

# **African Conceptualisations of Posttraumatic Stress Disorder and the Impact of Introducing Western Concepts**

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This paper, in its original form, was published as: Dawson, J. (2007). African conceptualisations of posttraumatic stress disorder and the impact of introducing Western concepts. *Psychology, Psychiatry, and Mental Health Monographs*, 2, 101-112. Sydney: New South Wales Institute of Psychiatry.

This paper was modified in 2007 for the thesis *When Fear Remains: The Development and Maintenance of Posttraumatic Stress Disorder*. Dawson, J. (2007). If you wish to use this research, please reference as: African conceptualisations of posttraumatic stress disorder and the impact of introducing Western concepts. Retrieved (date retrieved) from TraumAid International Web site <http://traumaid.org/TraumaResearch.aspx>

Data from this research was also presented in the form of a paper at the NSW Institute of Psychiatry Annual Conference 2004. *Trauma: Responses Across the Life Span Conference*. Dawson, J. African conceptualisations of PTSD.

Data from this research was included in invited papers at:

The Australasian Society for Traumatic Stress Studies Western Australia Chapter Convention 2005. *Disasters of the last decade: Multi-disciplinary responses to immediate and long-term consequences of large-scale disasters*. Dawson, J. (2005). Do no harm: Mitigating the impact of trauma safely following the tsunami in Sri Lanka and war-torn regions of Africa.

The University of Western Sydney Tsunami and Spirituality Conference 2006. Dawson, J. (2006). The impact of psychological, spiritual and practical interventions following large-scale disasters.

## *Abstract*

Post Traumatic Stress Disorder (PTSD) is a debilitating psychobiological disorder that can develop following exposure to an extreme stressor. Western conceptualisations of the disorder view PTSD symptoms as the result of extreme physiological and psychological trauma on the mind and body. Blame for the development of symptoms is externalised onto the traumatic event and the sufferer viewed as an innocent victim who requires medical and psychological help to overcome the impact of the trauma. In Africa where violent wars have left an enormous amount of people traumatised, it was enlightening to discover that Posttraumatic Stress Disorder is conceptualised differently by many Ugandan, Congolese and Sudanese communities and thus also treated differently. This paper discusses various African conceptualisations of PTSD and the impact of introducing Western concepts.

## ***Introduction to paper***

The research for this paper was conducted to gain background information for a later study on Posttraumatic Stress Disorder (PTSD). As the study was to be in a cross-cultural setting, the presence of a disorder that had been operationalised within a Western culture was not assumed. In order to validate the presence of PTSD in non-Western cultures the researcher interviewed community leaders and carers from Uganda, Sudan and the Democratic Republic of the Congo attending a trauma management workshop in Central Uganda. They were consulted as to the problems they were experiencing as a result of ongoing war atrocities.

Over a three-day period, representatives from these countries (n = 140) shared their stories with the researcher, in country and tribal groups. Data was collected through a process of respectful listening and clarification, as is the African custom. Consent was given to use the content of conversations for verbal and printed presentations of their stories. The following is a summary of the information gained relevant to the research conducted as part of this thesis.

## ***Conceptualisation of PTSD in Western Countries***

The specific cluster of symptoms recently labelled Posttraumatic Stress Disorder in Western writings has been described for centuries. Lipton (1994) notes that symptoms of PTSD can be found in literary sources dating as far back as the Old Testament and Greek Mythology. However, Western interest in the disorder is commonly traced to Freud's writings on Traumatic Neurosis, which laid the groundwork for early conceptualisations of PTSD (Wilson, 1995). The original Diagnostic and Statistical Manual of Mental Disorders (DSM) conceptualised PTSD symptoms as an anxiety disorder (Gross Stress Reaction), seen to develop from incidents of great stress. Subsequent DSM editions refined the criteria, and in 1980 PTSD was recognised as a distinct psychological disorder (Briere, 2004).

In the years following its official recognition, scientific interest and specialised research into this debilitating disorder has rapidly increased, providing a wealth of information in Western clinical and research literature. The picture that emerges from the literature is that PTSD is a highly complex psychological and neurobiological disorder that develops as a result of an encounter with an extreme traumatic stressor. Symptoms are linked to specific neurobiological

alterations and cognitive dysfunctions that occur following an actual traumatic event of some magnitude (Bonne, Grillon, Vythilingam, Neumeister & Charney, 2004).

The diagnostic criteria are inextricably linked to a concrete identifiable traumatic event and this makes PTSD a unique psychological disorder. The latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) states that in order to be diagnosed with PTSD the person must have been “exposed to a traumatic event in which both of the following were present: (1) Event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others; (2) The person’s response involved intense fear, helplessness or horror”. Criteria B, C, and D relate to the core PTSD symptoms of hyperarousal, intrusions, and avoidance that develop in the aftermath of the traumatic event and are still present one month later.

The above criteria describe an individual who continues to live in a state of hyperarousal and hypervigilance for a minimum of one month after encountering a life threatening stressor or threat. The trauma continues to be experienced over and over through flashbacks, reliving and nightmares. This ‘live’ nature of the trauma then results in ongoing distress, avoidance of trauma related cues, and a marked reduction in normal functioning. Research goes on to highlight a cascade of other ailments that then develop as the disorder becomes more chronic. For example, memory and concentration problems (Golier, Yehuda, Lupien, Harvey & Philip, 2003), poor academic achievement in children (Saigh, Mroueh & Bremner, 1997), cognitive impairment ( Yehuda, Golier, Halligan, & Harvey, 2004; Chae, et al., 2004), irritability and anger (Novaco & Chemtob, 2002; Davidson, Landerman, & Clary, 2004), physical ailments (Deykin et al., 2001; Woods & Wineman, 2004), and marriage and family problems (Cook et al., 2004) are all linked to the ongoing effects of PTSD symptoms. Drug and alcohol addiction is also a recognised complication of the disorder, as sufferers commonly use these addictions as a means to mitigate symptoms (Read, Brown & Kahler, 2004; Stewart et al., 1999).

The Western conceptualisation of PTSD views the above characteristic symptoms as being the result of extreme psychological and physiological trauma on the mind and body. Blame for the development of symptoms is externalised onto the traumatic event (Briere, 2004) and the PTSD sufferer is generally viewed as an innocent victim who requires or has the right to medical and psychological assistance to overcome the negative impact of the trauma. Although assistance is viewed as a need or a right within this conceptualisation, early intervention methods such as

debriefing procedures have been shown to be ineffective or even harmful (Ehlers & Clark 2003; Rose, Bisson & Wesley, 2001; Gist & Devilly, 2002). Whilst evidence suggests that cognitive behavioural programmes can be effective in treating PTSD (e.g., Blanchard et al., 2003; Bryant, Moulds & Nixon, 2003), drop out rates are often high (see Zayfert et al., 2005). It is not surprising in light of the above that financial compensation or a pension is often sought by PTSD sufferers in Western countries (Levy, 2004) and that malingering has also become a focus of research (e.g., Guriel & Fremouw, 2003).

### ***Conceptualisation of PTSD in African Countries***

In many African countries a staggering number of people are currently being subjected to violent war atrocities. Following are three first hand accounts that are representative of the atrocities shared with the principal researcher during the course of data collection in Africa. They are from people in three different African countries; the Democratic Republic of the Congo, Sudan, and Uganda.

#### **The Democratic Republic of the Congo**

*“One day in the evening, a group of nine gunmen came at her. They tied up her father and her two elder brothers. She was standing up. Her mother was getting raped by five soldiers. Four others were looting all things they met in the house. After that they also came to rape her. When she wanted to resist, she got a knife plunged in her thigh. She gave up and they raped her freely. After their bad deed, they killed the father and the two brothers. Marie stayed there thoughtful, silent, and immobile for a week. Her wound was infected, the vagina very wounded, the buttocks crushed and the elbows had infected wounds. She was suffering very much without telling anything”.*

#### **Northern Uganda**

*“I was bathing my beloved son in the sitting room and his father went to the bedroom to get the towel...I can't quite remember how we got outside ... there were soldiers standing there with guns. They started marching us to the bush about 25 of us including my husband and my little son who was naked – he was barely 3 weeks old. I kept on walking in a daze until a hoarse voice ordered me to stop walking. I came back to my senses and realised that all the others were seated, my son was badly shivering. Was I going to lose him I asked myself? “Can't I fight*

*back? Then I began to wail loudly and this invited Cain on all those abducted. Fortunately for me I was not beaten but was asked to watch how the rest was beaten because of my being stubborn. Men were tied to trees and beaten, until some lost consciousness. Young girls were taken nearby and raped. I became motionless... A second round of beatings came later and this time I was also badly beaten ... one man died. Later in the night many of the young girls were again raped”.*

## **Sudan**

*“In Sudan it is a terrible situation that we can’t bear – The Arabs have introduced the Sharia law - where women are restricted to dresses which cover all their bodies and not allowed to go to school ... our men often need to leave to work in other places ... there is much looting and rape ... soldiers kill people and chop them up – they take property and burn it – there is much anger there. A mother I know lost all her children and she now has mental problems she goes around shouting “no children – no children in Sudan” there is no way to help her as her children are all dead – it is very sad”.*

Those who had personally experienced such atrocities and those who were attempting to help their fellow countrymen reacted with horror, a sense of helplessness in preventing similar future atrocities, and ongoing fear for their lives. If these atrocities were viewed in terms of Western conceptualisations of traumatic events then high rates of PTSD would be expected. Yet only one of the 140 representatives of these countries had heard of PTSD, even though all had been in contact with Western agencies providing aid (e.g., food, HIV treatment, and counselling). However, when PTSD symptoms such as those outlined in the DSM–IV were described in more detail all expressed familiarity with the disorder. Their label, for the same cluster of hyperarousal, intrusion and avoidance symptoms known as PTSD in Western conceptualisations, was “insanity” or “madness”.

One exception to the labelling of PTSD symptoms, as “insanity” was the label “bad” or “difficult” assigned to former child soldiers in Northern Uganda who displayed PTSD symptoms (aggression, hyperarousal, difficulty concentrating on schoolwork, and defensive behaviours following contact with trauma related triggers such as, gunfire, soldiers, discipline, conflict, etc). A common phrase in relation to escaped child soldiers placed back in schools in Northern Uganda was “once a soldier always a soldier – these children are just bad”.

In contrast to the Western view, the development of PTSD symptoms was commonly attributed to a weakness in the individual, rather than the overwhelming nature of the stressor. Minimal intervention appeared to be offered and there was a general consensus that whilst most get over the “insanity” in time, that some continue to run around screaming, seeing soldiers and things that are just not there. Other things were noted by representatives of these war-torn countries: a deep shame attached to symptoms of the “insanity”; that rates of the “insanity” were high and shame was deepest in Sudanese women who had been raped but had to keep silent so as not to be disowned by their husbands; and an acknowledgment that the increasing numbers of people suffering from the “insanity” was due to the different nature of these wars. This statement by a Northern Ugandan woman, endorsed by representatives present from the Congo and Sudan, describes the wars as “meaningless disfigurement, massacres and cruelty never witnessed before ... it makes no sense ... the sole purpose appears to be to terrorise inhabitants”

Of interest, is that several representatives claimed that whilst war atrocities were experienced across all communities, the insanity was rare in small rural communities. They stated that it was predominantly a city disease. Exploration as to what was different in these small rural communities that might explain the reported low incidence of the “insanity” revealed the following:

It was evident that in these small rural communities:

- Supportive social networks were still in place.
- Community grieving customs were still in place.
- Individualised care relevant to age and context of trauma was available.
- Rituals that symbolised cleansing and a sense of shared community pain were present.

For example, a Congolese woman described how her small rural community had cared for some children who had been orphaned and brutally raped by invading soldiers: *“I took several of the children into my home to live with me as their parents had been murdered. One little girl didn’t want to talk about how she had been raped and torn so I just looked after her normally. One day she saw a soldier and I noticed that she began talking to herself about what had happened so I asked the soldier would he help as he was a good soldier and he agreed. He put a cloth over his head because he would have looked different to the soldier who had killed her*

*parents and raped her. She felt safe with me by then so she began to yell at him and hit him telling him all that he had done to her that day at the river. I noticed she had no more nightmares so we then got a soldier uniform and all the village children came and hit it with sticks calling out their anger and grief. The whole community then came and we had a bonfire and the children burned the uniform as a ritual of cleansing and now although they are sad they play like children again”.*

The reported characteristics of these small rural communities with low prevalence rates of the ‘insanity’ may help explain why a recent study by Derluyn, Broekaert, Schuyten and De Temmerman (2004) on former child soldiers in Northern Uganda found that 97% of 71 child soldiers assessed, reported posttraumatic stress responses of clinical importance. These children were separated from their communities and were living in large displacement camps (e.g., 250,000 people) fighting for food and safety rather than being nurtured by familiar community members.

Although the African and Western viewpoints appear to attribute the development of PTSD to different origins (i.e. a weakness in the individual versus an overwhelming stressor), many of the above African observations are not inconsistent with findings derived from Western research. For example, the Africans observation that most get over the ‘insanity’ in time is consistent with Western research that shows that many people go on to recover from PTSD without any formal intervention (see Christopher, 2004). Their observation that rape victims have high rates of PTSD and that shame is associated with PTSD is also found in Western research (see Campbell & Soeken, 1999; Leskela, Dieperink, & Thuras, 2002; Stone, 1992; Wong & Cook, 1992).

The reported lower rates of the ‘insanity’ in small rural communities also corresponds with Western research that has identified a lack of social support as a risk factor for PTSD (see Koenen, Stellman, Stellman, & Sommer, 2003). A supportive social structure is evident in the description outlined above of a small rural community caring for traumatised children. The Africans observation that the different nature of the recent wars has contributed to the increased rates of the ‘insanity’ may also correspond. Western research has identified that the meaning attached to a traumatic event is an important variable in PTSD (see Bramsen, van der Ploeg, van der Kamp & Adèr, 2002).

## ***Impact of Introducing Western Concepts***

The African's reports regarding the effectiveness of Western debriefing procedures similarly correspond with Western research. They reported that the Western debriefing procedures currently offered to former child soldiers was ineffective. A general consensus of the outcomes of these Western interventions in children currently living in displacement camps was that most children appeared the same – some even worse. Empirical evidence cited earlier supports this observation. Sadly, although empirical evidence supports this observation, many schoolteachers attributed the failure of these Western interventions onto the children. Teachers reported that the child continuing to suffer from PTSD symptoms was fortunate to have received a Western intervention. The lack of improvement in the child's 'insanity' was attributed to the child formerly being a rebel soldier. If symptoms persisted they were subjected to disciplinary measures or action was taken to remove the child from the school.

In contrast to structured brief interventions, the introduction of Western education to key community leaders had a more positive impact. Teaching on how PTSD impacts the brain and behaviour positively affected schoolteachers' treatment of escaped child soldiers in Northern Uganda. For example, Mrs. Gladys Oyat, School Principle to 580 traumatised girls in Northern Uganda, shared how prior to having a conceptual understanding of PTSD, she had been disciplining former child soldiers in her school for continuing to show PTSD symptoms after receiving interventions in the camps. She states, *“What is very true is that initially I had mixed feelings on children who had PTSD. Sometimes I would have both sympathy and empathy. However, most times I would think that they are over exaggerating and trying to be stubborn. For example, I told you about a girl who fought a friend badly and when invited by the teachers she started shivering and shouting, I am bad, I am bad, I am bad after the teacher told her that what she did was not right. To me that was being indiscipline. I would like to confess that I was determined to discontinue from school another of the girls with PTSD, who was a commander while in captivity”*.

She went on to state that after understanding the underlying processes in PTSD that she has changed her approach with these and similar girls. She approaches them with acceptance and assistance in the containment of symptoms and instructs her staff to do likewise. Gladys describes the results of this change in attitude and behaviour as follows: *“The girl [first girl] is now a very good girl. I realize that was anger when a friend referred to her as a rebel wife and*

mother. She [the girl who was a commander in captivity] continues to have a nightmare, confused, isolated, see images of people she killed even during day and not performing well in class her marks ranges from 0 -10 percent ... now I have empathy for her. I have not solved much of her problem but hope in due course, God will give some person to help her. To me, I don't now look at her as a lazy and confused girl always sleeping. But as someone who needs help, the success made so far is that the images during day has greatly reduce”.

### ***Concluding Comments***

In conclusion, it is clear that the cluster of symptoms known as PTSD exists across cultures. Whilst the African communities place more emphasis on the individual for the development of symptoms rather than externalising it onto the traumatic event, a lot of their understanding of the disorder is similar to Western conceptualisations. Their astute observations regarding the “insanity” correlate with what we know from Western empirical research and also add to our knowledge base of effective treatments for children suffering from PTSD. It is also evident that sharing knowledge of the disorder with each other can enhance both Western and African conceptualisations of the “insanity” / PTSD. Future directions in research will involve collaboration with several African communities to explore further potential risk and protective factors in the development of PTSD.

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