

TRAUMA FROM A GLOBAL PERSPECTIVE

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Trauma from widespread collective violence such as genocide and ethnic cleansing has not been discussed from a global perspective. It will be argued that the Western medical model of diagnostic labeling is inadequate for understanding victims of collective violence from around the world. Phenomenology and liberation philosophy will be discussed as alternatives to understanding trauma from collective violence that move beyond the Western medical model of diagnostic labeling. The insights gained from these alternative approaches will contribute to the development of nursing education, research, and practice relevant to the health of victims of collective violence around the globe.

The world report on violence and health by the World Health Organization (WHO, 2002) defines violence as the intentional use of physical force or power, threatened or actual, against oneself, another person, a group, or a community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation. WHO (2002) divides violence into three broad categories depending on who commits the violent act: self-directed, interpersonal (another individual or small group of individuals), and collective (inflicted by larger groups such as states, organized political groups, militias groups, and terrorist organizations). All forms of violence are a major health problem. Violence is escalating all over our global community with more than 1.6 million people losing their lives yearly (Leppäniemi, 2004; Pederson, 2002; Reza, Mercy & Krug, 2001; WHO, 2002). Many more are injured and suffer from a wide range of physical, sexual,

reproductive, and mental health problems (Leppäniemi, 2004; Mercy, Krug, Dahlberg, & Zwi, 2003; Pederson, 2002; WHO, 2002).

One of the mental health impacts of violence is psychological trauma, which has been recognized as a worldwide phenomenon (de Jong, 2002; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002; Krug, Dahlberg, Mercy, Zwi, Lozano, & Wilson, 2002). Trauma from self-directed (suicide) and interpersonal violence such as sexual, physical, and emotional abuse and rape have been discussed in the literature (Dube, Anda, Felitti, Chapman, Williamson, & Giles, 2001; Dube, Anda, Felitti, Edwards, & Croft, 2002; Heise & Garcia-Moreno, 2002; Hillis, Anda, Felitti, & Marchbanks, 2001; Jewkes, Sen, & Garcia-Moreno, 2002; Williamson, Thompson, Anda, Dietz, & Felitti, 2002). However, trauma from collective violence, such as genocide and ethnic cleansing, has not been discussed from a global perspective, nor with adequate emphasis. Since the end of the Cold War such violations have occurred at an alarming rate of frequency, producing severely negative health outcomes (Adams, Boscarino, & Galea, 2006; de Jong, 2002; Krug et al., 2002a; Krug et al., 2002b; Pederson, 2002). The definitional goal of genocide is to kill all members of a certain group producing mass deaths, and the definitional goal of ethnic cleansing is to expel all members of a certain ethnic group from a defined territory producing a huge number of refugees (Hastings, 2004). However, genocide and ethnic cleansing are closely related and in both cases can produce a large number of deaths and refugees. There is an urgent need to develop knowledge about trauma from collective violence from a global perspective for the health of our global community (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002; Krug, Dahlberg, Mercy, Zwi, Lozano, & Wilson, 2002).

The purpose of this paper will be to argue that Western models of trauma and the Post Traumatic Stress Disorder (PTSD) category are inadequate for understanding victims of collective violence from other parts of the globe. Phenomenology and liberation philosophy are discussed as alternatives to understanding trauma and the victims of collective violence that move beyond the Western medical model of diagnostic labeling. The insights gained from these alternative approaches will contribute to the development of nursing education, research, and practice relevant to the health of the global community.

WESTERN MODELS OF TRAUMA AND THE PTSD DIAGNOSTIC LABEL

The concept of trauma has been addressed through the analysis of an individualistic Western medical system that fosters iatrogenic

illness (Gorman, 2001). When a person has experienced a form of violence, lasting impressions can lead to health problems that are labeled as PTSD. The Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association [APA], 2000) defines PTSD with three core symptom clusters: intrusiveness or re-experiencing the trauma (nightmares, flashbacks, and recurring memories), hyper arousal (difficulty sleeping, irritability, hyper vigilance), and avoidance (reminders of events, dissociation).

Many authors (Bracken, 2002; Gorman, 2001; Lykes, 2000; Summerfield, 2004; Thomas & Bracken, 2004) have criticized the inadequacy of Western models of trauma and the PTSD diagnosis to explain trauma from collective violence such as mass torture, genocide, and ethnic cleansing that occurs on a wide scale around the world. The universality of the PTSD diagnostic category has been questioned because victims of collective violence are not homogeneous and do not necessarily fit into the individualistic PTSD category (Ehrenreich, 2003; Ozer & Weiss, 2004). Lykes (2000) pointed out a fundamental problem in models and philosophies based on medical individualistic assumptions about trauma. Traditional, positivistic philosophy is problematic because it remains embedded in Western Eurocentric medical individualistic conceptions of illness, where selective symptoms and behavioral indexes provide evidence of PTSD or other diseases (Lykes, 2000).

A critical issue is the use of the word "post," which suggests that the traumatic event was limited to a certain event in time (Becker, 1995). Hernández (2002) analyzed human rights life stories and found that some of the narrators of these stories had experienced a life time of exposure to traumatic events. Many people in the world had been displaced by military groups, had moved around several times, and had witnessed horrendous massacres, as well as had extensive personal and material losses (Hernández, 2002). Given the nature of continuity in these situations, even if the word "post" is considered only a marker of the beginning of the traumatic reactions, it is necessary to question who determines the beginning and in what circumstances (Summerfield, 2004).

Individuals may present symptoms over many years, and articulate them differently according to their circumstances. Diversity and differences in responses to trauma from collective violence around the globe must be acknowledged. There may be some aspects of the Western medical model, such as medication, that may be useful in some situations. The problem is presenting the effects of self-directed violence (suicide), terrible acts of nature, interpersonal violence, and collective violence such as genocide and ethnic cleansing befalling an entire society under the singular roof of PTSD (Ehrenreich, 2003). In addition, uncertainty

remains about how to conceptualize trauma and the long-term effects of exposure of whole generations and subsequent generations to mass atrocities and the destruction of their social and cultural worlds (Hernández, 2002a).

Another critical issue is the term "disorder." Ehrenreich (2003) makes two points. Historically "victimizers" in all parts of the world have used the supposed "disorder" of their victims to stigmatize these victims as deviant in different ways in order to justify the perpetrators' acts of cruelty and destruction under the guise of treatment. Second, expectable, normal reactions to the effects of war, political repression, mass torture, or witnessing genocide and ethnic cleansing should not be called a disorder. To label the victims of collective violence on a wide scale as disordered because of the symptoms they experience, represents a fundamental ethical problem (Summerfield, 2004). The ethical problem is turning those who have lived through the ordeal of trauma on a wide scale into a diagnosis, which suggests pathology and stigma rather than contextual circumstances. This seems to be a form of medical imperialism. It is questionable how much the diagnostic category of PTSD can capture universal truths about distress and suffering when it ignores the sociocultural and situational forces that shape the active appraisal the victim brings to bear on what has happened (Summerfield, 2004). Moreover, the victims of collective violence have not given consent for their lives to be objectified (typically from afar).

Instead of pathologising the victims, human rights activists and other civilians take the frame of regarding them as persons suffering the consequences of a disturbed society (Summerfield, 2004). The effects of trauma should be seen as meaningful conditional relations for sound and forceful constitution that makes survival possible in a very pathological situation (Summerfield, 2004). In other words, noting the resilience of those traumatized from ongoing collective violence all over the world should be emphasized rather than labeling victims as a diagnostic category (Hernández, 2002a). Clearly, the other focus should be on the perpetrators as the destroyers of the societal and cultural institutions through acts of genocide, such as in Rwanda, and through ethnic cleansing, such as in the former Yugoslavia.

There are additional issues with the notion of PTSD in relation to labeling individuals with a societal problem in the context of collective violence such as war, genocide, ethnic cleansing, and mass torture where whole families, communities, and nations can experience traumatic events and their effects. In the context of collective trauma, the hierarchy of needs reasserts itself: Concrete needs for food, health care, housing and jobs, the need for social reconstruction and reintegration,

and the necessity of social reconciliation may dwarf individual emotional issues (Ehrenreich, 2003). Although some evidence of individual traumatization is widespread, and many individuals may acknowledge symptoms of PTSD, symptom presentations rarely match (or are limited to) PTSD (Baron, Jensen, & deJong, 2004; Kagee, 2004). More commonly, traumatized individuals of collective violence seek help for somatic symptoms, marital conflict, or dissociative symptoms, while local observers perceive the primary consequences of collective violence to be increased levels of interpersonal conflict, widespread apathy, increased drug and alcohol use, marital breakdown, and violence directed at women and children (Baron, Jensen, & deJong, 2004; Kagee, 2004).

To summarize, the concept of PTSD has been a powerful tool for understanding the victims of violence. The great strength of the PTSD concept is that it unites the responses of a diverse group of trauma victims. But the strength of the PTSD diagnosis conceals a weakness: The responses of victims are not homogeneous and, therefore, it is misleading to view PTSD as the universal global response to traumatic stress. In particular, PTSD is limited when called upon to comprehend the responses of individual victims of collective violence at the hands of others. To view these responses as simply a more severe form of the response of victims to more encapsulated traumatic experiences, such as interpersonal violence or as involving merely additional associated symptoms, fails to capture the overall impact of these events (Ehrenreich, 2003). To focus on the symptoms of individuals rather than the impact of traumatic events on the collective experience of individuals' communities and cultures falsifies the experience of the victims. Thus, there is a pressing need for alternative approaches to understand the effects of trauma from collective violence and the victims from around the world.

PHENOMENOLOGY AND LIBERATION PHILOSOPHY

Phenomenology and liberation philosophy move beyond the individualistic Western medical model of diagnostic labeling toward a global perspective on understanding victims of collective violence. Phenomenology is a philosophy of the unique, the personal, the individual which is pursued against the background of an understanding of the logos of other, the whole, or the communal (Van Manen, 1998). To look at the concept of violence and trauma from the viewpoint of the individual within context, fits well with the stories presented in terms of "extreme traumatization" (Bracken, 2002; Thomas & Bracken, 2004). Collective violence, occurring in several countries all over the world, aims at the

destruction of people's sense of belonging to their society, community ties, and political affiliations (Hernandez, 2002b). War and other forms of collective violence have taken away relational reliance and community ties; therefore grounded and appropriate interpretative phenomenology needs to comprehend this in its complexity (Gorman, 2001).

An important reason for interpretive approaches is the opportunities they provide to bring victims' voices into the forefront of knowledge about the effects of collective violence rather than keeping these victims at the margins of society (Dussel, 2006). Such knowledge could be used in overcoming oppression because the subjective lived experience is affirmed without losing a sense of the ongoing historical group solidarity (Hernandez, 2002b).

Liberation philosophy replaces meta-narratives of "oppression" with personal emancipatory narratives (Burton & Kagan, 2004). Personal emancipatory narratives such as testimonials can recall painful collective violence and repressive retaliation such as mass incarceration, torture, genocide, and ethnic cleansing by dominant groups (Dussel, 2006). These narratives can be a powerful source of resilience for traumatized persons in countries all over the world. Narratives can foster hope and connectedness among traumatized persons and enable them to educate those, such as nurses, who wish to become allies in liberation struggles (Gorman, 2001). The strength of those traumatized by collective violence can serve as a catalyst for growth towards positive changes in their social world (Janoff-Bulman, 2004). The solidarity of their traumatic experiences can unify victims to overcome the oppression of their perpetrators through social and political means (Ibarro-Colado, 2006).

It is not enough to note cultural and sociopolitical differences among populations and to affirm cultural diversity. The alleviation of the difficulties of victims must begin with the acknowledgment of the cruelty of collective violence and of the sociopolitical deviance that gave rise to the trauma (Gorman, 2001). The effect of collective violence and trauma in the wider global community needs to be conceptualized in a way that breaks the dichotomy between the individual and the societal levels (Martin-Baro, 2003). The concept of "social trauma" (Martin-Baro, 2003) adds another dimension to articulating and understanding trauma in relation to the historical and societal dynamics that traumatized people have maintained for decades in mediating an interaction between individual and society. Phenomenological and liberation philosophy incorporate violence and trauma experienced by groups into a social context that can enhance the understanding of traumatized people.

IMPLICATIONS FOR NURSING EDUCATION, RESEARCH, AND PRACTICE

Nursing education in ethics in this age of globalization needs to pay attention to not only autonomy and human rights but also to the issues of social justice in our interconnected community (Bergum & Dossetor, 2004). If our ethical interest is the quality of relationships rather than the quality of our minds or bodies, then intersubjectivity or interconnectiveness needs to be a primary concern.

Seldom are victims of collective violence in other parts of our globe studied in their own habitats or from their own perspectives on their own lives. Nursing research studies demonstrating how individuals thrive despite collective violence in the form of genocide and ethnic cleansing could yield important information about basic health maintenance strategies.

Nursing practice should be especially attuned to contextual and "meta-level" considerations of victims of collective violence, such as power and role differentials and gender and age factors (Thomas & Bracken, 2004). It also is important in building a credible and informed working alliance to understand these qualities in terms of the larger relational and beliefs systems in which they are embedded. Dehumanization is inherent in collective violence, and group trauma results in individuals' personhood, social bonds, and values being attacked, leaving victims feeling acutely isolated and vulnerable. Intervention criteria should be rooted in communities and, therefore, nurses need to develop relationships with community members from around the globe.

When working with victims who have experienced collective violence from around the globe, a phenomenological stance needs to be maintained in order to appreciate the meaning of each individual's distinctive ways of being in the world. Within the conversions of multiglobal treatment and trauma recovery, the metaphor of the person regaining his or her verbal voice is central (Gorman, 2001). In both, there must be a therapeutic alliance in which the victim's story can be fully presented and as importantly can be authentically received. Nurses must be aware not only of the individual's distinctive struggles and strengths in terms of his or her background and world view, but also of the different multicultural perspectives that must be bridged with the victim in the therapeutic endeavor.

Nurses need to implement treatment not only in multicultural terms, but in terms of human rights, liberation, and reconstruction of identity in relation to significant collective others, the broader community, and the world at large (van der Veer, 2000). In the last several decades, the

international convergence of human rights concerns with mental health practices have led to the creation of programs to this end (Leppäniemi, 2004).

CONCLUSION

Since the end of the Cold War there has been an escalation in collective violence, such as genocide and ethnic cleansing, at an alarming rate all over our global community with victims numbering in the millions. To recognize that there are common human elements in people's responses to single traumas, prolonged and repeated trauma, and collectively experienced massive violence has been a source of enormous insight. But to fail to see the important differences between the responses to different kinds of trauma—to see the responses to more severe, collective experienced violence as merely special cases of the response to simpler forms of trauma—only impoverishes our understanding and weakens our ability to respond to the needs of victims of collective violence. Those exposed to collective violence can sustain trauma that needs to be understood by incorporating alternative approaches that move beyond the individualistic medical model of diagnostic labeling.

Phenomenology and liberation philosophy are alternative approaches that assist in understanding the victims of collective violence from a global perspective. The insights gained from these alternative approaches can contribute to the development of nursing education, research, and practice relevant to the health of victims of collective violence from around the world. The significance of addressing collective violence from a global perspective makes the effort one of the most important challenges for nursing in the twenty-first century.

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