13

Trauma and disasters in social and cultural context

Laurence J. Kirmayer, 1 Hanna Kienzler, 2 Abdel Hamid Afana 3 and Duncan Pedersen 4

1 Division of Social and Transcultural Psychiatry, McGill University and Culture and Mental Health Research Unit, Jewish General Hospital, Montreal, Canada
2 Department of Anthropology, McGill University, Montreal, Canada
3 International Rehabilitation Council for Torture Survivors (IRCT), Copenhagen, Denmark
4 Douglas Mental Health University Institute and Division of Social and Transcultural Psychiatry, McGill University, Montreal, Canada

13.1 INTRODUCTION

Trauma and disasters are important causes of human suffering both in terms of the sheer numbers of people affected and the complexity of the mental health problems that may follow. Violence has become one of the leading causes of death worldwide for people aged 15–44 years [1]. Of the total number of global injury-related deaths, about two-thirds are of ‘nonintentional’ origin (e.g. traffic accidents) while one-third are due to intentional violence, including suicides, homicides and organized violence (terrorism, wars and armed conflict, genocide and ethnic cleansing) [2]. Both the frequency and the numbers of people affected by violence and disasters have increased markedly over the last 100 years, while the proportion of people surviving has also risen [3]. This means that there are many more survivors who may be affected psychologically by traumatic events. As the density of human habitation and the intensity of technological development have increased, so too has the scale of disasters. Climate change, economic disparities and political conflicts all can be expected to compound the number and complexity of disasters in the years to come [4].

Social psychiatry has a long engagement with understanding the individual and collective impacts of trauma and disasters. Much of this interest has been driven by experiences of the impact of war on soldiers and civilian populations [5]. The Holocaust and other genocides have forced consideration of the effects of massive human rights violations on the survivors as well as on subsequent generations. The experience of refugees has drawn attention to the impact of displacement, forced migration and torture on mental health.

Of course, trauma is not only a consequence of such large-scale events but also a common occurrence in domestic life. Early psychodynamic theory
recognized the importance of childhood trauma as a factor in psychopathology, although this was largely displaced by an emphasis on intrapsychic conflict [6]. From the 1970s onward, the recognition of the high prevalence of child abuse and its long-term consequences has given renewed impetus to the study of trauma in psychiatry [7].

Research on the impact of natural disasters has also influenced the development of psychiatric theory and practice. Eric Lindemann’s study of the aftermath of the fire at the Coconut Grove nightclub emphasized the processes of normal grieving and the value of crisis intervention to reduce pathological outcomes of trauma and loss [8]. His work led him to establish the first community mental health centre in the US in 1948 [9]. Kai Erikson’s study of the Buffalo Creek flood in 1973 drew attention to the long-term effects on wellbeing of the destruction of communal bonds and connectedness [10]. In recent years, disaster psychiatry and psychology have emerged as distinct areas of study with textbooks, journals and societies devoted to research and discussion of clinical and social issues [11]. This development of the field has brought recognition that trauma and disasters may be associated with particular types of mental health problems requiring culturally informed interventions at both individual and community levels [12].

13.2 DEFINING AND DELIMITING TRAUMA AND DISASTER

Trauma is a term originally applied to physical injury and some of its immediate effects. Since the late 1900s, trauma has increasingly come to refer to a range of psychological impacts of the experience or threat of violence, injury and loss [13]. Events that are considered traumatic include violent personal assault, rape, physical or sexual abuse, severe automobile accidents, being diagnosed with a life-threatening illness, natural or technological disasters, being kidnapped, military combat, being taken hostage, terrorist attacks, torture and incarceration as a prisoner of war or in a concentration camp. The term ‘trauma’ emphasizes what is common across these different events, but clearly each has its own particular meanings and consequences.

Traumatic events vary widely in terms of the nature of the threat or injury, its frequency and duration, its personal significance (which may change over time), the relationship of the victim to the perpetrator (in the case of interpersonal violence or abuse), and the broader collective meaning and social response. What constitutes a trauma then is not entirely dependent on the nature of the event but also on the personal and social interpretation of the event and the responses of the affected person, their family and community, as well as the wider society. Culture influences the individual and collective experience of trauma at many levels: the perception and interpretation of events as threatening or traumatic; modes of expressing and explaining distress; coping responses and adaptation; patterns of help-seeking and treatment response. Most importantly, culture gives meaning to the traumatic event itself, allowing individuals, families and communities to make sense of violence and adversity in ways that may moderate or amplify their impact.

Disasters are situations or events involving ecological disruption, threat to life or injury that negatively affect large numbers of people and that overwhelm local capacity for adaptation, usually by destroying infrastructure. Disasters vary widely in their scale, scope and significance. It is useful to distinguish between natural and human-caused disasters. Natural disasters include geophysical and meteorological events like earthquakes, floods, tsunamis, tornados, volcanoes and drought. Human-caused disasters can be divided into: (i) technological accidents, such as airline or other mass transportation accidents, industrial accidents and structural collapses of bridges or buildings; and (ii) willful or intentional events such as mass murders, terrorism, war and genocide. The distinction between natural and human-caused, however, is often difficult to make and may change with new information and interpretations; for example, the destruction following an earthquake may become a human-caused disaster when it is realized that most of the deaths are due to the collapse of houses built with shoddy workmanship due to corruption in the construction industry. Many disasters span the natural and the
human-caused because they stem from the ways humankind has modified the environment (e.g. famine due to the interaction of methods of intensive agriculture and drought). Natural and human-made disasters may co-occur and interact in ways difficult to disentangle. For example, drought or famine can be caused by warfare and warfare can be ignited by famine. The frequent coexistence and mutual aggravation of natural and human-instigated disasters is central to the notion of complex emergency, defined as a catastrophic situation marked by the destruction of a population’s social, economic, and political infrastructure [14,15].

13.3 UNDERSTANDING TRAUMA

From an evolutionary perspective human beings have lived with the threat of violence, injury and death throughout history. We might expect therefore that there are mechanisms available to help us adapt to threats that do not destroy us [16]. The most common response to mild or moderate levels of trauma is acute distress followed rapidly by recovery. We are biologically primed to learn to be fearful and avoidant of potentially life-threatening situations [17]. When threats are more severe and inescapable, other mechanisms come into play, including dissociation, a cognitive and attentional process of blocking out or compartmentalizing memory and experience. This too may have adaptive functions, allowing individuals to survive intolerable situations like torture or confinement, but it can also impair later adaptation.

Although trauma can aggravate any psychiatric condition, certain disorders are presumed to have a direct causal link to trauma exposure. In any traumatic event, some individuals will have more severe or incapacitating acute symptoms and some will go on to have chronic distress and disability. Others may do well initially but manifest significant symptoms at a later time. These pathological outcomes reflect both individual and social vulnerabilities. Among the problems specifically linked to trauma are grief and other normal forms of reactive distress, depressive and anxiety disorders, and post-traumatic stress disorder (PTSD).

Trauma exposure may result in a variety of short- and long-term adaptive and pathological responses. Common responses during or immediately after the traumatic event include intense autonomic arousal associated with fear, agitated behaviour or ‘freezing’, and dissociative symptoms with an altered sense of time speeding up or slowing down, and feelings of derealization and depersonalization [18]. About 15–20% of people exposed to such acute events have symptoms and impairment lasting for several days or weeks [19]. Acute stress disorder (ASD), introduced in DSM-IV, occurs within the first 4 weeks of trauma exposure and is similar to PTSD but with prominent dissociative symptoms [20]. A severe acute stress response is a predictor of longer term distress, including PTSD [21].

DSM-IV-TR classifies PTSD as an anxiety disorder that is characterized by the ‘re-experiencing of an extremely traumatic event accompanied by symptoms of increased arousal and by avoidance of stimuli associated with the trauma’ ([20], p. 429). The essential features of PTSD are the development of specific symptoms following exposure to an event that involved actual or threatened death, or serious injury, to which the person responded with ‘intense fear, helplessness, or horror’ (p. 463). In addition to the stressor criterion A, the criteria for PTSD include three main symptom clusters: (B) intrusive recollection – intrusive thoughts, distressing dreams, reliving or dissociative ‘flashbacks’, psychological distress and physiological reactivity when exposed to reminders; (C) avoidant/numbing – efforts to avoid thoughts, feelings, conversations or activities associated with the stressor, difficulty remembering the traumatic event, social withdrawal and emotional numbing; and (D) hyperarousal – sleep problems, irritability or angry outbursts, concentration problems, hypervigilance and an exaggerated startle response. The diagnostic criteria for PTSD in ICD-10 are similar but do not include numbing and do not require functional impairment; these differences result in higher prevalence rates for PTSD with ICD-10 criteria [22].

PTSD has an explicit causal mechanism built into its diagnostic criteria: exposure to an unexpected or
unpredictable event that involves possible serious
injury or death to oneself or others and leads to
appraisal of the event as threatening and so to intense
fear, helplessness, horror and other negative emotions
(shame, guilt, anger); these in turn influence memory
and other cognitive-emotional-sensory processing of
the event such that it leaves lasting traces in the brain
and behaviour [23]. A major component of the syn-
drome of PTSD is subserved by a conditioned emo-
tional response of fear [17]. Reminders of the context
where threat originally occurred evoke anxiety and
this is managed by cognitive and behavioural efforts to
avoid such contextual cues, resulting in emotional
numbing and withdrawal.

Fear conditioning can be long lasting, but in the
ordinary course of events, repeated exposure to
the same cues without any fearsome outcome event-
tually results in a decrease in conditioned fear, hyper-
arousal and avoidance behaviour—a process called
‘extinction’. It is now known that extinction involves
a type of learning distinct from fear conditioning,
involving different neural pathways. In fact, the ori-
ginal conditioned fear is not erased or replaced but
simply suppressed by extinction learning. The two
types of learning have different characteristics; fear
conditioning is quicker and generalizes more easily
than extinction learning. As a result, a small change in
environmental cues can reinstate the originally
learned fear [24,25]. This helps to account for the
phenomenon of triggering or reactivation of symp-
toms in patients with PTSD [26].

These biological mechanisms are important for
understanding the causes and chronicity of PTSD,
the dynamics of triggering and re-experiencing, and
the effectiveness of exposure therapy as a treatment,
but PTSD involves additional cognitive and beha-
vioural responses mediated by forms of learning and
memory, as well as processes of recall and narrative
elaboration that are regulated by the personal meaning
of the traumatic events [27]. Both recollection and
narration also involve social processes so that trau-
matic outcomes reflect the culturally sanctioned occasions for remembering and forgetting [28].

The prevalence of PTSD in any population depends,
in part, on rates of exposure to trauma which, in turn,
depend on social circumstances [29]. Traumatic
events are common but unequally distributed in the
population. Surveys in the US have found 50–60% of
individuals are exposed to a traumatic event at some
point in their lives [30]. The likelihood of developing
PTSD after a traumatic event varies with the type of
event and the magnitude of the trauma, ranging from
5 to 10% of those exposed to a natural disaster, to 20%
of those exposed to criminal assault, 40% of those
exposed to combat and more than 50% of those
exposed to rape [30,31]. Women appear to have a
greater risk of developing PTSD after trauma expo-
sure, although this may partly reflect gender differ-
ences in symptom expression [22].

PTSD was initially framed as a normal or at least
inevitable response to extreme circumstances. How-
ever, longitudinal research soon clearly showed that
only some individuals exposed to the same type of
severely traumatic event develop PTSD and that pre-
morbid personality and psychopathology are important
determinants of vulnerability. As most people who
show transient symptoms resembling PTSD (height-
tened arousal, anxiety, irritability, nightmares, intru-
sive thoughts) will recover over a period of days, weeks
or months (depending on the severity of the trauma),
PTSD can be viewed a disorder of recovery [32]. Meta-
analyses of risk and protective factors for PTSD show
that among the strongest predictors of PTSD after
trauma exposure are life stress and lack of social
support [33]. Thus, social factors determine the risk
of exposure to trauma and the likelihood of recovery.
These risk and recovery factors are related to each
other through the structures of family, community and
wider social institutions. It is useful, therefore, to think
of a social ecology of trauma risk and recovery [34].

Depression is also a common response in many
situations involving trauma, particularly when there
has been significant loss. The losses commonly asso-
ciated with trauma and disasters may include loss of
loved ones and possessions, but also loss of status,
role, home, community and the familiar routines of
everyday life. The co-occurrence of depression and
PTSD complicates the course of each disorder [35].

Somatic symptoms are common consequences of
trauma and may reflect physiological dysregulation as
well as culturally shaped idioms of expression of
distress [36,37]. For example, a study of Salvadoran
women refugees in North America, who had fled El
Salvador to escape large-scale political violence,
found that the women described their suffering as ‘nervios’, a cultural idiom that covered an array of dysphoric emotions (anxiety, fear, anger) and diverse somatic complaints, including bodily pains, shaking, trembling and calor (sensations of heat). Although some of the bodily symptoms that follow trauma exposure may be related to PTSD, panic disorder, generalized anxiety disorder or depression, there are other processes of physiological dysregulation, increased muscle tension and bodily preoccupation mediated by cognitive and social processes that contribute to such ‘medically unexplained’ symptoms [38].

1.3.4 DISASTERS

Disasters have health impacts at multiple levels, individual (physiological, psychological), family, community, societal, international and global. The social impact of disasters reflects their magnitude, the level of pre-existing infrastructure, level of infrastructure preserved, the meaning of events (human-caused or not); the response of the community and local population; the response of government and larger society; and the international response. The impact of most disasters is more severe in developing countries, which lack resources and infrastructure to respond adequately.

Although a whole population or community may be exposed to a disaster, people are affected differently. The psychological impact of a disaster on any given individual depends on both the personal and collective significance of and response to the catastrophic event.

Groups recognized to be at particular risk for mental health consequences include women (especially pregnant women, single mothers, widows) and children. Internally displaced people, refugees and others previously exposed to trauma are also at increased risk for psychological re-traumatization. In general, people with pre-existing mental health problems, including depression and anxiety, are especially vulnerable [39].

The prevalence of psychiatric morbidity following a disaster is associated with its magnitude but also with the level of perceived threat to life and risk of recurrence, lack of predictability and controllability, loss, injury, exposure to the dead and grotesque, and the extent of destruction of community infrastructure [40]. Estimates of PTSD following a disaster range from 30 to 40% among those directly exposed to 10–20% for rescue workers and 5–10% for the general population [29]. Symptoms of depression and demoralization are strongly related to the degree of loss experienced as a result of the disaster [41].

Disasters are associated with increased levels of medically unexplained somatic symptoms both acutely and over survivors’ life spans [42].

Disasters lead to psychiatric morbidity through many pathways: physical injury, exposure to terrifying events, loss of loved ones, loss of employment, livelihood and income, loss of familiar environment, domestic and communal place. These losses and injuries interact with other social determinants of health including pre-existing social structural and political problems. For the same amount of loss and physical damage, human-made disasters may have more severe psychological consequences owing to the ways they undermine basic social emotions of trust and solidarity.

There are three broad approaches to the impact of trauma and disaster on mental health outcomes. The clinical psychiatric approach focuses on the effects of trauma in causing psychopathological conditions like PTSD, depression and other potentially disabling conditions. Individual vulnerability due to pre-existing personality traits, coping styles and mental health problems help predict who will develop persistent problems after trauma exposure.

A second approach focuses on individuals’ resources and resilience. For example, conservation of resources (COR) theory, developed by Hobfoll, groups resources into four broad categories: object resources (e.g. material possessions with either functional utility or symbolic value); condition resources (e.g. social roles or status like marriage, employment, membership in groups or organizations); personal characteristic resources (e.g. values, traits or attitudes like optimism, sense of meaning and purpose); and energy resources (e.g. time, money, information) [43]. Resource loss due to trauma is associated with distress [44]. Disasters produce distress and limit coping
by reducing individuals’ resources in each of these areas. Coping and adaptation, therefore, can be improved by interventions that maximize these resources. Of course these resource domains are not independent but correlated in ways that reflect a community’s social structure and dynamics.

A third approach recognizes the dynamic nature of the interaction between different resource domains and focuses on the role of social positioning in individual and group vulnerability and resilience. This more dynamic view could be termed ‘social ecological’, in that it sees each person as located within a system that has its own dynamics. Disasters differ from isolated traumatic events affecting individuals in that they affect the whole community, which ordinarily provides the secure base for each person’s adaptive responses to stress, trauma and loss. Depending on the degree to which a disaster disrupts the social fabric and weakens bonds between people, communities may respond with mobilization and increased solidarity or with demoralization, disorganization and disintegration. The level of psychiatric distress in the population plays a role in these social responses, but they have their own dynamics that reflect local histories and systemic issues of politics, identity and community. These local systemic dynamics are embedded in larger global economic and political responses that influence the mental health outcomes of disasters.

In the face of a disaster that seems to come from ‘outside’ and that does not destroy too much infrastructure, communities may pull together and experience a high degree of solidarity. For example, in January 1998, Quebec experienced an ice storm in which the accumulation of ice brought down the main power transmission lines into the city of Montreal, leaving 3 million people without electricity in the midst of winter. Despite the challenge posed by this loss of power and cold temperatures, there was an enhanced sense of comradeship among neighbours, who heated water for coffee over camping stoves and huddled around battery-operated radios waiting for news. There was no increase in use of mental health services by patients with severe mental illness [45]. However, even during this relatively limited event, with little social disruption or loss of life, many people experienced high levels of stress with potential long-term sequelae. For example, there is evidence for an effect of maternal stress during the ice storm on the subsequent cognitive development of their infants who were exposed in utero [46].

At the other extreme in terms of the magnitude of disaster, in Sri Lanka following the tsunami of 26 December 2004, there was massive loss of life and destruction of entire settlements and villages along two-thirds of the country’s coast. This occurred against a backdrop of political violence that had affected the country for decades, eroding family stability and community solidarity [47]. A survey in one severely affected area found that 40% of the population had mild to moderate symptoms of depression, anxiety or PTSD [48]. Another survey of children living in three tsunami affected areas found rates of PTSD that were not related to the tsunami of 4.6–8.5%, while tsunami related PTSD was found in an additional 13.9–38.8% [49]. Another study of adolescents from two villages in southern Sri Lanka found that post-tsunami depressive and PTSD symptoms were associated with prolonged displacement, social losses, family losses and their mothers’ level of mental health problems [50]. A positive mother–child relationship had a protective effect.

Generally, human-caused disasters result in more psychiatric morbidity than those that are attributed to natural events [51]. When events can be attributed to specific individuals or groups, fear and anger may be directed towards them. When the human causes are harder to identify, emotional distress may be more diffuse and anger may be harder to resolve, with greater risk for long-term mental health consequences.

Disasters due to terrorism are a dramatic illustration of these factors both because terrorist acts are directly caused by individual agency and because they deliberately aim to maximize the anxiety, insecurity, helplessness and vulnerability of a population [52]. In the wake of the attacks of 11 September 2001, high levels of symptomatology were reported not only among those directly affected at the ground zero, or living in the city of New York, but across the country. A survey immediately following the attacks found that 44% of adults had one or more ‘substantial’ symptoms of distress [53]; two months later this dropped to 16% [54]. New categories of trauma emerged, like
vicarious PTSD incurred while watching repetitive TV images of the attacks [55]. The threat of recurrence became an ongoing preoccupation, contributing to a new sense of collective vulnerability.

Of course, the distinction between ‘natural’ catastrophes like earthquakes, tsunamis, hurricanes and human-caused catastrophes like industrial accidents, war or terrorism depends on specific ways of interpreting events. Some people in the US believe that government should control the forces of nature; hence natural disasters can be blamed on human error or malfeasance [56]. From some religious or cultural perspectives, all events may have moral meaning as part of causal chains that include human or spiritual agency (like karma, sin or divine judgement). Contrariwise, people may view even events caused by human agency as preordained or following an impersonal logic. Thus, in the Cambodian genocides perpetrated by the Khmer Rouge, many people interpreted the catastrophe as following from their individual kamma (karma) and so felt a measure of responsibility for their own misfortune [57]. This attribution mutes the external expression of anger and desire for revenge and urges the survivor to follow a morally upright path. On the other hand, karma implies an ultimate moral order that would ensure that the perpetrators of the atrocities will pay for their actions in future miserable rebirths. Political circumstances also may limit any possibilities to name perpetrators and seek justice or redress.

Even events that seem to be entirely natural exert their effects unequally on a population in ways that reveal pre-existing social inequalities and injustices. In recent earthquakes, the pattern of destruction has reflected economic disparities and corruption as those with substandard housing, built by ‘cutting corners’, were most affected. The flooding of New Orleans due to hurricane Katrina had differential effects on the poor and marginalized that reflected the long history of racial discrimination [58]. Thus a natural disaster laid bare the structural violence of society. This social meaning has both material and moral consequences, influencing who finds safe haven and looks forward to rebuilding their life and who endures prolonged displacement, neglect and despair.

### 13.5 TECHNOLOGICAL DISASTERS

Urbanization and industrialization have brought with them many benefits but also new types of collective vulnerability. Mass transportation has created the potential for accidents that affect hundreds of people in an instant. New technologies have created new types of disaster with unique characteristics that follow from their unique physical properties. For example, the release of radioactivity from the Chernobyl disaster had long-term and long-range effects with an increase in cancer and other radiation-related diseases [39]. The petrochemical disaster in Bhopal resulted in an enormous range of respiratory, ocular, gastrointestinal and other conditions [59]. In both cases, there were also long-term psychological effects on the exposed populations, with persistent feelings of anxiety, depression and medically unexplained symptoms.

Independent of actual exposure, the conviction that one has been exposed to toxic chemicals or radiation may be a risk factor for long-term psychological distress, even among those who emigrate from the site of disaster [60]. Those who are evacuated may be at increased risk for mental health problems owing to the disruption of their lives. However, those who remain in the vicinity of an industrial accident may face the greatest challenge. In the case of the Three Mile Island nuclear reactor accident, people who continued to live near the reactor reported feeling less control over their lives and this was associated, in turn, with higher levels of somatic, anxiety and depressive symptoms even years after the event [61].

The legal and political meaning of technological disasters may bring vulnerable populations into direct conflict with powerful commercial interests. Technological disasters may be viewed as accidents due to risks inherent in a useful technology or as stemming from human errors, action or inaction. To the extent they are viewed as due to human action, there is always some person or corporate entity to blame. However, large corporations often are able to deflect the efforts of
individuals or groups to seek redress. Ongoing litigation and struggle over restitution from those responsible for the catastrophes can greatly complicate the prospects for recovery, as illustrated by the protracted struggles over compensation following the Exxon Valdez oil spill [62]. The spill disrupted fishing activities, creating severe economic hardship, but those who were plaintiffs in the civil suit suffered greater levels of stress over the course of the litigation. The persistent anger associated with perceived injustices that have not been acknowledged or redressed contributes to long-term distress following technological disasters [63].

13.6 WAR AND POLITICAL VIOLENCE

Ethnic conflict, organized violence and wars have been major causes of suffering, ill health and mortality throughout history [2]. In recent decades, the number of victims and survivors of traumatic events has significantly increased as war, armed conflict and political upheaval have engulfed civilian populations worldwide, contributing to additional burden of disease, death and disability. War has always exposed both combatants and civilians to trauma but, with the adoption of new methods of warfare, recent years have seen a dramatic increase in the proportion of civilian casualties. During World War II, about 50% of the direct casualties were civilians; in the 1980s this figure rose to 80% and by 1990 it was fully 90%, with the largest number being women and children [64].

War and political conflicts have structural causes and often occur in societies that are already facing economic hardship. The collapse of formal economies and the emergence of economic crises in the marginal areas of the global economy lead to further impoverishment, food insecurity and ethnic and religious tensions over diminishing resources. Consequently, predatory practices, rivalry, political violence and internal wars may erupt [65]. In the last 60 years there have been over 200 wars and armed conflicts, in which the main targets are often the poorest sectors of society and marginalized ethnic groups.

Armed conflict results in significant psychiatric morbidity but the pattern varies across cultures. In a study of 3048 respondents in Algeria, Cambodia, Eritrean refugees in Ethiopia and Gaza in Palestine, de Jong, Komproe and Van Ommeren compared rates of depression, anxiety disorders, PTSD and somatoform disorders among those exposed to armed-conflict-associated violence and those without such exposure [66]. Overall, PTSD was the most common disorder for those directly exposed to violence, while anxiety disorders were the most common disorder for those not directly exposed. There were high levels of comorbidity of PTSD with anxiety or mood disorders in Algeria and Cambodia. However, there was also substantial variation in the overall prevalence and relative rates of disorders, which was due not only to the nature or severity of the disorder but to cultural variations in modes of expression of distress. For example, in Cambodia, anxiety disorders were more common than PTSD among those exposed to violence. Somatoform disorders were more common among those exposed to violence only in the Palestine sample.

The health consequences of political violence and wars extend beyond death, disease and trauma-related psychiatric illness, to include the pervasive effects of destruction of the economic and social institutions and the whole fabric of society. As such, the consequences of violent conflict can be observed not only in individuals – in their biographies and life trajectories – but also in collective memory and identity and communal strategies for coping with violence and adversity [65,67].

13.7 REFUGEES

Refugees fleeing war or persecution are very vulnerable as they cannot count on protection from their own state, and it is often their own government that is responsible for threatening and persecuting them. The 1951 Refugee Convention defines a refugee as someone who 'owing to a well-founded fear of being
persecuted for reasons of race, religion, nationality, membership of a particular social group, or political option, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country’ [68]. The Refugee Convention obligates governments to provide a safe haven for those fleeing persecution. However, many countries treat refugee claimants with suspicion and have policies aimed at discouraging others from seeking asylum [69]. These policies of deterrence, which may include detention under harsh conditions, have serious mental health effects [70].

Epidemiological studies have demonstrated both short- and long-term effects of trauma on refugee mental health and disability. For example, a survey of Vietnamese refugees who resettled in Australia found that 8% of the participants had mental disorders [71]. Trauma exposure was the strongest predictor of mental health status. Although the risk of a mental disorder decreased over time, people who suffered more than three traumatic events had a higher risk of mental illness after 10 years compared with people with no traumatic exposure. A longitudinal study of Bosnian refugees found that fully 45% met DSM-IV criteria for depression, PTSD or both [72].

A meta-analysis of 56 reports published from 1959 to 2002, representing 22 221 refugees, found that mental health status was worse among those living in institutional accommodation, with restricted economic opportunity, internally displaced, repatriated to a country they had fled or with unresolved conflicts in their country of origin [73]. A study of 1348 refugees from Vietnam and Laos who were resettled in Canada after having lived in refugee camps for a variable period of time, found that although chronic strain (such as flight, internment and resettlement) was a major risk for mental health problems, post-migration factors, including support from the ethnic community and the prospect for integration in the receiving society, were crucial determinants of outcome [74]. For refugee children as well as for adults, the quality of their post-migration reception in the new country is a better predictor than pre-migration trauma exposure of mental health [75].

Survivors of political violence, persecution or torture, who must flee their countries of origin to survive, suffer complex losses and transitions associated with forced migration, the process of seeking asylum and the enduring dilemmas of exile [69]. The process of convincing immigration authorities that one has been tortured and so has a valid claim to refugee status may in itself become a situation of psychological retraumatization [69,76,77]. This may be exacerbated by the fact that such individuals may be reluctant to divulge experiences like torture, rape or other forms of trauma in health care settings. Refugees also may have continuing fears for the safety of family left behind and uncertainty about the possibility of reuniting with loved ones. Despite the profound impact of trauma on wellbeing, post-migration factors including social supports, employment and occupational status are among the strongest predictors of positive outcome [73,74,78]. Effective resettlement policies and programmes can therefore make a significant contribution to refugee mental health.

13.8 TORTURE

Torture constitutes an extreme form of trauma in which the perpetrator actively seeks not only to threaten the victim with pain, injury or death but also to dehumanize, control, humiliate and oppress the victim, and through them, a whole community [79]. Despite international efforts to prevent torture as a human rights violation, it continues to be practised by many countries [80]. The attack on the World Trade Centre on 11 September 2001 led to an increase in torture practices when many countries joined the so-called ‘war on terror’, using the slogan of ‘protecting public security’ to justify the use of torture to extract information – human rights violations in which health care professionals took part [81–84]. In reality, torture yields unreliable information and is used primarily as a tool for repressing political opposition and instilling fear in the community and society at large. The political use of torture has a corrosive effect on the moral order of a society and constitutes an important obstacle to the development of democratic institutions and universal human rights [85].

Compared to other forms of trauma or natural disasters, torture constitutes a profound violation of
personal integrity and dignity because it undermines the moral basis of human relatedness and community. Perpetrators create a situation of extreme powerlessness, uncertainty and loss of control in their victims, but the effects of torture spread far beyond the immediate victim to include fragmentation of family and community networks through the spread of fear and mistrust, and the erosion of social and political solidarity [86–90].

Torture involves a wide range of methods of physical and psychological abuse with diverse consequences for survivors. Rape and related forms of sexual torture have especially severe effects for both men and women [91]. Survivors who had strong political convictions and were prepared for the possibility of being tortured due to their activism generally fare better than those for whom the torture was arbitrary or unrelated to their convictions [92,93]. Many forms of torture leave victims with profound feelings of shame, guilt and disgrace because of the powerlessness, degradation and humiliation they have experienced, and this may impede help-seeking [94,95]. Individuals who must continue to live in proximity to the perpetrators of violence and torture must suppress or ‘manage’ their feelings to maintain the social order [96,97].

Common sequelae of torture include symptoms of anxiety, depression and symptoms of acute stress disorder with dissociative symptoms [98]. Post-traumatic stress disorder (PTSD) is very common among survivors and its likelihood increases with the severity of the torture [83,93,99]. Other common symptoms that may occur with PTSD or independently include: chronic pain, sexual dysfunction, phobias, nightmares, memory impairment, social withdrawal, difficulty maintaining intimate or long-term relationships, and psychotic-like symptoms including ideas of reference and superstitious thinking. Chronic pain may reflect neuropathic damage from torture, links between bodily sensations of memories of torture, processes of somatic amplification due to psychological distress and culturally shaped idioms of distress that encourage a focus on the body [100–102].

Feelings of violation, anger and injustice, while not always correlated with PTSD or another psychopathology, may constitute significant clinical problems in their own right [103]. The anger and aggression that survivors often experience as a consequence of their torture experiences may be displaced on to other people, particularly their families. Even when there is no overt conflict or abuse within the family, children may be strongly affected by the suffering of their parents and the community. For example, Pumak, Qouta and El Sarraj found that exposure to traumatic events increased Palestinian children’s political activities and psychological adjustment problems’ – both effects were independent of the quality of perceived parenting [104]. Rehabilitation interventions therefore must be extended to include the families and communities of the victims.

Treatment of survivors of torture requires a broad perspective on mental health that encompasses family, community and the politics of social integration. Community-based approaches have become increasingly accepted as an integral part of treatment. This model calls for a broader role for health professionals as advocates and facilitators who work collaboratively with other nonmedical professionals from law, media, community development and human rights to promote empowerment as survivors are assisted to help themselves. The focus of rehabilitation is on strengths rather than weaknesses, resilience rather than vulnerability, health not disease.

13.9 GENOCIDE

The United Nations Convention on the Prevention and Punishment of the Crime of Genocide (CPPCS), defines genocide as:

... any of the following acts committed with intent to destroy, in whole or in part, a national, ethnical, racial or religious group, as such: killing members of the group; causing serious bodily or mental harm to members of the group; deliberately inflicting on the group conditions of life, calculated to bring about its physical destruction in whole or in part; imposing measures intended to prevent births within the group; [and] forcibly transferring children of the group to another group.
The Holocaust and other genocides (e.g. in Rwanda, Bosnia–Herzegovina, Darfur) have starkly presented the immediate and transgenerational effects of massive human rights violations and the systematic destruction of communities [105]. Despite recognition of these catastrophes, there has been a tragic lack of political will in the international community to intervene in ways that could prevent or mitigate the loss of life.

Clearly genocide, involving violence on a massive scale, can have severe effects on survivors’ mental health. A study of four communities affected by the genocide in Rwanda found the prevalence of PTSD symptoms depended on traumatic exposure and varied from 12.2 to 33.8% [106]. A study of refugee survivors of the genocide in Bosnia–Herzegovina who resettled in Australia found no differences in PTSD risk for the group most exposed to human rights violations (internment in concentration camps, torture) compared to the general war-exposed group [107]. Exposure to threat to life predicted PTSD, while both threat to life and traumatic loss were associated with symptom severity and disability.

Mass human rights violations such as those that occur in situations of political violence, ethnic cleansing or genocide have effects at many levels. At the level of the individual, Silove has described these effects in terms of different adaptive systems, including systems involved in safety, attachment, sense of justice or fairness, existential meaning and social role or identity [87,108]. Each of these biosocial systems gives rise to specific forms of distress in response to specific types of threat or loss (Table 13.1). There are a variety of psychological and social adaptive responses that aim to re-establish the normal functioning or equilibrium of the system and when those fail, particular forms of psychopathology may result. Intervention strategies can be viewed as acting to restore these adaptive functions. These same mechanisms operate in other forms of trauma and disasters to varying degrees.

There has been much interest in the possibility of transgenerational transmission of trauma in the context of genocide [109,110]. Clearly, however, the experience of the second and third generation is not precisely the same as the first and the pathways of transmission point also to a transformation in the nature of suffering. A parent who has endured great trauma in a concentration camp may react in many ways: with irritability, distraction or overprotectiveness. Each of these will have different effects on the child, all of which might be attributed to the parent’s trauma. In most cases, these are not PTSD but problems in adjustment, anxiety, interpersonal relationships and so on.

Yehuda and colleagues examined transgenerational trauma in a group of adult offspring of Holocaust survivors and a demographically similar comparison group [111]. Although adult offspring of Holocaust survivors did not experience more traumatic events, they had a greater prevalence of current and lifetime PTSD and other psychiatric diagnoses than the demographically similar comparison subjects. The findings demonstrate an increased vulnerability to PTSD and other psychiatric disorders among offspring of Holocaust survivors, thus identifying adult offspring as a possible high-risk group within which to explore the individual differences that constitute risk factors for PTSD. Other studies have little evidence of increased psychopathology in the second- and third-generation children of Holocaust survivors [112].

Individual stories of trauma serve to ground collective identity and call for a moral and political response. The appropriation of trauma to stabilize a collective identity may have benefits for the individual. There must be a public place for stories of trauma for them to be told, acknowledged and legitimated. Collective identity, history and legal mechanisms can play a role in creating this place. Transgenerational links may serve psychological and political functions, becoming a central theme in the individual’s identity and a basis for the political aspirations of a group or even a nation [113].

For example, for indigenous peoples in North America, current mental health problems prevalent in some communities have come to be seen as the consequence of historical trauma following from European colonization of the Americas and subsequent policies of forced assimilation [114,115]. The effort to survive as a people when a whole way of life has been undermined and dismantled poses special social, moral and psychological challenges that are not captured by constructs like PTSD [116,117].
<table>
<thead>
<tr>
<th>Adaptive system</th>
<th>Function of system</th>
<th>Threat</th>
<th>Initial response</th>
<th>Adaptive strategies</th>
<th>Pathological outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety and security</td>
<td>Avoidance of danger</td>
<td>Injury or death</td>
<td>Fear</td>
<td>Seeking safety and reassurance</td>
<td>Anxiety</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hypervigilance</td>
<td>Self-soothing</td>
<td>PTSD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Fight or flight</td>
<td>Protectiveness toward self and others</td>
<td>GAD</td>
</tr>
<tr>
<td>Attachment</td>
<td>Maintenance of bonds of family and community</td>
<td>Loss of loved ones</td>
<td>Grief</td>
<td>Cognitive mastery of fear</td>
<td>Panic disorder</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Nostalgia</td>
<td>Mourning and bereavement rituals</td>
<td>Depression</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Loss of place or other objects of attachment</td>
<td>Homesickness</td>
<td>Reaffirming and establishing bonds with others</td>
<td></td>
</tr>
<tr>
<td>Justice, fairness, equity</td>
<td>Maintenance of social equity, exchange and</td>
<td>Discrimination, injustice, human rights</td>
<td>Anger</td>
<td>Reassertion of rights</td>
<td>Chronic anger and mistrust</td>
</tr>
<tr>
<td></td>
<td>reciprocity</td>
<td>violations</td>
<td></td>
<td>Lack of trust</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Suspicion of others</td>
<td></td>
</tr>
<tr>
<td>Social role, identity</td>
<td>Maintenance of positively valued sense of</td>
<td>Loss of work and status</td>
<td>Confusion</td>
<td>Restitution and redress</td>
<td>Paranoia</td>
</tr>
<tr>
<td></td>
<td>self and personhood</td>
<td></td>
<td></td>
<td></td>
<td>Antisocial behaviour</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Alienation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Existential meaning</td>
<td>Maintenance of cognitive coherence and</td>
<td>Destruction, suppression or denigration of</td>
<td>Confusion</td>
<td>Reclamation, revitalization or reinvention of</td>
<td>Helplessness</td>
</tr>
<tr>
<td></td>
<td>stability of plans</td>
<td>social and economic institutions</td>
<td></td>
<td>tradition</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Passivity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Demoralization</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Isolation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Withdrawal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Despair</td>
</tr>
</tbody>
</table>

Adapted from References [87] and [108]; modified with observations from Reference [47].
Current clinical guidelines for the treatment of trauma emphasize cognitive behavioural therapy, exposure therapy and the treatment of comorbidity (most often depression, anxiety disorders, substance use) [118]. There is some evidence for the effectiveness of trauma-focused psychotherapeutic interventions for individuals with persistent trauma-related symptoms or PTSD [119].

Prolonged exposure therapy aims to allow extinction of conditioned emotional responses of fear. Cognitive behaviour therapy works more broadly to change modes of interpreting and responding to trauma cues, reduce catastrophizing thoughts and reinforce adaptive coping. Narrative exposure therapy involves a blend of approaches and can be used with both children and adults across cultures [120–122]. It involves constructing a life narrative that includes a review of traumatic experiences, revisiting the associated emotions and bodily feelings to allow habituation to the physiological arousal; the process of narration gives the trauma memories and experiences structure through retelling and composing a written testimony.

Although antidepressants and other medications are widely used, there is little evidence for the effectiveness of pharmacotherapy in the treatment of PTSD or trauma-related disorders [123]. Treatment is usually symptomatic, to improve sleep, control pain and treat concomitant depression and anxiety. Beta-blockers have been used to reduce autonomic arousal. There is intriguing evidence that the use of propranolol during a guided process of trauma recall can diminish emotional arousal on subsequent recollection without the presence of the medication [124]. This raises the prospect that it may be possible to decouple trauma memory from some of its distressing and disabling physical effects.

There is increasing recognition of the need to consider mental health issues in disaster relief. The 2004 guidelines produced by the Sphere Project, which involved a global consultation process to establish minimum standards for humanitarian response, cover mental health for the first time [125]. There is an emerging consensus on best practices in disaster management, although the evidence base is limited [126]. The WHO Report on ‘Mental Health in Emergencies’ and the Inter-Agency Standing Committee (IASC) emphasize that it is crucial to protect and improve people’s mental health and psychosocial wellbeing in the midst of an emergency through (a) psychological first aid provided by a variety of community workers for people experiencing acute trauma-induced distress and (b) care by trained and supervised health staff for people with severe mental disorders, including severe PTSD [127,128]. The principles of psychological first aid include: maintaining a calm presence, providing a safe and comfortable setting, stabilizing emotionally overwhelmed survivors, gathering information about current needs and concerns, providing practical assistance, giving information about common psychological reactions and appropriate coping strategies, and linking the individual with local services and sources of further help. Humanitarian aid workers and community leaders need training in the basic psychological skills required to provide psychological first aid, emotional support and recognition of common mental health problems that should be referred to professionals [129].

Despite the consensus on best practices in an initial disaster response, there are still many questions about appropriate interventions. The interventions offered in disaster situations are diverse and include material support (shelter, food, clothing), psychoeducation, psychological debriefing, cognitive behavioural therapy (CBT), narrative exposure therapy, eye movement desensitization and reprocessing (EMDR) and community-based interventions. CBT and narrative exposure therapy have been shown to be helpful for individuals with trauma-related PTSD [122,130], and community-based approaches that work towards strengthening social supports and reintegration may fit better in some cultural contexts [131]. However, there is a lack of strong evidence for any specific treatment.

Although exposure therapy has proven effective for isolated discrete traumas, it remains uncertain
whether it is equally effective for those exposed to multiple, repetitive or pervasive trauma like that seen in survivors of torture or genocide [132,133]. There is little evidence that psychoeducational approaches can help prevent post-traumatic disorder or other types of psychological distress [134]. While there may be other benefits from existing interventions, and they may work for some individuals or groups, more work is needed to identify effective prevention strategies.

Psychological debriefing, which until recently was a popular intervention, is no longer recommended. Debriefing is based on the assumption that retelling the trauma story provides emotional release, relearning and cognitive reorganization. One influential version was developed as a group intervention in the US, as a support method for fire fighters [135]. This was a work group of professionals who knew each other, who were exposed to similar traumatic events, were trained to respond to disasters and remained connected to a larger stable social environment. All of these contextual elements may not be present when the method is applied in other settings: the people affected may have been thrown together by the events, they may have experienced very different levels and types of threat and loss, they may face a profoundly disrupted social environment and they may come from a cultural background that does not encourage open expression of private feelings or potentially shameful events. Even in the US, there is evidence that the intense re-exposure that may occur in psychological debriefing can retraumatize some individuals.

The funding and delivery of humanitarian aid is increasingly organized on an international level to facilitate faster and more effective responses to major emergencies affecting large numbers of people. As a result, however, disaster scenes may be inundated by mental health professionals and other disaster workers who further strain local resources and inadvertently contribute to the problems rather than to their solution.

There is agreement that post-disaster strategies must address the broad impact of disasters, promoting a sense of safety, calming, self- and collective efficacy, feelings of connectedness and hope [136]. Translating these general goals into specific interventions, however, requires consideration of individual and community psychology, an ecocultural perspective and awareness of local social, economic and political constraints and cultural meaning systems. Cultural issues have been only minimally integrated into current disaster guidelines [137].

Cultural issues raise important considerations in the practical response to disaster that may have mental health consequences. Efforts to rebuild infrastructure that do not sufficiently consider the social and cultural context may have negative effects on post-disaster adaptation. Following the 2004 tsunami, large quantities of aid poured into several Asian countries (in part because foreigners saw the tsunami as a blameless misfortune) and communities pulled together to confront and cope with adversities [138]. In Sri Lanka, for example, the aid was used to reconstruct housing in ways that have proved problematic for some communities. Fishermen were moved inland and resettled in houses built without the accustomed level of privacy, organization of interior space and ability to accommodate extended family [139]. Lack of attention to cultural context undermined the effectiveness of this well-intentioned support.

### 13.1.1 CONTINUING CONTROVERSIES

In addition to the unresolved questions about treatment efficacy, there are broader controversies in the field of trauma and disaster mental health, concerning the cross-cultural applicability and utility of the diagnosis of PTSD; the value of testimony or explicit talk about trauma versus containment; and the role of Truth and Reconciliation Commissions or other forms of restorative justice in recovery.

The construct of PTSD has been valuable for focusing attention on one specific form of anxiety response, but limited in terms of the wide range of impacts and the importance of other personal and social factors in producing resilient outcomes or prolonged suffering and pathology. The field of trauma and disaster psychiatry is far wider than the compass of PTSD.

Although the symptoms of PTSD can be identified across cultures, its clinical and social relevance
remain contentious. Structured diagnostic interviews and self-report scales based on the diagnostic criteria for PTSD have been translated into local languages, permitting investigators to distinguish trauma-related disorders from similar kinds of psychological distress. Other scales are available to assess the level of trauma exposure and trauma-related symptomatology [140]. These include the Harvard Trauma Questionnaire (HTQ) and measures for assessing anxiety and depression [141]. These instruments can be adapted to new cultural groups, though problems of clinical and cultural validity remain [142]. However, symptoms tend to be nonspecific indicators of distress and, in themselves, do not demonstrate the presence of a discrete disorder of clinical significance. Measures of functional impairment are essential to define a threshold for disorder warranting clinical attention.

Critics argue that mainstream approaches to diagnosis and treatment overlook the extent to which trauma experience is culture-specific. The Western discourse on trauma is embedded in a particular cultural and moral framework and becomes problematic in other cultural contexts [143]. Personal, political, social and cultural factors mediate the experience of war or other forms of violence. Practitioners unfamiliar with the local culture and situation apply generic assessment tools and interventions that force individuals into a limited repertoire of categories and responses [144]. People are encouraged to understand their suffering through the prism of individualistic psychological models that may not fit local values and concepts of the person [145]. As well, the dominance of the PTSD model tends to suppress other approaches and silence local perspectives on what is helpful and important in the wake of a disaster.

The distress and suffering that accompany war or other forms of collective violence are not necessarily pathological responses to traumatic events, but may be normal responses to existential predicaments [146]. Such suffering is resolved in a social context through familial, sociocultural, religious and economic activities that make the world comprehensible for people before, during and after catastrophes [14,147]. The roots of recovery from trauma and disaster lie in the restoration of the functional social environment, i.e. through improved living conditions, activities, employment, a stable community and social order. On this view, instead of offering psychological counselling, humanitarian aid programmes should acknowledge resilience and retain the social rehabilitation frameworks, starting with the strengthening of damaged local capacities in line with local priorities [148].

A related controversy concerns the appropriate strategy for dealing with severe trauma of the sort found among refugees and survivors of torture. While some approaches to rehabilitation of survivors of torture, genocide or other human rights violations emphasize the importance of giving testimony, this may not fit well with all social, cultural or religious contexts. The value of testimony has been embraced in Latin America and taken up by the International Rehabilitation Council for Torture Victims in Copenhagen [149]. However, many Asian traditions emphasize the values of equanimity and containment and may view the open airing of suffering as unhealthy and disruptive to the social order. Political and mental health goals then come into conflict with social norms and cultural values and the implications of this for trauma outcomes remain uncertain. Part of the benefit in telling one’s story comes from giving it a coherent frame, part comes from having a sympathetic other person bear witness and part comes from the larger social–historical process of recording a personal and collective truth. However, all of these depend to some extent on the social reception of the testimony. Further work is needed to understand the tradeoffs involved in speaking out or remaining silent in specific social, cultural and political contexts [150,151].

The functions of testimony have taken on new dimensions in the context of Truth and Reconciliation Commissions like that of South Africa, which aim to restore justice and moral order to a community rent by longstanding political violence and injustice. This, in turn, has raised questions about the social mechanisms for reconciliation and forgiveness that hope to repair both the justice and existential systems by ensuring public acknowledgement of past human rights violations and providing a healing ritual that brings some closure to otherwise unassimilable events. The metaphor of the psychological wound and the notion of healing have governed the truth and reconciliation process. However, this is an inaccurate or incomplete model of the complex psychological and social
processes put into play; the process involves issues of justice, equity and safety as well as woundedness and wholeness [152].

The ability of victims and their families to participate in legal proceedings or other public means of holding perpetrators accountable may provide comfort for them; it may also act as an effective tool for the prevention of torture [153]. In some instances, however, the truth and reconciliation process can be harmful to participants. Individuals who already have PTSD may benefit little and may have their traumatic memories activated and experience an exacerbation of their condition [154]. The public, ‘quasi-legal’ context of the Truth and Reconciliation Commission may be threatening to some people and destabilizing for a community. Mental health practitioners have a role to play to ensure that the process of recounting does not cause further damage. This may involve helping to design a setting and procedure that is therapeutic (e.g. by giving control to the narrator) and supporting individuals participating in Commission hearings [155]. Other forms of restorative justice based on traditional methods of conflict resolution face similar challenges when applied to mass violence.

13.12 CONCLUSION

Trauma has become a dominant trope in discussions of the contemporary world [156]. Like any metaphor it reveals and it conceals. What the metaphor of trauma reveals is the supervenient effects of extreme violence on suffering. Even healthy people can be torn down and permanently marked by the most severe forms of violence. Yet the response of most people, even to serious trauma, is resilience and recovery.

A social and cultural perspective suggests that it is crucial for clinicians to understand traumatic events and disasters in their broader social, economic and political context. These politics shape the production of psychiatric knowledge about trauma, the personal social and cultural contexts that are singled out for clinical attention, the ways that professionals and institutions apply trauma diagnoses and treatment, the dynamics of social support and the processes of conflict resolution. Although violence always has very personal impacts, it is clear that states, international organizations, global economic institutions and mass media are all involved in the creation, maintenance and resolution of the conflicts that lead to structural, interpersonal and mass violence [157]. Suffering is fundamentally a social experience in several ways: it involves an interpersonal engagement with pain and hardship lived in intimate and communal social relationships; it is framed in terms of available cultural models of the nature of adversity and corresponding appropriate moral responses; and it is part of professional discourses of medicine and the mental health professions that organize forms of suffering as bureaucratic categories and objects of technical intervention [158].

Understanding stories of trauma requires an understanding of the collective dimensions of violence and social suffering. Trauma experience is embedded in and emerges from multiple contexts, including biological processes of learning and memory; embodied experiences of injury, pain and fear; narratives of personal biography; the knowledge and practices of cultural and social systems; and the power and positioning of political struggles enacted on individual, family, community and national levels [27].

The language of trauma, however, tends to draw a simple arc from the violent event through the psychological processes of the individual (where they may exhibit resilience or vulnerability) to bodily symptoms of affliction. In reality, the events we call trauma are part of larger configurations of suffering that have their own social ecology and political economy. Discrete trauma and disasters occur against a backdrop of structural violence that renders some groups and individuals far more vulnerable; focusing exclusively on the trauma may deflect attention from these enduring forms of disadvantage – in some instance, however, a catastrophe may throw these into stark relief as was seen, for example, with hurricane Katrina. It is important for mental health practitioners and psychiatric researchers to appreciate these larger social contexts of suffering. Without such awareness,
we risk becoming part of the machinery that deflects attention from social inequalities and structural violence on to individuals’ psychology.

The war on terror, global warming and the press of humanity seeking to escape political violence and natural catastrophes all make the problems of trauma and disaster important issues in contemporary psychiatry. We need a body of research that takes social and cultural context carefully into consideration and clinical approaches that address the real concerns of individuals, families and communities responding to the range of challenges brought by trauma and disaster in all their myriad forms.

REFERENCES


45. McMurray, L. and Steiner, W. (2000) Natural disasters and service delivery to individuals with severe mental


56. Blocker, T. J. and Sherkat, D. E. (1992) In the eyes of the beholder: technological and naturalistic interpreta-


