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Culture as One Therapeutic Lever for Psychotrauma

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Introduction

This article is based on the work of transcultural psychiatry. It emphasizes the impact of culture on the occurrence of psychological trauma, and thereby identifies therapeutic areas not often considered. This is what psychological trauma owes explicitly to cultural particularities that I call cultural figures of the traumatic or traumatic cultural figures. This concerns the meaning that individuals and their socio-cultural environment assign to trauma: cultural representations, aetiological theories, and cultural therapeutic logics. This concerns the forms of expression of trauma, its semiology, its aetio-pathogenic processes, as well as its therapeutic approaches, prognosis, and evolution.

Progressive interest in cultural aspects in trauma

The interest in culture related to illness in general is not new. This is not the case with psychological trauma in particular. Ethnopsychiatry or ethnopsychoanalysis already draws attention to the cultural aspects of mental illness [1,2].

American medical anthropology through the interpretative current considers the medical system as a cultural system. Thus, culture is not only a means of representing illness, it is essential to its own constitution as a human reality. For Good [3], it is understood that some complex human phenomena are defined as diseases and thereby become the object of medical practices. Therefore, it is a mistaken belief that disease as we know it is uniquely natural and lies above or beyond (or deeper than) culture. This constitutes what Kleinman calls 'category fallacy' [4]. Healthcare professionals must therefore be persistent and demonstrate a genuine, non-judgmental interest in patients' cultures and beliefs. They must also express their belief to patients that knowledge of patients' Explanatory Models is important in planning an appropriate treatment regime [5].

Some questions facilitate the formulation of those explanatory models: "1. What do you call your problem? What name does it have? 2. What do you think has caused your problem? 3. Why do you think it started when it did? 4. What does your sickness do to you? How does it work? 5. How severe is it? Will it have a short or a long course? 6. What do you fear most about sickness? 7. What are the chief problems your sickness has caused for you? 8. What kind of treatment do you think you should receive? What are the most important results you hope to receive from the treatment?" [5].

The APA shows an interest in the cultural aspects of mental disorders, although some of their choices can be questioned for instance. In the DSM-IV there is an awareness that making a diagnosis can be a real challenge, when a clinician of a given ethnic or cultural group uses the DSM-IV classification to evaluate someone from another cultural group. These ethnic and cultural considerations are present from the introduction of the DSM-IV TR and continue to the end of the manual, with a sort of outline of a culture-specific formulation and glossary of culture bound syndromes [6]. This concern continued in the DSM-V (2013).

The transcultural clinic in France recently introduced specific work of cultural aspects of psychological trauma. The transcultural psychiatry teams of Pr Marie Rose Moro in Maison des Adolescents, Maison de Solenn of Cochin Hospital in Paris, and Pr Thierry Baubet's in Avicenne Hospital in Bobigny are pioneers in this field. These teams to which I belong produce numerous and recent work [7]. The clinical situations which constitute the material of the present article analysis come from these two places.

Complementarism and the transcultural approach to psychological trauma

Complementarism is the clinical method for transcultural approach used here. Conceived by Devereux [1,2], complementarism is, at its core, an obligatory and non-fusional double discourse of ethnology and clinical (psychoanalysis or psychiatric). It remains open to any other readings that could deepen comprehensibility and the care of psychic suffering.

Clinical approaches. In this way, the psychological trauma of our patients is apprehended using the fundamental points defined by Freud, including the problematic of the sexual aetiology of neuroses: seduction and/or fantasy, the

concepts of après-coup [8] and break-in of the excitation shield [9].

In the same way, the main diagnostic criteria for psychological trauma of the DSM can be found. Patients generally have characteristic symptoms following exposure to traumatic stressors, such as having experienced a life-threatening or seriously injurious event, either to themselves or to others, as well as hearing traumatic news. There is also persistent re-experiencing of the traumatic event, and avoidance of trauma-related stimuli with generalized blunting associated with neurovegetative symptoms. And social anxiety, isolation, and worry. These symptoms are usually long-standing in our patients, and represent significant suffering for them, with consequences on social, family and/or professional life.

Anthropological approaches. For our patients, many of these signs have cultural variances, which need special attention. For example, the disorders they suffer from are very resistant to the various treatments. These disorders do not always express themselves with the classic clinical signs of PTSD. The content of the underlying intrapsychic processes are sometimes specific. The disorders of our patients are often atypical. There are phenomena such as trances, night fears, apparitions, spirit visits, presences, incoercible screams, dreams of ancestors and of certain animals. In these various elements, and even in the dreams and nightmares of which some complain, it is not always easy to identify elements representing the traumatic event.

And these elements become more difficult to bear especially at night. These atypical nocturnal symptoms are generally considered the most troublesome, and the night itself with it. Our clinical experience has revealed that these nocturnal disturbances, including dream thoughts and contents, are culturally coded. They are congruent with cultural representations of the night, which clinicians must learn to identify and understand to allow the work of therapeutic elaboration.

The transcultural consultation device/system (je veux dire dispositif)

Transcultural consultation is a second-line consultation. This implies psychotherapeutic and/or psychiatric care upstream/beforhand. Patients are referred there either because the usual/classical care space is saturated with cultural material to which the clinician can no longer make sense; either because the symptoms are culturally coded, or because the patient explicitly asks his clinician that he wants to see caregivers who know how to work with cultural representations elsewhere. It also happens that the patient comes to see us directly because he has learned that we work with patients' cultures.

This consultation lasts 1 hour 30 minutes on average. It is done every 5 to 6 weeks. The psychotherapeutic sessions take place in 1/ groups and are based on 2/ the patient's language with the help of the interpreter/translator/mediator, and on 3/ cultural parameters. The nature and formulation of therapeutic proposals is codified. The patient is not asked a direct question, nor is a diagnosis made. The meaning of the illness and of the care is co-constructed with the patient. When a co-therapist speaks, he addresses the main therapist. It is only he who speaks directly to the patient, sometimes through the translator if there is one. Before each consultation, the group recalls the problem and develops hypotheses and clinical objectives. After the consultation, the counter-transfers are analysed, particular cultural ones, and the working tracks for the next time are documented.

These patients who teach us: a clinic that sees the world through the patient's eyes

Fabrice is one of many patients who enriched the transcultural clinic. He's a young man from a Central African country. We receive him in the transcultural consultation. The main therapist is Prof. Moro. I am part of the team therapist. During a war in his country, Fab was hit by some shrapnel. When he arrives in the first transcultural group session Fab. has just had foot surgery but he remains in pain, the pain that was already there before the surgery. Depression is also present and related to another disorder he suffered from. The symptomatology of the depressive episode is well characterised. Fabrice is tired, does not sleep well, does not have any appetite, and therefore loses weight. He does not take pleasure in anything. He feels dullness and presents a loss of vital momentum. He is sometimes overcome by fear. Visibly discouraged as if he no longer has strength to fight, he asks himself from time to time whether his life is worth living.

What makes Fabrice suffer the most, which attracts my attention and marks my interest, is what happens during his nights. Fabrice explains that he feels a presence at night. It touches him, pulls his foot. Fabrice explains he makes noises when it arrives to prevent himself to fall asleep and not to be scared. He is afraid of seeing this presence transform and materialise into someone. For him, if ever a man appears from this presence, he will die. He is so scared that he cannot sleep alone. He must always sleep next to someone. However, at night, he screams so loudly in his sleeps that no one can sleep next to him.

Under these conditions, he cannot even think of living with a partner. Fabrice is trapped in a vicious circle

As far as he can recall, he explains that the fear goes back a long way in his childhood. Once, he was with his father and suddenly his father couldn't find him, he had disappeared. Fabrice got lost into the forest and was found under a tree without knowing how he got there. He was found under a tree. It was then thought that he must have been a victim of witchcraft.

Since then, his parents have tried to treat him with traditional healers, without success. Fabrice himself has travelled from one country to another, seeking protection. But nothing helped. The harmful effects of witchcraft are very strong. "I was looking for protection, he says. I went to West Africa, where there is voodoo, to Burkina Faso". But the different consultants he met told him different things. They said it's my aunt, my daddy's little sister". Then, "it's your daddy". In other places, they said it's the paternal grandmother". "So, I was fed up". Witchcraft and the night appear to him as the greatest hindrance of his health.

Cultural representation of witchcraft and the night

Recognizing the implication of the night world comes down to making room for what the night symbolizes, both intrapsychically and culturally. Culturally, here, the night symbolizes the invisible world and the related main threat of witchcraft and death. It is therefore important to distinguish the geophysical night from the cultural representation of the night of these Africans. It is, as Perron writes, "two dimensions of representation, the first on the interior / exterior axis (internal space of representations / external space of perceptions and actions), the second on the axis of the psychological topic (whether it is the first, [...] or the second) [10].

From a metapsychological point of view, one can hypothesize a conscious representation and an unconscious representation of the night. This topical differentiation can be thought from the Freudian model of the representation of words and of the representation of things. Our patients, from an early age, are confronted with facts attributed to witchcraft, and the the words used by the adults to refer to it.

As such, when talking about the issue of night and therefore witchcraft, we deal with the thing- and word-representations themselves.

This makes it possible to think about the conscious and unconscious levels. Indeed, the connection of the thing-representation to the word-representation characterizes the preconscious-conscious system unlike the unconscious system which includes only thing-representation. The Ics system contains the investment of things, objects, the first and true investments of objects; the Pcs system appears when this representation of thing is overinvested because it is related to the word representations that correspond to it [11]. This overinvestment introduces the transition from the primary process to secondarization. The conscious representation includes the thing representation - plus the word representation that belongs to it -, unconscious representation is the thing representation alone [11].

The transcultural clinic should then find its way to these materials, whose universal processes should not obscure the cultural and symbolic status of subjective elements, which here boils down to the figuration of death anxiety. When repressed, it can constitute the nucleus from which a traumatic event will trigger a psychological trauma, like the two-stroke trauma or the aftermath of Freud [8]. It is as if cultural representations, through the cultural figures of the traumatic, would be the first phase of the trauma, repressed and reactivated by the event. Indeed, we would have in this case a kind of regressive investment of infantile materials, but with the difference that the fear of death is never totally unconscious, as can be the infantile sexuality with Freud [8].

In this logic, the clinical work requires going back to the repressed death anxiety and to elaborate it. Which is only possible when one begins to pay a certain attention to the cultural symbolisation of death anxiety, how it occurs in dreams as part of the night world and witchcraft.

The (many logics?) logic of dream interpretation

The analysis and interpretation of dreams occupy an important place in our therapeutic system, where it is successively analyzed from a metapsychological and from an anthropological point of view. The dream is certainly the 'royal road' which, as Freud said, leads to knowledge of the unconscious psychic. But this unconscious is enrooted in cultural repression. Daniel Pierre speaks in this sense of "Secondary elaboration as an inscription in culture" [12]. In this case, it is important to understand the nature and the idiosyncratic or cultural status of the elements of the dreams, which would led to make the latent obvious (mais je ne comprends pas ce que je traduis ici, à vrai dire)

Another risk is to neglect an important element for the interpretation of the dream because its cultural relevance has not been sufficiently explored.

From a psychodynamic standpoint, one would be mistaken dynamically, economically and even topically. This risk is close to what has been described by Kleinman [4,13]. According to him, the interpretative and diagnostic categories that derive from Western culture cannot be mechanically applied in other cultural areas. They would produce what he calls 'category fallacy' and 'misdiagnosis'. This involves taking ethnocentric diagnostics as universally valid categories and applying them to people from other cultures where they have not been validated. This carries a risk of "misdiagnosis".

Frida (another of our patients) and Fabrice both dream of cats. Paradoxically, these seemingly ordinary dreams of domestic animals distress them as if they were ferocious beasts. It is in cultural symbolism that we must look for the underlying representations that underlie this anxiety. Indeed, in their culture, cats and dogs are associated in several ways with witchcraft. Sorcerers disguise themselves as these pets to approach their victims. Another example: Fabrice dreams that his sister writes his name on a list. Culturally, writing someone's name on a list is a metaphor that means predisposing them to death by witchcraft, following other deaths, such as on the list.
Psychological trauma between the cultural and the psychic

By relying mainly on a complementarist way on the psychoanalytic, anthropological and ethno-psychoanalytic literature, our clinic highlighted the fact that these night expressions of psychological trauma in our migrant patients were culturally coded. These symptoms were infiltrated by representations, which in their culture represent "the real of death" [14,15]. For them, the highest expression of "the real of death" is the night world, the supernatural world, the world of witchcraft. The clinician should therefore learn to take this universe of meaning into account if he wants to deeply deal with these forms of trauma

Nighttime can represent the moment of their great vulnerability to the evil action of the powers of darkness. Internalized from an early age, at the infra-oedipal stage, maintained by the social culture, this vision of the world constitutes the infantile fund which will nourish a great dimension of their psychological life: defenses, conflicts, fantasies, anxieties, dreams and symptomatology. In this

logic, the psychoanalytic interpretation of psychic productions (signs, symptoms and dreams of patients, inhabited by non-Western cultures suffering from psychic trauma) is no longer sufficient in itself. These symptoms, infiltrated by cultural representations, need to be identified and treated as such by the clinician.

Cultural figures of trauma

Thus, it appears cultural figures are at the source of the trauma. They constitute the first stage of the trauma. Subjects have been exposed to it since an early age. These cultural figures of the traumatic pre-exist and are catalysts for subsequent traumatic experiences, which is the second stage of the trauma. In this logic, these kinds of "primary cultural trauma", or "pre-cultural trauma" participate in the complexity of psychic trauma in many migrants. This also constitutes a path for therapeutic work.

The Freudian idea of a two-stage trauma can be taken up here. The first stage relates to cultural representations and psychological processes, the second one to the event itself. This first step can easily be traced back to intrauterine life, to use Golse's theory [16] about the recording of "sensitivo-sensorielles" traces during foetal life. The event would then reactivate anxieties and archaic defense mechanisms, which draw on the register of cultural repression, which clinicians must learn to identify and develop.

Conclusion

We've shown that cultural representations can significantly invest practical cultural things such as night and witchcraft. These representations inhabit the subjects and impregnate phenomenon as well as the psychological trauma. They are not epiphenomena. The care of patients with these disorders leads to the recognition of the importance of these cultural figures of the traumatic.

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