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December 13, 2010

## **The Applicability of Posttraumatic Stress Disorder to Women of Non-Western Cultures**

This report investigates Posttraumatic Stress Disorder (PTSD) stemming from post-conflict and refugee situations in women of non-Western cultures. More specifically, it examines PTSD as a construction of the West, modeling a white, male-dominated, independent-culture, which leads to many limitations when the same diagnostic and therapeutic mechanisms are applied to cultures with different ideologies, values, and social constructions. This paper argues that not only is PTSD culturally insensitive, thus requiring adaptation to local context when post-traumatic symptoms are being examined and/or treated, but PTSD is also not gender sensitive. Trauma is presented and experienced differently in women than in men across cultures, and therefore PTSD – the discourse, conceptions, and practical applications of diagnosis and treatment – must expand to support the unique and multifaceted psycho-traumatic experiences of women.

Why is this important? There is no doubt that people who experience conflict and/or violence, either personally or by witnessing it occurring to others, rarely walk away unscathed. Today, however, as a global community, we are confronted with the fact that conflict is increasingly, and perhaps intentionally, moving into the domestic sphere of civilian life. This increased expansion into the domestic sphere is, in fact, essentially an invasion into the sphere of women. Furthermore, the use of violence against women as a weapon of war, including the devastating use of sexual violence and rape, is a tactic too

often utilized in conflict situations. Even women refugees who are removed from their domestic sphere when it becomes a battlefield, are put into camps that are commonly polluted with gender-based violence. Thus, women are survivors of war just as much as combatants on the frontline; however, their response to war is different and their healing and coping processes are inevitably gender-bound. With the ubiquitous tendency of conflict invading the sphere of the woman, aid workers and cultural psychologists must take a critical look at the unique manifestations of posttraumatic stress in women and view their cultural context as a central determinant of the treatment and healing process.

In order to decipher the limitations of the PTSD treatment for women, this paper will first examine the history and development of PTSD, highlighting its Western cultural construction and its focus on the particular needs of men, in the absence of discourse on gender differences. Subsequently, this paper will address the need for PTSD treatment to be adapted and will examine modern day attempts to do so, exploring some barriers to and potential remedies for cross-cultural and gender-specific use. Case studies will be employed to provide a sample of some of the complicated questions that arise, and discuss what cultural psychologists, therapists, aid workers, and others might learn.

The case studies will focus on the issues that women face in real life, as they relate to implications for the diagnosis and treatment of PTSD. These issues impact the self-image and value of these women to their communities, and include issues affected by violence to their person: sexual purity, somatic ailments, language and culture, and place in the community.

## A Brief History

The very history of PTSD reveals gender assumptions – and omissions -- in its cultural construction. PTSD was officially added to the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM-III) in 1980. Its identification and insertion stemmed from the need to label and diagnose the many symptoms that were being observed in veterans after the Vietnam War. As early as 1970, PTSD was officially defined to provide a stigma-free diagnosis for framing a person's response to traumatic events (Acocella, 1999; 45). However, because the definition was established with the American (male) soldier as blueprint, gender and culture were grossly overlooked and their impact underestimated.

Though PTSD was not given official status by Western psychiatrists until inclusion in DSM-III, the display of common symptoms after a traumatic experience was not new to the field of mental health. For centuries, women had been diagnosed with “hysteria” often in response to trauma of a sexual nature. It is important to note that the very term carries gender-related implications – *hysteria* is Greek for uterus – and the diagnosis implies that there is something intrinsically and internally weak within the woman due to her gender. Interestingly, widely published data on the subject of multiple personality disorder states that, “*nine out of ten diagnosed multiples are women*”; Hacking notes that these data do not indicate a gender disparity in terms of actual responses or symptoms to trauma, but rather a gender disparity in “who is counted.” Hysteria, and the discourse and diagnoses related to it, is “thoroughly gender-laden” (Hacking, 1998; 69). Women who react to trauma are hysterical, they are weak; men who

react to trauma have the diagnosis of PTSD to explain why *external* events have them presenting with these symptoms; in other words, it's not their fault.

In essence, in order to compensate for the weakness and loss of control exhibited by masculine soldiers after the war, a term was needed that removed blame from the individual and explained the occurrence in strictly outward and external language. Something happened *to* the men that made them react this way. On the other hand, when women exhibited similar symptoms, the diagnosis of hysteria sent a very different message – something *within* the woman makes her incapable of handling life. And yet despite its history and evolution, PTSD is put forth as a gender-neutral and universal tool.

Thus, the question must be asked, how does defining or constructing symptoms/responses without regard to gender and culture, affect those diagnosed and/or treated for PTSD? The data to establish a diagnosis of PTSD did not include women, so PTSD is inherently not a “woman’s disorder.” So what are the drawbacks and, perhaps dangers of trying to universalize this diagnosis and use it as a framework to help women in post-conflict or refugee situations? If the culture that created PTSD was not gender-sensitive in its creation, its use must be cautioned when applied in other cultures where the cultural construction of gender provides a different sense of the self, symptoms of trauma, response/treatment for trauma, and what it means to be healed.

### **Limitations on Current Concepts**

It is generally accepted that women are the bearers of their culture and therefore, it is important to examine how PTSD diagnosis and treatment might pose problems in non-western cultures, absent the inclusion of gender (Sideris, 2003; 720). Bracken *et al.*

critically caution against basing the diagnosis, discourse, and treatment conceptions of posttraumatic responses, solely in medical terms. Though symptoms and signs can be identified if sought for in an individual, this does not guarantee they hold the same meaning in different contexts and settings (Bracken *et al.*, 1995; 1074). The biomedical framework for PTSD can be challenged when the issue of *whose* concept of “how the body works” is scrutinized. There are some who question the scientific concept of how the body functions – breaking the process into molecules, organs and systems – as compared to a school of thought that recognizes that non-medical symptoms and syndromes can be culturally related and the two concepts are not independent.

There is a danger to universalizing responses as *fundamental human responses*; what it even means to be human and how individuals deal with various situations changes across culture. PTSD diagnosis and treatment asserts that certain responses, such as “intrusive thinking and denial,” will be present regardless of whether the response was from an “hysterectomy, mental illness, rape, nuclear warfare, or being told of increased risk of premature death because of heavy smoking or high blood pressure” (Bracken *et al.*, 1995; 1076). I would challenge this and say that a woman who experienced rape as a weapon of war may not present with *any* of the same responses as a woman who sees an advertisement on the subway that is displaying cautionary health statistics about the use of tobacco – in fact, the smoker may experience more denial than the woman who was sexually violated!

The limitations of the current assumptions for diagnosis extend to treatment; often discounted are many forms of healing that are outside a cultural framework that is based on the biomedical model and independence. As Bracken states, “typical Western

response to trauma focuses on the intra-psychic experience, which is not emphasized and thus plays a comparatively minor role in these less ‘egocentric’ societies” (Bracken *et al.*, 1995; 1074). He asserts that psychotherapies designed in egocentric cultures are inappropriate and can be damaging in “socio-centric” societies where recovery of an individual is inherently linked with her community. Furthermore, with focus on biomedical, pharmacological, or intra-psychic treatment, there is a great “possibility of undermining already existing medical and non-medical approaches to the alleviation of distress caused by organized violence” (Bracken *et. al.*, 1995; 1081). Psychologists working with patients in Iraq discovered that while PTSD measures that were used to document “core responses to trauma,” they found that the measurements were “not comprehensive in their coverage of the multiple adaptive stresses that characterize the human response to disasters” (Shoeb *et al.*, 2007; 449). Violence is much older than the school of Western psychology – thus, it is advantageous for cultural psychologists to explore and examine already existing methods of coping and healing that have been in existence and effective in these local contexts and to decipher how women’s coping methods might be vastly different from those of men.

### **Women are Inherently Different**

In every culture there are certain factors that help shape women’s understanding of themselves in relation to others. Bracken neatly breaks down these factors into certain “realities” all of which play a role and overlap to create the individual’s understanding of how her own, locally-constructed-world, works. “The social reality” includes the influence of “family circumstances, available social networks, economic position and

employment status.” For women, even in the most “progressively” Western cultures, this tends to mean a subordination on some level to men, implicitly if not explicitly. In some cultures this means lower status, economic dependence, and necessary interconnectedness with her family/social community, predominantly because of gender. “The Political reality” refers to the individual’s “social position as determined by gender, class and ethnic factors and possible role as a victim of state repression” or other form of marginalization or superiority. “The Cultural reality” relates to an individual’s “linguistic position, spiritual or religious involvement, basic ontological beliefs and concepts of self, community and illness” (Bracken *et al.*, 1995; 1077). All of these realities intertwine and define a woman’s role in her community as well as her beliefs about herself. While these realities will differ for each person, a psychiatrist or aid worker may be able to discern some of these realities and characteristics by identifying how gender in a specific culture influences a woman’s reality. This is crucial because these realities *must* be addressed in order to try to help women “make sense of their experiences” and to interpret the symptoms presented and prescribe treatments that are both accurate and helpful (Bracken *et al.*, 1995; 1076).

Treatment methods for women are inherently tied to their cultural reality. Often, even the *study* of trauma caused by violence in the domestic sphere, prior to providing clinical assistance to women, is only legitimate in “a context that challenges the subordination of women” (Bracken *et al.*, 1995; 1080). For instance, a treatment manual for PTSD treatment for women, in the context of US/Western culture, emphasizes the benefit of empowering women and making them independent (Elliot *et al.*, 2005; 471). At the same time, in a non-western or gendered-specified context, Bracken noted that

community cohesiveness and political solidarity greatly determine the experience of and how one copes with, the traumas of war (Bracken *et al.* 1995; 1078). However, in many cultures, women who have experienced sexual violence – often a by-product of conflict itself or life in refugee camps – are severely stigmatized. Consequently, these women do not get the benefit of the healing nature of cohesiveness; additionally, in interdependent cultures or male-dominated hierarchical societies, women's independence is often not the goal for women and may conflict with the fabric of their society. Treatment strategies need to be aware of this fine line that women often walk and develop appropriate strategies.

In a national sample of American women, Resnick found that the highest rates of PTSD were found in cases of physical assault and rape and that the histories of those who developed PTSD were characterized with the *fear* of being killed or seriously injured as well as actually being injured (Resnick *et al.*, 1993; 989-990). This would imply that for these American women, the prevalence of the *threat* of assault as well as the reality of assault increased their chances of PTSD. This raises an interesting implication that may in fact be challenged in other cultures. Increasingly, women in some parts of the world live in long-term conflict situations and the threat of violence is an expected part of each day. However, psychiatrists have been surprised to find that the rate of PTSD is noticeably low in these women – despite the pervasive threat of and real violence surrounding them. Do these women have a coping method of their own, one that differs from that of Western women? Or is the Western definition of posttraumatic stress too limited to include these women's responses? The reality is probably both are true.



The following section closely examines a few case studies of populations of women who have experienced trauma in conflict and/or refugee situations. The particular issues that arose and the ways in which methods of PTSD diagnosis and treatment were, or in retrospect, could have been adapted in order to deduce the lessons for the future approaches and treatment of women in posttraumatic stress situations in non-Western cultures, will be analyzed.

### **Real Life Challenges in the Lives of Women and Implications for PTSD Treatment**

This section will address case studies of women in Iraq, Mozambique, Uganda, and Cambodia, examining the role of sexual purity, somatic ailments, language, voice, and place in community, and their implications for diagnosing and treating PTSD resulting from the violence experienced by the women.

#### **Sexual Purity and Somatic Complaints:**

A predominant plight unique to women is the underlying, age-old issue of a woman's sexual purity and reproductive capacity. This issue has a direct and particularly gender-based impact on their experience and response to trauma – specifically rape. As Sideris noted after her experience dealing with Mozambican women refugees: “patriarchy, which charges women with responsibility for sexual purity and gives men the power to disown damaged women, unifies the experience of victims of sexual violation in different context” (Sideris, 2003; 722). In many cultures, a woman's value is linked to her capacity to reproduce and in some cultures that weight is a powerful

influence on the woman's identity. Rape is a direct offense to a woman's sexual purity, her ability to reproduce, and thus her own identity.

In this case, what exactly should be treated? The rape or the victim's sexual purity? Can purity be returned? For many women, being raped and the loss of sexual purity translate into somatic complaints that relate to the ability to reproduce. In Uganda, where fertility is of utmost importance, psychologists were able to detect symptoms of PTSD in women; however, they were surprised to find that these symptoms were not their predominant complaints or their major source of suffering. In fact, the psychologists had to pose a series of questions to even detect PTSD-related symptoms because the women did not present with any of them as complaints; rather, they complained of infections that made them unable to reproduce (Giller, 1992; 604). As Sideris admits, "their somatic complaints were not just 'epiphenomena', but the way in which these women actually experienced their distress" (Sideris, 2003; 1078). Thus, the therapy intervention had to be adapted to address the physical and somatic complaints of the women, since the anticipated PTSD symptoms defined by Western psychology (DSM-IV) were of little or no apparent concern to these women. Though the psychologists adapted their therapies in response to their patients' complaints, their actions raise another question. Who decides what is the *real* cause of the symptoms? Is the trauma the rape or the symbolic infection? If the cause is considered purely an infection, does it get treated as one? Or, if the psychologist insists it is the rape that is causing these women distress and the psychologist pursues cathartic therapy to heal the "scars of the rape" but ignores the somatic complaints, does this help the patient? Who gets to decide and name what is wrong and what responsibilities come with that power?

### Cultural Language and Women's Normative Right to a Voice:

In both the diagnostic stages and therapy stages one must be mindful of the impact culture and norms pose on language – delineating what is acceptable language – and the voice women may or may not possess in a specific culture. The boundaries of what women can say, feel they are permitted to say, and/or are safe to say, is something to which aid providers must be particularly attuned. Shoeb, who adapted the Harvard Trauma Questionnaire for a population of Iraqi refugees, emphasized the necessity of understanding the cultural and local “idioms of distress” in order to shed light on how the Iraqis understand and articulate their own distress and situational well-being (Shoeb *et al.*, 2007; 448). Of note, Shoeb reported that certain stigmatizations greatly restricted the language but in a gender-paradoxical manner. For men, being sodomized is literally a religious and culturally-unspeakable act<sup>1</sup>; consequently, to avoid alienation of the male victim, sexual violence of this nature was referred to as being “forcibly arranged in various humiliating or sexually explicit positions” (Shoeb *et al.*, 2007; 455). However, women who were raped, were “raped.” No special terms or descriptors were used to soften or reduce stigmatization. Thus, the language used was, of itself, alienating, which resulted in many women failing to admit or discuss their traumatic experiences.

In addition, in Mozambique, it was reported that women who were raped during conflict situations, did not use the language of rape, nor did they consider the rape to be the cause of their distress. “Injury to the spirit” was causing them angst and the general symptoms diagnosable for PTSD (Sideris, 2003; 716). Injury to the spirit, however, is

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<sup>1</sup> The act of sodomization is considered a “*kufir*, which is the most blasphemous act that can be committed by a Muslim” (455)

outside the realm of biomedical language that is used by Western psychologists. The spiritual and the interconnectedness of the spirit, the soul, the mind, and the body, are largely neglected in the biomedical framework. If any healing of these women were to occur, the psychologists would have to identify strategies and treatments to heal the spirit, using language and cultural practices of the women patients.

Clearly, the use of language can shed light on the idioms used by the woman rape victim, and help her better understand her own distress; unfortunately, language, especially for women, is not always freely expressed. After her work with women in Mozambique, Sideris expressed the need for cultural psychologists and aid workers to, “really consider the different needs of survivors, but more importantly, to be vigilant of how gendered relations of power repress the voices of particular survivor populations” (Sideris, 2003; 714). In Iraq, for example, women were rarely allowed to be interviewed without a male relative present. This posed a major problem, as any mention of rape would mandate that the family reject her – an action often more devastating and traumatic in outcome than the violence experienced. The aid workers felt they were able to do little but ask the question of whether or not the woman was raped. Even though most denied they had been raped, the victims would at least know that the aid workers were aware that women were being sexually abused (Shoeb *et al.*, 2007 458) Furthermore, not only does the cultural censorship of women affect their *access* to an accurate diagnosis and treatment, it also affects their *understanding* of their experience. For many of these Iraqi women, who may have been raped, keeping silent, going against the more cathartic forms of Western treatment, is an integral and understood part of the experience. And ironically, the secrecy and resultant security that they are not exposed to their families and thus will

not be rejected (or worse), is on some levels a comfort. Clearly, rejection and stigmatization, are more devastating for the victimized women. (This is addressed in greater detail in the next section.)

#### Marginalization and the Devastating Loss of Social Network:

Throughout the many case studies of women from different cultures, who experienced sexual violence during conflict or as refugees, several factors that influenced the diagnosis and treatment for PTSD were examined. These included issues related to language, distress manifesting as somatic rather than psychological symptoms, and the inability to express distress in terms recognized or “detectable” by Western standards. However, one circumstance in particular contributed to causing, worsening, or preventing improvement in PTSD symptoms – loss of the victim’s social network.

A case study of Southeast Asian refugees resulted in formulating a special classification for widowed Cambodian women, who were identified as manifesting the highest rates of PTSD and co-morbid disorders. The psychiatrists found that many of these women had experienced sexual violence and abuse; however, what was more devastating to these Cambodian women was the substantial social rejection and hostility they experienced from contact with various Asian communities. The hostility lessened only when they moved to the United States (a non-interdependent, and theoretically, non-patriarchal society). As noted by the psychiatrists, these women reported that, “they had no one (including family members) on whom they could rely” (Mollica *et al.*, 1987; 1569). In many Asian societies, women without a husband were immediately considered to be the lowest rank. Single men did not experience this social rejection, and were given

a higher status simply because of gender. In highly interdependent cultures, this can mean life or death and in terms of psychological therapies or interventions, this can severely impact any form of recovery. In this particular scenario, treatment of these refugees for PTSD involved pharmacotherapy; however, the psychiatrists acknowledged that they were unsure of how to treat the predominant symptoms experienced by most of their patients, such as nightmares, related to the loss of the source of empowerment, status, and sense of self, within their communities.

In Iraq, too, it was found that “loss of social networks and separation from family members were important factors that seemed to perpetuate psychiatric symptoms, particularly depression and PTSD” (Shoeb *et al.*, 2007; 45). This was true, too, for Mozambique women; an individual’s identity is inherently tied to “social belonging – family bonds which provide support, access to land which sustains life and kinship and participation in familiar social practices which create meaning” (Sideris, 2003; 716). For women, the traumatic experience does not end with the termination of the violent act; most often it is the repercussions that are equally life-threatening and psychologically harmful. In interdependent cultures or patriarchal societies, women’s mental health relies on their connection to their families and communities as well as their economic status and social standing. Consequently, employing a biomedical framework to diagnose and treat for PTSD – a framework that primarily addresses the individual’s medically relevant symptoms, focuses merely on curing the individual *outside of her community* – will not provide her much relief. This method seeks to empower and heal the victim by working with her to address what is *believed* to be the *cause* of her stress, rather than addressing the social context or the cultural marginalization and rejection she may be experiencing.

## **Conclusion**

From the case studies introduced here, it is evident that a woman's response to trauma is not easily quantifiable or translatable into Western terminology or ideology. Clearly, PTSD diagnosis and treatment, as defined by Western standards, does not account for the multifaceted impact of culture on a woman's experience, understanding, presentation and manifestation of symptoms after a traumatic event. Nor does the end of conflict or the end of an incident of rape, mean the end of the victimized woman's trauma. Marginalization and cultural stigmatization often have a more devastating and exacerbating impact on women who have experienced sexual violence. It will take aid workers and cultural psychologists who are willing and adept at evaluating local idioms of distress and analyzing the many realities of life that intersect to create a local woman's particular experience. From there, diagnostic and intervention infrastructures must be adjusted to support the contextual needs of the woman. At the outset of this paper, a question was posed: What is the impact of defining and/or constructing symptoms/responses for PTSD without regard to gender and culture, and how might this affect those diagnosed and/or treated for PTSD? Clearly, failure to incorporate site-specific culture and gender, creates grave limitations by creating a language and ideology surrounding PTSD that is cultural and gender-limited. Women are on the battlefield in increasing numbers these days as combatants and victims of combat. Therefore, the conceptions surrounding PTSD must be expanded to fit a broader range of human reactions and responses to trauma and its application must adapt culturally with special attention to gender.

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