatemala. Moreover, refugee populations have swollen across the developed world, introducing new challenges to think about culture and political violence. The need to broaden our understanding of trauma applies in these communities as well. North American and European providers could benefit from looking at how our Guatemalan colleagues are handling these challenges.

There is also reason to speculate that North American clinicians may be "mapping" new concepts and integrating various traditions just like their Guatemalan counterparts. We should be careful not to assume that North American culture can be thought of monolithically. The United

States is home to profound diversity, not unlike Guatemala, which may present clinicians with similar cross-cultural concerns. The many different clinical orientations within psychology make different assumptions about theory and philosophy (Waterman, 2013), and the field clearly reflects a creative process of exchange and interpretation. Approximately one-quarter to one-third of mental health professionals in the United States continue to identify as "eclectic/ integrative"—representing the largest category of clinical orientations. There is some evidence of a slow but steady downward trend over the last few decades, but this integrative movement persists among practicing clinicians even as academic psychology has increasingly moved towards a medical model (Norcross, Karpiak and Santoro 2005; Norcross and Karpiak, 2012; Perlman, 1985).

Like their Guatemalan colleagues, North American psychologists may be similarly engaged in the process of navigating differing cultural assumptions. Consistent with the ideas presented in this work, the enduring popularity of the integrative approach may suggest that these providers are also "mapping" ways of working with and around different ideas. To clarify, it is explicitly not the position of this work that cultural assumptions are somehow the only factor that shape clinical practice. Certainly, others (i.e., financial reimbursement) play a powerful role, but the need to thoughtfully navigate different concepts in order to actualize treatment interventions is inescapable. Again, this work can only present hypotheses that are based in data, all of which should then be subjected to further study and revision.

In an attempt to anticipate some of the possible criticism of this work, let me recognize that some readers may object to my presentation of the trauma literature. Some critics may argue that my reading of the PTSD construct is too narrow and presents only a logical "straw man" that

is too easily dismissed. Criticism of this kind would suggest that the PTSD construct more naturally extends to encompass phenomenon such as interpersonal or value/meaning-based considerations. In rebuttal, I argue that my presentation of the concept comes strictly from the written material of the DSM and its criteria. Reading "between the lines" as an extension of the concept constitutes an expansion of its assumptions. As a theoretical model, PTSD should be understood to hew closely its explicit and falsifiable premises, which preclude invitations to speculate about what else might be warranted either in extension or combination. Clinicians who find themselves readily incorporating these ideas are going beyond the model in a process of mapping interpretive space. To do so already implicitly supports the argument that our discussion of trauma must go beyond the PTSD model in some form of pluralism.

I also argue that theoretical models may demonstrate congruence in concepts, but this should not be mistaken as a unitary concept. For example, a neurological model of traumatic experience may provide a medical complement to a cognitive-behavioral model—perhaps by providing a biologically-based understanding of feelings of guilt and negative self-attribution. Their explanations of the event cover different levels of analysis, but are also congruent in that they fit together well. But suppose that neuroscience unseats the claims of this medical model. New discoveries may lead to a reformulation of our understanding of biology. The revisions to this model would not necessarily invalidate the cognitivist perspective as an explanatory model. It may invite a reconsideration of assumptions and premises, but each model must be judged according to the integrity of its assumptions in line with established facts. Because each model makes its own organizing assumptions, we should not confuse their congruence as an evidence of singularity. We might find congruence across medical, cognitive-behavioral, psychodynamic,

interpersonal, or spiritual models, but this does not mean that the virtues of one necessarily validate (or invalidate) the others. As I have done throughout this work, it is important to tease apart different assumptions and ideas in order to see how they influence one another.

Secondly, some proponents of the medical model might reject alternative trauma concepts on the grounds that they see therapy as a specific type of treatment process. If they see therapy as a clinical practice, then they might reason that it belongs to the field of clinical psychology. These critics might argue that interpersonal theories belong more in social psychology, which might tempt the conclusion that interpersonal concepts do not belong in the therapeutic process. The same may be said of spirituality. This line of reasoning might follow naturally from traditional academic distinctions, but it hardly corresponds to the contours of day-to-day practice. We would do well to remember that the divisions of academia and the field of psychology are also cultural conventions. For example, the distinction between clinical and social psychology in Latin America does not always follow the same prescription of roles and practices, whether the division are more or less starkly divided (Hernández-Wolfe, 2013; Jaranson, 1998). It would be ethnocentric to assume that the North American distinctions of disciplinary study can sustain their practical utility in all settings around the world.

The distinction between the individual clinical concerns and the macro-social legacies of violence is not as viable in Guatemala. Arguably, it's not viable in the south side of Chicago, or the backyards of Camden, or the urban decay of Detroit. The notion that trauma can be separated from its ecological and historical context invokes a particular set of assumptions—and a degree of social power—in crafting a narrative. There is no "right" or "wrong" constellation of core assumptions to use in constructing a trauma narrative, but different concepts make different

dialogues possible. Each and every concept inescapably reflects a set of value propositions, all of which position the discourse in relation to ideas of social (in)justice.

Some readers might object to such philosophical arguments as being irrelevant to the empirical study of trauma as though the data can speak for itself. For these critics, they might argue that in an empirical debate, if the proposition cannot be subjected to data-driven falsification, then it does not belong in an empirical field. The claims in this work about "core assumptions" are not falsifiable, but rather based on theoretical premises. Strict positivists might then suggest that these ideas should have no standing. This work has laid out the erroneous assumptions of this idea by demonstrating how different epistemologies reflect different value propositions. Insisting *a priori* that only certain types of ideas or evidence will have merit biases the discussion and forecloses on the cultural values that will be deemed acceptable. In other words, it is easier to win the debate when you are allowed to define what can or cannot be included. An emphasis on empiricism is not a value-neutral proposition. This study represents an attempt to open our discussion of trauma to more perspectives.

V. Limitations and Future Research

This study faces a multitude of limitations that are important to acknowledge. Limitations start with its basis as a small, snowballing convenience sample. Furthermore, there is no way to know if the sample is at all representative of psychologists in the country because there is no clear way to establish the professional composition of mental health providers in Guatemala. All of the participants were *ladinos* and predominantly women. All indications suggest that it over-represents university affiliation and advanced degrees, along with possibly

over-representing professional affiliations. There is no way to account for socio-economic status or demographic factors in the sample—or know how these compare to the composition of the field.

The data gathered for this study was collected through single session semi-structured interviews along with a brief demographic questionnaire. Because this work is qualitative, it is important to recognize that alternative approaches to the interview may have elicited different material that could have supported different or contradictory conclusions. As the interviewer, I also may have influenced what material was shared through my choice of follow-up questions, level of Spanish fluency, or consideration of different themes. The goal of these interviews was to capture a range of ideas, but it was not designed to insure that the material would be broadly representative.

The semi-structured interview directly asked about certain topic areas that are not traditionally part of trauma concepts (e.g., the influence of social instability), which may have exaggerated the salience of this information in the data. While this could have artificially inflated the importance of different topics, it is important to recognize that in some domains, participants readily declined the content of the question. For example, when asked about how often they discuss social issues in therapy, many participants readily indicated that they did not do so. There is no reason to assume from the data that participants adjusted their answers to accommodate the questions in the interview. Questions were asked in an open-ended manner. There is only limited basis to assume that the nature of the semi-structured interview introduced any topics that were not already germane to the participants' working conceptualizations.

Another possible limitation in the study is that there is no way to assess for the possible distorting influence of current events such as the episode described in the introduction. Around the time of data collection for this study, General Efraín Ríos Montt, former president of Guatemala and a principle architect of the military's most violent counter-insurgency strategy, was recently tried for genocide in a Guatemalan court, only to have his conviction overturned. It is possible that participants in this study were more actively thinking about the ramifications of war trauma at the time of the interviews than they would normally. Nevertheless, this would not undermine any of the conclusions of the study as it still represents their understanding of trauma. It remains to be seen how much their concepts evolve or change over time in the context of history.

There is no way to make assumptions about how common or prevalent the different ideas represented in this study are across Guatemala. These ideas may represent the opinions of a small minority or reflect much broader trends. Similarly, a strength of this study lies in its collection of ideas from participants who work with many different types of people. A different sample would likely have produced a somewhat varied presentation of ideas. The process of this qualitative research cannot ignore the history of betrayal and the context of violence that may severely curtail who speaks with whom, when and why. Again, Menchú (1984) speaks to this central issue in her autobiography:

> My father used to say: 'There are many secrets we must not tell. We must keep our secrets.' He said that no rich man, no landowner, no priest, or nun, must ever know our secrets. If we don't protect our ancestors' secrets, we'll be responsible for killing them. (pg. 188)

All in all, there is no way to know the extent of ideas about trauma in Guatemala, and this study only shows a sliver of the possibilities. This study does not provide a basis for making such generalities.

This study depends on hermeneutic inquiry, which means that it cannot escape the limitations of my perspective as an outside observer in Guatemala. While some of the accounting of the data can be based on the frequency of responses, interpretation of the interviews and the generation of hypotheses reflects my specific understanding. This study does not speak to a wide array of healing practices currently used in Guatemala, such as those practiced by priests, shamans, community leaders, etc. Readers would do well to consider that much if not most of the work of trauma recovery takes place outside of clinical therapy.

Future research may approach these ideas from many directions. This work provides a philosophical deconstruction of ideas, but theory invites debate. Whereas psychology and psychiatry have strong empirical traditions, common practice in philosophy is to subject ideas and arguments to rigorous debate in the eyes of many different theories. As qualitative research, this work focuses on hypothesis generation rather than hypothesis testing, but all of the ideas proposed in this work should be put to empirical examination by psychologists, anthropologists, sociologists, and others. Clinical research in Guatemala is virtually untapped, and future research should attempt to lay a foundation for subsequent studies before quantitative trials can be conducted.

While this study samples Guatemalan psychologists, it may be interesting to conduct similar research with other groups and cultures—including North American psychologists—to provide points of comparison. Comparative research across trauma concepts may be a

particularly fruitful arena as an analysis of core assumptions would invite consideration of similarities and differences. For example, the genesis of PTSD attempted to unify strands of research from different areas informed by fear and intensity, but this is not to say that we could not recognize other types commonalities in traumatic events. For example, we might comparatively study trauma concepts that take a primarily subjective point of reference, or that formulate the mechanism in terms of disruptions in meaning. There are many possibilities, and this type of integrative work could look across orientations and cultures; it might yield new ways of synthesizing concepts in ways that are mindful of their continuing core assumptions. I suggest that the field should be less constrained by a need for a unified trauma concept and more intently focused on concepts that respond to the lived experiences of identified populations in need.

Conclusion

This work explores how we understand psychological trauma. It reviewed the history of both the trauma concept and the development of PTSD before reviewing the state of current research. It described common criticism and controversies from multiple perspectives and disciplines, including psychology, transcultural psychiatry and anthropology. This work then provided a framework for organizing these debates based on four core conceptual questions that enable us to examine the types of assumptions inherent in trauma concepts. A qualitative study then illustrated how to employ these concepts by analyzing how a sample of Guatemalan psychologists conceptualize and work with trauma. In light of the prevalence, history, and range of experiences in the country, this study provides a unique window into how trauma concepts may differ as diverse peoples engage in the difficult work of healing from awful events. The result is an impassioned argument in favor of pluralism in our use of trauma concepts.

The criticism reviewed in this work recognized both attempts to strengthen and refute the PTSD construct. Concerns about its empirical basis, its heterogeneity and its apparently dimensional structure argue for key revisions that might reformulate the construct. By making it more empirically sound, it has potential to consolidate a particular type of understanding, but various criticisms challenge its premises. Differentiating between traumatic stress and "life stress" reopens questions about the breadth of the construct. More weighted criticism targets the universalist assumptions of the medical model, the challenges of hermeneutic translation, the exclusively intrapsychic focus, and its cultural foundations. These arguments dispute the basis of the construct and call into question its explanatory claims. Taken en masse, these criticism raise

important and difficult questions about applying the PTSD construct both clinically and cross-culturally.

The analysis in this work suggests that despite these criticisms and questions, not all is lost in defense of the diagnosis. This work offers a framework for organizing the debates and controversies around PTSD that is based on identifying core assumptions in the construct. This process involves articulating a point of reference (question of reference), formulating an appreciation of suffering (question of suffering), and establishing linear causal relationships between the event, its mechanism and the response (questions of suffering and response). These are not dimensions of a "natural kind," but rather they reflect the interplay of assumptions and ideas incumbent in any worldview. They exist in a dynamic state of interlocking tension whereby the premises of any one issue have implications for the others. These questions do not have "right" answers, but they face pressures to be congruent and coherent with sets of beliefs. As we study awful experiences, new discoveries pose new questions and force reconsiderations of old assumptions. Like a child's mobile, the dimensions of a construct hang in state of balance.

The original research from Guatemala presented in this work showcases how different assumptions can radically redefine trauma concepts. Guatemala's rich traditions of cultural diversity have survived a history of cruelty and heartbreak, and the resilience of its people may teach us about cycles of survival and perpetration—provided that we listen to how they understand their experience of trauma. Merely importing an occidental psychiatric construct threatens to ignore how one set of assumptions can eclipse local beliefs. The diagnosis may provide clinical science with a rigorous way of testing its assumptions through the scientific method, but this does not free it from cultural assumptions.

Part of the issue in the blanket usage of PTSD is not necessarily in the formulation itself (although some of this criticism is valid), but in the over-extension of what this construct purportedly tells us about trauma. It is ethnocentric to assume that one set of assumptions is "better" than another, and we see the socio-cultural and political dimension of trauma concepts most clearly when we acknowledge the power that comes with controlling the terms of the debate.

There are dangers in assuming that any single concept offers the "right" way to understand trauma. For example, one trauma concept may be organized around ideas about how a fear response exceeds the objective threat. A second concept may start with the decimation of meaning. When it comes to helping survivors, we should be careful not to assume a priori which concept will speak most clearly to their greatest needs. Clinical psychology has to ask itself, what is its primary concern? Is it most concerned with medicalized disorders? Because if that is the case, then we may very well miss the suffering of the people it serves. There is no reason to assume that one trauma concept can adequately explain any and every experience of traumatic suffering.

More broadly, a provincial understanding of trauma may have cultural implications. In a polemical book, journalist Ethan Watters (2010) argues that a "globalization of the American psyche" is underway by leveling the foundational beliefs of other cultures. He argues that hegemony of the U.S. American nosology has infused the socio-economic politics of humanitarian aid and pharmaceutical marketing at the expense of local healing traditions. In his view, psychiatry is far from a neutral scientific project, but rather recapitulates colonial attitudes about the inferiority of non-Euro Western people (See also Summerfield, 1998).

Polemics notwithstanding, it remains to be seen how the practice of global mental health can demonstrate the depth of self-awareness and humility necessary to show respect for other cultures. Indeed, there are many earnest and thoughtful people engaged in this work, but one cannot enter a genuine and egalitarian cross-cultural exchange without being open to the potential for radical transformation. Perhaps the truest test of the field's liberal values will be in the way that occidental clinical science allows itself to be changed by the differences it discovers by listening with an open mind. "Exchange without change" runs the risk of being patronizing. The diversity of human experience demands a pluralistic approach to understanding trauma. The clinical practice of therapy may require the hermeneutic use of "maps" rather than the technical adherence to "models". This work begins to provide a framework for understanding the complexity and challenges of pluralism.

What this work cannot provide is a means to understand the complex process of drawing a clinical "map". It identifies various features and influences, but it cannot presume to outline the full complexity of this process. How are concepts actualized into different treatments? That is, what guides the process of planning an intervention so that the model's insights are put into practice? What makes a concept useful in a given context? How do the demands of different contexts like Guatemala—with its unique history, cultures, traditions, etc.—influence the development of trauma concepts? How can a concept (like PTSD) be integrated and applied in a context where different core assumptions are made? An intellectual history becomes inescapable: When core assumptions come into conflict, how do these tensions get resolved? What can we learn by tracing the history of different priorities and assumptions in trauma? This

work offers different hypotheses, but all of them should be fully tested through philosophical, qualitative and quantitative research.

One of the implications of this work should be a reconsideration of what guides therapeutic practice. Clinical interventions make assumptions—and our awareness thereof should create an ethical imperative to examine how those assumptions inform the therapeutic encounter. It may seem striking (especially coming from a clinical psychologist) to suggest that therapy should not be guided by therapists and clinical researchers alone. There are tremendous roles for philosophers, sociologists, anthropologists and historians to play in shedding light on the insights and limitations of any particular point of view. No point of view can see the back of its own proverbial head, and interdisciplinary work may help expand our peripheral vision (even if it does not allow us to see everything in the round).

Science—as it conforms to the standards of Western empiricism—may only take us so far. We can have a concept that has proven to be both reliable and valid that is nevertheless entirely inadequate for understanding a given experience. One of the mistakes that I argue that the field of mental health makes in conceptualizing its research is to think of validity as definitive, as offering the final word on a subject. Instead, we should recognize that there are many perfectly valid ways to understand a given issue. The organizing assumptions of an idea represent its value propositions, while its power to shape a response reflects its meaning and its merits. In the language of economics, different understandings have different utility. In the language of epistemology, they tell different truths.

To co-opt the parable of the blind men and the elephant, three blind men each take hold of the elephant—one at its trunk, one its leg, the other its ear—and each gives a different

description of what this animal is. In developing a research construct, one might take a photo of the elephant's trunk. One might reliably demonstrate an ability to re-take that photo again and again in focus and in ways that accurately capture details about its appearance. The picture is valid, but that does not mean that this photo has shown everything there is to see about the elephant, inside and out, in motion and over time, in spirit and from legend.

This analogy has its limitations—the greatest of which is the hypothetical existence of the elephant. In the story, the elephant gives us a rhetorical prop to envision just how much might lay beyond our perceptions. But what if we could never truly sketch an image of the elephant? In the parable, the men are blind which challenges them to envision what else might be before them. What if we were left holding a trunk-like appendage without any vantage to ever know how much more we have to grasp? Science might tell us something about points of contact, but this does not tell the whole story. In crafting a narrative, we mold the elephant from the clay of experience. In terms of trauma, survivors have to try to find form in catastrophe, to shed light on the darkness, to take hold of meaning in the face of the unknown. The full scope of the beast before them is to some extent an expression of what they can grasp.

The arguments in this work come from a post-modern perspective, which disputes the idea that there is a monolithic "Truth" about trauma or any other human experience. There is no flesh-and-blood elephant to be discovered in all its details. We craft understandings that are more or less in focus with our reality, but these snapshots are not the denouement of ontology. In other words, the way we make sense of things does not settle once and for all the question about what is real or important.

This is not to say that relativity makes equals of all comers. The interdependence created by our assumptions stitches together a worldview. The same is true in understanding how the four core questions of a trauma concept co-create the framework of the construct. The strength and integrity of a worldview depend on the coherence of its ideas. Can we reconcile the answers to 'this' question with the answers to 'that' question? When we think about the world, does it make sense or is it plagued with unexplained contradictions? Does it only make sense when we plug our nose, close our eyes, and ignore the inconsistencies, such as in the case of pseudoscience? Orthodoxy that ignores contradictory evidence is another example, as is empirical science that overstates its claims. A coherent worldview is reliable and valid, even though it does not have all the answers.

A concept like PTSD can be valid in a Western nosology such that the perspective of psychiatry can go on to investigate and explain experiences of trauma across cultures. After all, psychiatry may only be one point of view, but suffering from around the world is still 'in view' of the occidental sciences. In the language of anthropology, the etic perspective can stand its ground when compared with emic explanations, even if they assume different values, and therefore have different explanatory values. But none of this means that it is the "right" way to look at it. It does not even mean that PTSD would always prove useful for working with diverse groups.

As in most human endeavors, there is good reason to think that we can all learn from one another. Sharing perspectives is often how we find new ways to grow. If Western psychiatry wants to lend its perspective to non-Western groups, then perhaps new utility will come out of this exchange. Certainly, there is ample evidence that traditional therapies can be used with

diverse cultural groups—especially if the yard stick measures Western-defined aims and outcomes (e.g., d'Ardenne, 2005). By the same token, there is a lot that the field could learn from non-Western cultures. We might learn new ways of looking at trauma that could also help First World populations heal and grow—but only if we are willing to sit with the complexity that comes from challenging our foundational assumptions. Cross cultural work may seem confusing or "messy", or possibly scary and uncomfortable, but this is trauma after all. There is no way around that.

References

Adams, R. N. (1988). Conclusions: What can we know about the harvest of violence? In R. M. Carmack (Ed.), *Harvest of violence: The Maya indians and the Guatemalan crisis* (pp. 274-291). Norman, OK: University of Oklahoma Press.

Agger, I., & Jensen, S. B. (1996). Trauma and healing on the individual level. *Trauma and healing under state terrorism* (pp. 90-116). Atlantic Highlands, NJ: Zed Books.

Aguilar, G., & Recinos, L. A. (1996). Historia y estado actual de la psicología en Guatemala. *Revista Latinoamericana De Psicología, 28*(2), 197-232.

Alarcón, R. D., Becker, A. E., Lewis-Fernandez, R., Like, R. C., Desai, P., Foulks, E., . . . Primm, A. (2009). Issues for DSM-V: The role of culture in psychiatric diagnosis. *The Journal of Nervous and Mental Disease, 197*(8), 559-560. doi:10.1097/NMD.0b013e3181b0cbff

Albee, G. W. (1982). Preventing psychopathology and promoting human potential. *American Psychologist, 37*(9), 1043-1050.

Allwood, M. A., Bell-Dolan, D., & Husain, S. A. (2002). Children's trauma and adjustment reactions to violent and nonviolent war experiences. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*(4), 450-457.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (Fourth Edition, text revision ed.). Arlington, VA: American Psychiatric Association.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (Fifth Edition ed.). Arlington, VA: American Psychiatric Association.

American Psychological Association. (June 1, 2010). Ethical principles of psychologists and code of conduct. Retrieved from http://www.apa.org/ethics/code/

Amone-P'Olak, K., Garnefski, N., & Kraaij, V. (2007). Adolescents caught between fires: Cognitive emotion regulation in response to war experiences in northern Uganda. *Journal of Adolescence, 30*, 655-669. doi:10.1016/j.adolescence.2006.05.004

Anckerman, S., Dominguez, M., Soto, N., Kjaerulf, F., Berliner, P., & Mikkelsen, E. N. (2005). Psycho-social support to large numbers of traumatized people in post-conflict societies: An approach to community development in Guatemala. *Journal of Community & Applied Social Psychology, 15*, 136-152. doi:10.1002/casp.811

Anthony, M. M., Pickren, W., & Koerner, N. (2009). Historical perspectives on psychiatric classification and anxiety disorders. In D. McKay, J. S. Abramowitz, S. Taylor & G. Asmundson (Eds.), *Current perspectives on the anxiety disorders: Implications for DSM-V and beyond* (pp. 9-40). New York: Springer.

APA Office of Ethnic and Minority Affairs. (1993). Guidelines for providers of psychological services to ethnic, linguistic and culturally diverse populations. *American Psychologist, 48*(1), 45-48.

Archibold, R. C. (2012, November 29, 2012). Commission calls for Guatemala to protect patients. *NY Times*

Arias, A. (2009). Letter from Guatemala: Indigenous women on civil war. *PMLA, 124*(5), 1874-1877.

Arnault, D. S., & Shimabukuro, S. (2012). The clinical ethnographic interview: A user-friendly guide to the cultural formulation of distress and help seeking. *Transcultural Psychiatry, 49*(2), 302-322. doi:10.1177/1363461511425877

Aron, A., Corne, S., Fursland, A., & Zelwer, B. (1991). The gender-specific terror of El Salvador and Guatemala: Post-traumatic stress disorder in Central American refugee women. *Women's Studies International Forum, 14*(1/2), 37-47.

Asmundson, G., Frombach, I., McQuaid, J., Pedrelli, P., Lenox, R., & Stein, M. B. (2000). Dimensionality of posttraumatic stress symptoms: A confirmatory factor analysis of DSM-IV symptom clusters and other symptom models. *Behavior Research and Therapy, 38*, 203-214.

Asner-Self, K. K., & Marotta, S. A. (2005). Developmental indices among Central American immigrants exposed to war-related trauma: Clinical implications for counselors. *Journal of Counseling and Development, 83*, 162-171.

Asociación Médicos Descalzos. (2012). Eje salud mental. Retrieved from https://sites.google.com/site/medeschinique/home/salud-mental

Associated Press. (2012, December 24, 2012). Guatemala: Prosecutor assassinated. *NY Times*

Associated Press. (2013, January 14, 2013). Guatemala: Gunmen kill mayor. *NY Times*

Ataque pone fin a quietud en poblado. (2013, June 15, 2013). *Prensa Libre*, pp. 4.

Aupperle, R. L., Melrose, A. J., Stein, M. B., & Paulus, M. P. (2012). Executive function and PTSD: Disengaging from trauma. *Neuropharmacology, 62*, 686-694. doi:10.1016/j.neuropharm.2011.02.0 08

Averill, P. M. (2000). Posttraumatic stress disorder in older adults: A conceptual review. *Journal of Anxiety Disorders, 14*(2), 133-156.

Baker, D. G., Nievergelt, C. M., & O'Connor, D. T. (2012). Biomarkers of PTSD: Neuropeptides and immune signaling. *Neuropharmacology, 62*, 663-673. doi:10.1016/j.neuropharm. 2011.02.027

Baldwin, S. A., Williams, D. C., & Houts, A. C. (2004). The creation, expansion, and embodiment of posttraumatic stress disorder. *The Scientific Review of Mental Health Practice, 3*(1)

Banks, A. (2002). Polypharmacy of posttraumatic stress disorder. In N. Ghaemi (Ed.), *Polypharmacy in psychiatry* (pp. 151-173). New York: Dekker.

Basoglu, M., Jaranson, J. M., Mollica, R., & Kastrup, M. (2001). Torture and mental health: A research overview. In E. Gerrity, T. M. Keane & F. Tuma (Eds.), *Mental health consequences of torture* (pp. 35-62). New York: Kluwer Academic.

Bedard-Gilligan, M., & Zoellner, L. A. (2008). The utility of the A1 and A2 criteria in the diagnosis of PTSD. *Behavior Research and Therapy, 46*, 1062-1069. doi:10.1016/j.brat. 2008.06.009

Benish, S. G., Imel, Z. E., & Wampold, B. E. (2008). The relative efficacy of bona fide psychotherapies for treating post-traumatic stress disorder: A meta-analysis of direct comparisons. *Clinical Psychology Review, 28*, 746-758. doi:10.1016/j.cpr.2007.10.005

Beristan, C. M., González, J. L., & Paez, D. (1999). Memoria colectiva y genocidio político en Guatemala: Antecedentes y efectos de los procesos de la memoria colectiva. *Psicología Política, 18*, 77-99.

Beristan, C. M., Paez, D., & González, J. L. (2000). Rituals, social sharing, silence, emotions and collective memory claims in the case of the Guatemalan genocide. *Piscothema, 12*, 117-130.

Berliner, P., Dominguez, M., Kjaerulf, F., & Mikkelsen, E. N. (2006). What can be learned from 'crazy' psychologists? A community approach to psychosocial support in post-conflict guatemala. *Intervention, 0*(0), 1-7.

Bisson, J. I., Ehlers, A., Matthews, R., Pilling, S., Richards, D., & Turner, S. (2007). Psychological treatments for chronic post-traumatic stress disorder: Systematic review and meta-analysis. *British Journal of Psychiatry, 190*, 97-104. doi:10.1192/bjp.bp.106.021402

Blackwell, D. (2005). Psychotherapy, politics and trauma: Working with survivors of torture and organized violence. *Group Analysis, 38*, 307-323. doi:10.1177/0533316405052386

Blain, L. M., Galovski, T., & Robinson, T. (2010). Gender differences in recovery from posttraumatic stress disorder: A critical review. *Aggression and Violent Behavior, 15*, 463-474. doi:10.1016/j.avb.2010.09.001

Boals, A., & Schuettler, D. (2009). PTSD symptoms in response to traumatic and non-traumatic events: The role of respondent perception and A2 criterion. *Journal of Anxiety Disorders, 23*, 458-462. doi:10.1016/j.janxdis.2008.09.003

Bodkin, J. A., Pope, H. G., Detke, M. J., & Hudson, J. I. (2007). Is PTSD caused by traumatic stress? *Journal of Anxiety Disorders, 21*, 176-182. doi:10.1016/j.janxdis.2006.09.004

Bohman, J. (1991). *New philosophy of social science: Problems of indeterminacy*. Cambridge, MA: MIT Press.

Bonanno, G. A. (2004). Loss, trauma, and human resilience. *American Psychologist, 59*(1), 20-28. doi:10.1037/0003-066X.59.1.20

Bonanno, G. A., Brewin, C., Kaniasty, K., & La Greca, A. M. (2010). Weighing the costs of disaster: Consequences, risks and resilience in individuals, families, and communities. *Psychological Science in the Public Interest, 1*(1), 1-49. doi:10.1177/1529100610387086

Bonanno, G. A., & Mancini, A. D. (2008). The human capacity to thrive in the face of potential trauma. *Pediatrics, 121*(2), 369-374. doi:10.1542/peds.2007-1648

Booth-Kewley, S., Larson, G. E., Highfill-McRoy, R. M., Garland, C. F., & Gaskin, T. A. (2010). Correlates of posttraumatic stress disorder symptoms in marines back from war. *Journal of Traumatic Stress, 23*(1), 69-77. doi:10.1002/jts.20485

Boulanger, G. (2007). *Wounded by reality: Understanding and treating adult onset trauma*. New Jersey: The Analytic Press.

Bracken, P. J. (1998). Hidden agendas: Deconstructing post traumatic stress disorder. In P. J. Bracken, & C. Petty (Eds.), *Rethinking the trauma of war* (pp. 38-59). London: Free Association Books.

Bracken, P. J. (2001). Post-modernity and post-traumatic stress disorder. *Social Science and Medicine, 53*, 733-743.

Bracken, P. J., Giller, J. E., & Summerfield, D. (1995). Psychological responses to war and atrocity: The limitations of current concepts. *Social Science and Medicine, 40*(8), 1073-1982.

Bracken, P. J., Giller, J. E., & Summerfield, D. (1997). Rethinking mental health work with survivors of wartime violence and refugees. *Journal of Refugee Studies, 10*(4), 431-442.

Bradley, R., Green, J., Russ, E., Dutra, L., & Westen, D. (2005). A multidimensional meta-analysis of psychotherapy for PTSD. *American Journal of Psychiatry, 162*, 214-227.

Breslau, J. (2000). Globalizing disaster trauma: Psychiatry, science and culture after the kobe earthquake. *Ethos, 28*(2), 174-197.

Breslau, J. (2004). Cultures of trauma: Anthropological views of posttraumatic stress disorder in international health. *Culture, Medicine and Psychiatry, 28*(2), 113-126.

Brewin, C., & Holmes, E. A. (2003). Psychological theories of posttraumatic stress disorder. *Clinical Psychology Review, 23*, 339-376. doi:10.1016/S0272-7358(03)00033-3

Brewin, C., Lanius, R. A., Novac, A., Schnyder, U., & Galea, S. (2009). Reformulating PTSD for DSM-V: Life after criterion A. *Journal of Traumatic Stress, 22*(5), 366-373.

Briere, J. N., & Scott, C. (2013). Cognitive interventions. *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment* (2nd ed., pp. 125-136). Thousand Oaks, CA: Sage.

Briere, J. N., & Scott, C. (2013). Distress reduction and affect regulation training. *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment* (2nd ed., pp. 111-124). Thousand Oaks, CA: Sage.

Briere, J. N., & Scott, C. (2013). Mindfulness in trauma treatment. *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment* (pp. 187-201). Thousand Oaks, CA: Sage.

Briere, J. N., & Scott, C. (2013). Psychoeducation. *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment* (2nd ed., pp. 103-110). Thousand Oaks, CA: Sage.

Brinton Lykes, M. (1994). Terror, silencing and children: International multidisciplinary collaboration with guatemalan maya communities. *Social Science and Medicine, 38*(4), 543-552.

Brinton Lykes, M., Blanche, M. T., & Hamber, B. (2003). Narrating survival and change in guatemala and south africa: The politics of representation and a liberatory community psychology. *American Journal of Community Psychology, 31*(1/2), 79-90.

Broman, J. J., Ruggiero, K. J., Green, B. A., Kilpatrick, D. G., Danielson, C. K., Resnick, H. S., & Saunders, B. E. (2006). Taxometric investigation of PTSD: Data from two nationally representative samples. *Behavior Therapy, 37*, 364-380.

Broman, J. J., Ruggiero, K. J., Green, B. A., Smith, D. W., Hanson, R. F., Kilpatrick, D. G., & Saunders, B. E. (2009). The latent structure of posttraumatic stress disorder among adolescents. *Journal of Traumatic Stress, 22*(2), 146-152. doi:10.1002/jts.20399

Bryant, R. A. (2010). The complexity of complex PTSD. *American Journal of Psychiatry, 167*(8), 878-880. doi:10.1176/appi.ajp.2010.10040606

Buckley, T. C., Blanchard, E. B., & Hickling, E. J. (1998). A confirmatory factor analysis of posttraumatic stress symptoms. *Behavior Research and Therapy, 36*, 1091-1099.

Burgess, A. W., & Holmstrom, L. L. (1974). Rape trauma syndrome. *American Journal of Psychiatry, 131*(9), 981-986.

Burrell, J. (2009). Intergenerational conflict in the postwar era. In W. E. Little, & T. J. Smith (Eds.), *Mayas in Postwar Guatemala: Harvest of violence revisited* (pp. 96-109). Tuscaloosa, AL: University of Alabama Press.

Cahill, S. P., & Foa, E. (2007). Psychological theories of PTSD. In M. J. Friedman, T. M. Keane & P. A. Resick (Eds.), *Handbook of PTSD* (pp. 55-77). New York: Guilford.

Cahill, S. P., & Pontoski, K. (2005). Post-traumatic stress disorder and acute stress disorder I. *Psychiatry, 2*(4), 14-25.

Cahill, S. P., Pontoski, K., & D'Olio, C. M. (2005). Posttraumatic stress disorder and acute stress disorder II: Considerations for treatment and prevention. *Psychiatry, 2*(9), 34-46.

Calhoun, P. S., Hertzberg, J. S., Kirby, A. C., Dennis, M. F., Hair, L. P., Dedert, E. A., & Beckham, J. C. (2012). The effect of draft DSM-V criteria on posttraumatic stress disorder prevalence. *Depression and Anxiety, 29*, 1032-1042. doi:10.1002/da.22012

Campbell, R. (2008). The psychological impact of rape victims' experiences with the legal, medical, and mental health systems *American Psychologist, 63*(8), 702-717. doi: 10.1037/0003-066X.63.8.702

Cavanagh, S. R., Shin, L. M., Karamouz, N., & Rauch, S. L. (2006). Psychiatric and emotional sequelae of surgical amputation. *Psychosomatics, 47*, 459-464.

Chakraborty, A. (1991). Culture, colonialism, and psychiatry. *Lancet, 337*(8751), 1204-1212.

Cheung, P. (1994). Posttraumatic stress disorder among Cambodian refugees in New Zealand. *The International Journal of Social Psychiatry, 40*(1), 17-26.

Church, D., Yount, G., & Brooks, A. J. (2012). The effect of emotional freedom techniques on stress biochemistry. *The Journal of Nervous and Mental Disease, 200*(10), 891-896. doi: 10.1097/NMD.0b013e31826b9fc1

Clark, T. (2001). Baby should not be thrown out with bath water. *British Medical Journal, 322*(7297), 1303.

Coates, S. (2003). Chapter 1: Introduction: Trauma and Human Bonds. In S. Coates, J. L. Rosenthal & D. S. Schechter (Eds.), *September 11: Trauma and Human Bonds* (pp. 1-14). Hillsdale, NJ: The Analytic Press.

Cohen, J. (2001). Doctors should relieve suffering, not debate its existence. *British Medical Journal, 322*(7297), 1301.

Comas-Díaz, L., Lykes, M. B., & Alarcón, R. D. (1998). Ethnic conflict and the Psychology of Liberation in Guatemala, Peru, and Puerto Rico. *American Psychologist, 53*(7), 778-792.

Cómite de Defensa de los Derechos del Pueblo. (1989). The effects of torture and political repression in a sample of Chilean families. *Social Science and Medicine, 28*(7), 735-740.

Consolí, A. J., Grazioso, M., & López, M. (2006). Building International Relations: Advancing counseling and fostering human development. *Counseling and Human Development, 39*(4), 1-20.

Consolí, A. J., Hernández Tzaquitzal, M., & González, A. (2013). Mayan Cosmovision and Integrative Counseling: A case study from Guatemala. In S. Poyrazli, & C. E. Thompson

(Eds.), *International case studies in mental health* (1st ed., pp. 141-153). Thousand Oaks, CA: Sage Publications.

Copeland, N. (2011). 'Guatemala will never change': Radical pessimism and the politics of personal interest in the western highlands. *Journal of Latin American Studies, 43*, 485-515. doi:10.1017/S0022216X11000411

Corrigan, P. W., & Watson, A. C. (2004). Stop the stigma: Call mental illness a brain disease. *Schizophrenia Bulletin, 30*(3), 477-479.

Cosminsky, S. (1977). The impact of methods of analysis of illness concepts in a Guatemalan community. *Social Science and Medicine, 11*(5), 325-332.

Cushman, P. (1995). *Constructing the self, constructing america: A cultural history of psychotherapy*. New York: Da Capo Press.

Damasio, A. (1994). *Descartes' error: Emotion, reason, and the human brain* (2005th ed.). New York: Penguin Books.

d'Ardenne, P., Capuzzo, N., Ruaro, L., & Priebe, S. (2005). One size fits all? Cultural sensitivity in a psychological service for traumatised refugees. *Diversity in Health and Social Care, 2*, 29-36.

Davis, L., & Morales Chinchilla, E. (1975). Psychotherapy in Guatemala. *Interamerican Journal of Psychology, 9*(1-2), 173-175.

Davis, S. H. (1988). Introduction: Sowing the seeds of violence. In R. M. Carmack (Ed.), *Harvest of violence: The Maya Indians and the Guatemalan Crisis* (pp. 3-36). Norman, OK: University of Oklahoma Press.

de Jong, J. T. V. M., Komproe, I. H., & van Ommeren, M. (2003). Common mental disorders in postconflict settings. *The Lancet, 361*, 2128-2130.

Debiec, J., & LeDoux, J. E. (2009). The amygdala networks of fear: From animal models to human psychopathology. In D. McKay, J. S. Abramowitz, S. Taylor & G. Asmundson (Eds.), *Current perspectives on the anxiety disorders: Implications for DSM-V and beyond* (pp. 107-126). New York: Springer.

Devilly, G. J. (2001). Accountable methods of validation are needed. *British Medical Journal, 322*(7297), 1302.

Devilly, G. J. (2005). Power therapies and possible threats to the science of psychology and psychiatry. *Australian and New Zealand Journal of Psychiatry, 39*, 437-445.

Diaz-Loving, R. (1998). Contributions of Mexican Ethnopsychology to the Revolution of the Etic-Emic Dilemma in Personality. *Journal of Cross-Cultural Psychology, 29*, 104-118.

Ehlers, A., Maercker, A., & Boos, A. (2000). Posttraumatic stress disorder following political imprisonment: The role of mental defeat, alienation, and perceived permanent change. *Journal of Abnormal Psychology, 109*(1), 45-55.

Eisenberg, L. (1977). Disease and Illness: Distinctions between professional and popular ideas of sickness. *Culture, Medicine and Psychiatry, 1*, 9-23.

Eisenbruch, M. (1984). Cross-cultural aspects of bereavement.I: A conceptual framework for comparative analysis. *Culture, Medicine and Psychiatry, 8*, 283-309.

Eisenbruch, M., de Jong, J. T. V. M., & van de Put, W. (2004). Bringing order out of chaos: A culturally competent approach to managing the problems of refugees and victims of organized violence. *Journal of Traumatic Stress, 17*(2), 123-131.

Eisenman, D. P., Gelberg, L., Liu, H., & Shapiro, M. F. (2003). Mental health and health-related quality of life among adult latino primary care patients living in the united states with previous exposure to political violence. *JAMA, 290*(5), 627-634.

Esparza, M. (2005). Post-war Guatemala: Long-term effects of psychological and ideological militarization of the K'iche mayans. *Journal of Genocide Research, 7*(3), 377-391.

Fabrega, J., H., & Manning, P. K. (1973). An integrated theory of disease: Ladino-mestizo views of disease in the chiapas highlands. *Psychosomatic Medicine, 35*(3), 223-239.

Farias, P. (1994). Central and South American Refugees: Some mental health challenges. In A. J. Marsella, T. Bornemann, S. Ekbald & J. Orley (Eds.), *Amidst Peril and Pain* (pp. 101-113). Washington, D.C.: American Psychology Association.

Farias, P. J. (1992). El modelo biomédico frente a la tradición indígena maya. el caso de los refugiados Guatemaltecos en Chiapas. *Textos Del VI Coloquio. Magia y Medicina,* Mexico. 62-70.

Fausset, R. (2013, October 4, 2013). Suspected mastermind of Guatemala police massacre arrested in Mexico. *LA Times*

Fernández García, M. C. (2004). *Lynching in Guatemala: Legacy of war and impunity.* Unpublished manuscript.

Fernando, G. A. (2004). Working with survivors of war in non-western cultures: The role of the clinical psychologist. *Intervention, 2*(2), 108-117.

Fishman, D. B. (2005). Editor's introduction to PCSP: From single case to database. *Pragmatic Case Studies in Psychotherapy, 1*(1), 1-50.

Foa, E., Hembree, E. A., Cahill, S. P., Rauch, S. A. M., Riggs, D. S., Feeny, N. C., & Yadin, E. (2005). Randomized trial of prolonged exposure for posttraumatic stress disorder with and without cognitive restructuring: Outcome at academic and community clinics. *Journal of Consulting and Clinical Psychology, 73*(5), 953-964. doi:10.1037/0022-006X.73.5.953

Foa, E., Hembree, E. A., & Rothbaum, B. O. (2007). *Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences*. New York: Oxford University Press.

Foa, E., & Rothbaum, B. O. (1998). Imaginal Exposure: Reliving the trauma. *Treating the Trauma of Rape: Cognitive-behavioral therapy for PTSD* (pp. 158-175). New York: Guilford.

Forbes, D., Haslam, N., Williams, B. J., & Creamer, M. (2005). Testing the latent structure of posttraumatic stress disorder: A taxometric study of combat veterans. *Journal of Traumatic Stress, 18*(6), 647-656. doi:10.1002/jts.20073

Ford, J. D. (2009). Neurobiological and developmental research: Clinical implications. In C. A. Courtois, & J. D. Ford (Eds.), *Treating complex traumatic stress disorder: An evidence-based guide* (pp. 31-58). New York: Guilford.

Foxen, P. (2000). Cacophony of voices: A K'iche' mayan narrative of rememberance and forgetting. *Transcultural Psychiatry, 37*(3), 355-381. doi:10.1177/1363461500003700305

Foxen, P. (2010). Local narratives of distress and resilience: Lessons in psychosocial well-being among the K'iche' maya in postwar Guatemala. *Journal of Latin American and Caribbean Anthropology, 15*(1), 66-89.

Frankl, V. (1959/1992). *Man's search for meaning* (1992nd ed.). Boston: Beacon Press.

Fremont, W. P. (2004). Childhood reactions to terrorism-induced trauma: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*(4), 381-392. doi:10.1097/01.CHI.0000112484.08386.50

Friedman, M. J. (2009). Chapter 15: PTSD and other Posttraumatic Syndromes. In D. McKay, J. S. Abramowitz, S. Taylor & G. Asmundson (Eds.), *Current perspectives on the anxiety disorders: Implications for DSM-V and beyond* (pp. 377-409). New York: Springer.

Friedman, M. J., Resick, P. A., Bryant, R. A., & Brewin, C. (2011). Considering PTSD for DSM-5. *Depression and Anxiety, 28*, 750-769.

Friedman, M. J., Resick, P. A., & Keane, T. M. (2007). PTSD: Twenty-five years of progress and challenges. In M. J. Friedman, T. M. Keane & P. A. Resick (Eds.), *Handbook of PTSD* (pp. 3-18). New York: Guilford.

Friedman, M., & Marsella, A. J. (1996). Chapter 1: Posttraumatic stress disorder: An overview of the concept. In A. J. Marsella, M. Friedman & R. M. Scurfield (Eds.), *Ethnocultural aspects of posttraumatic stress disorder: Issues, research and clinical applications* (pp. 11-32). Washington, D.C.: American Psychological Association.

Fromm, M. G. (2014). Interview with Frank Ochberg. *Psychoanalytic Psychology, 31*(2), 206-216.

Gafner, G., & Benson, S. (2001). Indirect Ego-Strengthening in Treating PTSD in Immigrants from Central America. *Contemporary Hypnosis, 18*(3), 135-144.

Gergen, K. J. (1997). The place of the psyche in a constructed world. *Theory and Psychology, 7*, 31-36.

Gergen, K. J. (2001). Psychological science in a postmodern context. *American Psychologist, 56*(10), 803-813. doi:10.1037//0003-066X.56.10.803

Gerrity, E., Keane, T. M., & Tuma, F. (2001). The survivor's perspective: Voices from the center. In E. Gerrity, T. M. Keane & F. Tuma (Eds.), *Mental health consequences of torture* (pp. 13-34). New York: Kluwer Academic.

Gerrity, E., & Solomon, S. D. (1996). The treatment of PTSD and related stress disorders: Current research and clinical knowledge. In A. J. Marsella, M. J. Friedman, E. Gerrity & R. M. Scurfield (Eds.), *Ethnocultural Aspects of Posttraumatic Stress Disorder: Issues, research, and clinical applications* (pp. 87-102). Washington, D.C.: American Psychological Association.

Ghaemi, N. (2009). Nosologomania: DSM & Karl Jasper's Critique of Kraepelin. *Philosophy, Ethics, and Humanities in Medicine, 4*(10) doi:10.1186/1747-5341-4-10

Gilkerson, L. (1998). Brain Care: Supporting healthy emotional development. *Child Care Information Exchange, 5*(98), 66-68.

Godoy, A. S. (2002). Lynchings and the Democratization of Terror in Postwar Guatemala: Implications for human rights. *Human Rights Quarterly, 24*, 640-661.

Godoy-Paiz, P., Toner, B., & Vidal, C. (2011). "Something in our hearts": Challenges to mental health among urban Mayan women in post-war Guatemala. *Ethnicity and Inequalities in Health and Social Care, 4*(3), 127-137. doi:10.1108/17570981111249266

Gold, S. D., Marx, B. P., Soler-Baillo, J. M., & Sloan, D. M. (2005). Is life stress more traumatic than traumatic stress? *Anxiety Disorders, 19*, 687-689. doi:10.1016/j.janxdis.2004.06.002

Goldín, L., & Rosenbaum, R. (2009). Everyday violence of exclusion: Women in precarious neighborhoods of Guatemala City. In W. E. Little, & T. J. Smith (Eds.), *Mayas in Postwar Guatemala: Harvest of violence revisited* (pp. 67-83). Tuscaloosa, AL: University of Alabama Press.

Goldman, F. (1999, Murder comes for the bishop. *The New Yorker, 75*, 60-78.

Goldson, E. (1996). The effect of war on children. *Child Abuse & Neglect, 20*(9), 809-819.

Gondolf, E. W. (1998). Procedures for Assessing Women Battering. *Assessing Woman Battering in Mental Health Services* (pp. 65-94). Thousand Oaks, CA: Sage Publications.

Gorman, W. (2001). Refugee Survivors of Torture: Trauma and treatment. *Professional Psychology: Research and Practice, 32*(5), 443-451.

Gossen, G. H. (1994). From Olmecs to Zapatistas: A once and future history of souls. *American Anthropologist, 96*(3), 553-570.

Grandin, G. (2000). Chronicles of a Guatemalan Genocide Foretold: Violence, trauma, and the limits of historical inquiry. *Nepantla, 1*, 391-412.

Grazioso, M., Keller, J., Swazo, R., & Consolí, A. J. (2013). Guatemala. In T. H. Hohensil, N. E. Amundson & S. G. Niles (Eds.), *Counseling around the world: An international handbook* (pp. 389-398). Alexandria: American Counseling Association.

Groark, K. P. (2005). Vital warmth and well-being: Steambathing as household therapy among the Tzeltal and Tzotzil Maya of highland Chiapas, Mexico. *Social Science and Medicine, 61*, 785-795. doi:10.1016/j.socscimed.2004.08.044

Groark, K. P. (2009). Discourses of the soul: The Negotiation of Personal Agency in Tzotzil Maya Dream Narrative. *American Ethnologist, 36*(4), 705-721. doi:10.1111/j. 1548-1425.2009.01205.x

Grubrich-Simitis, I. (1981). Extreme Traumatization as Cumulative Trauma: Psychoanalytic investigations of the effects of concentration camp experiences on survivors and their children. *Psychoanalytic Study of the Child, 36*, 415-450.

Hale, C. R. (2006). *Más que un indio*. Sante Fe, NM: School of American Research Press.

Harvey, M. (1996). An ecological view of psychological trauma and trauma recovery. *Journal of Traumatic Stress, 9*(1), 3-23.

Harvey, M. (2007). Towards an ecological understanding of resilience in trauma survivors. *Journal of Aggression, Maltreatment and Trauma, 14*(1), 9-32. doi:10.1300/J146v14n01_02

Haslam, N. (2002). Kinds of Kinds: A conceptual taxonomy of psychiatric categories. *Philosophy, Psychiatry, & Psychology, 9*(3), 203-217. doi:10.1353/ppp.2003.0043

Hegadoren, K. M., Lasiuk, G. C., & Coupland, N. J. (2006). Posttraumatic stress disorder part III: Health effects of interpersonal violence among women. *Perspectives in Psychiatric Care, 42*(3), 163-173.

Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress, 5*(3), 377-391.

Herman, J. L. (1992). *Trauma and recovery*. United States: BasicBooks.

Herman, J. L. (2008). Craft and science in the treatment of traumatized people. *Journal of Trauma and Dissociation, 9*(3), 293-300. doi:10.1080/15299730802138966

Hernández-Wolfe, P. (2013). *A borderlands view on latinos, latin americans, and decolonization: Rethinking mental health*. Plymouth, UK: Jason Aronson.

Hinton, D. E., & Lewis-Fernandez, R. (2011). The cross-cultural validity of posttraumatic stress disorder: Implications for DSM-5. *Depression and Anxiety, 28*, 783-801.

Hoffman, J. (2014, November, 28, 2014). More pastors embrace talk of mental ills. *New York Times*

Holdorff, B., & Dening, T. (2011). The fight for 'traumatic neurosis', 1889-1916: Hermann Oppenheim and his opponents in Berlin. *History of Psychiatry, 22*(4), 465-476. doi: 10.1177/0957154X10390495

Human Rights Watch. (2012). World report 2012: Guatemala. Retrieved from http://www.hrw.org/world-report-2012/guatemala

Hyman, S. E. (2010). The Diagnosis of Mental Disorders: The problem of reification. *Annual Review of Clinical Psychology, 6*, 155-179. doi:10.1146/annurev.clinpsy.3.022806.091532

Iglesias, A., & Iglesias, A. (2005). Hypnotic treatment of PTSD in children who have complicated bereavement. *American Journal of Clinical Hypnosis, 48*(2-3), 183-189.

Insel, T. (2013, April 29, 2013). Director's blog: Transforming diagnosis. Retrieved from http://www.nimh.nih.gov/about/director/2013/transforming-diagnosis.shtml

Institute of Medicine. (2007). *Treatment of posttraumatic stress disorder: An assessment of the evidence*. Washington, D.C.: The National Academies Press.

Institute of Medicine. (2014). *Treatment for Posttraumatic Stress Disorder in Military and Veteran Populations: Final Assessment.* (). Washington, D.C.: Institute of Medicine of the National Academies.

International Society for Traumatic Stress Studies. (1997). *Childhood trauma remembered: A report on the current scientific knowledge base and its applications*. Northbrook, IL: International Society for Traumatic Stress Studies.

Iraheta Monroy, M. R. (2003). Psicotrauma en sobrevivientes de guerra en Guatemala. *Medicina Legal De Costa Rica, 20*(2), 87-96.

Isaacs, A. (2010). At war with the past? The politics of truth seeking in Guatemala. *The International Journal of Transitional Justice, 4*(2), 251-274. doi:10.1098/ijtj/ijq005

Jacob, K. S., Mirza, I., Garrido-Cumbrera, M., Seedat, S., Mari, J. J., Sreenivas, V., & Saxena, S. (2007). Mental health systems in countries: Where are we now? *The Lancet, 370*, 1061-1077. doi:10.1016/S0140- 6736(07)61241-0

Jacobsen, L. K., Southwick, S., & Kosten, T. R. (2001). Substance use disorders in patients with posttraumatic stress disorder: A review of the literature. *American Journal of Psychiatry, 158*, 1184-1190.

Jakobsen, M., Thoresen, S., & Eide-Johansen, L. E. (2011). The validity of screening for post-traumatic stress disorder and other mental health problems among asylum seekers from different countries. *Journal of Refugee Studies, 24*(1), 171-186. doi:10.1093/jrs/feq053

James, S., & Prillentensky, I. (2002). Cultural diversity and mental health: Towards integrative practice. *Clinical Psychology Review, 22*, 1133-1154.

Jaranson, J. M. (1998). The science and politics of rehabilitating torture survivors. In J. M. Jaranson, & M. K. Popkin (Eds.), *Caring for victims of torture* (pp. 15-40). Washington, D.C.: American Psychiatric Press.

Jaranson, J. M., Kinzie, J. D., Friedman, M., Ortiz, D. S., Friedman, M. J., Southwick, S., . . . Mollica, R. (2001). Assessment, diagnosis, and treatment. In E. Gerrity, T. M. Keane & F. Tuma (Eds.), *The mental health consequences of torture* (pp. 249-275). New York: Kluwer Academic.

Jenkins, J. H. (1988). Conceptions of schizophrenia as a problem of nerves: A cross-cultural comparison of Mexican-Americans and Anglo-Americans. *Social Science and Medicine, 26*(12), 1233-1243.

Jenkins, J. H. (1991). The state construction of affect: Political ethos and mental health among Salvadoran refugees. *Culture, Medicine and Psychiatry, 15*, 139-165.

Jenkins, J. H. (1996). Culture, emotion and PTSD. In A. J. Marsella, M. J. Friedman, E. Gerrity & R. M. Scurfield (Eds.), *Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications* (pp. 165-182). Washington, D.C.: American Psychological Association.

Johnson, D. R., & Lubin, H. (2005). The counting method as exposure therapy: Revisions and case examples. *Traumatology, 11*(3), 189-198.

Johnson, H., & Thompson, A. (2008). The development and maintenance of post-traumatic stress disorder (PTSD) in civilian adult survivors of war trauma and torture: A review. *Clinical Psychology Review, 28*, 36-47.

Jones, E., Vermaas, R. H., McCartney, H., Beech, C., Palmer, I., Hyams, K., & Wessely, S. (2003). Flashbacks and post-traumatic stress disorder: The genesis of a 20th-century diagnosis. *British Journal of Psychiatry, 182*, 158-163. doi:10.1192/bjp.182.2.158

Jones, E., & Wessely, S. (2007). A paradigm shift in the conceptualization of psychological trauma in the 20th century. *Journal of Anxiety Disorders, 21*, 164-175. doi:10.1016/ j.janxdis.2006.09.009

Jones, E., Woolven, R., Durodie, B., & Wessely, S. (2004). Civiliian morale during the second world war: Responses to air raids re-examined. *Social History of Medicine, 17*(3), 463-479.

Karasz, A. (2005). Cultural differences in conceptual models of depression. *Social Science and Medicine, 60*, 1625-1635. doi:10.1016/j.socscimed.2004.08.011

Keane, T. M., Marshall, A. D., & Taft, C. (2006). Posttraumatic stress disorder: Etiology, epidemiology and treatment outcome. *Annual Review of Clinical Psychology, 2*, 161-197. doi:10.1146/annurev.clinpsy.2.022305.095305

Kelley, L. P., Weathers, F. W., McDevitt-Murphy, M. E., Eakin, D., & Flood, A. M. (2009). A comparison of PTSD symptom patterns in three types of civilian trauma. *Journal of Traumatic Stress, 22*(3), 227-235.

Kendell, R., & Jablensky, A. (2003). Distinguishing between the validity and utility of psychiatric diagnoses. *American Journal of Psychiatry, 160*(1), 4-12.

Kendler, K. S., Muñoz, R. A., & Murphy, G. (2010). The Development of the Feighner Criteria: A historical perspective. *American Journal of Psychiatry, 167*, 134-142.

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the national comorbidity survey. *Archives of General Psychiatry, 52*, 1048-1060.

Kienzler, H. (2008). Debating war-trauma and post-traumatic stress disorder (PTSD) in an interdisciplinary arena. *Social Science and Medicine, 67*, 218-227.

Kilpatrick, D. G., Resnick, H. S., & Acierno, R. (2009). Should PTSD criterion A be retained? *Journal of Traumatic Stress, 22*(5), 374-383.

Kinzie, J. D., & Goetz, R. R. (1996). A century of controversy surrounding posttraumatic stress-spectrum syndromes: The impact on DSM-III and DSM-IV. *Journal of Traumatic Stress, 9*(2), 159-179.

Kleinman, A. M. (1977). Depression, somatization and the "new cross-cultural psychiatry". *Social Science and Medicine, 11*, 3-10.

Kleinman, A. M. (1987). Anthropology and psychiatry. The role of culture in cross-cultural research on illness. *British Journal of Psychiatry, 151*, 447-454. doi:10.1192/bjp.151.4.447

Kleinman, A. M. (1995). Violence, culture and the politics of trauma. *Writing at the margin: Discourse between anthropology and medicine* (pp. 173-192). Berkeley: University of California Press.

Kleinman, A. M., Eisenberg, L., & Good, B. (1978). Culture, illness, and care: Clinical lessons from anthropologic and cross-cultural research. *Annals of Internal Medicine, 88*, 251-258.

Kleinman, A. M., & Kleinman, J. (1991). Suffering and its professional transformation: Toward an ethnography of interpersonal experience. *Culture, Medicine and Psychiatry, 15*(3), 275-301.

Kockelman, P. (2007). Inalienable possession and personhood in Q'eqchi'-mayan community. *Language in Society, 36*, 343-369. doi:10.10170S0047404507070170

Kockelman, P. (2011). A Mayan Ontology of Poultry: Selfhood, affect, animals, and ethnography. *Language in Society, 40*, 427-454. doi:10.1017/S0047404511000467

Kogler, H. H. (1999). *The power of dialogue: Critical hermeneutics after Gadamer and Foucault* (P. Hendrickson Trans.). Cambridge, MA: MIT Press.

Lamprecht, F., & Sack, M. (2002). Posttraumatic stress disorder revisited. *Psychosomatic Medicine, 64*, 222-274.

Lasiuk, G. C., & Hegadoren, K. M. (2006). Posttraumatic stress disorder part I: Historical development of the concept. *Perspectives in Psychiatric Care, 42*(1), 13-20.

Lasiuk, G. C., & Hegadoren, K. M. (2006). Posttraumatic stress disorder part II: Development of the construct within the north american taxonomy. *Perspectives in Psychiatric Care, 42*(2), 72-81.

Laub, D., & Auerhahn, N. C. (1989). Failed empathy-- A central theme in the survivor's holocaust experience. *Psychoanalytic Psychology, 6*(4), 377-400.

Lauber, C., Nordt, C., Falcato, L., & Rossler, W. (2003). Do people recognise mental illness? *European Archives of Psychiatry and Clinical Neuroscience, 253*, 248-251. doi:10.1007/s00406-003-0439-0

Lerner, P., & Micale, M. S. (2001). Trauma, psychiatry, and history: A conceptual and historiographical introduction. *Traumatic pasts: History, psychiatry and trauma in the modern age, 1870-1930* (pp. 1-27). New York: Cambridge University.

Levenson, D. (2002). Reactions to Trauma: The 1976 earthquake in Guatemala. *International Labor and Working-Class History, 62*, 60-68.

Lewis, S. E. (1995). A search for meaning: Making sense of depression. *Journal of Mental Health, 4*(4), 369-382.

Ley, C., & Rato Barrio, M. (2011). Movement and sport therapy with women in Guatemalan context of violence and conflict. *Body, Movement and Dance in Psychotherapy: An International Journal for Theory, Research and Practice, 6*(2), 145-160.

Light, D. (1992). Healing their wounds: Guatemalan refugee women as political activists. *Women and Therapy, 13*(3), 297-308.

Lira, E. (1998). Guatemala: Uncovering the past, recovering the future. In D. Eade (Ed.), *Development and rights: Selected essays from development in practice* (1st ed., pp. 138-148). Oxford: Oxfam GB.

Little, W. (2009). Chapter 4: Living and selling in the "new violence" of Guatemala. In W. E. Little, & T. J. Smith (Eds.), *Mayas in Postwar Guatemala: Harvest of Violence Revisited* (pp. 54-66). Tuscaloosa, AL: University of Alabama Press.

Littlewood, R. (1980). Anthropology and psychiatry—an alternative approach. *British Journal of Medical Psychology, 53*, 213-225.

Littlewood, R. (1990). From categories to contexts: A decade of the 'new cross-cultural psychiatry'. *British Journal of Psychiatry, 156*, 308-327. doi:10.1192/bjp.156.3.308

Littlewood, R. (1991). Against pathology. The new psychiatry and its critics. *BJP, 159*, 696-702. doi:10.1192/bjp.159.5.696

Littlewood, R. (1992). DSM-IV and culture: Is the classification internationally valid? *Psychological Bulletin, 16*, 257-261. doi:10.1192/pb.16.5.257

Littlewood, R. (1992). Towards an intercultural therapy. In J. Kareem, & R. Littlewood (Eds.), *Intercultural therapy: Themes, interpretations and practice* (pp. 3-13). Oxford: Blackwell Scientific Publications.

Littlewood, R. (1996). Psychiatry's culture. *International Journal of Social Psychiatry, 42*(4), 245-268.

Littlewood, R. (2002). Trauma and the Kanun: Two responses to loss in Albania and Kosovo. *International Journal of Social Psychiatry, 48*, 86-95. doi:10.117/002076402128783136

Littlewood, R., & Lipsedge, M. (1987). The butterfly and the serpent: Culture, psychopathology and biomedicine. *Culture, Medicine and Psychiatry, 11*, 289-335.

Litva, A. (2001). Social usefulness of any diagnosis needs consideration. *British Medical Journal, 322*(7297), 1302.

Litz, B. (2014). Clinical heuristics and strategies for service members and veterans with war-related PTSD. *Psychoanalytic Psychology, 31*(2), 192-205. doi:10.1037/a0036372

Litz, B. T., Stein, N., Delaney, E., Lebowitz, L., Nash, W. P., Silva, C., & Maguen, S. (2009). Moral injury and moral repair in war veterans: A preliminary model and intervention strategy. *Clinical Psychology Review, 29*, 695-706. doi:10.1016/j.cpr.2009.07.003

Long, M., Elhai, J. D., Schweinle, A., Gray, M. J., Grubaugh, A. L., & Frueh, B. C. (2008). Differences in posttraumatic stress disorder diagnostic rates and symptom severity between criterion A1 and non-criterion A1 stressors. *Journal of Anxiety Disorders, 22*, 1255-1263. doi:10.1016/j.janxdis.2008.01.006

Lopez, A., Boccellari, A., & Hall, K. (1988). Posttraumatic stress disorder in a Central American refugee. *Hospital and Community Psychiatry, 39*(12), 1309-1312.

Lorenz, E. (1993). *The essence of chaos*. Seattle: University of Washington Press.

Maguen, S., & Litz, B. (2012). Moral injury in veterans of war. *PTSD Research Quarterly, 23*(1), 1-6.

Margolis, J., & Valadez, F. (2008). An experience with a large group of guerrillas: A mammoth group. *Group, 32*(4), 273-288.

Marsella, A. J., Friedman, M. J., & Spain, E. H. (1992). A selective review of the literature on ethnocultural aspects of PTSD. *PTSD Research Quarterly, 3*(2), 1-8.

Martin, J., & Sugarman, J. (2001). Interpreting human kinds: Beginnings of a hermeneutic psychology. *Theory and Psychology, 11*, 193-207.

Martinez, A., & Fabri, M. (1991). The dilemma of revictimization. *Torture: Quarterly Journal on Rehabilitation of Torture Victims and Prevention of Torture, 3*(1), 47-48.

Martinez, E. J. (2003). Peace as Masquerade: Militarization and post-war terror in Guatemala. *Canadian Woman Studies, 22*(2), 40-46.

McCabe, R. E., Swinson, R. P., & Jacobs, A. M. (2009). Neo-Kraepelinian diagnosis: Adequacy for OCD, GAD, and PTSD. In D. McKay, J. S. Abramowitz, S. Taylor & G. Asmundson (Eds.), *Current perspectives on the anxiety disorders: Implications for DSM-V and beyond* (pp. 77-103). New York: Springer.

McCloskey, L. A., Southwick, K., Fernández-Esquer, M. E., & Locke, C. (1995). The psychological effects of political and domestic violence on Central American and Mexican immigrant mothers and children. *Journal of Community Psychology, 23*, 95-116.

McCracken, G. D. (1988). *The long interview*. Newbury Park, CA: Sage Publications.

McDevitt-Murphy, M. E., Shea, M. T., Yen, S., Grilo, C. M., Sanislow, C. A., Markowitz, J. C., & Skodol, A. E. (2012). Prospective investigation of a PTSD personality typology among individuals with personality disorders. *Comprehensive Psychiatry, 53*, 441-450.

McDonagh, A., Friedman, M., McHugo, G., Ford, J., Sengupta, A., Mueser, K., . . . Descamps, M. (2005). Randomized trial of cognitive-behavioral therapy for chronic posttraumatic stress disorder in adult female survivors of childhood sexual abuse. *Journal of Consulting and Clinical Psychology, 73*(3), 515-524. doi:10.1037/0022-006X.73.3.515

McFall, R. M. (1991). Manifesto for a Science of Clinical Psychology. *The Clinical Psychologist, 44*(6), 75-88.

McHugh, P. R., & Treisman, G. (2007). PTSD: A problematic diagnostic category. *Journal of Anxiety Disorders, 21*, 211-222.

McNally, R. J. (2001). Tertullian's Motto and Callahan's Method. *Journal of Clinical Psychology, 57*(10), 1171-1174.

McNally, R. J. (2009). Can we fix PTSD in DSM-V. *Depression and Anxiety, 26*, 597-600.

McNally, R. J., & Saigh, P. A. (1993). On the distinction between traumatic simple phobia and posttraumatic stress disorder. In J. Davidson, & E. Foa (Eds.), *Posttraumatic stress disorder: DSM-IV and beyond* (pp. 207-212). Washington, D.C.: American Psychiatric Press.

Melville, M. B., & Brinton Lykes, M. (1992). Guatemala indian children and the sociocultural effects of government-sponsored terrorism. *Social Science and Medicine, 34*(5), 553-548.

Menchú, R. (1984). In Burgos-Debray E. (Ed.), *I, Rigoberta Menchú: An Indian Woman in Guatemala* (A. Wright Trans.). London: Verso.

Menjivar, C. (2011). *Enduring violence*. Berkley, CA: University of California Press.

Merskey, H., & Piper, A. (2007). Posttraumatic stress disorder is overloaded. *Canadian Journal of Psychiatry, 52*, 499-500.

Metz, B. E. (2006). Introduction: What's Indigenous, What's Maya? *Ch'orti'-Maya Survival in Eastern Guatemala: Indigeneity in Transition* (pp. 1-12). Albuquerque, NM: University of New Mexico Press.

Miller, K. E. (1996). The effect of state terrorism and exile on indigenous Guatemala refugee children: A mental health assessment and an analysis of children's narratives. *Child Development, 67*, 89-106.

Miller, K. E., & Billings, D. L. (1994). Playing to Grow: A primary mental health intervention with Guatemalan refugee children. *American Journal of Orthopsychiatry, 64*(3), 346-356.

Miresco, M. J., & Kirmayer, L. (2006). The persistence of mind-brain dualism in psychiatric reasoning about clinical scenarios. *The American Journal of Psychiatry, 163*(5), 913-918.

Mol, S., Arntz, A., Metsemakers, J., Dinant, G. J., Vilters-van Montfort, P., & Knottnerus, J. A. (2005). Symptoms of post-traumatic stress disorder after non-traumatic events: Evidence from an open population study. *British Journal of Psychiatry, 186*, 494-499. doi:10.1192/bjp.186.6.494

Moreno, A., & Grodin, M. A. (2002). Torture and its Neurological Sequelae. *Spinal Cord, 40*, 213-223.

Morse, J. M., & Richards, L. (2002). *Read me first: For a users' guide to qualitative methods*. Thousand Oaks, CA: Sage Publications.

Mucci, C. (2013). *Beyond individual and collective trauma: Intergenerational transmission, psychoanalytic treatment, and the dynamics of forgiveness*. London: Karnac.

Murthy, S., & Lakshminarayanna, R. (2006). Mental health consequences of war: A brief review of research findings. *World Psychiatry, 5*(1), 25-30.

Narcotráfico está detrás de masacre. (2013, June 15, 2013). *Prensa Libre*, pp. 1-3.

National Institute for Clinical Excellence. (2005). *Post-Traumatic Stress Disorder: The management of PTSD in adults and children in primary and secondary care.* (No. National Clinical Practice Guideline Number 26). Great Britain: Gaskell and the British Psychological Society.

Neumeister, A., Henry, S., & Krystal, J. H. (2007). Neurocircuitry and Neuroplasticity. In M. J. Friedman, T. M. Keane & P. A. Resick (Eds.), *Handbook of PTSD* (pp. 151-165). New York: Guilford.

Neuner, F., Schauer, M., Klaschik, C., Karunakara, U., & Elbert, T. (2004). A comparison of narrative exposure therapy, supportive counseling, and psychoeducation for treating posttraumatic stress disorder in an African refugee settlement. *Journal of Consulting and Clinical Psychology, 72*(4), 579-587. doi:10.1037/0022-006X.72.4.579

Newman, M. (2001). Post-traumatic stress disorder. In N. J. Smelser, & P. Baltes (Eds.), *International encyclopedia of social and behavioral sciences* (2nd ed., pp. 11881-11885). Oxford: Elsevier Science Ltd.

Norcross, J., & Karpiak, C. P. (2012). Clinical psychologists in the 2010s: 50 years of the APA division of clinical psychology. *Clinical Psychology: Science and Practice, 19*(1), 1-12.

Norcross, J., Karpiak, C. P., & Santoro, S. O. (2005). Clinical psychologists across the years: The division of clinical psychology from 1960 to 2003. *Journal of Clinical Psychology, 61*(12), 1467-1483. doi:10.1002/jclp.20135

Ogden, P., Pain, C., Minton, K., & Fisher, J. (2005). Including the body in mainstream psychotherapy for traumatized individuals. *Psychologist-Psychoanalyst, 25*(4), 19-24.

Orley, J. (1994). Psychological disorders among refugees: Some clinical and epidemiological considerations. In A. J. Marsella, T. Bornemann, S. Ekbald & J. Orley (Eds.), *Amidst peril and pain* (). Washington, D.C.: American Psychological Association.

Padgett, D. K., Patrick, C., Burns, B. J., & Schlesinger, H. J. (1994). Ethnicity and the use of outpatient mental health services in a national insured population. *American Journal of Public Health, 84*, 222-226.

Palic, S., & Elklit, A. (2011). Psychosocial treatment of posttraumatic stress disorder in adult refugees: A systematic review of prospective treatment outcome studies and a critique. *Journal of Affective Disorders, 131*, 8-23.

Parkinson, C. (2013, October 4, 2013). Mexico catches alleged ringleader of Guatemala police massacre. *Insight Crime*

Paunovic, N., & Ost, L. G. (2001). Cognitive-behavior therapy vs. exposure therapy in the treatment of PTSD in refugees. *Behavior Research and Therapy, 39*, 1183-1197.

Pedersen, D. (2002). Political violence, ethnic conflict, and contemporary wars: Broad implications for health and social well-being. *Social Science and Medicine, 55*, 175-190.

Perlman, B. (1985). A national survey of APA-affiliated master-level clinicians: Description and comparison. *Professional Psychology: Research and Practice, 16*(4), 553-564.

Policias recibieron amenaza. (2013, June 16, 2013). *Prensa Libre*, pp. 6.

Porter, M., & Haslam, N. (2005). Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons: A meta-analysis. *Jama, 294*(5), 602-612.

Poyrazli, S., & Thompson, C. E. (2013). Introduction: Toward an inclusive international psychology. In S. Poyrazli, & C. E. Thompson (Eds.), *International Case Studies in Mental Health* (pp. 1-12). Los Angeles: Sage Publications.

Priebe, S., Bogic, M., Ashcroft, R., Franciskovic, T., Galeazzi, G. M., Kucukalic, A., . . . Ajdukovic, D. (2010). Experience with human rights violations and subsequent mental disorders - A study following the war in the Balkans. *Social Science and Medicine, 71*, 2170-2177.

Pynoos, R. S., Steinberg, A. M., Layne, C. M., Briggs, E. C., Ostrowski, S. A., & Fairbank, J. A. (2009). DSM-V PTSD diagnostic criteria for children and adolescents: A developmental perspective and recommendations. *Journal of Traumatic Stress, 22*(5), 391-398.

Radan, A. (2007). Exposure to violence and expressions of resilience in Central American women survivors of war. *Journal of Aggression, Maltreatment and Trauma, 14*(1/2), 147-164.

Rasmussen, A., Smith, H., & Keller, A. S. (2007). Factor structure of PTSD symptoms among west and central African refugees. *Journal of Traumatic Stress, 20*(3), 271-280. doi:10.1002/jts.20208

Ray, S. (2008). Evolution of posttraumatic stress disorder and future directions. *Archives of Psychiatric Nursing, 22*(4), 217-225.

Read, J., Haslam, N., Sayce, L., & Davies, E. (2006). Prejudice and schizophrenia: A review of the 'mental illness is an illness like any other' approach. *Acta Psychiatrica Scandinavica, 114*, 303-318. doi:10.1111/j.1600-0447.2006.00824.x

Rechtman, R. (2000). Stories of trauma and idioms of distress: From cultural narratives to clinical assessment. *Transcultural Psychiatry, 37*(3), 403-415.

Regier, D. A., Narrow, W. E., Kuhl, E. A., & Kupfer, D. J. (2009). The conceptual development of DSM-V. *American Journal of Psychiatry, 166*(6), 645-650. doi:10.1176/appi.ajp.2009.09020279

Remijnse, S. (2001). Remembering civil patrols in Joyabaj, Guatemala. *Bulletin of Latin American Research, 20*(4), 454-469.

Resick, P. A., & Miller, M. W. (2009). Posttraumatic stress disorder: Anxiety or traumatic stress disorder. *Journal of Traumatic Stress, 22*(5), 384-390. doi:10.1002/jts.20437

Reuters. (2013, July 14, 2013). Guatemala arrests over remote police station massacre. *BBC News*

Reuters. (2014, August 29, 2014). Central America hit by severe drought. *NY Times*

Reuters. (2014, July 8, 2014). Earthquake shakes Guatemala and Mexico. *NY Times*

Reuters. (2014, May 22, 2014). Guatemalan ex-president Alfonso Portillo jailed in US. *BBC News*

Richman, N. (1998). Looking before and after: Refugees and asylum-seekers in the west. In P. J. Bracken, & C. Petty (Eds.), *Rethinking the trauma of war*. London: Free Association Books.

Robles, F. (2014, June 4, 2014). Wave of minors on their own rush to cross southwest border. *NY Times*

Rohr, E. (2009). Farewell to a Dead Horse: Group analytic supervision training in post-war Guatemala. *Group Analysis, 42*, 107-119.

Rohr, E. (2012). Traces of trauma in post-conflict Guatemala: Theoretical reflections on the effects of trauma on social organisation. In L. Auested (Ed.), *Psychoanalysis and Politics: Exclusion and the politics of representation* (pp. 173-198). London: Karnac.

Rohr, M. (2006). Historical Resources of the Maya: An important building block for counseling in Guatemala. In J. S. Olsen, J. O. Haagensen, A. G. Madsen & F. and Rasmussen (Eds.), *From counseling to psychosocial development* (1st ed., pp. 65-70). Denmark: Rehabilitation and Research Center for Torture Victims.

Rosen, G. (2004). Traumatic events, criterion creep and the creation of post-traumatic stress disorder. *The Scientific Review of Mental Health Practice, 3*(2), 39-42.

Rosen, G. and Frueh, B.C. (2007). Challenges to the PTSD construct and its database: The importance of scientific debate. *Journal of Anxiety Disorders, 21*, 161-167.

Rosen, G., & Lilienfield, S. O. (2008). Posttraumatic stress disorder: An empirical evaluation of core assumptions. *Clinical Psychology Review, 28*, 837-868. doi:10.1016/j.cpr.2007.12.002

Rosen, G., & Taylor, S. (2007). Pseudo-PTSD. *Journal of Anxiety Disorders, 21*, 201-210. doi: 10.1016/j.janxdis.2006.09.011

Rosenthal, E. (2013, January 5, 2013). More guns = more killing. *NY Times*

Rousseau, C. (2005). Test of Time: Diving into complexity: John Sigal's work on the long-term consequences of the holocaust. *Clinical Child Psychology and Psychiatry, 10*, 262. doi: 10.1177/1359104505051216

Rousseau, C., de la Aldea, E., Rojas, M. V., & Foxen, P. (2005). After the NGO's departure: Changing memory strategies of young Mayan refugees who returned to Guatemala as a community. *Anthropology and Medicine, 12*(1), 1-19.

Rousseau, C., Morales, M., & Foxen, P. (2001). Going home: Giving voice to memory strategies of young Mayan refugees who returned to Guatemala as a community. *Culture, Medicine and Psychiatry, 25*, 135-168.

Rubin, D. C. (2011). The Coherence of Memories for Trauma: Evidence from Posttraumatic Stress Disorder. *Consciousness and Cognition, 20*, 857-865.

Ruiz-Goiriena, R. (2014, May 7, 2014). A year after genocide trial, has justice been done? *CNN*

Ruscio, A. M., Ruscio, J., & Keane, T. M. (2002). The latent structure of posttraumatic stress disorder: A taxometric investigation of reactions to extreme stress. *Journal of Abnormal Psychology, 111*(2), 290-301. doi:10.1037//0021-843X.111.2.290

Ryder, A., Yang, J., & Heine, S. J. (2002). Somatization vs. psychologization of emotional distress: A paradigmatic example for cultural psychopathology. *Online Readings in Psychology and Culture, 10*(2)

Sabin, M., Cardozo, B. L., Nackerud, L., Kaiser, R., & Varese, L. (2003). Factors associated with poor mental health among Guatemalan refugees living in Mexico 20 years after civil conflict. *Jama, 290*(5), 635-642.

Sabin, M., Sabin, K., Kim, H. Y., Vergara, M., & Varese, L. (2006). The mental health status of Mayan refugees after repatriation to Guatemala. *Revista Panamericana De Salud Pública, 19*(3), 163-171.

Scaer, R. (2005). *The Trauma Spectrum: Hidden wounds and human resiliency*. New York: W.W. Norton & Co.

Scheeringa, M., Peebles, C. D., Cook, C. A., & Zeanah, C. H. (2001). Towards Establishing Procedural, Criterion, and Discriminant Validity for PTSD in Early Childhood. *Child and Adolescent Psychiatry, 40*(1), 52-60. doi:10.1097/00004583-200101000-00016

Schottenbauer, M. A., Glass, C. R., Arnkoff, D. B., & Gray, S. H. (2008). Contributions of psychodynamic approaches to treatment of PTSD and trauma: A review of the empirical treatment and psychopathology literature. *Psychiatry, 71*(1), 13-34.

Schweizer, S., & Dalgleish, T. (2011). Emotional working memory capacity in posttraumatic stress disorder (PTSD). *Behavior Research and Therapy, 49*, 498-504. doi:10.1016/j.brat.2011.05.007

Sellborn, M., & Bagby, R. M. (2009). Identifying PTSD Personality Subtypes in a Workplace Trauma Sample. *Journal of Traumatic Stress, 22*(5), 471-475. doi:10.1002/jts.20452

Shalev, A. (2001). Disorder takes away human dignity and character. *British Medical Journal, 322*(7297), 1301.

Shapiro, F. (2007). EMDR, Adaptive Information Processing, and Case Conceptualization. *Journal of EMDR Practice and Research, 1*(2), 68-87. doi:10.1891/1933-3196.1.2.68

Shay, J. (2014). Moral Injury. *Psychoanalytic Psychology, 31*(2), 182-191. doi:10.1037/a0036090

Sherman, J. J. (1998). Effects of Psychotherapeutic Treatments for PTSD: A meta-analysis of controlled clinical trials. *Journal of Traumatic Stress, 11*(3), 413-435.

Siegel, D. (2003). An Interpersonal Neurobiology of Psychotherapy: The developing mind and the resolution of trauma. In D. Siegel, & M. F. Soloman (Eds.), *Healing trauma* (pp. 1-56). New York: W.W. Norton & Company.

Silove, D. (1996). Torture and Refugee Trauma: Implications for Nosology and Treatment of Posttraumatic Syndromes. In F. L. Mak, & C. C. Nadelson (Eds.), *International Review of Psychiatry, vol. 2* (pp. 211-232). Arlington, VA: American Psychiatric Association.

Silove, D. (1999). The psychological effects of torture, mass human rights violations, and refugee trauma: Toward an integrated conceptual framework. *The Journal of Nervous and Mental Disease, 187*(4), 200-207.

Silove, D., & Kinzie, J. D. (2001). Survivors of war trauma, mass violence, and civilian terror. In E. Gerrity, T. M. Keane & F. Tuma (Eds.), *Mental Health Consequences of Torture* (pp. 159-174). New York: Kluwer Academic.

Smith, T. J., & Offit, T. A. (2010). Confronting Violence in Postwar Guatemala: An Introduction. *Journal of Latin American and Caribbean Anthropology, 15*(1), 1-45.

Solomon, Z., & Mikulincer, M. (2006). Trajectories of PTSD: A 20-year longitudinal study. *The American Journal of Psychiatry, 163*(4), 659-666.

Southwick, S., Davis, L., Aikins, D. E., Rasmusson, A., Barron, J., & Morgan III, C. (2007). Neurobiological Alterations Associated with PTSD. In M. J. Friedman, T. M. Keane & P. A. Resick (Eds.), *Handbook of PTSD* (pp. 166-189). New York: Guilford.

Spiegel, A. (2005, January 5, 2005). The Dictionary of Disorder. *The New Yorker,* Retrieved from http://www.newyorker.com/magazine/2005/01/03/the-dictionary-of-disorder

Spiegel, D., & Vermetten, E. (2007). Post-Traumatic Stress Disorder: Medicine or Politics (not both). *The Lancet, 369*, 992.

Spitzer, R. L., First, M. B., & Wakefield, J. C. (2007). Saving PTSD from itself in DSM-V. *Journal of Anxiety Disorders, 21*, 233-241. doi:10.1016/j.janxdis.2006.09.006

Spitzer, R. L., & Wakefield, J. C. (1999). DSM-IV diagnostic criterion for clinical significance: Does it help solve the false positives problem? *The American Journal of Psychiatry, 156*(12), 1856-1865.

Steel, Z., Bateman Steel, C., & Silove, D. (2009). Human Rights and the Trauma Model: Genuine partners or uneasy allies. *Journal of Traumatic Stress, 22*(5), 358-365.

Stein, M. B., Walker, J. R., & Forde, D. (2000). Gender Differences in Susceptibility to Posttraumatic Stress Disorder. *Behavior Research and Therapy, 38*, 619-628.

Stolorow, R. D. (2007). *Trauma and Human Existence: Autobiographical, Psychoanalytic, and Philosophical Reflections*. New York: Routledge.

Strauss, A., & Corbin, J. (1990). *Basics of Qualitative Research*. Newbury Park, CA: Sage Publications.

Sturm, D., Baubet, T., & Moro, M. R. (2007). Mobilizing Social and Symbolic Resources in Transcultural Therapies with Refugees and Asylum Seekers: The Story of Mr. Diallo. In B. Drozdek, & J. P. Wilson (Eds.), *Voices of Trauma: Treating psychological trauma across cultures* (pp. 211-232). New York: Springer.

Suárez-Orozco, M. M., & Robben, A. (2000). Interdisciplinary perspectives on violence and trauma. In A. Robben, & M. M. and Suárez-Orozco (Eds.), *Cultures Under Siege: Collective violence and trauma* (pp. 1-42). New York: Cambridge University Press.

Summerfield, D. (1998). The social experience of war and some issues for the humanitarian field. In P. J. Bracken, & C. Petty (Eds.), *Rethinking the Trauma of War* (pp. 9-37). London: Free Association Books.

Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Social Science and Medicine, 48*, 1449-1462.

Summerfield, D. (2000). Childhood, War, Refugeedom and 'Trauma': Three core questions for mental health professionals. *Transcultural Psychiatry, 37*(3), 417-433.

Summerfield, D. (2001). The Invention of Post-Traumatic Stress Disorder and the Social Usefulness of a Psychiatric Category. *BMJ, 322*, 95-98.

Symes, L. (1995). Post Traumatic Stress Disorder: An Evolving Concept. *Archives of Psychiatric Nursing, 9*(4), 195-202.

Thakker, J., & Ward, T. (1998). Culture and Classification: The cross-cultural application of the DSM-IV. *Clinical Psychology Review, 18*(5), 501-529.

Thompson, M., & McGorry, P. (1995). Psychological sequelae of torture and trauma in Chilean and Salvadorean migrants: A pilot study. *Australian and New Zealand Journal of Psychiatry, 29*, 84-95.

Treating complex traumatic stress disorders: An evidenced-based guide (2009). In Courtois C. A., Ford J. D. (Eds.), . New York: Guilford.

Tribe, R. (2007). Health Pluralism: A more appropriate alternative to western models of therapy in the context of the civil conflict and natural disaster in Sri Lanka? *Journal of Refugee Studies, 20*(1), 21-36. doi:10. 1093/jrs/fel031

Tummala-Narra, P. (2007). Conceptualizing trauma and resilience across diverse contexts. *Journal of Aggression, Maltreatment and Trauma, 14*(1-2), 33-53. doi:10.1300/ J146v14n01_03

Tyhurst, J. S. (1951). Individual Reactions to Community Disaster: The natural history of psychiatric phenomena. *The American Journal of Psychiatry, 107*(10), 764-769.

Urrutia, G. (1987). Mental health problems of encamped refugees: Guatemala refugees in Mexican camps, 1978-1984. *Bulletin of the Menninger Clinic, 51*(2), 170-185.

Van der Kolk, B. (2006). Clinical Implications of Neuroscience Research in PTSD. *Annual New York Academy of Sciences, 1071*, 277-293. doi:10.1196/annals.1364.022

Van der Kolk, B. (2007). The History of Trauma in Psychiatry. In M. J. Friedman, T. M. Keane & P. A. Resick (Eds.), *Handbook of PTSD* (pp. 19-36). New York: Guilford.

Van der Kolk, B., & McFarlane, A. C. (1996). The Black Hole of Trauma. In B. Van der Kolk, A. C. McFarlane & L. Weisaeth (Eds.), *Traumatic Stress* (pp. 3-24). New York: Guilford.

Van Etten, M. L., & Taylor, S. (1998). Comparative Efficacy of Treatments for Post-Traumatic Stress Disorder: A Meta-Analysis. *Clinical Psychology and Psychotherapy, 5*, 126-144.

van Hooff, M., McFarlane, A. C., Baur, J., Abraham, M., & Barnes, D. J. (2009). The stressor criterion-A1 and PTSD: A matter of opinion? *Journal of Anxiety Disorders, 23*, 77-86.

Viñar, M. N. (2005). The Specificity of torture: The human wilderness when words fail. *International Journal of Psychoanalysis, 86*, 311-333.

Volkan, V. D. (2001). Transgenerational Transmissions and Chosen Traumas: An aspect of large-group identity. *Group Analysis, 34*(1), 79-97. doi:10.1177/05333160122077730

von Peter, S. (2008). The experience of 'mental trauma' and its transcultural application. *Transcultural Psychiatry, 45*, 639-651. doi:10.1177/1363461508100786

Wake, S., & Kitchiner, D. (2013). Post-traumatic stress disorder after intensive care. *British Medical Journal, 346* doi:10.1136/bmj.f3232

Wakefield, J. (1992). The Concept of Mental Disorder: On the boundary between biological facts and social values. *American Psychologist, 47*(3), 373-388.

Wakefield, J. C. (1999). Evolutionary Versus Prototype Analyses of the Concept of Disorder. *Journal of Abnormal Psychology, 108*(3), 374-399.

Walton, J. R., Nuttall, R. L., & Nuttall, E. V. (1997). The Impact of War on the Mental Health of Children: A Salvadoran Study. *Child Abuse & Neglect, 21*(8), 737-749.

Warner, F. R. (2007). Social Support and Distress among Q'eqchi' Refugee Women in Maya Tecún, Mexico. *Medical Anthropology Quarterly, 21*(2), 193-217. doi:10.1525/MAQ. 2007.21.2.193

Waterman, A. (2013). The Humanistic Psychology-Positive Psychology Divide: Contrasts in PhilosophicalFoundations. *American Psychologist, 68*(3), 124-133. doi:10.1037/a0032168

Watson, D. (2009). Rethinking the Anxiety Disorders in DSM-V and Beyond: Quantitative dimensional models of anxiety and related psychopathology. In D. McKay, J. S. Abramowitz, S. Taylor & G. Asmundson (Eds.), *Current Perspectives on the Anxiety Disorders: Implications for DSM-V and Beyond* (pp. 275-302). New York: Springer.

Watters, C. (2001). Emerging paradigms in the mental health care of refugees. *Social Science and Medicine, 52*, 1709-1718.

Watters, E. (2010). *Crazy Like Us: The Globalization of the American Psyche*. New York: Free Press.

Wearne, P. (1994). *The Maya of Guatemala*. London: Minority Rights Group.

Weathers, F. W., & Keane, T. M. (2007). The criterion A problem Revisted: Controversies and challenges in defining and measuring psychological trauma. *Journal of Traumatic Stress, 20*(2), 107-121.

Weine, S. M., Becker, D. F., McGlashan, T. H., Laub, D., Lazrove, S., Vojvoda, D., & Hyman, L. (1995). Psychiatric Consequences of "Ethnic Cleansing": Clinical Assessments and Trauma Testimonies of Newly Resettled Bosnian Refugees. *The American Journal of Psychiatry, 152*(4), 536-542.

Weine, S. M., Kulenovic, A. D., Pavkovic, I., & Gibbons, R. (1998). Testimony psychotherapy in Bosnian refugees: A pilot study. *The American Journal of Psychiatry, 155*(12), 1720-1726.

Welsh, J., & Ulltveit-Moe, T. (2000). Guatemalan government acknowledges human-rights abuses. *The Lancet, 356*, 1436.

Widiger, T., & Sankis, L. M. (2000). Adult Psychopathology: Issues and Controversies. *Annual Review of Psychology, 51*, 377-404.

Wilson, J. P. (1994). The Historical Evolution of PTSD Diagnostic Criteria: From Freud to DSM-IV. *Journal of Traumatic Stress, 7*(4), 681-698.

Wilson, J. P. (2007). Reversing Cultures: The Wounded Teaching the Healers. In B. Drozdek, & J. P. Wilson (Eds.), *Voices of Trauma: Treating Survivors Across Cultures* (pp. 87-104). New York: Springer.

Wilson, M. (1993). DSM-III and the Transformation of American Psychiatry: A History. *American Journal of Psychiatry, 150*(3), 399-410.

Wilson, R. (1995). *Maya resurgence in Guatemala: Q'eqchi' Experiences*. Norman, OK: University of Oklahoma Press.

Woodrick, A. C. (1995). A Lifetime of Mourning: Grief work among Yucatec Maya Women. *Ethos, 23*(4), 401-423.

Xenakis, S. N. (2014). Posttraumatic stress disorder: Beyond best practices. *Psychoanalytic Psychology, 31*(2), 236-244.

Yandell, M. (2015, January 7, 2015). The War Within. *Christian Century,* , 12-13.

Yellow Horse Brave Heart, M., Chase, J., Elkins, J., & Altschul, D. B. (2011). Historical trauma among Indigenous Peoples of the Americas: Concepts, Research, and Clinical Considerations. *Journal of Psychoactive Drugs, 43*(4), 282-290. doi: 10.1080/02791072.2011.628913

Young, A. (1995). *Harmony of Illusions*. Princeton, NJ: Princeton University Press.

Zoellner, L. A., Feeny, N. C., Cochran, B., & Pruitt, L. (2003). Treatment Choice for PTSD. *Behavior Research and Therapy, 41*, 879-886. doi:10.1016/S0005-7967(02)00100-6

Zur, J. (1994). The Psychological Impact of Impunity. *Anthropology Today, 10*(3), 1994-12.

Zur, J. (1996). From PTSD to Voices in Context: From an "experience-far" to an "experience-near" understanding of responses to war and atrocity across cultures. *International Journal of Social Psychiatry, 42*, 305-317.

Appendices
Understanding Trauma in Guatemala:
A Cross-Cultural Perspective

Initial Questionnaire

Dear _____,

First of all, let me say thank you again for your interest in participating in this research. Your participation is voluntary, and I appreciate your willingness to share your time, wisdom and energy. As it was mentioned in previous material, this study attempts to investigate how trauma is understood by psychologists in Guatemala in order to explore how culture and history influence concepts of trauma and trauma treatment.

The following questions are part of a demographic and clinical questionnaire. These questions are intended to clarify details about the type of work that you do in your clinical practice. Please answer them to the best of your ability and send your answers in a return email to the primary investigator at this email address. All answers will be kept confidential. I anticipate this questionnaire will take 20 minutes to complete. Please complete and return this questionnaire before the interview.

If you have any questions, please do not hesitate to contact me, either by email or by phone (see below).

Demographic Information:

1. How old are you?
2. What is your level of training (master's or doctorate)?
3. What type of setting do you work in (i.e., hospital, private practice, public clinic, etc.)?
4. What [regional] department(s) do you work in?
5. What, if any, do you consider your area(s) of clinical expertise?
6. How many years have you been in practice?
7. Where did you get your training?
8. What theoretical orientations do you identify with (psychodynamic, behavioral, integrative, etc.)?
9. Do you use a major diagnostic system in your practice (i.e., DSM-IV-TR, ICD)? If so, which one(s)? If not, please briefly describe your approach to case conceptualization.

Client Population

1. What populations do you see in your practice?
    a. Typical age range
    b. Gender(s)
    c. Cultural/Ethnic background
    d. Socio-economic background
    e. Religious background
    f. Sexual orientation
2. What are the three most common clinical issues that you treat?

3. How are your clients referred to you?
4. What language(s) do your clients typically speak?
5. In what languages do you conduct therapy? Do you ever work with interpreters or ask family members to interpret for you?
6. What modalities do you use (i.e., individual, couples, family, group, community-wide interventions)?
7. How many weeks/months/years do you typically work with your clients in treatment?
8. How long are your therapy sessions (i.e., 30 minutes, 1 hour)?
9. What resources are available in your community for clients in crisis (i.e., psychiatric hospitalization, family members or elders who can take responsibility)?
10. Have you noticed any demographic changes in your client population over the last five years? If so, what are they?

Thank you again for your time. I look forward to speaking with you during our interview.

Sincerely,

Jeff Brand
Primary Investigator
Graduate School of Applied & Professional Psychology
Rutgers University
152 Frelinghuysen Rd.
Piscataway, NJ 08854
jbuchananbrand@gmail.com
telephone: 1-971-227-0142

Semi-Structured Interview

Access to Treatment & Engaging Clients in Need

1. In your opinion, is it fair and accurate to say that the majority of people in Guatemala do not have access to mental healthcare?
2. How would you describe the attitudes of your clients towards therapy?
3. How do you work with clients—individuals, families, communities—who may be unfamiliar or skeptical of therapy?

Client Population

1. Can you tell me about a typical case or features that are common among your cases?
2. Can you tell me about a difficult case?
    a. What makes it difficult or stand out from the rest?

Trauma Concepts

1. How do you understand trauma? What do you think are the core features of psychological trauma?
2. In your opinion, how is trauma looked at in Guatemalan society? For example, is it seen as tragic and preventable, or as something that is unfortunate but not unexpected?

Treatment Planning

1. How do you decide where to focus in treatment? How do you decide what is most important to the client and to making progress?
2. When working with a client whose trauma history is complex—involving childhood trauma, severe traumas, or multiple incidents—how does this influence your work?

Trauma and Culture

1. Is there anything you notice that is distinct about working with your population?
   If yes:
    a. What is it?
    b. What makes it distinct?
    c. How do you explain these differences?
2. *If the psychologist works with different ethnic/cultural groups*: Do you see differences between the different ethnic groups in terms of treatment (*ladinos*, Mayans, Garifuna, etc.)?
3. In your trauma work, do you see cultural reasons to use different types of intervention with some groups more than others?
   If yes:
    a. What are those differences in interventions?
    b. Why?
4. In your experience, how have your clients' beliefs—both personal and cultural—shaped the way you worked with them in treatment?
5. In treatment, how often do you talk about social issues like poverty, political violence, cultural discrimination, etc.?

6. Social issues like poverty, crime, and a lack of trust in social institutions can introduce instability into clients' lives. How do you manage questions of safety and stability in trauma treatment with potentially distressing social issues?
7. How do you determine with your clients the difference between responses that are normal and abnormal?
8. How do you determine between responses that are adaptive and pathological?

Resilience & Recovery

1. What do you see as the major sources of resilience and strength in your clients?
2. How do you understand psychological health? What does it mean to have recovered from psychological trauma?

Miscellaneous

1. In your opinion, what are the most important things to learn for young practitioners in the field who are going to be practicing in Guatemala in order to do good trauma work?
2. Is there anything you think it would be helpful for me to know about your trauma work that we haven't talked about?
3. Is there anything else you'd like to share with me today?