



University of Southern Denmark

## The need to contextualise psychotraumatology research

## The need to contextualize psycho-traumatology research

Vallieres, Frederique; Ceannt, Ruth; Hyland, Philip; Bramsen, Rikke Holm; Hansen, Maj; Murphy, Jamie

*Published in:*  
The Lancet Global Health

*DOI:*  
10.1016/S2214-109X(15)00244-2

*Publication date:*  
2016

*Document version:*  
Final published version

*Document license:*  
CC BY

*Citation for pulished version (APA):*  
Vallieres, F., Ceannt, R., Hyland, P., Bramsen, R. H., Hansen, M., & Murphy, J. (2016). The need to contextualise psychotraumatology research: The need to contextualize psycho-traumatology research. *The Lancet Global Health*, 4(2), e87–e88. [https://doi.org/10.1016/S2214-109X\(15\)00244-2](https://doi.org/10.1016/S2214-109X(15)00244-2)

Go to publication entry in University of Southern Denmark's Research Portal

### Terms of use

This work is brought to you by the University of Southern Denmark.  
Unless otherwise specified it has been shared according to the terms for self-archiving.  
If no other license is stated, these terms apply:

- You may download this work for personal use only.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying this open access version

If you believe that this document breaches copyright please contact us providing details and we will investigate your claim.  
Please direct all enquiries to [puresupport@bib.sdu.dk](mailto:puresupport@bib.sdu.dk)

## The need to contextualise psychotraumatology research



The current geopolitical landscape has resulted in unprecedented numbers of refugee populations. For the first time since World War 2, the total number of people forced to flee their homes as refugees, asylum seekers, and internally displaced persons has exceeded 50 million.<sup>1</sup> In the first 8 months of 2015 alone, more than 540 000 asylum applications were filed across European Union member states. In addition to increased physical health risks, asylum seekers and refugees are at a higher risk than average for the development of a range of comorbid psychiatric diagnoses including mood, anxiety-related, psychotic, and substance-use disorders.<sup>2</sup> Suicidality is particularly high in refugees diagnosed with post-traumatic stress disorder; some studies report rates as high as 64% for suicidal ideation and plans.<sup>3</sup> Additionally, asylum seekers and refugees are at risk of further traumatisation through rape and sexual exploitation, loss of family members, physical abuse, community violence, and the loss of social structures, cultural practices, and familial systems that might lessen the impact of traumatic events.

Despite the frequency of traumatic exposure, as demonstrated by results of epidemiological research, human beings seem to be very resilient, with estimates of trauma-related disorders in the general population being quite low.<sup>4</sup> The European Study of the Epidemiology of Mental Disorders reported an average lifetime prevalence rate of post-traumatic stress disorder of 1.9% (based on a sample of 21 425 adults across six countries in western Europe).<sup>5</sup> In North America, rates hover around 8% in adults.<sup>6</sup> By comparison, rates of trauma-related disorders are far higher in people displaced by conflict, with the estimated prevalence of post-traumatic stress disorder ranging between 13% and 25%.<sup>7</sup> As the population of migrants in Europe rises, the prevalence of trauma-related disorders is also likely to rise, increasing the need to deepen understanding of these disorders in diverse populations.

As part of a large subset of disorders associated with stress, post-traumatic stress disorder was initially introduced in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Today, post-traumatic stress disorder is outlined in the two standard diagnostic nosologies used by mental health researchers and practitioners across the world: DSM-5

and the International Classification of Diseases (ICD) published worldwide by WHO. Explicit within both diagnostic nomenclatures is the proposition that human beings, irrespective of all contextual factors, experience psychopathological responses to trauma in the same way, and that all individuals share common cognitive and affective processes. In other words, a psychopathological response to a traumatic life event should be manifested identically, irrespective of whether a person experiences a trauma in Belfast, Baghdad, Beirut, Boston, Bali, or Bukavu.

This is a rather extraordinary (albeit not uncommon) claim about the nature of human psychology and how human beings respond to traumatic life events. Indeed, the overwhelming majority of evidence gathered over the past 35 years with regard to the manifestation of negative psychological responses to trauma has been obtained from WEIRD samples—ie, people from western, educated, industrialised, rich, and democratic societies.<sup>8</sup> Contrastingly, the evidence suggests that individuals from low-income countries are more likely to experience trauma, and have trauma-related disorders, than are people from high-income countries, as a result of greater exposure to several social and economic risk factors.<sup>9</sup> This has given rise to a situation where current methods to assess and diagnose pathological responses to trauma, prevention interventions, and psychological treatment programmes have been predominantly developed and validated among unrepresentative samples of the human population. In the rush to identify a universal set of symptoms, we might have neglected the effect that cultural and environmental factors might have on shaping individual responses to trauma.

Research into responses to suffering worldwide has hinted towards differences in the way individuals externalise responses to trauma, which are dependent on a multitude of factors, including cultural background, the context in which the trauma occurs, the meanings attached to traumatic experiences, and various other social and cultural determinants both before and after exposure.<sup>10</sup> Asylum seekers come from a wide variety of cultural backgrounds; they are not a homogeneous group, and neither are the traumatic events to which they are exposed. Therefore, the next generation of

psychotraumatologists must be trained to work cross-culturally and interdisciplinarily.

Responding to the 2004 Indian Ocean earthquake and tsunami, Shekhar Saxena, Director of the Department of Mental Health and Substance Abuse at WHO, compared the arrival of foreign mental health workers, who did not understand local culture or speak the local language, to sending the wrong medication. More than a decade later, we continue to face the possibility that our standard models of understanding and treating traumatic responses might be inaccurate and ineffective in many regions of the world. Mitigating the impact of an untreated, traumatised population on society as a whole requires that we empirically question our implicit assumption of a common manifestation of psychopathological responses to trauma, as asserted by our current measures, manuals, interventions, and treatments.

\**Frederique Vallières, Ruth Ceannt, Philip Hyland, Rikke Bramsen, Maj Hansen, Jamie Murphy*  
 Centre for Global Health, Univeristy of Dublin, Trinity College, 7–9 South Leinster Street, Dublin 2, Ireland (FV, RC); Psychology Department, National College of Ireland, International Financial Services Centre, Dublin, Ireland (PH); Department of Psychology, University of Southern Denmark, Odense, Denmark (RB, MH); and Psychology Research Institute, School of Psychology, University of Ulster, Magee Campus, Londonderry, UK (JM)  
 vallierf@tcd.ie

We declare no competing interests.

Copyright © Vallières et al. Open Access article distributed under the terms of CC BY.

- 1 UNHCR, the UN Refugee Agency. World Refugee Day: global forced displacement tops 50 million for first time in post-World War II era. <http://www.unhcr.org/53a155bc6.html> (accessed Sept 21, 2015).
- 2 Zlotnick C, Johnson J, Kohn R, Vicente B, Riosco P, Saldivia S. Epidemiology of trauma, post-traumatic stress disorder (PTSD) and co-morbid disorders in Chile. *Psychol Med* 2006; **36**: 1523–33.
- 3 Panagiotti M, Gooding P, Tarrier N. Post-traumatic stress disorder and suicidal behavior: a narrative review. *Clin Psychol Rev* 2009; **29**: 471–82.
- 4 Olff M. Trauma and PTSD: setting the research agenda. *Eur J Psychotraumatol* 2015; **6**: 28092.
- 5 Alonso J, Angermeyer M, Bernert S, et al. Prevalence of mental disorders in Europe: results from the European Study of the Epidemiology of Mental Disorders (ESEMeD) project. *Acta Psychiatr Scand Suppl* 2004; **109**: 21–27.
- 6 Kessler R, Petukhova M, Sampson N, Zaslavsky A, Wittchen H. Twelve-month and lifetime prevalence and lifetime morbid risk of anxiety and mood disorders in the United States. *Int J Methods Psychiatr Res* 2012; **21**: 169–84.
- 7 Steel Z, Chey T, Silove D, Marnane C, Bryant R, van Ommeren M. Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement. *JAMA* 2009; **302**: 537–49.
- 8 Henrich J, Heine S, Norenzayan A. The weirdest people in the world? *Behav Brain Sci* 2010; **33**: 61–83.
- 9 Fodor KE, Unterhitzenberger J, Chou C-Y, et al. Is traumatic stress research global? A bibliometric analysis. *Eur J Psychotraumatol* 2014; **5**.
- 10 Kroll J. Posttraumatic symptoms and the complexity of responses to trauma. *JAMA* 2003; **290**: 667–70.