MONASH University

Understanding Trauma: Traumatic Experience, Posttraumatic Stress Disorder, and Recovery in Cultural Context

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Abstract

Definitions and interpretations of trauma have undergone revision over time reflecting the prevailing social values and normative frameworks of the society within which it is defined. Today, the category of posttraumatic stress disorder (PTSD) is commonly used as a description for trauma response globally. Questions remain as to PTSD's validity in culturally diverse groups. A universalist approach to trauma exploration has found PTSD symptom endorsement cross-culturally. Conversely, a relativist approach to trauma research has documented culturally diverse descriptions and interpretations of trauma. Progression of clinical practice with traumatised groups needs to explore a synthesis of approaches, beyond debate over the validity of PTSD, taking into account diversity in cultural frameworks without overlooking psychiatric diagnoses. In turn, notions of recovery cross-culturally necessarily require refining to account for diversity. Meaning in life (MIL) has been documented as a culturally non-specific pathway to recovery. Following traumatic events, it is still unclear however whether MIL, as understood in American and European psychological discourse, is conceptualised consistently in culturally diverse groups. Notions of MIL utilised in clinical work need to respond to the conceptualisation of trauma within diverse groups if MIL is to be appropriately utilised as a mechanism for recovery.

The aim of this thesis was to embark on the quest for a synthesis between understandings of trauma in diverse socio-cultural contexts and PTSD. Moreover, this thesis aimed to explore the way that MIL conceptualisation can differ between diverse cultural groups. Utilising a mixed-methods approach, three empirical studies examined the constructs of trauma, PTSD and MIL in 20 Holocaust survivors and 20 Sudanese refugees. Participants engaged in semi-structured interviews, specifically designed for use in the current research, answering questions around the effects of traumatic events and their understanding of MIL.

Quantitative measures examining PTSD symptomatology, a sense of coherence, the search for meaning, the presence of meaning and quality of life (QOL) were also employed.

The first study sought to investigate the conceptualisations of trauma from within the two culturally diverse groups. Semi-structured interviews were administered to 25 out of the total 40 participants. Descriptive phenomenological analysis was employed to analyse participant data. Group differences were found in that Sudanese refugees reported feeling powerlessness, somatic symptoms, and expressed the importance of not thinking about the past. Similarities were documented in that both groups reported the persistence of traumatic memory, trauma to impact identity, trauma to change one's relationship with the social world, and existential anxiety.

The second study aimed to contextualise PTSD within two culturally diverse groups. PTSD scores and PTSD symptoms were assessed for their relationship with QOL. Quantitative questionnaires were administered to 40 participants. No significant differences were found between groups on PTSD scores and PTSD symptom endorsement, and 15/16 PTSD symptoms were found to correlate negatively with QOL. Traumatic memory, as a symptom of PTSD, was simultaneously though found to differ significantly between-groups in its correlations with QOL. Results support the use of PTSD cross-culturally, though identify the need to consider PTSD symptom interpretation so as to contextualise PTSD appropriately within diverse groups.

The third study aimed to explore the similarities and differences in the way that two culturally diverse groups conceptualised and related to MIL, having endured a traumatic event. This study utilised a mixed-methods approach analysing both qualitative responses to questions around MIL, and quantitative endorsement of the presence of meaning, the search for meaning, a sense of coherence, and QOL. Groups were found to similarly identify a purpose in future generations and preventing future war and conflict. Both groups expressed

a limited understanding of war and their traumatic event, and yielded zero correlations between a sense of coherence and QOL. Groups differed in that Holocaust survivors reported a purpose in remembering, whereas Sudanese refugees expressed a purpose in looking forward.

Considered together, results highlight that trauma is both universal and culturally specific. Universal attributes of trauma found in both groups, beyond the endorsement of PTSD symptoms, are highlighted and recommended for further exploration in future research. Differences found between groups demonstrate the power of interpretation and association in contributing to the qualities of the trauma experience. In particular, each group conceptualised traumatic memory differently in study 1, coinciding with a significantly different relationship found between traumatic memory and QOL in study 2, as well as a divergent emphasis on the role of traumatic memory in contributing to a purpose in life in study 3. Interpretations of trauma and trauma symptoms not only create their qualities, but also influence the impact trauma has on the individual. Suggestions for ways to interpret the human trauma experience that can synchronise differences between groups, and effectively facilitate MIL following traumatic events, are discussed.

Declaration

This thesis contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

Signature: 

Print Name: Jarrod White

Date: 09/02/17

General Declaration
Monash University

In accordance with Monash University Doctorate Regulation 17.2 the following declarations are made:

I hereby declare that this thesis contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

This thesis includes 3 original papers submitted for publication in peer reviewed journals. The core theme of the thesis is understanding the way that culture and context can influence conceptualisations of trauma, recovery, and meaning in life. The ideas, development and writing up of all the papers in the thesis were the principal responsibility of myself, the student, working within the School of Psychological Sciences under the supervision of Professor Louise Newman and associate supervision of Professor Lenore Manderson and Dr. Glenn Melvin. The inclusion of co-authors reflects the fact that the work came from active collaboration between researchers and acknowledges input into team-based research

In the case of chapters four, five, and six, my contribution to the work involved the following:

Project conceptualisation and design (in consultation with my supervisors), review of appropriate literature, securing of ethical approval, data collection, data analysis (in consultation with my supervisors and departmental statisticians) and manuscript preparation. My supervisors provided input into completed manuscript drafts.

Thesis Chapter	**Publication Title**	**Status**	**Nature and % of student contribution**	**Co-author name(s) Nature and % of Co-author's contribution***	**Co-author(s), Monash student Y/N***
Four	Understandings of trauma: Contrasting Sudanese refugees and Holocaust survivors	Submitted	70%, As above	Professor Louise Newman Professor Lenore Manderson Dr. Glenn Melvin 30% Consultation in formulating study design, data collection, discussion of ideas expressed in manuscript and	N

				critical review of manuscript.	
Five	Contextualizing posttraumatic stress disorder within culturally diverse groups: a comparison of Holocaust survivors and Sudanese refugees	Submitted	70%, As Above	As above 25%, and Katrina Simpson Overseeing statistical analysis 5%	N
Six	Finding meaning in the wake of trauma: a cross-cultural comparison	Submitted	70%, As Above	As above	N

I have renumbered sections of submitted or published papers in order to generate a consistent presentation within the thesis.

Student signature: [redacted] **Date:** 8/02/17

The undersigned hereby certify that the above declaration correctly reflects the nature and extent of the student's and co-authors' contributions to this work. In instances where I am not the responsible author I have consulted with the responsible author to agree on the respective contributions of the authors.

Main Supervisor signature: **Date:** 6/2/17

[redacted]

Prof Louise Newman
Director
CWMH

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Papers Submitted During Candidature

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White, J.E. Newman, L., Melvin, G., Manderson, L., & Simpson, K. (2017). Finding meaning in the wake of trauma: A cross-cultural comparison. Manuscript submitted to *Journal of cross-cultural mental health,* February, 2017

Terminology, acronyms, and referencing

Acronyms

PTSD	Posttraumatic stress disorder
MIL	Meaning in life
QOL	Quality of life
DSM	Diagnostic and statistical manual of mental disorders
ICD	International classification of diseases
DPA	Descriptive phenomenological analysis
IPA	Interpretative phenomenological analysis

Terminology

Trauma	The use of this term refers to emotional and psychological trauma, unless otherwise stipulated
American and European model of trauma	Refers to the understanding of trauma as outlined in the DSM and ICD. The DSM is utilised more frequently in the current thesis due to the participant samples and study

The use of '-ise' for word ending was adopted throughout this thesis except for in papers (chapters 4, 5 and 6) on account of their submission to UK and US journals.

Referencing

Referencing is conducted in APA style formatting.

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Introduction and thesis outline

Western psychological theory contains assumptions about internal functioning and responses to traumatic events. There is ongoing discussion about the clinical model of trauma, promoting an underlying assumption of psychopathological potential in response to deeply traumatic events (Kienzler, 2008; Nicolas, Wheatley, & Guillaume, 2015). Whilst there is a need to acknowledge suffering as a response to traumatic events, assumptions about the nature of suffering and the relationship of suffering to trauma have been criticised for their applicability to diverse cultural groups (Kirmayer, Gone & Moses, 2014; Summerfield 2001). Culture shapes the meaning one gives to the world, the understanding of self, models of the mind, and therefore the way "one interprets and practices the suffering of self" (Kidron, 2012, p.12). Research into cultural constructions of trauma has revealed various models for the way that trauma impacts the self. Maintaining a universal emphasis on psychopathology following traumatic events hinders consideration of both cultural and contextual trauma response.

Researchers exploring the ramifications of trauma in diverse cultural groups have paid significant attention to PTSD (Drury & Williams, 2012; Fazel & Stein, 2002). A focus on PTSD, however, has been considered narrow in encapsulating variation in cross-cultural trauma response (Silove, 1999; Summerfield, 2001). Following a long-evolving history of the trauma concept, both in American and European medical and psychological discourse, PTSD has emerged as a way of understanding psychopathological trauma response. Yet interpretations of trauma, and explanations of trauma sequelae, have been shown to differ depending on cultural context (Marsella, Friedman, Gerrity, & Scurfield, 1996).

Debate over the validity of PTSD in cross-cultural settings has highlighted that a single approach to trauma and care is not effective (Friedman-Peleg & Bilu, 2011; Kienzler,

2008; Silove, Steele, & Bauman, 2007). Universalist proponents of a PTSD approach have studied PTSD globally finding PTSD prevalence to vary between cultural groups (Oruca et al. 2008; Peltzer, 1999; Meffert et al. 2010; Mollica, McInnes, Poole, & Tor, 1998; Steel, Silove, Phan, & Bauman, 2002). This approach however is limited by its potential to impose an American and European lens on diverse cultural experiences of trauma, if the perspectives from within that cultural group are not taken into consideration (Kira & Tummala-Narra, 2014; Nicolas, Wheatley, & Guillaume, 2015). There is also variability documented in interpretation of PTSD symptoms depending on context (Kleinman, 1987; Steel, Steel, & Silove, 2009). While a relativist approach to trauma has uncovered a myriad of culture-specific trauma responses (Freidman, Keane, & Resick, 2007; Kohrt et al. 2014; Marsella, Friedman, Gerrity, & Scurfield, 1996), solely focusing on cultural diversity is also limited. This approach is limited in its ability to generalise widely conceptualisations of trauma, and compare between groups (Draguns & Tanaka-Matsumi, 2003; Good and Hannah, 2015). Finding a synthesis between these two approaches can assist in accounting for broader social, political, and contextual factors that frame responses to trauma, without ignoring psychopathology following traumatic events (Beneduce, 2016; De Haene, Grietens & Verschueren, 2010; Van Rooyen & Ngweni, 2012). How cultural groups not only differ but stay the same in their experience of trauma needs to be considered for the progression of clinical practice with traumatised groups.

Questions have also been raised about the notion of trauma recovery seen from a cross-cultural perspective. Recovery from trauma has often been considered in terms of a decline over time in either case-ness for PTSD or average PTSD symptom levels (Breslau, 2001; Port, Engdahl, & Frazier, 2001; Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992). Adaptation to trauma in cross-cultural settings however has considered alternate conceptualisations of recovery (Kirmayer, 2002; Papadopoulous, 2007; Silove, 1999). In

particular, meaning in life (MIL) has been deemed an essential component of traumatic recovery in a wide array of cultural groups (Silove, 2013). It has been included in a number of recovery and adaptation models (Frankl, 1963; Park, 2010; Silove, 2013) as "arguably the most important, pressing, and profound concern of human beings" (Park, 2016, p. 69). Yet just as with trauma, it is unclear whether American and European notions of an individualised MIL construct, entailing both comprehension of the world and the pursuit of purpose, relate to trauma recovery in cross-cultural settings. Shlegel and Hicks (2016) explained that the way in which the interpretation of meaning may differ cross-culturally remains relatively unexplored.

The overarching aim of this thesis was to add to the understanding of the experience of trauma and recovery from a cross-cultural perspective by examining trauma from both a universalist and relativist approach within two vastly diverse cultural groups. The aim was to synthesise these two approaches by examining the ways that groups both differed and were similar in their conceptualisations of trauma and PTSD. Similarities between diverse cultural groups indicate where universal approaches to trauma and PTSD are worthwhile pursuits, and differences indicate where the relativist perspective is needed. To that end, the lived experience of trauma in two diverse cultural groups, Holocaust survivors and Sudanese refugees, was explored. The specific aims of individual chapters were to explore differences and similarities between cultural groups in conceptualisation of trauma, to contextualise PTSD within divergent cultural groups by comparing PTSD case-ness and symptoms with quality of life (QOL) scores, and to explore similarities and differences in cultural notions of meaning in life in traumatised groups. By examining qualitative explanations of trauma, endorsement rates of PTSD, PTSD's connection to QOL, and meaning in life as a method of recovery from trauma, it was hoped that similarities and differences would provide clues as to where a universalist and relativist approach to trauma can be synthesised.

This thesis was undertaken as a thesis by publication, and as a result, it contains three empirical papers. Due to the format of a thesis by publication, the three papers are interrelated. The entire thesis comprises 7 chapters, detailed herein.

Chapter 1 provides an overview of definitional issues, and the literature pertaining to a history of the trauma concept over time. It begins with an introduction to the complexity of defining the pain of trauma. Next, a history of the trauma concept is presented, demonstrating the way that the social context has influenced the interpretation of trauma, leading to the emergence of the PTSD diagnosis (Summerfield, 2001; Young, 1995). This discussion culminates in an explanation of trauma outlined in both the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD), as well as an explanation of the PTSD model. Following this, the critique of a PTSD focus is elucidated, detailing contention over the appropriateness of pathologising traumatic response (Beneduce, 2016; Nicolas, Wheatley, & Guillaume, 2015).

Chapter 2 presents a literature review pertaining to the cross-cultural examination of trauma and MIL. It begins by introducing the variable of culture in understanding mental health. Universalist and relativist approaches to cultural trauma are then outlined, with their respective limitations, elucidating the importance of synthesis in the debate. Discussion shifts towards ensuing confusion with the conceptualisation of recovery from a cross-cultural perspective. Emphasis is placed on the role of MIL following traumatic events as the universalist and relativist perspectives on MIL are explored cross-culturally. This chapter concludes with a summary emphasising the need to synchronise notions of trauma with notions of recovery, followed by an outline of the current research's aims and hypotheses.

Chapter 3 includes the rationale for and details pertaining to the methodologies employed for this thesis. Given the limited detail of study methodology afforded within the empirical papers, this chapter provides extended explanation of research design, participants,

procedures and data analysis. Data analysis begins with a review of phenomenological analysis, contrasting descriptive phenomenological analysis (DPA) with interpretive phenomenological analysis (IPA). Following this, a step-by-step outline of the analysis is provided. The chapter concludes with consideration of the particular ethical considerations that applied to this research.

Chapter 4 presents the first empirical study. Descriptive phenomenological analysis is used to explore the lived trauma experiences of participants from a Holocaust survivor group and a Sudanese refugee group, both of which endured war and conflict. Themes are discussed pertaining to the differences and similarities in the way these two groups understand trauma. Four key similarities in particular emerge between groups including persistent traumatic memory, change in one's identity, a change in one's relationship with the social world, and existential anxiety.

Chapter 5 details the second empirical study exploring PTSD case-ness and symptoms in the same two cultural groups. PTSD is identified using the Harvard Trauma Questionnaire-Revised, and contextualised using QOL scores derived from the World Health Organization Quality of Life Scale. Differences and similarities between groups are documented in symptom endorsement and in correlations found between PTSD case-ness/ PTSD symptoms and QOL.

Chapter 6 presents the final empirical study. Utilising a mixed methods approach MIL is explored in the same two cultural groups. Groups are contrasted based on similarities and differences in the way they conceptualised MIL qualitatively, and on quantitative measures of MIL including the Meaning in Life Questionnaire and the Orientation to Life Questionnaire. MIL scores are contextualised using correlations with QOL scores from the World Health Organization Quality of Life Scale.

Chapter 7 provides an integrated discussion of the results derived from the three empirical studies. The results are considered within the framework of the overarching aims of the thesis and the prevailing literature on notions of trauma and PTSD from a cross-cultural perspective. Implications for theory development and clinical practice are discussed, followed by an outline of thesis limitations and directions for future research.

Chapter 1:

American and European models of trauma

The current chapter presents a history of the concept of trauma as used in psychiatric and psychological services. In doing so, the evolution of ideas about the impact of trauma in accordance with a changing social environment is demonstrated. This chapter concludes by turning to critique the emphasis on psychopathology, highlighting a need to adopt a broader perspective on trauma and its impact in order to avoid splitting the psychological from the social experiences of trauma in interventions.

1.1 Defining trauma

Although they are not entirely the same, and are codified in different ways, the American and European conceptions of psychological and emotional trauma assume that the individual will undergo a negative psychological and emotional response following a range of traumatic events (APA, 2013; Malt, Schnyder, & Weisaeth, 1996). This notion of psychological and emotional trauma is similar to the conceptualisation of physical trauma. Physical trauma to the body induces feelings of shock and pain (University of Florida Health, 2017). The link between the traumatic event and the internal response is less direct for psychological trauma. The model of psychological and emotional trauma assumes that even without direct physical impact, a traumatic event can lead to internal physical and emotional pain in both the short and long term (McFarlane, 2010). Psychological and emotional trauma, from now on referred to as trauma, is more difficult to observe than physical trauma (Clark, 2013), particularly given variations documented in individual and community responses to traumatic events.

Terr (1987) defines trauma as occurring "when a sudden, unexpected, intense external experience overwhelms the individual's coping and defense operations, creating the feeling of utter helplessness" (p. 263). Terr's definition of trauma is open, expressing the link between traumatic event and internal response. It allows for a variety of experiences by communicating internal pain as 'utter helplessness', implying a model of disorder. For the purposes of this thesis, the 'utter helplessness', will be contained to what Krystal (1985, p.135) referred to as "catastrophic trauma". Catastrophic trauma occurs when the individual is confronted by inevitable danger, and is helpless in the face of danger to escape, either in reality or perceptually.

The concept of trauma, whilst widely used (Summerfield, 2001), lacks specific operational clarity throughout literature. The word trauma, emanating from the Greek word meaning "penetration" (Valent, 2005, p. 2), is often used to describe physical as well as psychological and emotional pain. Scarry (1985, p. 4) writes that pain is without "reality", existing as "unseeable classes of objects". There is, in turn, inherent difficulty in operationalising this unobservable entity in a way that is both specific enough to limit experience, and sensitive enough to include the variety of experience. Perhaps as a consequence, there is prolific use of metaphor and analogy in descriptions of trauma. Shengold (1989, p. 19) refers to the experience of trauma as "soul murder". This term is used to describe the psychological death of the individual that occurs as a result of childhood abuse. Valent (2013, p. 6) too uses metaphor to discuss psychological and emotional trauma and its consequences. He describes the experience as a "pebble in the pond" as a way of explaining the way that trauma can pervade a range of components in one's life, extending beyond the individual to affect others, including both interpersonal relationships and social engagement. The traumatic event, he suggests, sends ripples throughout the pond, the individual's world, in terms of length, breadth, and depth. Scarry (1985) describes intense

pain as the "making and unmaking" (p. 1) of worlds. Scarry explains everything to fragment on account of a traumatic event. She explains that intense pain has the effect of crippling one's sense of self, as well as obliterating one's sense of the world. As a by-product, trauma has the ability to destroy language. Though whilst the external component of a traumatic event can be observed, and at times lead to physical pain, the internal component of trauma remains unobservable, without form, and difficult to express. It therefore remains subjective and difficult to define. In Terr's (1987) aforementioned definition, 'utter helplessness' is a subjective experience necessarily.

Understanding the elusiveness inherent in observing the internal components of trauma is important in understanding truths when considering trauma. First, attempts to understand trauma may always fall short of the true experience, given subjectivity and its unobservable qualities. Second, the experience of psychological and emotional trauma, regardless of observable signs, can only be as conceptually clear in psychological and emotional impact as the interaction between the individual communicating the experience and those attempting to understand both the experience and reactions to it. This leaves the conceptualisation of trauma susceptible to variation depending on social values and normative frameworks, subjective communication, and observation of experience.

1.2 The American and European development of trauma symptomatology

While the experience of trauma can only ever be approximated using language, in order to aid understanding, efforts have been made for well over a century to articulate the unobservable. The following synopsis highlights the way that understandings and interpretations of psychological and emotional trauma have evolved. It becomes clear that interpretations of trauma, and in turn, the nature of trauma itself, evolved in conjunction with

changing social imperatives, prevailing social beliefs, and developing models of the mind (Summerfield, 2001; Young, 1995).

Since the middle of the 19th century, traumatic events have been discussed by scholars increasingly linked to the discipline of psychology (Friedman, Keane, & Resick, 2007). The French psychiatrist Briquet (1859) was the first to elucidate an association between traumatic events and symptoms of hysteria. At the time, hysteria was a prevailing mental disorder believed to be particular to women, especially prominent in women unable to conceive (Tasca, Rapettic, Carta, & Fadda, 2012). Belief in the constraint of this mental illness to women dated as far back as the ancient Egyptians, who believed the cause of hysterical disorders were related to the random and temperamental movement of the uterus (Cosmacini, 1997). Briquet (1859) described specific traumatic events as an origin of hysteria for 381 out of a total 501 patients. The effects of this, still particular to women, were understood to include somatisation, intense emotional reactions, and dissociation.

Interpretation of traumatic effect began to change in the late 19th century with the emergence of Freud's psychoanalytic theory and a new model of the mind. Previously, Pierre Janet had explicated the mind to be bound together in a unified stream of consciousness (Haule, 1986). Dissociation, a key component of the hysteria disorder, was considered to occur when a component of the single conscious stream was split and began functioning outside of awareness and control (Kihlstrom, 2005). Freud however subscribed to a conception of the mind as compartmentalised into the conscious, subconscious and unconscious (Tasca, Rapettic, Carta, & Fadda, 2012). Breuer and Freud (1895), in their initial conceptions of psychoanalytic theory, believed the traumatic event to remain outside of conscious awareness: "the traumatic experience is constantly forcing itself upon the patient … the patient is, as one might say, fixated on the trauma" (p. 25). This view conceived symptoms of hysteria as a return of repressed impulses including repressed traumatic

memory. Repressed traumatic memory, located in the preconscious, would force itself to manifest in conscious behavior.

Three changes are noteworthy in Freud's reorientation of trauma. First, the role of memory in trauma emerged here as an important factor. Memory has since been maintained as a core component of trauma understanding (Van Rooyen & Ngweni, 2012). Second, Freud wrote, counter to the socialised view of hysteria as being particular to women, that he was suffering from his own hysteria, and therefore, hysteria affected both men and women (Mattioli & Scalzone, 2002; Tasca, Rapettic, Carta, & Fadda, 2012). Third, Freud's alternative model of the mind also resulted in an altering of the previous explanation and understanding of trauma itself.

After World War One, the conceived effects of trauma were recalibrated on numerous occasions in American and European discourse (Freidman, Keane, & Resick, 2007). Differing descriptions and interpretations of consequences of trauma emerged, reflecting the reports of soldiers returning from World War One. During the war, Myers (1915), a British psychiatrist, was the first to use the term 'shell shock' in the medical literature. He argued that the explosion of shells during the war caused psychic shock, leading to neuroses. The symptoms of trauma were described as a "dazed, disoriented state" (Scott, 1990, p. 296). Others were questioning shell shock for the fact that the same symptoms could also be found in soldiers who had not been exposed to the shock of bomb shells, and not all of those who were exposed to shells displayed the condition (Leri, 1919).

Smith and Pear (1918), for example, preferred categorising the experience as war strain. They explained that symptoms emerged from emotional disturbances as a result of war in general. The phenomena they attributed to trauma included insomnia, loss of memory, terrifying dreams and pain. An emotional component to the onset of trauma symptoms allowed for inclusivity of experience. It also however, facilitated an alternative interpretation

of trauma leading to stigmatisation of the victim (Friedman, Keane, & Resick, 2007). Psychiatrists and soldiers believed that those who exhibited symptoms were weak (Bentley, 2005; Shalev, Yehuda, & McFarlane, 2000). German psychiatrist Bonhoeffer explained the real cause of trauma to be inherent in the compensation soldiers received, with compensation positively reinforcing soldier endorsement of symptoms (Borghini, Garzia, Borghini, & Borghini, 2016). Simulation and suggestibility became the hallmarks of trauma, and treating symptoms was aimed at targeting willfulness (Friedman, Keane, & Resick, 2007). Interpretations of trauma therefore once again shifted due to socially driven explanations.

During the Vietnam War, a shift again occurred in trauma interpretation. Since trauma response had been stigmatised, there was a lack of public and institutionalised recognition of the psychological impact of war (Bloom, 2000; Freidman, Keane, & Resick, 2007). Soldiers though, were still returning from war suffering. Vietnam War veterans lobbied for a diagnosis to categorise their experience. In 1970, New York psychiatrists responded by conducting therapy groups for recently returned veterans, and this approach spread quickly throughout the United States (Shalev, Yehuda, & McFarlane, 2000; Van Der Kolk, McFarlane, & Weisath, 1996). Numerous committee and consensus meetings and presentations at the American Psychiatric Association culminated in the inclusion of PTSD in the Diagnostic and Statistical Manual of Mental Disorders (DSM), 3rd edition, in 1980 (Van Der Kolk, McFarlane, & Weisath). The diagnosis of PTSD was reserved for stressors outside the range of normal human experience, exonerating the ill person by shifting the 'blame' for illness onto an external event (Fassin & Rechtman, 2009). The then new understanding of trauma was typified by the symptoms of re-experiencing the traumatic event, numbing and autonomic arousal (APA, 1980).

Today, the term of post-traumatic stress is utilised commonly and colloquially among the general public. It has, over the last few decades, become so ubiquitous that it is used at

times to denote reactions to relatively commonplace incidents, such as a relationship break-up or a stressful work meeting (Summerfield, 1999; 2001). This can be explained by the 'looping effect' (Hacking, 1995). The looping effect suggests that the likelihood of individuals understanding their trauma as PTSD is dependent on the popularity of the term (Kirmayer, Gone, & Moses, 2014). Hacking (2006) calls this "making up people" (p. 23), for the way that individuals define themselves according to prevailing categories.

Since its inclusion in the DSM, the concept of trauma in American and European psychiatric and psychological discourse has flourished. The PTSD category has been incorporated into both the International Classification of Diseases, 10th edition, Diagnostic Criteria for Research (ICD-10-DCR; WHO, 1993) as well as the DSM-IV, undergoing a number of revisions since the DSM-III (APA, 1994). The symptom approach tries to classify and describe typical patterns for the trauma response. Despite relatively subtle differences in PTSD criteria (Stein et al. 2014), core components of the PTSD category (re-experiencing, avoidance, hyper-arousal symptoms) are consistent between the two manuals. The DSM, now in its fifth edition, has a separate *trauma and stressor-related disorders* chapter (APA, 2013).

This conceptualisation of trauma incorporates a model of the mind assuming that internal mental stress response exists on a continuum ranging from normal/functional to abnormal/dysfunctional. Within this understanding of trauma is the diathesis-stress model suggesting that certain individuals, depending on their biological make-up and psychological risk factors, are disproportionately susceptible to trauma following environmental stressors (Belsky & Pluess, 2009). Those with genetic vulnerabilities, as presumed in the model, are more likely to experience abnormal/dysfunctional responses to horrific and terrifying events. Including trauma and stressor related disorders in the DSM implies that if trauma response to a traumatic event has an impact on the capacity of an individual to function, individuals can benefit from intervention.

Following an event defined by the DSM as "exposure to actual or threatened death, serious injury, or sexual violence" (APA, 2013, p. 271), most people are considered to experience some form of trauma. The American Psychiatric Association officially recognized an acute trauma reaction in 1994 by including a diagnosis for *acute stress disorder* in the DSM-IV (APA, 1994), also found in the DSM 5 (APA, 2013). Acute stress disorder describes initial trauma, differing from the PTSD diagnosis in that symptoms of disorder are contained within a three-day to one-month period. Acute stress disorder acknowledges that the symptoms of a trauma response can be pathological if very intense, despite being transient.

Beyond the normative and acute responses to trauma, PTSD is a categorisation and collection of symptoms that cohere and reflect dysfunction (APA, 2013). Symptoms of PTSD are thought to reflect the presence of an unobserved latent entity, an underlying disorder, which causes the emergence of the symptoms and explains the way they cohere as a syndrome (Borsboom & Cramer, 2013; Borsboom, Mellenbergh, & van Heerden, 2003). In this latent variable model, a stressor causes trauma response, which in turn causes the symptoms that reflect its presence (McNally et al., 2015). Since the DSM-III, the PTSD category has gained a fourth component (APA, 1994). In its latest rendition, the DSM 5, PTSD is now compartmentalised into four key symptom domains: intrusive symptoms, persistent avoidance symptoms, negative alterations in cognitions and mood, and marked alterations in arousal and reactivity (APA, 2013). Between the DSM-IV and DSM 5, three symptoms were included and eight symptoms experienced editing. Included was a key change to "the fundamental" (Hoge et al., 2016, p.1) term *re-experiencing*, replacing it with the term *intrusion*, requiring traumatic memory to be involuntary.

There is still much debate as to the scholarly and public value of the PTSD diagnosis (Friedman-Peleg & Bilu, 2011). Whether the current interpretation of trauma, outlined by a

model incorporating the potential for dysfunction in trauma response, is useful for pursuing trauma recovery is still contentious. Questions surround the efficacy of the psychopathology model as a sole component of trauma (Nickerson & Bryant, 2014; Summerfield, 1999). Just as with notions of 'psychology' and 'mental health', PTSD has social and cultural origins (Summerfield, 2001). Throughout history, an intimate connection between social, historical, cultural and political conditions have been demonstrated in the way that the interpretation of trauma and its effects changed over time. The conceptualisation of trauma evolved from a disorder particular to women, to coinciding with Freud's model of the mind, to responding to mechanisms of war (shells) in World War I, to a diagnosis validating the psychological victimhood of soldiers. Therefore, it is argued that trauma needs to be considered using a broader perspective of interpretation and understanding than that of a sole focus on psychopathology (Beneduce, 2016; Kirmayer, Gone, & Moses, 2014).

1.3 Critiquing psychopathology as a dominant conceptualisation of trauma

The "new medical discourse" (Friedman-Peleg & Bilu, 2011, p.411) has accorded PTSD a role in the organisation of disaster efforts, war and conflict world-wide. Since the inclusion of PTSD in the DSM following the Vietnam War, post-disaster and war efforts, including research, have focused on vindicating and reducing PTSD (Kienzler, 2008). For example, mental health practitioners in Haiti during and after the major political instability of 1995-2000 became deliberators of entitlement, allocating material aid based on PTSD recognition (Friedman-Peleg & Bilu, 2011). Yet, a sole focus on PTSD following traumatic events has been criticised for over-medicalising responses to trauma (Summerfield, 1999) and arguably masking greater social and moral imperatives (Manderson, Cartwright, & Hardon, 2016; Summerfield, 2012). PTSD has its origins in social movements. Young (1995, p.5) wrote that "the disorder is not timeless, nor does it possess an intrinsic unity, rather, it is

glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated". Summerfield (2001) similarly explained PTSD to be a collectively held belief by a particular culture at a particular point in time. At the same time, while these critiques present worthy consideration, an abundance of research has demonstrated PTSD to be prevalent in wide range of diverse groups in different contexts (Bronstein & Montgomery, 2011; Hodes, Jagdev, Chandra & Cunnif, 2008; Papageorgiou et al., 2000). Therefore, to ignore the diagnosis of PTSD all together, is to potentially overlook the distress of many.

A sole focus on psychopathology presents a quandary for its potential to perpetuate mental health concerns. Medicalization has been described as occurring when non-medical phenomena are classified in terms of medical categorisations (Zola, 1972). The "medicalization" (Pridmore, 2006, ch 32, p.1**)** of trauma can invalidate the extreme responses to traumatic events by reducing human rights abuses to medical outcomes (Almedom & Summerfield, 2004; Conrad, Mackie, & Mehrotra, 2010; Steel, Steel, Silove, 2009). When it comes to the experience of horrifying and terrifying events, locating trauma response within a framework of psychopathology can invalidate the less typical responses to these less typical events. Psychiatric symptoms have been stigmatised as signs of weakness not only in some non-Western cultural groups, but also in various American and European societies and contexts (Pridmore, 2006; Slobodin, Caspi, & Klein, 2014), including within a military context (Manderson, Cartwright, & Hardon, 2016). Therefore, caution must be used when identifying PTSD, as the stigma related to a focus on individual psychopathology can further invalidate the experience of trauma.

A further criticism of a sole focus on psychopathology is that such a focus may impact social discourse and action pertaining to traumatic events in a way that confuses appropriate and useful responses. By focusing on the alleviation of a socially constructed disorder, it is argued that moral imperatives in response to traumatic events are masked

(Almedom & Summerfield, 2004; Silove, Steel, & Bauman, 2007; Steel, Steel and Silove 2009). Even if the PTSD diagnosis is a "real" description of trauma (Hinton & Lewis-Fernandez, 2011, p. 784), a focus on the diagnosis alone can at times lead to the neglect of research and interventions regarding external stressors and societal factors, such as resettlement, familial, and intra-individual factors (Carlsson, Olsen, Mortensen & Kastrup, 2006; Porter & Haslam, 2005), leading to and causing trauma response. Beneduce (2016) argued that "psychiatric diagnosis itself can be a way to dislocate and repress a socially painful and unspeakable history" (p. 275). By focusing on the individual psychopathology post-disaster, the reasons for the disaster on a larger scale have potential to be actively obscured and acquitted from the collective consciousness (Caruth, 1995). Manderson, Cartwright and Hardon (2016) highlight that by categorising the pain of the victims and the pain of those who caused that suffering with the same diagnosis, without making any significant distinction, the assessment of trauma can overlook the moral significance of war and violence. This is, in part, what Beneduce referred to when he noted the "concealing side effects" (2016, p.275) of psychiatric diagnosis involved in mass-trauma.

Yet, to ignore completely a Western medical discourse and label high prevalence rates of recorded psychopathology as "disease-mongering" in line with Summerfield (2012, p. 520), has the potential to invalidate legitimate suffering. Many empirical studies have documented high PTSD prevalence rates in refugee groups from all over the globe (Fazel & Stein, 2002; Fazel, Reed, Panter-Brick & Stein, 2012; Murray, Davidson & Schweitzer, 2008) which can continue for many years following resettlement (Ehntholt & Yule, 2006). That a sole focus on PTSD has the potential to over-medicalize distress and obscure moral and social imperatives, does not suggest that PTSD should be completely discarded. History has shown, as demonstrated above during the years of the Vietnam War, that if legitimate psychopathology is not accounted for, individuals will lobby for an institutionalised

recognition of suffering. In order to overcome limitations identified in past approaches therefore, extreme views on either side need to be avoided.

Summary

Understandings of psychological and emotional trauma have evolved over time. The social environment shapes the interpretation of trauma response influencing definition, recognition and approach to recovery. The prevailing American and European model of trauma assumes traumatic events to impact the mind, creating a trauma response identifiable on a continuum ranging from adaptive/functional to maladaptive/dysfunctional. Yet whilst the establishment of the PTSD category has recognized the victimhood of trauma survivors (Summerfield, 2012), responses to trauma need to integrate both individual factors (e.g. biological and psychological) and socio-cultural factors (e.g. context). Broader conceptualisations of trauma response are required in order to account for PTSD without over-medicalizing the trauma response. This is particularly imperative for work with traumatized groups globally when considering the American and European conceptualisation of trauma in diverse cultural contexts; to be considered in the following chapter.

Chapter 2:

Culture, trauma, posttraumatic stress disorder and meaning in Life

With 59.5 million world refugees world-wide (UNHCR, 2016) impacted by war and conflict, trauma assessment and intervention has become an imperative task globally (Yeomans & Forman, 2009). A key concern, however, is whether PTSD is universal, and whether, incorporated into American and European models of clinical trauma and recovery, it applies in the same way to diverse cultural groups (Silove, Steel & Bauman, 2007; Summerfield, 2001; 2012; Young, 1995). In Chapter 1, the meaning of trauma was demonstrated to be, in part, crafted by the social environment (Summerfield, 2001; Young, 1995). The social and cultural environment has also played a role in crafting alternate interpretations for trauma (Rasmussen, Keatley, & Joscelyne, 2014; Silove, 2013; Steel, Silove & Bauman, 2007).

Applying an American and European model of psychological and emotional trauma cross-culturally has been a matter of contention (Kienzler, 2008; Summerfield, 2001). PTSD is currently a common way of understanding a disordered trauma response grounded within an American and European practice of clinical mental health as developed by psychologists and psychiatrists (APA, 2013). A basic premise underpinning a clinical approach to trauma is that when a traumatic event occurs, the mind is impacted. Such impact can potentially lead to disorder and personal disruption, resulting in a diagnosis of PTSD, and is considered to require intervention. Questions of cross-cultural applicability not only pertain to the assessment of PTSD, but also to understanding notions of trauma recovery. Attention has been paid to the utility of MIL as a pathway to recovery (Park, 2010; Silove, 2013), though uncertainty persists also in the application of American and European conceptions of MIL to culturally variable groups following traumatic events (Park, 2016; Shlegel & Hicks, 2016).

In cross-cultural considerations of mental health, two schools of thoughts have dominated exploration. The universalist approach, represented particularly by an etic approach, has attempted to examine the applicability "of objective, value-free, scientific knowledge that is embodied in clinical guidelines" (Moncrieff & Timimi, 2013, p. 60) in diverse cultural groups. The task of etic research has been to assess for and endorse symptoms classified as contributing to the mental health category being explored. It uses prevailing American and European constructs, and assesses for the validity of these constructs in various cultural groups. In contrast, proponents of a relativist approach, utilising emic research methods and approaches, explore constructs as formulated from within particular cultural groups (Draguns & Tanaka-Matsumi, 2003). Donnelly (1984), in expounding on the importance of considering notions of normal according to cultural standards, writes that cultural relativism is an "undeniable fact" (p. 400). Both approaches however have their limitations. The universalist approach is limited by assumptions of meaning, and the relativist approach by its inability to compare and contrast (Draguns & Tanaka-Matsumi, 2003). In the following chapter, universalist and relativist considerations in cross-cultural mental health research are outlined as they apply to trauma, PTSD, recovery and MIL.

2.1 The role of culture in mental health

Mental health has varied in understanding cross-culturally. Culture is conventionally defined as "(s)hared learned behavior" transmitted across generations facilitating societal adaptation, represented by "artifacts, roles, and institutions", bound in "values, beliefs, attitudes, epistemology, consciousness and biological functioning" (Marsella, 1988, p. 8-9). Culture impacts the social environment of every individual. It creates, from individuals, collective norms regarding behaviors, cognitions, emotions and theories of mind (Hinton, &

Lewis-Fernandez, 2011). It therefore entails its own conceptions of 'psychology' and 'mental health' (Shlegel & Hicks, 2016), providing its members with particular understanding of internal cognitive and emotional functioning.

Theories around mental health and the mind have been found to differ across cultures (Lillard, 1998). Lillard explained theory of mind to refer to the capacity and way in which mental states are attributed to oneself and to others. Through the transmission of culture, group members learn to perceive themselves, and thereby their relationship with the mind, in a particular way. Studies have found different developmental patterns between European/American children and children from different cultural groups, that contribute to alternate theories of mind (Liu et al. 2008; Naito & Koyama, 2006). For example, Triandis (1994) highlighted that the way people understand the intention and motivation behind the behavior of others can differ depending on cultural group membership being individualistic or collectivist. Frank and Temple (2009) explained that "Western children may conceptualise the mind as being personal and intentional" while some non-Western cultures may conceptualise the mind as "interpersonal" (p. 215). In individualistic cultures, as defined within psychology (Lillard 1998; Triandis, 1994), people are motivated by their own desires and are therefore more individualised in thinking about the mind. In the collectivist approach, people are motivated by needs and socially dictated behavior, and are therefore more collective in thinking about the mind (Paul, 1995). This is perhaps why Bryant-Davis (2005, p.1) explained culture to be "at the root of sociology and psychology... It gives children their ideas about life". As children grow within their own cultural environments, they develop and make sense of practices and the surrounding world, developing a particular experience of subjectivity and a theory of the mind (Lillard, 1998; Miller & Goodnow, 1995).

Varying theories of the mind can influence different notions of madness. The idea of 'madness' is not unique to American and European discourse, although aetiologies of

madness tend to differ between cultures (Kohrt et al. 2014). Even when American and European clinical mental health categories have been endorsed through observation or quantitative assessment (Hinton, Hoffman, & Orr, 2010; Perilla, Norris, & Lavizzo, 2002; Nixon & Bryant-Davis, 2005), aetiologies attributed to these categories have been found to differ (Kleinman, 1987). For example, a recent study by Ventovogel, Jordans, Reis and de Jong (2013), comparing participants from Burundi, South Sudan and the Democratic Republic of the Congo, found explanations for mental illness to fluctuate from the supernatural, to psychosocial, to natural causes. In a study conducted by Kolstad and Gjesvik (2014), the perceptions of mental health problems as sickness was uncommon not only among rural Chinese, but also among the urban, educated population. Steel and colleagues (2005) explained Vietnamese aetiological explanations for mental illness to differ again. They reported Vietnamese to uphold inclusive conceptual frameworks for understanding mental health, in which the mind, body and the cosmos all play a role.

2.2 Applying the American and European model of trauma and recovery cross-culturally: The universalist approach

In concert with cultural heterogeneity in understandings of the self and the mind, the American and European clinical model of trauma has been questioned in its universal applicability (Nicolas, Wheatley, & Guillaume, 2015). Issues concerning culture-specific versus universal trauma response and extreme stress have not been resolved (Hoshmand 2007; Wilson & Tang, 2007). In the quest for understanding global trauma experience, both the universal and relativist approaches have been confronted by barriers. As a result, a "sometimes fierce" (Kienzler, 2008, p. 218) debate has revolved around the application of the clinical model of trauma, including PTSD, to diverse cultural groups, despite that symptoms

of PTSD can be found in diverse groups (Al-Saffar, Borga, Edman, & Hallstrom 2003; Tempany 2009; Vermetten & Olff, 2013).

Two core barriers are apparent in applying a universal approach to trauma. First, understanding trauma in terms of PTSD in all contexts has the potential to impose an American and European framework on potentially diverse experiences found in cultural groups (Kira & Tummala-Narra, 2014; Kirmayer, Gone, & Moses, 2014). Second, PTSD symptoms vary in meaning (Silove, Steel, & Bauman, 2007). Therefore, category endorsement on its own is insufficient: it overlooks the interpretation, and in turn meaning, of the trauma responses in different cultures and settings (Kleinman, 1987).

2.2.1 Universally applying PTSD

In accordance with the diathesis-stress model, biological markers when interacting with a traumatic environment and social contexts, have been thought to influence the onset of the disorder (Auxemery, 2012). Whilst the interpretation of biologically endorsed PTSD features can vary, arguments for the universal applicability of PTSD reference the vulnerabilities for, and the features of PTSD that are seen across cultures. It is assumed that people have the same biological makeup, and therefore, given specific circumstances, any person can develop PTSD.

Psychophysiological studies have documented universal markers that are believed to be involved in contributing to one's likelihood of experiencing PTSD (Bremner, 2002; Vermetten, & Bremner; 2002;). Hinton and Lewis-Fernandez (2011) refer to a number of studies that have found MAO-B activity as a biomarker for PTSD, producing a startled response and exaggerated physiological activity, included in criterion E for PTSD; marked alterations in arousal and reactivity. Other symptoms of PTSD reflecting physiological responses that have been documented in different cultural groups following stress include difficulty concentrating (Andreassi, 2000; Orr & Roth, 2000), hypervigilance (Bremner,

Southwick, & Charney, 1999; Karl, Malta, & Maercker, 2005), an exaggerated startle response (Pole et al. 2003; Shalev et al. 1997), and physiological reactivity (Orr, McNally, Rosen, & Shaleve, 2004). On the basis of this evidence, it has been argued that stress and trauma can result in changes to the nervous system that produce relatively homogenous effects across groups of people (Nickerson, Bryant, Silove, & Steele, 2011; Vermetten & Olff, 2013).

In concert, high rates of PTSD prevalence have been recorded globally. De Jong and colleagues (2001) reported high prevalence rates of PTSD in diverse settings in association with war or conflict, including Algeria, Cambodia, Palestine and the former Yugoslavia. North and colleagues (2005) compared Kenyan survivors of the American embassy bombing in Nairobi with American survivors of the federal building bombing in Oklahoma City, and showed that the two populations returned similar rates of PTSD. Carlson and Rosser-Hogan (1994) documented high prevalence rates in Cambodian refugees living in Thailand. A high prevalence rate of PTSD has also been found in Iranians (Al-Saffar, Borga, Edman, & Hallstrom 2003), reinforcing the idea that PTSD can be "similarly measured across different settings" (Yeomans & Forman, 2009, p.225).

Given the vast heterogeneity that characterises research with traumatised populations, making generalisations regarding the prevalence rates of psychopathology is difficult (Fazel, Wheeler, & Danesh, 2005). Steel, Silove, Phan, and Bauman (2002) found a four percent prevalence rate of PTSD in Vietnamese victims of war. Oruca and colleages (2008) found that 26.3% of Bosnians and Croatians had PTSD following civil war and genocide. Among Sudanese, PTSD prevalence rates range from 13% to 63% (Meffert et al. 2010; Peltzer, 1999). Mollica and colleagues (1998) found prevalence rates of PTSD in Cambodians to range from 79% to 86%. Variance in findings is possibly attributable to variance in methods and instrumentation (Drury & Williams, 2012; Ehntholt & Yule, 2006; Yeomans & Forman,

2008). Many measures have been developed for PTSD, though many studies in various cultural groups have used measures created by Americans and Europeans for American and European populations (Freidman, Keane, Resick, 2007; Tempany, 2009). These measures are based on Western values, assumptions and norms. When utilised with those from a non-Western culture, issues of English proficiency and conceptual differences can decrease the validity of results. To redress this, some culturally validated measures have been created, such as the Harvard Trauma Questionnaire (Mollica, et al. 1992; Mollica et al. 1996; Mollica, 1998). However, the use of different measures in different studies confounds comparisons of prevalence rates between populations and so variation in PTSD may not be distinct from variation in how it is assessed.

The study of PTSD and its symptoms quantitatively, whilst producing inconsistent findings, has also demonstrated the possibility of PTSD endorsement cross-culturally (Oruca et al. 1998; Steel, Silove, Phan, & Bauman, 2002). Nevertheless, without contextualisation of these symptoms and the PTSD category, it is not clear whether the phenomena are understood and interpreted to mean the same thing in different groups. Therefore, the universal approach is confronted by the following two limitations.

2.2.2 The potential to overlook diverse experiences of trauma

Perceiving PTSD to be a by-product of traumatic events is demonstrated to have emerged over time, in part as a response to the social climate (Kienzler, 2008; Summerfield, 2001; Young, 1995). One barrier to the cross-cultural assessment of PTSD is the potential for culturally-specific conceptualisations of trauma to be overlooked. In the previous chapter, an American and European model of trauma was outlined to assume the potential for PTSD depending on the interaction between individual and environment. This PTSD model places emphasis on clinical outcomes, though diverse cultural groups, with different models of the mind, can understand the experiences of trauma differently. There is a danger inherent in

using a a ‘one-size fits all’ approach to trauma experience. PTSD on its own, as a conceptualisation of trauma in culturally specific groups is therefore limited as its reduces the trauma experienced in diverse cultural groups to a clinical set of symptoms that may not aptly explain the experience of diverse groups (Nicolas, Wheatley, & Guillaume, 2015).

Current notions of PTSD assume that trauma occurs following a traumatic event. The ‘post’ in PTSD can reduce the often complex experience of terrifying events to a single moment or moments (Burstow, 2003; Kira & Tummala-Narra, 2014; Straker, 2013; Summerfield, 2004). The diagnosis assumes that there is a pre-event life, the intrusion of a traumatic event, then the trauma response (Lester, 2013). Often, especially in the case of war and violence, terrifying events can persist, and are multifaceted. As is the case within many oppressed cultural groups, such as Indigenous Australians, traumatic events can be perpetrated by social systems and transmitted through generations (Kira & Tummala-Narra, 2014). Whilst it may not be the aim of PTSD to account for this range of experience, the category of PTSD is then limited in its application to trauma experience by the scope of the stressor experienced as being particular to a past stressor. In doing so, the PTSD category does not account for prolonged traumatic experiences typical of war and conflict.

This is especially apparent in the case of refugees. The refugee experience is one marked by ongoing conditions of threat, uncertainty about the future, lack of control, and an absence of social support or resources to achieve recovery (Hobfoll, 2012; Hollifield et al., 2002). Refugees experience triggering traumatic events in their country of origin and these events are often perpetuated by trauma stemming from uncertainty, challenges of seeking safety and asylum, and difficulties associated with resettlement (Davidson, Murray, & Schweitzer, 2008; Lustig et al. 2004; Porter & Haslam, 2005). A refugee may experience interpersonal trauma associated with physical, sexual, verbal or emotional violations perpetrated by another person or a group of people (Bryant-Davis, 2005). The events may

continue among family and other community members still suffering from war and political violence (Silove, 1999).

Previous literature has discussed a "breaking point" (Kira et al. 2015, p. 95) where trauma response, including PTSD, might vary significantly after multiple traumatic events. For refugees and those experiencing war, trauma is likely a response to a wide array of experiences and may only occur after a build-up of traumatic events. For example, the Holocaust survivor experience includes a variety of traumatic events including loss of rights, loss of loved ones, the experience of concentration camps, the suppression of identity, witnessing violence, and physical, verbal and emotional abuse (Krystal, 1985). The 'post-traumatic' description of trauma is then limited when considering the potential for the continuity of the traumatic event, the multi-faceted nature of traumatic experience that goes beyond initial stressors, and continuing trauma or trauma-related responses beyond the events and experience (Kira, Amer, & Wroble, 2014, Kira & Tummala-Narra, 2014).

In a clinical mental health model of PTSD, trauma experience is reduced to individualised effects. It is then limited when considering the impact of socio-political trauma on entire population groups (Agbayabi-Siewert, Takeuchi & Pangan, 1999; Kira & Tummala-Narra, 2014; Lester, 2013; Shiekh & Furnham, 2000). At the core of the diathesis-stress model is an individualised model focusing on an individual's vulnerabilities (Belsky & Pluess, 2009). A current clinical model of trauma from an American and European perspective does not have scope to consider collective trauma that can occur in response to traumatic events impacting a mass group of people. Some research has demonstrated that the processing of trauma and the experience of suffering can be regarded as a collective construction (De Jong & Reis, 2013; Kleinman, 1995; Steel, Steel, Silove 2009). Nicolas, Wheatley and Guillaume (2015) explained that the magnitude of a given traumatic event has been explained to be dependent on local and community response to it. The application of an

American and European trauma model cross-culturally therefore can be limited when applying it to many societies built on collective principles (Kira & Tummala-narra, 2014).

Collective trauma processing appears to be a way to respond to and process horrendous events affecting a group of people (Nicolas, Wheatley, & Guillaume, 2015). Freidman-Peleg and Bilue (2014) discuss the notion of "national trauma" (p. 416) in Israel/Palestine, and in doing so, they combine individual psychopathology and indicators of shared experience and identity. Through this approach to trauma, the narratives of soldiers and their families collectively create a "family of suffering" (p. 425) in response to ongoing conflict. Similarly, De Jong and Reis (2013) discussed collective trauma processing as it pertains to the Balanta population of Guinea Bissau. They reported that 12% of the Balanta population took part in a dissociative cult known as "Kiyang-yang" (p. 644) in response to eleven years of conflict. Similarly, Ahrens, Isas, and Lopez (2010) demonstrated the substantial role that the collective plays in shaping the experience of Spanish-speaking Latinos in the US, where socio-cultural beliefs contributed to silence and a lack of help-seeking. Viewing the collective response as a sign of psychopathology has the potential therefore to overlook culturally acceptable ways of responding to both trauma and traumatic events if culturally appropriate responses to trauma are not also considered alongside PTSD.

The diagnosis of trauma as a medical pathology, therefore, includes an individualised notion of disorder that is limited in its examination of collective trauma, and the importance of community resilience for individual well-being (Sousa, 2015). Trauma affects people on both an individual and communal level (Ungar, 2011). Applying the American and European model of trauma universally may therefore miss variations in understandings of self held by various cultural groups. In so doing, strategies by which groups aim to achieve recovery can also be overlooked (Bryant-Davis et al., 2010; Lester, 2013; Kleinman, 1995; Reis, 2013).

2.2.3 The category fallacy and variability in symptom interpretation

The second limitation of the universalist approach and the etic literature is bound in the category fallacy identifying that the same phenomena may mean something entirely different depending on the context of assessment (Kleinman, 1987). Diverse cultural interpretations have been reported for symptoms reflecting PTSD (Kohrt et al, 2014). The latter two examples given above of collective cultural responses to trauma in Balanta and among Latinos are particularly pertinent as both dissociation and avoidance are treated as symptoms of psychopathology in American and European discourse (APA, 2013). However, simply because symptoms of PTSD can be identified in one context of assessment, this does not necessarily indicate that the interpretation, and consequently the meaning, of symptoms transcend cultural boundaries (Steel, Steel, & Silove, 2009; Summerfield, 2001; Tempany, 2009).

PTSD has been found to vary in goodness-of-fit between samples. While some researchers have found the factor structure of PTSD to be comparable in different cultural groups (Sack, Seeley, & Clarke, 1997; Smith, Perrin, Dyregrov, & Yule, 2003), Michalopoulos and associates (2015) found individuals from high socio-economic backgrounds to better fit the PTSD factor structure than people from cultural groups in low and middle income countries. Similarly, Jones and colleagues (2003) have argued that specific aspects of PTSD, such as flashbacks in Western populations, are uniquely expressed in certain cultures and have not been documented in others.

In both European and American populations, as well as diverse cultural groups clinical levels of PTSD does not necessitate functional impairment (Miller et al., 2009; Summerfield, 1999). The DSM 5 diagnostic criteria for PTSD currently includes the criteria that individuals must also be experiencing "clinically significant distress or impairment in social, occupational, or other important areas of functioning" (Criterion G; APA, 2013, p.

272). This clause recognises the potential for both the endorsement of PTSD symptoms and continued functioning. However, whilst PTSD symptoms can coincide with a lack of impairment, Tempany (2009) reported, in her meta-analysis on Sudanese refugee trauma, the majority of studies to find PTSD levels to co-exist with in-tact daily functioning (Goodman, 2004; Jeppsson & Hjern, 2005; Paardekooper, De Jong, & Hermanns, 1999; Tempany, 2009). Therefore, despite the endorsement of PTSD symptoms, traumatic stress may not be of principal concern to populations even where it is documented (Breslau, 2004; Englund, 1998; Miller et al., 2009; Savic, Chur-Hansen, Mahmood, & Moore, 2016).

One explanation for findings is that PTSD symptoms have been documented as altering in interpretation and meaning throughout the literature. Rumination, for example, understood as a symptom of both depression and PTSD (APA, 2013), has also been considered a way to accomplish processing of events (Filipp, 1999). Similarly, intrusive memory has been used as a measure of distress (e.g. APA, 2013), but also as an index of meaning-making (DuHamel et al. 2004; Salsman, Segerstrom, Brechting, Carlson, & Andrykowski, 2009; Zakowski, Valdimarsdottir, & Bovbjerg, 2001).

Cultural discrepancy in the meaning of symptoms is well demonstrated by the way that cultures deviate in interpretations of avoidance following trauma. Avoidance has been interpreted as a symptom of PTSD (APA, 2013; De Jong et al., 2001), yet it is also an adjustment method to the grief of trauma in some populations (Marsella, Friedman, Gerrity, & Scurfield, 1996; Norris, & Aroian, 2008; Slobodin, Caspi, & Klein, 2014). For example, Slobodin, Caspi, and Klein (2014) documented the role of avoidance symptoms in Bedouin members of the Israel Defense force, and found that participants who reported the most avoidance symptoms were least likely to develop PTSD. Bedouins perceived the role of avoidance as adaptive post-trauma. In Somali and Oromo refugees, Halcon and colleagues (2004) found avoidance strategies to help participants deal with sadness following trauma. In

studies with young refugee populations from Sudan, avoidance has also been used as a coping strategy after traumatic events (Goodman, 2004; Luster, Qin, Bates, Johnson & Rana, 2009). Rasmussen, Keatley, and Joscelyne (2014) have reported that "perhaps the most striking finding" (p.52) of studies on PTSD in different cultural contexts is the minimal salience of avoidance in cultural notions of posttraumatic distress.

Cultural factors have also been shown to influence the propensity to dissociate **(**Kirmayer & Santhanam, 2001**)**, and the meaning of dissociation. Dissociation is a psychological defense mechanism that may develop in response to traumatic events (APA, 2013), but it also occurs in ritual contexts, when it is shaped and controlled by cultural expectations. For example, likelihood of dissociation is heightened in the Balinese training for dance performances (Bateson, 1975). Social occasions in which disassociation is appropriate or even expected allow individuals to maintain these skills and render such behavior more acceptable than in other circumstances (Kirmayer, 1992). Whilst dissociative experiences have been reported in American and non-Western contexts (Carlson & Rosser Hogan, 1991; Ross, Joshi, & Currie, 1990), aetiologies differ between contexts. The idea of spirit possession found in many cultures integrates dissociative experience in a culturally acceptable manner, with dissociation no longer met with angst, nor seen as pathological; rather it may be seen as useful in healing (Marsella, Friedman, Gerrity, & Scurfield, 1996). While dissociation is not culturally specific, therefore, its purpose is altered by the meaning attributed to its occurrence in different contexts.

As Stamm and Friedman have noted (2000), identifying PTSD within a group does not explain the expression of posttraumatic distress or disorder. Therefore, contextualising trauma within the understandings of particular groups is imperative to increasing understanding of trauma response. Particular symptoms promoting disorder in one cultural context may be seen as adaptive in a different context (Tummalla-Narra, 2008). Trauma may

have universal components but responses to events and symptoms expressed within specific contexts may not fit with psychiatric notions of pathology (Stamm, Stamm, Hudnall, & Higson-Smith, 2004). Variation in the interpretation and meaning of symptoms indicates that grouping symptoms into categories of distress does not necessarily dictate consistent explanations for symptoms (Miller et al., 2009; Summerfield, 1999).

2.3 Applying the American and European model of trauma and recovery cross-culturally: The relativist approach

Although madness and distress appear to be global constructs, idioms of distress and the aetiology of madness differs across cultures (Patel & Winston, 1994). An idiom of distress is defined as "embodied symbolic language for psychosocial suffering that derives its legitimacy from its shared metaphors, meaning, and understanding in a group" (De Jong & Reis, 2010, p. 302). Tearfund (2006) asserted that every culture provides its members with a language to communicate distress. The DSM 5 (APA, 2013), acknowledging the importance of recognising cultural variation in notions of distress, contains a cultural formulation interview. This section aims to help clinicians assess more appropriately diverse cultural experiences of "suffering, behavioral problems, or troubling thoughts and emotions" through the use of a cultural formulation interview deemed critical to the assessment of "cultural concepts of distress" (Kohrt et al. 2014, p. 366). As discussed in Chapter 1, research focusing on the validity of PTSD as a universal category may unintentionally and paradoxically decrease appropriate social response to traumatic events (Almedom & Summerfield, 2004; Silove, Steel, & Bauman, 2007; Steel, Steel and Silove 2009). Steel, Steel and Silove (2009) identified that the more cultural differences are ignored, the less human rights are upheld. Emic research has therefore pursued the exploration of trauma by emphasising cultural difference, uniqueness, and sensitivity (Draguns & Tanaka-Matsumi, 2003).

A range of culture-specific idioms of distress describing local psychopathology have been documented (Freidman, Keane, & Resick, 2007; Marsella, Friedman, Gerrity, & Scurfield, 1996). Some of these idioms represent somatic complaints. *Dhat* syndrome (semen loss), described in India, is considered to characterise psychosexual dysfunction and weakness, physical and mental illness (Sumathipala, Siribaddana, & Bhugra, 2004). *Hwa Bang* has been endorsed in East Asia as distress, characterised by a fiery, burning sensation in the chest due to pent-up anger (Min & Suh, 2010). Other idioms reflect disordered thought patterns. *Brain Fag*, first described in Nigeria, is characterised locally as "thinking too much" (Ola & Igbokwe, 2011), although notions of "thinking too much" appear much more widely as rumination. *Nervios related disorders* have been documented in Latinos and is explained by initial persistent ideas fixated in the brain (Salgado de Snyder, De Jesus Diaz-Perez, & Ojeda, 2000). It relates to both socially acceptable nervousness and severe deterioration of the mind, spirit and nerves (Guarnaccia, Lewis-Fernandez, & Marano, 2003). Other idioms of distress describe various forms of emotional distress. *Hozun* is characterised as deep sadness and has been documented among Darfuris (Rasmussen, Katoni, Keller, Wilkinsons, 2011). *Susto*, meaning fright, has been documented in much of South America (Baer et al., 2003).

Culturally discrepant idioms of distress have been recorded as responses to traumatic events, largely representing somatic complaints, that differ from a PTSD presentation. For example, abdominal and lower back pain has been described among Sudanese people (Franco-Paredez, 2009). *Rooy go*, sore neck syndrome, has been endorsed by Cambodians in the United States (Hinton, Um, & Ba, 2001). *Khyal attack,* denoting blood and wind like substances surging upwards in the body, has also been described by Cambodians (Hinton, Hinton, Eng, & Chuong, 2012). Salvadorian refugee women exiled in North America reported *calor*, the experience of intense heat rapidly spreading throughout the entire body (Jenkins, 1991). It becomes clear then how, in a recent review by Rasmussen, Keatley, and

Joscelyne (2014), overwhelming evidence was found for the incongruence of the DSM 5 model of PTSD and other trauma-related mental health constructs around the world (Ahrens, Rios-Mandel, Isas, & Lopez, 2010; Bryant-Davis, 2010; Jones, 2015).

One potential explanation for such vast discrepancy between cultures is bound in varying theories of the mind leading to different aetiological explanations for trauma (Tumalla-narra, 2008). Zulus for example have been documented as explaining trauma in terms of disruption between the natural and supernatural domains of life (Jones, 2015). Tibetan refugees have been reported to understand trauma as an imbalance of the *srog-rlung,* the life sustaining wind (Benedict, Mancini, & Grodin, 2009). Reis (2013) and Neuner et al. (2004) found *cen*, spirits of the dead who haunt the living, to explain traumatic reactions in the Acholi of Uganda. In Cambodia, *baksbat* ("broken courage") is used to explain trauma found in Cambodians (Chhim, 2014). Finally, in the Holocaust survivor literature, guilt and a continued search for meaning are identified as explanations for trauma symptoms (Armour, 2010; Kleber & Brom, 1992).

2.3.1 Limits to a culturally relativist approach: Can different groups be compared?

Emic research provides in depth understanding of a particular cultural group, but due to the importance of accentuating difference, the relativist approach has confronted barriers in generalising more widely (Draguns & Tanka-Matsumi, 2003). Whilst exploring culturally relative concepts of distress allows for recognition and contextualisation of difference, this approach faces difficulties in generalising to cultural collectives from specific sample groups studied. The ability to compare symptoms between groups in a manner that can contribute to discourse around universal notions of trauma is hindered (Draguns & Tanaka-Matsumi, 2003; Good & Hannah, 2015). The focus on cultural specificity means that psychiatric conditions can be overlooked (Kohrt et al. 2014), and the difference between normal distress and

extreme distress due to traumatic events, on a global scale, becomes unclear. This makes generalisations for the provision of wide-reaching treatment difficult.

Generalising results from one study sample to another becomes difficult when acknowledging the fluidity of culture and the way this can contribute to the experiences of specific cultural groups. This is particularly so when considering the experience of the refugee, who by nature of experience has encountered a diversity of cultures. Recently, the term "hyperdiversity" emerged as a way of referring to the increasing diversity bound in the "complex and mosaic-like mix of national origin, ethnicity, race, immigration status and nativity" that occurs in many contexts (Amin, 2010; Good & Hannah, 2015, p. 201; Hannah, 2011; Kirmayer, 2007). Increasing globalisation has been thought to lead to cultures, all over the world, becoming more homogenous. Uz (2015) described this influence to predominantly move in the direction from a non-Western origin towards Western immersion. Each cultural group is made up of a unique tapestry of cultural influences that contribute to its own cultural make-up. Therefore, generalisations of various study samples are confounded by the unique sets of cultural encounters particular to the samples in the study.

Varying time since trauma also leads to difficulty in comparing various cultural groups who have experienced traumatic events at different points in time. Temporal differences have an impact on the way that a trauma response is understood at a particular point in time (O'Donnell, Creamer, & Pattison, 2004). Some responses to trauma often require passages of time to pass before they manifest or are deemed reasonable responses to horrific events (Valent, 1995). Time since trauma is an important consideration when comparing groups given that, at times, initial responses to trauma have been noted as resolving themselves or decreasing over time (Jovanovic et al. 2012). Moreover, inconsistencies have been found in other studies assessing positive adaptation to trauma over time (Linley & Stephen, 2004; Prati & Pietrantoni, 2009; Stanton, Bower, & Low, 2006).

Given the complexity of traumatic events, and the turbulent experience of refugees (Davidson, Murray, & Schweitzer, 2008; Porter, & Haslam, 2005), it is also difficult to locate the precise time since the conclusion of a traumatic event.

Further, each researcher or clinician is likely to interpret the encounter with traumatised respondents in a distinct manner. Draguns and Tanaka-Matsumi (2003, p.771) proposed that "culturally characteristic features of abnormal behavior are invariably expressed in the course of an encounter between the patient and the observer(s)". As mentioned in chapter 1, understanding of trauma is is communicated through the discourse between observer and observed. The relationship between the observer and observed is always unique, and comparing studies conducted by different researchers is limited by inevitable variation. The relativist literature therefore, whilst able to contextualise specifically, must remain relative to the specific context.

Difficulty in comparing between sample groups has led to confusion around how best to categorise trauma within particular groups. Given the link between theory of mind and "norms of the community" (Andrews, 2009, p. 433), differences in culture include differences in understandings of what might be disordered. Trauma responses may be distressing, but also common to a group, in which case categorising a response as psychopathological is difficult. Isolating aspects of psychopathology "torn out of the matrix of their occurrence" (Draguns & Tanaka-Matsumi, 2003, p. 756) would be to impose an external framework of psychopathology deemed inappropriate according to those who emphasise relativism. Nicolas, Wheatley and Guillaume (2015, p.40) explained there is confusion in the literature as to whether cross-culturally identified responses to traumatic events are pathological or normal responses to "existential predicaments". *Baksbat* (broken courage), found in Cambodians as a response to trauma, for example, has been described as a normal response to a life-threatening event (Chhim, 2014). Confusion among authors in the

Sudanese literature has resulted in different ways of conceptualising and describing PTSD: again as psychopathology or as normal reactions to a combination of past and present stressors (Baron, 2002; Peltzer, 1999; Tempany, 2009).

Focusing on a particular context and insisting on the relativity of cultural experience, increasing uncertainty of the validity of labeling trauma response, can lead to a neglect of psychiatric categories. Whilst the universalist approach to PTSD has been heavily scrutinised, over-emphasis on sensitivity to culture can increase the danger of overlooking diagnoses (Silove, Steele, & Bauman, 2007). Before PTSD was incorporated into the DSM, individual trauma suffering was considered a sign of weakness (Pridmore, 2006; Slobodin, Caspi, & Klein, 2014). To discard entirely the PTSD category in various cultural contexts and ignore psychiatric conditions may cause individuals experiencing chronic PTSD symptoms to be unacknowledged. Despite their substantial disabilities and disordered functioning, the absence of a cultural 'label' may lead to a misidentification of their suffering (Steel, Steel, Silove, 2009).

The utility of emic research in informing generalisable treatment then becomes questionable. There is a danger in “essentializing” (Good & Hannah, 2015, p. 208) groups from different studies as all part of the same culture, thereby not appropriately recognising difference between seemingly similar, or the same, cultural groups in different contexts. In refugee health care, this is especially relevant where specific treatments are created for use with certain populations. Hannah (2011), for example, examined a program for the Somali ‘Bantu’ population in Boston, constructed to be culturally appropriate, but found it to be challenged by the significant cultural variation and ethnic discrepancy within the group. Treatment therefore based on purely relativist approaches can only be considered on a case-by-case approach.

2.3.2 Requiring a synthesis of approach

Universal and relativist approaches remain at opposing ends of a spectrum. The relativist boasts the ability to contextualise though lacks ability to generalise more widely. The universalist boasts the potential for comparison, though comparing endorsement of the prevailing PTSD category may ignore valid descriptions of distress that reflect particular cultural understandings. Therefore, "the time has come to end the debate about the validity of the PTSD diagnosis" (Friedman, Resick, & Keane, 2007, p.13). Difference in philosophical and methodological approaches to the cross-cultural examination of trauma requires a synthesis to overcome the limitations of each (Good and Hannah, 2015; Van Rooyen & Ngweni, 2012; Wendt & Gone; 2012). Continuing with debate around the validity of PTSD cross-culturally does little to provide effective strategies for healing in the aftermath of traumatic events. PTSD needs to be contextualised if it is to be appropriately utilised as a marker for distress. Clarification on the psychological and emotional trauma response requires a comparison of diverse cultural groups on both PTSD and culturally-specific notions of trauma. This requires a contextualisation of an American and European model of PTSD within diverse local conceptions of trauma, incorporating a sensitivity to variable theories of the mind.

Synthesised understandings of trauma can provide benefit to, and has implications for, the process of healing from traumatic events. Considering culture in the context of trauma enquiry, as in the case of PTSD's insertion into the DSM, stems from a social responsiveness to trauma (Summerfield, 2001; Young 1995). Harmonising cultural difference can lead to increased validation of diverse trauma experiences, help in providing effective aid for unique groups, and facilitate the process of recovery important for addressing the needs and concerns of both communities and individuals following traumatic events (Kienzler, 2008; Kirmayer, 2004).

2.4 Recovery from traumatic events from a cross-cultural perspective

Healing from trauma has often been framed in terms of therapy for psychic wounds (Bonanno & Mancini, 2010). Approaches to trauma outcome have explored recovery trajectories based on American and European notions of mental health, pursuing either a reduction in psychopathology over time (Breslau, 2001) or a gradual decline in average levels of PTSD (Port, Engdahl, & Frazier, 2001). A focus on the eradication of both PTSD and other psychopathological categories cross-culturally is premised on the underlying American and European model of trauma and mental health. Efforts to consider recovery from trauma in various cultural groups, however, require an exploration of broader local and cultural explanations. On a global scale, notions of recovery need to reflect the variability in culturally specific ways of understanding the impact of traumatic events.

Recovery is readily viewed as the eradication of PTSD symptoms (Bonnano & Mancini, 2010) and has a long history of exploration (Breslau, 2001; Port, Engdahl, & Frazier 2001; Roberts, Damundu, Lomoro, & Sandorp, 2010; Rothbaum Foa, Riggs, Murdock, & Walsh, 1992). Reflecting this approach, Bonnano (2004) defined recovery from trauma as "a trajectory in which normal functioning temporarily gives way to threshold or subthreshold psychopathology… and then gradually returns to pre-event levels" (p.20). In an American and European setting, this understanding of recovery from trauma and PTSD is prevalent. However, a sole focus on a clinical notion of recovery from a cross-cultural perspective suffers from the same limitations inherent in presuming the universality of PTSD.

Viewing recovery through a clinical mental health lens incorporates the same emphasis on the individualised trauma response, as well as single traumatic events. Focusing only on these two types of trauma is insufficient to explain diverse cultural experience. Cultures characterised as having collective worldviews, for example, communities of Black

South Africans (Mampane & Bouwer, 2006) and indigenous people of North America (Blackstock & Treome, 2005), promote survival of the collective network rather than survival of the individual. Ungar (2011) related collective trauma recovery to the experience of trauma everywhere, writing "recovery from trauma is not an individual capacity alone but a function of the individual's social ecology to facilitate recovery and growth" (p. 258). Furthermore, recovery from the European and American notion of trauma suffers from an aforementioned single-event bias where the 'Post' in PTSD presumes the cessation of the traumatic event when recovery from trauma begins. This overlooks the potential for trauma to be ongoing. Some authors have referred to trauma as entailing its own "developmental arc" (Lester, 2013, p756), extending past the traumatic event itself (Rousseau & Measham, 2007; Valent, 2005)**.** Lester (2013) posited that trauma is the "event plus its ongoing psychic, emotional, embodied interpersonal life" (p. 758). The single-event bias of PTSD therefore undermines the experience of cumulative or chronic trauma often experienced on a global scale (Lester, 2013).

Further, by working to eradicate PTSD symptoms, treatment can unwittingly also undermine pathways to recovery. There is the potential for PTSD symptoms to entail positive adaptations, and in turn by targeting the minimisation of PTSD symptoms it is possible that clinicians are also reducing the capacity of the individual to be resilient (Silove, 2013). In previously mentioned studies, Latinos (Ahrens, Rios-Mandel, Isas, & Lopez, 2010), Israeli Bedouins (Slobodin, Caspi, & Klein, 2014), and Somali and Oramo refugees (Halcon et al., 2004), have been found to express avoidance as collectively held beliefs about adaptation to traumatic events. Assessing for the reduction of individual PTSD avoidance symptoms therefore does little to foster understanding of how best to achieve recovery in these groups. Effective recovery from traumatic events requires that clinicians allow for the influence of culture on theory of mind, and the ensuing variation in conceptualising the experience of

trauma (Bryant-Davis, 2010). The work of recovery needs to be in constructing a "meaningful clinical reality" (p. 1807) that can be provided by any system that facilitates an experience of well-being and QOL for an individual (Janes, 1999). QOL has been defined, varying across cultures, as the "individual's perception of their position in life in the context of culture and value systems in which they live, and in relation to their goals, expectations, standards, and concerns" (WHO, 1996, p.5). QOL relates to one's wellbeing or satisfaction with life (Fayers & Machin, 2000) and is thought to include physical and material well-being, relations with others, personal development and fulfillment, and positive mental health (Flanagan, 1978; Kovess-Masfety, Murray, & Gureje, 2005). Focusing on markers of QOL, as opposed to solely on reducing markers of PTSD, is important to help consider whether PTSD symptoms are contributing to adaptation or disorder.

Focusing on recovery following traumatic events, as opposed to factors that cause disease, coincides with Antonovsky's (1979; 1987) theory of *salutogenesis,* outlining how people survive, adapt to, and overcome even the most horrific stressors. A number of approaches have emerged focusing on recovery from traumatic events that reflect a paradigm shift in research from an exploration of the psychopathological, towards an exploration of factors that facilitate adaptation (Pan, 2011). For example, Kirmayer (2002) argues that conceptualising the refugee experience as the interaction between host societies and refugee communities is more effective than viewing their experience through a PTSD lens. Papadopoulous (2007) explained the experience of refugee trauma through an *adversity-activated development* model. He asserted that refugees grow in development as a direct link to adversity experienced, and also gain new characteristics as a result.

Silove (1999) developed his Core Adaptive Systems (ADAPT) model to address adaptive processes following trauma that have been documented globally. In this model, he outlined five major adaptive systems instrumental to overcoming distress from traumatic

events, that are particularly pertinent to refugee populations. The five adaptive systems include personal safety, attachment and bond maintenance, identity and role functioning, justice, and existential meaning. These adaptive systems are considered to be "more pervasive" (Silove, 1999, p. 3) than the symptoms of post-traumatic pathology. In his 2013 paper, Silove addresses how it is that these systems operate not only at the individual level, but also at the community level, endorsing and expanding the focus of recovery to include the collective trauma response.

Like Silove's fifth adaptive system, Park's (2010) *meaning making model* focuses on meaning as a pathway to recovery following a traumatic event. The meaning-making model outlines a process by which individuals pursue harmonisation between cognitive frameworks to interpret their experiences, including seemingly contradictory traumatic events. According to this model, distress arises because appraised meanings of stressors are discrepant with an aspect of the individual's meaning system (Steger & Park 2012). People who report better meaning-making appear to experience lower levels of depression and PTSD (Frazer, Conlon, & Glazer, 2001; Updegraff, Silvers, & Holman, 2008), and so it is believed that "this process, when successful leads to better adjustment to the stressful event" (Park, 2010, p. 258).

2.5 The existential domain: conceptions of MIL from a cross-cultural perspective

Meaning making has long been considered in trauma work as a process by which people can recover from traumatic events (Frankl, 1967; Silove, 1999). However, it is unclear whether American and European conceptions of MIL are applicable to diverse cultural groups, or whether MIL and the way it is understood is a "peculiar focus of the West" (Park, 2016, p. 72). In concert with Silove's (1999) fifth adaptive system, MIL has been considered an integral component of trauma recovery in diverse cultural groups. Silove (2013) explains exposure to traumatic events alters a survivor's faith in the benevolence of people, facilitating

a crisis in one's sense of faith and trust in the world as well as one's own meaning systems. As with the application of PTSD cross-culturally, however, Shlegel and Hicks (2016) explain that the experience of MIL has been considered predominantly in samples of Europeans and Americans, or by using an American and European conceptualisation of MIL.

Having meaning in one's life is considered a central theme in human well-being and flourishing (Kobau, Sniezek, Zack, Lucas, & Burns, 2010; Ryff & Singer, 1998; Steger, 2012; Steger, Kashdan, & Oishi, 2008). Park (2016) described MIL as "arguably the most important, pressing, and profound concern of human beings" (p. 1). Steger (2009) defined MIL as "the extent to which people comprehend, make sense of, or see significance in their lives, accompanied by the degree to which they perceive themselves to have a purpose, mission, or overarching aim in life" (p.682). Two components of MIL accordingly have been considered fundamental to the make-up of the construct. The first dimension is purpose: having one or more overarching, long-term life aspirations that motivate relevant activity (King, Hicks, Krull, & Del Gaiso, 2006; Park, 2010). The second dimension is comprehension: the ability to make sense of and understand one's life, including one's self, the external world, and how one fits and operates within the world (Steger & Kashdan, 2013). The construct of MIL has often been additionally compartmentalised into both the search for meaning, and the presence of meaning. The search for meaning has been deemed relatively independent from whether one has found meaning (Davis, Wortman, Lehman & Silver, 2000; Steger, Frazier, Oishi, & Kaler, 2006; Steger, Oishi, & Kesibir, 2009) and has been defined as "the strength, intensity, and activity of people's desire and efforts to establish and or augment their understanding of the meaning, significance, and purpose of their lives" (Steger, Kashdan, Sullivan, & Lorentz, 2008, p. 200).

Trauma survivors often report trauma to impact perceptions of meaning and purpose. Viktor Frankl (1967) is commonly cited in meaning in life research as a founding inspiration.

A psychiatrist and Holocaust survivor, Frankl argued that people function best when they perceive a sense of meaning and possess a life purpose. The Shattered Assumptions Theory, outlined by Janoff-Bulman (1992), also implicates the role of meaning post traumatic events. The fundamental assertion of Shattered Assumptions theory, like Park's (2010) meaning making model, is that trauma symptoms result when traumatic experiences cannot be readily assimilated into previously held worldviews (Edmondson et al., 2011). The assumptions proposed to be shattered by Janoff-Bulman (see also Silove, 2013) include beliefs in a benevolent world in which the individual is meaningful and worthy. The shock of physical pain or emotional betrayal challenges, and can destroy a person's sense of meaning and coherence. Sense of coherence is also discussed as process facilitating not only general wellbeing and QOL, but also adaptation to trauma (Van der hal-van Raalte, Van IJzendoorn, & Bakermans-Kranenburg, 2008; Winger, Adams, & Mosher, 2016). It refers to a global disposition for adaptive coping in the face of stressful encounters (Antonosky, 1979; 1987). It is defined as one's ability to comprehend his or her environment, to feel as though the environment is manageable, and make sense of adversity in a meaningful way (Braun-Lewensohn, Sagy, & Roth, 2010). Both meaningful purpose for, and understandings of, existence are therefore believed to give people the psychological resources and motivation to persevere through hardship (Schnell & Becker, 2006; Steger & Kashdan, 2013; Stillman et al, 2009; Wong & Fry 1998).

2.6 The universalist and relativist approaches to MIL from a cross-cultural perspective

MIL has been considered integral to recovery from traumatic events by many theorists (Frankl, 1967; Park, 2010; Silove, 1999; Steger, 2012). Particularly recently though, a number of authors have expressed the need to consider MIL from a cross-cultural perspective (O'Donnell et al. 2014; Park, 2016; Shlegel & Hicks, 2016). They explain there

appears to be a lack of clarity around the cross-cultural application of MIL, not only in terms of its conceptualisation, but also in terms of the way it can help facilitate recovery post traumatic events.

The examination of MIL cross-culturally has utilised both universalist and relativist approaches. Similar to the examination of mental health cross-culturally, both of these approaches have suffered limitations. The universalist approach suffers from a limitation of variable interpretation. Etic research using quantitative measures has assessed for the endorsement of MIL cross-culturally. In many groups, MIL has been endorsed as positively correlating with QOL. Chinese students migrating to Australia (Pan, 2011), students in South Africa (Khumalo, Wissing, & Schutte, 2014), menopausal women living in Tehran (Jafary, Farahbakhsh, Shafiabadi, & Delavar, 2011), African-American female primary caregivers (Lamis, Wilson, Tarantino, Lansford, & Kaslow, 2014), people in Pakistan following an earthquake (Feder et al., 2013), and Pakistanis migrating to Canada (Jibeen, 2011), have all been found to yield a positive correlation between MIL and QOL.

While these studies have consistent findings in the relationship between MIL and QOL cross-culturally, the subjectivity and meaning of MIL in quantitative work cross-culturally remains unaccounted for. Meaning is a subjective construct developing in dynamic interchanges between individuals and their contexts (Steger, Frazier, Oishi, & Kaler, 2006). Culture, as previously outlined, provides a framework for understanding and making sense of the surrounding world. Culture therefore also provides the language and framework by which its members understand and experience MIL (Shlegel & Hicks, 2016). There is a difficulty reflecting the richness or complexity of MIL theories in operationalised constructs, and the abstract and profound nature of meaning and meaning making renders theoretical models very difficult to test (Davis, Wortman, Lehman, & Silver 2000). Park (2016, p.4) wrote that "perhaps one way to live with the tension of trying to define MIL is to humbly acknowledge

that our scientific endeavors are necessarily an approximation". Objective screens do not themselves comprise objective constructs of meaning, but rather reflect subjective inner experience (Park, 2010).

Within a European and North American context, interpretations of components of MIL have differed. According to Park's (2010) meaning-making model, the search for meaning represents adaptive recovery. Others however have suggested that meaning-making efforts represent unproductive rumination leading to poorer outcomes (Bonanno et al. 2005) such as anxiety (Steger, Frazier, Oishi, & Kaler, 2006), stress reactivity, social isolation, maladaptive personality traits (Steger, Kashdan, Sullivan, & Lorentz, 2008), and depression (Khumalo, Wissing, & Schutte, 2014). Others have expressed the search for meaning to be unrelated to QOL only among people who feel life to be highly meaningful (e.g. Cohen and Cairns, 2012; Park, 2010). Davis, Wortman, Lehman and Silver (2000) explained that even among those who find meaning, the search for meaning continues: that is, MIL is a process not an outcome or fixed point (Steger, Oishi, & Kesbier 2011).

Moreover, as with the application of PTSD cross-culturally, imposing Western understandings of the construct assumes an individual quality that may be too narrow when considering collectivist culture. Many studies, such as those cited above, have considered MIL as a solely individualised construct (Fegg, Kudla, Brandslatter, Deffner, & Kuchenhoff, 2016). Theories of recovery however need to incorporate healing pertinent to collective issues to consider the wider social context (Kirmayer, Gone, & Moses, 2014). MIL in some groups may be represented by a purpose that stems beyond individual action, requiring communal input. For example, yearnings found in African groups to contribute to prosocial causes that could have a meaningful impact on others were documented by Mariano and Vaillant (2012). Moreover, one's sense of coherence has been considered a useful way to measure individualised MIL, particularly in relation to the comprehension component

(Antonovsky, 1979; Martela, & Steger, 2016; Winger, Adams, & Mosher, 2016). Research by Braun-Lewensohn and Sagy (2011), however, found minority groups, Druze in northern Israel, with lower socio-economic status to subscribe to a communal rather than personal sense of coherence.

Quantitative studies into MIL from a cross-cultural perspective, while providing insight into levels of European and American conceptions of MIL, and its relationship with QOL, do not illuminate the full picture. This has led to recognition of potential confounds in results. In a study by Mohammad, Unher, and Sugawara (2010), for example, Egyptian students were found to score significantly higher on purpose in life than Japanese students. It is unclear however as to whether Egyptians have more purpose in life, or whether potentially different understandings of MIL lead to discrepant results. So too was this limitation present in a study of Japanese and American groups (Steger, Kawabata, Shimai, & Otake, 2008). The search for meaning was found to moderate the relation between presence of meaning and QOL in an American group only, although it was unclear whether this finding was due to differences in levels of MIL, or cultural differences in the understanding of MIL.

Emic research on the other hand adopts a relativist approach to the exploration of MIL. Utilising qualitative methods, this research has uncovered diverse cultural sources of MIL. In a study of South African students, for instance, MIL was found to exist in the form of relationships with family, hope, education, achievement and religion (Nell, 2014). In a sample of African Muslims students, Mohamad, AbdRazak, and Mutiu (2011) found having a close relationship with God and serving God's purpose to help one perceive life as meaningful. In interviews conducted with two Japanese survivors of natural disaster, the concept of *tanoshimi* (fun or hobby) was discussed as meaningful (Kono, & Shinew, 2015). In a study of Afrikaans and English speaking South Africans, meaning was found in

belonging to a family and spirituality (Coetzee, Wissing, & Temane, 2010). Across different cultural groups, therefore, the content of MIL is susceptible to variation.

Little work had directly compared and contrasted cultural groups on MIL conceptualisation (Park, 2016; Shlegel & Hicks, 2016). Whether the search for meaning and a sense of coherence are important for recovery following traumatic events in different cultural groups still requires consolidation (Zeidner & Aharoni-David, 2015). In order to utilise MIL as an appropriate pathway to recovery from trauma, its significance in culturally divergent groups therefore requires comparison in a way that synthesises universal and relative considerations.

2.7 Summary and limitations of existing literature

The social (Summerfield, 2012; Young, 1995) and cultural (Kohrt et al., 2014; Silove, 1999) environment can contribute to variation in conceptualisation of trauma and response. An American and European based culture now understands that viewing trauma through a universal psychiatric lens only is insufficient (Kienzler, 2008; Nicolas, Wheatley, & Guillaume, 2015; Silove, 2013; Summerfield, 2001). A sole focus on symptom reduction is not enough to counter the experience of trauma globally (Almedom & Summerfield, 2004; Benduce, 2016; Hinton & Lewis-Fernandez, 2011; Kirmayer, Gone, & Moses, 2014). Trauma discourse must recognise culturally variable conceptualisations of trauma so as to appropriately aid people in the process of healing (Alexander 2004; Silove, 2013; Lester, 2013). Assuming variation across culture to incorporate the same understanding of trauma and PTSD is incongruent with cultural difference.

Assessing trauma in a relative manner cross-culturally has uncovered both difference in models and manifestation (Kohrt, 2014; Rasmussen, Keatley, & Joscelyne 2014), leading to insight into the vast heterogeneity in cultural understandings and explanation of trauma

and recovery. At the same time, the relativist approach presents a danger of obscuring authentic psychiatric categories due to uncertainty as to appropriate categorisation of difference (Kohrt et al. 2014; Steel, Steel, & Silove, 2009). Moreover, the implications for broader and more generalised notions of trauma and recovery are often limited due to the uniqueness of the group and the specificity of findings (Draguns & Tanaka-Matsumi, 2003; Good & Hannah, 2015).

Rasmussen, Keatley, & Joscelyne (2014, p.54) posited that "global variety does not preclude commonality". In advocating for improved support for traumatised populations, synthesising relativist and universal approaches, difference and similarity respectively, is required for greater cultural competence (Denham, 2008; Hatala, Desjardins, Bombay, 2016; Kirmayer, Gone, & Moses, 2014, Ramirez & Hammack, 2014). Cultural competence in trauma is "the duty to investigate cultural alterity in detail" (Beneduce, 2016, p. 262), and to consider the complex relationship between cultural formulations of distress and individual trauma trajectories. Whilst cultural difference must create a foundation for enquiry, criticisms of the utility of PTSD classification cross-culturally have hindered universalist understanding. The quest for a "middle ground" (Van Rooyen & Ngweni, 2012, p. 51) is the quest to understand similarity from a base of cultural difference. Synchronicity of American and European conceptions of clinical trauma and PTSD with cultural variability will garner a more concrete awareness and appreciation of the human experience of trauma.

As the quest to scale up responses to poor mental health in global contexts continues (Chisholm, 2007; Eaton et al., 2011; Patel & Bloch, 2009), phenomenological approaches need to be considered (De Jong, 2004; Kienzler, 2008; Pedersen & Bauffati, 1989). In the pursuit of a common ground between the clinical and the social experiences of trauma, it is important for trauma from a cross-cultural perspective to be seen as an expression of past suffering, present symptoms, and appropriate response, all at once (Beneduce, 2016).

Comparing diverse cultural groups on conceptualisations of trauma aims to consider a wider framework which incorporates the medical and social, the individual and collective, the local and global, and allows for a synthesis of cultural difference as well as inclusivity of trauma experience (Beneduce, 2016; Brough et al. 2013; Kirmayer, Gone, & Moses, 2014). The goal, in turn, is to achieve a synchronisation of various understandings of trauma and appropriate approaches to recovery.

2.7 Research aims and hypotheses

The first overarching aim was to compare the conceptualisations of the trauma experience of people in two culturally divergent groups. Holocaust survivors and Sudanese refugees were compared using qualitative methods. To consider two vastly different groups was the investigatory pursuits of the first paper, chapter 4, to be presented, aiming to:

a. Compare and contrast similarities and differences in the way that two distinctive cultural groups explain and interpret the effects of, and appropriate response to, a traumatic experience.

The second aim was to contextualise PTSD by exploring the significance of symptoms in these two diverse cultural groups. This was investigated in the second mixed-methods paper (Chapter 5). The specific aims of this study were to:

a. Examine similarities and differences in PTSD case-ness and symptom endorsement within two divergent cultural groups
b. Examine the way that PTSD-case-ness and individual PTSD symptoms correlate with QOL in two divergent cultural groups

The following hypothesis was made relating to the studies aims:

i. PTSD case-ness will be significantly negatively correlated with QOL in both groups.

The third aim was to compare and contrast two culturally divergent groups in their conceptualisation of MIL and in so doing, consider the relevance and significance of American and European descriptions of MIL to survivors of traumatic events from different backgrounds. This was investigated in the third mixed-methods paper (Chapter 6). The specific aims of this study were to:

a. Compare and contrast similarities and differences in the way that two culturally divergent groups comprehend meaning, understanding, and purpose following a traumatic event.
b. Compare and contrast the relationship between QOL and a sense of coherence, the presence of meaning, and the search for meaning in two divergent cultural groups

The following hypotheses were made relating to the studies second aim:

i. A presence for meaning would be significantly positively correlated with QOL in both groups
ii. A search for meaning would be significantly negatively correlated with QOL in both groups
iii. A sense of coherence would be significantly positively correlated with QOL in both groups

In the following chapter, the methodology used to satisfy the aims and hypotheses of this thesis is outlined.

Chapter 3:

Methodology

The present chapter provides an overarching description of, and rationale for, the method used to satisfy the aims of this thesis. The chapter begins with the project design and a summary of the rationale for the current methodology based on aforementioned gaps in the literature. Following this, the procedures utilised are explained including participant recruitment, community consultation and engagement, the measures used, and the data collection process. A description of the data analysis in this chapter is divided into two components: one for qualitative analysis and the other for quantitative analysis. Discussion pertaining to data analysis adopts two roles. First, this chapter provides an extended explanation and rationale for the chosen paradigms of enquiry. Second, this chapter outlines the particular analytical procedures used so as to be transparent in technique. Finally, this chapter concludes with a discussion of ethical considerations, both encountered and anticipated.

3.1 Rationale for the methodological approach

A mixed methods approach was utilised for the current study. A synthesis of the universalist and relativist approaches to trauma and recovery has been called for (Good & Hannah, 2015; Van-Rooyen & Ngweni, 2012; Wendt & Gone; 2012). Using both qualitative and quantitative measures was deemed important so as to account for the limitations inherent in universalist and relativist frameworks (Johnson & Onwuengbuzie, 2004; Weine et al., 2013), and has been explained to suit research with diverse cultural samples (Weisner & Fiese, 2011).

Universal approaches have typically assessed for the prevailing category of PTSD (Kienzler, 2008) and have commonly utilised quantitative assessment to measure symptom endorsement of PTSD **(**De Jong et al., 2001; Meffert et al. 2010; Oruca et al. 2008**)**. Including a quantitative PTSD measure, specifically the Harvard Trauma Questionnaire-Revised, allowed for the consideration of the prevailing American and European psychopathological paradigm of trauma response. This approach helped in considering a criticism of relativist research for its potential to overlook authentic psychopathology (Steel, Steel, & Silove, 2009).

Yet as argued in the preceding chapter, the universal approach to PTSD symptom endorsement alone has been reportedly insufficient in explaining the meaning of symptoms and trauma from a cross-cultural perspective (Kleinman, 1987; Steel, Steel, & Silove, 2009; Summerfield, 2001). In order to overcome this limitation, two approaches were undertaken. First quantitative assessment was undertaken using the World Health Quality of Life Scale, brief version (WHOQOL-BREF). This helped explore relationships found between PTSD, its symptoms, and QOL in diverse cultural groups. Qualitative data exploring culturally constructed trauma response, beyond PTSD, supplied conceptualisations of trauma providing a framework for contextualising PTSD symptoms in diverse groups. Both the WHOQOL-BREF and qualitative data further helped explore cultural group conceptualisation of meaning in life, as opposed to relying on meaning in life endorsement.

Relativist research has typically been limited by the lack of generalizability of its findings (Draguns & Tanaka-Matsumi, 2003). Relativist research has commonly considered the uniqueness and difference of context, and so there has been a difficulty inherent in comparing findings from emic studies (Good & Hannah, 2015). Interviewing diverse groups, using the same interviewer, and the same questions, was undertaken in this study to allow for comparison of differences and similarities between groups. This helped not only in

considering differences and similarities in the way that diverse cultural groups conceptualised trauma, but also MIL.

3.2 Project Design

Both qualitative interviews and quantitative questionnaires were used. Qualitative interviews were conducted with 25 participants, 13 Holocaust survivors and 12 Sudanese refugees. After engaging in a face-to-face interview with the researcher, these participants completed four quantitative questionnaires under supervision. Another 15 participants, seven Holocaust survivors and eight Sudanese refugees, completed the four quantitative questionnaires under the supervision of the same researcher.

Whilst a concurrent nested approach to mixed-methods research (Creswell & Plano Clark, 2011) was adopted, the research prioritised the qualitative method. Both qualitative and quantitative data were collected concurrently, though the quantitative research was used in an explanatory manner to clarify theories developed through phenomenological inquiry (Mayoh & Onwuegbuzie, 2015). For each individual participant, the phenomenological interview was conducted before the completion of any questionnaires so as to practically avoid a potential confound. Presenting quantitative questionnaires first may have biased participants to respond to qualitative questions automatically in ways consistent with the type of quantitative content presented. Moreover, it followed that the quantitative data was untouched until the analysis of the phenomenological interviews was complete so as not to bias the researcher in any way.

3.3 Participants

A total of 20 Sudanese refugees and 20 Holocaust Survivors residing in Melbourne, Australia participated in the current study. Participants were only included if they had been

residing in Australia for a minimum of six months. This was to exclude any impediment on results stemming from the immediate strain of adapting to a new country. A further exclusion criterion was an inability to speak English. Capacity to speak in English was determined based on the participant's ability not only to read the consent form, but to explain back to researcher the nature of the study.

Sudanese Refugees

Sudanese refugee participants consisted of individuals aged between 18-48, residing in Melbourne. Sudanese refugees have escaped from a 20-year-long conflict raging in their home country between the Government of Sudan in the North and the rebel Sudan People's Liberation Army/Movement in the South (Morrison & de Waal, 2005). Between the years of 1983-2005, in what is known as the second civil war, approximately 1.9 million deaths and 5 million displaced people were recorded (Roberts, Damundu, Lomoro, & Sondorp, 2010). Extreme challenges however remain in the region as political instability continues (Simich, Este, & Hamilton 2010). In 2007, the Department of Immigration and Citizenship reported that more than 26,000 Sudanese refugees had immigrated to Australia via the humanitarian programme visa scheme (Department of immigration and citizenship, 2007). In 2005-06, of the 13,000 refugees gaining permanent residency, 33 per cent of successful applicants were Sudanese (Marlowe, 2010). The United Nations (UN) Convention Relating to the Status of Refugees (United Nations High Commissioner for Refugees, 1951) defined a refugee as anyone who,

> owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or, owing to such fear, is unwilling to avail himself of the protection of that country. (Article 1A(2))

‘Stand-up’ Australia, a not-for-profit organisation, helped recruit Sudanese refugee participants from their refugee support program. ‘Stand-up’ has cultivated a 10-year partnership with a number of Sudanese communities around the Victorian region. Participants in the current study were all beneficiaries of at least one of the capacity building programs offered by ‘Stand-Up’ including:

- Encounters – a one-to-one mentoring program for Sudanese refugees
- Women’s group –skills development, confidence building, socialisation and English language support for Sudanese refugee women

Table 1 presents the Sudanese refugee demographic statistics for both the qualitative sample and the entire sample.

Table 1

Demographic characteristics of Sudanese Refugees by mode of assessment

Characteristics	Whole Sample (quantitative) (n=20) *n(%) / M(SD)*	Semi-structured interviews (n=12) *n(%) / M(SD)*
Demographics		
Male gender	9 (45%)	7 (58.33%)
DOB	26.11.1982	13.08.1982
Participant age	32.25 (9.07)	32.56 (10.22)
Years resettled in Australia	10.25 (4.35)	9.91 (4.44)
Tribal affiliation		
Dinka	6 (30%)	3 (25%)
Nuer	4 (20%)	2 (16.66%)
Nubian	7 (35%)	4 (33.33%)
Fur	2 (10%)	2 (16.66%)
Zaghawa	1 (5%)	1 (8.33%)

Holocaust Survivors

Holocaust survivor participants consisted of individuals aged between 82-93 years, residing in suburban Melbourne. The Holocaust was "the systematic, bureaucratic, state-sponsored persecution and murder of six million Jews by the Nazi regime and its collaborators" (United States Holocaust Memorial Museum https://www.ushmm.org/wlc/en/article.php?ModuleId=10005143). In 1933, the Jewish population of Europe was estimated to be over nine million. By 1945, nearly two out of every three European Jews had been exterminated as part of the 'Final Solution', the Nazi policy to eliminate the Jews of Europe (Browning, 1992). Between the years of 1938 and 1961, the

Jewish population in Australia doubled with an influx of 35,000 European Holocaust survivors. Today, the community has one of the highest contingencies of Holocaust survivors outside of Israel (Markus, Jacobs, & Aronov, 2009). Holocaust survivor participants were recruited for the study by the Jewish Holocaust Museum and Research Centre (JHC) in Melbourne. Table 2 presents the Holocaust survivor demographic statistics for both the qualitative sample and the entire sample.

Table 2

Demographic characteristics of Holocaust survivors by mode of assessment

Characteristics	Whole Sample (quantitative) (n=20) *n(%) / M(SD)*	Semi-structured interviews (n=13) *n(%) / M(SD)*
Demographics		
Male gender	11 (55%)	7 (53.84%)
DOB	24.03.1927	30.07.1927
Participant age	87.51 (3.37)	87.23 (3.44)
Years resettled in Australia	62.54 (5.8)	62.76 (6.12)
Country of origin		
Poland	10 (50%)	7 (53.84%)
Germany	4 (20%)	2 (15.38%)
Austria	2 (10%)	2 (15.38%)
France	2 (10%)	1 (7.69%)
Netherlands	2 (10%)	1 (7.69%)

3.3.1 Time since trauma

A clear difference between the two groups is the time elapsed since their primary traumatic event. The Holocaust concluded 69 years prior to the commencement of the current data collection, whereas the Second Sudanese Civil War concluded 9 years prior, with political instability and conflict remaining. Inconsistent effects of time since trauma, on trauma response, have been documented (Linley & Stephen, 2004; Prati & Pietrantoni, 2009; Stanton et al. 2006), and so time since trauma may also possibly contribute to any differences found when comparing these two cultural groups.

Yet compartmentalising and dividing culture and time since traumatic events is not simple. Culture can be shaped by a variety of mechanisms including symbols, rituals, values, heroes and myths (Jandt, 2013). Time elapsed since a mass traumatic experience therefore may in turn contribute to shaping these mechanisms, particularly that of values dictating what is normal and what is abnormal in the traumatised group (Hofstede, 1994). In this way, time since trauma may interact with culture to produce differences in the interpretation or conceptualisation of the trauma experience.

In choosing two groups to be utilised for the current study, cultural difference was pursued. Vast difference was preferred in order to allow for a comparison between distinctively different groups. In this respect, age is also a large difference between the two groups, also previously demonstrated to influence one's responses to traumatic events (Cook, 2001; Kaiser, Wachen, Potter, Moye, & Davison, 2016). Therefore, whilst both time elapsed and age may confound the results attributable to culture's impact on the experience of trauma explored, both also contribute to the contextual differences between groups and so allow for an exploration of the need to consider the social context when assessing vastly different group experiences of trauma. Moreover, vast difference between the two samples was pursued so as to add depth to the profoundness of any similarities documented. Time since

trauma and age may contribute to difference in context. This further enhances the applicability of any similarities found between groups to universal understandings of trauma.

3.4 Procedure

Ethics approval was obtained from the Monash University Human Research Ethics Committee (MUHREC), on the 15th of July 2014 (see Appendix A).

3.4.1 Community Consultation and Engagement

Prior to the study, engagement with both communities was vital in helping the primary researcher integrate effectively. The primary researcher was involved as a volunteer at both Stand-up Australia and the JHC prior to the commencement of the study. The primary researcher spent two years at Stand-up Australia engaging with the Sudanese community, volunteering in the homework club program, a support program for young children of refugee families, and on school holiday programs. At the JHC, the primary researcher was involved with the 'March of the Living' program as a youth leader. The 'March of the Living' is a two-week program for 16-year-old Jewish-Australian students, who visited the sites of the Holocaust and participated in an organised march through Auschwitz with Jews from all over the world. Engagement helped in building trust between the primary researcher and these two organisations, provided opportunities to learn about the customs and traditions of particularly the Sudanese community, and allowed for a sensitive and respectful approach when dealing with community members.

Before the commencement of the current study, separate meetings were held with the Refugee Programs Director for 'Stand-up' and the Director of Community Relations at the JHC. During meetings, an overview of the project was provided along with potential benefits and risks of the research, as outlined in the ethics application. Following expressed interest in the project, a planning meeting was arranged, with each organisation liaison officer

separately, regarding the consent process, convenient dates, locations of interviews, and the approach to participant recruitment. In these meetings it was decided that the liaison officer from each organisation would contact participants initially, before providing the primary researcher with contact details. This would allow for greater sensitivity when approaching potential participants, given the already established relationship between the liaison officer and those being recruited.

Before any processes were finalised with Stand-up Australia, two more meetings were held in order to further seek permission to approach the Sudanese community. The first meeting was held in the home of an independent Sudanese community member nominated by Stand-up Australia. The second meeting was conducted with the Secretary General of the Nuba Mountains International Organization. In both of these meetings, the aims of the research, the potential benefits and risks to the participants, and the interviews/questionnaires were discussed openly so as to allow for feedback from the community members. No amendments to the measures were made. Appointed Sudanese members encouraged the primary researcher to ascertain permission from female participants, before assessment, to sit one-on-one with the primary research in an interview. Permission was granted by all female Sudanese participants. Consent from both community members was obtained (see Appendix B).

3.4.2 Consent procedures

Participants were first approached by the organisation liaison officers and were provided a synopsis of the research. This synopsis was discussed with the liaison officer during an initial meeting and a hard copy was sent through to the organisation prior to participant recruitment (see Appendix C). Participants willing to engage with the researcher were provided with the primary researcher's contact details. Once the participant contacted the primary researcher, a meeting time was established to go over the consent process and

participate in the interview and questionnaire process. For Holocaust Survivors, meetings were held at the JHC. Sudanese refugees were met at either their homes, or in a private room booked at their local library. The first meeting with participants began with outlining the goals of the research project. An emphasis was placed on the participant's role as the expert within the research and on the right of the participant to withdraw from the study at any time. The consent form and explanatory statement were verbally explained before the participant read through them. Once the participant had finished reading the documentation, they were asked to re-iterate the aims and procedures of the research, as well as the potential risks and benefits of the research. This was accomplished by all participants. Participants were offered a chance to ask any questions about the research. Following this, they were invited to sign the consent form (for consent form see Appendix D).

3.4.3 Data Collection Procedures

Data collection was conducted from the 1 August 2014 and was completed on 7 July 2015. The raw data for the current study were the completed quantitative questionnaires, and participant descriptions in response to semi-structured interviews, their words and first person accounts. Qualitative data were captured using both audio recording on a dictaphone, and video recording with a camera, during face-to-face interviews with each participant. Fifteen participants allowed for video recording, whilst ten participants opted for audio recording only. Video recording was considered so as to provide additional visual aids in the transcribing phase of data analysis, in the case of potentially confusing annunciation or pronunciation difficult to comprehend via audio recording. The participants were ensured of confidentiality again at this point. The majority of Sudanese participants did not wish to partake in any video recording, and reported being uncomfortable discussing the Sudanese political climate through this media. Some Sudanese participants were particularly concerned about family members remaining in Sudan. They were afraid of endangering family

members' lives were the Sudan government to access interview footage. The majority of Holocaust survivors allowed for video recording. Those who did not expressed discomfort with being filmed. Once a video or audio record was completed, it was uploaded onto a secure Network Drive provided by Monash University. Only the research supervisors and the primary researcher were granted access to this material. Once uploaded, the original footage and audio files were deleted. The uploaded files were then used for transcription into text for further analysis. The transcribed text was used as the raw data for analysis.

All interviews lasted between 40-60 minutes. During the interview, the primary researcher at times identified markers in participant responses needing further clarification for understanding, or where it was important not to assume the participant's intended meaning. Once the participant had spontaneously reached a silence, a follow-up question was asked, such as "You mentioned x, can you explain that to me?" This question was not purposefully leading in the sense of trying to extract particular information. Rather, it was a technique used intended to illuminate an aspect that was presented, though not fully explained by the participant (Giorgi & Giorgi, 2003).

A common dissent to qualitative data collection is that when re-telling events, retrospective viewpoint is tainted by the passage of time and the pursuit of a present end (Neisser & Dopling, 1987**)**. This seems to apply especially in the case of Holocaust Survivors, where experiences occurred many years prior. Remembered memories of events have been potentially influenced by regular retellings and by other personal and public accounts of the event (e.g. cinema, books, and testimonies). Moreover, the retelling of an event may differ each time depending on the ideas that respondents are attempting to emphasise, based on the context of the retelling.

Whilst indeed this may be the case, an adequate response to this dissent can be found in Hycner (1985), who affirms that any description of an experience is different from the

lived experience itself. Narrative is always one step removed from the actual experience. Language as a medium dictates a process of reflection on experience that is necessarily removed from the experience. Accordingly, all that can be hoped to achieve in any interview context, including in all clinical interviewing settings, is an account of the individual's experience including retrospective viewpoint.

Therefore, confounding variables limiting the accuracy of memory do not undermine the aims of the current study. Autobiographical memory has been described as narrative used to help create a coherent sense of self (Fivush, 2010). An advantage of this can often be in a fuller description provided. Reflection allows for the participant to integrate the experience consciously and verbally. This perhaps entails what one might consider a fabrication of memory due to the passage of time or the processing of experience. However, synthesising experience with reflection does not undermine the current research. The aim is to explore the way that two different cultural groups understand and conceptualise trauma and MIL. Whether the participant's memory is distorted by time since the trauma, or a motive in the interview, matters little. The current 'world', as described by the participant, is still just as valid. The way that an individual expresses his or her own understanding and interpretation of experience is still as telling. In considering the Sudanese, for example, a shaped story that is consistent with what is required from the United Nations, aid agencies, and government organisations may have been told. This does not however undermine the legitimacy of the narrative the Sudanese participants depict. The narrative remains the way in which the individual makes sense of their own experience, and the medium through which communication of experience occurs (McAdams, 2001).

Following the interview, participants were presented with four quantitative questionnaires. All participants completed questionnaires under supervision of the primary researcher so that clarification around questions could be obtained if need be. Common

questions consisted of, “What if it is different for me on different days?” or “What if I can’t choose between two”. To concerns such as these, response was consistent; “Pick the number that best applies to you”. Being in the room with the participants whilst they completed the questionnaires allowed for the primary researcher to glean insight into participant concerns. Moreover, it provided the primary researcher with insight into the contextual factors that may have informed responses. For example, when responding to questions of ‘body pain’ and ‘physical troubles’ on the HTQ-R, Holocaust survivors often referred to their age as a factor leading to physical difficulty saying things like “For my age…”. Questionnaires, once completed, were entered into IBM Statistical Package for the Social Sciences (SPSS), version 22.0. Hard copies of the questionnaires were contained in a locker at Monash University, which was available only to the primary researcher and supervisors.

3.5 Measures

Semi-Structured Interview

A semi-structured interview was created in consultation with primary supervisor Professor Louise Newman and supervisor Professor Lenore Manderson. Both have extensive research and practical experience in working with cultural diversity and mental health. Through phenomenological driven questions, participants are granted the opportunity to express themselves freely, reflect on their ideas, and develop thoughts (Smith, Flowers, & Larkin, 2009). To begin the interview, the participant is invited to “tell me about your experiences before you came to Australia”. This question is open ended and intended to offer the participant freedom of scope in their potential response. Following this, the participant is asked to explore the effects of the experiences stated. Finally, the participant is asked to consider recovery and components of MIL. The consistent questions included in the semi-structured interview can be found in Appendix E. Depending on responses provided by

respondents, follow up subsidiary questions are nested under questions 2-6. When seeking clarification of terms or further information from respondents, the researcher uses discretion given the "great room for imaginative work in collecting data" in phenomenological analysis (Smith, Flowers, & Larkin, 2009, p. 56).

Harvard Trauma Questionnaire-Revised (HTQ-R)

The HTQ-R, created by the Harvard Program in Refugee Trauma (Harvard Program in Refugee Trauma; HPRT, 2011), is a PTSD and trauma screening tool. It begins with a traumatic events checklist of 40 items, each question requiring a yes/no response. The checklist asks participants to rate their experience of particular symptoms over the past week using a 4-point frequency scale (1 = not at all, 4 = extremely). Section 2 of the HTQ-R asks respondent to provide extended responses explaining details of the traumatic events experienced. Given the use of semi-structured interviews already examining qualitative responses, this section was excluded from the study. Section 3 requires respondents to indicate if they experienced any head injury during the traumatic event, whether they lost consciousness, and if so for how long. Section 4 is a trauma symptoms checklist asking participants to report the severity of a trauma symptoms experienced over the past week on a 4-point likert scale (1 = not at all, 4 = extremely). The first 16 items on this checklist outline each of the DSM-IV PTSD symptoms used for the PTSD scale. The 24 additional items complete the total trauma scale, comprised also of trauma symptoms found to be of particular concern to refugees according to the HPRT. The HTQ-R has been adapted from the original HTQ in that it includes an additional 24 traumatic events in the 'traumatic events checklist' and 10 more items on the 'total trauma scale' (HPRT, 2011). The HTQ has been documented as the most widely used international instrument measuring trauma exposure and PTSD symptoms across refugee populations (Steel, Steel, & Silove, 2009)**.** The HTQ has been used with Sudanese (Meffert et al., 2010) and refugees from alternative backgrounds (HPRT). It

has been found to be statistically reliable (a=.87, Rasmussen, 2007) in multiple studies across multiple traumatised populations (Hollifield et al., 2002). It has shown high inter-rater (r= 0.98), test-retest (r = 0.92), and internal reliability (r = 0.96) (Mollica et al., 1996). In a study amongst highly traumatised Vietnamese prisoners, a cut-off of 1.17 yielded a high level of sensitivity (0.98) and specificity (1.0) (Fawzi, et al. 1997).

Orientation to Life Questionnaire (OLQ)

The OLQ (Antonovsky, 1987) was developed as an assessment for a sense of coherence. This screen reflects the three-factor structure of a sense of coherence measuring comprehensibility (e.g. "do you have the feeling that you are in an unfamiliar situation and don't know what to do?"), manageability (e.g. "how often do you have feelings that you're not sure you can keep under control?"), and meaning (e.g. "how often do you have the feeling that there's little meaning in the things you do in your daily life?"). Items are rated on a 7-point rating scale, with higher scores mostly indicating a greater sense of coherence, and reverse-scoring on some items. The 13-item short form adaptation of the 29-item OLQ was utilised in the current study, having been widely utilised previously (Ding et al. 2011, Feldt et al. 2007; Moksnes & Haugan, 2013; Richardson et al. 2007). The 13-item version has demonstrated more accurate goodness of fit with the three-factor structure of a sense of coherence than the original 29-item version (Schalkwyk & Rothman, 2008). The OLQ has also been endorsed as a valid measure in various cultures, especially in adult samples (Lindstrom & Eriksson, 2010). In a sample of 203 Holocaust survivors the OLQ was found to have a reliability of $a = 0.79$ (Van der hal-van Raalte, Van Ijzendoorn, & Bakermans-Kranenburg, 2008) and has shown internal consistency with a Cronbach's alpha ranging from .70 to .92 (Eriksson & Lindstrom, 2005; Hittner, 2007).

Meaning in Life Questionnaire (MLQ)

The MLQ is a 10-item instrument measuring meaning in life (Steger, Frazier, Oishi, & Kaler, 2006). It measures respondent conception of meaning in their lives by dividing meaning into both a presence of meaning (e.g. "I understand my life's meaning"), and a search for meaning (e.g. "I am looking for something that makes my life feel meaningful"). Respondents answer each item on a 7-point likert scale (1 = absolutely true, 7 = absolutely untrue). Research has consistently supported the two-subscale structure using various methods of enquiry including factor analysis, reliability of scales and relationships with both conceptually related variables and other measures such as the Purpose in Life Test and the Life Regard Index (Steger, Kawabata, Shimai, & Otake, 2008). Each of these two scales have yielded internal consistency co-efficients above .80 (Steger & Shin, 2010). The MLQ has also been endorsed and validated in a myriad of diverse cultural samples (Boyraz, Lightsey, & Can, 2013; Temane, Khumalo, & Wissing, 2014).

World Health Organization Quality of Life scale, brief version (WHOQOL-BREF)

The WHOQOL-BREF scale was developed by the WHOQOL group (1998). Permission was obtained from the World Health Organization prior to use (see Appendix J). It was derived from research with 15 international field centers drafted according to statements made by patients, people with good health, and health professionals cross-culturally (Orley & Kuyken, 1994; World Health Organization, 1996). The WHOQOL-BREF produces scores for four domains related to QOL: physical health (e.g. "to what extent do you feel that physical pain prevents you from doing what you need to do?"), psychological (e.g. "how much do you enjoy life?"), social relationships (e.g. "How satisfied are you with your personal relationships?"), and environment (e.g. "How safe do you feel in your daily life?"). Domain scores produced by the WHOQOL-BREF have been shown to correlate highly (0.89 or above) with WHOQOL-100 domain scores and demonstrated good discriminant validity, content validity, internal consistency and test-retest reliability (WHOQOL group, 1998). The

WHOQOL-BREF has been extensively used for sociodemographic research in both various cultures and the aged (Phungrassami, Katikarn, Watanaarepornchai, & Sangtawan, 2004; Sreedevi, Cherkil, Kuttikattu, Kamalamma, & Oldenburg, 2016). Using cross-sectional data from 23 countries Skevington, Lotfy, & O'Connel (2004) found the WHOQOL-BREF to have good to excellent psychometric properties of reliability and validity. In a study on women with breast problems (Van Esch, Den Oudsten, & De Vries, 2011), the WHOQOL-BREF was shown to have good reliability with Cronbach's alphas of each domain exceeding .70.

3.6 Data Analysis

3.6.1 Choosing the phenomenological approach

Exploring the lived experience of trauma and MIL was central to achieving the aims for the current study. Such exploration required a method of scientific enquiry, phenomenological analysis, capable of discovering the meaning of individual and community life that necessarily went beyond quantitative endorsement of symptoms. Science for many people, or even for many graduate students of psychology, has frequently reflected an attitude of unquestioned empiricism (Applebaum, 2012). Positivist premises of empiricism have been so firmly established in the cultural mainstream that they are typically equated with what Kuhn (1996) coined 'normal science'. Applebaum explains that the 'natural science', understood generally to underscore empirical work an experimentation, can be substituted by the alternate 'human science' (Husserl & Carr, 1970) dedicated to uncovering the human experience. The 'human science' focuses on understanding human experience rather than examining objects in space, objectively. Empiricism therefore was bracketed as merely one form of science, deemed relevant to only part of the current study. Scientific enquiry was

therefore conceptualised as a multiplicity of disciplinary enquiries in the current study (Applebaum, 2012).

A critique of the empiricists' science was proposed by Husserl and is explained by McCarthy (1990), who writes that "practicing scientists uncritically assume through their theories they know reality as it is in itself" (p. 69). Husserl (1977), and McCarthy argued that the objective world investigated by "normal science" is nothing more than a constructed world "abstracted from the fullness of lived experience" (Makkreel, 1999, p.564). Objects and attitudes are researched due to the collective subjective narrative leading to the point of them being researched. As Foucault argued, "there is no such thing as objective science, every science is in fact an 'ideology'" (Megill, 1985, p.249). Scientific attitudes are then in fact constituted attitudes, the objects of enquiry being constituted objects (Applebaum, 2012). Qualitative researchers have further argued that empirical science is not based on the experience of life but on the artificial production of effects, which would not come about simply on their own (Gadamer, Gaiger, & Walker, 1996). As a result, natural science is perceived as insufficient on its own in uncovering lived meaning.

For Husserl (1977), the notion of phenomenology incorporates a perspective of the mind that acknowledges consciousness as the most fundamental life quality. He reported consciousness to synthesise experience through its intentional acts towards objects, both sensorial and mental. This is known as intentionality (Husserl, 1982). Acknowledging intentionality positions the researcher to discover the convergence of the objective 'real' with the imagined, remembered, consciously perceived 'irreal'. For Husserl, it is at this convergence point where the experience of the individual is created. A phenomenological framework is based on acknowledging participant intentionality, helping illuminate the lived experience of the individual as they intentionally engage with reality (Husserl, 1977).

Participant perceptions, the meaning of the 'real', are therefore afforded credibility as data for the way that perception is, in effect, reality.

Yet, just as empirical work faces criticism for a perceived inability to comment deeply on "who and what we are" (Dodd, 2004), so too phenomenological qualitative work is confronted with a criticism of its ability to discover meaning. Skepticism of the subjective lies in the proposition that phenomenological work is an interpretation by the researcher (Applebaum, 2012). In response, some qualitative researchers may seek refuge in a romantic aesthetic approach rather than a scientific one (Applebaum, 2012; Eagleton, 1990). Whilst this preserves to some degree the intrinsic nature of subjectivity from the auspices of empirical science, it has been argued that it also reduces the impact of research to its emotional or intellectual ability to move the reader (Luce-Kapler, 2008). In doing so, the focus of research shifts from the participant response, to a focus on the researcher who is positioned "center stage" (Atkinson, Delamonst, Denzin, & Lincoln, 2005, p 824). Research is transformed into an attempt to produce experiences that are emotive for the reading audience, rather than experiences that are knowledge-yielding. This is not to suggest that aesthetic (i.e. poetic, literary) dimensions of psychological research have no place, rather, that an over-reliance on romanticising the psychological can undermine the findings.

In order to overcome a dialectic between art and science, psychological research is reliant on synthesising the two. Creating parameters around the phenomenological method is important so as to avoid it being labelled opinion-driven. Applebaum (2012) argues that qualitative work should therefore follow criteria. Giorgi (1997) posits that in order to be considered a science, any mode of inquiry must be systematic, methodical, general, and critical. To be systematic, the research needs to be capable of producing inter-related findings that contribute to a picture of a whole. To be methodical, the research needs to be repeatable, which in the context of human science refers to the straightforward, explicit, sequential

acknowledgement of steps in the process (Giorgi 2006). General knowledge emanating from the work suggests that the information found is more expansive than the life of any particular participant. The validity of qualitative research is measured by meaning rather than statistics. Finally, the research is critical if practitioners can invite and respond to critiquing members of the scientific community by publishing procedures and findings.

3.6.2 Descriptive Phenomenological Analysis (DPA) versus Interpretative Phenomenological Analysis (IPA)

Two forms of phenomenological analysis are prominent in the recent qualitative literature, with contemporary proponents of these two different forms entered into debate. Giorgi (2010; 2011) and Smith (2010) argued around the utility of DPA versus IPA, respectively. DPA coincides with Husserl and Carr's (1970) phenomenology. It requires a suspension of presuppositions of participants in order to completely understand the participant's intentionality as they engage with an experience. In DPA there is a restriction from making assertions based on intuitions (Giorgi, 1986) so that interpretation does not stray far from the data. Whilst idiographic analysis can form a part of this process, the eventual aim is to explain descriptive analysis in a generalised manner. IPA (Smith, Flowers, & Larkin, 2009), in contrast, is based on the work of hermeneutic philosophers such as Heidegger (1962) and Gadamer (1990), who argue for the individual's intrinsic embeddedness in the world of language and social relationships. They argue that no one can completely negate or bracket interpretations based on presuppositions relating to experience. For IPA, the essential meaning of description is interpretation as a consequence of the individual's inevitable and unavoidable basic structure of "being-in-the-world" (Heidegger, 1962, p. 37). In this sense, idiographic meanings are integral, while they may or may not offer general insights.

Smith's IPA has been scrutinised by Giorgi (2011) for its ill-fit with the criteria for science. In particular Giorgi (2011) criticised Smith for not outlining clearly enough a delineated step-by-step method for his implementation of IPA. Smith (2010) proposed IPA to be an "accessible" (p. 187) method acknowledging that his own method is not prescriptive, merely suggestive. Giorgi (2011) took issue with a simplification of methodology suggesting that such simplification can undermine rigorous methodology, allowing the reader to conceive phenomenological analysis as non-scientific. Smith is not alone in proposing that phenomenological methodology cannot be prescriptive in nature. Hycner (1985) wrote that there can be no "cookbook recipe" (p. 280) for phenomenological analysis. Similarly, Langdridge (2008, p.1131) commented, "boundaries would be antithetical to the spirit of the phenomenological tradition that prizes individuality and creativity". Giorgi (2011) however explained that if a method does not have fixed steps in a fixed order, then it is not truly a method for scientific enquiry.

Giorgi's critique of IPA included criticism of the way Smith (2009) engaged with the term "bracketing". Smith used the term to refer to a bracketing of the understood objective world, as well as a bracketing of researcher concepts or ideas stemming from anything but the source being studied. Giorgi (2011) advocated only for the former understanding of bracketing, suggesting that only the former aligns with true phenomenology. Giorgi takes issue with this approach by stating that it is not "the main meaning of phenomenological reduction" (2011, p. 199). Yet earlier, Finlay (2008) argued that the challenge of phenomenological research is to simultaneously embody contradictory attitudes of being scientifically removed from, yet also interacting with, participants in the midst of their own experiencing. This interaction must take place in the context of bracketing the participant's natural world and the researcher's own presuppositions surrounding the research question (Finlay, 2008; Hycner 1985).

A range of other arguments have been posited by both Giorgi (2011) and Smith (2010) that appear to be aimed at discrediting the other, rather than actively working towards a better understanding of phenomenological epistemology and analysis. Smith (2010) attacks Giorgi (2010) for an ill-fit of a column label, a gender misidentification of a participant, and for not reading enough of the literature. Giorgi (2011) attacks Smith (2010) for not being prescriptive enough, and then attacks him for being prescriptive at all. He further uses hyperbolic language to undermine Smith (2010), suggesting that Smith has an "anything goes!" (Giorgi, 2011, p.212) stance. Moreover, Giorgi (2011) attacked Smith (2010) for not including a number of terms in his method such as 'the assumptions of the attitude of the phenomenological reduction', and 'free imaginative variation'. However, in the defense of Smith, he wrote that IPA is based on "core emphases of the [phenomenological] approach" (2009, p.34). Smith (2010) did also explain the need to bracket prior assumptions and the researcher's natural attitude as well as the need to seek the necessary essence or structure of a given phenomenon. Indeed, these terms highlighted by Giorgi were not mentioned specifically by Smith; however, Giorgi as a long-standing phenomenological analyst likely desires more specific outlining.

3.6.3 A synthesis of IPA and DPA for the overall thesis

Smith (2010) and Giorgi (2011) seem to be so encompassed by interpretation or description, respectively, that they cannot meet each other in the middle. Giorgi is requesting Smith to describe everything, and Smith is asking for Giorgi to exercise some interpretation. Whilst IPA and DPA place very different emphases on description, others have argued that the two are not as far apart as the aforementioned debate indicates (Finlay, 2008). Therefore, for the overall methodology of the current thesis, a synthesis was sought between the two phenomenological approaches. Some see description and interpretation as existing on a continuum, suggesting that when description is mediated by expression, a stronger element of

interpretation is involved (Finlay 2008). Gadamer (1990) has pointed out that interpretation can either be pointing to something, aligned with DPA, or pointing out the meaning of something, aligned with IPA. Both ae forms of interpretation. In this way, depending on conceptualisation, description and interpretation can overlap in their practical application when using phenomenological analysis.

DPA and IPA have also been reported, as mentioned above, to differ in terms of generalizability of the raw data, with IPA emphasising idiographic analysis. Halling (2008), however, has argued that the particular can identify general structures of experience. He advocated for researchers to constantly move between experience and abstraction. Researchers can understand the individual in an interview in relation to the experience being expressed, but also attempt to understand what the expression means in a broader sense. In essence, this is not dissimilar from any individual's everyday movement between experience and reflection. The experience is understood not only as its own experience but also in the context of previous experiences. Therefore, despite the debate between the proponents of these approaches, phenomenological analysis can be synthesized in these two views on generalising the experience of the individual.

Competing visions of phenomenological analysis have stemmed from different philosophical values and theoretical preferences. When put into practice, however, whether human beings theoretically can objectively describe the world, or necessarily exist as part of it, makes little difference to the researcher's implementation of the phenomenological reduction, the description of essential meaning, and the interpretation of relevant meaning. In phenomenological analysis of any kind, all three are key processes in methodology. In a phenomenological reduction, whether one claims that he or she is bracketing the 'natural attitude' from a blank slate, in line with DPA, or as part of a reflective process (Finlay, 2008), in line with IPA, makes little difference to the final product of the initial bracketing. In fact,

these processes need not be mutually exclusive and can co-exist practically. When describing essential meaning, output is the same whether one claims to be doing so without contaminants, in line with DPA (Broome, 2011), or is necessarily unable to remove oneself from them, in line with IPA. Finally, whether understandings of interpretation render it an additional procedure (Giorgi, 2011) or an inevitable basic structure of description (Heidegger 1962), the interpretation output can still be the same. The researcher himself or herself cannot practically determine from which standpoint they come (although they perhaps can from a theoretical perspective), given that any determination would simply be a subjective one.

Therefore, although Smith and Giorgi work from opposing dialectics, a synthesis of the two, in the practical realm, seems to make the most sense. This is done by understanding that all phenomenology is descriptive in the sense that it aims to describe rather than explain (Finlay 2008). Simultaneously, however, one cannot possibly separate experience from interpretation given that any experience of a 'thing' is something that has already been interpreted (Smith, Jarman, & Osborn, 1999). Moreover, both Giorgi (2009) and Smith (2010) explain that a particular step in methodology can be flexible in its implementation, "the point is that there is flexibility in how each of the steps is taken" (Smith, 2010, p.189). Therefore, the constituents of an appropriate phenomenological method are seemingly agreed upon to be prescriptive steps, which are afforded flexibility in their interpretation by researchers. The following methodology, using also Hycner's (1985) basic structure of phenomenological analysis, incorporated important elements of both Giorgi's DPA and Smith's IPA.

3.7.4 Qualitative Analysis

Qualitative methodology was used for both studies 1 and 3 of this thesis. A synthesis of DPA and IPA was utilised for the current methodology, though depending on the phenomenological framework informing each study, the methodology differed slightly.

Predominantly Giorgi's (2009) DPA, also outlined by Broome (2011), framed the qualitative methodology, and the language utilised for the methodology, throughout this thesis.

In synthesising methodologies, only slight variation in each study's methodology was undertaken, specifically at step 3 of the process. It was here that Study 1 adhered strictly to Giorgi's (2009) method of DPA. The aim of Study 1 was to explore the way that diverse cultural groups conceptualise trauma and trauma response. Specifically, questions pertained to the way that diverse groups differ and stay the same in their models for understanding and conceptualising trauma. DPA was chosen for this study due to its emphasis on describing "the structure of psychological phenomenon" (Broome, 2011, p.8). A focus in this step therefore was to refrain from interpreting thereby going beyond description in the data analysis. Study 3 adopted Smith, Flowers and Larkin's (2009) IPA as a component of its mixed-methods approach. The first aim of study 3 was to consider the way that diverse cultural groups, having experienced a traumatic event, conceptualised MIL. Specifically, questions related to the way that diverse groups differ in their understanding of meaning, purpose, and comprehension. Due to the abstract and complex nature of MIL constructs (Park, 2016), interpretation was conceded as an unavoidable component in the data analysis process. Step 3 therefore practically differed here in that a abstract level of coding, interpreting the data, was included. The following is an outline of the method used in both studies, including identification of where study 1's use of DPA differed from study 3's use of IPA.

Preliminary data analysis

In phenomenological research, one must be open to the world as it presents itself. It was imperative therefore to view, as best as possible, material as its own phenomenon rather than as a representation of any existing theory. As Husserl (1982, p. 44) writes, "take no position with respect to the ultimate reality of what I see; instead, I simply witness it just as it

presents itself to me". This first step then required a bracketing of the natural attitude, assuming the attitude of the phenomenological reduction. This involved overcoming existential belief in the objective world (Schutz, 1967), understanding that there are many ways to conceptualise the same phenomenon. The aim was to shift attention away from objects in the world as they occur in nature, to objects in the world as they appear for the consciousness of participants. This process helped satisfy Husserl's concept of intentionality by focusing on the participants' consciousness in its intended interaction with objects in the environment. Everyday knowledge, including presuppositions, was bracketed so as to enter the world of the unique individual being interviewed. In order to better complete this task, the primary researcher created a list of presuppositions (see Appendix K). This was performed prior to the first interview and was attended to when new presuppositions were emerging from the interviews during the data collection phase. This process by definition had to be iterative; what was once not a presupposition may have only become one following the researchers own experience of partaking in an interview. Ashworth (1996) suggests that at least three particular areas of presuppositions need to be set aside;

a. Scientific theories, knowledge and explanation
b. Judgments around the truth or falsity of claims being made by the participants
c. Personal views and experiences of the researcher that would cloud descriptions of the phenomenon itself.

Following each interview, the primary researcher created a page summary reflecting on the interview itself (for an example see Appendix L), based on instinct of the interview without referring to any specific data. The aim was to identify themes emerging for the researcher so as to appropriately become aware of presuppositions that may have been accumulated. Smith, Flowers, and Larkin, (2009) noted, "it is important to treat the next case on its own terms, to do justice to its own individuality" (p.14). It was important for the

primary researcher therefore to be aware of any hypersensitivity to particular content in each interview that may stem from previous interviews. Creating a summary of each interview also allowed the primary researcher to be aware of any distractions or misdirections from the aims of the research that may have emerged within a particular interview, so as to avoid them in future assessment.

Data Analysis

The first step in the analysis was to create hard copies of the data by way of transcription. This incorporated word-for-word transcribing including the identification of seemingly noteworthy non-verbal communication such as laughing, crying, staring, and excessive pauses. Following the completed transcription of all interviews the entire 'naïve description' (Giorgi, 2009), the untouched transcription, was read in order to get a sense of the whole experience. A critical reflection of the whole interview was done in order to appropriately consider the entire experience of the participant. This was considered alongside the list of presuppositions. Essentially, the primary researcher reflected on the interview whilst attempting to hold on to the position of the phenomenological reduction (Broome, 2011).

The second step was to demarcate meaning units so that the data could be approached in manageable portions (Giogi, 2009). Coding assisted in this process that involved first numbering each line of the interview transcript. Following this, the primary researcher again read through the transcriptions delineating each line, phrase, sentence, or paragraph into a 'chunk' based on where shifts were identified in meaning. To distinguish each meaning unit, a forward slash (/) was placed in between the meeting of two meaning units. The beginning of each meaning unit was then allocated a number. It is important to note that how, or where, the meaning units were delineated was recognised as not an absolute process (Giorgi). An iterative process was therefore again adopted throughout this analysis. At the completion of

every five transcripts, the delineation of meaning units of each five were reflected upon to determine whether any changes to meaning units could be made. Meaning units were reflected on and altered if familiarity with the data provided greater clarity around a demarcation of units.

The third step involved making the first change to the data in the analytical process. While remaining faithful to the meaning units expressed by the participants, the third step was to re-express meaning units in the third person. This helped the primary researcher remain in the phenomenological attitude as outlined by DPA. This transforming of the data involved not only re-expressing meaning units in third person, but further transforming them into essential psychological structures of meaning units (Giorgi, 2009). Essentially, this involved describing the individuated and personal level of the participant by describing the world of the participant as their consciousness acted towards the experience being described (for an example excerpt see appendix M). To help in this process, Husserl's notion of imaginative variation was performed by changing qualities of the meaning unit, doing so as an intellectual exercise only, in order to determine which qualities were essential to the statement of participants (Giorgi, 1985). Each individual meaning unit was dwelled on in order to consider what was being psychologically expressed by it. If the meaning of the statement was changed by varying a word in the data, then the particular word was deemed pivotal to description.

Study 3 differed in its application of step 3 here. Like study 1, the first change to the data was coding at the descriptive level. This was similarly accomplished using the aforementioned DPA approach. An additional component however was incorporated into coding. An abstract level of coding was included where data, still in accordance with the participant's expressed experience, was interpreted from the researcher's analytical perspective. Here, the researcher used personal experience as a basis from which to interpret

the participant's stated experience. A further phenomenological concept utilised in this process was acknowledging 'presences' and 'absences' (Sokolowski, 2000). The explicit, the words of the participant, was considered in order to help reveal the existence of any implicit without this being overtly mentioned in the data (for an example excerpt see Appendix N). Moreover, a technique utilised was underlining seemingly important extracts, followed by annotating why the extract was deemed important (Braun & Clarke, 2013; Smith, Flowers & Larkin, 2009).

In order to increase the validity of essential psychological structures and interpretations, each member of the supervisory team was asked to complete their own analyses of a number of the transcripts. In total, the first 8 of the 25 transcripts to be analysed were examined by at least one other supervisor. Essential psychological structures and interpretations as constructed by the primary researcher were then compared with supervisor conceptualisations of the data in order to examine inter-rater reliability of the essential psychological structures and interpretations found. This aided the primary researcher in providing reference points for analysis of the remaining 17 transcripts. In the case where the primary researcher's analysis differed greatly from supervisors' conceptualisations of the data, excerpts were discarded from further analysis so as to utilise only the more robust data.

The fourth step in data analysis involved assessing the essential psychological structures and interpretations against the research question to determine relevance. For study 1, essential psychological structures were maintained for further analysis if they related to the individual's lived experience of trauma (for example see Appendix O). For study 3, essential psychological structures and interpretations were maintained if they related to the individual's lived experience of meaning, purpose, and comprehension (for example see Appendix P). Essential psychological structures and interpretations that were not deemed to coincide with research questions were not used in the fifth stage of analysis.

The fifth stage of data analysis involved establishing links between essential psychological structures. Using linking terms (e.g. elaborates, evidence for, contradicts, differentiates) helped describe and cluster data. Throughout the process memos were taken so as to explain the rationale behind the clustering of essential psychological structures. This was important so as to provide an opportunity for later reflection on the clustering process. What was left were the general psychological structures for each interview, otherwise known as themes. By linking together essential psychological structures the researcher created a synthesis of the constituents, theming the whole experience. In order to assess the fit of themes, a further summary of the interview was written for each participant incorporating the GPS that had been elicited from their data (for an example of a de-identified interview summary see Appendix Q). This helped in once again providing a sense of the whole. All stages, 1-5, were completed for each individual transcript.

Finally, the sixth stage of data analysis involved assessing all of the interviews for common themes in each group, as well as individual variation in themes. Five particular processes, adapted from Hycner's (1985) explanation of qualitative analysis, were utilised in order to establish the themes:

a. Counting: Categorising data and measuring the frequency of occurrence of themes
b. Patterning: noting recurring patterns or themes
c. Clustering: Grouping of objects, persons, activities, settings etc. with similar characteristics
d. Relating GPSs: discovery of the type of relationships between two or more themes
e. Building of causal networks: Development of chains or webs of networks between themes

Once common themes were established between individual transcripts within each group, the primary researcher created a mind map for each group outlining the key themes (see Appendix R). This allowed for a clear visual aid as to pertinent similarities and differences between groups when comparing mind maps. Finally, mind map themes became subordinate themes used for deriving themes to emerge for each study between groups.

3.6.5 Quantitative Analysis

Quantitative analysis was only conducted following qualitative analysis. Ordering analysis in this manner was done so as to avoid the potential for quantitative findings to influence qualitative analysis. All questionnaire data were tabulated and analysed using IBM SPSS version 22.0. Nominal Scales were given numerical values. Before assessing for the mean differences between the two groups, assumptions of normality were assessed.

Quantitative analysis for Study 2

The overarching aim for this study was to contextualise PTSD case-ness and symptom endorsement in two diverse cultural groups. The first specific aim was to examine differences in PTSD case-ness and trauma symptom endorsement between Holocaust survivors and Sudanese refugees. In the previous literature, researchers have reported various PTSD prevalence rates in both Holocaust survivor and Sudanese refugee samples (Barak & Szor, 2000; Tempany, 2009; Yehuda et al. 1995). Therefore, generating a hypothesis for this aim was untenable. This first aim was necessary however, so as to provide greater clarity for the second aim. T-tests were utilised to explore differences between groups on PTSD case-ness and Mann-Whitney U's helped explore differences between groups on trauma symptom endorsement.

The second aim was to consider the meaning of PTSD case-ness and PTSD symptom endorsement in Holocaust survivor and Sudanese refugee samples. The hypothesis for this aim was that PTSD case-ness would significantly negatively correlate with QOL in both

samples. Generating hypotheses for the relationship between each specific PTSD symptom and QOL however was again deemed untenable given the paucity of literature assessing individual symptom correlations with QOL. Pearson correlations were utilised so as to explore relationships between PTSD case-ness/symptom endorsement and QOL endorsement. A third aim was to examine between-group differences in Pearson correlations found. To accomplish this, Z-scores were explored measuring between-group differences on each Pearson correlation.

Quantitative analysis for study 3

The overarching aim for the third study was to explore similarities and differences in the way that two diverse cultural groups, both having experienced a traumatic event, interpret and relate to MIL. The first specific aim for this study was to qualitatively examine differences and similarities in the way that Holocaust survivors and Sudanese refugees conceive of meaning, purpose, and comprehension. IPA analysis was used for this analysis, discussed above.

The second specific aim for this study was to compare differences and similarities in the way that operationalised MIL constructs, namely a sense of coherence, a search for meaning, and the presence of meaning, relate to QOL in Holocaust survivor and Sudanese refugee samples. This aim was divided into three components. The first component involved examining between-group differences in the endorsement of a presence of meaning, the search for meaning, and a sense of coherence. T-tests were utilised to compare between-group differences. No hypotheses were made here due to a lack of prior literature comparing Holocaust survivors and Sudanese refugees on endorsement of these operationalised MIL constructs. The second component of this aim involved examining within-group relationships between operationalised MIL constructs and QOL. Three hypotheses were made. It was hypothesised that a presence of meaning would correlate significantly positively with QOL in

both groups. It was hypothesised that a search for meaning would correlate significantly negatively with QOL in both groups. Finally, it was hypothesised that a sense of coherence would correlate significantly positively with QOL in both groups. To satisfy this component, Pearson correlations between each operationalised MIL construct and QOL were examined. Finally, a third component of this aim was to compare between-group differences in Pearson correlations. To accomplish this, Z-scores were explored measuring between-group differences in Pearson correlations.

3.6.6 Triangulation of the data

The use of triangulation was posited by Webb and co-authors (1966) who advocated for the association of multiple measures so as to help uncover unique variance that otherwise may be neglected by a single approach. The word 'triangulation' is used to denote a wide range of possible ways to compare multiple methods of research. Methodological purists have explicitly presented their chosen paradigm as superior for conducting research (Howe, 1988; Johnson & Onwuegbuzie, 2004). They rely on an aforementioned philosophical distinction between the existence of an objective reality directly contrasting the phenomenological pursuit of subjective experience (Mayah & Onwuegbuzie, 2015). Garza (2007) however stated that "the flexibility of phenomenological research and the adaptability of its methods to ever widening arcs of inquiry is one of its greatest strengths" (p.338). Phenomenological research has been posited to aptly befit convergence with quantitative work. Husserl's (1977) phenomenology ultimately aims to make intelligible all objectivity while also respecting the value of human subjectivity. Even post-positivist thought concedes that objectivity can at best be approximated and that certainty is always revisable (Phillips & Burbules, 2000). By bracketing both the natural attitude and preconceived notions of the researcher, phenomenological reduction too strives for this (Mayah & Onwuegbuzie, 2015). Identifying the essential psychological structure in each interview promotes an objective

undercurrent of common subjective insight found within groups. This appreciation, that the structure of the lived experience may contain consistent concrete details as well as diverse elements, reflects the role of the objective within phenomenology. Therefore, a level of compatibility is allowed for between phenomenological inquiry and quantitative analysis (Mayah & Onwuegbuzie, 2015).

Importantly conclusions drawn from data triangulation were subjective. The researcher was left to rely on a capacity, advocated for by Weiss (1968, p.349), to "organise materials within a plausible framework". The way it was done in the current study was based on two levels of difference.

a. The group: Holocaust survivor interviews were compared with Holocaust survivor questionnaires, whereas Sudanese Refugee interviews were compared with Sudanese Refugee questionnaires
b. The collective: The population's qualitative interviews as a collective were compared with the population's quantitative questionnaires as a collective

3.7 Ethical Considerations

3.7.1 Confidentiality

Following the transcribing stage, all identifying information that could have exposed the participants' and other people's identities, and even places that could have been revealing, were de-identified. Participant names were replaced with pseudonyms. Only the primary researcher and supervisor team were privy to the identities and other private details of the participants as outlined in interviews and quantitative questionnaires. Moreover, following the completion of questionnaires, participant names were replaced with an allocated identification number used for data analysis. Only the primary researcher had access to the list of names and corresponding ID numbers.

3.7.2 Managing Unequal Relationships

In any human research there is the possibility that a power imbalance between the researcher and participant can create an unequal relationship. This was particularly a concern in the recruitment phase of the research. As a result, 'Stand-up' and the JHC were involved as organisations enlisted to approach individuals. A number of relationships needed to be considered and managed carefully in creating equal relationships in this project.

Pursuing an equal relationship between the researcher and participant was managed by emphasising the role of the participant as expert. Due to the inquisitive nature of the interview, bestowing the role of expert onto the participant was even more crucial for the appropriate exploration of content. This was initially promoted in the recruitment process. Liaisons from each community organisation were provided a brief, outlining the expert role of the participant in the research to be emphasised when recruiting. This emphasis was further promoted during the consent process where the consent form explained the importance of learning from the participant, as opposed to learning about the participant. Furthermore, during the interview, the researcher attempted to promote an interview process that was participant-led. Promoting empowerment of the interviewee was deemed important by asking minimal questions and allowing for the participant to take the lead in conversation (Block, Warr, Gibbs & Riggs, 2013).

A further imbalance requiring consideration was in the cultural divide between particularly the Sudanese refugee participants and the primary researcher. In order to minimise this potentially unequal relationship, rapport between the primary researcher and the Sudanese community had been developed since 2012. The primary researcher devoted time to learning about the community from the people within it, as emphasised by Marlowe (2010) in his work with the Sudanese community. The primary researcher had been immersed within Sudanese community programs for four years prior to data collection,

participating in both the homework club and the encounters programs at 'Stand Up'. The primary researcher also attended a number of holiday family programs in Dandenong where the Sudanese community would gather to partake in a range of activities. The primary researcher had also been involved in a number of programs conducted through the JHC such as 'the March of the Living' and Holocaust memorial ceremonies.

Further, the primary researcher explained to participants at the beginning of the consent process, that should the participant feel as though they were being treated unfairly, or were uneasy with the questions or the memories they triggered, then they had the right to withdraw from the research at any time. This was further stipulated in the consent form read by each participant. Finally, the primary researcher was enrolled in the Doctorate of Clinical Psychology course, including training in working with diverse cultural populations. Components of this training were delivered by supervising researcher, Professor Lenore Manderson.

3.8.3 Re-traumatisation

It was not envisioned that the current study would pose any direct risk to participants. The majority of participants evidenced a willingness to engage in the interview and discuss their experiences. However, in discussing previous experiences, particularly given the potentially traumatic events to be discussed by participants, it was important to consider the psychological sensitivity of some of the topics. Specifically, it was important to consider the potential re-traumatisation of the participants. In order to appropriately deal with this consideration, a number of processes were followed:

- Following both the interview and the completion of questionnaires, a discussion with the participant ensued around potential avenues for distress relief should the participant require any help.

- A follow-up call was made to each participant the day after data collection, if consent was given for this. The purpose of this was to check-in with the participant, and offer support should the participant require/desire this.
- Meetings with liaison officers from each organisation, as well as community leaders appointed by 'Stand-up', were conducted prior to data collection. During these meetings the types of questions to be covered in both the semi-structured interview and the questionnaires were discussed. This was done so as to ascertain, from those entrenched with the community, whether they believed any of the semi-structured interview questions or questionnaires were likely to cause distress.
- It was explained to each participant during the consent process that if that they did not have to answer all questions posed to them, and that they were free to stop talking about any topic, at any time, that may be difficult for them to speak about.
- The primary researcher was primed to manage issues that may have arisen during the interviewing process. At the time of interviewing, the primary researcher was undertaking the Doctor of Clinical Psychology course and was trained as a registered provisional psychologist. Specifically, the primary researcher was trained to observe participants' body language and respond appropriately. In the case of extended pauses, shaking or trembling, crying, extended rumination, or fixated staring signalling detachment or dissociation, the primary researcher would engage in 'heat-off' techniques. The artillery of techniques included offering the participant a break during the interview, offering the participant a tissue, offering the participant a pause in the recording, changing the topic of conversation to something more light-hearted, or asking the participant if they would like to partake in a grounding exercise (mindfulness techniques), in order to reorient the participant to the room.

- The main supervisor, Professor Louise Newman, had offered to make herself available during the time of the interview for a phone session should the participant require further help. Professor Newman is a consultant psychiatrist with years of clinical experience in trauma and cross-cultural contexts.
- As part of the information covered in the consent process, the participants were provided with contact details of local services capable of helping in the event of traumatisation. Had this been a concern raised from the participant to either the primary researcher, the JHC, 'Stand-up', or their respective liaisons, a referral was to be facilitated on the participants' behalf by Professor Newman. No referrals were required during the research process.
- Following HTQ-R data analysis, participants were phoned again were they found to be elevated on PTSD case-ness, above the cut-off point. Given the purpose of exploration, it was not yet clear whether PTSD case-ness signified dysfunction. Therefore, sensitivity was required. The purpose of this phone call was framed to participants as a 'check-in' so as not to potentially alarm participants unnecessarily. Participants were offered a follow up meeting with the primary researcher should they desire. The primary researcher explained the rationale for the meeting in terms of the potentially distressing nature of interviews in a general sense. All of these participants however reported enjoying the interview process, some explaining that they found it a useful opportunity to share their experiences. Whilst seemingly appreciative, no follow up meetings were sought by participants.

Chapter 4:

Understanding trauma: Contrasting Sudanese refugees and Holocaust survivors

Preamble to Empirical Paper

The following chapter presents the first empirical study of the thesis. The aim of this paper was to compare and contrast the way that two distinct cultural groups conceptualise trauma. Previous relativist research has documented the way that culture group membership can influence trauma conceptualisation. Authors have also highlighted difficulties in comparing individual research studies undertaking a relativist approach due to discrepancies in context. This study makes a significant contribution to the literature by exploring two distinct cultural groups in the same research study, documenting similarities and differences in the way that these groups understand trauma. In particular, using descriptive phenomenological analysis of semi-structured interviews, both differences and similarities were found. Similarities between the two distinct groups provide insight and further understanding of the human trauma experience. In this way, the current study's relativist approach importantly also contributes to universal exploration of trauma.

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Understandings of trauma: Contrasting Sudanese refugees and Holocaust survivors

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[redacted]

Abstract

Responses to deeply traumatic events vary across cultural contexts. With little insight into why these discrepancies occur, more work needs to directly contrast cultural models for understanding trauma and the meaning of responses to traumatic experiences. Using descriptive phenomenological analysis, researchers examined semi-structured interviews with Sudanese refugees and with Holocaust survivors. Group differences in the meaning of traumatic memory, somatoform symptoms, changes to identity, and impact on one's world schema, were found. Overarching similarities also became apparent, including the persistence of traumatic memory, an impact on identity, a change in one's relationship to the international community, and the emergence of existential anxiety. Findings contribute to uncovering delineation points between cultural models for understanding trauma, though simultaneously they present a potential cross-cultural language useful for understanding traumatic reactions.

Key words: Trauma, Refugee, Culture, Holocaust, Memory

The basic rights of an estimated 59.5 million refugees are violated in countless places across the globe, their flight precipitated by war, genocide, civil violence, and terrorism (UNHCR, 2016). According to a clinical understanding of mental health, such traumatic events can lead to a high prevalence of acute and chronic PTSD (APA, 2013). Understandings of trauma and post-traumatic reactions, however, can vary according to the cultural context of assessment (Marsella, 2010; Michalopoulos et al. 2015; Nicolas, Wheatley, Guillaume, 2015; Shannon, et al. 2015; Summerfield, 2012). Comparing and contrasting cultural variation in models for understanding traumatic response is important for the progression of clinical practice with refugees. Understanding in what ways the trauma experience differs between groups allows for sensitivity to cultural context, paramount for appropriate engagement with different groups following war (Silove, 2013).

The dominant clinical terminology for trauma, for which PTSD has become a central diagnosis, has been critiqued for its applicability to refugee groups on the grounds that normative frameworks differ across context, and symptoms are interpreted differently in different cultures (Kirmayer, Gone & Moses, 2014; Steel, Steel, & Silove, 2009; Summerfield, 2012). According to the model of trauma dominant in the United States, as set out in the Diagnostic and Statistical Manual (DSM), acute responses to "war… threatened or actual physical assault … violence" (APA, 2013, p. 265) are considered an inevitable part of stress-response. Should symptoms persist beyond a one-month period, however, they reflect a disordered response to trauma categorized by the PTSD diagnosis (Kira & Tumala-Narra, 2014; Terr, 1987). Questions have been raised regarding the fit of this model to refugee groups who may not view the world in ways that concur with a clinical lens, or may not consider the same post-traumatic response to be maladaptive (Von Peter, 2008).

Social and contextual factors have been shown to influence the experience of trauma (Hinton & Lewish-Fernandez, 2011; Summerfield, 2012). Research uncovering various

cultural models of traumatic response has identified a wide discrepancy (Kirmayer & Sartorius, 2007; Kohrt et al. 2014). Culture here is defined as a framework through which individuals construct their realities, meanings, and identities (Nicolas, Wheatley, & Guillaume, 2015). In this article, Marsella's (1988) definition of culture as "shared learned behaviour… transmitted from one generation to another to promote individual and group adjustment and adaptation" is apt (p.30). But equally, culture shapes models of mental health and psychopathology (Summerfield, 2001). Broad social context also influences the experience of trauma. The time elapsed since a traumatic event impacts the way that trauma is understood (O'Donnel, Creamer, & Pattison, 2004) and the resolution of initial trauma response (Jovanovic et al. 2012). Age also influences the experience of trauma, with older adults more likely to report physical trauma symptoms and difficulty with memory disturbance (Cook, 2001; Kaiser, Wachen, Potter, Moye, & Davison, 2016).

Little work has directly compared divergent cultural contexts, with the intent of highlighting differences in the conceptualization of trauma (Nickerson & Bryant, 2014). Whilst some research has explored diverse cultural responses to trauma in specific groups, in exploring a specific participant sample complicates generalizations more widely, and makes comparisons between groups difficult (Good & Hannah, 2015). In partly addressing this gap, Silove (1999) identified similarity in trauma cross-culturally by outlining five major adaptive systems effected by the experience of refugee trauma. He attempted to link psychopathological outcomes with impacts on adaptive functions caused by traumatic events. This model included the adaptive functions of personal safety, attachment and bond maintenance, identity and role functioning, justice, and existential meaning deemed to be cross-culturally non-specific in the trauma experience. Lacking, however, were comparisons aimed at exploring the ways that culture and context might contribute to differences, if any, in the conceptualizations of traumatic response (Silove, Steel, & Bauman, 2007; Van Rooyen

& Ngweni, 2012). This is critical for any interventions, given that psychologists and psychiatrists aim to relate and understand the trauma experience in diverse groups while also allowing for sensitivity to difference.

The aim of the research on which this article is based was therefore to explore differences and similarities in the conceptualization of trauma, the effects of traumatic events in two quite different groups. The study focused on Sudanese refugee immigrants and Holocaust survivors in Australia, for whom there were differences of cultural background, time since trauma, and age. The Melbourne community currently has one of the highest contingencies of Holocaust survivors outside of Israel (Markus, Jacobs, & Aronov, 2009), and in 2005-06, in a large migration burst, 33 per cent of refugees gaining permanent residency in Australia were Sudanese (Marlowe, 2010). Both Holocaust survivors and Sudanese refugees have been documented with high rates of PTSD in past research (Barak & Szor, 2000; Tempany, 2009; Yehuda et al. 1995). Conflict within Sudan has existed for centuries, although the immigrants in this study had left as a result of recent conflict. War between the Northern, Arab-Muslim dominated region and the Southern region, comprised primarily of Nubian and Nilotic non-Muslim Black African groups, has been characterized by torture, rape and genocide (Jaeckle and Georgakopoulos, 2010). The year 2015 marked the 70th anniversary of the Holocaust, a six-year genocide culminating in approximately six million Jewish deaths, and several million deaths from other groups, in Germany and collaborating nation states. Those who survived the Holocaust and participated in this study had migrated to Australia, for the most part, soon after the end of World War Two.

Method

Participants and procedure

Holocaust survivors were recruited by the Director of Community Relations at the Melbourne Jewish Holocaust Centre (JHC). Sudanese participants were recruited by the Refugee Programs Director of a Melbourne not-for-profit organization, with a community member providing liaison to ensure sensitivity and familiarity when approaching potential participants. In line with previous literature, Sudanese cultural identity was utilized for participant recruitment (Goodman, 2004; Marlowe & Adamson 2011; Tipping, Bretherton, & Kaplan, 2007). A convenience sampling approach was adopted for participants from both groups, and therefore samples are not representative of entire populations. Ethics approval was obtained from (withheld for review process).

Interested participants met with the primary researcher (first author) and read through the explanatory statement, outlining the purpose, aims, and procedure of the study. To ensure comprehension of the study, and sufficient command of the English language for interview purposes, participants were asked to relay back the nature of the study; all were able to do so and informed consent was then obtained. Holocaust survivors were interviewed at the JHC or at their homes, depending on preference; Sudanese refugees were interviewed either at the NGO offices or at their homes, depending on preference. Semi-structured interviews were either video recorded (n=15) or audio recorded (n=10) and then transcribed verbatim. Video-taping provided a visual aid for the researcher in the transcription of any words audibly difficult to differentiate. The majority of Sudanese participants did not wish to have a video recording, largely feeling uncomfortable discussing the political climate in Sudan on this media. The majority of Holocaust survivors allowed video recording; those who did not expressed discomfort with being filmed. A phone call was made to each participant the following day by the primary researcher to debrief. Participants were generally comfortable with the interview, and many expressed gratitude for the opportunity. None reported feeling confronted or at risk.

Materials

A semi-structure interview guide was utilised and included six open ended questions regarding the interviewee's experiences. In this article, we focus on the first two questions of this interview specifically: "Can you tell me about your experiences before coming to Australia?", and "Did these experiences effect you? If so how?". The questions were framed without specifying terms that may have influenced participants to respond in a particular manner. Categorizing words such as "trauma," "PTSD", "depression", and "distress" were not used by the interviewer, unless to clarify the participant's use of the term, and these terms were not included in the explanatory statement or in consent procedures. This was done in order to appropriately 'bracket' (Giorgi, 2009) the natural attitude, the researchers taken-for-granted assumptions, integral to a phenomenological approach. All interviews were conducted by the first author in English and lasted 40 - 60 minutes.

Data Analysis

All interviews were transcribed verbatim. The research questions invited the use of phenomenological analysis of first person accounts of participants' lived experience. Data were analysed using descriptive phenomenological analysis (DPA) as detailed by Giorgi (2009) and Broome (2011).

Familiarization with the data set was achieved through transcribing and reading the entire untouched transcription in order to gain a sense of the whole (Giorgi, 2009). Data were then subject to coding, numbering each line in the transcript and demarcating meaning units. Meaning units were re-expressed in third person, each transformation describing the meaning unit without any interpretation or positing about its 'truth'. This helped remain close to the phenomenology of experience, by describing the unit in terms of the participants' own

meaning. There was however complexity in comparing vastly different groups. The meaning of words, as well as the willingness to discuss various kinds of traumatic effect, may have differed depending on group membership. In order to increase the validity of meaning units, three members of a research supervisory team were asked to complete their own analyses of 8 of the 25 transcripts. Where primary analysis differed greatly from supervisor conceptualisations of the data, excerpts were discarded from further analysis. Essential meanings of each individual transcript were then categorized into emergent themes, based on interdependence and convergent meanings between essential meanings (Giorgi & Giorgi, 2003). These steps were adopted for each transcript.

Results

As described above, the data reported were drawn from semi-structured interviews with 13 Holocaust survivors (7 male, 6 female, 82-93 years) and 12 Sudanese refugees (7 male, 5 female, 20-48 years). Demographics for participants are highlighted in Table 1 below.

Table 1.

Participant demographics.

Characteristics	Holocaust survivors (n=13)	Sudanese Refugees (n=12)
	n(%) / M(SD)	*n(%) / M(SD)*
Demographics		
Male gender	7 (53.84%)	7 (58.33%)
DOB	30.07.1927	13.08.1982
Participant age	87.23 (3.44)	32.56 (10.22)
Years resettled in Aus.	62.76 (6.12)	9.91 (4.44)
Country of origin		
Poland	7 (53.84%)	
Germany	2 (15.38%)	
Austria	2 (15.38%)	
France	1 (7.69%)	
Netherlands	1 (7.69%)	
Tribal affiliation		
Dinka		3 (25%)
Nuer		2 (16.66%)
Nubian		4 (33.33%)
Fur		2 (16.66%)
Zaghawa		1 (8.33%)

Themes were identified using a range of qualitative techniques including identifying 'parts and wholes', identifying 'presences and absences', and counting commonalities, patterning, and clustering of essential meanings (Sokolowski, 2000). Interdependence and convergence of themes between transcripts was conducted within participant groups. Assessment established six key themes: *Persistent traumatic memory in both groups, Not thinking versus remembering, Somatisation and somatic metaphor, Trauma impacts the self in both groups, Abandonment versus burden,* and *Existential anxiety in both groups.* *Persistent traumatic memory in both groups* was derived by identifying commonalities in groups discussing both persistent memory and being unable to forget. The theme *Not thinking versus remembering* emerged based on participant explanations of memory. *Somatisation and Somatic metaphor in the Sudanese group* was derived based on Sudanese discussion of bodily effects of their experience. *Trauma impacts the self in both groups* was formed based on participant explanations of the effects of trauma on self-image. *Abandonment versus burden* was a theme formed by comparing the way groups explained the effects of trauma to impact their relationships with others outside of their community. *Existential anxiety in both groups* emerged based on concern about the future that was common to both groups. In describing themes below, quotations from participants are attributed using pseudonyms to preserve confidentiality.

Persistent traumatic memory in both groups

Participants in both groups described persistent traumatic memory. Braham explained that even if he hadn't been working as a volunteer at the Holocaust Centre, "I would still have here (pointing to head) about the wartimes, still there, that doesn't vanish. When I die that will die with me… as long as I am smart, I will never forget that". Rachael discussed the "imprint" of the experience, stating "the punishment, it never left me… I forgave them now

but I never will forget it". Other Holocaust survivors discussed more specific traumatic memories. Noah emphasised the effect on him of the death of his father, explaining: "If I have a memory of the Holocaust that I will never forget, which will always stay with me, that's it". He recounted:

> Wooden logs were used to support the structure. They forced them to put the logs on the ground. They forced the Jews to lay down onto the logs, on the first level. They put another set of logs and built a pyramid and set it on fire. So that's the way my father perished.

Sudanese participants also all referred to the persistence of traumatic memory. Chriz explained that the experience "never goes away, only when you die, because something here in your mind never goes away". Matida, like Rachel, discussed the imprint of traumatic memory: "I don't think it's something you can forget... it's like part of who I am". Again, other Sudanese spoke of specific persistent memories. Abi discussed the memory of her baby sister drowning while her family attempted escape. "This is one of the memories that stuck. It was her [mother], bending over my little sister and trying to resuscitate her, and I just remember people crying and eventually they gave up". Abi suggests that certain memories are not and cannot be forgotten. She continued, "I think it's part of you, unfortunately, all of those bad images".

The expressed frequency of memory differentiated Holocaust survivor and Sudanese discussions of memory. Holocaust survivors described that persistent memories occurred very often or every day. Noah reported: "The memories come back. I relive those memories every day." Similarly, Jacob relived the imprint continuously: "You can never forget it, you're living with it. Any other memorial day is one day, our memories are 365 days a year. We live with it. We meet our nights everyday". Talia described the nightly frequency of memory, and the ways in which this affected her behaviour: "I leave the light on outside to

see if any boots come towards me, because I was picked up by soldiers with boots at 4 o'clock to be tortured". In contrast, Sudanese differentiated between the involuntary persistence of traumatic memory and the intentionality of traumatic memory recall. Nanomi alluded to this when he said, "you cannot forget, but you don't remember every time". Chriz discussed controlling the frequency of recall claiming, "some people don't control themselves, they just keep thinking".

Not thinking versus remembering

Although the persistence of memory was common among members of both groups, Sudanese asserted the importance of not thinking about the past. Sudanese participants cautioned against remembering. Abdalla explained that the aim was to "not think about the past". Chriz explained that "it's no good when you're thinking too much". He continued, "when they think about what happened to them, some people just can't eat for the whole day…. then you become sadder". Sudanese participants equated thinking about the past with stress, as Shaker explained: "This is a lot more stress that you find yourself in and (it) challenges you when you brew, think and reflect back". Matida reported, "you drive yourself crazy because you mentally processing things…. you're stressing yourself". Abi used the word "stressful" and clarified this in terms of "thinking a lot, you know, you find yourself thinking a lot". She continued to explain this link: "The funny thing is that you come to Australia, and you look back and then it begins to actually almost traumatize you even more because it's like you never had an opportunity to get disgusted by how things were". For Sudanese participants, despite the indelibility of traumatic memory, its stressful impact was perceptively in their own control. Yaya explained: "I just stopped because I don't want to think about it anymore".

Holocaust survivors in contrast did not speak of problems with the act of remembering. Braham explained that at weddings, "whether it's in the middle of the party or the second half of the party, we come always back to the Holocaust". Despite the contrast between the joyous occasion and unpleasant memories, he continued, "I wouldn't call it a problem, that's the way it is". Samuel took this further in his discussion of the role of frequent memory: "It affects me because I live with it every day…so I made a mission in my life to try and remember". Samuel identified a purposeful function in memory, and like other Holocaust survivors, he explained that frequent remembering was not problematic.

Somatization and somatic metaphor in the Sudanese group

Many Sudanese referred to the somatizing effects of the past, or of thinking about the past; this was not the case in Holocaust survivor accounts. Alimah explained that after the passing of her uncle, she "cried and felt sick". When prompted to expand, she reported, "I feel sick…. You know, I feel like my heart is pumping, you know, and I feel headache, I feel muscles sleepy, and I feel something that is not well, nausea". Chriz spoke of the heart, initially using it as the metaphorical location of pain: "Crying in your heart, you're not happy and you're feeling something is very painful but tears do not come out …. Wow, it's very painful". He then affirmed the literal nature of this pain, "if they just keep thinking, you're going to be um heart attack, it can give you heart attack". Mohammed provided a sensory account of trauma's effects, relating the impact of these events to his sense of taste. He stated,

> We are not feeling… You know, we, we are living good life, we are eating good food, we are drinking water, clean water… If he's surviving a good life, he's supposed to taste that life... We don't taste the, the things, the life. Someone, some people, they used to say the life is like joy. But if you are not feeling good, you can't taste the joy.

Mohammed expressed the way that events potentially impacted one's ability to enjoy life. In a metaphorical sense, too, he used bodily symptoms to communicate feelings.

Trauma impacts the self in both groups

Holocaust survivors in particularly felt that they had been damaged by, or were different following, traumatic events. Golda explained, "I wasn't quite a normal teenager after the war… After the war normal teenager goes with boys, goes out to enjoy themselves, has a feeling of happiness, feeling of satisfaction. I didn't have that". Adina explained, "it makes me crazy, I am half-crazy probably". Jacob elaborated on this: "I don't think we are all normal, I don't think so. According to the Heidelberg University, the Germans they recognise that … And that's why they give us a few dollars a month. How can you be?" Jacob suggested that it was impossible to be normal following the Holocaust. Noah identified a change in the self as common to all survivors, and outlined a common process:

> There's first period, survive the ghetto. Second period, survive the concentration camp. Liberation, sudden realisation life is not what you expect it… You expect to see the beautiful world which didn't happen and suddenly you realise you, you see, you pretend within yourself that you can still be a normal person. You can't be a normal person. The experience changes you completely.

Sudanese participants described this change to identity by referring to a sense of powerlessness as an effect of trauma. They described themselves as powerless to influence the ongoing conflict, help others, or better their own circumstances following trauma. Nanomi asserted: "Everything that happens that you see in your eye, you cannot do anything. You don't have the power to do (anything), to protect your country". This sense of powerlessness pertained not only to the conflict, but also to helping others who were suffering. Matida reported, "I think it's more knowing because all my families back there like

going through what I did… but I don't have to and there's nothing I can do to help them, and that's the hardest bit". Abi also stated that "all you can do is really cry for the person that is hurt, because intervening means you are beaten, and not intervening means you are a coward". She later identified "this stems from a bit of hopelessness". The hopelessness of the situations in which she found herself led her to feel powerlessness. Suleyman also discussed the powerlessness that people felt when they tried to escape conflict.

> Sometimes they [the government in South Sudan] would kill the dad… So if you see something like this, the first of like the traumatic things in your life, then you just escape… some way on though, in some time you gonna have position to say, oh he killed my dad, you gonna try to live with this. They leave you know what's called leave you in fear or you know, powerless sorta, that you can't talk about these issues because I would feel that if they were gonna kill my dad, they are gonna kill me too.

Here, the effect of "traumatic things" was seen to affect people's power over their circumstances and the environment. Kariem claimed, "we supposed to be doing what other people are doing" referring to rebuilding a life in Australia. He continued, "but it takes time, and with time I still feel like I can't do it". This feeling of "can't do," of powerlessness, was therefore particularly salient in this group as an effect of trauma on the self.

Abandoned versus burden

A salient difference in the way that Holocaust survivors and Sudanese immigrants discussed the consequences of the past was in how they related to the international community. Holocaust survivors spoke of the world abandoning them. Jacob stated that "the world knew all about it, and did nothing… they knew everything that happened there." He continued by expressing emotionally,

> Twelve thousand men, women, children, babies, pregnant women, old people, sick people. Nothing. Where was the world? The world couldn't give a damn… But they knew all about it. They had photos, they had the films. They knew what happened, but they refused to help

Similarly, Rachel claimed that "the world, the world didn't help". Menachem portrayed a persistent belief in the world's indifference to oppression and conflict stemming from the Holocaust: "And today… you know as well as I do what's going on in the world, in the Middle East, where thousands of them get slaughtered every day. Nobody seems to care about them. Because where's the outcry of the world? Where is it? Have you heard?" For Holocaust survivors the international community had a duty to help, and failed, and this duty of obligation remains unfulfilled.

In contrast, Sudanese identified themselves as a burden. Abi claimed "the things you want to talk about are not necessarily the things I want to talk about… things like saving the world when you have a war going on. So I feel like I'm a burden sometimes to people because I feel like I'm too serious". Abdalla explained this feeling as a cultural "heirloom":

> So the culture in Sudan… when I need someone, when we need something we explained what we need or tell people the situation and then it's up to other people to figure out how can you help with it so we don't directly ask you do one two three and four. We feel like if you can't help with our conflict that means we putting you in a really bad situation and it's a cultural thing.

The difference here is that Sudanese participants, although they might have needed or valued help, did not expect the international community to act.

Existential anxiety in both groups

Both Holocaust survivors and Sudanese refugees expressed anxiety pertaining to the future on account of past trauma. Holocaust survivors worried that history might repeat itself. Rachel explained, "it's the same thing, it's happening again. History is repeating itself. Hate, it's a scourge". Ruth discussed the current plight of the world, fearing for future generations, "I think about it a lot… seeing everything what's going on in each corner, killings you know, all kinds". All Holocaust survivors discussed a fear of Islam. Menachem summarized this shared fear: "I worry about a complete takeover by the Muslim population".

Sudanese refugees expressed uncertainty in their own future, similarly concerned that what happened in the past may happen again. Abi worried, "tomorrow I could wake up and everything could be gone. That's one of the things that emerge from growing up in the camp where nothing is certain". Abdalla described the Sudanese community as having "a sense of insecurity… some have been living in peace and then, overnight, everything was turned upside down". He continued, "talk to them like what are your plans, what do you want to do? And they are basically just afraid that what happened in Sudan and what happened in the region can happen again". Demonstrating this point, Mohammed expressed "my future is still dark… I can't see it, no lights, no any".

Discussion

Findings underscore differences between but also key similarities in the way participants from these two distinct cultural groups conceptualized the impact of traumatic events. Relevant differences were found in the interpretation of traumatic memory, somatoform symptoms, the change to self, and the impact on one's relationship with the international community. Group differences are consistent with the literature, supporting the idea of the cultural construction of trauma (Franco-Paredes, 2009; Marsella, 2010; Summerfield, 2012; Nicolas, Wheatley and Guillaume, 2015). Yet while differences in conceptualizations of

trauma were found, some overarching similarities in the understanding of traumatic effect emerged transcending context. These similarities can help bridge difference in understanding the trauma experience.

The first commonality, coinciding with previous research expressing a critical memory component in the trauma experience (Lawrence-Wood, et al., 2015; Van Rooyen and Ngweni, 2012), was the affirmation of traumatic memory's persistence following traumatic events. Salience of traumatic memory's persistence is reflected in the Holocaust survivor group. Their primary traumatic event concluding 70 years prior, yet they still engage with memories of the past, every day. This finding shadows the writings of Elie Wiesel: "Never shall I forget that night, that first night in camp, which has turned my life into one long night… never" (1958: 32).

Differences between groups in the qualities of persistent traumatic memory were also identified. First, Holocaust survivors explained persistent and frequent memory as "the way it is", purporting traumatic memory to help fulfil a purpose of remembering. In contrast, Sudanese understood traumatic memory to be associated with distress, and expressed that they found it an ongoing challenge to avoid the memory. Second, Holocaust survivors understood frequent traumatic memory to be a direct consequence of the war on all survivors. In contrast, for Sudanese, frequency of memory was only reported to affect those who succumbed to thinking about the past. Reflection and rumination was therefore seen as a pathway to traumatization for Sudanese, as opposed to a consequence of traumatization for Holocaust survivors.

Differences found may not be solely due to cultural difference. Difference in response to traumatic memory can be explained by both culture and time since trauma. Kidron (2012) explained the act of remembrance to be a core component of Jewish culture. Primo Levy (1984) supported the idea of the benefit of remembering when he wrote of "calling up a

moment of anguish in a tranquil mood, seated quietly at one's desk, is a source of profound satisfaction" (p. 57). In contrast, being forward looking has previously been described as a prioritized or valued trait in Sudanese culture (Savic, Chur-Hansen, Mahmood, and Moore, 2016). This finding is moreover consistent with previous literature highlighting 'thinking too much' as a component of refugee trauma (Hinton, Reiss, & de Jong, 2015; Shannon, et al., 2015). Time elapsed since trauma may also help explain this difference. Valent (1995) explained Holocaust survivor memory as only re-surfacing once people had sufficiently rebuilt their lives. Sudanese refugees, still in the process of rebuilding their lives after migration to Australia (Marlowe, 2012), deemed memory of the past to hinder their progress. Irrespective of the precise cause, results demonstrate how social context can shape understandings of, and the response to, the trauma experience.

Other similarities to emerge from the data can help bridge differences found between groups. Both groups found traumatic events to impact identity. Holocaust survivors described their experiences to render the self 'different', 'crazy', and 'abnormal'. Sudanese conceived the effects of trauma to manifest in feelings about the self as powerless. In both cases the individual enduring the trauma had an altered identity as a result, consistent with earlier work (Silove, 1999) pointing to threat to identity following trauma. A third commonality was that one's relationship with the international community was altered. Again, within this similarity, difference was apparent. Holocaust survivors viewed the international community, following the traumatic event, through a lens of abandonment, whereas Sudanese described feeling like a burden on the world. Cultural narratives possibly underpin this difference, as Abdalla, a Sudanese refugee participant, stated: "It's a cultural thing". This difference may have also emerged due to the difference in conflicts experienced. The Holocaust was an asymmetrical genocide involving a large proportion of the western world, leaving more scope for global intervention than the war in Sudan, a civil conflict focused in the one country. Existential

anxiety was a final similarity between the two groups. Anxiety pertained to a repetition of the traumatic event, although with different specific qualities depending on context. Holocaust survivors admitted to this anxiety, 70 years on, and Sudanese refugee accounts of anxiety, highlight the ways in which the effect of trauma can persist: "It happened once, therefore it can happen again" (Homer, 2001, p. 225).

Similarities indicate a language with which to interpret the human experience of traumatic events. Three of the similarities provide support for components of Silove's (1999/2013) ADAPT model. A change to one's identity provides support for his identity and role functioning system, a change to one's relationship with the social world provides support for his attachment and bond maintenance system, and existential anxiety provides support for his personal safety system. The persistence of traumatic memory emerged as a valuable consideration in additional cross-cultural research, potentially worth integrating into Silove's ADAPT model. Results demonstrate that traumatic events may impede memory, irrespective of social context, potentially in an adaptive manner. Therefore, the current study provides a broader conceptualization of the experience of trauma than that of a PTSD diagnosis, integrating contextual and cultural differences with similarities in experience following traumatic events. Nevetheless, the current study's findings suggest that future research can be conducted to explore a potential synthesis between culturally and contextually diverse constructions of trauma and PTSD symptoms (Van Rooyen & Ngweni, 2012).

Conclusion

The increasing numbers of refugees worldwide requires development in service provision and cross-cultural understanding of trauma (Silove, Steel & Bauman, 2007). The current study results indicate a common language with which to understand traumatic experience across diverse populations. By highlighting the commonality of traumatic

experience, the quest for a universal language is furthered. In using broader conceptualizations of the trauma experience than are included under the label of PTSD, the similarities in the current study allow for, rather than preclude, difference. Clinicians and aid workers can use similarities across groups, as outlined, to help build rapport, express understanding, and address concerns in diverse populations as a result of war and violence.

References

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders, 5th edition.* Washington DC: American Psychiatric Publishing.

Armour, M. (2010). Meaning making in survivorship: Application to Holocaust survivors. *Journal of Human Behavior in the Social Environment, 20*(4), 440-468.

Bettelheim, B. (1979). *The informed heart: Autonomy in a mass age.* New York: Avon Books

Broome, R.E. (2011). Descriptive phenomenological psychological method: An example of a methodology section from doctoral dissertation. Retrieved online at http://phenomenologyblog.com/wp-content/uploads/2012/04/Broome-2011-Phenomenological-Psychological-Dissertation-Method-Chapter.pdf

Cook, J.M. (2001). Post-traumatic stress disorder in older adults. *PTSD Research Quarterly*, *12*, 1-7

Franco-Paredes, C. (2010). An unusual clinical presentation of posttraumatic stress disorder in a Sudanese refugee. [Case Reports]. *Journal of Immigrant and Minority Health, 12*(2), 267-269.

Giorgi, A. (2009). *The descriptive phenomenological method in psychology: A modified Husserlian approach*. Pittsburg, PA: Duquesne University Press.

Giorgi, A.P., & Giorgi, B.M.. 2003. Chapter 13: The descriptive phenomenological psychological method. In Camic, Paul, M., Jean E. Rhodes and Lucy Yardley, eds., *Qualitative research in psychology: Expanding perspectives in methodology and design* (pp. 243-273). Washington, DC: American Psychological Association.

Good, M.D., & Hannah, S.D. (2015). "Shattering culture": perspectives on cultural competence and evidence-based practice in mental health services. *Transcultural Psychiatry 52*(2): 198–221.

Goodman, J.H. (2004). Coping with trauma and hardship among unaccompanied refugee youths from Sudan. *Qualitative Health Research, 14*(9), 1177-1196.

Hinton, D.E., Reiss. R., de Jong, J. (2015). The "thinking a lot" idiom of distress and PTSD: an examination of their relationship among traumatized Cambodian refugees using the "thinking a lot" questionnaire. *Medical Anthropo*logy, *29*, 357-380.

Homer, F. (2001). *Primo Levi and the Politics of Survival*. Columbia, MO and London: University of Missouri Press

Jaeckle, T. & Georgakopoulos, A. (2010). Cultural representations of identity, trauma and transnationalism among Dinka refugees: implications for conflict analysis and resolution. *International Journal of Psychological Studies, 2*(2), 1-13.

Jovanovic, T., Sakoman, A.J., Kozarić-Kovačić, D., Havelka Meštrović, A., Duncan, E.J., Davis, M., & Norrholm, S.D. (2013). Acute stress disorder versus chronic posttraumatic stress disorder: inhibition of fear as a function of time since trauma, *Depression and Anxiety*, *30*(3), 217-224.

Kaiser A. P., Wachen J. S., Potter C. ,Moye J., & Davison, E . (2014). Posttraumatic stress symptoms among older adults: A review. Retrieved from http://www.ptsd.va.gov/professional/treatment/older/ptsd_symptoms_older_adults.asp

Kira, I.A., & Tummala-Narra, P. (2015). Psychotherapy with refugees: Emerging paradigm. *Journal of Loss and Trauma, 20*(5), 449-467.

Kirmayer, L.J., Gone, J.P., & Moses, J. (2014). Rethinking historical trauma. Transcultural Psychiatry, 51(3), 299-319.

Kirmayer, L., & Sartorius, N. (2007). Cultural models and somatic syndromes. *Psychosocial Medicine, 69*, 832-840.

Kohrt, B.A., Rasmussen, A., Kaiser, B.N., Haroz, E.E., Maharjan, S.J., Mutamba, B.B., de Jong, J.T.V.M., & Hinton, D. (2013). Cultural concepts of distress and psychiatric

disorders: literature review and research recommendations for global mental health epidemiology. *International Journal of Epidemiology, 43,* 365-406

Lawrence-Wood, E., Van Hooff, M., Baur, J., & McFarlane, A.C. (2015). Re-experiencing phenomena following a disaster: The long-term predictive role of intrusion symptoms in the development of post-trauma depression and anxiety. *Journal of Affective Disorders, 190*, 278-281.

Levi, P. (1984). *The periodic table.* Schocken Books: New York

Marlowe, J., Harris, A., & Lyons, T. (2012). *South Sudanese Diaspora in Australia and New Zealand: Reconciling the past with the present.* Newcastle, UK: Cambridge Scholars Publishing.

Marlowe, J., & Adamson, C. (2011). Teaching trauma: Critically engaging a troublesome term. *Social Work Education, 30*(6), 623-634.

Marsella, A.J. (1988). Cross-cultural research on severe mental disorders: Issues and findings. *Acta Psychiatrica Scandinavica Supplementum, 344,* 7-22.

Marsella, A.J., Friedman, M.J., Gerrity, E.T. & Scurfield, R.M. (1996). *Ethnocultural aspects of posttraumatic stress disorder*. Washington, DC: American Psychological Association.

Marsella, A.J. (2010). Ethnocultural aspects of PTSD: An overview of concepts, issues, and treatments. *Traumatology, 16*(4), 17-26.

Michalopoulos, L.M., Unick, G.J. Haroz, E., Bass, J., Murray, L.K., & Bolton, P.A. (2015). Exploring the fit of western PTSD models across three non-western low- and middle-income countries. *Traumatology, 21*(2), 55-63.

Nicolas, G., Wheatley, A., & Guillaume, C. (2015). Does one trauma fit all? Exploring the relevance of PTSD across cultures. *International Journal of Culture and Mental Health, 8*(1), 34-45.

Nickerson, A., & Bryant R.A. (2014). The mechanisms of psychosocial injury following human rights violations, mass trauma, and torture. *Clinical Psychology: Science and Practice. 21,* 172-191

O'Donnell, M.L., Creamer, M. and Pattison, P. 2004. Posttraumatic stress disorder and depression following trauma: understanding comorbidity. *American Journal of Psychiatry, 161*(8), 1390-1396. http://dx.doi.org/10.1176/appi.ajp.161.8.1390.

Savic, M., Chur-Hansen, A., Mahmood, M.A., & Moore, V.M. (2016). 'We don't have to go and see a special person to solve this problem': Trauma, mental health beliefs and processes for addressing 'mental health issues' among Sudanese refugees in Australia. *International Journal of Social Psychiatry, 62*(1), 76-83.

Shannon, P.J., Wieling, E., McCleary, J.S., & Becher, E. (2015). Exploring the mental health effects of political trauma with newly arrived refugees. *Qualitative Health Research, 25*(4), 493-257.

Silove, D. (1999). The psychosocial effects of torture, mass human rights violations, and refugee trauma: toward an integrated conceptual framework. *Journal of Nervous and Mental Disease, 187*(4), 200-207.

Silove, D. (2013). The ADAPT model: a conceptual framework for mental health and psychosocial programming in post conflict settings, *Intervention, 11*(3), 237-248.

Silove, D., Steel, Z., and Bauman, A. (2007). Mass psychological trauma and PTSD: Epidemic or cultural illusion? Chapter in Wilson and Tang, C.S. (Eds). *Cross-cultural assessment of psychological trauma and PTSD*. Springer: New York.

Sokolowski, R. (2000). *Introduction to Phenomenology.* New York: Springer.

Steel, Z., Steel, C.B., & Silove, D. (2009). Human rights and the trauma model: genuine partners or uneasy allies? *Journal of Traumatic Stress, 22*(5), 358-365.

Summerfield, D. (2012). Afterword: Against "global mental health." *Transcultural Psychiatry, 49*(3-4), 519-530.

Tipping, S., Bretherton, D. and Kaplan, I. (2007). Meaning in life and social connectedness: The experience of Sudanese young people (re) settling in Australia. In Lusher, Dean, and Nick Haslam (Eds.) *Yearning to breathe free: Seeking asylum in Australia,* (pp. 157-168). NSW, Sydney: The Federation Press.

Terr, L.C. (1987). Childhood psychic trauma. In J.D. Noshpitz (Ed.), *Basic Handbook of Child Psychiatry, Volume 5: Advances and New Directions* (pp. 262 - 272). New York: Basic Books.

United Nations Human Rights Council. (2016). *Figures at a glance*. Retrieved from http://www.unhcr.org/figures-at-a-glance.html on 4 June, 2016

Valent, P. (1995). Documented childhood trauma (Holocaust): Its sequelae and applications to other traumas. *Psychiatry, Psychology and Law, 2*(1), 81-89.

Van Rooyen, K, & Ngweni, Z.C. (2012). Culture and post-traumatic stress disorder (PTSD): A proposed conceptual framework. *South African Journal of Psychology, 42*(1), 51-60.

Von Peter, S. (2008). The experience of 'mental trauma' and its transcultural application. *Transcultural Psychiatry, 45*(4), 639-651.

Wiesel, E. (1958). *Night.* New York: Hill and Wang.

Zeidner, M., & Aharoni-David, E. (2015). Memories of Holocaust-related traumatic experiences, sense of coherence and survivors' subjective well-being in late life: some puzzling findings. *Anxiety, Stress & Coping, 28*(3), 254-71.

Chapter 5:

Contextualizing posttraumatic stress disorder within diverse cultural groups: a comparison of Holocaust survivors and Sudanese refugees

Preamble to Empirical paper

This chapter presents the second empirical study of the thesis. The aim of this paper was to contextualise PTSD and its symptoms within two distinct cultural groups. After having considered Holocaust survivor and Sudanese refugee conceptualisations of trauma from an in-depth qualitative perspective, the current study was afforded greater confidence in appropriately contextualising PTSD within these two groups. Previous research has criticised universal approaches to PTSD for overlooking potential variability in symptom interpretation. Relying on PTSD symptom counts alone does little to uncover the interpretation and meaning of symptoms. This study therefore contributes to the literature by exploring PTSD within two different cultural contexts, doing so by correlating PTSD and its symptoms with QOL in each group. This study reveals the utility of PTSD assessment in divergent groups, both groups yielding almost identical correlations between PTSD scores and QOL. Simultaneously, this study highlights variability in the way that individual symptoms can relate to QOL depending on cultural group membership. Using a universal approach therefore provides support for PTSD and the need to contextualise PTSD symptoms appropriately in order to aptly understand dysfunctional trauma response.

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Contextualizing posttraumatic stress disorder within diverse cultural groups: a comparison of Holocaust survivors and Sudanese refugees

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Abstract

Debate over the validity of Posttraumatic Stress Disorder (PTSD) in culturally and contextually diverse groups needs to consider a middle ground for the progression of clinical practice with traumatized groups. Sensitivity to contextual variation in trauma response is important, without overlooking PTSD. The current study explores PTSD within two diverse cultural samples; Sudanese refugees and Holocaust survivors living in Australia. Measures used included the Harvard Trauma Questionnaire- Revised (HTQ-R) and the World Health Organization Quality of Life Scale – Brief (WHOQOL-Bref). Samples were contrasted using T-tests for PTSD case-ness, Mann-Whitney U's comparing PTSD symptom endorsement, and Pearson correlations exploring relationships between PTSD case-ness/ symptoms with Quality of Life (QOL). Whilst PTSD case-ness was found to negatively correlate with QOL in both groups, group differences were found in relationship strength between traumatic memory and QOL. PTSD symptoms produced similar correlations with QOL between groups, though there is also a need to contextualize PTSD and its symptoms appropriately by not only considering symptom endorsement, but also symptom interpretation and association.

Key Terms: PTSD, Trauma, Holocaust, Sudanese, Culture

Over the last three decades, the cross cultural validity of PTSD as a description for traumatic response has been critiqued (Michalopulos et al., 2015). Debate has developed over the universal applicability of PTSD and the importance of considering cultural variation in understandings of trauma (Summerfield, 2012)**.** One side asserts that PTSD and its features are seen across cultures the other considers PTSD and its symptoms to be constructed specifically in a European-American context and therefore not applicable to diverse cultural groups (Auxemery, 2012; Kienzier, 2008; Kirra & Tummala-Narra, 2014; Summerfield, 2001; Young, 1995). Persisting with polarized debate, however, risks continuing a simplistic approach to minimizing the distress of people impacted by traumatic experiences. Debate overlooks the potential to synthesize PTSD within culturally variable constructions of trauma. A "middle ground" (Van Rooyen & Ngweni, 2012, p. 51) allows for the applicability of the PTSD construct if contextualized appropriately. To date however there has been little exploration of a conceptual middle ground.

PTSD is used to describe an individual's long-lasting (more than 1 month) reaction to traumatic event/s consisting of intrusion, avoidance, cognitions and mood, and arousal symptoms (American Psychiatric Association, 2013). However, research into diverse cultural contexts have reported an eclectic mix of alternate trauma reactions (Marsella, 2010; Nicolas, Wheatley, Guillaume, 2015; Shannon, Wieling, McCleary, & Becher, 2015; Silove, 1999; Summerfield, 2012). Cultural context can influence understandings of normal and acceptable behaviour (Lasiuk & Hedadoren, 2006). Culture provides a framework for individuals to communicate their suffering and to understand emotional and psychological pain (Kidron, 2012). Because of the diversity that follows from this, cultural difference can lead to various conceptualizations of trauma pathology. Research exploring cultural relativity in the trauma response has noted diversity and the need to promote cultural sensitivity when assessing for

trauma (Chhim, 2014; Kidron, 2012; Marsella et al. 1996; Shannon, Wieling, McCleary, & Becher, 2015).

Social and contextual factors can also influence the conceptualization of trauma and its identification. The time elapsed since a traumatic event impacts the way that trauma is understood (O'Donnel, Creamer, & Pattison, 2004) and the resolution of initial trauma response (Jovanovic et al. 2012). Some responses to trauma often require passages of time to pass before they manifest or are deemed reasonable responses to horrific events (Valent, 1995). In work with Holocaust survivors, country of residence has been demonstrated to influence psychological-wellbeing and adaptation post-trauma (Barel, Sagi-Scwhartz, Van Ijzendoorn, & Barkeman-Kranenburg, 2010). Age also influences the experience of trauma, with older adults more likely to report physical trauma symptoms and difficulty with memory disturbance (Kaiser, Wachen, Potter, Moye, & Davison, 2017).

While attention to cultural and contextual variation is important, ignoring the clinical framework of PTSD cross-culturally entails the neglect of potential post-traumatic psychiatric conditions and distress. Many studies have found elevated PTSD rates in diverse cultural samples (e.g., Nickerson, Bryant, Silove, & Steele, 2011; Vermetten & Olff, 2013). In a recent study by Michalopoulos et al. (2015), PTSD factor structures yielded adequate to good fit among Burmese, Iraqi and Congolese respondents, suggesting that PTSD as a diagnosis can be relevant to non-Western cultural groups. In the Sudanese refugee and Holocaust survivor literature, both groups have been found to express diverse cultural trauma responses, but also elevated PTSD rates (Armour, 2010; Garwood, 1996; Barak & Szor, 2000; Paardekooper, De Jong, & Hermanns, 1999; Sadavoy, 1997; Tempany, 2009; Yehuda, Kahana, Schmeidler, Southwick, Wilson, & Giller, 1995). Failing to identify or diagnose mental distress can have a negative impact on functioning and adaptation following traumatic events (Silove, Steele, & Bauman, 2007).

Endorsing PTSD symptoms alone however is not enough to indicate that PTSD is truly present cross-culturally. Tempany (2009), reported that a range of studies highlight both elevated PTSD levels and intact daily functioning measured by indicators of quality of life (QOL) (Goodman, 2004; Jeppsson & Hjern, 2005; Paardekooper, De Jong, & Hermanns, 1999). QOL is defined as the perception a person has of his or her own life relating to personal well-being or satisfaction with life (Fayers & Machin, 2000; WHO, 1996), and so it seems axiomatic for PTSD levels to correlate with lower QOL. The 'category fallacy' (Kleinman, 1987) however indicates that the same symptoms may adopt entirely different interpretations or associations depending on the cultural context of assessment. If the interpretation and association of the symptom differs, then this renders the individual's response to trauma potentially no longer identifiable as a symptom of PTSD. This indicates a need to consider more than symptom endorsement in identifying PTSD.

PTSD symptoms, and the experiences of these symptoms, can therefore have different associations and interpretations (Shannon, Wieling, McCleary, & Becher, 2015; Summerfield, 2012; Tempany 2009). Silove (2013) posited that trauma response can exist on a continuum from adaptive to maladaptive. Demonstrating this are variable conceptions of intrusive memory as either a fundamental symptom of PTSD (APA, 2013; Beck et al. 2009) or as an index of meaning making, cognitive processing, and post-traumatic growth (DuHamel et al. 2004; Helgeson et al. 2006; Salsman, Segerstrom, Brechting, Carlson, & Andrykowski, 2009; Updegraff & Marshall, 2005). Similarly, avoidance symptoms have been interpreted as either symptoms of PTSD (APA, 2013; De Jong, Kopmroe, & Van-Ommeren, 2001) or as adaptive ways of adjusting to grief or trauma (Marsella et al. 1996; Slobodin, Caspi, & Klein, 2014). Alternate interpretations and associations of symptoms imply the need to explore how very different groups relate to the same symptoms. Without

contextualization and understanding group differences, the meaning of endorsed symptoms in diagnostic assessment and screening remains unclear.

Van Rooyen and Ngweni (2012) argue that "in undertaking cross-cultural inquiry the middle ground is often a safe place to start" (p. 571). Debate over the cross-cultural validity of PTSD is no longer effective as a way of engaging with trauma responses in various cultures (Friedman et al., 2007; Kienzier, 2008). Most research has either focused on cultural sensitivity or attacked the PTSD diagnosis for being insensitive cross-culturally. The alternative, a synthesis contextualizing PTSD symptoms within various cultural groups, has received little attention (Van Rooyen & Ngweni, 2012). The impact of PTSD and its symptoms need to be considered cross-culturally and across context. The current study explores PTSD case-ness and symptom endorsement in both a Holocaust survivor group and a Sudanese refugee group living in Australia. A first aim was to examine group differences in PTSD case-ness and symptom endorsement. A second aim was to explore the influence of PTSD symptoms cross-culturally, assessing the relationships between QOL and PTSD/ PTSD symptoms. In accordance with the literature on PTSD and distress (APA, 2013), it was hypothesized first that PTSD case-ness would significantly negatively correlate with QOL in both groups, and second, that individual symptoms would negatively correlate with QOL.

Method

Participants and procedure

The study reported here was conducted in Australia with a sample of Sudanese refugees and Holocaust survivors. Both groups have survived a genocide, defined as "acts committed with intent to destroy, in whole or in part, a national, ethnical, racial or religious group" (OSAPG, 1948). Holocaust survivor participants endured the targeted extermination of their people in Europe during World War Two. Sudanese refugee participants have

experienced ongoing violence and conflict, specifically during the second Sudanese war spanning the years of 1983 to 2005 (Pendle, 2014). Forty participants, 20 who were Holocaust survivors and 20 from the Sudanese community, were recruited through Melbourne-based community organizations. Ethical approval for the current study was obtained.

Participants in all cases met with the primary researcher (first author) and were invited to read through the explanatory statement and the consent form. Participants were asked to relay back to the primary researcher the nature of the study. This helped validate participant comprehension of the study, and that they were competent in their command of the English language for screening purposes. All were able to do so. Following this, Holocaust survivors and Sudanese refugees completed questionnaires separately. Participants were phoned the following day to debrief. None reported feeling confronted or at risk.

Measures

The Harvard Trauma Questionnaire – Revised (HTQ-R)

The HTQ-R (The Harvard Program in Refugee Trauma (HPRT), 1998) is a screening tool for PTSD, updated from the original Harvard Trauma Questionnaire (Mollica et al., 1992). The HTQ-R begins with a "trauma events checklist". Respondents then rate their experience over the past week of trauma symptoms using a 4-point frequency scale (1= not at all, 2= a little, 3 = quite a bit, 4 = extremely). This component of the screen contains 40 items contributing to two scales. The first scale, the PTSD scale, consists of the first 16 items mirroring the symptoms found in the DSM-IV (APA, 1994). The second scale has 24 items that assess symptoms derived from the HPRT's research with refugees. Together, the two scales constitute the total trauma scale. Individuals with scores on either the PTSD and/ or total trauma scale greater or equal to a mean of 2.5 are considered to be likely to receive a diagnosis of PTSD. The HTQ is reported to be the most widely used international instrument

measuring trauma exposure and PTSD symptoms across refugee populations (Steel et al. 2009), and has been used previously with a Sudanese population in Cairo (Meffert et al., 2010). The HTQ has been found to be reliable (*a* = 0.87; Rasmussen, Smith, & Keller, 2007) and valid in multiple traumatized populations (Hollifield et al. 2002). It has shown high inter-rater (r= 0.98), test-retest (r = 0.92), and internal reliability (α = 0.96) (Mollica et al. 1996).

World Health Organization Quality of Life scale, brief version (WHOQOL-BREF)

The World Health Organization Quality of Life-BREF (WHOQOL Group, 1998) was developed as a cross-cultural instrument to measure subjective QOL and has been widely used in refugee studies (Huijts et al., 2012; Teodorescu et al., 2012b). The WHOQOL-BREF is a 26-item screen, derived from the original WHOQOL-100, divided into 4 domains: physical health, psychological health, social relationships, and environment. Likert scales range from 1 to 5 (not at all/very dissatisfied to completely/very satisfied). Domain scores produced by the WHOQOL-BREF have been shown to correlate highly (0.89 or above) with the WHOQOL-100 domain scores. The WHOQOL-BREF has been extensively used for sociodemographic research with a myriad of cultural groups (Van Der Hal-Van Raalte, Van IJzendoorn, & Bakermans-Kranenburg, 2008).

Data Analysis

Initial screening on HTQ-R and QOL scales for missing data, univariate outliers and normality, found there was no missing data, univariate outliers or normality violations according to the Kolmorgorov-Smirnov values when screening .05 level for all variables (Field, 2013). HTQ-R data was screened to identify missing cases and check for normality. To satisfy the first aim, two independent samples t-tests were conducted. The first assessed for significant differences between cultural groups on the HTQ-R's PTSD scores, the second assessed for difference on the total trauma scale of the HTQ-R (inclusive of DSM-IV PTSD

items). Following this, between-group differences on all HTQ-R symptoms were assessed. Mann-Whitney U tests were utilized here given the nominal scale of the HTQ-R.

In order to satisfy the second aim, Pearson correlations were conducted to assess for the relationship between PTSD scores and QOL within each group. To address the first hypothesis, Pearson correlations between PTSD case-ness and QOL were assessed. The second hypothesis was addressed using Pearson correlations between individual PTSD symptoms and QOL. Significant differences between group correlations were assessed for using Z scores at the one- and two-tailed levels.

Results

Participant demographics and trauma symptoms

Results from 40 participants were analyzed. Twenty Holocaust survivors (11 males, 9 females), aged between 82-93 years (m = 88 years), and twenty Sudanese refugees (9 males, 11, females) aged between 20-48 years (m = 34 years), participated. A false discovery rate (Benjamini, Krieger, & Yekutieli, 2006) was used in considering the number of analyses undertaken and a balance between type 1 and type 2 errors. Twenty percent of Sudanese participants (M = 1.90, SD = 0.65) and ten percent of Holocaust survivors (M = 1.73, SD = 0.47) were found to endorse case-ness for PTSD. T-tests revealed no significant difference between groups on PTSD scores $t(38) = -.777$, $p > 0.05$ or the total trauma score $t(38) = -.735$, $p > 0.05$. Individual symptoms were assessed for difference between groups. Results of individual Mann-Whitney U tests are outlined below in Table 1.

Table 1:

Mann-Whitney U tests for symptom endorsement showing means, mean ranks for each group & significance levels.

	Symptom	Mean	Holocaust mean rank	Sudanese mean rank	Mann-Whitney U	Significance
1	Recurrent thoughts/memories	2.50	20.40	20.60	138	.97
2	Reliving	1.95	19.90	21.10	188	.76
3	Nightmares	2.05	21.73	19.23	174.5	.50
4	Detached	1.63	17.38	23.65	137.5	.09
5	Emotional numbing	1.28	19.88	21.13	187.5	.74
6	Jumpy/easily startled	1.85	21.70	19.30	176	.53
7	Difficulty concentrating	1.93	18.25	22.75	155	.23
8	Trouble sleeping	2.08	21.73	19.28	175.5	.51
9	On guard	1.88	21.55	19.45	179	.58
10	Irritable	1.60	19.30	21.70	176	.53
11	Avoiding activities	1.75	16.98	24.03	129.5	.06
12	Unable to remember	1.38	20.65	20.35	197	.95
13	Less interest in activities	1.65	18.85	22.15	167	.38
14	Foreshortened future	1.63	21.00	20.00	190	.80
15	Avoiding thoughts	1.75	17.40	23.60	138	.09
16	Sudden emotional/ physiological reaction	2.28	17.58	23.45	141.5	.11
17	Less skills than before	1.63	22.50	18.50	160	.29
18	Difficulty with new situations	1.80	18.48	22.53	159.5	.28

19	Exhausted	1.95	22.70	18.30	156	.24
20	Body pain	1.88	24.80	16.20	114	.02*
21	Physical trouble	1.70	25.40	15.60	102	.01**
22	Poor memory	1.63	23.80	17.20	134	.08
23	Reminded by others	1.20	19.93	21.08	188.5	.79
24	Difficulty attending	1.68	17.93	23.08	148.5	.17
25	Split person	1.18	20.58	20.43	198.5	.97
26	Difficulty with daily plans	1.35	21.80	19.20	174	.50
27	Blaming self	1.65	16.28	24.73	115.5	.02*
28	Guilty	1.70	21.55	19.45	179	.58
29	Hopelessness	1.63	17.50	23.50	140	.11
30	Ashamed	1.30	17.70	23.30	144	.13
31	Others don't understand	2.03	19.70	21.30	184	.69
32	Others are hostile	1.35	18.00	23.00	150	.18
33	No one to rely on	1.20	19.50	21.50	180	.60
34	Feeling betrayed	1.48	17.50	23.50	140	.19
35	Humiliated	1.48	17.08	23.93	131.5	.06
36	No trust in others	1.58	18.10	22.90	152	.20
37	Powerless	1.90	13.95	27.05	69	.00**
38	Thinking why	2.05	18.83	22.18	166.5	.37
39	Only one to have suffered	1.10	18.50	22.50	160	.29
40	Need for revenge	1.35	20.50	20.50	200	1

Difference is significant ** $p < .01$ level (2-tailed), * $p < .05$.

Recurrent thoughts/memories, item 1, returned the most elevated mean. Results demonstrate Holocaust survivors to have scored significantly higher than Sudanese refugees on 'body pain' and 'physical troubles' and significantly less on 'blaming self', 'humiliated', and 'powerless'. No significant differences were found on PTSD symptoms between groups.

Pearson correlations

Holocaust survivors r = -.48, n = 20, p = .03 and Sudanese refugees r = -.46, n = 20, p = .04 produced similarly significant negative correlations between PTSD scores and QOL, evidenced by a Z score of 0.07, well below the critical values. Individual symptom correlations with QOL are outlined below in Table 2 as are Z scores comparing correlations.

Table 2

Pearson correlations for QOL and PTSD scores for each group and Z-scores for PTSD symptoms

	Symptom	Quality of Life Pearson's r. Holocaust survivors (*n = 20)*	Quality of Life Pearson's r. Sudanese refugees (*n = 20)*	Z scores
1	Recurrent Thoughts/memories	.40	-.37	2.37^^
2	Reliving	-.50	-.35	-.54
3	Nightmares	-.40	-.20	.64
4	Detached	-.30	-.61**	-1.16
5	Emotional numbing	-.23	-.38	-.32
6	Jumpy/easily startled	-.34	-.29	.16
7	Difficulty concentrating	-.48	-.45	.11

8	Trouble sleeping	-.26	-.28	-.06
9	On guard	-.20	-.16	.12
10	Irritable	-.13	-.48*	-1.14
11	Avoiding activities	-.22	-.10	.36
12	Unable to remember	-.15	-.39	-.76
13	Less interest in activities	-.50	-.67**	-.76
14	Foreshortened future	-.33	-.26	.22
15	Avoiding thoughts	-.29	-.12	.52
16	Sudden emotional/ physiological reaction	-.24	-.18	.18

* Correlation is significant $p < 0.05$ level (2-tailed), ** Correlation is significant $p < 0.01$ level (2-tailed), ^ Z score is significant $p < 0.05$ (2-tailed) and ^^ Z Score is significant $p < 0.01$ (2-tailed)

Holocaust survivor data produced statistically significant correlations between QOL and 'reliving', 'difficulty concentrating', and 'less interest in activities'. Sudanese refugee data produced statistically significant correlations between QOL and items 'detached', 'difficulty concentrating', 'irritable', 'less interest in activities'. Only 'difficulty concentrating' and 'less interest in activities' yielded statistically significant correlations with QOL in both groups.

Eight of 16 correlations were found to differ significantly in strength between groups beyond critical values. Only 'recurrent thoughts or memories' yielded a positive correlation with QOL for Holocaust survivors; the remainder of items yielded a negative correlation.

Discussion

PTSD scores and symptom endorsement were examined alongside QOL in an effort to contextualize PTSD within diverse cultural groups. The first aim was to consider differences and similarities in symptom endorsement and PTSD scores within two different cultural groups. No significant difference between Holocaust survivors and Sudanese refugees was found on PTSD scores. Similarly, no group endorsement of individual symptoms was found to significantly differ on the PTSD scale between groups. A second aim of this study was to explore the association between PTSD symptoms and QOL in the two groups. The first hypothesis was supported as both groups yielded a significant negative correlation between PTSD scores and QOL. The relationship found was almost identical. The second hypothesis was partially met, as all but one correlation between individual items on the HTQ-R and QOL returned a negative relationship. The overwhelming majority of markers used to assess for PTSD, were found to relate negatively to items measuring one's self-rated personal well-being or satisfaction with life.

These findings support research promoting the universal applicability of PTSD symptoms (Hinton & Lewis-Fernandez, 2011). The consistency with which negative relationships were produced in both groups supports not only the use of PTSD symptoms cross-culturally, but also the identification of PTSD as a marker of disorder post-trauma. Yet these results are surprising given previous literature highlighting the influence culture and context can have on PTSD (Hinton and Lewis-Fernandez, 2011; Jovanovic et al. 2012; Kaiser, Wachen, Potter, Moye, & Davison, 2017). Minimal differences found between groups may have been extended in larger samples. Typically, approaches to trauma outcome have expected dissipation in symptoms over time (Bonanno & Mancini, 2012) and so perhaps the prevalence of PTSD was higher amongst Holocaust survivors closer to World War II than for Sudanese refugees near the time of their traumatic exposure.

Alternatively, the difference found between groups in the correlation on item 1 can help in explaining persistent PTSD symptoms in Holocaust survivors. Previous research has outlined the salience of traumatic memory in PTSD and the inevitability of traumatic memory formation post-traumatic events (Dyregov, Gupta, Gjestad, & Raundalen, 2002; Mollica, 2006; Rasmussen, Smith, & Keller, 2007). In concert, item 1, recurrent memories of the trauma, was found to be most highly endorsed by both Holocaust survivors and Sudanese refugees, and most similarly ($t=0.97$). Yet a significant between-group difference was found in the direction of the relationship between item 1 and QOL. Item 1 was found to yield a positive relationship with QOL in the Holocaust survivor group, and a negative relationship in the Sudanese refugee group. Valent (1995) reflects on the difficulty of remembering by indicating that "with memories come the reliving of threats" (p. 86). Therefore Holocaust survivors may welcome memory of past trauma despite it being accompanied by persistent additional PTSD symptoms.

Differing results here demonstrate how context can play a role in the interpretation and association of symptoms. Intrusive memory in the past has been shown to vary in interpretation (Park, 2010; Salsman, Segerstrom, Brechting, Carlson, & Andrykowski, 2009). Altmaier (2013) suggested that intrusive or unobtrusive memory does not exist objectively, rather, one's response to memory imbues it with such qualities. The findings for item 1 indicate that the association of a symptom may, in turn, have an influence on sequelae, or at least the relationship that symptom has with one's QOL. Researchers have documented memory to be a mechanism through which Holocaust survivors teach the next generation (O'Rourke et al. 2015; Valent, 1995). Kidron (2012) explained that "the remembrance and re-enactment of the past are key tropes in Jewish culture… the individual perceived as the eternal witness, embodying memory" (p. 732). Holocaust survivor data in the current study demonstrated a positive association between recurrent memories of the past and QOL, aligning with previously documented purposeful traumatic memory. Conversely, a recent study by Savic, Cur-Hansen, Mahmood, & Moore (2016) found Sudanese in Australia to express looking forward as a key cultural quality. Sudanese refugees have previously reported coping with trauma to include not thinking about the memories of traumatic events (Goodman, 2004). Sudanese refugees in the current study demonstrated a negative association between recurrent memories of the past and QOL. When contextualized therefore, the similarly high endorsement of item 1 can have a different interpretation depending on cultural group norms, leading to a significantly variable relationship with QOL.

This results can also help explain previous confusion in categorizing distress in various cultural groups. Endorsement of PTSD symptoms does not mean the same thing in different contexts, and so it is possible for high PTSD endorsement to coincide with functionality (Jeppsson & Hjern, 2005; Tempany, 2009). Failure to explore the meaning of symptoms can lead to confusion and may lead to misdiagnosis. Contextualizing PTSD

symptoms is therefore critical to appropriate intervention. The task for clinicians and researchers is to explore not only symptom endorsement, but also the interpretation and influence of symptoms (Summerfield, 2012). Using screens and diagnostic instruments that have not been contextualized, without understanding the spectrum of symptom interpretation, can lead to the unnecessary medicalization of distress (Silove, Steele, & Bauman, 2007).

Time since trauma may have confounded results. Significantly higher Sudanese refugee endorsement of powerlessness, as well as discrepancies in the significance of traumatic memory may be due to differences in time since trauma. Powerlessness is likely to be maintained in the current sample of Sudanese refugees whose extended community are still confronting an ongoing conflict (Marlowe, 2012). Powerlessness has been previously documented in other refugee groups including Holocaust survivors (Baron 2002; Garwood, 1996; Shannon et al. 2015), though comparatively was much lower for Holocaust survivors in the current study. Moreover, Holocaust survivors were once not as open to speaking about and remembering the Holocaust (Valent, 1995). Time since trauma may have influenced the current study's relationship between Holocaust survivor traumatic memory and QOL. Pinpointing culture as a sole cause for difference is then difficult. However, this confound still supports promoting the need to contextualize PTSD symptoms. It may be that time since trauma and culture work in tandem to create difference, or that time since trauma impacts cultural construction of trauma response. Whilst more work is warranted examining the way that time since trauma can effect cultural evolution of the trauma response, the current study nevertheless endorses the influence context can have on PTSD symptom interpretation. The value of a study like this is the ability to adopt an integrative process of incorporating PTSD into local understandings. This study recognizes the value in the universal application of PTSD, whilst simultaneously emphasizing the need to incorporate PTSD symptoms in relative difference.

Conclusion

In the quest for a synthesis between PTSD and the cultural construction of trauma, the study reported here provides evidence for PTSD screening and assessment in various cultural groups. This is demonstrated by significant negative correlations between PTSD and QOL. However, assessment of PTSD cross-culturally needs to consider an extra dimension, that of symptom interpretation. In recognising the importance of interpretation, an implication is that caution must be adopted when utilizing screens and diagnostic instruments. As has been recommended in studies exploring the measurement of interpersonal violence (Dekeseredy and Schwarz, 1998; Lindhorst & Tajima, 2008), it is recommended that PTSD screens and diagnostic instruments consider the dimensions of an individual's situation, culture, and socially constructed meaning of a symptom in order to appropriately identify disorder. Clinicians and researchers need to delve beyond the endorsement of a PTSD symptom as existing independently of its interpretation (Silove, Steel, & Bauman, 2007).

References

Armour, M.A. (2010). Meaning making in survivorship: application to Holocaust survivors. *Journal of Human Behavior in the social environment, 20*(4), 440-468.

Altmaier, E. (2013). Through a glass-darkly: personal reflection on the role of meaning in response to trauma. *Counselling psychology quarterly, 26*(1), 106-113.

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders, 4th edition.* Washington DC: American Psychiatric Publishing.

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental disorders (5th ed).* Washington, DC: American Psychiatric Publishing.

Auxemery, Y. (2012). Posttraumatic stress disorder (PTSD) as a consequence of the interaction between an individual genetic susceptibility, a traumatogenic event and a social context. *Encephale*, *38*(5), 373-80.

Barak, Y., & Szor, H. (2000). Lifelong posttraumatic stress disorder: evidence from aging Holocaust survivors, *Dialogues Clinical Neuroscience, 2*(1), 57-62

Barel, E., Sag-Scwhartz, A., Van Ijzendoorn, M.H., & Barkeman-Kranenburgm M.J. (2010). Surviving the Holocaust: A meta-analysis of the long term sequelae of a genocide. *American Psychological Association, 136*(5), 677-698.

Beck, J.G., Grant, D.M., Clapp, J.D., & Palyo, S.A. (2009). Understanding the interpersonal impact of trauma: Contributions of PTSD and depression, *Journal of Anxiety disorders, 23*(4), 443-450.

Benjamini, Y., Krieger, A. & Yekutieli, D. (2006) Adaptive linear step-up procedures that control the false discovery rate. *Biometrika, 93*, 491-507.

Chhim, S. (2014). A place for Baksbat (Broken Courage) in Forensic Psychiatry at the extraordinary chambers in the courts of Cambodia (ECCC), *Psychiatry, Psychology and Law, 21*(2), 286-296.

De Jong, J.T.V.M., Kopmroe, I.H., & Van-Ommeren, M. (2001). Lifetime events and posttraumatic stress disorder in 4 post-conflict settings. *Journal of the American Medical Association, 286,* 555-562.

Dekeseredy, W.S., and Schwartz, M.D. (1998). Measuring the extent of woman abuse in intimate heterosexual relationships: a critique of the conflict tactics scale. *Applied research forum,* Retrieved from: http://stoprelationshipabuse.org/wp-content/uploads/2013/06/A-Critique-of-the-Conflict-Tactics-Scales.pdf

Dyregov, A., Gupta, L., Gjestad, R., & Raundalen, M. (2002). Is the culture always right? *Traumatology, 8,* 135-145.

Ehlers, A., & Clark, D. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy, 38,* 319-345.

Field, A. (20130). Discovering statistics using IBM SPSS statistics (fourth edition). Sussex: Sage Publishing.

Friedman, M.J., Keane,T.M., & Resick, P.A. (2007). *Handbook of PTSD: Science and Practice.* New York: Guilford Press.

Garwood, A. (1996). The Holocaust and the power of powerlessness: survivor guilt an unhealed wound. *British Journal of Psychotherapy, 13*(2), 243-258.

Goodman, J.H. (2004). Coping with trauma and hardship among unaccompanied refugee youths from Sudan. *Qualitative Health Research, 14*(9), 1177-1196.

Hinton, D.E., & Lewis-Fernandez, R. (2011). The cross-cultural validity of posttraumatic stress disorder: Implications for DSM-5. *The Journal of Depression and Anxiety, 28*(9), 783-801.

Hollifield, M., Warner, T.D., Lian, N., Krakow, B., Jenkins, J.H., Kesler, J., & Westermeyer, J. (2002). Measuring trauma and health status in refugees. *JAMA: the journal of the American Medical Association, 288*(5), 611-621.

Huijts, I., Kleijn, W.C., van Emmerik, A.A., Noordhof, A., & Smith, A.J. (2012). Dealing with man-made trauma: the relationship between coping style, posttraumatic stress, and quality of life in resettled, traumatized refugees in the Netherlands. *Journal of Traumatic Stress, 25*(1), 71-78.

Jeppsson, O., & Hjern, A. (2005). Traumatic stress in context: A study of un-accompanied minors from Southern Sudan. In D. Ingleby (Ed.), *Forced migration and mental health: Rethinking the care of refugees and displaced persons* (pp. 67–80). New York: Springer.

Jovanovic, T., Sakoman, A.J., Kozarić-Kovačić, D., Havelka Meštrović, A., Duncan, E.J., Davis, M., & Norrholm, S.D. (2012). Acute stress disorder versus chronic posttraumatic stress disorder: inhibition of fear as a function of time since trauma, *Depression and Anxiety*, *30*(3), 217-224.

Kaiser A. P. Wachen J. S. Potter C. Moye J. , & Davison E . (2017). Posttraumatic stress symptoms among older adults: A review. Retrieved from http://www.ptsd.va.gov/professional/treatment/older/ptsd_symptoms_older_adults.asp

Kienzier, H. (2008). Debating war-trauma and post-traumatic stress disorder (PTSD) in an interdisciplinary area. *Social Sciences & Medicine, 67*(2), 218-227.

Kira, I., & Tummala-Narra, P. (2014). Psychotherapy with Refugees: Emerging Paradigm. *Journal of Loss and Trauma: International Perspectives on Stress & Coping*, *19*, 1-19.

Kidron, C.A. (2012). Alterity and the particular limits of universalism: comparing Jewish-Israeli holocaust and Canadian-Cambodian genocide legacies. *Current anthropology, 53*(6), 723-754

Kirmayer, L.J., Kienzier, H., Afana, A.H., & Pedersen, D. (2010). Trauma and disasters in social and cultural context. In C. Morgan & D. Bhugra (Eds.), *Principles of social psychiatry, second edition (PP.155-177).* Chichester: John Wiley & Sons.

Kleinman, A. (1987). Anthropology and psychiatry: The role of culture in cross-cultural research on illness. *British Journal of Psychiatry*, *151*, 447–454.

Lasiuk, G.C. & Hegadoren, K.M. (2006). Posttraumatic stress disorder Part III: Health effects of interpersonal violence amoung women. *Perspectives in Psychiactric Care,* Aug;42(3):163-73.

Lindhorst, T., & Tajima, E. (2008). Reconceptualizing and operationalizing context in survey research on intimate partner violence. *Journal of Interpersonal Violence, 23*(3), 362-388.

Marlowe, J., Harris, A., & Lyons, T. (2012). *South Sudanese Diaspora in Australia and New Zealand: Reconciling the past with the present.* Newcastle: Cambridge Scholars Publishing

Marsella, A.J., Freidman, M.J., Gerrity, E.T., and Scurfield, R.M. (1996). *Ethnoculturaql aspects of posttraumatic stress disorder*. Washington DC: American Psychological Association.

Marsella, A.J. (2010). Ethnocultural aspects of PTSD: An overview of concepts, issues, and treatments. *Traumatology, 16*(4), 17-26.

Michalopoulos, L.M., Unick, G.J., Haroz, E.E., Bass, J., Murray, L.K., & Bolton, P.A. (2015). Exploring the fit of western PTSD models across three non-western low- and middle-income countries. *Traumatology, 21*(2), 55-63.

Meffert, S.M., Musalob, K., Abdoc, A.O., Ahmed Abd Allac, O., Elmakkic, Y., Omerc, A., Yousifc, S., Metzlera, T.J., & Marmard, C.R. (2010). Feelings of betrayal by the United Nations High Commissioner for Refugees and emotionally distressed Sudanese refugees in Cairo. *Medicine, Conflict and Survival, 26*(2), 160-172.

Mollica, R., Caspi-Yavin, Y., Bollini, P., Truong, T., Tor, S., & Lavelle, J. (1992). The Harvard Trauma Questionnaire: Validating a Cross-Cultural Instrument for Measuring

Torture, Trauma, and Posttraumatic Stress Disorder in Indochinese Refugees, *The Journal of Nervous and Mental Disease, 180*(2), 111-116.

Mollica, R.F., Caspi-Yavin, Y., Lavelle, J., Tor, S., Yang, T., Chan, S., Pham, T., Ryan, A., Marneffe, D. (1996). The Harvard Trauma (HTQ) Manual: Cambodian, Laotian, and Vietnamese versions. *Torture. 1*, 19-42.

Mollica, R.F. (2006). *Healing invisible wounds: Paths to hope and recovery in a violent world.* Orlando, FL: Harcourt.

Nicolas, G., Wheatley, A., & Guillaume, C. (2015). Does one trauma fit all? Exploring the relevance of PTSD across cultures. *International Journal of Culture and Mental Health, 8*(1), 34-45.

Nickerson, A., Bryant, R.A., Silove, D., & Steel, Z. (2011). A critical review of psychological treatments of post traumatic stress disorder in refugees. *Clinical Psychology Review, 31,* 399-417.

O'Donnell, M.L., Creamer, M., & Pattison, P. (2004). Posttraumatic stress disorder and depression following trauma: understanding comorbidity. *American Journal of Psychiatry, 161*(8), 1390-1396. doi: 10.1176/appi.ajp.161.8.1390.

Office of the UN special adviser on the prevention of Genocide (OSAPG). Retrieved from: http://www.un.org/en/preventgenocide/adviser/pdf/osapg_analysis_framework.pdf

O'Rourke, N., Canham, S., Wertman, A., Chaudhury, H., Carmel, S., Bachner, Y.G., & Peres, H. (2015). Holocaust survivors' memories of past trauma and the function of reminiscence. *The gerontologist, 00*(00), 1-10.

Paardekooper, B., de Jong, J. T., & Hermanns, J. M. A. (1999). The psychological impact of war and the refugee situation on South Sudanese children in refugee camps in Northern Uganda: An exploratory study. *Journal of Child Psychology & Psychiatry*, *40*(4), 529–536.

Park, C. L. (2010). Making sense of the meaning literature: An integrative review of meaning making and its effects on adjustment to stressful life events. Psychological Bulletin, 136, 257–301.

Pendle, N. (2014). Interrupting the balance: reconsidering the complexities of conflict in South Sudan. *Disasters, 38*(2): 227−248.

Rasmussen, A, Smith, H, & Keller, A.S. (2007). Factor structure of PTSD symptoms among West and Central Africans refugees. *Journal of Traumatic Stress, 20*(3), 271-280.

Salsman, J.M., Segerstrom, S.C., Brechting, E.H., Carlson, C.R., & Andrkowski, M.A. (2009). Posttraumatic growth and PTSD symptomatology among colorectal cancer survivors: a 3-month longitudinal examination of cognitive processing. *Psychooncology, 18*(1), 30-41.

Sadavoy J. (1997). Survivors. A review of the late-life effects of prior psychological trauma. *Am J Geriatr Psychiatry, 5*, 287–301.

Shannon, P.J.,Wieling, E., McCleary, J.S., & Becher, E. (2015). Exploring the mental health effects of political trauma with newly arrived refugees. *Qualitative Health Research, 25*(4), 493-257.

Silove, D. (1999). The psychosocial effects of torture, mass human rights violations, and refugee trauma: Toward an integrated conceptual framework. *Journal of Nervous and Mental Disease, 187*(4), 200-207.

Silove, D., Steel, Z., & Bauman, A. (2007). Mass psychological trauma and PTSD: Epidemic or cultural illusion? Chapter 13 in Wilson & Tang, C.S. (Eds). *Cross-cultural assessment of psychological trauma and PTSD*. Springer: New York.

Silove, D. (2013). The ADAPT model: a conceptual framework for mental health and psychosocial programming in post conflict settings, *Intervention, 11*(3), 237-248.

Slobodin, O., Caspi, Y., & Klein, E. (2014). Trauma amid 'culture of avoidance': symptom profile of PTSD in Bedouin members of the Israel Defense Forces. *International Journal of Culture and Mental Health*, *7*(1), 1-10.

Steel, Z., Steel, C.B., & Silove, D. (2009). Human rights and the trauma model: genuine partners or uneasy allies? *Journal of Traumatic Stress, 22*(5), 358-365.

Summerfield, D. (2001). The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category. *BMJ, 322*(7278), 95-98.

Summerfield, D. (2012). Afterword: Against "global mental health". *Transcultural psychiatry, 49*(3-4), 519-530.

Teodorescu, D.S., Heir, T., Hauff, E., Wentzel-Larsen, T., & Lien, L. (2012). Mental health problems and post-migration stress among multi-traumatized refugees attending outpatient clinics upon resettlement to Norway. *Scandinavian Journal of Psychology, 53*(4), 316-332.

Tempany, M. (2009). What research tells us about the mental health and psychosocial wellbeing of Sudanese refugees: a literature review, *Transcultural psychiatry, 46*(2), 300-315.

Van Der Hal-Van Raalte, EA.M., Van IJzendoorn, M.H , & Bakermans-Kranenburg, M.J. (2008). Sense of coherence moderates late effects of early childhood Holocaust exposure. *Journal of Clinical Psychology, 64*(12), 1352-1367.

Van Rooyen, K., & Ngweni, Z.C. (2012). Culture and post-traumatic stress disorder (PTSD): A proposed conceptural framework. *South African Journal of Psychology, 42*(1), 51-60.

Valent, P. (1995). Documented childhood trauma (Holocaust): Its sequelae and application to other traumas. *Psychiatry, Psychology, and Law, 2*(1), 81-89.

Vermetten, E., & Olff, M. (2013). Psychotraumatology in the Netherlands [proceedings paper]. *European Journal of Psychotraumatology, 4*. doi: 10.3402/ejpt.v4i0.20832

WHOQOL Group (1998). Development of the World Health Organization WHOQOL-BREF quality of life assessment. *Psychol Med, 28*(3), 551-8.

World Health Organization. (1996). *WHOQOL-BREF Introduction, administration, scoring and generic version of the assessment, field trial version.* Geneva: Programme of Mental Health.

Yehuda R., Kahana B., Schmeidler J., Southwick S.M., Wilson S., & Giller E.L (1995). Impact of cumulative lifetime trauma and recent stress on current posttraumatic stress disorder symptoms in Holocaust survivors. *Am J Psychiatry, 152*, 1815–1818.

Young, A. (1995). *The harmony of illusions: inventing post-traumatic stress disorder.* New Jersey: Princeton University Press.

Chapter 6:

Finding meaning in the wake of trauma: a cross-cultural comparison

Preamble to Empirical Paper

The following chapter presents the final empirical study of the thesis. The aim of this mixed-methods paper was to compare the similarities and differences in the way that two distinct groups conceptualise and relate to MIL following a traumatic event. Having considered trauma from both culturally relative and universal perspectives, the third study was well poised to shift the focus of this thesis to trauma recovery. Previous research has long considered recreating MIL to aid in trauma recovery. Little work has contrasted cultural conceptualisations of MIL and examined the applicability of the American and European conception of MIL to diverse cultural groups following traumatic events. The current study contributes to the literature by contrasting Holocaust survivors and Sudanese refugees in the way that they conceptualise MIL, and in the way operationalised MIL constructs including a sense of coherence, the search for meaning, and the presence of meaning, relate to QOL. Using a mixed methods approach, the current study considers both a universal and relativist approach to the examination MIL. Similarities found relating to a purpose in life as well as the struggle to comprehend traumatic events provide considerations for working with MIL following traumatic events within diverse cultural contexts. Implications and directions for clinicians working with refugees and traumatized people are offered.

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Finding meaning in the wake of trauma: a cross-cultural comparison

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Abstract

Objective: MIL has been defined as including both a purpose in life and the extent to which individuals comprehend their lives. The aim of this study was to compare and contrast the way that various cultural groups compare in MIL conceptualization.

Method: A mixed methods approach was undertaken in order to compare Holocaust survivors and Sudanese refugees; both groups previously experiencing interpersonal trauma, war and conflict. Twenty-five participants (12 Sudanese refugees, 13 Holocaust survivors) completed semi-structured interviews, whereas 40 participants (20 Sudanese refugees, 20 Holocaust survivors) were compared on the Meaning in Life Questionnaire, the Orientation to Life Scale, and the World Health Organization Quality of Life Scale, brief version. Holocaust survivors were aged between 82-93 years and Sudanese refugees aged between 20-48 years.

Results: The extent to which groups searched for meaning, and content of purpose in life, differed between groups. Pearson correlations revealed only Sudanese refugees to yield a significant positive correlation between the presence of meaning and quality of life ($p = .049$). Similarities between groups were also found in that both groups reported a purpose pertaining to future generations and ending conflict, as well as an undermining of former beliefs due to war and conflict. Both groups similarly yielded no correlation between a sense of coherence and quality of life.

Conclusion: Findings provide important considerations for trauma recovery work with refugees and diverse cultural groups globally.

Kew words: Purpose, Existential meaning, Holocaust, Sudanese, Culture

Frankl (1985), expressed man's search for meaning to be the "primary motivational force in man" (p. 34). He wrote on the challenge of finding meaning in the face of experiences shattering values and beliefs. Recreating MIL has long been considered a primary way in which individuals recover from trauma (Altmaier, 2013; Silove 2013). In European and American settings MIL is divided into comprehension and purpose (King, Hicks, Krull, & Del Gaiso, 2006), as well as the search for and presence of meaning (Steger, Oishi, & Kashdan, 2009). Whilst MIL has been explored cross-culturally, there is a lack of clarity around whether European and American conceptualizations of MIL apply to various cultural groups (O'Donnell et al. 2014; Park, 2016; Shlegel & Hicks, 2016). Culture, defined as a framework through which individuals construct their realities, meanings, and identities (Nicolas, Wheatley, & Guillaume, 2015), shapes peoples' beliefs and understandings about one's life and the world; it is in some ways the "ultimate system of meaning" (Shlegel & Hicks, p. 5). Progress in aiding recovery from trauma globally requires exploration of the way that MIL may differ between diverse cultural groups.

Traumatic events have been described as destroying the way one comprehends the surrounding world. Shattered Assumption Theory (Janoff-Bulman, 1992), explains the destructive nature of trauma on an individual's belief system or assumptive world as meaningful. The theory's fundamental assertion is that traumatic events shatter people's assumptions in a benevolent world and a world in which they themselves have worth as meaningful beings. Shattered assumptions theory considers trauma symptoms to emerge when traumatic events cannot be readily harmonized with one's previously held worldviews. Similarly, Park (2010), in her model of meaning-making asserts that people develop trauma symptoms if they are unable to make meaning following traumatic events. According to Park, individuals adjust to trauma by harmonizing preconceived notions about the world and appraisals of stressors.

Whilst previous research exploring MIL has found that the presence of meaning and quality of life (QOL) are consistently positively related (Linley & Joseph, 2011; Russell, White, & Parker, 2006; Steger, Frazier, Oishi, & Kaler, 2006; Steger, Kawabata, Shimai, & Otake, 2008), the search for meaning and a sense of coherence has produced inconsistent relationships with QOL (Martela & Steger, 2016). QOL is defined as including physical, mental, and social wellbeing, as well as happiness and satisfaction with life (Fayers & Machin, 2000; WHO, 1996), The search for meaning has yielded negative correlations with QOL (Steger, Kashdan, Sullivan, & Lorentz, 2008), positively moderated the relationship between presence of meaning and QOL (Steger, Oishi, & Kesebir, 2011), and produced zero to minimal correlations with QOL in those who feel life to be highly meaningful (Steger, Kawabata, Shimai, & Otake, 2008). A sense of coherence, outlined by Antonovsky (1979) as a process by which people maintain health and well-being and avoid distress, has also yielded inconsistent relationships with QOL in the past. One's sense of coherence is defined as an enduring tendency to see life experiences as rational and predictable, to have one's personal resources available to meet demands, and to make sense of challenges arising from adversity (Antonovsky; Braun-Lewensohn, Sagy, & Roth, 2010). Whilst a sense of coherence has often positively correlated with QOL (Eriksson & Lindstrom, 2005; Martela, & Steger, 2016; Winger, Adams, & Mosher, 2016), at other times a sense of coherence and QOL were found to be unrelated (Sagy & Braun-Lewensohn, 2009; Zeidner & Aharoni-david, 2015).

One explanation for inconsistency is in variable interpretation of MIL, and difficulty reflecting the complexity of MIL constructs in operationalized assessment. Park (2016) explained results of MIL studies to largely reflect differences in definitions and interpretations of MIL. The search for meaning, for example, has been interpreted in a variety of ways. Some have described the search for meaning as a warning sign for unresolved cognitive processing relating to distress (Bonnano, et al. 2005; Helgeson, Reynolds, &

Tomich, 2006), and others as vital to the development of positive change (Frankl, 1967; Linley, & Joseph, 2011). Similarly, a sense of coherence has been questioned for its inclusion of 'predictability' in its definition, Flensborg-Madsen, Ventegodt, and Merrick (2005, p. 770) arguing that "unpredictability is a generic feature that is definitive of the human condition". Moreover, traumatic events shatter one's assumptions about the world. To maintain a sense of coherence in the wake of trauma is ostensibly, by definition, indicating that a trauma has not occurred. Difference in interpretation of MIL leaves quantitative measures used variable, depending on how the respondent interprets MIL subjectively (Steger, Frazier, Oishi, & Kaler, 2006). The abstract and profound nature of meaning and meaning-making renders theoretical models very difficult therefore to test objectively (Davis, Wortman, Lehman, & Silver, 2000), and therefore likely leads to inconsistency in relationships found with QOL.

Variation in the interpretation and definition of MIL is even more of a concern when considering the experience of trauma and recovery from a cross-cultural perspective. Cultural mechanisms such as stories, rituals, and theory of mind vary cross-culturally (Hinton & Lewis-Fernandez, 2011; Lillard, 1998; Marsella, 1988), thereby influencing the lens through which individuals understand their world. Silove (2013) described existential meaning to be one of five culturally non-specific concerns following traumatic events. Though whilst a range of studies have found MIL to be reported in diverse cultural samples (Feder et al. 2013Pan, 2011; Jafary, Farahbakhsh, Shafiabadi, & Delavar, 2011; Lamis, Wilson, Tarantino, Lansford, & Kaslow, 2014; Porter & Haslam, 2005), there is a lack of clarity in the way that MIL differs cross-culturally (O'Donnell et al. 2014; Park, 2016; Shlegel & Hicks, 2016;). Qualitative studies have found the content of meaning in life to vary between cultural groups. Past research has documented MIL to be comprised of hope in African students (Nell, 2014), one's relationship with God and spirituality in Sudanese and South Africans (Coetzee, Wissing, & Temane, 2010; Goodman, 2004), fun/hobbies (*tanoshimi*) in

Japanese surviving an earthquake (Kono, & Shinew, 2015), education in Sudanese (Tipping, Bretherton, & Kaplan, 2007) and family in Jews surviving the Holocaust (Armour, 2010). In order to effectively recreate MIL following traumatic events globally, there needs to be a clearer understanding of the way that groups both differ and are alike in their quest for meaning.

Steger, Kawabata, Shimai, & Otake (2008) identified that there has been little systematic investigation of cross-cultural differences and similarities in meaning in life. The current study aims therefore to address this gap in the literature, by exploring the conceptualization of MIL following traumatic events from a cross-cultural perspective. Holocaust survivors were compared with Sudanese refugees using mixed methods. The aim was to compare similarities and differences in the way that two different cultural groups conceive of meaning, comprehension, and purpose following a traumatic event. A second aim was to examine the way that operationalized MIL constructs relate to QOL in these groups. It was hypothesized that a sense of coherence and the presence of meaning would be correlated positively with QOL in both groups, whereas the search for meaning would be correlated negatively with QOL in both groups.

Method

Participants and procedure

Holocaust survivors living in Melbourne, Australia, were recruited for the study having undergone a traumatic event 70 years prior. Sudanese participants were recruited for the study having endured conflict in their country of origin spanning over 20 years. The Director of Community Relations at the Melbourne Jewish Holocaust Centre recruited Holocaust survivors for the current study. The Refugee support worker at 'Stand-Up Australia' recruited Sudanese refugees for the current study. Participants for both groups

were recruited depending on their ability to speak fluent English, using a convenience sampling approach. Samples therefore are non-representative of entire populations. Ethics permission for the study was obtained from the University Human Research Ethics Committee. Informed consent was obtained from all participants after reading a plain English statement outlining the purpose, aims, and procedure of the study. Participants were asked to relay back the nature of the study; all were able to do so. All participants approached for the study participated in the study. Semi-structured interviews were conducted followed by the completion of questionnaires. Holocaust survivors and Sudanese refugees were interviewed either at their respective not-for-profit organizations or at their homes, depending on preference by the primary researcher who had training by supervisors and extensive training in clinical interviewing and risk management as part of the Clinical Doctorate Program. No participants reported feeling confronted or at risk following a phone call placed by the primary research to debrief the following day.

Measures

Semi-structured Interview

Interview questions were created by first 'bracketing' (Giorgi, 2009) the researchers preconceived notions of MIL, creating a list of presuppositions, integral to a phenomenological approach. The semi-structured interview, was conducted as part of a larger interview. Three categorical questions, each with a subsidiary follow-up open-ended question, were asked regarding the interviewee's conception of meaning, purpose, and understanding of the surrounding world. All interviews were conducted by the first author and lasted approximately 40 minutes. The full interview consisted of the following questions, questions 4, 5, and 6, pertinent to the current study:

1. Can you tell me about your experiences before arriving in Australia?

2. Do these experiences effect you? How?
3. Can you recover from these experiences? How?
4. Do you have meaning in life? Can you explain this to me?
5. Do you have a purpose? Can you explain this to me?
6. Do you understand the world around you? Can you explain this to me?

Meaning in Life Questionnaire (MLQ)

The MLQ is a 10-item questionnaire that measures meaning in life (Steger, Frazier, Oishi, & Kaler, 2006). The questionnaire consists of two subscales, presence of meaning (how much respondents feel their lives have meaning) and the search for meaning (how much respondents strive to find meaning). Each subscale consists of 5 items rated out of 7, depending on how much the respondent agrees with each statement, ranging from '1 - absolutely untrue' to '7 - absolutely true'. Each scale has been found to have internal consistency co-efficients above $a > 0.80$ (Steger & Shin, 2010). The MLQ has been validated in a other cultural groups including South African and Turkish samples (Boyraz, Lightsey, & Can, 2013; Temane, Khumalo, & Wissing, 2014). Test-retest stability coefficients have been found to be good (0.70), and the MLQ has demonstrated convergent validity between informants as well as convergent validity with the Life Regard Index and Purpose in Life questionnaire (Steger, Kawabata, Shimai, & Otake, 2008).

Orientation to Life Questionnaire (OLQ), 13-item

The OLQ (Antonovsky, 1987) was developed to assess ones sense of coherence. The 13-item version was adapted from the original 29-item screen, and has since been supported in previous work (Feldt et al. 2007; Lindstrom & Eriksson, 2005). This screen using a 7 point Likert scale and asks participants to rate how much they agree with each statement. The higher one's score on the screen, the higher their sense of coherence. The OLQ consists of three subscales, comprehensibility, manageability, and meaningfulness, each scale comprised

of 4-5 items. The 13-item version has been shown to have better fit statistics with the factor structure than the original 29-item version (Schalkwyk & Rothman, 2008). The OLQ has shown good internal consistency with a Cronbach's alpha ranging from .70 to .92, and has been regarded as applicable across cultures (Lindstrom & Eriksson, 2005; Moksnes, Espnes, & Haugan, 2013; Sardu, Mereu, Sotgiu, Andrissi, Jacobson, & Contu, 2012).

World Health Organization Quality of Life scale, brief version (WHOQOL-BREF)

The World Health Organization Quality of Life-BREF was developed as a cross-cultural instrument to measure subjective QOL (WHOQOL Group, 1998). The WHOQOL-BREF is a 26-item screen, derived from the original WHOQOL-100, divided into 4 domains: physical health, psychological health, social relationships, and environment. Likert scales range from 1 to 5 (e.g., not at all/very dissatisfied to completely/very satisfied). Domain scores produced by the WHOQOL-BREF have been shown to correlate highly (0.89 or above) with the WHOQOL-100 domain scores. The WHOQOL-BREF has been extensively used for sociodemographic research among various cultural groups (Phungrassami, Katikarn, Watanaarepornchai, & Sangtawan, 2004; Sreedevi, Cherkil, Kuttikattu, Kamalamma, & Oldenburg, 2016). This screen has been widely used in refugee studies (Huijts et al., 2012; Teodorescu et al., 2012).

Data Analysis

Interviews were audio-recorded, and recordings were transcribed verbatim. Data was analysed manually using interpretative phenomenological analysis (IPA), as detailed by Smith, Flowers, and Larkin (2009), and Braun and Clarke (2013). IPA was chosen given the current examination of participants' lived experience of MIL, the abstract nature of MIL, and a desire to draw comparisons between the experiences of different groups (Braun & Clark, 2013). A research journal of presuppositions was maintained throughout the project in order

to enhance a reflective approach and to help remain cognisant of the phenomenological attitude. Critical realism (Braun & Clark) underpinned data whereby the participants' own accounts were taken as reality, but considered in terms of pertinent historical, political and cultural contexts (Opperman, Braun, Clarke & Rogers, 2013). First, familiarization with the dataset was accomplished through reading the data as a whole. Second, initial coding was undertaken, demarcating each meaning unit and coding each unit at the descriptive level first, and then at a conceptual level for each individual transcript. Fourth, emergent themes were considered for each transcript. Fifth, subordinate themes were developed based on relationships between transcript themes. Each of these stages were mirrored for every transcript. Finally, themes were reviewed across transcripts, examining similarities and differences at an individual, within-group level, and between-group level. Subordinate theme titles were adjusted to reflect commonalities and differences within and across groups.

Qualitative analysis was undertaken first to prevent quantitative findings influencing qualitative analysis. Following qualitative analysis, quantitative data was imported into an SPSS database (IBM SPSS statistics version 21). T-tests were conducted between groups on measures of 'presence', 'search', sense of coherence, and QOL. Following this, Pearson Correlations were conducted exploring the relationships between 'presence', 'search', sense of coherence and QOL and Z scores were assessed for group differences in correlations.

Results

Qualitative analysis

Qualitative data was drawn from semi-structured interviews with 13 Holocaust survivors (7 male, 6 female, 82-93 years) and 12 Sudanese refugees (7 male, 5 female, 20-48 years). For participant demographics, see Table 1 below. Each participant was allocated a pseudonym. Salient themes emerging from the data were *meaning and purpose in the future*

generations, purpose in memory versus purpose going forwards, limited understanding of conflict.

Table 1

Demographics for participants in qualitative study

Characteristics	Sudanese refugees (n=13) *n(%) / M(SD)*	Holocaust survivors (n=13) *n(%) / M(SD)*
Demographics		
Male gender	7 (58.33%)	7 (53.84%)
DOB	13.08.1982	30.07.1927
Participant age	32.56 (10.22)	87.23 (3.44)
Years resettled in Australia	9.91 (4.44)	62.76 (6.12)

Meaning and purpose in the future generations

Many Holocaust survivors responded to the question of meaning by referring to family. Rivka reported that "there is nothing more important than your family, your husband, your children, your cousins". Similarly, Ruth expressed "if my life has meaning? Yes because I tell you what, I have a nice family, I have children, I have grandchildren, and I have great grandchildren". Rivka identified when asked about her purpose, "I want to marry off my great grandchildren" and "My granddaughter is expecting and I want to be here for her new child". Ruth when asked about her purpose, responded "to see the family through". The sentiment was mirrored in Talia's response. She claimed her life to be "very meaningful, more than 60 descendants, more than 100 throughout the world". Later, when asked whether she had a purpose in life, Talia responded "Yes because we have now 60 descendants".

For Sudanese refugees, the content of responses to meaning and purpose also emphasized future generations. Alimah, when asked about meaning reported "of course, because I have kids", Alimah indicated purpose to be in creating a better future, specifically for her children, "my purpose in my life, I want to help my kids to get a better life". Shaker similarly explained that he wants to create a better life for his family, "well I do [have meaning]….I have my own children, have my world around me in a peaceful manner, rather than to see the world in a similar way to experience it as I have as a young boy". He continued, "I also extend this purpose to the rest of my family". Both Alimah and Shaker highlighted the importance of transgenerational recovery, embedding a sense of history in the recovery process undertaken and carried out by their children.

Purpose in memory versus purpose looking forward

A difference between groups was found in Holocaust survivors referring to purpose in terms of remembrance. Jacob discussed,

> We passed it on from one to another, remember, if you make it, tell the world. Take revenge on the dungeons in Auschwitz. This was our testament to the people that passed away. They'll never forget us, tell the world… Tell the world what happened behind the iron gates, behind the barbed wire.

Braham also explained his purpose in terms of remembering stating, memory "gives me a purpose in this respect. For instance, why I am talking? Because I felt that, that way I keep the memory of my family and of the 6 million Jews put together". He continued,

> Pass it [the memory] on to the young generations and try to convince them that they have to protect our country. I'm not talking only now as a Jew, I'm talking now as an Australian citizen. They have to protect our country that no hatred should be propagated between our people and they should protect themselves and others and not

> to be bystanders. To protect anybody to come who tries to convince you to use the disease of hatred, to hate other people whether it is their religion, their nationality, looks, whatever.

Here Braham identified purpose in memory honouring the deceased, and also purpose in memory for the way that it can contribute to a better world. Braham identified his purpose in using the memory to teach future generations. In this way, purpose in the future generations and purpose in memory coincide, aiming to prevent the traumatic event from reoccurring.

Instead of memory, Sudanese referred to purpose as looking forward. Abdalla, who expressed purpose to be in creating a future in Australia, responded, "In Australia I just started a whole new life. I threw out everything behind". Nanomi explained "yeh the purpose is here in Australia, you know oversee the future". Similarly, Shaker expressed his purpose in creating a better future than the world he experienced as a child,

> Keep moving on in doing something and even while I'm here in Australia, I still have been involved in what I believe is the cause for justice and freedom for my homeland which is currently South Sudan…. I have lost my childhood into a freedom fighter movement where you know being a soldier. So I know you keep standing up for things that I believe or important matters.

Whilst there was a difference between groups in the means, memory versus looking forward, both groups explained their purpose to relate to creating a better future void of the traumatic events they experienced, aiming to preventing future war and conflict. Noah, a Holocaust survivor, when asked about his purpose explained how uses the past to create a better future,

> There's another thing the Holocaust taught me about. How hatred can destroy people, it destroys nations… So before you asked me the meaning of life. Just trying to teach

> people brotherhood, understanding, tolerance. That the eyes, or the skin, or the hair doesn't determine who you are.

Similarly, Nanomi also expressed his desire to prevent future conflict,

> Second purpose, I help from all the organisations around the world to stop the people in the war, stop the rape and then the fighting… we need to stop the fighting and then leave the people to their own country, that's it. No more.

Kariem also explained "a purpose in life, I feel important to my understanding ah everyone have to live peacefully… sharing life with others".

Limited understanding of conflict

When asked whether they understand the world around them, participants from both groups responded similarly. Both Holocaust survivors and Sudanese refugees reported difficulty understanding mass conflict due to the way in which it could not easily be explained by God and religion. Talia, a Holocaust survivor commented, "No, it's very hard for me to understand… I feel anger because I don't think we deserved it and if there is a God, then just to constant pick on us?". Rachel responded to the question of understanding by referring to her son who asked his teacher a question,

> My son Bernie asked, tell me why if there was a God, why did he allow innocent children to be killed? He was 8 years old. That teacher was stunned… and two days later when I took him back he gave him the answer. And the answer was because the Jews went away from religion. Oh well, that was not an answer.

Rachel here identified that the teacher's response was not satisfactory to explain the traumatic event. Belief in God was undermined by the killing of innocent children during the Holocaust. As a result, she posited, "a lot of them went away from religion".

Similarly, Sudanese refugees expressed limited understanding of mass conflict for the way that it is unecplained by God or relgion. Nanomi asserted, "We need to stop fighting… I don't understand this, yea we have Allah… but the way the world works is not in Qur'an". By this, Nanomi expressed that the Qur'an, the central religious text of Islam, does not help him understand conflict and so belief in Allah is not enough to help him understand the traumatic events endured. Suleyman explained,

> The world's evil without knowing really true God and religion… Sudan and Syria you know people are killing themselves, brothers, so this is kind of to me beyond evil. This is beyond evil. You can't kill your own brothers, so this I don't know.

Here, Suleyman expressed also to have a limited understanding of conflict. He suggested that evil is explained by religion, though that the conflict in Sudan is beyond the scope of evil explained by religion. Therefore, the conflict in Sudan, for Suleyman, is beyond understanding.

Quantitative Analysis

Quantitative analysis was conducted in order to further inform the qualitative data. Demographics for the participants undertaking questionnaires are listed in Table 2 below. Descriptive statistics were then identified, presented in Table 3 below. Differences and similarities between cultural groups were explored using t-tests to examine the groups on a sense of coherence, the presence of meaning, the search for meaning, and QOL. Following this, Pearson correlations assessed for the relationship between each of the former three variables and QOL in each group.

Table 2

Demographics for participants in quantitative study

Characteristics	Sudanese refugees (n=20) *n(%) / M(SD)*	Holocaust survivors (n=20) *n(%) / M(SD)*
Demographics		
Male gender	9 (45%)	11 (55%)
DOB	26.11.1982	24.03.1927
Participant age	32.25 (9.07)	87.51 (3.37)
Years resettled in Australia	10.25 (4.35)	62.54 (5.8)
Tribal affiliation/ Country		
Dinka	6 (30%)	
Nuer	4 (20%)	
Nubian	7 (35%)	
Fur	2 (10%)	
Zaghawa	1 (5%)	
Poland		10 (50%)
Germany		4 (20%)
Austria		2 (10%)
France		2 (10%)
Netherlands		2 (10%)

Table 3:

Mean and standard deviation for sense of coherence, search for meaning, presence of meaning, quality of life in Holocaust survivors and Sudanese refugees.

	Sense of coherence		Search for meaning		Presence of meaning		Quality of life	
	M	SD	M	SD	M	SD	M	SD
Holocaust	91.33	14.12	21.30	7.10	24.70	3.86	55.35	6.42
Sudanese	96.35	9.68	27.65	6.90	25.00	3.64	53.40	4.04

T-tests

Four independent sample t-tests were conducted between groups to assess group differences on sense of coherence, the search for meaning, the presence of meaning, and QOL. Equal variance was assumed for all tests. T-tests revealed no significant differences between groups on QOL $t(38) = 1.31$, $p = .20$, sense of coherence $t(38) = 1.15$, $p = .26$, and presence of meaning $t(38) = -.30$, $p = .77$. The search for meaning, however, was significantly higher in Sudanese refugees $t(38) = -2.88$, $p < .01$.

Pearson Correlations for Sense of Coherence, Search for Meaning and Presence of Meaning on QOL.

Six Pearson correlations were conducted to test the relationships between QOL and the other three variables in each group. No significant correlations were found between a sense of coherence and QOL in the Holocaust survivor group $r = -.15$, $n = 20$, $p = .52$, or the Sudanese refugee group $r = -.04$, $n = 20$, $p = .86$. On assessment there was no significant difference between these correlations ($z = 0.32$). Correlations were not significant, and basically yielded no correlation, between search for meaning and QOL in the Holocaust survivor group $r = .02$, $n = 20$, $p = .93$. A small positive correlation was found between

search for meaning and QOL in the Sudanese refugee group $r = .19$, $n = 20$, $p = .41$. No significant difference was identified between these two correlations ($z = -0.5$). In addition, a positive, non-significant correlation was found between presence of meaning and QOL in the Holocaust survivor group $r = .19$, $n = 20$, $p = .42$, and a significant positive relationship was found between presence of meaning and QOL in the Sudanese refugee group $r = .44$, $n = 20$, $p = .049$. There was also no significant difference between these two correlations at the two-tailed level ($z = -0.82$).

Discussion

Diverse cultural groups were compared to contribute to gaps in understanding the way that conceptualizations of MIL differ between groups following traumatic events. A mixed methods approach was undertaken, using quantitative assessments to inform qualitative interviews. Qualitative exploration found both groups to identify purpose in future generations and the prevention of future conflict. Both groups also similarly reported a limited understanding of conflict. Similarities found coincide with research documenting meaning in life to be reported cross-culturally, including Sudanese and Holocaust survivors (Armour, 2010; Goodman, 2004; Porter & Haslam, 2005; Tipping, Bretherton, & Kaplan, 2007; Zeidner & Aharoni-David, 2015).

As with previous research documenting various content to comprise MIL in diverse groups (Coetzee, Wissing, & Temane, 2010; Goodman, 2004; Kono, & Shinew, 2015; Nell, 2014), the current study found differences in the way that Holocaust survivors and Sudanese refugees considered purpose. Holocaust survivors described purpose inherent in memory, whereas Sudanese refugees discussed purpose in terms of looking forward. This accords with cultural differences found previously. Jews, and particularly Holocaust survivors, have been found to promote the importance of remembrance in cultural traditions (Kidron, 2012).

Sudanese have reported looking forwards as a key coping strategy for dealing with trauma (Savic, chur-Hansen, Mahmood, & Moore, 2016). Culture therefore can play a role in the content found to comprise MIL.

Yielding similarities in diverse groups provides insight into the applicability of European and American conceptualizations of MIL following traumatic events. In both groups, participants responded to questions of meaning and purpose by referring to their future generations, and creating a better future. This accords with European-American definitions of meaning in life highlighting one's purpose to be a key component (King et al. 2006; Martel & Steger, 2016; Park 2010). Previously, theorists have explained MIL to be comprised of not only purpose but also comprehension (Martela, & Steger, 2016; Winger, Adams, & Mosher, 2016). Both Holocaust survivors and Sudanese refugees, whilst reporting having meaning and purpose, expressed limited comprehension of conflict, often referring to the traumatic event they experienced. One explanation for the lack of comprehension found is Shattered Assumptions Theory. Traumatic events have been explained to undermine formerly held beliefs about the world (Janoff-Bulman, 1992). In concert with this theory, both groups affirmed their previous understanding of God to be insufficient in comprehending the traumatic event experienced as well as the continuity of similar conflict. Qualitative responses therefore demonstrate how, following traumatic events, limited understanding can co-exist with a presence of MIL and purpose.

Moreover, the current study, counter to hypotheses, found a sense of coherence and QOL to produce a zero to minimal relationship in both groups. Previously, both comprehension and purpose have been considered important contributors to meaning in life, and meaning in life to be an important component of recovery (Armour, 2010; Martela & Steger, 2016; Park, 2010). Though whilst a previous review (Eriksson & Lindstrom, 2005) has found sense of coherence to be related to QOL in a variety of studies, findings suggest

that following traumatic events, cross-culturally individuals may be required to find sources of QOL in mechanisms other than comprehension (Zeidner & Aharoni-David, 2015). Whilst this analysis has been limited by a small sample size, cross-culturally, it may be that MIL need not include being able to make sense of one's surrounding world.

Similarities found also provide insight into the way that people across two diverse cultures can find meaning following traumatic events highlighting implications for clinical work with diverse traumatized groups. In both groups, purpose stated was a purpose related to the experience of traumatic events and conflict. Frankl (1967) discussed the notion of tragic optimism. Within this notion he identified that individuals can be optimistic despite the experience of overwhelmingly adverse circumstances. He suggests that in the face of trauma and suffering individuals can have a sense of future and optimism whilst simultaneously having a sense of loss. Participants in the current study too, despite reporting loss, indicated a sense of purpose in creating a better future, for future generations, and stemming conflict. Both groups harmonized tension between the traumatic event experienced and global pursuits, in accordance with Park's (2010) meaning making model, by reconciling situational horror with an emerging purpose aimed at preventing the re-occurrence of the traumatic event, in turn creating a future void of conflict. Utilizing the trauma experienced to create a sense of purpose can therefore be an effective approach for intervention with various cultural groups.

Working to derive a purpose stemming from trauma is particularly important in groups where the search for meaning is found to be high. Results found significantly higher search for meaning in the Sudanese refugee group. Additionally, Pearson correlations found presence of meaning to significantly correlate with QOL in the Sudanese refugee group, though not in the Holocaust survivor group. Steger, Oishi, and Kesebir (2011) found presence of meaning to be strongly associated with life satisfaction among those who were actively

searching for meaning. A heightened emphasis on the search for meaning may direct attention to meaning-relevant information, promoting the use of such information in judgments regarding QOL (Oishi et al. 1999). In groups where the search for meaning is found to be high, a presence of meaning and purpose is therefore an important component of recovery intervention.

A limitation of the current study is in the explanatory power of culture in difference found between groups. Differences in the search for meaning, and also Holocaust survivor emphasis on memory, may instead be explained by time since trauma. Holocaust survivors are entering the "final season of their lives" (Zeidner & Aharoni-David, 2015, p. 254) where the presence of purpose may be less sought after than for Sudanese refugees who are confronting the challenges of establishing themselves in a new country. So too, finding purpose in reflecting back may only be possible once the rebuilding of lives in a new country have been securely established (Valent, 1995), as is the case with Holocaust survivors. Nevertheless, time since trauma contributes to context, and so it is still important to consider contextual factors including both time since trauma and culture, when being sensitive to difference in MIL conceptualization. Further, whilst time since trauma may complicate the accurate underpinning of difference, it serves to strengthen the profundity of similarities found between groups. Although the current study's small sample size render generalizations to wider Holocaust survivor and Sudanese refugee populations difficult, the difference between samples in culture and context allows for insight into the way MIL can be similarly conceptualized cross-culturally.

Conclusion

Conceptualizing MIL has required clarification in various cultural samples. By comparing diverse groups in Holocaust survivors and Sudanese refugees, the current research provides

support for the applicability of purpose in recovery work. Silove (2013) noted that adaptive, collective responses to crises of existential meaning involve re-establishing practices of meaning and involve finding new possibilities for the expression of meaning. Working with groups from diverse cultural, traumatized backgrounds to express purpose bound in the future generation and the prevention of future conflict can be useful to recovery intervention, particularly in groups searching for meaning. Difference found between Holocaust survivor memory and the Sudanese refugee emphasis on looking forward demonstrates that cultural sensitivity is required when helping groups establish purpose. Future research examining ways in which collectives facilitate purposeful expression through the establishment of meaningful institutions is worthwhile. Such work will provide imperatives essential to the increasing need for trauma recovery work with refugee groups globally.

References

Altmaier, E. (2013). Through a glass-darkly: personal reflection on the role of meaning in response to trauma. *Counselling psychology quarterly, 26*(1), 106-113.

Antonovsky A. (1979) Health, stress and coping. San Francisco: Jossey-Bass.

Antonovsky, A. (1987). Antonovsky's sense of coherence scale and job attitudes: Three studies. *South African Journal of Psychology, 31*, 30–37.

Armour, M.A. (2010). Meaning making in survivorship: application to Holocaust survivors. *Journal of Human Behavior in the social environment, 20*(4), 440-468.

Bonanno, G.A., Papa, A., Lalande, K. Zhang, N., & Noll, J.G. (2005). Grief processing and deliberate grief avoidance: A prospective comparison of bereaved spouses and parents in the united states and the People's republic of China. *Journal of Consulting and Clinical Psychology, 73,* 86-98.

Boyraz, G., Lightsey, O.R. Jr., Can, A. (2013). The Turkish version of the Meaning in Life Questionnaire: assessing the measurement invariance across Turkish and American adult samples. *Journal of Personality Assessment, 95*(4), 423-431.

Braun, V., & Clarke, V. (2013). Successful qualitative research a practical guide for beginners. London, UK: SAGE Publications Ltd.

Braun-Lewensohn, O. Sagy, A., & Roth, G. (2010). Coping strategies among adolescents: Israeli Jews and Arabs facing missile attacks. *Anxiety, Stress, & Coping: An international Journal, 23*(1), 35-51.

Coetzee, H.K., Wissing, M.P., & Temane, Q.M. (2010). Meaningfulness as experienced by a group of South Africans. *Tydskrif vir Geesteswetenskappe, 50*(3), 293-312.

Davis, C., Wortman, C.B., Lehman, D.R., & Silver, R. (2000). Searching for meaning in loss: Are clinical assumptions correct? *Death studies, 24,* 497-540.

Eriksson, M. & Lindstrom, B. (2005). Antonovsky's sense of coherence scale and its relation with quality of life: a systematic review. *Journal of Epidemiology Community Health, 61*(11), 938-944.

Fayers, P.M., & Machin, D. (2000). *Quality of Life: Assessment, Analysis and Interpretation.* John Wiley & Sons.

Feder, A. Ahmad, S., Lee, E.J., Morgan, J.E., Singh, R. Smith, B.W. Southwick, S.M., & Charney, D.S. (2013). Coping and PTSD symptoms a Pakistan earthquake survivors: Purpose in life, religious coping and social support. *Journal of Affective Disorders, 147*(1-3), 156-163.

Feldt, T., Lintula, H., Suominen, S., Koskenvuo, M., Vahtera, J., & Kivimäki, M. (2007). Structural validity and temporal stability of the 13-item sense of coherence scale: Prospective evidence from the population-based study. *Quality of Life Research, 16*(3), 483–493.

Frankl, V. (1967). Logotherapy and existentialism. *Psycotherapy: Theory, Research & Pracrice, 4*(3), 138-142.

Frankl, V. (1985). *The unheard cry for meaning: Psychotherapy and humanism*. New York, NY: Simon & Schuster.

Giorgi, A. (2009). *The descriptive phenomenological method in psychology: A modificed Husserlian approach*. Pittsburg, PA: Duquesne University.

Goodman, J.H. (2004). Coping with trauma and hardship among unaccompanied refugee youths from Sudan. *Qualitative Health Research, 14*(9), 1177-1196.

Helgeson, V.S., Reynolds, K.A., & Tomich, P.L. (2006). A meta-anlytic review of benefit finding and growth. *Journal of Consulting and Clinical Psychology, 74*, 797-816.

Hinton, D.E., & Lewis-Fernandez, R. (2011). The cross-cultural validity of posttraumatic stress disorder: Implications for DSM-5. *The Journal of Depression and Anxiety, 28*(9), 783-801.

Huijts, I., Kleijn, W.C., van Emmerik, A.A., Noordhof, A., Smith, A.J. (2012). Dealing with man-made trauma: the relationship between coping style, posttraumatic stress, and quality of life in resettled, traumatized refugees in the Netherlands. *Journal of Traumatic Stress, 25*(1), 71-78.

Jaeckle, T. & Georgakopoulos, A. (2010). Cultural representations of identity, trauma and transnationalism among Dinka refugees: implications for conflict analysis and resolution. *International Journal of Psychological Studies, 2*(2), 1-13.

Jafary, F., Farahbakjsh, K., Shafiahadi, A., Delavar, A. (2011). Quality of life and menopause: Developing a theoretical model based on meaning in life, self-efficacy beliefs, and body image. *Aging & Mental Health, 15*(5), 630-637.

Janoff-Bulman, R. (1992). *Shattered Assumptions: towards a new psychology of trauma.* New York: Free Press.

Kidron, C.A. (2012). Altereity and the particular limits of universalism: comparing Jewish-Israeli holocaust and Canadian-cambodian genocide legacies. *Current Anthropology, 53*(6), 723-754.

King, L.A., Hicks, J.A., Krull, J.L., & Del Gaiso, A.K. (2006) Positive effect and the experience of meaning in life. *Journal of Personality and Social Psychology, 90*, 179-196.

Kono, S., Shinew, K.J. (2015). Roles of leisure in the post-disaster psychology recovery after the great East Japan earthquake and tsunami. *Leisure Sciences, 37*(1), 1-19.

Lamis, D.A., Wilson, C.K., Tarantino, N., Lansford, J.E., & Kaslow, N.J. (2014). Neighbourhood disorder, spiritual well-being, and parenting in African American Women. *Journal of Family Psychology, 28*(6), 769-778.

Lillard, A. (1998). Ethnopsychologies: Cultural Variations in Theories of Mind. *Psychological Bulletin, 123*(1), 3-32.

Linley, P.A., & Joseph, S. (2011). Meaning in Life and Posttraumatic Growth. *Journal of Loss and Trauma, 16*(2), 150-159.

Lindstrom, B., & Eriksson, M. (2005). Salutogenesis. *Journal of Epidemiology Community Health, 59,* 440-442.

Flensborg-Madsen, T. Ventegodt, S., & Merrick, J. (2005). Why is Antonovsky's Sense of Coherence Not Correlated to Physical Health? Analysing Antonovsky's 29-item Sense of Coherence Scale (SOC-29). *The Scientific World Journal, 5,* 767-776.

Marsella, Anthony J. 1988. Cross-cultural research on severe mental disorders: Issues and findings. *Acta Psychiatrica Scandinavica Supplementum, 344,* 7-22

Martela, F., & Steger, M.F. (2016). The three meanings of meaning in life: distinguishing coherence, purpose, and significance. *The Journal of Positive Psychology, 11*(5), 1-15.

Moksnes, U.K., Espnes, G.A., & Haugan, G. (2013). Stress, sense of coherence and emotional symptoms in adolescents. *Psychological Health, 29*(1), 32-49.

Nell, W. (2014). Sources of life meaning among South African university students. *Journal of Psychology in Africa, 24*(1), 82-91.

Nicolas, G., Wheatley, A., & Guillaume, C. (2015). Does one trauma fit all? Exploring the relevance of PTSD across cultures. *International Journal of Culture and Mental Health, 8*(1), 34-45.

O'Donnell, M.B., Bentele, C.N., Grossman, H.B., Le, Y., Jang, H., & Steger, M.F. (2014). You, me, and meaning: an integrative review of connections between relationships and meaning in life. *Journal of Psychology in Africa, 24*(1), 44-50.

Oishi, S., Diener, E., Suh, E., & Lucas, R.E. (1999). Value as a moderator in subjective well-being. *Journal of Personality 67*, 157-184.

Opperman, E., Braun, V., Clarke, V., & Rogers, C. (2013). "It feels so good it almost hurts"" Young adults' experiences of orgasm and sexual pleasure. *Journal of Sex Research*, [Epub ahead of print], 1-13. doi: 10.1080/00224499.2012.756982

Pan, J.Y. (2011). A resilience-based and meaning-oriented model of acculturation: A sample of mainland Chinese postgraduate students in Hong Kong. *International Journal of Intercultural Relations, 35*(5), 592-603.

Park, Crystal. L. (2016). Unresolved tensions in the study of meaning in life. *Journal of Constructivist Psychology, 30*(1), 69-73.

Park, C. L. (2010). Making sense of the meaning literature: An integrative review of meaning making and its effects on adjustment to stressful life events. *Psychological Bulletin, 136*, 257–301.

Phungrassami, T., Katikarn, R., Watanaarepornchai, S., & Sangtawan, D. (2004). Quality of Life assessment in radiotherapy patients by WHOQOL-BREF-THAI: A feasibility study. *Journal of Medical Association Thai, 87*(12), 1459-1465.

Porter, M., & Haslam, N. (2005). Predisplacement and Postdisplacement Factors Associated With Mental Health of Refugees and Internally Displaced Persons: A Meta-analysis. *JAMA: Journal of the American Medical Association, 294*(5), 602-612.

Russell, C. S., White, M. B., & Parker, C. (2006). Why me? Why now? Why multiple sclerosis? Making meaning and perceived quality of life in a Midwestern sample of patients with multiple sclerosis. *Families, Systems & Health, 24,* 65-81.

Sardu, C., Mereu, A., Sotgiu, A., Jacobson, M.K., & Contu, P. (2012). Antonovsky's Sense of Coherence Scale: Cultural validation of SOC Questionnaire and socio-demographic patterns in an Italian population. *Clinical Practice Epidemiological Mental Health, 8,* 1-6.

Sagy, S., & Braun-Lewensohn, O. (2009). Adolescents under rocket fire: when are coping resources significant in reducing emotional distress, *Global Health Promotion, 16*(4), 5-15.

Savich, M., Chur-Hansen, A., Mahmood, M.A., Moore, V.M. (2016). 'We don't have to go and see a special person to solve this problem': Trauma, mental health beliefs and processes for addressing 'mental health issues' among Sudanese refugees in Australia. *International Journal of Social Psychiatry, 62*(1), 76-83.

Schalkwyk, L.V. and Rothman, S. (2008). Validation of the Orientation to Life Questionnaire (OLQ) in a chemical factor. *South African Journal of Industrial Psychology, 34*(2), 31-39.

Shlegel, R.J. and Hicks, J.A. (2016). Reflections on the scientific study of meaning in life. *Journal of Constructivist Psychology, 30*(1), 1-6.

Silove, D. (2013). The ADAPT model: a conceptual framework for mental health and psychosocial programming in post conflict settings. *Intervention, 11*(3), 237-248.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: SAGE Publications.

Sreedevi, A., Cherkil, S., Kuttikattu, D.S., Kamalamma, L., & Oldenburg, B. (2016). Validation of the WHOQOL-BREF in Malayalam and Determinants of Quality of Life among people with type 2 Diabetes in Kerala, India. *Asia Pacific Journal of Public Health, 28*(1), 62-69.

Steger, M.F, Frazier, P., Oishi, S., & Kaler, M. (2006). The Meaning in Life Questionnaire: Assessing the presence of and search for meaning in life. *Journal of Counselling Psychology, 53*, 80-93.

Steger, M.F., Oishi, S., & Kashdan, T.B. (2009). Meaning in life across the life span: Levels and correlates of meaning in life from emerging adulthood to older adulthood. *The Journal of Positive Psychology, 4*, 43-52.

Steger, M.F., Kashdan, T.B., Sullivan, B.A., & Lorentz, D. (2008). Understanding the search for meaning in life: Personality, cognitive style, and the dynamic between seeking and experiencing meaning. *Journal of Personality, 76,* 199-228.

Steger, M.F., Kawabata, Y., Shimai, S. & Otake, K. (2008). The meaningful life in Japan and the United States: Levels and correlates of meaning in life. *Journal of Research in Personality, 42,* 660-678

Steger, M.F., Oishi, S., & Kesebir, S. (2011). Is a life without meaning satisfying? The moderating role of the search for meaning in satisfaction with life judgments. *The Journal of Positive Psychology, 6*(3), 173-180.

Steger, M. F., & Shin, J. Y. (2010). The relevance of the Meaning in Life Questionnaire to therapeutic practice: A look at the initial evidence. *International Forum on Logotherapy, 33*, 95-104.

Temane, L., Khumalo, I.P., & Wissing, M.P. (2014). Validation of the Meaning in Questionnaire in a South African context. *Journal of Psychology in Africa, 24*(1), 51-60

Teodorescu, D.S., Heir, T., Hauff, E., Wentzel-Larsen, T., & Lien, L. (2012). Mental health problems and post-migration stress among multi-traumatized refugees attending outpatient clinics upon resettlement to Norway. *Scandinavian Journal of Psychology, 53*(4), 316-332

Tipping, S., Bretherton, D. and Kaplan, I. (2007). Meaning in life and social connectedness: The experience of Sudanese young people (re) settling in Australia. In L. Dean, and N. Haslam (Eds.) *Yearning to breathe free: Seeking asylum in Australia,* (pp. 157-168). NSW: The Federation Press.

Valent, P. (1995). Documented childhood trauma (Holocaust): Its sequelae and applications to other traumas. *Psychiatry, Psychology and Law, 2*(1), 81-89

The WHOQOL Group. (1998). Development of the World Health Organization WHOQOL-BREF quality of life assessment. *Psychological Medicine*, *28*(3), 551-8

Winger, J.G., Adams, R.N., Mosher, C.E., (2016). Relations of meaning in life and sense of coherence to distress in cancer patients: a meta-analysis. *Psychooncology. 25*(1), 2-10.

Zeidner, M. & Aharoni-David, E. (2015). Memories of Holocaust-related traumatic experiences, sense of coherence, and survivors' subjective well-being in late life: some puzzling findings. *Anxiety, Stress & Coping: An international Journal, 28*(3), 254-271.

Chapter 7:

Discussion and conclusion

This chapter synthesises and discusses the findings from the three empirical papers in the preceding chapters, within the context of a wider literature on trauma and recovery from a cross-cultural perspective. Following, is a discussion of the theoretical and clinical implications for the assessment of trauma and introduction of intervention with diverse cultural groups undergoing traumatic experiences. This chapter concludes with a discussion of the limitations of findings and suggestions for future research.

7.1 Reviewing the rationale of the thesis

Understandings of trauma are shaped by a social climate including contemporary social values, normative frameworks, and prevailing beliefs about the mind (Kira & Tummala-Narra, 2014; Nickerson, Bryant, Silove, & Steel, 2011; Summerfield, 2001; Young, 1995). The experience and conceptualisation of trauma has been shown to vary depending on context, along with conceptions of normal and maladaptive behaviour (Kidron, 2012; Kohrt et al., 2014; Lillard, 1998; Marsella, 1988). A broader framework of trauma needs to account for the influence of culturally derived interpretations of trauma and appropriate responses to it (Khawaja, White, Schweitzer & Greenslade, 2008; Kienzler, 2008; Lustig et al., 2004).

Literature documenting global responses to the increasingly diverse pool of individuals suffering from traumatic events has encountered barriers. The universalist approach to trauma has explored the prevailing PTSD category cross-culturally (Meffert et al. 2010; Mollica et al., 1998; Oruca et al., 2008; Peltzer, 1999; Steele, Silove, Phan, & Bauman, 2002). However, across cultures, examining PTSD as an individual disorder has been

criticised for overlooking collective trauma (Agbayabi-Siewert, Takeuchi & Pangan, 1999; Lester, 2013; Sheikh & Furnham, 2000), overlooking cumulative and long-term trauma (Burstow, 2003; Straker, 2013, Kira & Tummala-Narra, 2014; Summerfield, 2004), assuming PTSD symptoms to reflect the same disorder in all contexts (Steel, Steel, & Silove, 2009; Summerfield, 2001), and imposing a lens of psychopathology (Nicolas, Wheatley, & Guillaume, 2015). Relativist approaches have alternatively explored trauma response from within specific cultural groups (Benedict, Mancini, & Grodin, 2009; Jones, 2015; Kohrt et al. 2014; Tumalla-narra, 2008). Each study formulated from within a culture has been limited however in its ability to compare and generalise results due to the uniqueness and specificity of its exploration. (Draguns & Tanaka-Matsumi, 2003; Good & Hannah, 2015). Moreover, by focusing on culturally specific trauma response, the relativist approach has the potential to overlook authentic psychiatric diagnoses, specifically PTSD (Silove, Steele, & Bauman, 2007). This has led to persistent confusion as to appropriate interpretation of trauma on a global scale (Nickerson, & Bryant, 2014; Nicolas, Wheatley, & Guillaume, 2015).

A synthesis is needed to address shortcomings in the literature and to proceed with effective discourse around trauma (Wendt & Gone; 2012; Van Rooyen & Ngweni, 2012). Diverse cultural explanations of trauma need to be considered without overlooking PTSD. Universalist approaches to trauma need to consider cultural relativity. Moreover, recovery work needs to acknowledge diversity in interpretations of, and responses to trauma. In particular, the American and European MIL construct, as a pathway to recovery, needs further exploration conceptually in diverse cultural groups (Park, 2016; Shlegel & Hicks, 2016). Understanding and synthesising similarities, whilst acknowledging the diversity of experience, is crucial for continued work with diverse populations.

Three empirical studies were conducted in order to examine these issues. The first study considered a comparison of diverse cultural conceptualisations of trauma (Chapter 4).

The second study attempted to contextualise PTSD and its symptoms within diverse cultural groups by assessing for their relationships with QOL (Chapter 5). The third study examined similarities and differences in the way that people belonging to diverse cultural groups, having undergone war and conflict, conceptualised and related to MIL (Chapter 6). The following section discusses the results of the three studies and their implications in the context of the broader literature.

7.2 Comparing cultural conceptualisations of trauma

An exploration of trauma in diverse cultural groups has returned results concurring with the view that some elements of trauma are universal whereas other elements may be culturally specific or distinctive (Ungar, 2011; Van Rooyen & Ngweni, 2012). Differences found centered around three key criteria: somatoform symptoms expressed by Sudanese refugees, feeling of powerlessness in Sudanese refugees, and differing responses to traumatic memory. A complexity of factors contributing to difference between groups makes pinpointing explanations for difference difficult. As with previous emic research (Goodman, 2004; Franco-Paredes, 2010; Guarnaccia, Lewis-Fernandez, & Marano, 2003), relative differences are conceptually difficult to generalise due to the specificity of study samples. However, using difference as a base is useful when acknowledging similarity. Similarity based on different cultural groups allows for insight into the human experience of trauma.

Three main differences were found between the two studied populations. First, in concert with the literature on somatic symptoms as a common trauma experience (Hinton & Lewis-Fernandez, 2011; Kohrt et al. 2014; Marsella, Freidman, Gerrity, & Scurfield, 1996; Silove, 2013), Sudanese refugees discussed somatic complaints as an effect of traumatic events. Somatic symptoms, such as headaches, nausea, and heart pain, were not discussed in Holocaust survivor accounts. Second, in accordance with the work of Baron (2002) who

found Southern Sudanese in Uganda to report feelings of powerlessness, the current research found Sudanese refugees to identify powerlessness as a result of traumatic experience. Whilst powerlessness has been reported in other cultural groups such as Bhutanese, Burmese and Ethiopian populations (Shannon, Wieling, McCleary, & Becher, 2015), Holocaust survivors in the current study made no mention of this effect. Finally, where Holocaust survivors reported traumatic memory to serve purpose, as found previously (Levi, 1984; Valent, 1995; Wiesel, 1958), Sudanese recommended not thinking about memories of the past so as to avoid stress from 'thinking too much'. Not thinking about the past has been a response found previously other refugee groups (Hinton, Reiss, & De Jong, 2015; Shannon et al., 2015). The two diverse cultural samples therefore communicated their understanding of, and ways of dealing with, the trauma experience differently.

Explanations for differences may be inherent in culturally specific understandings. Hinton and Lewis-Fernandez (2011), in their definition of culture, suggested that culture shapes the communication of norms around somatic symptoms. This was reflected in different experiences of somatisation between different groups. One potential explanation for this may be in diverse theories of the mind. In some cultures, emotion is not considered to be a separate entity from physical feelings (Jenkins 1991; Marsellla, Freidman, Gerrity, & Scurfield, 1996; Mehta, 2011). In cultural contexts where the mind and body are considered to be separate, communication of psychological and emotional trauma may be more likely to occur directly, without alluding to physical concerns (Lillard, 1998; Marsella, Friedman, Gerrity, & Scurfield, 1996; Scheper-Hughes & Lock, 1987). Holocaust survivors, as Europeans living in Australia for six or more decades, therefore, may be less likely to refer to the lingering effects of emotional and psychological trauma as manifesting physically. Conversely, Sudanese refugees appear to be more likely to conflate emotion with feelings in a physical sense, and thus report somatic trauma symptoms.

Cultural difference may also help explain the differences in the cultural groups' responses to traumatic memory. The word *zachor* (meaning memory) speaks to the importance of remembrance that pervades Jewish tradition (Kidron, 2012). The act of remembrance is found in weekly rituals such as that of keeping the *Sabbath* to remember creation. It is also found in annual rituals such as the Passover *Seder* to commemorate the exodus from Egypt and in the annual fasting day of *Tisha Be'Av* (the ninth day of the Month of Av) to commemorate past tragedies. Jewish cultural rituals and traditions relate to the importance of remembering the past, and may facilitate the difference found in approach to memory. Conversely, recent work with Sudanese refugees has referred to stoicism and a "desire to move forward" (Savic, Chur-Hansen, Mahmood, & Moore, 2016, p.76) as prioritised traits in Sudanese culture.

Difference in attitude towards the past may be due to a cultural difference in the way that groups prioritise thoughts generally. Lillard (1998) argued that in European and American cultures, thinking is considered a means to understanding. In other cultural groups, such as the Japanese, thinking is thought of as a means to surface level understanding. In this culture, the priority is to think less and engage with the external world to a greater extent so as to be more connected with the surrounding world (Dember, Melton, Nguyen, & Howe, 1993). It may be that attitudes towards memories of the past stem from cultural narratives around the importance of thoughts, in which case, culture can explain the difference found in response to traumatic memory. Holocaust survivors may prioritise thoughts, therefore memory, whereas Sudanese refugees may prioritise engagement with the sensory, external environment.

Whilst cultural underpinnings may explain differences, other explanations for these findings are possible. Time since the primary traumatic event may also contribute to difference. Sudanese refugee participants discussed being unable to influence the ongoing

conflict affecting their family and community members in Sudan. Where proximity to the traumatic event is closer and the time since their own traumatic experience is more recent, the strain to maintain feeling empowered persists (Lester, 2013). Feeling powerless may therefore be a by-product of ongoing conflict in Sudan, rather than cultural difference. Lester (2013) explained that trauma survivors, as a general rule, often strained against the notion that they were powerless. Similarly, Shannon and colleagues (2015) outlined a key theme in their research with refugees to be the interconnectedness between trauma symptoms and political causes. Holocaust survivors too have previously been documented as feeling powerless following traumatic events, Garwood (1996, p.245) explaining the feeling of powerlessness to be "of the greatest importance" to survivors. Therefore, the difference reported in relation to feelings of powerlessness may be due to the time-lapse since the traumatic event rather than due to cultural deviation.

Similarly, time elapsed since the traumatic event may have impacted the difference found in group responses to traumatic memory. Holocaust survivors have not always equated the act of remembrance with a purposeful sharing of memory (Sichrovsky, 1986). "Survivor Silence" (Kidron, 2009, p.5) for many years following the Holocaust was thought to represent psychological repression and the "unspeakability" of the traumatic past. Valent (1995, p. 85) wrote that child survivors of the Holocaust needed "the perspective of age, the security of rebuilt lives, the security of their children, and the waning influence of their parents" to reconsider their memory of the past as meaningful. Sudanese refugees who are still rebuilding their lives in Australia may require more of a lapse in the passage of time to be able to reorient current perspectives on the utility of traumatic memory. So whilst cultural schemas may play a role in the between-group difference found, as with reported feelings of powerlessness, time since the traumatic event may also be an influential factor.

The current study therefore provides support for the various authors arguing for the need to consider the social, not only the biological, when understanding trauma response (Beneduce, 2016; Summerfield, 2001; Young, 1995). Whilst uncertainty surrounds the precise reason for difference, in pursuing a synthesis, it may be that both time since trauma and culture contribute to difference. Kidron (2012), in accordance with others (Hacking 1997; Lambek and Antze 1996; Tearfund 2006), posited that "the experience of trauma and the resultant disorder entail culturally constituted meaning systems framing how one interprets and practices the suffering self" (p. 725). If time since trauma impacts the meaning of trauma, as has been demonstrated previously **(**Jovanovic et al. 2012; Linley & Stephen, 2004; Prati & Pietrantoni, 2009; Stanton et al. 2006;**),** then time since trauma can also interact with cultural narratives and collective communication, creating the trauma experience that various cultural groups comprehend. Irrespective of the precise cause of difference, it can be argued that the social environment impacts the understanding of the trauma response. Results demonstrate that time since trauma, culture, or an interaction of both, can lead to malleable understandings of trauma, consistent with the published literature (Kohrt et al. 2014; Nicolas, Wheatley, & Guillaume, 2015; Young, 1995; Summerfield, 2001).

In noting difference, similarities become telling for the insight they provide into the trauma experience. Irrespective of whether difference is due to culture or time since trauma, similarities in the lived experience of trauma were also found between groups. The first overarching similarity, the persistence of traumatic memory, has long been described as an indelible consequence of horrific events (Copping, Shakespeare-Finch, & Patton, 2010; Lawrence-Wood, Van Hooff, Baur, & McFarlane, 2015; Van Rooyen and Ngweni, 2012; Weisel, 1958). The persistence of memory has been outlined before in Holocaust survivor literature (Frankl, 1967; Levi, 1984). It has also been documented in other cultural groups such as the Acholi of Uganda in the form of nightmares and disturbing visions (Reis, 2013),

and in Tibetan refugees where traumatic memory, “the memory of his temple burning”, persists (Benedict, Mancini, & Grodin, 2009, p. 2). Indeed, the persistence of traumatic memory appears to be a universal effect of traumatic events.

The second overarching similarity, impact on one’s identity, is also well supported as an effect of trauma cross-culturally (Fullilove, 1996; Keyes & Kane, 2004; Silove, 2013). Holocaust survivors reported themselves to no longer be ‘normal’ whereas Sudanese refugees discussed being powerless on account of traumatic events. Silove (1999) presents the identity/role system as integral to his ADAPT model of refugee trauma experience. Traumatic events in this model profoundly impact one’s self conception. In a study by Keyes and Kane (2004), Bosnian women in the US reported war to impact their ethnic identity. A change in one’s identity following a traumatic event is evident even in the labels attributed to participants, whether they be assumed or imposed. By now referring to themselves as either a ‘survivor’ or as a ‘refugee’, identity has been altered on account of a past traumatic event. The change to identity therefore seems to be a critical component of the human experience of trauma.

A change in one’s relationship with the international community following a traumatic event was reported by both Sudanese refugees and Holocaust survivors. This experience of trauma coincides with Janoff-Bulman’s (1992) conception of the shattering of one’s world, along with one’s assumptions about the world. Holocaust survivors explained the world to have abandoned them, and Sudanese refugees discussed feeling like a burden on the world. The changing nature of one’s relationship with the social world as part of the trauma experience has been described previously (Edmondson et al., 2011). In particular, Lester (2013) explained that “a traumatic event is traumatic precisely because it shears us from our connection with others” (p. 754). Nickerson and Bryant (2014) similarly discussed how human rights violations challenge fundamental beliefs about the moral nature of human

beings, and in turn force one to question interpersonal relationships. Cross-culturally, then, a commonality in the experience of trauma is that one's relationship with the interpersonal world is changed.

Finally, existential anxiety pertaining to the reoccurrence of the traumatic event, or a similar event, was consistently reported by participants in both groups. Holocaust survivors reported worrying predominantly about a Muslim 'take-over', and Sudanese refugees expressed concern that their situation could change overnight, as it did for many in Sudan. Ongoing fear of trauma reoccurrence has also been demonstrated in other cultural groups, Silove (1999) expressing the need for safety to be of key concern to trauma survivors. Burmese citizens, who have lived under the oppressive conditions of militarisation for decades, reported being consistently on guard despite a change in the political climate (Manderson, Cartwright, & Hardon, 2016). Fear conditioning is prominent in current PTSD theorising and is central to theoretical models that relate fear to the emergence of hyper-arousal symptoms (Zoellner, Rothbaum, & Feeny, 2011). It seems then that Primo Levi wrote with relevance to a range of cultural groups when he asserted, "it happened, therefore it can happen again…It can happen, and it can happen everywhere" (Maitles, 2002, p.237).

Similarities provide insight into the universality of the human trauma experience. This work is not the first to consider culturally non-specific notions of trauma. Silove (1999) expounded on five adaptive systems, applicable to various cultures, considered to be impacted by traumatic events. The current findings serve to validate a number of Silove's systems by grounding the systems themselves within the lived trauma experience of two disparate cultural groups. Silove's *roles and identity system* is validated by the change to identity reported. Silove's *bonds and network system* is supported by the change found to one's relationship with the social world. Silove's *safety system* is supported by the commonality found in existential anxiety. Evidence supporting the manifestation of these

adaptive systems in trauma survivors is particularly insightful when considering the Holocaust survivor group. Due to both the elder age of Holocaust survivor respondents, and the time elapsed since their trauma, Holocaust survivor results support the persistent relevance of Silove's ADAPT systems. The current findings present an additional consideration in the experience of trauma from a cross-cultural perspective, the persistence of traumatic memory. Findings demonstrate how traumatic memory can be dealt with adaptively, and how traumatic memory can be perceived as maladaptive. This work thereby supports the consideration of persistent traumatic memory as an adaptive system in cross-cultural studies on trauma, worth consideration in Silove's ADAPT model.

Similarities in the current study were arrived at using in-depth qualitative analysis. By comparing two groups, the current study addresses a previous limitation of a relativist approach as well as a limitation of the universalist perspective. By comparing groups directly, variation in the way that different time-points in the research process can influence findings are eliminated. Further, comparing directly between groups overcomes a limitation in variation of researcher perspectives that can occur when comparing multiple relativist studies (Draguns & Tanaka-Matsumi, 2003). As noted in chapter 2, the relationship between the researcher and the observed is always distinct, contributing to the uniqueness of the study. Directly comparing groups using the same researchers allows for a more consistent relationship between the two. Finally, the current study explored universality from a phenomenological standpoint. In so doing, it overcomes criticism of previous universal approaches that examine the prevailing mental health category of PTSD. The current work adds to other ethno-psychological studies that have been important in elaborating on the ways that trauma is culturally constructed (Kidron, 2012; Kohrt et al. 2014).

Findings from the current study demonstrate a synthesis of similarity with difference. The importance of synthesising similarity with difference is in being able to relate to all

people from different groups. Cultural variability in the experience of trauma is expected, and so Stamm and co-authors (2004) argued that theories of cultural trauma are best when they are not too specific. Acknowledging difference is imperative for sensitivity to culture. Difference though can be couched in similarity. The differences between groups in feelings of powerlessness is a difference in the way groups changed in identity. The difference between groups in perceptions of traumatic memory relates to a difference in the persistence of traumatic memory. Broad similarities allow for the breadth, acceptance and inclusion of cultural difference. In a world confronted by political instability and an increasing refugee contingent, the need to relate to difference is paramount. Abdalla, a Sudanese participant, claimed "people love people that understand them". The four overarching similarities documented can be used as a language with which to communicate an acknowledgement, understanding, and validation of traumatic experience. Using non-specific theories of trauma as a starting base can therefore aid in global intervention following traumatic events.

7.3 Contextualising PTSD within two divergent cultural groups

Previous literature cautions overlooking or minimising the significance of psychiatric conditions (Silove, Steel, & Bauman, 2007). Therefore, a further aim was to consider PTSD within two diverse cultural contexts. Again, findings encompassed both difference and similarity in the consideration of PTSD symptoms within diverse groups. In pursuing a synthesis of the cross-cultural debate over the validity of PTSD, similarities provide evidence for the importance of considering PTSD in diverse cultural groups. At the same time, difference was noted between groups in the relationship between traumatic memory and QOL. This suggests that symptoms may need to be contextualised within different cultural and group conceptualisations of trauma if they are to be assessed appropriately.

Significant differences found on symptom endorsement can be understood within trauma conceptualisation elicited from the qualitative data in chapter 4. Sudanese refugees were found to score significantly higher on items of powerlessness and self-blame. Powerlessness yielded the largest significant difference between groups. Chapter 4 described how Sudanese refugees reported powerlessness as an effect of the traumatic events they experienced, absent from Holocaust survivor accounts. The difference found on self-blame can also be contextualised in terms of previous qualitative differences. Sudanese refugees expressed feeling like a burden, and so internalised blame. Garwood (1996, p. 247) links powerlessness and self-blame. He reports "self-blame in the face of powerlessness is a commonly observed phenomenon" for the way that powerlessness evokes feelings of a vulnerable, immobilised state where the individual did not act. The qualitative data from Chapter 4 therefore helps explain the emergence of these two significant differences on the HTQ-R in Chapter 5.

In explaining further difference, the need to contextualise symptoms appropriately, rather than rely on symptom counts alone, becomes apparent. Sudanese refugees scored significantly lower on items of *physical troubles* and *body pain*. Here however, findings are counter to results found in Chapter 4 where Sudanese refugees reported somatic symptoms absent from Holocaust survivor accounts. At face value, higher endorsement of these items suggest that Holocaust survivor trauma incorporates more somatic complaints. Holocaust survivor participants were aged between 82 and 93 years, whereas Sudanese participants were all between 20 and 48 years. Older individuals have been found to more commonly endorse physical symptoms due to typical body decline with older age (Kaiser, Wachen, Potter, Moye, & Davison, 2016). Therefore, coinciding with authors who posited the importance of understand the meaning behind the symptoms (Beneduce, 2016; Kleinman,

1987; Summerfield, 2012), qualitative and quantitative results together demonstrate that appropriate assessment requires contextualising symptom endorsement.

The need to contextualise symptom endorsement is further emphasised when examining item 1 on the PTSD scale of the HTQ-R, "recurrent thoughts or memories of the most horrifying or terrible events". On endorsement of this item, no group difference was found. Groups endorsed this item most commonly, and most similarly. In considering symptom endorsement alone, this finding coincides with previous research describing the essential component of memory in the trauma response (Breur & Freud, 1895; Rubin, Berntsen, & Bohni, 2008; Van Rooyen & Ngweni, 2012). Yet in each group, a different direction of the correlation between item 1 and QOL was found, along with a Z score reflecting a significantly different correlation. Holocaust survivors returned a positive correlation between item 1 and QOL, whilst Sudanese refugees returned a negative correlation.

Assuming endorsement of this item to indicate the presence of a distressing PTSD symptom overlooks diversity in the interpretation of this symptom. Previous work has explained the importance of considering PTSD symptoms as existing on a continuum from maladaptive to adaptive (Silove, 2013), rather than as categorical constructs. Narrow and Kuhl (2011) explained dimensional approaches to psychiatric diagnosis to be preferable when compared with categorical classification. Correlations on item 1 demonstrate the possibility for both positive and negative adaptations in approach to the same symptom. In concert with the writings of Van Rooyen and Ngweni (2012), in order to explain symptom based findings, a full understanding of underlying memory schemas within culturally specific groups are important. The qualitative work from Chapter 4 helps in this pursuit. Qualitatively, Holocaust survivors reported traumatic memory to serve a purpose. Alternatively, Sudanese refugees

described the importance of not thinking about the past. Within each group, the existence of traumatic memory reflects something entirely different.

This difference in traumatic memory, found using a universalist approach to trauma and PTSD, indicates the need to consider contextualising symptoms rather than assuming their consistent interpretation and association cross-culturally. Authors before have suggested that symptom endorsement alone is insufficient in understanding the impact of PTSD symptoms on survivors of traumatic events (Beneduce, 2016; Slobodin, Caspi, & Klein, 2014; Steel, Steel, & Silove, 2009; Summerfield, 2001; Tempany, 2009**)**. Contextualising PTSD symptoms appropriately, depending on the collective understanding of the cultural group, helps avoid misdiagnosis. Contextualisation of symptom endorsement allows for both the universal application of psychiatric categories where relevant, and the consideration of cultural relativity.

Similarities found using a universalist approach to PTSD provide support for the importance of maintaining psychiatric assessment in diverse cultural contexts. As hypothesised, PTSD scores were significantly, negatively correlated with QOL in both groups. Despite differences between groups culturally and contextually, PTSD's correlation with QOL found in the Holocaust survivor group (-.48) was almost identical to that found in the Sudanese refugee group (-.46). Moreover, item 1 in the Holocaust survivor group was the only item yielding a positive correlation with QOL in both groups. Every other item on the HTQ-R's PTSD scale yielded a negative correlation with QOL. Results therefore provide support for previous work considering the cross-cultural applicability of the PTSD diagnosis (Auxemery, 2012; Hinton & Lewis-Fernandez, 2011; Nickerson, Bryant, Silove, & Steele, 2011; Vermetten & Olff, 2013), as well as the utility of continued examination of PTSD within various cultural groups if contextualised appropriately.

Results reflects the need to consider recovery using a broader framework than the eradication of PTSD symptoms. No significant difference was found between groups on PTSD symptom endorsement, and PTSD cut-off scores. This finding is intriguing when considering time elapsed since each group's primary traumatic event. Holocaust survivors experienced their trauma 70 years prior. Typically, approaches to trauma outcome have expected dissipation in symptoms over time (Bonanno & Mancini, 2012). Chronic dysfunction (Bonnano, 2004) would now therefore classify the Holocaust survivor experience of PTSD symptoms, according to commonly identified recovery trajectories. However, variability in symptom meaning suggests that perhaps classifying the persistent endorsement of PTSD as chronic dysfunction in different settings may be too narrowly conceived. Findings demonstrate that symptoms of PTSD can persist well into later life. This, coupled with variability in symptom meaning, suggests that other frameworks of recovery are important to consider.

7.4 Considering the significance of MIL in trauma recovery cross-culturally

Utilising MIL to aid in recovery has long been considered an integral component in trauma work (Frankl, 1967; Park, 2010; Silove, 1999), although questions have been raised about the application of the American and European conceptualisations of MIL across cultures following trauma (Park, 2016; Shlegel & Hicks, 2016; Zeidner & Aharoni-David, 2015). Therefore, a further aim was to consider MIL in diverse cultural groups. Using both Holocaust survivors and Sudanese refugees, the third study aimed then to explore similarities and differences in group conceptualisations of MIL. Qualitative and quantitative approaches were used in order to pursue a synthesis of both universal and relativist approaches to cultural research. Differences were found in concert with previous literature documenting the various ways that diverse cultural groups find meaning (Coetzee, Wissing, & Temane, 2010;

Goodman, 2004; Kono, & Shinew, 2015; Nell, 2014). Differences were found in relation to both the search and presence for meaning, and to purpose. Interestingly, similarities were also found in relation to both the search for meaning, and to purpose. Moreover, both groups expressed a challenge to previous world-views, and endorsed no relationship between a sense of coherence and QOL. Both similarities and differences are important to consider in devising useful strategies for trauma recovery work in different settings.

An initial difference was found in relation to the, only partially met, first hypothesis for this study. While Sudanese refugees yielded a significantly positive relationship between the presence of meaning and QOL, Holocaust survivors yielded a non-significant correlation between the two. That Holocaust survivors recorded a non-significant relationship between the presence of meaning and QOL is counter to the hypothesis. This result is surprising given the overwhelming literature affirming a direct positive relationship between the presence of meaning and QOL (Khumalo, Wissing, & Schutte, 2014; Park, 2016; Park, 2010; Steger, Frazier, Oishi, & Kaler, 2006; Steger, Kawabata, Shimai, & Otake, 2008). At face value, results may indicate that MIL is important for recovery in a Sudanese refugee group and not in Holocaust survivor group. However, given the strong association between meaning and QOL in the available literature, alternative explanations need to be considered, other than cultural difference. As with differences found in Chapters 4 and 5, group differences need contextualising in order to be appropriately understood.

To help explain this difference, group scores on the search for meaning are helpful. The search for meaning was found to be significantly higher in Sudanese refugees than in Holocaust survivors. Park's (2010) meaning-making model suggests that, following a trauma, individuals search for meaning as a way to reconcile stressors with previously held world-views. Given the time elapsed since Holocaust survivors' primary traumatic event, it follows that the search for meaning is less apparent in these participants. Importantly, if not searching

for meaning, the presence of meaning has been argued to have less influence on overall QOL. Steger, Oishi, and Kesibir (2011) found the search for meaning to moderate the relationship between the presence of meaning and QOL, such that the presence of meaning was strongly associated with life satisfaction only among those who were searching for meaning. In those where the search for meaning is found to be high, the presence of meaning has a larger influence on QOL.

A further difference was found in the way that groups responded to the qualitative question about purpose. Holocaust survivors described their purpose to be bound in remembrance of the traumatic event. Through memory, Holocaust survivors hoped to honor the deceased, and simultaneously educate the younger generations so as to prevent reoccurrence of the traumatic event. Conversely, Sudanese defined their purpose as looking forward to a better future. Sudanese refugees made no mention of remembering their traumatic event, which was deemed purposeful in a Holocaust survivor group, but rather focused on the continued Sudanese conflict. With the cessation of the Holocaust 70 years prior, Holocaust survivors now look back to derive purpose. With the conflict in Sudan still affecting the Sudanese community, Sudanese refugees look to the future to derive purpose.

This difference can be understood in the context of findings pertaining to cultural group conceptualisations of traumatic memory. In Chapter 4, Sudanese refugees reported the importance of not thinking about the past. In Chapter 5, Sudanese refugees yielded a negative relationship between traumatic memory and QOL. It follows that a purpose derived from looking forward, as opposed to remembering in the case of Holocaust survivors, is meaningful to Sudanese. Conversely, in Chapter 4, Holocaust survivors reported traumatic memory to serve a function. In Chapter 5, Holocaust survivors were quantitatively found to yield a positive correlation between traumatic memory and QOL. It follows similarly, that memory bound in the trauma from the Holocaust, provides survivors with the means to

achieve a purpose in life. Cultural difference in the conceptualising of traumatic memory can thus be synthesised with cultural difference in explained purpose.

Clinical practice in trauma recovery work needs to consider interpretation of MIL. Recognising cultural difference in this respect is crucial for appropriate recovery work with divergent groups. Acknowledgement of difference enables sensitivity to the diversity of experience. For example, in the current sample, working to re-establish meaning may be of particular importance to Sudanese refugees who are searching for meaning. Moreover, synthesising MIL conceptualisation with trauma conceptualisation, for example identifying the purpose of persistent traumatic memory in the Holocaust survivor sample, helps in tailoring intervention to specific cultural groups. Recognising specific conceptualisations of trauma is critical in order to appropriately recreate purpose following a traumatic event. Findings particularly stress incorporating varying interpretation of persistent traumatic memory in the recreation of purpose. This way, a synthesis is achieved between the experience of trauma and the consideration of MIL as recovery.

Similarity between groups was found pertaining to the search for meaning. The second hypothesis predicting a significant relationship between the search for meaning and QOL in both groups was not supported. While past authors have found the continued search for meaning to correlate with poorer outcomes, including lower QOL, anxiety, and stress (Bonanno et al. 2005; Steger, Frazier, Oishi, & Kaler, 2006; Steger, Kashdan, Sullivan, & Lorentz, 2008), the search for meaning yielded non-significant relationships with QOL in both groups. This finding can be explained in context of an aforementioned link between the search for meaning, the presence of meaning, and QOL. Just as the search for meaning has been found to moderate the relationship between a presence of meaning and QOL, past research has suggested that the search for meaning is not related to lower QOL among people who also feel life is highly meaningful (e.g. Cohen & Cairns, 2012; Park et al. 2010).

Qualitative interviews found individuals in the current study to report having meaning in their lives. Further, t-tests revealed no significant difference in the presence of meaning endorsed quantitatively between groups. The more meaning one has in life, the less the search for meaning negatively impacts one's QOL. Although the literature has often compartmentalised the search and presence of meaning (Davis, Wortman, Lehman & Silver, 2000; Steger, Frazier, Oishi, & Kaler, 2006; Steger, Oishi, & Kashdan, 2009), these findings suggest that the two can operate in a parallel manner, being present simultaneously. The presence of meaning does not preclude the continued search for meaning, nor does the search for meaning necessarily indicate a lack of MIL.

Similarity was also found in responses pertaining to purpose. Both groups similarly explained purpose in terms of stemming future conflict. Holocaust survivors remember in order to prevent. Elie Wiesel (2012, p. 150) demonstrated how reflection promotes prevention when he wrote:

> Never again becomes more than a slogan: It's a prayer, a promise, a vow. There will never again be hatred, people say. Never again jail and torture. Never again the suffering of innocent people, or the shooting of starving, frightened, terrified children. And never again the glorification of base, ugly, dark violence.

This purpose manifests in the abundance of Holocaust museums and memorials around the world. Similarly, Sudanese refugees expressed a purpose in stopping future conflict in Sudan. This purpose too is manifest in current institutions and practices. Rather than in museums built to remember, the Sudanese purpose manifests in current advocacy groups looking forward, such as the Australia's South Sudan Peace Initiative advocating for the cessation of war in Sudan (Initiative of Change, 2013).

This similarity in purpose helps demonstrate the aptness of considering MIL in trauma recovery work cross-culturally, supporting Silove's (1999) fifth component of his

ADAPT model. When synthesising purpose with the reported lived experience of trauma, it becomes clear that MIL for both of these groups can be a response to the trauma experience. Both groups expressed the persistence of traumatic memory, whilst at the same time interpreting its function differently. For Holocaust survivors, by turning the indelible mark, the persistence, of traumatic memory into purpose, they reorient the nature of traumatic memory into that which is adaptive. This is evidenced by results in Chapter 5 linking traumatic memory with greater QOL in this group. For Sudanese refugees, by looking forwards purposefully, attention is shifted away from the past and the persistence of traumatic memory. Traumatic memory is perceived as maladaptive, evidenced by a negative correlation found with QOL in Chapter 5, and so they focus on what is continuing to happen to their community.

Similarly, purpose aimed at preventing future conflict can be synthesised with groups reporting the persistence of existential anxiety in the lived experience of trauma. Both groups expressed a concern in Chapter 4 that the traumatic event could happen again. Accordingly, their expressed purpose is a means by which groups confront this existential anxiety. Frankl (1967), explains, “optimism in the face of tragedy” (p. 139) allows for “human potential” (p. 140) by turning suffering into achievement, growth, and responsibility for action. In particular, taking responsibility for action is a way that both groups confront existential anxiety. MIL therefore can be a useful mechanism for dealing with trauma cross-culturally, by contributing to adaptive ways in which diverse cultural groups confront existential anxiety. As explained by Valent (1995, p. 85), “their special significance in bearing witness and giving testimony may avert similar evil in the future and provide some purpose to the otherwise pointless massacres”.

A final similarity was found in group response to both qualitative and quantitative questions pertaining to comprehension. Qualitatively, both groups expressed a discord

between their prior comprehension of the world and the occurrence of the traumatic event experienced. Yet both groups still maintained having MIL. Holocaust survivors and Sudanese refugees explained that prior belief in God and Allah was challenged by the Holocaust and by the conflict in Sudan, respectively. The trauma literature has explained that following a traumatic event, one's prior beliefs and assumptions about the world are commonly shattered (Janoff-Bulman, 1992; Park, 2010). Ellie Wiesel (1968, p.182), after 20 years of trying to understand the tragedy of the Holocaust explained, "I still do not understand what happened, or how, or why. All the words in all the mouths of the philosophers and psychologists are not worth the silent tears of that child and his mother". Qualitative findings were further supported by quantitative measurement of a sense of coherence. Counter to previous literature supporting a link between a sense of coherence and QOL (Eriksson & Lindstrom, 2005), and the study's third hypothesis that a sense of coherence and QOL would be positively correlated in both groups, Holocaust survivors and Sudanese refugees yielded little to practically no correlation between the two. The similarity here presents an important consideration for the use of a sense of coherence and comprehension in trauma recovery work cross-culturally. A sense of coherence commonly has been a method of promoting quality and satisfaction with life (Van der hal-van Raalte, Van IJzendoorn, & Bakermans-Kranenburg, 2008; Winger, Adams, & Moshe, 2016). Though while a sense of coherence has value in facilitating QOL in an American and European context, in the face of extremely traumatic events thought to shatter one's assumptions about the world, the comprehension component of the MIL construct may be less likely to yield gains in recovery work than the pursuit of purpose.

In comparing divergent cultural groups and finding similarity, insight for recovery work on a more global scale is presented. Results portraying similarity demonstrate that intervention in a range of cultural groups following trauma may benefit from prioritising the

pursuit of a purpose over the pursuit of comprehension. This is not to belittle the benefit of harmonising an understanding of one's stressor with previous world views. However, in the current study, purpose has been shown to be a strategy helping respondents confront the trauma experience. Purpose emanating from trauma can help Sudanese refugees and Holocaust survivors in dealing with both the persistence of traumatic memory and existential anxiety, despite any difference in their interpretation. Indeed, it is important not to underestimate the horrific nature of traumatic experience. Altmaeier (2013) posited that it can be invalidating and victimising to suggest that benefit can be derived from all traumatic experiences. Recognising the potential purpose to stem from tragedy, thereby helping victims confront the trauma experience, can be a method of pursuing adaptation following trauma (Silove, 2013; 1999).

7.5 Theoretical implications

The current thesis contributes to a synthesising of viewpoints. It provides insight into the way that an American and European clinical model of trauma can coincide with culturally-specific notions of trauma. The similarities found help in considering the components of a broader trauma framework than that of psychopathology. Four key similarities in conceptualising the trauma experience, the similarly negative correlation found between PTSD and QOL, and similarities in the conceptualisation of MIL, suggest that cultural difference does not preclude commonality. Acknowledgement of difference identifies the need for flexibility within this broad framework. A key consideration in cross-cultural research is that variability in interpretation of the same phenomenon is possible (Kleinman, 1987; Summerfield, 2001; Tempany, 2009). Findings of the current thesis supported this notion, demonstrating that variability in interpretation is important to consider for the way that it can interact with the impact of, and response to, trauma.

The recognition of difference cross-culturally provides insight into the malleability of trauma conceptualisation based on one's social environment. Significant differences in PTSD and QOL correlations between groups, as well as differences in qualitative responses to trauma, indicate the potential for variability in symptom interpretation cross-culturally. This accords with the progression and evolution of trauma understanding over time, as outlined in chapter 1, and literature documenting the various conceptualisations of trauma cross-culturally (Kohrt et al. 2014; Nickerson & Bryant, 2014; Nicolas, Wheatley & Guillame, 2015**).** A deep understanding of trauma symptoms cross-culturally needs to reflect flexibility in interpretation.

A theoretical implication emanating from the recognition of difference in interpretation, is that interpretation of trauma not only alters trauma's meaning, but can also impact the significance of trauma on people's lives, changing the way individuals respond to it. This was found to be particularly pertinent in the case of persistent traumatic memory. Holocaust survivors and Sudanese refugees adopted contrary interpretations of traumatic memory and therefore responded to its persistence differently. This altering interpretation coincided with an altered relationship between traumatic memory and QOL. Persistent traumatic memory in and of itself is categorically not 'bad' nor 'good', not 'maladaptive' nor 'adaptive', in all situations. Findings highlight that, rather than the objective existence of a direct link between traumatic memory and outcome, the interpretation of traumatic memory plays a role in the influence of traumatic memory on people's lives.

Currently, the PTSD category in the DSM 5 interprets traumatic memory in one way. The PTSD category recognises only intrusive memory, defining traumatic memory as "recurrent, involuntary and intrusive distressing memories" (p. 273). Omissions of the words 'intrusive' and 'involuntary' render item 1 on the HTQ-R therefore different to current clinical understandings of intrusive memory. Hoge and colleagues (2016) have explained that

the DSM 5 symptom, with a focus on involuntary memory, overlooks "recurrent thought/memory processes common in PTSD with intentional or habitual qualities" (p. E1). Holocaust survivors demonstrated that whilst some memory of traumatic events may indeed be involuntary, to focus exclusively on involuntary memory ignores the memories of a traumatic past deemed purposeful. Moreover, Altmaier (2013) asserted that intrusiveness of memory depends on one's response to initial traumatic memory formation. Traumatic memory persists, though its persistence alone does not determine its quality objectively. Rather interpretation of the memory determines whether it is intrusive or unobtrusive (Altmaier, 2013). In different settings, intrusive traumatic memory can depend on the socialised interpretation of the memory, rather than the objective existence of its intrusive quality. This is what Rubin and colleagues (2008, p.986) alluded to when positing that the "processes of remembering" determines the impact of remembering itself.

Some may argue against this notion, suggesting that if traumatic memory is not intrusive or involuntary then it is not indicative of disorder or befitting of the trauma label. However, response to this argument is two-fold. First, given the horrific nature of traumatic events, and the specificity of each experience, assuming one response to be disordered for including intrusive and involuntary traumatic memory, incorporates insensitivity to experience. It seems extraordinary to suggest that a functioning human is one who has no intrusiveness of memory when witnessing "something as disturbing as watching a body blown apart or a gang rape" (Manderson, Cartwright, Hardon, 2016, p. 289). Suggesting there to be an 'incorrect' way to respond to life-altering events can invalidate the variability of cultural difference, and assume psychopathology cross-culturally (Steel, Steel, & Silove, 2009; Summerfield, 2001). In the current research, Sudanese refugee preoccupation with the current stressor of ongoing conflict, and the simultaneous need to avoid memory, may allow for the intrusive quality of memory. Moreover, it is juxtaposed with Holocaust survivor

preoccupation with memory and the past. An explanation of disorder then based on a past traumatic event and the persistence of involuntary and intrusive traumatic memory therefore may not fit Sudanese explanations for trauma. This consideration coincides with recent research emphasising that in Sudanese populations, despite having experienced trauma, the need to address trauma is of low priority (Savic, Chur-Hansen, Mahmood, & Moore, 2016). Particularly the 'post' in PTSD can undermine the traumatic experience for survivors who are dealing with current stress rather than stress born from past experience (Lester, 2013). This can further help explain how previous research with Sudanese refugees has found both high rates of PTSD and simultaneously high rates of QOL (Tempany, 2009). If, despite their endorsement, high rates of PTSD symptoms are not necessarily indicating disorder, then categorising symptoms as disordered fails to acknowledge the hierarchy of concern in diverse cultural groups (Kirmayer, Kienzler, Afana, & Pederson, 2010; Savic, Chur-Hansen, Mahmood, & Moore, 2016).

Second, failure to recognize the pain of Holocaust survivor traumatic memory for its ill-fit with the PTSD label, due to the voluntary and unobtrusive qualities of purposeful memory, can invalidate and delegitimise Holocaust survivor experience. Valent (1995) reflects on the difficulty of remembering by indicating that "with memories come the reliving of threats" (p. 86). Even if memories are voluntary, they are still accompanied by the pain of trauma. Deeming traumatic memory as purposeful does little to relinquish the pain, evidenced by Jacob's assertion in Chapter 4, "I resurrect my family, and when we finish the lecture, bury them again". The pain incorporated in remembering traumatic events cannot be underestimated. Valent (2012, p.5) explains that "(h)ow much pain we are prepared to suffer depends on how much meaning and purpose our memories will serve". To suggest then that the reliving of traumatic memory is not befitting of the pain encapsulated by the notion of trauma, undermines this group's trauma experience.

If PTSD is to be more inclusive of diverse cultural experiences, there needs to be flexibility in the way traumatic memory is conceived. To include traumatic memory as a component of psychopathology overlooks the capacity for positive adaptation in the experience of trauma. There is a need to avoid assuming "a deterministic model" (Silove, 2013, p. 238). The current thesis demonstrated how it is possible for symptoms thought of as pathological in one context of assessment to be critical to MIL in another setting. It follows that symptoms of PTSD, although perhaps observed, do not necessarily determine the presence of disorder. Traumatic memory was found to provide purpose to Holocaust survivors. Although most PTSD symptoms were found to correlate negatively with QOL, PTSD symptoms have also been previously reported to be potentially useful as a pathway to recovery (Lester, 2013). Endorsement of symptoms alone therefore should not be the end point of assessment. Symptoms are pointing towards "the things behind the things" (Morrison, 2005 p. 45, in Beneduce, 2016). Conceptualising trauma response as a collection of symptoms indicating disorder ignores variable meaning of symptom experience. Whilst this may be one way of interpreting symptoms, whether it is a useful way in different groups requires appropriate contextualisation.

It is important to circumvent a culture of victimisation that can be perpetuated by a preoccupation with trauma and PTSD (Silove, Steel, & Bauman, 2007). Caution in diagnosing PTSD may be particularly pertinent in groups struggling with feelings of powerlessness. The Sudanese group, for example, was found to endorse significantly higher scores on the HTQ-R's 'powerless' item, part of the total trauma scale, than Holocaust survivors. Belief in one's ability to have control and power over one's life has been shown to be related to higher mental and physical well-being (Park 2010). Particularly given that previous research has found clinical categories to be uncommon in the Sudanese depiction of

mental health (Savic, chur-hansen, Mahmood, & Moore, 2016), diagnosing symptoms of PTSD as disorder can perpetuate feelings of powerlessness.

Caution therefore must be considered when attributing a psychopathological and disordered description to PTSD symptoms. Schwartz (2014, 7:25) explained that "our human nature is much more created than it is discovered". In this, he suggests that the way things are interpreted creates their meaning, rather than exposes it. This is particularly so when considering something as elusive, unobservable, and hidden as internal pain (Scarry, 1985). A central assumption behind psychiatric diagnoses and the latent-variable model of clinical medicine is that psychiatric disorders have an objective existence in the world, whether discovered or not (McNally et al. 2014; Summerfield, 2001; Young, 1995). However, the current findings indicate that the way that trauma symptoms are interpreted by a group alters their nature. Criterion 'G' of the PTSD classification outlining that the symptoms need to cause "clinically significant distress or impairment in social, occupational, or other important areas of functioning" (APA, p. 272) is an important discriminator when using the PTSD diagnosis cross-culturally. The trauma experience depends on the way different groups interpret it, for "it is only human nature to have a human nature that is very much the product of the society in which people live" (Schwartz, 2014, 7:15).

Therefore, in the pursuit of a synthesis between clinical models of trauma and culturally diverse conceptualisations, effective ways of interpreting trauma are important for consideration (Silove, Steel, & Bauman, 2007). Research with diverse cultural groups in the current study demonstrates that difference, whether due to culture, time since trauma, or unspecified factors, can lead to malleable interpretations of trauma. The challenge is to interpret trauma in a way that captures universal experience, and also validates variability in experience, recognising that healing "may not always look like healing according to dominant models of recovery" (Lester, 2013, p. 755). Using the PTSD category as a way to

understand the human experience of trauma perpetually creates an understanding of the mind requiring a clinical response to trauma. This can be useful if it serves to validate the pain of survivors, though it also has risks in leading to further victimization by categorizing experience as disordered. Whilst institutions that reinforce this perception of the mind are valuable for alleviating reliable and valid pathology following traumatic events, institutions also need to be flexible, guiding trauma work to use the most effective pathway to recovery in diverse cultural groups.

7.6 Clinical Implications

The current thesis provides direction for the progression of clinical practice with groups of people that have suffered through violence, war and conflict. In synthesising clinical and diverse cultural perspectives, in accordance with Boehnlian's (2007) contention, it is important that any patient and clinician strive for a "congruence of their respective models of illness causation and ideas for treatment" (p. 271). The current study provides insight into ways to progress with this approach so as to create a therapeutic environment of validation and understanding. In an effort to address the previous criticism of the universal approach to PTSD, the current thesis phenomenologically examined the lived experience of trauma cross-culturally, through interviews with two groups. In so doing, it identified between-group similarities which has promoted the likeness of people without using a prevailing description of disorder. Shlegel and Hicks (2016, p. 4) recognised the importance of being able to acknowledge similarity, "people are looking for others who understand their true selves, allow them the opportunity to express those true selves, and appreciate them for their true selves". A universal consideration of trauma, with a phenomenological approach, allows for an integration of diverse cultural models with an American and European clinical model. Moreover, it allows for a synthesis of diverse trauma conceptualisation with diverse

notions of recovery extending beyond the clinical eradication of symptoms. Facilitating the pursuit of MIL is one way that the current thesis provides particular direction for clinicians and aid workers in dealing with the aftermath of traumatic events.

Similarities found in the current research indicate notions of trauma and recovery that can operate cross-culturally. Symptoms of PTSD were shown to be endorsed in diverse cultural groups. Symptoms of PTSD were predominantly found to negatively correlate with QOL in both groups. Similarity in the lived trauma experience was shown to include the persistence of traumatic memory, the change in identity, the change in one's relationship to the social world, and existential anxiety. Also, similarities were highlighted in cultural conceptualisation of MIL. Purpose related to both future generations and preventing future conflict. Non-significant relationships were found between a sense of coherence and QOL in both groups.

Based on current findings, clinicians and aid workers can begin by attending to the four similarities found between groups in trauma conceptualisation with diverse groups. These similarities have also been supported by previous research. Validating and working with the trauma experience as consisting of persistent traumatic memory (Van Rooyen & Ngweni, 2012; Weisel, 1958; Lawrence-Wood et al. 2015), a change in identity (Silove, 1999; 2013), a change in relationship to the external world (Janoff-Bulman, 1992; Park, 2010), and existential anxiety (Silove, 2013; Wiesel, 1958; Zoellner, Rothbaum, & Feeny, 2011), can demonstrate understanding when working with individuals from diverse cultural groups. Those helping to provide aid can build rapport with survivors and refugees by demonstrating an appreciation of their trauma response through these four pillars.

In working with a culturally inclusive notion of persistent traumatic memory, considering culturally specific responses is important in appropriate pursuit of recovery. Working to eradicate the traumatic memory will prove to be ineffective (Webb & Windseth,

2009). For some groups, as with the Holocaust survivors, remembering the past will be an effective way of managing trauma. The current thesis has demonstrated that for groups who approach traumatic memory in a similar way, remembering can contribute to MIL, specifically by providing a purpose in honoring the dead. In agreement, Herman (1992, p. 1**)** wrote that remembering the past can be a "prerequisite for both the restoration of the social order and for the healing of individual victims". For other groups, still confronting their primary trauma or having more recently endured trauma, as was the case for the Sudanese refugees in the current study, focusing on progress can aid in confronting persistent traumatic memory, as opposed to focusing on the past (Marlow, 2010). A focus on progress is not to deny the occurrence of the traumatic event, though it can help in shifting individual attention away from that which is culturally deemed important not to think about. It may be that Sudanese refugees, as they become more established (Valent, 19995), shift in their focus from looking forward to reflection. Other cultural groups too have been documented as looking forward, such as Buddhist Cambodians (Kidron, 2012). For these groups, helping them "find meaningful livelihoods … and imagine a viable future" is more important for their context (Kirmayer, Gone, & Moses, 2014, p. 311). Utilising PTSD endorsement of traumatic memory, coupled with further qualifiers identifying the interpretation of traumatic memory can provide insight into the approach best adopted with individuals from various cultural groups.

Similarities found cross-culturally in changes to identity, and changes to one's relationship with the world, implicate the need to use caution when considering diagnostic categories for trauma. Identity changes in Holocaust survivors were reported to include feeling "different" and "abnormal", whilst Sudanese refugees reported feeling "powerless". Holocaust survivors and Sudanese refugees also explained feeling abandoned by, and a burden on, the world, respectively. Diagnostic categories, whilst validating victimhood, focus

on individual disorder and therefore potentially perpetuate such identity shifts and the conception of the self as a victim in relation to others (Fassin & Rechtman, 2009). Silove, Steel and Bauman (2007**)** explained the danger in this by suggesting that preoccupations with PTSD can further victimise trauma survivors, leading to maladaptive behavior. Particularly given the aforementioned power of interpretation, helping survivors of traumatic events identify themselves and their standing in relation to the world in a way that harnesses recovery will be most effective. This is not to undermine the value of a PTSD label, but instead recognises its place in a broader framework of pursuing recovery.

Clinicians and aid workers can draw on similarities found by emphasising community building strategies and interpersonal work in the pursuit of trauma recovery. Previous literature has explained these strategies to strengthen individual identity and bonds with others (Silove, 2013; Silove, Steel & Bauman, 2007), whilst also aligning with more collective world views inherent in diverse cultural groups (Ungar, 2011). Lester (2013, p. 759) argued that clinicians need to focus on "the interpersonal and social work of how one relates to other people" in order to produce the best outcomes in recovering from trauma. In groups where an importance is placed on remembering, war museums and remembrance rituals can be useful ways of acknowledging the horror of traumatic events (Manderson, Cartwright, & Hardon, 2016). Moreover, they help in building individual identity and bonds in the context of community (Silove, 2013). Alternatively, if the group places emphasis on progress and looking forward, advocacy groups and reconciliation events (Bloomfield, Barnes, & Huyse, 2003) can also help build an effective identity, transforming bonds with the wider community. Whilst the effectiveness and evidence base of collective and holistic approaches to trauma-informed care require more research (Victorian Foundation for Survivors of Torture, 2016), Silove (2013, p.242) explained the importance of these approaches; "only when contemporary policies and practices in the post conflict environment

are seen to be genuinely reflecting the human rights lessons of the past, are survivors likely to feel a degree of genuine vindication for their sacrifices".

The current thesis further supports community and interpersonal approaches for the way that they can help individuals construct avenues for fulfilling a purpose in life. Following the traumatic events experienced by participants, MIL was found to predominantly consist of the pursuit for purpose. Findings firstly indicate that clinicians working to help individuals establish MIL following traumatic events, need concern intervention less with comprehension and more with the establishment of a purpose, particularly in groups where the search for meaning is high. Holocaust survivors and Sudanese refugees outlined the purpose preventing future conflict. Community building strategies such as remembrance rituals and advocacy groups then can not only contribute to identity and interpersonal growth, but also facilitate the expression of purpose. Helping groups express purpose through community and interpersonal strategies aids groups in managing persistent traumatic memory, change to identity, and a change in relationship to the social world. Moreover, mentioned previously is the way that purpose in preventing future war and conflict aids groups in confronting similarly found existential anxiety. Museums, memorials, and advocacy groups therefore also help individuals manage existential anxiety around the reoccurrence of events by providing them with an opportunity to actively work towards preventing them.

Clinicians and aid workers can advocate for the importance of helping survivors of traumatic events in establishing meaning and purpose in resettlement (Kinzie, 1989; Silove, 2013). Mental health programs can advocate for the importance of pursuing purposeful expression of trauma. By advocating for the facilitation of purpose tailored towards the needs of specific cultural groups, clinicians and aid works can help by being beacons of "empathic human connection" (Lester, 2013, p. 758), absent during the period of a traumatic event.

Placing an emphasis on building institutions for the expression of purpose can therefore aid in individual and community recovery. Moreover, it speaks to the importance of considering trauma on a larger scale than individual psychopathology (Kirmayer, Gone, & Moses, 2014).

7.7 Limitations and Future Directions

The findings from the current study provide important reflections for work with traumatised groups from all over the world. These findings need to be considered in the context of limitations, so as to provide clues as to directions for future research. Due to the intensive interviewing and qualitative analysis performed, sample sizes are small. This presents a limitation for quantitative analyses, the results of which, although at times statistically significant, are underpowered. Beyond this, limitations pertain to three key areas, namely, generalizability of results to wider groups, time since trauma as confounding the establishment of culture as a cause of difference, and finally, the limitations of measuring recovery.

The current thesis is limited in its ability to generalise a number of the findings to wider groups, due to constraints in the number and variety of participants utilised in the study. Qualitatively, the more participants included, the more comprehensive the findings, the more applicable they may be to the wider Holocaust survivors and Sudanese refugee populations. Moreover, Holocaust survivors and Sudanese refugees are both groups living in Australia, and this allows for the possibility that participants from both groups have, in part, acclimatized to prevailing Australian clinical approaches to trauma. This presents a consideration in that they are less removed and less discrepant in their understandings of trauma than perhaps would be for groups sampled from different parts of the world. Increased globalisation has contributed to the fluidity of culture, and as cultures confront one another, it becomes increasingly difficult to disentangle the "hyperdiversity" within culture (Good &

Hannah, 2015, p. 201). Therefore, this constraint is prominent in most studies with refugees who by the nature of their experience, have encountered, learned from, and engaged with various cultural groups.

Whilst this does not detract from the credibility of differences found, this may detract from the current study's ability to generalise similarity. Generalising is also limited by the number of groups studied. Future research would benefit, using the phenomenological approach set out in this thesis, from examining other cultural groups from more disparate locations, to assess for commonality between their lived experience of trauma and the similarities described in the current thesis. Comparing alternative cultural groups using a similar method will provide more insight into the applicability of the four similarities documented. In particular, traumatic memory as an adaptive system following traumatic events will benefit from further exploration in various cultural groups.

Establishing a cause for difference is limited in the current thesis. It is difficult to affirm difference based solely on culture. It is possible that time since trauma has contributed in part to the differences found between groups. Growth after trauma and a resolving of symptoms, though not consistent, have been found to occur over time elapsed since a traumatic event (Jovanovic et al. 2012; Prati & Pietrantoni, 2009; Stanton et al. 2006). Difficulty pinpointing a precise sole cause of difference detracts not from the acknowledgment of similarity. The more complex the contextual differences between groups, the more profound the similarities. However, it is not entirely clear whether differences found in traumatic memory, feelings of powerlessness, and somatisation, are due to culture, or due to Sudanese refugees having experienced less time elapsed since their primary traumatic event.

While the primary trauma of the Holocaust occurred long before the primary trauma of Sudanese refugee participants, measuring time since trauma in this way is perhaps too

narrowly conceived. Traumatic experiences of refugees have been demonstrated as cumulative and complex (Davidson, Murray, & Schweitzer, 2008). Additional, cumulative traumatic events may impact trauma resolution. Further, a model of trauma whereby a traumatic event occurs and a trauma reaction follows, assumes that remnants of the traumatic event have subsided. Particularly in the case for those reliving traumatic events or those experiencing the continuity of initial stressors, traumatic events may continue to impact trauma response (Lester, 2013).

More importantly, if time since trauma does contribute to difference in the cultural construction of trauma, or feeds into a more complex contextual difference between groups, then context still shapes the way that individuals and groups perceive trauma. Conceptualisations of trauma are still malleable, irrespective of age (Kaiser, Wachen, Potter, Moye, & Davison, 2016), time since trauma, or culture. Findings that identify difference in trauma interpretation are consequently still valuable for the way that they demonstrate the impact of the social on the trauma experience. The social environment interacts with the way one interprets trauma, and therefore the trauma experience itself. Without sensitivity to this difference, approaches to recovery will fall short.

More research is needed to explore pathways of synthesising difference and interpreting similarities in trauma conceptualisation. A focus on difference must continue so as to allow for sensitivity and flexibility. Survivor populations each have a variety of unique needs. Without understanding the variability in needs, as well as the contextual factors such as culture, time since trauma, and age, that contribute to these needs, intervention cannot be tailored appropriately. However, more work needs to consider ways of bridging difference. Future research could consider constructing more models of trauma that synthesise the differences in the needs of survivor populations (Silove, Steel, & Bauman, 2007). By bridging differences, ground level trauma recovery work is provided with methods and

intervention strategies that are flexible and adaptable. This is crucial given the contextually-dependent heterogeneity in trauma response and interpretation (Marsella, 2010; Michalopoulos et al. 2015; Shannon, Wieling, McCleary, & Becher, 2015; Summerfield, 2012). Future research will benefit clinicians working with trauma by helping consider how best to interpret synthesised cultural conceptualisations of trauma, the similarities. Interpretation has been demonstrated to powerfully create the qualities of that which people are trying to understand (Hacking, 2006; Schwartz, 2014). It has been well established that a focus on psychopathology is not an effective interpretation for the similarity in trauma response cross-culturally. Instead, future work needs to consider how best to interpret similarity in trauma experience that facilitates recovery in different settings.

In considering how best to interpret culturally synthesised trauma conceptualisations in ways that effectively facilitate recovery, a final limitation emerges. There is difficulty in commenting accurately on precisely how best to assess for recovery. The current methodology has utilised MIL and a cross-culturally applicable measure of QOL as markers of recovery. Yet, how recovery from traumatic events appears to different groups still remains unclear (Sousa, 2013). Notions of recovery are particularly confused by the documented persistence of trauma experience in Holocaust survivors. Whether recovery from the trauma experience, beyond an assessment of PTSD symptoms, is even an applicable concept given the persistence of trauma (Beneduce, 2016; Lester, 2013) is an open question.

The findings of this thesis pertaining to MIL help consider where to begin with how to interpret and understand trauma recovery. Purpose in life was found in both groups to similarly target preventing future conflict. Perhaps interpretation of trauma models from a cross-cultural perspective needs to focus not only on trauma recovery, but also on how individuals can work to prevent the trauma from reoccurring. Future research and clinical work may benefit from considering ways to interpret trauma that not only help provide

strategies for overcoming individual trauma itself, thereby facilitating recovery, but also help traumatised groups in a purpose aimed at preventing interpersonal traumatic events from happening again. Symptoms of PTSD have been described by Beneduce (2016) as "palimpsests," which he defined as "expressions of tacit historical knowledge". He explained that behind these palimpsests, what the PTSD symptoms actually reflect are a painful past of conflict, war and violence. In the examination of the meaning of trauma in this thesis, similarities pointed to groups fearing the reoccurrence of the traumatic event and purposefully pursuing its prevention. As Valent (2012, p. 10) stated, "(j)ust as in illness we initially try to heal the patient, after the trauma we initially support the afflicted, but eventually we turn to the causes of illnesses and traumas so we must eventually, and it may take generations, turn our attention to causes and causers of catastrophes". Finding a way to institutionally and systematically categorise synthesised, trauma conceptualisation cross-culturally, in a way that promotes prevention will not only therefore validate experiences of trauma in various cultural groups, but also facilitate the fulfillment of MIL in traumatised communities. Pursuing prevention as an interpretation of trauma will help, in the current climate, reflect the lessons of traumatic pasts in order for diverse cultural, traumatised groups to feel vindicated.

Conclusion

The meaning of trauma as a concept has evolved over time to now firmly be placed in an American and European discourse of mental health. Debate over the cross-cultural validity of the clinical PTSD model is no longer effective for the progression of global trauma work with populations from around the world (Friedman, Resick, & Keane, 2007; Kienzler, 2008; Summerfield, 2012). The current thesis has grappled with the pursuit of a synthesis, the goal being to explore PTSD and conceptualisation of trauma and recovery from a cross-cultural perspective in order to arrive at a culturally applicable understanding of the elusive, intangible notion of trauma. A comparison of diverse cultural groups has affirmed that trauma appears to be a universal experience incorporating particularities specific to different people, populations and events (Nicolas, Wheatley & Guillaume, 2015; Nickerson & Bryant, 2014; Van Rooyen & Ngweni, 2012; Ungar, 2011). How best to interpret similarities between groups remains important for the way that interpretation of trauma response has been shown to influence the significance of the response (Altmaier, 2013; Slobodin, Caspi, & Klein, 2014). Synthesising trauma with recovery provides insight as to how MIL can be used to interpret universal trauma.

Major similarities identified helped bridge the difference between groups in their lived trauma experience. A change in identity, a change in one's relationship with the world, and existential anxiety over the reoccurrence of the traumatic event, supports previously documented, cross-culturally applicable notions of trauma (Keyes & Kane, 2004; Silove, 1999; 2013). Persistent traumatic memory adds to the literature as a culturally non-specific trauma experience. Traumatic memory has been well supported (Copping, Shakespeare-Finch, & Patton, 2010; Kidron, 2012; Levi, 1984; Rubin, Berntsen, & Bohni, 2008), and is primed for use as a cornerstone for universal trauma work relating to, and validating the experience of, diverse cultural groups.

An exploration of PTSD found PTSD symptoms to be requiring of contextualisation, for the way that interpretation of symptoms can influence trauma response. Symptoms of PTSD exist on continuums spanning from adaptive to maladaptive (Silove, 2013; Silove, Steel, & Bauman, 2007). Persistent traumatic memory was found to differ between groups in keeping with phenomenologically driven group conceptualisations of trauma. Results then demonstrated that PTSD symptoms can alter in their relationship with QOL depending on context, in line with previous findings (Kleinman, 1987; Summerfield, 2001; Tempany, 2009). These results emphasise the need to contextualise PTSD appropriately if it is to be used as a description for trauma globally. Therefore, pursuing recovery and healing from trauma needs to be more broadly considered than as an eradication of PTSD symptoms (Webb & Windseth, 2009).

Pursuing a synthesis of diverse cultural trauma conceptualisations with findings from the exploration of MIL cross-culturally, demonstrates that preventing the reoccurrence of traumatic events is a culturally non-specific pursuit following trauma. Exploring MIL as a pathway to recovery (Frankl, 1967; Park, 2016; Shlegel & Hicks, 2016; Silove, 1999) demonstrated diverse cultural groups to promote the quest for a purpose in life (King, Hicks, Krull, & Del Gaiso, 2006; Park, 2010; Steger, 2009; Steger & Kashdan, 2013). Particularly in groups searching for meaning, clinicians helping individuals find a purpose on account of their traumatic event experienced can aid in rebuilding the quality of their lives. Establishing community infrastructure (Lester, 2013; Manderson, Carwright, & Hardon, 2016; Silove, 2013; Ungar, 2011) for the expression of purpose can help groups in interpersonal recovery. Therefore, synthesising trauma and recovery from a cross-cultural perspective may involve interpreting the universal trauma response, rather than predominantly through the lens of clinical mental health, as a global quest for the prevention of conflict, violence and war.

Reorienting trauma conceptualisation in this way accords with the experience of participants from both groups in the current study.

> *Jacob:* I remember standing there on the snow-bound mound near the border of Austria, and crying my head off. Yeah. Then I said, look, one thing I promise that never again, never again is the Christian world going to stand by and watch them, watch 1.5 millions of our babies being murdered… I said, never again, on the first of May, 1945. But the never again is passed onto the new generation. Because then after the war, which we never believed was going to happen, all these countries, people were murdered. United Nations troops were standing next to them, when they were murdering people in Uganda, and did nothing. Didn't lift a finger. What happened to the never again? They're sitting in New York, drinking cognac free of tax, and there are people getting murdered. Look at it now, look at Syria, look at Iraq, nothing.

> *Shaker:* I do it because I feel I have obligation, I feel there are others that have sacrificed their lives for me, whether it be my father or brother, or my relatives from my parents of both sides, or a number of my friends that I knew who have died in conflict or haven't been able to work, or drowned in a river cos they couldn't swim, they were being forced to run and some had to jump into the river when you are having someone run behind you with a gun you have to find somewhere to hide… that's one thing that I believe I have kept the spirit of moving on and it's standing up on behalf of others that I believe I have this opportunity today to share what it means to struggle and stand up for freedom for others who are unable to do it and don't have opportunities to do so.

References

Ahrens, C.E., Isas, L., & Viveros, M. (2011). Enhancing Latinas' Participation in Research on Sexual Assault: Cultural Considerations in the Design and Implementation of Research in the Latino Community. *Violence Against Women, 17*(2), 177-188. doi: 10.1177/1077801210397701

Agbayani-Siewert, P., Takeuchi, D. T., & Pangan, R.W. (1999). Mental Illness in a Multicultural Context. In C.S. Aneshensel, & J. C. Phelan (Eds.). *Handbook of the Sociology of Menial Health* (pp. 19 - 36). New York: Klumer Academic Press/ Plenum Publishers.

Al-Saffar, S., Borga, P., Edman, G., & Hallstrom, T. (2003). The aetiology of posttraumatic stress disorder in four ethnic groups in outpatient psychiatry. *Social Psychiatry and Psychiatric Epidemiology, 38,* 456–462. doi: 10.1007/s00127-003-0659-7

Alexander, J. C. (2004). Toward a theory of cultural trauma. In J. C. Alexander, R. Eyerman, B. Giesen, N. J. Smelser, & P. Sztompka (Eds.), *Cultural trauma and collective identity* (pp. 1–30). Berkeley, CA: University of California Press.

Almedom, A., & Summerfield, D. (2004). Mental well-being in settings of complex emergency: an overview. *Journal of Biosocial Science, 36*, 381–388. doi: 10.1017/S0021932004006832

Altmaier, E. (2013). Through a glass-darkly: personal reflection on the role of meaning in response to trauma. *Counselling psychology quarterly, 26*(1), 106-113. doi: 10.1080/09515070.2012.728760

American Psychiatric Association. (1980). Diagnostic and statistical manual of mental disorders (3rd ed.). Washington, DC: American Psychiatric Association.

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders, 4th edition.* Washington DC: American Psychiatric Publishing.

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders, 5th edition.* Washington DC: American Psychiatric Publishing.

Amin, A. (2010). The remainders of race. *Theory, Culture & Society, 27*, 1–23. doi: 10.1177/0263276409350361

Andreassi, J. L. (2000). *Psychophysiology: Human behaviour and physiological response.* New Jersey: Lawrence Erlbaum Associates, Inc.

Andrews, K. (2009). Understanding norms without a theory of mind. *Animal Sentience, Intelligence, and Emotion*, *52*(5), 433-448. doi: 10.1080/00201740903302584

Antonovsky A. (1979). *Health, stress and coping.* San Francisco, CA: Jossey-Bass

Antonovsky, A. (1987). Antonovsky's sense of coherence scale and job attitudes: Three studies. *South African Journal of Psychology, 31*, 30–37.

Applebaum, M. (2012). Phenomenological Psychological Research as Science. *Journal of Phenomenological Psychology, 43*(1), 36-72. doi: 10.1163/156916212X632952

Armour, M. (2010). Meaning making in survivorship: Application to Holocaust survivors. *Journal of Human Behavior in the Social Environment, 20*(4), 440-468. doi: 10.1080/10911350903274997

Armstrong, T. L., & Swartzman, L. C. (2001). Cross-cultural differences in illness models and expectations for the health-care provider: Client/patient interaction. In S. S. Kazarian, & D. R. Evans (Eds.), *Handbook of cultural health psychology* (pp. 63–84). London, UK: Academic Press.

Ashworth, P. (1996). Presuppose nothing! The suspension of assumptions in phenomenological psychological methodology. *Journal of Phenomenological Psychology, 27*(1), i-25. doi: 10.1163/156916296X00014

Atkinson, P., Delamont, S., Denzin, N. K., & Lincoln Y. S. (2005). *Analytic perspectives. The Sage handbook of qualitative research (3rd ed.)*. Thousand Oaks, CA: Sage Publications, Inc.

Auxemery, Y. (2012). Posttraumatic stress disorder (PTSD) as a consequence of the interaction between an individual genetic susceptibility, a traumatogenic event and a social context. *Encephale, 38*(5), 373-380. doi: 10.1016/j.encep.2011.12.003

Baer, R.D., Weller, S.C., de Alba Garcia, J.G., Glazer, M., Trotter, R., Pachter, L., & Klein, R.E. (2003). A cross-cultural approach to the study of the folk illness nervios. *Culture, Medicine, and Psychiatry, 27*(3), 315-337. doi: 10.1023/A:1025351231862

Barak, Y., & Szor, H (2000). Lifelong posttraumatic stress disorder: evidence from aging Holocaust survivors. *Dialogues Clinical Neuroscience, 2*(1), 57-62. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3181591/

Baron, N. (2002). Community based psychosocial and mental health services for southern Sudanese refugees in long term exile in Uganda. In J. de Jong (Ed.), *Trauma, war, and violence: Public mental health in socio-cultural context* (pp. 157–203). New York: Kluwer Academic/Plenum Publishers.

Bateson, G. (1975). Some Components of Socialization for Trance. *Ethos, 3*, 143–155. doi: 10.1525/eth.1975.3.2.02a00050

Belsky, J., & Pluess, M. (2009). Beyond diathesis-stress: differential susceptibility to environmental influences. *Psychological bulletin, 135* (6), 885-908. doi: 10.1037/a0017376

Benedict, A.L, Mancini, L., & Grodin, M.A. 2009. Struggling to meditate: Contextualising integrated treatment of traumatised Tibetan refugee monks. *Mental Health, Religion, & Culture, 12*(5), 485-499. doi: 10.1080/13674670902788908

Beneduce, R. (2016). Traumatic pasts and the historical imagination: Symptoms of loss, postcolonial suffering, and counter-memories among African migrants. *Transcultural Psychiatry, 53*(3), 261-285. doi: 10.1177/1363461516645079

Bentley, S. (2005). A Short History of PTSD: From Thermopylae to Hue Soldiers Have Always Had a Disturbing Reaction to War. *The VVA Veteran*. Retrieved from October 30, 2014. http://www.vva.org/archive/TheVeteran/2005_03/feature_HistoryPTSD.htm.

Bergmann, M., & Jucovy, M. (1982). *Generations of the Holocaust*. New York: Basic Books.

Blackstock, C., & Trocme´, N. (2005). Community-based child welfare for Aboriginal children: Supporting resilience through structural change. In M. Ungar (Ed.), *Handbook for working with children and youth: Pathways to resilience across cultures and contexts* (pp. 105-120). Thousand Oaks, CA: Sage

Bloom, S. L. (2000). Our Hearts and Our Hopes Are Turned to Peace: Origins of the International Society for Traumatic Stress Studies. In A.Y. Shalev, R. Yehuda, & A.C. McFarlane (Eds.), *International Handbook of Human Response to Trauma* (pp. 27 – 50). New York: Plenum.

Bloomfield, D., Barnes, T. & Huyse, L. (2003). *Reconciliation after violent conflict: A handbook*. Stockholm, IDEA.

Boehnlein, J.K. (2007). Religion and spirituality after trauma. In L.J. Kirmayer, R. Lemelson, and M. Barad (Eds.), *Understanding Trauma: Integrating Biological, Clinical, and Cultural Perspectives* (pp. 259-274). Cambridge: Cambridge University Press.

Bonanno, G. A. (2004). Loss, trauma, and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events? *American Psychologist, 59,* 20–28. doi: 10.1037/0003-066X.59.1.20

Bonanno, G.A., & Mancini, A.D. (2012). Beyond resilience and PTSD: mapping the heterogeneity of responses to potential trauma. *Psychological trauma: Theory, research, practice and policy, 4*(1), 74-83. doi:10.1037/a0017829

Bonanno, G. A., Papa, A., Lalande, K., Zhang, N., & Noll, J. G. (2005). Grief processing and deliberate grief avoidance: A prospective comparison of bereaved spouses and parents in the United States and the People's Republic of China. *Journal of Consulting and Clinical Psychology, 73*, 86–98. doi: 10.1037/0022-006X.73.1.86

Borghini, F., Garzia, F., Borghini, A., & Borghini, G. (2016). *The psychology of security, emergency, and risk.* Southampton, Boston: Witpress.

Borsboom, D., & Cramer, A.O.J. (2013). Network analysis: An integrative approach to the structure of psychopathology. *Annual Review of Clinical Psychology, 9*, 91–121. doi: 10.1146/annurev-clinpsy-050212-185608

Borsboom, D., Mellenbergh, G.J., & Van Heerden, J. (2003). The theoretical status of latent variables. *Psychological Review*, *110,* 203–219. doi:10.1037/0033-195X.110.2.203

Boyraz, G., Lightsey, O.R. Jr., & Can, A. (2013). The Turkish version of the Meaning in Life Questionnaire: assessing the measurement invariance across Turkish and American adult samples. *Journal of Personality Assessment, 95*(4), 423-431. doi: 10.1080/00223891.2013.765882

Block, K., Warr, D., Gibbs, L., & Riggs, E. (2012). Addressing ethical and methodological challenges in research with refugee-background young people: reflections from the field. *Journal of Refugee Studies, 26*(1), 69-87. doi: 10.1093/jrs/fes/002

Braun, V., & Clarke, V. (2013). *Successful qualitative research a practical guide for beginners*. London, UK: SAGE Publications Ltd.

Braun-Lewensohn, O., & Sagy, S. (2011). Salutogenesis and culture: personal and community sense of coherence among adolescents belonging to three different cultural

groups. *Internal Review of Psychiatry, 23*(6), 533-41. doi: 10.3109/09540261.2011.637905.

Braun-Lewensohn, O. Sagy, A., & Roth, G. (2010). Coping strategies among adolescents: Israeli Jews and Arabs facing missile attacks. *Anxiety, Stress, & Coping: An international Journal, 23*(1), 35-51. doi: 10.1080/10615800802647601

Bremner, J.D. (2002). *Does Stress Damage the Brain? Understanding Trauma-related Disorders from a Mind-Body Perspective*. New York, NY: W.W. Norton.

Bremner, J. D., Southwick, S.M., & Charney, D. (1999). The neurobiology of posttraumatic stress disorder: An integration of animal and human research. In Saigh, P.A. and Bremner, J.D. (Eds.), *Posttraumatic stress disorder: a comprehensive text* (pp. 103 – 131). Boston, MA: Allyn and Bacon.

Breslau, N. (2001). Outcomes of posttraumatic stress disorder. *Journal of Clinical Psychiatry, 62*(17), 55–59. Retrieved from: http://www-psychiatrist-com.ezproxy.lib.monash.edu.au/JCP/article/_layouts/ppp.psych.controls/BinaryViewer.ashx?Article=/JCP/article/Pages/2001/v62s17/v62s1710.aspx&Type=Article

Breslau, J. (2004). Cultures of trauma: anthropological views of posttraumatic stress disorder in international health. *Culture, Medicine and Psychiatry, 28*(2), 113- 126. doi: 10.1023/B:MEDI.0000034421.07612.c8

Breuer, J., & Freud, S. (1895). Studies in Hysteria. In J. Strachey (Eds.), *Complete Psychological Works*, 1954, London: Hogarth Press.

Brewin, C.R., Gregory, J.D., Lipton, M., & Burgess, N. (2010). Intrusive Images in Psychological Disorders. *Psychological review, 117*(1), 210-232. doi: 10.1037/a0018113

Bronstein, I., & Montgomery, P. (2011). Psychological Distress in Refugee Children: A Systematic Review. *Clinical Child and Family Psychology Review, 14*, 44-56. doi: 10.1007/s10567-010-0081-0

Brough, M., Schweitzer, R., Shakespeare-Finch, J., Vromans, L., & King, J. (2013). Unpacking the micro-macro nexus: Narratives of suffering and hope among refugees from Burma recently settled in Australia. *Journal of Refugee Studies, 26*(2), 207-225. doi: 10.1093/jrs/fes025

Broome, R.E. (2011). *Descriptive phenomenological psychological method: An example of a methodology section from doctoral dissertation*. Retrieved from: http://phenomenologyblog.com/wp-content/uploads/2012/04/Broome-2011-Phenomenological-Psychological-Dissertation-Method-Chapter.pdf

Briquet, P. (1859, as cited in Tasca, Rapettic, Carta, & Fadda, 2012). *Traité de l'Hystérie*. Paris: JB Baillière et Fils.

Browning, C. (1992). *Ordinary men.* London: Penguin Books

Bryant, R.A., Creamer, M., O'Donnell, M., Silove, D., & McFarlane, A.C. (2008). A study of the protective function of acute morphine administration on subsequent posttraumatic stress disorder. *Biological Psychiatry, 65*(5):438–40. doi: 10.1016/j.biopsych.2008.10.032

Bryant-Davis, T. (2005). *Thriving in the wake of trauma: a multicultural guide.* Westport, CT: Praeger Publishers.

Bryant-Davis, T., Ullman, S. E., Tsong, Y., Tillman, S., & Smith, K. (2010). Struggling to survive: Sexual assault, poverty, and mental health outcomes of African American women. *American Journal of Orthopsychiatry, 80*(1), 61-70. doi: 10.1111/j.1939

Burstow, B. (2003). Toward a radical understanding of trauma and trauma work. *Violence Against Women, 9,* 1293–1317. doi: 10.1177/1077801203255555

Carlson, E.B., & Rosser-Hogan R. (1994). Cross-cultural response to trauma: a study of traumatic experiences and posttraumatic symptoms in Cambodian refugees. *Journal of Traumatic Stress*,*7*(1), 43-58. doi: 10.1002/jts.2490070106

Carlsson, J. M., Olsen, D. R., Mortensen, E. L., & Kastrup, M. (2006). Mental health and health-related quality of life: a 10-year follow-up of tortured refugees. *Journal of Nervous and Mental Disease, 194,* 725-731. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/17041283

Caruth, C. (1995). *Trauma: Explorations in Memory*. Baltimore: Johns Hopkins Press.

Chhim, S. (2014). A place for baksbat (broken courage) in forensic psychiatry at the extraordinary chambers in the courts of Cambodia (ECCC). *Psychiatry, Psychology and Law, 21*(2), 286-296. doi: 10.1080/13218719.2013.809652

Chisholm D., et al. (2007). Scale up services for mental disorders: a call for action. *Lancet* 2007, *370*, 1241–52. doi: 10.1016/S0140-6736(07)61242-2

Clark, A. (2013). Whatever next? Predictive brains, situated agents, and the future of cognitive science. *Behavioural and brain sciences, 36*(3), 181-2533. doi:10.1017/S0140525X12000477

Coetzee, H.K., Wissing, M.P., & Temane, Q.M. (2010). Meaningfulness as experienced by a group of South Africans. *Tydskrif vir Geesteswetenskappe, 50*(3), 293-312. doi: 10.1007/s11205-010-9632-5

Cohen, K., & Cairns, D. (2012). Is searching for meaning in life associated with reduced subjective well-being? Confirmation and possible mediators. *Journal of Happiness Studies, 13,* 313-331. doi: 10.1007/s10902-011-9265-7

Copping, A., Shakespeare-Finch, J., & Paton, D. (2010). Towards a culturally competent mental health system: Sudanese, Sierra Leonean, and Liberian experiences with life crises. *Journal of Pacific Rim Psychology, 4*(1), 53-60. doi: 10.1375/prp.4.1.53

Conrad, P., Mackie, T., & Mehrotra, A. (2010). Estimating the costs of medicalization. *Social Science and Medicine, 70*, 1943-1947. doi:10.1016/j.socscimed.2010.02.019

Cosmacini, G. (1997). *The long art: the history of medicine from antiquity to the present*. Rome: Oxford University Press

Creswell J.W., & Plano Clark, V.L. (2010). *Designing and conducting mixed methods research (2nd ed.)*. Thousand Oaks, CA: Sage.

Davidson, G., Murray, K., & Schweitzer, R. (2008). Review of refugee mental health and wellbeing: Australian perspectives. *Australian Psychologist, 43*, 160 - 174. doi: 10.1080/00050060802163041

Davis, L.L., English, B.A., Ambrose, S.M., & Petty, F. (2001). Pharmacotherapy for posttraumatic stress disorder: a comprehensive review. *Expert Opinion Pharmacotherapy, 2,* 1583–1595. doi: 10.1517/14656566.2.10.1583

Davis, C., Wortman, C.B., Lehman, D.R., & Silver, R. (2000). Searching for meaning in loss: Are clinical assumptions correct? *Death Studies, 24,* 497-540. doi: 10.1080/07481180050121471

De Haene, L., Grietens, H., & Verschueren, K. (2010). Holding harm: Narrative methods in mental health research on refugee trauma. *Qualitative Health Research,* 20, 1664–1676. doi: 10.1177/1049732310376521

De Jong, J.T.V.M., & Reis, R. (2010). Kiyang-yang, a West-African postwar idiom of distress. *Culture, Medicine, Psychiatry, 34,* 301-321. doi: 10.1007/s11013-010-9178-7

De Jong, J.T.V.M., Komproe, I.H., Van Ommeren, M., El Masri, M., Araya, M., Khaled, N., & Somasundaram, D. (2001). Lifetime events and posttraumatic stress disorder in four postconflict settings. *Journal of the American Medical Association*, *286*, 555–562. doi: 10.1001/jama.286.5.555

De Jong, J., & Reis R. (2013). Collective trauma processing: Dissociation as a way of processing postwar traumatic stress in Guinea Bissau. *Transcultural Psychiatry*, *50*, 644-661. doi:10.1177/1363461513500517

Department of immigration and citizenship (2007). *Australia's Refugee and Humanitarian Programme*, Retrieved August 2013 from http://www.migration.gov.au/media/fact-sheets/60refugee.htm#f.

Dember, W.N., Melton, R.S., Nguyen, D.Q., & Howe, S.R. (1993). Meta-emotion: Tests of the Lutz hypothesis. *Bulletin of the Psychonomic Society, 31*, 579-582. doi: 10.3758/BF03337360

Denham, A. R. (2008). Rethinking historical trauma: Narratives of resilience. *Transcultural Psychiatry, 45*(3), 391–414. doi: 10.1177/1363461508094673

Ding, Y., Bao, L., Xu, H., & Hallberg, I. R. (2011). Psychometric properties of the Chinese version of sense of coherence scale in women with cervical cancer. *Psycho-Oncology, 21,* 1205–1214. doi: 10.1002/pon.2029

Dodd J. (2004). *Crisis and reflection: An essay on Husserl's crisis of the European sciences*. New York: Springer

Donnelly, J. (1984). Cultural relativism and universal human rights. *Human rights quarterly, 6*(4), 400-419. doi: 10.2307/762182

Draguns, J.G., & Tanaka-Matsumi, J. (2003). Assessment of psychopathology across and within cultures: issues and findings. *Behaviour, Research and Therapy, 41*(7), 755-776. doi: 10.1016/S0005-7967(02)00190-0

Drury, J., & Williams, R. (2012). Children and young people who are refugees, internally displaced persons or survivors or perpetrators of war, mass violence and terrorism. *Current Opinion in Psychiatry, 25*, 277-284. doi: 10.1097/YCO.0b013e328353eea6

DuHamel, K.N., Manne, S., Nereo, N., Ostroff, J., Martini, R., Parsons, S., Redd, W. H. (2004). Cognitive processing among mothers of children undergoing bone marrow/stem cell transplantation. *Psychosomatic Medicine, 66*, 92–103. doi: 10.1097/01.PSY.0000108104.23738.04

Eagleton, T. (1990). *The ideology of the aesthetic*. Cambridge, MA: Basil Blackwell Inc.

Eaton J., McCay, L., Semrau, M., Chatterjee, S., Baingana, F., Araya, R… & Saxena, S. (2011). Scale up of services for mental health in low-income and middle-income countries. *Lancet*, *378*, 1592–1603. doi:10.1016/S0140

Edmondson, D., Chaudoir, S.R., Mills, M.A., Park, C.L., Holub, J. & Bartkowiak, J.M. (2011). From Shattered Assumptions to Weakened Worldviews: Trauma Symptoms Signal Anxiety Buffer Disruption. *Journal of Loss Trauma, 16*(4): 358–385. doi: 10.1080/15325024.2011.572030

England, M., Mysyk, A., & Gallegos, J.A.A. (2007). An examination of nervios among Mexican seasonal farm workers. *Nursing Inquiry, 14,* 189–201. doi: 10.1111/j.1440-1800.2007.00368.x

Englund, H. (1998). Death, trauma and ritual: Mozambican refugees in Malawi. *Social Science and Medicine, 46*, 1165-1174. doi: 10.1016/S0277-9536(97)10044-2

Ehntholt, K. A., & Yule, W. (2006). Practitioner review: Assessment and treatment of refugee children and adolescents who have experienced war-related trauma. Journal of *Child Psychology and Psychiatry, 47*(12), 1197-1210. doi: 10.1111/j.1469-7610.2006.01638.x

Eriksson, M., & Lindstrom, B. (2005). Validity of Antonovsky's sense of coherence scale: A systematic review. *Journal of Epidemiology and Community Health, 59,* 460–466. doi:10.1136/jech.2003.018085

Fassin, D., & Rechtman, R. (2009). *The empire of trauma: an inquiry into the condition of victimhood.* New Jersey: Princeton University Press.

Fawzi, M.C.S., Murphy, E., Pham, T., Lin, L., Poole, C., & Mollica R.F. (1997). The validity of screening for post-traumatic stress disorder and major depression among Vietnamese former political prisoners. *Acta Psychiatr Scand, 95*, 87-93. doi: 10.1111/j.1600-0447.1997.tb00379.x

Fayers, P.M., & Machin, D. (2000). *Quality of Life: Assessment, Analysis and Interpretation.* New York*:* John Wiley & Sons.

Fazel, M., & Stein, A. (2002). The mental health of refugee children. *Community child health, public health, and epidemiology, 87*(5), 366-370. doi: 10.1136/adc.87.5.366

Fazel, M., Reed, R., Panter-Brick, C., & Stein, A. (2012). Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors. *Lancet, 379,* 266-282. doi: 10.1016/S0140-6736(11)60051-2

Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *Lancet, 365,* 1309-1314. Doi:10.1016/S0140-6736)05)61027-6.

Fegg, M., Kudla, D., Brandstätter, M., Deffner, V., & Küchenhoff, H. (2016). Individual meaning in life assessed with the Schedule for Meaning in Life Evaluation: toward a circumplex meaning model. *Palliative Support Care, 14*(2), 91-98. doi: 10.1017/S1478951515000656

Feldt, T., Lintula, H., Suominen, S., & Koskenuvo, M. (2007). Structural validity and temporal stability of the 13-item sense of coherence scale: Prospective evidence from the population-based HeSSup study. *Quality of Life Research, 16*, 483–493. doi: 10.1007/s11136-006-9130-z

Flanagan, J.C. (1978). A research approach to improving our quality of life. *American Psychologist, 33,* 138–147. 10.1037//0003-066X.33.2.138

Filipp, S.H. (1999). A three-stage model of coping with loss and trauma. In A. Maercker, M. Schützwohl, & Z. Solomon (Eds.), *Posttraumatic stress disorder: A lifespan developmental perspective* (pp. 43−78). Seattle, WA: Hogrefe and Huber.

Finlay, L. (2008). A dance between the reduction and reflexivity: Explicating the "phenomenological psychological attitude". *Journal of Phenomenological Psychology, 39,* 1-32. doi: 10.1163/156916208X311601

Fivush, R. (2010). Speaking silence: The social construction of voice and silence in cultural and autobiographical narratives. *Memory, 18,* 88–98. doi: 10.1080/09658210903029404

Franco-Paredes, C. (2010). An unusual clinical presentation of posttraumatic stress disorder in a Sudanese refugee. [Case Reports]. *Journal of Immigrant & Minority Health, 12*(2), 267-269.

Frank, C.K., & Temple, E. (2009). Cultural effects on the neural basis of theory of mind. In J.Y. Chiao (Eds.). *Progress in Brain Research*. Elsevier. doi: 10.1016/S00796123(09)17815-9

Frankl, V. (1967). Logotherapy and existentialism. *Psycotherapy: Theory, Research & Practice, 4*(3), 138-142. doi: 10.1037/h0087982

Freudenthal, G. (1986) *Atom and Individual in the Age of Newton*. Dordrecht: Reidel

Feder, A., Ahmad, S., Lee, E.J., Morgan, J.E., Singh, R., Smith, B.W., Southwick, S.M., & Charney, D.S. (2013). Coping and PTSD symptoms in Pakistani earthquake survivors: Purpose in life, religious coping and social support. *Journal of Affective Disorders, 147*(1-3), 156-163. doi: 10.1016/j.jad.2012.10.027

Frazier, P., Conlon, A., & Glaser, T. (2001). Positive and negative life changes following sexual assault. *Journal of Consulting and Clinical Psychology, 69*, 1048–1055. doi: 10.1037/AJ022-006X

Friedman, M.J., Keane, T.M., & Resick, P.A. (2007). *Handbook of PTSD: Science and Practice.* New York: Guilford Press.

Friedman, M.J., Resick, P.A., & Keane, T.M., (2007). PTSD: twenty-five years of progress and challenges. In M.J. Friedman, T.M. Keane, & P.A. Resick (Eds.), *Handbook of PTSD: Science and Practice* (3-18). New York: Guilford Press.

Friedman, M.J., Resick, P.A., Bryant, R.A., & Brewin, C.R. (2011). Considering PTSD for DSM-5. *Depression and Anxiety, 28*(9), 750-769. doi: 10.1002/ da.20767.

Friedman-Peleg, K., & Bilu, Y. (2011). From PTSD to "national trauma": The case of the Israel Trauma Center for victims of terror and war. *Transcultural psychiatry, 48*(4), 416-436. doi: 10.1177/1363461511410239

Fullilove, M. T. (1996). Psychiatric implications of displacement: Contributions from the psychology of place. *The American Journal of Psychiatry*, *153*(12), 1516-1523. doi: 10.1176/ajp.153.12.1516

Gadamer, H.G. (1990). The hermeneutical problem. In G. Ormiston & A. Schrift (Eds.), *The hermeneutic tradition: From Ast to Ricouer* (pp. 273-297). New York: State University of New York Press.

Gadamer, H. G., Gaiger J., & Walker N. (1996). *The enigma of health: The art of healing in a scientific age*. Stanford: Stanford University Press.

Galatzer-Levy, I. R., & Bryant, R. A. (2013). 636,120 ways to have posttraumatic stress disorder. *Perspectives on Psychological Science, 8,* 651–662. doi: 10.1177/1745691613504115

Galatzer-Levy, I.R., Ankri, Y., Freedman, S., Israeli-Shalev, Y., Roitman, P., Gilad, M., & Shalev, A.Y. (2013). Early PTSD Symptom Trajectories: Persistence, Recovery, and Response to Treatment: Results from the Jerusalem Trauma Outreach and Prevention Study (J-TOPS), *Plos One, 8*(8). doi: 10.1371/journal.pone.0070084

Garwood, A. (1996). The Holocaust and the power of powerlessness: survivor guilt an unhealed wound. *British Journal of Psychotherapy, 13*(2), 243-258. doi: 10.1111/j.1752-0118.1996.tb00880.x

Garza, G. (2007). Varieties of phenomenological research at the University of Dallas: An emerging typology. *Qualitative Research in Psychology*, *4*, 313-342. doi: 10.1080/14780880701551170

Giorgi, A. (1985). Sketch of a psychological phenomenological method. In A. Giorgi (Ed.), *Phenomenology and psychological research* (pp. 8-22). Pittsburgh, PA: Duquesne University Press.

Giorgi A. (1997). The theory, practice, and evaluation of the phenomenological method as a qualitative research procedure. J*ournal of Phenomenological Psychology, 28*(2), 235–60. doi: 10.1163/156916297X00103

Giorgi, A. (2006). Difficulties encountered in the application of the phenomenological method in the social sciences. *India-Pacific Journal of Phenomenology. 8*(1), 353–61. doi: 10.1080/20797222.2008.11433956

Giorgi, A. (2009). *The descriptive phenomenological method in psychology: A modificed Husserlian approach*. Pittsburg, PA: Duquesne University.

Giorgi, A. (2010). Phenomenology and the practice of science. *Existential Analysis, 21*, 3-22. Retrieved from: www.go.galegroup.com/ps/i.do?p=AONE&sw=w&u=monash&v=2.1&id=GALE%7CA288874122&it=r&asid=3a304741bff9dca75afc2e5adabfed37

Giorgi, A. (2011). IPA and Science: A Response to Jonathan Smith. *Journal of Phenomenological Psychology,42*(2), 195-216. doi: 10.1163/156916211X599762

Giorgi, A.P., & Giorgi, B.M. (2003). Chapter 13: The descriptive phenomenological psychological method. In P.M. Camic, J.E. Rhodes & L. Yardley. (Eds.), *Qualitative research in psychology: Expanding perspectives in methodology and design* (pp. 243-273). Washington, DC: American Psychological Association.

Good, M.D., & Hannah, S.D. (2015). "Shattering culture": perspectives on cultural competence and evidence-based practice in mental health services. *Transcultural Psychiatry 2015, 52*(2) 198–221. doi: 10.1177/1363461514557348

Goodman, J. H. (2004). Coping with trauma and hardship among unaccompanied refugee youths from Sudan. *Qualitative Health Research*, *14*(9), 1177–1196. doi: 10.1177/1049732304265923

Guarnaccia, P.J., Lewis-Fernandez, R., & Marano, M.R. (2003). Toward a Puerto Rican popular nosology: nervios and ataque de nervios. *Culture, Medicine, Psychiatry, 27*, 339–66. doi: 10.1023/A:1025303315932

Hacking, I. (1997). *Mad travelers*. Charlottesville, VA: University Press of Virginia.

Hacking, I. (1995). The looping effects of human kinds. In D. Sperber. & A.J. Premack (Eds). *Causal cognition: a multi-disciplinary debate* (pp. 351-383). New York: Ocford University Press.

Hacking, I. (2006). Making up people. *London Review of Books, 28*(16), 23-26. Retrieved from http://www.lrb.co.uk.ezproxy.lib.monash.edu.au/v28/n16/ian-hacking/making-up-people

Halcon, L., Robertson, C., Savik, K., Johnson, D., Spring, M., Butcher, J., Westermeyer, J., & Jaranson, J. (2004). Trauma and coping in Somali and Oromo refugee youth. *Journal of Adolescent Health, 35*(1), 17 - 25. doi: 10.1016/j.jadohealth.2003.08.005

Halling, S. (2008). *Intimacy, transcendence, and psychology: Closeness and openness in everyday life*. New York: Palgrave Macmillan.

Hannah, S. D. (2011). Clinical care in environments of hyperdiversity. In M.-J. D. Good, S. S. Willen, S. D. Hannah, K. Vickery, & L. T. Park (Eds.) *Shattering culture: American medicine responds to cultural diversity* (pp. 35–69). New York, NY: Russell Sage Foundation.

Harvard Program in Refugee Trauma. (2011). *The Harvard Trauma Questionnaire.* Retrieved from http://hprt-cambridge.org/screening/harvard-trauma-questionnaire/

Hatala, A.R., Desjardins, M., & Bombay, A. (2016). Reframing narratives of Aboriginal health inequity: Exploring Cree Elder Resilience and Well-Being in Contexts of Historical Trauma. *Qualitative Health Research, 26*(14), 1911-1927. doi: 10.1177/1049732315609569

Haule, J.R. (1986). Pierre Janet and dissociation: the first transference theory and its origins in Hypnosis. *American Journal of Clinical Hypnosis*, *29*, 86–94. doi: 10.1080/00029157.1986.10402690

Hebbani, A.G., Obijiofor, L. & Bristed, H. (2012). Acculturation challenges that confront Sudanese former refugees in Australia. Retrieved from: http://www98.griffith.edu.au/dspace/bitstream/handle/10072/52958/84884_1.pdf;jsessionid=FA60ABD1D0A694C83FCD4311E09262BB?sequence=1

Heidegger, M. (1962). *Being and Time*. (trans. Macquarrie, J., & Robinson, E.). N. Y.: Harper & Row.

Herman, J. (1992). *Trauma and Recovery.* New York: Basic Books.

Hills, A.M. (2011). *Foolproof guide to statistics using IBM SPSS, 2nd edition.* French Forests NSW: Pearson Australia.

Hinton, D.E., Hinton, A.L., Eng, K.T, & Choung, S. (2012). PTSD and Key Somatic

Complaints and Cultural Syndromes among Rural Cambodians: The Results of a Needs Assessment Survey. *Medical Anthropology, 26*, 383–407. doi: 10.1111/j.1548-1387.2012.01224.x

Hinton, D.E., Hofmann, S.G., & Orr, S.P., (2010). A psychobiocultural model of orthostatic panic among Cambodian refugees: flashbacks, catastrophic cognitions, and reduced orthostatic blood-pressure response. *Psychological Trauma: Theory, Research and Practice, 2*, 63–70. doi: 10.1037/a0018978

Hinton, D.E., & Lewis-Fernandez, R. (2011). The cross-cultural validity of posttraumatic stress disorder: Implications for DSM-5. *The Journal of Depression and Anxiety, 28*(9), 783-801. doi: 10.1002/da.20753

Hinton, D.E., Reiss. R., De Jong, J. (2015). The "thinking a lot" idiom of distress and PTSD: an examination of their relationship among traumatized Cambodian refugees using the "thinking a lot" questionnaire. *Medical Anthropo*logy, *29*, 357-380. doi: 10.1111/maq.12204

Hinton, D.E., Um, K., & Ba, P. (2001). Kyol goeu ("wind overload") part I: A cultural syndrome of orthostatic panic among Khmer refugees. *Transcultural Psychiatry*, *38*, 403–432. doi: 10.1177/136346150103800401

Hittner, J.B. (2007). Factorial invariance of the 13-item sense of coherence scale across gender. *Journal of Health Psychology, 12,* 273–280. doi: 10.1177/1359105307074256

Hobfoll, S. (2012). Conservation of Resources and Disaster in Cultural Context: The Caravans and Passageways for Resources. *Psychiatry, 75*(3), 227-232. doi: 10.1521/psyc.2012.75.3.227

Hodes, M., Jagdev, D., Chandra, N., & Cunniff, A. (2008). Risk and resilience for psychological distress amongst unaccompanied asylum seeking adolescents. *Journal of*

Child Psychology and Psychiatry, 49, 723-732. doi: 10.1111/j.1469-7610.2008.01912.x.

Hofstede, G. (1994). *Cultures and organization: software of the mind: intercultural.* London, HarperCollins.

Hofstede, G. & Hofstede, G.J. (2005). *Cultures and Organizations. Software of the Mind (2nd ed)*. New York: McGraw-Hill.

Hoge, C.W., Yehuda, R., Castro, C.A., McFarlane, A.C., Vermetten, E., & Jetly, R. (2016). Unintended consequences of changing the definition of Posttraumatic Stress Disorder in DSM-5. *JAMA: Journal of American Medical Association,* 73(7), 750-752. doi: 10.1001/jamapsychiatry.2016.0647

Hollan, D. W. (1992). Emotion, work and value of emotional equanimity among the Toraja. *Ethnology, 31*(1), 45-56. doi: 10.2307/3773441

Hollifield, M., Warner, T.D., Lian, N., Krakow, B., Jenkins, J.H., Kesler, J., & Westermeyer, J. (2002). Measuring trauma and health status in refugees: a critical review. *JAMA: the journal of the American Medical Association, 288*(5), 611-621. doi:10.1001/jama.288.5.611

Hoshmand, L.T. (2007). Cultural-ecological perspectives on the understanding and assessment of trauma. In J.P. Wilson & C. Tang (Eds.) *Cross-cultural assessment of psychological trauma and PTSD* (pp. 31-50). New York: Springer-Verl.

Howe, K. R. (1988). Against the quantitative-qualitative incompatability thesis, or, Dogmas die hard. *Educational Researcher,17,* 10-16. doi: 10.3102/0013189X017008010

Hycner, R.H. (1985). Some guidelines for the phenomenological analysis of interview data. *Human Studies, 8*, 279-303. doi: 10.1007/BF00142995

Husserl E., & Carr, D. (1970). *The crisis of European sciences and transcendental phenomenology: An introduction to phenomenological philosophy*. Evanston: Northwestern University Press.

Husserl, E. (1977). *Phenomenological psychology.* (trans. J. Scanlon). The Hague: Nijhoff.

Husserl, E. (1982). *Ideas pertaining to a pure phenomenology and to a phenomenological philosophy: First book, General introduction to a pure phenomenology*. (trans. F. Kersten). Boston: Kluwer Academic Publishers.

Initiatives of Change. (2013). *South Sudan Initiative.* Retrieved from: http://au.iofc.org/south-sudan-initiative

Jafary, F., Farahbakjsh, K., Shafiahadi, A., & Delavar, A. (2011). Quality of life and menopause: Developing a theoretical model based on meaning in life, self-efficacy beliefs, and body image. *Aging & Mental Health, 15*(5), 630-637. doi: 10.1080/13607863.2010.548056.

Jandt, F. (2013). *An introduction to intercultural communication: identities in a global community, 7th ed.* Thousand Oaks, CA: Sage.

Janes, C.R. (1999). The health transition, global modernity and the crisis of traditional medicine: The Tibetan case. *Social Science, & Medicine, 48*(12), 1803-1820. doi: 10.1016/S0277-9536(99)00082-9

Janoff-Bulman, R. (1992). *Shattered Assumptions: towards a new psychology of trauma.* New York: Free Press.

Jenkins, J.H. (1991). The State Constructions of Affect: Political Ethos and Mental Health among Salvadoran Refugees. *Culture, Medicine and Psychiatry, 15,* 139-65. doi: 10.1007/BF00119042

Janoff-Bulman, R. (1992). *Shattered Assumptions: towards a new psychology of trauma.* New York: Free Press.

Jeppsson, O., & Hjern, A. (2005). Traumatic stress in context: A study of un-accompanied minors from Southern Sudan. In D. Ingleby (Ed.), *Forced migration and mental health: Rethinking the care of refugees and displaced persons* (pp. 67–80). New York: Springer.

Jibeen, T. (2011). Moderators of Acculturative Stress in Pakistani Immigrants: The role of Personal and Social Resources. *International Journal of Intercultural Relations, 35*(5), 523-553. doi: 10.1016/j.ijintrel.2011.04.002

Johnson, R. B., & Onwuegbuzie, A. J. (2004). Mixed Methods Research: A Research Paradigm Whose Time Has Come. *Educational Researcher, 33*(7), 14-26. doi: 10.3102/0013189x033007014

Jones, P. (2015). Trauma and dramatherapy: dreams, play and the social construction of culture. *South African Theatre Journal, 28*(1), 4-16. Doi: 10.1080/10137548.2015.1011897

Jones, E., Vermaas, R.H., McCartney, H., Beech, C., Palmer, I., Hyams, K., & Wessely, S. (2003). Flashbacks and post-traumatic stress disorder: the genesis of a 20th-century diagnosis. *British Journal Psychiatry, 182,* 158–163. doi: 10.1192/bjp.

Jovanovic, T., Sakoman A.J., Kozarić-Kovačić, D., Havelka Meštrović, A., Duncan, E.J., Davis, M., & Norrholm, S.D. (2013). Acute stress disorder versus chronic posttraumatic stress disorder: inhibition of fear as a function of time since trauma, *Depression and Anxiety*, *30*(3), 217-224. doi: 10.1002/da.21991

Kaiser A. P., Wachen J. S., Potter C. ,Moye J., & Davison, E . (2014). Posttraumatic stress symptoms among older adults: A review. Retrieved from http://www.ptsd.va.gov/professional/treatment/older/ptsd_symptoms_older_adults.asp

Karl, A., Malta, L.S., & Maercker, A. (2005). Meta-analytic review of event-related potential studies in posttraumatic stress disorder, *Biological Psychology*, *71*, 123-147. doi:10.1016/j.biopsycho.2005.03.004

Kessler, R.C., Demler, O., Frank, R.G., Olfson, M., Pincus, H.A., Walters, E.E… & Zaslavsky, A.M. (2005). US Prevalence and treatment of mental disorders: 1990-2003. *New England Journal of Medicine, 352*(24)*,* 2515-2523. doi: 10.1056/NEJMsa043266

Keyes, E.F., & Kane, C.F. (2004). Belonging and adapting: mental health of Bosnian refugees living in the United States. *Issues in Mental Health Nursing, 25*, 809-831. doi: 10.1080/01612840490506392

Khawaja, N., White, K., Schweitzer, R., & Greenslade, J. (2008). Difficulties and coping strategies of Sudanese refugees: a qualitative approach. *Transcultural Psychiatry, 45*, 489-512. doi: 10.1177/1363461508094678

Khumalo, I.P., Wissing, M.P., & Schutte, L. (2014). Presence of meaning and search for meaning as mediators between spirituality and psychological well-being in a South African sample. *Journal of Psychology in South Africa, 24*(1), 61-72. doi: 10.1080/14330237.2014.904095

Kidron, C.A. (2009). Toward an ethnography of silence: The lived presence of the past in the everyday life of holocaust trauma survivors and their descendants in Israel. *Current Anthropology, 50*(1), 5-27. doi: 10.1086/595623

Kidron, C.A. (2012). Alterity and the particular limits of universalism comparing Jewish-Israeli Holocaust and Canadian-Cambodian genocide legacies. *Current Anthropology, 53*(6), 723-754. doi: 10.1086/668449

Kienzler, H. (2008). Debating war-trauma and post-traumatic stress disorder (PTSD) in an interdisciplinary area. *Social Sciences & Medicine, 67*(2), 218-227. doi: 10.1016/j.socscimed.2008.03.030

Kihlstrom, J.F. (2005). *Dissociative Disorders.* Retrieved from http://socrates.berkeley.edu/~kihlstrm/DisDis_ARCP2005.htm

King, L.A., Hicks, J.A., Krull, J.L., & Del Gaiso, A.K. (2006). Positive effect and the experience of meaning in life. *Journal of Personality and social Psychology, 90*, 179-196. doi: 10.1037/0022-3514.90.1.179

Kinzie, J. D. (1989). Therapeutic approaches to traumatized Cambodian refugees. *Journal of Traumatic Stress, 2,* 75–91. doi: 10.1002/jts.2490020108

Kira, I.A., and Tummala-Narra, P. (2015). Psychotherapy with refugees: Emerging paradigm. *Journal of Loss and Trauma,20*(5), 449-467. doi: 10.1080/15325024.2014.949145

Kira, I., Amer, M.M., & Wrobel, N.H. (2014). Arab refugees: Trauma, resilience, and recovery. In S.C. Nassar-McMillan, K. Ajrouch & J. Hakim-Larson (Eds.), *A biopsychosocial approach to Arab Americans: Perspectives on culture, development, and health* (pp. 175–195). New York, NY: Springer.

Kira, I.A., Omidy, A.Z., Fawzi, M., Rice, K.G., Fawzi, M., Lewandowski, L., & Bujold-Bugeaud, M. (2015). Are the negative mental health effects of gender discrimination (GD) salient across cultures? Does self-esteem mediate these effects: GD as a continuous traumatic stress and the pathways to its negative dynamics. *Psychology, 06*(01), 93-116. doi: 10.4236/psych.2015.61009

Kirmayer, L.J. (1992). Social Constructions of Hypnosis. *International Journal of Clinical and Experimental Hypnosis, 40*(4): 276–300. doi: 10.1080/00207149208409662

Kirmayer, L. J. (2002). The refugee's predicament. *L'Evolution Psychiatrique*, *67*, 724-742. doi: 10.1016/S0014-3855%2802%2900166-4

Kirmayer, L.J. (2004). The cultural diversity of healing: meaning, metaphor and mechanism. *British Medical Bulletin, 69*(1)*,* 33–48. doi: 10.1093/bmb/ldh006

Kirmayer, L.J. (2007). Cultural psychiatry in historical perspective. In D. Bhugra, & K. Bhui (Eds.) *Textbook of cultural psychiatry* (pp. 3–19). Cambridge, UK: Cambridge University Press.

Kirmayer, L.J., & Santhanam, R. (2001). The Anthropology of Hysteria. In P. Halligan, C. Bass, & J. Marshall (Eds.). *Contemporary Approaches to the Study of Hysteria: Clinical and Theoretical Perspectives* (pp. 251–270). Oxford: Oxford University Press.

Kirmayer, L.J., Gone, J.P., & Moses, J. (2014). Rethinking historical trauma. *Transcultural Psychiatry, 51*(3), 299-319. doi: 10.1177/1363461514536358

Kleber, R. J., & Brom, D. (1992). *Coping with trauma: Theory, prevention and treatment*. Lisse: Swets & Zeitlinger.

Kleinman, A. (1987). Anthropology and psychiatry: The role of culture in cross-cultural research on illness. *British Journal of Psychiatry*, *151*, 447–454. doi: 10.1192/bjp.151.4.447

Kleinman, A. (1995). *Writing at the margin: Discourse between anthropology and medicine*. Berkeley, CA: University of California Press.

Kobau, R., Sniezek, J., Zack, M.M., Lucas, R.E., & Burns, A. (2010). Wellbeing assessment: An evaluation of wellbeing scales for public health and population estimated of wellbeing among US adults. *Applied Psychology: Health and Wellbeing, 2,* 272–297. doi: 10.1111/j.1758-0854.2010.01035.x

Kohrt, B.A., Rasmussen, A., Kaiser, B.N., Haroz, E.E., Maharjan, S.J., Mutamba, B.B., de Jong, J.T.V.M., & Hinton, D. (2014). Cultural concepts of distress and psychiatric disorders: literature review and research recommendations for global mental health epidemiology. *International Journal of Epidemiology, 43*(2), 365-406. doi: 10.1093/ije/dyt227

Kolstad, A., & Gjesvik, N. (2014). Collectivism, individualism, and pragmatism in China: implications for perceptions of mental health. *Transcultural Psychiatry, 51*(2), 264-285. doi: 10.1177/1363461514525220

Kono, S., & Shinew, K.J. (2015). Roles of leisure in the post-disaster psychology recovery after the great East Japan earthquake and tsunami. *Leisure Sciences, 37*(1), 1-19. 10.1080/01490400.2014.935836

Kovess-Masfety, V., Murray, M., & Gureje, O. (2005). Evolution of our understanding of positive mental health. In H. Herman, S. Saxena, and R. Moodie (Eds.) *Promoting Mental Health: Concepts, Emerging Evidence, Practice* (pp. 35-46). Geneva: World Health Organization.

Krell, R. (1997). *Psychiatry and the Holocaust (Vol. 4)*. New Brunswick, NJ: Transaction Publishers.

Krystal, H. (1985). Trauma and the stimulus barrier. *Psychoanalytic Inquiry, 5*, 131–161. doi: 10.1080/07351698509533579

Kuhn, T. S. (1996). *The Structure of Scientific Revolutions (3rd Ed.)*. Chicago: University of Chicago Press.

Lambek, M., & P. Antze. (1996). Introduction: forecasting memory. In P. Antze and M. Lambek, (Eds.), *Tense past: cultural essays in trauma and memory* (pp. xi–xxxviii). New York: Routledge.

Lamis, D.A., Wilson, C.K., Tarantino, N., Lansford, J.E., & Kaslow, N.J. (2014). Neighbourhood disorder, spiritual well-being, and parenting in African American Women. *Journal of Family Psychology, 28*(6), 769-778. doi: 10.1037/a0036373

Lancet Global Mental Health Group. (2007). Scale up services for mental disorders: a call for action. *Lancet* 2007, *370*, 1241–52. doi: 10.1016/S0140-6736(07)61242-2

Langdridge, D. (2008). Phenomenology and critical social psychology: Directions and debates in theory and research. *Social and Personality Psychology Compass, 2*, 1126-1142. doi: 10.1111/j.1751-9004.2008.00114.x

Lawrence-Wood, E., Van Hooff, M., Baur, J., & McFarlane, A.C. (2015). Re-experiencing phenomena following a disaster: The long-term predictive role of intrusion symptoms in the development of post-trauma depression and anxiety. *Journal of Affective Disorders, 190*, 278-281. doi: 10.1016/j.jad.2015.10.029.

Leri, A. (1919). *Shell shock, commotional and emotional aspects.* London: University Press.

Lester, R. (2013). Back from the Edge of Existence: A Critical Anthropology of Trauma.v *Transcultural Psychiatry, 50*(5): 753-762. doi: 10.1177/1363461513504520

Levi, P. (1984). *The Periodic Table.* New York: Schocken Books.

Lillard, A. (1998). Ethnopsychologies: Cultural Variations in Theories of Mind. *Psychological Bulletin, 123*(1), 3-32. doi: 10.1037/0033-2909.123.1.3

Lindstrom, B., & Eriksson, M. (2010). *The Hitchhiker's guide to salutogenesis. Salutogenic pathways to health promotion*. (Research Report No. 2) Helsinki: Folkha¨lsan Research Centre, Health promotion research programme.

Linley, P. & Stephen, J. (2004). Positive Change Following Trauma and Adversity: A Review. *Journal of Traumatic Stress*, *17*(1), 11-21. doi: 10.1023/B:JOTS.0000014671.27856.7e

Lillard, A. (1998). Ethnopsychologies: Cultural Variations in Theories of Mind. *Psychological Bulletin, 123*(1), 3-32. doi: 10.1037/0033-2909.123.1.3

Liu, D., Wellman, H. M., Tardiff, T., & Sabbagh, M.A. (2008). Theory of mind development in Chinese children: A meta- analysis of false-belief understanding across cultures and languages. *Developmental Psychology, 44*(2), 523–531. doi: 10.1037/0012-1649.44.2.523

Luce-Kapler, R. (2008). *Literature in qualitative research. The Sage encyclopedia of qualitative research methods, Volume 1*. Los Angeles, CA: Sage Publications, Inc.

Luster, T., Qin, D., Bates, L., Johnson, D., & Rana, M. (2009). The lost boys of Sudan: coping with ambiguous loss and separation from parents. *American Journal of Orthopsychiatry, 79*, 203-211. doi: 10.1037/a0015559

Lustig, S.L, Kia-Keating, M., Knight, W.G., Geltman, P., Ellis, H., Kinzie, J.D., & Saxe, G.N. (2004). Review of child and adolescent refugee mental health. *Journal of the American Academy of Child & Adolescent Psychiatry*, 43(1), 24-36. doi: 10.1097/00004583-200401000-00012

Maitles, H. (2002). Surviving the Holocaust: the anger and guilt of Primo Levi. *Journal of Genocide Research, 4*(2), 237–251. doi: 10.1080/14623520220137985

Makkreel R.A., Popkin R.H., & Wilhelm, D. (1999). *From value to meaning. The Columbia history of Western philosophy*. New York: Columbia University Press.

Malt, U., Schnyder, U., & Weisaeth, L. (1996). ICD-10 Mental and behavioral consequences of traumatic stress. In F. L. Mak & C. C. Nadelson (Eds.), *International Review of Psychiatry* (Vol. 2, pp. 151-176). Washington, DC: American Psychiatric Press.

Mampane, R., & Bouwer, C. (2006). Identifying resilient and non-resilient middle-adolescents in a formerly black-only school. *South African Journal of Education, 26*, 443-456. doi: 10.4314/saje.v26i3.25081

Manderson, L., Cartwright, E., & Hardon, A. (2016). War, violence and social repair. In L. Manderson, E. Cartwright, & A. Hardon, A., (Eds). *The Routledge Handbook of Medical Anthropology* (Chapter 13). London: Routledge.

Mariano, J.M., & Vaillant, G.E. (2012). Youth purpose among the 'greatest generation.' *The Journal of Positive Psychology, 7*(4), 281–293. doi: 10.1080/17439760.2012.686624

Markus, A., Jacobs, N., & Aronov, T. (2009). *Preliminary Findings: Melbourne & Sydney, Report Series of the Gen08 Survey, Report 1*. Melbourne: Monash University Australian Center for Jewish Civilization.

Marlowe, J.M. (2010). Beyond the discourse of trauma: Shifting the focus on Sudanese refugees. *Journal of Refugee Studies, 23*(2), 183-198. doi: 10.1093/jrs/feq013

Marlowe, J., Harris, A., & Lyons, T. (2012). *South Sudanese Diaspora in Australia and New Zealand: Reconciling the past with the present.* Newcastle, UK: Cambridge Scholars Publishing.

Marsella, A.J. (1988). Cross-cultural research on severe mental disorders: Issues and findings. *Acta Psychiatrica Scandinavica Supplementum, 344,* 7-22. doi: 10.1111/j.1600-0447.1988.tb08998.x

Marsella, A.J. (2010). Ethnocultural aspects of PTSD: An overview of concepts, issues, and treatments. *Traumatology, 16*(4), 17-26. doi: 0.1177/1534765610388062

Marsella, A.J., Friedman, M.J., Gerrity, E.T., & Scurfield, R.M. (1996). Ethnocultural aspects of PTSD: Some closing thoughts. In A. J. Marsella, M. J. Friedman, E. T. Gerrity, & R. M. Scurfield (Eds.), *Ethnocultural Aspects of Posttraumatic Stress Disorder: Issues, research, and clinical applications* (pp. 529 – 538). Washington, DC: American Psychological Association.

Marsella, A.J., Friedman, M.J., & Spain, E.H. (1996). Ethnocultural aspects of PTSD: An overview of issues and research directions. In A.J. Marsella, M.J. Friedman, E.T. Gerrity, & R.M. Scurfield (Eds.). *Ethnocultural Aspects of Posttraumatic Stress Disorder: Issues, research, and clinical applications* (chapter 4). Washington, DC: American Psychological Association

Martela, F. & Steger, M.F. (2016). The three meanings of meaning in life: distinguishing coherence, purpose, and significance. *Journal of Positive Psychology, 11* 531-545. doi: 10.1080/17439760.2015.1137623

Mattioli, G., & Scalzone, F. (2002). *Current hysteria. Disease or obsolete original position?* Milan: Franco Angeli.

Mayoh, J., & Onwuegbuzie, A.J. (2015). Toward a conceptualization of mixed methods phenomenological research. *Journal of Mixed Methods Research,* 9(1), 91-107 doi: 10.1177/1558689813505358

McAdams, D.P. (2001). The psychology of life stories. *Review of General Psychology, 5*, 100–122. doi: 10.1037/1089-2680.5.2.100

McCarthy, M.H. (1990) *The crisis of philosophy*. Albany, NY: SUNY Press.

McFarlane, A. (2010). The long-term costs of traumatic stress: intertwined physical and psychological consequences. *World psychiatry, 9*(1), 3-10. doi: 10.1002/j.2051-5545.2010.tb00254.x

McNally, R.J., Robinaugh, D.J., Wu, G.W.Y., Wang, L., Deserno, M.K., & Borsboom, D. (2015). Mental disorders as causal systems: a network approach to Post-traumatic stress disorder. *Clinical psychological science, 3*(6)*,* 836-849. doi: 10.1177/2167702614553230

Meffert, S.M., Musalo, K.. Abdo, A.O., Alla, O.A., Elmakki, Y.O., Omar, A.A… & Marmar, C.R. (2010). Feelings of betrayal by the United Nations High Commissioner for Refugees and emotionally distressed Sudanese refugees in Cairo. *Medicine, Conflict and Survival, 26*(2), 160-172. doi: 10.1080/13623699.2010.491395

Megill A. (1985). *Prophets of extremity: Nietzsche, Heidegger, Foucault, Derrida*. Berkeley: University of California Press.

Mehta, N. (2011). Mind-Body Dualism: A critique from a health perspective. *Mens Sana Monographs, 9*(1), 202-209. doi: 10.4103/0973-1229.77436

Michalopoulos, L.M., Unick, G.J., Haroz, E., Bass, J., Murray, L.K., & Bolton, P.A. (2015). Exploring the fit of western PTSD models across three non-western low- and middle-income countries. *Traumatology, 21*(2), 55-63. doi: 10.1037/trm0000020

Miller, K.E., Omidian, P., Kulkarni, M., Yaqubi, A., Daudzai, H., & Rasmussen, A. (2009). The validity and clinical utility of post-traumatic stress disorder in Afghanistan. *Transcultural Psychiatry, 46,* 219-237. doi: 10.1177/1363461509105813

Miller, P.J., & Goodnow, J.J. (1995). Cultural practices: Toward an integration of development and culture. In J.J. Goodnow, Miller, P.J., & Kessel, F. (Eds.), *Cultural practices as contexts for development* (pp. 5-16). San Francisco: Jossey-Bass.

Min, S.K., & Suh, S.Y. (2010). The anger syndrome hwa-byung and its comorbidity. *Journal of Affect Disorder, 124*, 211–14. doi: 10.1016/j.jad.2009.10.011

Mohamad, M., AbdRazak, A. & Mutiu, S. (2011). Meaning in Life among Muslim Students. In D.E. Ongen, C. Hursen, M. Halat, & H. Boz (Eds). *Procedia Social and Behavioral Sciences: volume 30.* Elsevier Ltd: Published online.

Mohammed, E.N.F, Unher, M., & Sugawara, M. (2010). Psychological well-being: a comparative study between Japanese students and Egyptian students. *Psychologia, 52*(2), 68-85. doi: 10.2117/psysoc.2010.68

Moksnes, U.K., Espnes, G.A., & Haugan, G. (2013). Stress, sense of coherence and emotional symptoms in adolescents. *Psychological Health, 29*(1), 32-49. doi: 10.1080/08870446.2013.822868

Moncrieff, J., & Timimi, S. (2013). The social and cultural construction of psychiatric knowledge: an analysis of NICE guidelines on depression and ADHD. *Anthropology and Medicine, 20*(1), 59-71. doi: 10.1080/13648470.2012.747591

Mollica, R.F., Caspi-Yavin, Y., Bollini, P., Truong, T., Tor, S., & Lavelle, J. (1992). The Harvard Trauma Questionnaire: Validating a cross-cultural instrument for measuring torture, trauma and posttraumatic stress disorder in Indochinese refugees. *Journal of Nervous Mental Disease 180*, 111-116. doi: 10.1097/00005053-199202000-00008

Mollica, R.F., Caspi-Yavin, Y., Bollini, P., Truong, T., Tor, S., Lavelle, J. (1996) Harvard Trauma Questionnaire: Brief summary of its development, statistical properties, use, and scoring. In N. Goldfeld, M. Pine, & J. Pine (Eds.) *Measuring and Managing Health Care Quality: Procedures, Techniques, and Protocols, Volume 1*. Gaithersburg, MD: Aspen Publishers.

Mollica, R.F., McInnes, K., Poole, C., & Tor, S. (1998). Dose-effect relationships of trauma to symptoms of depression and post-traumatic stress disorder among Cambodian survivors of mass violence. *The British Journal of Psychiatry*, *173*(6), 482-488. doi: 10.1192/bjp.173.6.482

Morrison, T. (2005). *Belove*d. London, UK: Vintage.

Morrison, J. S., & de Waal, A. (2005). Can Sudan escape its intractibility? In C. A. Crocker, F. O. Hampson, & P. Aall (Eds.), *Grasping the nettle: Analyzing cases of intractable conflict* (pp. 161–182). Washington, DC: United States Institute of Peace Press.

Murray, K., Davidson, G., & Schweitzer, R. (2008). *Psychological wellbeing of refugees resettling in Australia: A literature review prepared for The Australian Psychological Society*. Melbourne: The Australian Psychological Society.

Myers, C.S. (1915). A contribution to the study of shell shock. *Lancet, 185*(4772), 316–320. doi: 10.1016/S0140-6736(00)52916-X

Naito, M., & Koyama, K. (2006). The development of false- belief understanding in Japanese children: Delay and difference? *International Journal of Behavioral Development, 30*(4), 290–304. doi: 10.1177/0165025406063622

Narrow, W.E., & Kuhl, E.A. (2011). Dimensional approaches to psychiatric diagnosis in DSM-5. *The Journal of Mental Health Policy and Economics, 14*(4), 197-200. PMID: 22116169

Neisser, U., & Dopling, J. (1997). *The conceptual self in context: culture, experience, self-understanding*. Cambridge: Cambridge University Press.

Nell, W. (2014). Sources of life meaning among South African university students. *Journal of Psychology in Africa, 24*(1), 82-91. doi: 10.1080/14330237.2014.904087

Neuner, F., Schauer, M., Klaschik, C., Karunakara, U., Elbert, T., (2004). A comparison of Narrative Exposure Therapy, supportive counseling, and psychoeducation for treating posttraumatic stress disorder in an African refugee settlement. *Journal of Consulting and Clinical Psychology, 72*(4), 579-587. doi: 10.1037/0022-006X.72.4.579.

Nickerson, A., & Bryant, R.A. (2014). The mechanisms of psychosocial injury following human rights violations, mass trauma, and torture. *Clinical psychology: Science and Practice* 21, 172-191. doi: 10.1111/cpsp.12064

Nickerson, A., Bryant, R.A., Silove, D., & Steel, Z. (2011). A critical review of psychological treatments of posttraumatic stress disorder in refugees. *Clinical Psychology Review, 31,* 399-417. doi: 10.1016/j.cpr.2010.10.004

Nicolas, G., Wheatley, A., & Guillaume, C. (2015). Does one trauma fit all? Exploring the relevance of PTSD across cultures. *International Journal of Culture and Mental Health, 8*(1), 34-45. doi: 10.1080/17542863.2014.892519

Nixon, R.D., & Bryant, R.A. (2005). Induced arousal and re-experiencing in acute distress disorder. *Journal of Anxiety Disorders*, *19*, 587–594. doi: 10.1016/j.janxdis.2004.05.001

Norris, A.E., & Aroian, K.J. (2008). Avoidance symptoms and assessment of posttraumatic stress disorder in Arab immigrant women. *Journal of Traumatic Stress, 21*, 471 478. doi:10.1002/jts.20363

North, C.S., Pfefferbaum, B., Narayanan, P., Thielman, S., McCoy, G., Dumont, C., Kawasaki, A., Ryosho, N., & Spitznagel, E.L. (2005). Comparison of post-disaster psychiatric disorders after terrorist bombings in Nairobi and Oklahoma City. *British Journal of Psychiatry, 186,* 487-493. doi: 10.1192/bjp.186.6.487

Obrist, B. & Buchi, S. (2008). Stress as an Idiom for Resilience: Health and Migration among Sub-Saharan Africans in Switzerland. *Anthropology & Medicine*, *15*(3), 251-261. doi: 10.1080/13648470802357596

O'Donnell, M.B., Bentele C.N., Grossman, H.B., Le, Y., Jang, H., & Steger, M.F. (2014) You, me, and meaning: an integrative review of connections between relationships and meaning in life. *Journal of Psychology in Africa, 24*(1), 44-50. doi: 10.1080/14330237.2014.904097

O'Donnell, M.L., Creamer, M., & Pattison, P. (2004). Posttraumatic stress disorder and depression following trauma: understanding comorbidity. *American Journal of Psychiatry, 161*(8), 1390-1396. doi: 10.1176/appi.ajp.161.8.1390.

Ola, B.A., & Igbokwe, D.O. (2011). Factorial validation and reliability analysis of the Brain Fag Syndrome Scale. *African Health Science,11*, 334–40. Retreived from: http://eprints.covenantuniversity.edu.ng/1628/1/Factorial%20validation%20and%20reliability%20analysis%20of%20the%20brain%20fag%20syndrome%20scale.pdf

Orley, J., & Kuyken, W. (1994). *Quality of Life Assessment: International Perspectives*. Heidelberg: Springer Verlag.

Orr, S.P., & Roth, W.T. (2000). Psychophysiological assessment: Clinical applications for PTSD. *Journal of Affective Disorders*, *61*, 225 - 240. doi: 10.1016/S0165-0327(00)00340-2

Orr, S.P., McNally, R.J., Rosen, G.M., & Shalev, A.Y. (2004). Psychophysiologic reactivity: Implications for conceptualising PTSD. In G.M., Rosen (Ed). *Posttraumatic Stress Disorder: Issues and Controversies* (pp. 101 – 126). West Sussex: John Wiley & Sons, Ltd.

Oruca, L., Kapetanovicb, A., Pojskicc, N., Mileyb, K., Forstbauerb, S., Mollica, R.F. & Henderson, D.C. (2008). Screening for PTSD and depression in Bosnia and Herzegovina: validating the Harvard Trauma Questionnaire and the Hopkins Symptom Checklist. *International Journal of Culture and Mental Health, 1*(2), 105-116. doi: 10.1080/17542860802456620

Owens, G.P., Steger, M.F., Whitesell, A.A., Herrera, C.J. (2009). Posttraumatic Stress Disorder, Guilt, Depression, and Meaning in Life Among Military Veterans. *Journal of Traumatic Stress, 22*(6), 654-657. DOI: 10.1002/jts.20460

Paardekooper, B., De Jong, J.T., & Hermanns, J.M.A. (1999). The psychological impact of war and the refugee situation on South Sudanese children in refugee camps in Northern Uganda: An exploratory study. *Journal of Child Psychology & Psychiatry, 40*(4), 529–536. doi: 10.1111/1469-7610.00471

Pan, J.Y. (2011). A resilience-based and meaning-oriented model of acculturation: A sample of mainland Chinese postgraduate students in Hong Kong. *International Journal of Intercultural Relations, 35*(5), 592-603. doi: 10.1016/j.ijintrel.2011.02.009

Papadopoulos, R.K. (2007). Refugees, trauma and Adversity-Activated Development. *European Journal of Psychotherapy and Counselling, 9*(3), 301-312. doi: 10.1080/13642530701496930

Papageorgiou, V., Frangou-Garunovic, A., Iordanidou, R., Yule, W., Smith, P., & Vostanis, P. (2000). War trauma and psychopathology in Bosnian refugee children. European *Child and Adolescent Psychiatry, 9*(2), 84-90. doi: 10.1007/s007870050002.

Park, C.L. (2016). Unresolved tensions in the study of meaning in life. *Journal of constructivist psychology, 6,* 1-5. doi: 10.1080/10720537.2015.1119083

Park, C.L. (2010). Making sense of the meaning literature: An integrative review of meaning making and its effects on adjustment to stressful life events. *Psychological Bulletin, 136,* 257–301. doi: 10.1037/a001830

Patel V., & Bloch, S. (2009). The ethical imperative to scale up health care services for people with severe mental disorders in low and middle income countries. *Postgraduate Medicine Journal, 85*, 509–13. doi: 10.1136/pgmj.2009.081596

Patel, V., & Winston, M. (1994). Universality of mental illness revisited: assumptions, artefacts, and new directions. *British Journal of Psychiatry, 165,* 437-440. doi: 10.1192/bjp.165.4.437

Paul, R. A. (1995). Act and intention in Sherpa culture and society. In L. Rosen (Ed.), *Other intentions: Cultural contexts and the attribution of inner states* (pp. 15-45). Santa Fe, NM: School of American Research Press.

Peltzer, K. (1999). Trauma and mental health problems of Sudanese refugees in Uganda. *Central African Journal of Medicine, 45*(5), 110–113. doi: 10.4314/cajm.v45i5.8465

Perilla, J.L., Norris, F.H., & Lavizzo, E.A. (2002). Ethnicity, culture, and disaster response: identifying and explaining ethnic differences in PTSD six months after Hurricane Andrew. *Journal of Social Clinical Psychology, 21*, 20–45. doi: 10.1521/jscp.21.1.20.22404

Phillips, D.C. & Burbules, N.C. (2000). *Postpositivism and educational research*. New York: Rowman & Littlefield Publishers Inc.

Phungrassami, T., Katikarn, R., Watanaarepornchai, S., & Sangtawan, D. (2004). Quality of Life assessment in radiotherapy patients by WHOQOL-BREF-THAI: A feasibility study. *Journal of Medical Association Thai, 87*(12), 1459-1465. doi: 10.1.1.620.7897

Pole, N., Neylan, T.C., Best, S.R., Orr, S.P., & Marmar, C.R. (2003). Fear-potentiated startle and posttraumatic stress symptoms in urban police officers. *Journal of Traumatic Stress*, *16*(5), 471 - 479. doi: 10.1023/A:1025758411370

Port, C. L., Engdahl, B., & Frazier, P. (2001). A longitudinal and retro-spective study of PTSD among older prisoners of war. *American Journal of Psychiatry, 158*,1474–1479. doi: 10.1176/appi.ajp.158.9.1474

Porter, M., & Haslam, N. (2005). Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons: A meta-analysis. *JAMA: Journal of the American Medical Association, 294*(5), 602-612. doi: h10.1001/jama.294.5.602

Prati, G., & Pietrantoni, L. (2009). Optimism, social support, and coping strategies as factors contributing to posttraumatic growth: A meta-analysis. *Journal of Loss and Trauma, 14*(5), 364-388. doi: 10.1080/15325020902724271

Pridmore, S. (2006). Medicalization of distress. In S, Pridmore (Ed.) *Download of Psychiatry*. Retrieved from http://eprints.utas.edu.au/287/ (last modified, 2013)

Ramirez, C.L., & Hammack, P.L. (2014). Surviving colonization and the quest for healing: narrative and resilience among California Indian tribal leaders. *Transcultural Psychiatry, 51*(1), 112-33. doi: 10.1177/1363461513520096

Rasmussen, A., Katoni, B., Keller, A.S., & Wilkinson, J. (2011). Posttraumatic idioms of distress among Darfur refugees: Hozun and Majnun. *Transcultural Psychiatry, 48,* 392–415. doi: 10.1177/1363461511409283

Rasmussen, A., Keatley, E., & Joscelyne, A. (2014). Posttraumatic stress in emergency settings outside North America and Europe: A review of the emic literature. *Social Science & Medicine, 109,* 44-54. doi: 10.1016/j.socscimed.2014.03.015

Rasmussen, A, Smith, H, & Keller, A.S. (2007). Factor structure of PTSD symptoms among West and Central Africans refugees. *Journal of Traumatic Stress, 20*(3), 271-280. doi: 10.1002/jts.20208

Reis, R., (2013). Children enacting idioms of witchcraft and spirit possession as a response to trauma: therapeutically beneficial, and for whom? *Transcultural Psychiatry, 50*(5), 622-643. doi: 10.1177/1363461513503880

Richardson, C.G., Ratner, P.A., & Zumbo, B.D. (2007). A test of the age-based measurement invariance and temporal stability of Antonovsky's sense of coherence scale. Education and Psychological, *Measurement, 67*, 679–696. doi: 10.1177/0013164406292089

Roberts, B., Damundu, E.Y., Lomoro, O., & Sondorp, E. (2010). The influence of demographic characteristics, living conditions, and trauma exposure on the overall health of a conflict-affected population in Southern Sudan. *BMC Public Health, 10,* 518-227. doi: 10.1186/1471-2458-10-518

Roberts, A.L., Gilman, S.E., Breslau, J., Breslau, N., & Koenen, K.C. (2011). Race/ethnic differences in exposure to traumatic events, development of post-traumatic stress disorder, and treatment-seeking for post-traumatic stress disorder in the United States. *Psychological Medicine, 41*,71–83. doi: 10.1017/S0033291710000401

Ross, C., Joshi, A. & R. Currie, R. (1990). Dissociative Experiences in the General Population. *American Journal of Psychiatry, 147*,1547–1552. doi: 10.1176/ajp.147.11.1547

Rothbaum, B.O., Foa, E.B., Riggs, D.S., Murdock, T., & Walsh, W. (1992). A prospective examination of post-traumatic stress disorder in rape victims. *Journal of Traumatic Stress, 5,* 455–475. doi: 10.1007/BF00977239

Rousseau, C., & Measham, T. (2007). Posttraumatic suffering as a source of transformation. In L. Kirmayer, R. Lemelson, & M. Barad (Eds.) *Understanding trauma: Integrating biological, clinical, and cultural perspectives* (pp. 275–293). New York, NY: Cambridge University Press.

Rubin, D.C., Berntsen. D., & Bohni, M.K. (2008). A memory-based model of posttraumatic stress disorder: evaluating basic assumptions underlying the PTSD diagnosis. *Psychological Review*, *115*, 985-1011. doi: 10.1037/a0013397

Ryff, C. D., & Singer, B. H. (1998). The contours of positive human health. *Psychological Inquiry*, *9,* 1–28. doi: 10.1207/s15327965pli0901_1

Sack, W., Seeley, J., & Clarke, G. (1997). Does PTSD transcend cultural barriers? A study from the Khmer Adolescent Refugee Project. *Journal of the American Academy of Child and Adolescent Psychiatry*, *36*(1), 49-54. doi: 10.1097/00004583-199701000-00017

Salgado de Snyder, V.N., De Jesus Diaz-Perez, M., & Ojeda V. (2000). The Prevalence of Nervios and Associated Symptomatology Among Inhabitants of Mexican Rural Communities. *Culture, Medicine, Psychiatry, 24*, 453–70. doi: 10.1023/A:1005655331794

Salsman, J.M., Segerstrom, S.C., Brechting, E.H., Carlson, C.R., & Andrykowski, M.A. (2009). Posttraumatic growth and PTSD symptomatology among colorectal cancer survivors: a 3-month longitudinal examination of cognitive processing. *Psycho-Oncology, 18,* 30-41. doi: 10.1002/pon.1367

Savic, M., Chur-Hansen, A., Mahmood, M.A., & Moore, V.M. (2016). 'We don't have to go and see a special person to solve this problem': Trauma, mental health beliefs and processes for addressing 'mental health issues' among Sudanese refugees in Australia. *International Journal of Social Psychiatry, 62*(1), 76-83. doi: 10.1177/0020764015595664

Scarry, E. (1985). *The body in pain: The making and unmaking of the world*. New York: Oxford University Press.

Schalkwyk, L.V. & Rothman, S. (2008). Validation of the Orientation to Life Questionnaire (OLQ) in a chemical factory. *SA Journal of Industrial Psychology, 34*(2), 31-39. doi: 10.4102/sajip.v34i2.725

Scheper-Hughes, N., & Lock, M. (1987). The mindful body: A Prolegomenon to Future Work in Medical Anthropology. *Medical Anthropology Quarterly, 1,* 6-47. doi: 10.1525/maq.1987.1.1.02a00020

Schieffelin, E. L. (1985). The cultural analysis of depressive affect: An example from Papua New Guinea. In A. M. Kleinman & B. Good (Eds.) (pp. 101-133)., *Culture and depression*. Berkeley: University of California Press.

Schnell, T., & Becker, P. (2006). Personality and meaning in life. *Personality and Individual Differences, 41,* 117–129. doi: 10.1016/j.paid.2005.11.030

Schutz, A. (1967). *The Phenomenology of the Social World*. Evanston, IL: Northwestern University Press.

Schwartz, B. (2014, March). Barry Schwartz: The way we think about work is broken [Video File]. Retrieved from https://www.ted.com/talks/barry_schwartz_the_way_we_think_about_work_is_broken

Scott, W.J. (1990). PTSD in the DSM-III: A case in the politics of diagnosis and disease. *Social Problems, 37*(3), 294-310. doi: 10.2307/800744

Seligman, R., & Kirmayer, L.J. (2008). Dissociative Experience and Cultural Neuroscience: Narrative, Metaphor and Mechanism. *Culture, Medicine and Psychiatry, 32*, 31-64. doi: 10.1007/s11013-007-9077-8

Shannon, P.J., Wieling, E., McCleary, J.S., & Becher, E. (2015). Exploring the mental health effects of political trauma with newly arrived refugees. *Qualitative Health Research*, 25(4), 493-257. doi: 10.1177/1049732314549475

Shalev, A.Y., Peri, T., Orr, S.P., Bonne, O., & Pitman, R.K. (1997). Auditory startle responses in help-seeking trauma survivors, *Psychiatry Research*, *69*, 1-7. doi: 10.1016/S0165-1781(96)03001-6

Shalev, A.Y., Yehuda, R., & McFarlane, A.C. (2000). *International handbook of human response to trauma.* New York: Kluwer Academic/Plenum.

Shengold, L. (1989). *Soul murder: the effects of childhood abuse and deprivation.* Fawcett Columbine.

Shiekh, S., & Furnham, A. (2000). A cross-cultural study of mental health beliefs and attitudes towards seeking professional help. *Social Psychiatry Psychiatric Epidemiology, 35*(7), 326-335. doi: 10.1007/s001270050246

Shlegel, R.J., & Hicks, J.A. (2016). Reflections on the scientific study of meaning in life. *Journal of* constructivist *psychology, 30*(1), 1-6. doi: 10.1080/10720537.2015.1119080

Sichrovsky, P. (1986) *Strangers in their Own Land*. London: I.B. Tauris.

Silove, D. (1999). The psychosocial effects of torture, mass human rights violations, and refugee trauma: toward an integrated conceptual framework. *Journal of Nervous & Mental Disease, 187*(4), 200-207. doi: 10.1097/00005053-199904000-00002

Silove, D. (2013). The ADAPT model: a conceptual framework for mental health and psychosocial programming in post conflict settings. *Intervention, 11*(3), 237-248. doi: 10.1097/WTF.0000000000000005

Silove, D., Steel, Z., & Bauman, A. (2007). Mass psychological trauma and PTSD: Epidemic or cultural illusion? In J.P., Wilson, & Tang, C.S. (Eds). *Cross-cultural assessment of psychological trauma and PTSD* (pp. 319 – 336). Springer: New York.

Simich, L. Este, D., & Hamilton, H. (2010). Meanings of home and mental well-being among Sudanese refugees in Canada. *Ethnicity & Health, 15*(2), 199-212. DOI: 10.1080/13557851003615560

Skevington, S.M., Lotfy, M., & O'Connell, K.A. (2004). The world health organization's WHOQOL-Bref quality of life assessment: psychometric properties and results of the international field trial. A report from the WHOQOL group. *Quality of life Research, 13*(2), 299-310. doi: 10.1023/B:QURE.0000018486.91360.00

Slobodin, O., Caspi, Y., & Klein, E. (2014). Trauma amid 'culture of avoidance': symptom profile of PTSD in Bedouin members of the Israel Defense Forces. *International Journal of Culture and Mental Health*, *7*(1), 1-10. doi: 10.1080/17542863.2012.681670

Smith, J.A. (2010). Interpretive phenomenological analysis: A reply to Amedeo Giorgi. *Existential Analysis*, *21*(2):186–92. Retrieved from: www.go.galegroup.com/ps/i.do?p=AONE&sw=w&u=monash&v=2.1&id=GALE%7CA288874193&it=r&asid=0be7d152fd4d3a2544fc35e927ad242a

Smith, J. A., Flowers, P., & Larkin, M. (2009*). Interpretative Phenomenological Analysis. Theory, Method and Research*. London: SAGE Publications.

Smith J.A., Jarman, M. & Osborn, M. (1999). Doing interpretative phenomenological analysis. In M. Murray and Chamberlain, K. (eds). *Qualitative Health Psychology: Theories and Methods* (pp. 218–240). London: Sage Publications.

Smith, G. E., & Pear, T. H. (1918). *Shell shock and its lessons*. Manchester: University Press. Retrieved from http://www.gwpda.org/medical/shshock/

Smith, P., Perrin, S., Dyregrov, A. & Yule, W. (2003). Principal component analysis of the impact of event scale with children at war. *Personality and Individual Differences, 34*, 315–322. doi: 10.1016/s0191-8869(02)00047-8

Sokolowski, R. (2000). *Introduction to phenomenology.* New York: Springer.

Sousa, C.A. (2013). Political violence, collective functioning and health: A review of the literature. *Medicine, Conflict, and Survival, 29*(1), 169-197. doi: 10.1080/13623699.2013.813109

Sreedevi, A., Cherkil, S., Kuttikattu, D.S., Kamalamma, L., & Oldenburg, B. (2016). Validation of the WHOQOL-BREF in Malayalam and Determinants of Quality of Life among people with type 2 Diabetes in Kerala, India. *Asia Pacific Journal of Public Health, 28*(1), 62-69. doi: 10.1177/1010539515605888

Stamm, B.H., & Friedman, M.J. (2000). Cultural diversity in the appraisal and expression of traumatic exposure. In A. Shaley, R. Yehuda, & A. McFarlane (Eds.) *International Handbook of Human Response in Trauma,* (pp. 69-85), New York: Plenum Press.

Stamm, B.H., Stamm, H.E., Hudnall, A.C., & Higson-Smith, C. (2004). Considering a theory of cultural trauma and loss. *Journal of Loss and Trauma, 9*(1), 89-111. doi: 10.1080/15325020490255412

Stanton, A. L., Bower, J. E., & Low, C. A. (2006). Posttraumatic growth after cancer. In L. G. Calhoun & R. G. Tedeschi (Eds.), *Handbook of posttraumatic growth: Research and practice* (pp. 138–175). Mahwah, NJ: Erlbaum.

Steel, Z., Silove, D., Chey, T., Bauman, A., Phan, T., & Phan, T. (2005). Mental disorders, disability and health service use amongst Vietnamese refugees and the host Australian population. *Acta Psychiatrica Scandinavica, 111*(4), 300-309. doi: 10.1111/j.1600-0447.2004.00458.x

Steel, Z., Silove, D., Phan, T., & Bauman, A. (2002). Long-term effect of psychological trauma on the mental health of Vietnamese refugees resettled in Australia: A population-based study. *Lancet, 360,* 1056-1062. doi:10.1016/S0140-6736(02)11142-1

Steel, Z., Steel, C.B., & Silove, D. (2009). Human rights and the trauma model: genuine partners or uneasy allies? *Journal of Traumatic Stress, 22*(5), 358-365. doi: 10.1002/jts.20449

Steger, M.F. (2009) Meaning in life. In S.J. Lopez, C.R. Snyder, (Eds). *Oxford handbook of positive psychology* (pp. 679–687). Oxford: Oxford University Press.

Steger, M.F. (2012). Experiencing meaning in life: Optimal functioning at the nexus of spirituality, psychopathology, and well-being. In P.T.P. Wong (Eds.) *The Human Quest for Meaning, 2nd ed* (pp. 165–184). New York: Routledge.

Steger, M.F, Frazier, P., Oishi, S., & Kaler, M. (2006). The Meaning in Life Questionnaire: Assessing the presence of and search for meaning in life. *Journal of Counseling Psychology, 53*, 80-93. doi: 10.1037/0022-0167.53.1.80

Steger, M.F., & Kashdan, T.B. (2013). The unbearable lightness of meaning: Well-being and unstable meaning in life. *The Journal of Positive Psychology: Dedicated to furthering research and promoting good practice, 8*(2), 103-115 doi: 10.1080/17439760.2013.771208

Steger, M.F., Kashdan, T.B., & Oishi, S. (2008). Being good by doing good: Daily eudemonic activity and well-being. *Journal of Research in Personality*, 42(1), 22-42. doi: 10.1016/j.jrp.2007.03.004

Steger, M.F., Kashdan, T.B., Sullivan, B.A., & Lorentz, D. (2008). Understanding the search for meaning in life: Personality, cognitive style, and the dynamic between seeking and experiencing meaning. *Journal of Personality, 76,* 199-228. doi: 10.1111/j.1467-6494.2007.00484.x

Steger, M.F., Kawabata, Y., Shimai, S. & Otake, K. (2008). The meaningful life in Japan and the United States: Levels and correlates of meaning in life. *Journal of Research in Personality, 42,* 660-678. doi:10.1016/j.jrp.2007.09.003

Steger, M.F., Oishi, S., & Kashdan, T.B. (2009). Meaning in life across the life span: Levels and correlates of meaning in life from emerging adulthood to older adulthood. *The Journal of Positive Psychology, 4*, 43-52. doi: 10.1080/17439760802303127

Steger, M.F., Oishi, S., & Kesebir, S. (2011). Is a life without meaning satisfying? The moderating role of the search for meaning in satisfaction with life judgments. *The Journal of Positive Psychology, 6*(3), 173-180. doi: 10.1080/17439760.2011.569171

Steger, M.F., & Park, C.L. (2012). The creation of meaning following trauma: meaning making and trajectories of distress and recovery. In R.A. McMackin, T.M. Keane, E. Newman, & J.M. Fogler (Eds.) *Toward an integrated approach to trauma focused therapy: placing evidence-based interventions in an expanded psychological context* (pp. 171–19). Washington, DC: American Psychological Association Press.

Steger, M. F., & Shin, J. Y. (2010). The relevance of the Meaning in Life Questionnaire to therapeutic practice: A look at the initial evidence. *International Forum on Logotherapy, 33,* 95-104. Retrieved from: http://www.michaelfsteger.com/wp-content/uploads/2012/08/Steger-Shin-IFL-2010.pdf

Stein, D.J., McLaughlin, K.A., Koenen, K.C., Atwoli, L., Friedman, M.J., Hill, E.D… & Kessler, R.C. (2014). DSM-5 and ICD-11 definitions of posttraumatic stress disorder: investigating "narrow" and "broad" approaches. *Depression and Anxiety, 31*(6), 494-505. doi: 10.1002/da.22279

Straker, G. (2013). Continuous traumatic stress: Personal reflections 25 years on. *Peace and Conflict: Journal of Peace Psychology, 19*, 209–217. doi: 10.1037/a0032532

Stillman, T. S., Baumeister, R. F., Lambert, N. M., Crescioni, A. W., DeWall, C. N., &

Fincham, F. D. (2009). Alone and without purpose: Life loses meaning following social exclusion. *Journal of Experimental Social Psychology*, *45*(4), 686–694. doi: 10.1016/j.jesp.2009.03.007

Sumathipala, A,, Siribaddana, S.H., & Bhugra, D. (2004). Culture- bound syndromes: the story of dhat syndrome. *British Journal of Psychiatry, 184*, 200–09. doi: 10.1192/bjp.184.3.200

Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Social Science & Medicine, 48*(10), 1449-1462. doi: 10.1016/S0277-9536(98)00450-X

Summerfield, D. (2001). The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category. *BMJ, 322*(7278), 95-98. doi: 10.1136/bmj.322.7278.95

Summerfield, D. (2004). Cross-cultural perspectives on the medicalization of human suffering. In G. M. Rosen (Ed.). *Posttraumatic stress disorder: Issues and controversies* (pp. 233-245). Chichester, UK: Wiley. doi: 10.1002/9780470713570.ch12

Summerfield, D. (2012). Afterword: Against "global mental health". *Transcultural psychiatry, 49*(3-4), 519-530. doi:10.1177/1363461512454701

Summerfield, D., & Hume, F. (1993). War and posttraumatic stress disorder: the question of social context. *Journal of Nervous and Mental Disease, 181*, 522. Retrieved from: http://journals.lww.com/jonmd/Citation/1993/08000/War_and_Posttraumatic_Stress_Disorder__The.12.aspx

Tardiff, T., & Wellman, H. M. (2000). Acquisition of mental state lan- guage in Mandarin- and Cantonese-speaking children. *Developmental Psychology, 36*, 25–43. doi: 10.1037//0012-1649.36.1.25

Tasca, C., Rapetti, M., Carta, M.G., & Fadda, B. (2012). Women and Hysteria In The History Of Mental Health. *Clinical Practice Epidemiology Mental Health*, *8*, 110–119. doi: 10.2174/1745017901208010110

Tearfund, A.M. (2006). *Assessing Psychological Distress – Which Lens?* Retrieved from http://www.odihpn.org/report.asp?id=2861[p5].

Temane, L., Khumalo, I.P., & Wissing, M.P. (2014). Validation of the Meaning in Questionnaire in a South African context. *Journal of Psychology in Africa, 24*(1), 51-60. doi: 10.1080/14330237.2014. 904088

Tempany, M. (2009). What Research tells us about the mental health and psychosocial wellbeing of Sudanese refugees: A Literature Review. *Transcultural Psychiatry, 46,* 300-316. doi: 10.1177/1363461509105820

Terr, L.C. (1987). Childhood psychic trauma. In J.D. Noshpitz (Ed.), *Basic Handbook of Child Psychiatry, Volume 5: Advances and New Directions* (pp. 262 - 272). New York: Basic Books.

Triandis, H. C. (1994). *Culture and social behavior*. New York: McGraw-Hill.

Tummala-Narra, P. (2007). Conceptualizing trauma and resilience across diverse contexts. *Journal of Aggression, Maltreatment & Trauma, 14*, (1-2), 33-53. doi: 10.1300/J146v14n01_03

University of Florida Health. (2017). *Traumatic injury.* Retrieved 5th February, 2017, from https://ufhealth.org/traumatic-injury

Ungar, M. (2011). Resilience, trauma, context, culture. *Trauma, Violence, and Abuse, 14*(3), 255-266. doi: 10.1177/1524838013487805

United Nations Human Rights Council. (2016). *Figures at a glance*. Retrieved from http://www.unhcr.org/figures-at-a-glance.html on 4 June, 2016

United Nations High Commissioner for Refugees. (1951). *Text of the Convention and Protocol Relating to the Status of Refugees*. Retrieved 24 February, 2014, from http://www.unhcr.org/3b66c2aa10.html

United States Holocaust Memorial Museum. *Introduction to the Holocaust.* Washington, DC. Retrieved from: https://www.ushmm.org/wlc/en/article.php?ModuleId=10005143

Updegraff, J.A., Silver, R.C., & Holman, E.A. (2008). Searching for and finding meaning in collective trauma: Results from a national longitudinal study of the 9/11 terrorist attacks. *Journal of Personality and Social Psychology, 95*, 709–722. doi: 10.1037/0022-3514.95.3.709.

Uz, I. (2015). The index of cultural tightness and looseness among 68 countries. *Journal of Cross-Cultural Psychology, 46*(3), 319-335. doi: 10.1177/0022022114563611

Valent, P. (1995). Documented childhood trauma (Holocaust): Its sequelae and applications to other traumas. *Psychiatry, Psychology and Law, 2*(1), 81-89. doi: 10.1080/13218719509524853

Valent, P. (2005). Trauma, right brain, and psychotherapy. Retrieved from http://www.paulvalent.com/wp-content/uploads/2013/02/right_brain_03.pdf

Valent, P. (2012). How is and will the Holocaust be remembered? Retrieved from: http://www.paulvalent.com/wp-content/uploads/2013/02/How-will-the-hol-be-remembered.pdf

Valent, P. (2013). Clinical formulations; phenomenological and traumatodynamic considerations. Retrieved from http://www.paulvalent.com/wp-content/uploads/2013/02/stress_trauma_maladaptive_01.pdf

Van der Kolk, B. McFarlane, A., & Weisaeth, L. (1996). T*raumatic Stress: the effects of overwhelming experience on mind, body, and society.* New York: Guilford Press.

Van der hal-van Raalte, E.A.M., Van IJzendoorn, M.H., Bakermans-Kranenburg, M.J. (2008). Sense of coherence moderates late effects of early childhood Holocaust exposure. *Journal of Clinical Psychology, 64*(12), 1352-1367. doi: 10.1002/jclp.20528

Van Esch, L., Den Oudsten, B.L., & De Vries, J. (2011). The World Health Organization Quality of Life Instrument-Short Form (WHOQOL-BREF) in women with breast problems. *International Journal of Clinical and Health Psychology, 11*(1), 5-22. Retrieved from: http://www.redalyc.org/pdf/337/33715423001.pdf

Van Rooyen, K., & Ngweni, Z.C. 2012. Culture and post-traumatic stress disorder (PTSD): A proposed conceptural framework. *South African Journal of Psychology, 42*(1), 51-60. doi: 10.1177/008124631204200106

Ventovogel, P., Jordans, M., Reis. R., & de Jong, J. (2013). Madness or sadness? Local concepts of mental illness in four conflict-affected African communities. *Conflict and Health, 7*(3). doi: 10.1186/1752-1505-7-3

Vermetten E., & Bremner, J.D. (2002) Circuits and systems in stress. II. Applications to neurobiology and treatment of PTSD. *Depress Anxiety*, *16*, 14–38. doi: 10.1002/da.10017

Vermetten, E., & Olff, M. (2013). Psychotraumatology in the Netherlands [proceedings paper]. *European Journal of Psychotraumatology, 4*. doi: 10.3402/ejpt.v4i0.20832

Victorian Foundation for Survivors of Torture. (2016). *Integrated trauma recovery service model.* Retrieved from http://www.foundationhouse.org.au/wp-content/uploads/2016/05/FOUNDATION-HOUSE-MODEL-4-BOOKLET_ONLINE-FA.pdf

Webb, E.J., Campbell, D.T., Schwartz, R.D. & Sechrest, L. (1966) *Unobtrusive Measures. Non-reactive Research in the Social Sciences*. Chicago: Rand McNally.

Webb, R.E., & Windseth, J.C. (2009). Traumas with and without a sense of agency. *Journal of aggression, maltreatment, & Trauma, 18*(5), 532-546. doi: 10.1080/10926770903050993

Weine, S.M., Ware, N., Tugenberg, T., Hakizimana, L., Dahnweih, G., Currie, M., Wagner, M., & Levin, E. (2013). Thriving, managing, and struggling: a mixed methods study of adolescent African refugees' psychosocial adjustment. *Adolescent Psychiatry, 3*, 72-81. doi: 10.2174/2210676611303010013

Weisner, T., & Fiese, B. (2011). Introduction to Special Section of the Journal of Family Psychology, Advances in Mixed Methods in Family Psychology: Integrative and Applied Solutions for Family Science. *Journal of Family Psychology, 25(*6), 795-798. doi: 10.1037/a0026203

Weiss, R.S. (1968). Issues in holistic research. In H.S. Becker, B., Geer, D., Riesman, & R. Weiss (eds.). *Institutions and the Person,* (pp. 342-350). Chicago: Aldine.

Wendt, D. C., & Gone, J. P. (2012). Rethinking cultural competence: Insights from indigenous community treatment settings. *Transcultural Psychiatry, 49,* 206–222. doi: 10.1177/1363461511425622 ·

The WHOQOL Group. (1998). Development of the World Health Organization WHOQOL-BREF quality of life assessment. *Psychol Med*, *28*(3), 551-8. doi: 10.1017/S0033291798006667

Wiesel, E. (1958). *Night.* New York: Hill and Wang.

Wiesel. E. (1968). *Legends of Our Time*. New York: Holt, Rinehart, Winston, Inc.

Wiesel, E. (2012). *Hostage.* New York: Random House, Inc.

Wilson, & Tang, C.S. (2007). *Cross-cultural assessment of psychological trauma and PTSD*. Springer: New York.

Winger, J.G., Adams, R.N., & Mosher, C.E., (2016). Relations of meaning in life and sense of coherence to distress in cancer patients: a meta-analysis. *Psychooncology, 25*(1), 2-10. doi:10.1002/pon.3798

Wong, P.T.P., & Fry, P.S. (1998). *The Human Quest for Meaning*. Mahwah, NJ: Erlbaum.

World Health Organization. (1993). *The ICD-10 Classification of Mental and Behavioural Disorders: Diagnostic Criteria for Research.* Geneva: World Health Organization.

World Health Organization. (1996). *WHOQOL-BREF Introduction, administration, scoring and generic version of the assessment, field trial version.* Geneva: Programme of Mental Health.

WHOQOL Group (1998). Development of the World Health Organization WHOQOL-BREF quality of life assessment. *Psychol Med, 28*(3), 551-8. doi: 10.1017/S0033291798006667

Yazdi, A. A., German, T. P., Defeyter, M. A., & Siegal, M. (2006). Competence and performance in belief-desire reasoning across two cultures: The truth, the whole truth and nothing but the truth about false belief? *Cognition, 100*, 343–368. doi: 10.1016/j.cognition.2005.05.004

Yehuda R., Kahana B., Schmeidler J., Southwick S.M., Wilson S., & Giller E.L. (1995). Impact of cumulative lifetime trauma and recent stress on current posttraumatic stress disorder symptoms in Holocaust survivors. *Am J Psychiatry, 152*, 1815–1818. doi: 10.1176/ajp.152.12.1815

Yehuda R., Southwïck, S.M., Nussbaum E.L., Wahby, V., Giller, E.L. Jr, & Mason, J.W. (1990). Low Urinary Cortisol Excretion in Patients with Posttraumatic Stress Disorder. *Journal Nervous Mental Disorders, 178*, 366–369. doi: 10.1097/00005053-199006000-00004

Yeomans, P.D., & Forman, E.M. (2009). Cultural factors in traumatic stress. In S. Eshun, & Gurung, R.A.R. (Eds.). *Culture and Mental Health: Sociocultural influences, theory, and practice.* Wiley-Blackwell, Oxford, UK. doi: 10.1002/9781444305807.ch11

Young, A. (1995). *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder.* Princeton, NJ: Princeton University Press.

Zakowski, S.G., Valdimarsdottir, H.B., & Bovbjerg, D.B. (2001). Emotional expressivity and intrusive cognitions in women with family histories of breast cancer: Application of a cognitive processing model. *British Journal of Health Psychology, 6*(2), 151-165. doi: 10.1348/135910701169124

Zeidner, M. & Aharoni-David, E. (2015). Memories of Holocaust-related traumatic experiences, sense of coherence, and survivors' subjective well-being in late life: some puzzling findings. *Anxiety, Stress & Coping: An International Journal, 28*(3), 254-271. doi: 10.1080/10615806.2014.954244

Zoellner, L.A., Rothbaum, B.O., & Feeny, N.C. (2011). PTSD not an anxiety disorder? DSM committee proposal turns back the hands of time. *Depression and Anxiety, 28*(10), 853-856. doi: 10.1002/da.20899

Zola, I. (1972). Medicine as an institution of social control. *The sociological review*, *20*(4), 487-504. doi: 10.1111/j.1467-954X.1972.tb00220.x

Appendices

Appendix A: Monash University human ethics approval

MONASH University

Monash University Human Research Ethics Committee (MUHREC)
Research Office

Human Ethics Certificate of Approval

This is to certify that the project below was considered by the Monash University Human Research Ethics Committee. The Committee was satisfied that the proposal meets the requirements of the *National Statement on Ethical Conduct in Human Research* and has granted approval.

Project Number:	CF14/1107 -2014000477	
Project Title:	Understanding models of trauma and recovery	
Chief Investigator:	Prof Louise Newman	
Approved:	**From:** 15 July 2014	**To:** 15 July 2019

Terms of approval - *Failure to comply with the terms below is in breach of your approval and the Australian Code for the Responsible Conduct of Research.*

1. The Chief investigator is responsible for ensuring that permission letters are obtained, if relevant, before any data collection can occur at the specified organisation.
2. Approval is only valid whilst you hold a position at Monash University.
3. It is the responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval and to ensure the project is conducted as approved by MUHREC.
4. You should notify MUHREC immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.
5. The Explanatory Statement must be on Monash University letterhead and the Monash University complaints clause must include your project number.
6. **Amendments to the approved project (including changes in personnel):** Require the submission of a Request for Amendment form to MUHREC and must not begin without written approval from MUHREC. Substantial variations may require a new application.
7. **Future correspondence:** Please quote the project number and project title above in any further correspondence.
8. **Annual reports:** Continued approval of this project is dependent on the submission of an Annual Report. This is determined by the date of your letter of approval.
9. **Final report:** A Final Report should be provided at the conclusion of the project. MUHREC should be notified if the project is discontinued before the expected date of completion.
10. **Monitoring:** Projects may be subject to an audit or any other form of monitoring by MUHREC at any time.
11. **Retention and storage of data:** The Chief Investigator is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.

[redacted]

Professor Nip Thomson
Chair, MUHREC

cc: Dr Glen Melvin, Prof Lenore Manderson, Mr Jarrod White

Postal – Monash University, Vic 3800, Australia
Building 3E, Room 111, Clayton Campus, Wellington Road, Clayton
[redacted]

Appendix B: Permission granted by Sudanese community members

jewishaid australia

PERMISSION LETTER

Project: Understanding models of trauma and recover

Date 20/6/14

Chief investigators full monash postal address:
Centre for Developmental Psychiatry and Psychology,
CAMHS building,
Monash Medical Centre
246 Clayton Road
Clayton, VIC 3168
Australia

Dear Jarrod White,

Thank you for your request to recruit participants from Jewish Aid Australia for the above-named research

I have read and understood the explanatory statement regarding the research project and hereby give permission for this research to be conducted

Yours Sincerely

[redacted]

Lisa Buchner
Refugee Support Director

Komi Bana [redacted]
Secretary General of Nuba Mountains International Organization

[redacted]

Babiker Ishad
Darfur community member

Appendix C: Synopsis of research provided to not-for-profit organisations

Understanding Cultural Models

Towards a better understanding of the Holocaust survivor community

Hi,

My name is Jarrod White. I am student completing my Doctorate of Psychology at Monash University and I have also been a volunteer at the Jewish Holocaust centre for the past 4 years helping out with the March of the Living.

As part of my course requirement I am studying how refugee communities rebuild following their experiences. For this I am surveying Sudanese refugee and Jewish Holocaust survivors. The aim of my research is to help in understanding the way that your experiences have effected you, and if or how you recover from these experiences. You are the expert and I believe that the Australian and psychological community needs to understand how your community feels about their experiences and how the Holocaust survivor community understands a sense of meaning in life currently. My hope is that through a better understanding, psychologists as well as the rest of the Australian community can learn to better help your community so that the future generations, the children, can grow up to live in a country that effectively and appropriately meets the needs of your community.

In addition to an interview that will last approximately 40-60 minutes, to help with my research I will ask if you could please answer questionnaires about:

1. Your experiences before you came to Australia
2. Your feelings about your current quality of life
3. Your ability to understand the world around you
4. Your meaning and purpose in your life

Filling out these questionnaires should take approximately 20 – 25 minutes. Any help with this would be very much appreciated. I hope that through this research you can help me, help your community in a way that you think is best.

Thanking you

Jarrod White

Doctorate of (clinical) psychology

MONASH University

Understanding Cultural Models

Towards a better understanding of the Sudanese Community

Hi,

My name is Jarrod White. I am student completing my Doctorate of Psychology at Monash University and I have also been a volunteer at Stand Up for the past 4 years helping out with the homework club and the iCan mentoring program.

As part of my course requirement I am studying how refugee communities rebuild following immigration to Australia as a result of difficult circumstances in their home country. For this I am surveying Sudanese refugee and Jewish Holocaust survivors.

The aim of my research is to help build a bridge of understanding and partnership between the Australian community, the field of psychology, and the Sudanese community/ies. You are the expert and I believe that the Australian community needs to understand how the Sudanese community feels about their current circumstances in Australia and how the Sudanese community hopes to rebuild a sense of meaning and purpose within this country. My hope is that through a better understanding, psychologists all around Australia as well as the rest of the Australian community can learn to better help the Sudanese community so that the future generations, the children of the Sudanese community, can grow up to live in a country that effectively and appropriately meets the needs of its new inhabitants.

To help with this I ask if you could please fill out four questionnaires asking you about:

1. Your feelings about your life here in Australia
2. Your ability to understand the Australian society and connect with the world you live in
3. How you see your meaning and purpose in your life
4. Your experiences before you came to Australia

Filling out these questionnaires should take approximately 20 – 25 minutes. If it could be organized so that we can all do this on one day it would be the most useful. Any help with this would be very much appreciated. I hope that through this research you can help me, help your community in a way that you think is best.

Thank you

Jarrod White

Doctorate of (clinical) psychology

Appendix D: Participant explanation and consent form

Participant Explanatory Statement and Consent Form

Research: Understanding stressful experiences and cultural context

Researcher: Jarrod White. Doctor of Psychology (Clinical) Candidate, School of Psychology and Psychiatry, Monash University [redacted]

Supervisors: Professor Louise Newman, Director, Monash Centre for Developmental Psychiatry and Psychology [redacted] Dr. Glenn Melvin, Senior Lecturer and Psychologist, Monash Centre for Developmental Psychiatry and Psychology [redacted] and Professor Lenore Manderson

Why are we doing this research?

My name is Jarrod White and I am a student at Monash University completing my Doctorate in Psychology. I am also a volunteer at Jewish Aid Australia and I am a third generation Holocaust survivor (i.e. my grandparents lived through the Holocaust). As part of my university course I do research in an area that I choose. In studying psychology it is clear to me that psychologists work to help people who have lived through extremely stressful experiences. The problem today though is that psychologists do not understand enough about those from different cultures in order to help them effectively. Different cultures have different ways of understand both mental health and stressful experiences. In order to help, psychologists need to learn how to help. This is why I am doing my research. So that psychologists can better learn to help those who have suffered. In this case, you are the expert. Therefore I will, as part of this research, ask you to teach me about the mental health understanding of your community and how your culture understands responses to stressful events.

Introduction

The aim of this research is to explore the way in which varying cultural groups understand the impact of stressful experiences. You have been invited to take part in this research along with a group of other individuals from refugee backgrounds. The participants in this study are all from either a Sudanese background or are survivors of the Holocaust.
We would like to hear from you about your experiences in your home country and how they may have impacted you. We will also be looking at the way in which stress may be impacting your life and whether you feel as though you have meaning in your life.

This information and consent form tells you about what is involved in the research project and what sort of things you will do as part of the project. Please read this information carefully and feel free to ask any questions about anything you want to know more about or don't understand.

Your participation in this research is voluntary. If you don't wish to take part in this research, you don't have to. If you decide to take part in this research but then change your mind at a later stage, you are free to stop participating in the project. But once you have completed the questionnaires, information from these cannot be withdrawn from the project. Your decision to take part or not, or to take part and then withdraw, will not affect your relationship with the researchers or any other organization.

If you decide that you are happy to take part in this research you are asked to please sign the consent section of this form. By signing this you are telling us that you

- understand what you have read
- agree to take part in this research
- agree to be involved in the procedures described in this document
- agree to the use of your personal information as described in this document

You will be given copies of your information and consent forms to keep

What are the possible benefits of participating in this research?

The information gained from this research project will help us better understand the challenges facing people who have experienced stressful events. The information gained will also help us better understand your culture so that people can be more accepting, tolerant and understanding of cultural practices and ways of living. It will help psychologists understand how best to help individuals from your culture who have experienced a traumatic event. In having a greater understanding of the impact of traumatic events on individuals from different cultures, we can work to better meet your needs and the future needs of individuals who suffer from mass violence and genocide.

What does participation in this research project involve?

Firstly Only some participants will be asked to participate in an interview. For those undertaking the interview:
You will then be asked to take part in a conversation with the researcher. The researcher will ask you about your experiences in adapting to your new life in Australia. These conversation, if you desire, will be audio-taped or video-taped and then written down. A copy of the written version of the interview can be given to you if you would like to read it. If you agree to take part in this discussion, the researcher would like to talk to you for between 40 to 60 minutes.

You will be asked to complete 4 brief questionnaires. These questionnaires will provide information about your experience of stress and will ask you to rate how meaningful you

feel your life is. It will also ask which, if any**,** stressful events you have experienced before. The questionnaires should take you approximately 20-25 minutes all together to complete. This means that if you are also engaging in the interview, your total participation in this research will require approximately 1 hour and 25 minutes (for questionnaires [25 minutes] and interview [60 minutes]).

What are the possible risks?

Some individuals may be upset in speaking about some traumatic past experiences. In the unlikely event of you becoming upset as a result of participation in the project, the researcher will discuss this with you and talk about the different options of support available to you

Below is a list of helpful agencies who may be contacted in the event that you wish to speak to someone if you feel upset in speaking about your adjustment to life in Australia. The research is able to support referral to these agencies if you request:

Organisation	Service provided	Contact number	Operating hours	Language
Asylum Seeker Resource Centre	Assists refugees and migrants settle into Victoria	8772 1380	Business hours	Multi-lingual
Foundation House	Assists refugees and migrants recover from past experiences	8788 3333	Business hours	Multi-lingual
Lifeline	Telephone crisis support	13 11 14	24 hour service	English
Suicide Helpline	Telephone support service for people thinking about suicide or worried about the safety of someone else	1300 651 251	24 hour service	English
Refugee Health Clinic, Dandenong Hospital David St. Dandenong	Clinic objectives are improved health outcomes close follow up and treatment of communicable and psychiatric disease and to divert chronic and complex care from hospital inpatient admissions.	03 9554 8093	Monday 1.30 - 5.30 pm	Multi-lingual
Refugee Health Clinic 67 Power Rd Doveton	Clinic objectives are improved health outcomes close follow up and treatment of communicable and psychiatric disease and to divert chronic and complex care from hospital inpatient admissions.	03 9212 5700	Sally Sant 83984111 Team leader – Counselling area	Multi-lingual

What will happen to information about me?

Any information obtained from this research will be kept fully confidential. Information will only be disclosed with your permission. Psychologists/researchers are required to notify the Department of Human Services only if they believe that any family member is at risk of harm or disclose an experience of physical or sexual abuse

Information gathered will be stored securely for at least 5 years and then destroyed confidentially. The information collected will be stored in locked cupboards at the School of Psychology and Psychiatry at Monash University. It will only be used by the researcher. Your name and contact details will be kept separately from the information you provide. Also there will be nothing in any report, presentation, or publication on the study that could identify you or your family. You have the right to access and to requestion correction of information held about you in accordance with the Freedom of Information Act 19882 (Vic).

What publications might stem from this research?

The results of this research will form a thesis, as part of the course requirements for the completion of the Doctorate of Clinical Psychology program. There may also be publications in research journals and presentations made to conferences which discuss the results of this research. There will be no identifying information in any publications or presentations that will be based upon this research.

How will we be informed about the final results of this research project?

You will be given feedback on progress over the course of the study. A summary report of the outcome of the research will be mailed to all participants at the end of the study (this will be about 2 years away).

If you have any questions about the research project, please feel free to contact Jarrod White, School of Psychology and Psychiatry, Monash University, Clayton, VIC [redacted]

If you are unable to read this or understand the questions an interpreter will be provided

Participant Consent Form

Title: Understanding models of trauma and recovery: A comparison of Sudanese refugees with Holocaust Survivors

NOTE: This consent form will remain with the Monash University researcher for their records

I agree to take part in the Monash University research project specified above. I have had the project explained to me, and I have read, or have had read to me, the Explanatory Statement in a language I understand, which I keep for my records. I understand that agreeing to take part means that:

I agree to complete questionnaires asking me about my emotions and behaviours and about how I cope with challenges	☐ Yes	☐ No

The following relates only to those undertaking the interviews:

I agree to be interviewed by the researcher	☐ Yes	☐ No
I agree to allow the interview to be audio-taped	☐ Yes	☐ No
I agree to allow the interview to be video-taped	☐ Yes	☐ No

I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way.

I understand that any data that the researcher extracts from the interview and questionnaires for use in reports or published findings will not, under any circumstances, contain names or identifying characteristics.

I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party.

I understand that data from the interview will be kept in a secure storage and accessible to the research team. I also understand that the data will be destroyed after a 5 year period unless I consent to it being used in future research.

Participant's name: _____

Signature: _____

Date: _____

Declaration by the researcher*: I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Researcher's name (printed): _____

Signature: _____

Date: _____

** Note: All parties signing the consent form must date their own signature.*

If you have any complaints or concerns about this research project, please complete this slip of paper in the reply-paid envelope, and post it back to Monash University**.** Susie Thompson is the administrative officer at the Centre of Developmental Psychiatry and Psychology at Monash University. She is not directly involved in the research project and therefore will call you back at a suitable time with an interpreter (if need be) to discuss your concerns further. Moreover she will direct those in need to the Monash University Human Research Ethics Committee if required.

Please complete the following details and post this slip of paper back in the attached envelope.

Name: .....
Language/Dialect you require an interpreter in: .....
Phone number(s) to contact you on: .....
Preferred contact time (e.g. "Mondays from 3pm til 5pm"): .....

Appendix E: Semi-structured interview

1. Can you tell me about your experiences before arriving in Australia?
2. Do these experiences effect you? How?
3. Can you recover from these experiences? How?
4. Do you have meaning in life? Can you explain this to me?
5. Do you have a purpose? Can you explain this to me?
6. Do you understand the world around you? Can you explain this to me?

Appendix F: Harvard Trauma Questionnaire- Revised

INSTRUCTIONS

We would like to ask you about your past history and present symptoms. This information will be used to help us provide you with better medical care. However, you may find some questions upsetting. If so, please feel free not to answer. This will certainly not affect your treatment. The answer to the questions will be kept confidential.

PART 1: TRAUMA EVENTS

Please indicate whether you have experienced any of the following events (check YES or NO)

		YES	NO
1.	Lack of shelter		
2.	Lack of food or water		
3.	Ill health without access to medical care		
4.	Confiscation or destruction of personal property		
5.	Combat situation (e.g. shelling and grenade attacks)		
6.	Forced evacuation under dangerous conditions		
7.	Beating to the body		
8.	Rape		
9.	Other types of sexual abuse or sexual humiliation		
10.	Knifing or axing		
11.	Torture, i.e., while in captivity you received deliberate and systematic infliction of physical or mental suffering		
12.	Serious physical injury from combat situation or landmine		

		YES	NO
13.	Imprisonment		
14.	Forced labor (like animal or slave)		
15.	Extortion or robbery		
16.	Brainwashing		
17.	Forced to hide		
18.	Kidnapped		
19.	Other forced separation from family members		
20.	Forced to find and bury bodies		
21.	Enforced isolation from others		
22.	Someone was forced to betray you and place you at risk of death or injury		
23.	Prevented from burying someone		
24.	Forced to desecrate or destroy the bodies or graves of deceased persons		
25.	Forced to physically harm family member, or friend		
26.	Forced to physically harm someone who is not family or friend		
27.	Forced to destroy someone else's property or possessions		
28.	Forced to betray family member, or friend placing them at risk of death or injury		
29.	Forced to betray someone who is not family or friend placing them at risk of death or injury		
30.	Murder, or death due to violence, of spouse		

		YES	NO
31.	Murder, or death due to violence, of child		
32.	Murder, or death due to violence, of other family member or friend		
33.	Disappearance or kidnapping of spouse		
34.	Disappearance or kidnapping of child		
35.	Disappearance or kidnapping of other family member or friend		
36.	Serious physical injury of family member or friend due to combat situation or landmine		
37.	Witness beatings to head or body		
38.	Witness torture		
39.	Witness killing/murder		
40.	Witness rape or sexual abuse		
41.	Another situation that was very frightening or in which you felt your life was in danger. Specify:		

PART 4: TRAUMA SYMPTOMS

The following are symptoms that people sometimes have after experiencing hurtful or terrifying events in their lives. Please read each one carefully and decide how much the symptoms bothered you in the past week.

		(1) Not at all	(2) A little	(3) Quite a bit	(4) Extremely
1.	Recurrent thoughts or memories of the most hurtful or terrifying events				
2.	Feeling as though the event is happening again				
3.	Recurrent nightmares				
4.	Feeling detached or withdrawn from people				
5.	Unable to feel emotions				
6.	Feeling jumpy, easily startled				
7.	Difficulty concentrating				
8.	Trouble sleeping				
9.	Feeling on guard				
10.	Feeling irritable or having outbursts of anger				
11.	Avoiding activities that remind you of the traumatic or hurtful event				

		(1) Not at all	(2) A little	(3) Quite a bit	(4) Extremely
12.	Inability to remember parts of the most hurtful or traumatic events				
13.	Less interest in daily activities				
14.	Feeling as if you don't have a future				
15.	Avoiding thoughts or feelings associated with the traumatic or hurtful events				
16.	Sudden emotional or physical reaction when reminded of the most hurtful or traumatic events				
17.	Feeling that you have less skills than you had before				
18.	Having difficulty dealing with new situations				
19.	Feeling exhausted				
20.	Bodily pain				
21.	Troubled by physical problem(s)				
22.	Poor memory				
23.	Finding out or being told by other people that you have done something that you cannot remember				
24.	Difficulty paying attention				
25.	Feeling as if you are split into two people and one of you is watching what the other is doing				
26.	Feeling unable to make daily plans				

		(1) Not at all	(2) A little	(3) Quite a bit	(4) Extremely
27.	Blaming yourself for things that have happened				
28.	Feeling guilty for having survived.				
29.	Hopelessness.				
30.	Feeling ashamed of the hurtful or traumatic events that have happened to you				
31.	Feeling that people do not understand what happened to you.				
32.	Feeling others are hostile to you				
33.	Feeling that you have no one to rely upon				
34.	Feeling that someone you trusted betrayed you				
35.	Feeling humiliated by your experience.				
36.	Feeling no trust in others.				
37.	Feeling powerless to help others.				
38.	Spending time thinking why these events happened to you				
39.	Feeling that you are the only one that suffered these events.				
40.	Feeling a need for revenge.				

Appendix G: Orientation to Life Questionnaire

ORIENTATION TO LIFE QUESTIONNAIRE

Here is a series of questions relating to various aspects of our lives. Each question has seven possible answers. Please mark the number which expresses your answer, with numbers 1 and 7 being the extreme answers. If the words under 1 are right for you, circle 1; if the words under 7 are right for you, circle 7. If you feel differently, circle the number which best expresses your feeling. Please give only one answer to each question.

1. Do you have the feeling that you don't really care about what goes on around you?

1	2	3	4	5	6	7
very seldom or never						very often

2. Has it happened in the past that you were surprised by the behavior of people whom you thought you knew well?

1	2	3	4	5	6	7
never happened						always happened

3. Has it happened that people whom you counted on disappointed you?

1	2	3	4	5	6	7
never happened						always happened

4. Until now your life has had:

1	2	3	4	5	6	7
no clear goals or purpose at all						very clear goals and purpose

5. Do you have the feeling that you're being treated unfairly?

1	2	3	4	5	6	7
very often						very seldom or never

6. Do you have the feeling that you are in an unfamiliar situation and don't know what to do?

1	2	3	4	5	6	7
very often						very seldom or never

7. Doing the things you do every day is:

1	2	3	4	5	6	7
a source of deep pleasure and satisfaction						a source of pain and boredom

8. Do you have very mixed-up feelings and ideas?

1	2	3	4	5	6	7
very often						very seldom or never

9. Does it happen that you have feelings inside you would rather not feel?

1	2	3	4	5	6	7
very often						very seldom or never

10. Many people - even those with a strong character - sometimes feel like sad sacks (losers) in certain situations. How often have you felt this way in the past?

1	2	3	4	5	6	7
never						very often

11. When something happened, have you generally found that:

1	2	3	4	5	6	7
you overestimated or underestimated its importance						you saw things in the right proportion

12. How often do you have the feeling that there's little meaning in the things you do in daily life?

1	2	3	4	5	6	7
very often						very seldom or never

13. How often do you have feelings that you're not sure you can keep under control?

1	2	3	4	5	6	7
very often						very seldom or never

Appendix H: Meaning in Life Questionnaire

Strack, K, M. (2007). A measure of interest to logotherapy researchers: The Meaning In Life Questionnaire. *The International Forum for Logotherapy, 30*, 109-111.

The Meaning in Life Questionnaire (MLQ) is a 10-item self-report inventory designed to measure life meaning. The MLQ has good internal consistency, with coefficient alphas ranging in the low to high .80s for the Presence subscale and mid .80s to low .90s for the Search subscale. A main focus of logotherapy is the discovery of life meaning. Along these lines, logotherapy posits that: (1) there is meaning in life, (2) people are motivated by the Will to Meaning, and (3) people are free to find their own meaning. Since the MLQ is a new instrument that was developed predominantly with female, Caucasian, undergraduate student samples, further research is necessary to investigate the measure's psychometric properties with diverse populations.

Scale

Please take a moment to think about what makes your life and existence feel important and significant to you. Please respond to the following statements as truthfully and accurately as you can, and also please remember that these are very subjective questions and that there are no right or wrong answers. Please answer according to the scale below:

Absolutely Untrue	Mostly Untrue	Somewhat Untrue	Can't Say True or False	Somewhat True	Mostly True	Absolutely True
1	2	3	4	5	6	7

_____1. I understand my life's meaning.

_____2. I am looking for something that makes my life feel meaningful.

_____3. I am always looking to find my life's purpose.

_____4. My life has a clear sense of purpose.

_____5. I have a good sense of what makes my life meaningful.

_____6. I have discovered a satisfying life purpose.

_____7. I am always searching for something that makes my life feel significant.

_____8. I am seeking a purpose or mission for my life.

_____9. My life has no clear purpose.

_____10. I am searching for meaning in my life.

Scoring:

Item 9 is reverse scored.

Items 1, 4, 5, 6, & 9 make up the Presence of Meaning subscale
Items 2, 3, 7, 8, & 10 make up the Search for Meaning subscale

Scoring is kept continuous.

Appendix I: World Health Organization Quality of Life Scale

MSA/MNH/PSF/97.6
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I.D. number | | | | |

ABOUT YOU

Before you begin we would like to ask you to answer a few general questions about yourself: by circling the correct answer or by filling in the space provided.

What is your **gender**? Male Female

What is you **date of birth**? _____ / _____ / _____
Day / Month / Year

What is the highest **education** you received?
None at all
Primary school
Secondary school
Tertiary

What is your **marital status**?
Single
Married
Living as married
Separated
Divorced
Widowed

Are you currently **ill**? Yes No

If something is wrong with your health what do you think it is?_____illness/ problem

Instructions

This assessment asks how you feel about your quality of life, health, or other areas of your life. **Please answer all the questions.** If you are unsure about which response to give to a question, **please choose the one** that appears most appropriate. This can often be your first response.

Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life **in the last two weeks.** For example, thinking about the last two weeks, a question might ask:

		Not at all	Not much	Moderately	A great deal	Completely
	Do you get the kind of support from others that you need?	1	2	3	4	5

You should circle the number that best fits how much support you got from others over the last two weeks. So you would circle the number 4 if you got a great deal of support from others as follows.

		Not at all	Not much	Moderately	A great deal	Completely
	Do you get the kind of support from others that you need?	1	2	3	4	5

You would circle number 1 if you did not get any of the support that you needed from others in the last two weeks.

Please read each question, assess your feelings, and circle the number on the scale for each question that gives the best answer for you.

		Very poor	Poor	Neither poor nor good	Good	Very good
1(G1)	How would you rate your quality of life?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
2 (G4)	How satisfied are you with your health?	1	2	3	4	5

The following questions ask about **how much** you have experienced certain things in the last two weeks.

		Not at all	A little	A moderate amount	Very much	An extreme amount
3 (F1.4)	To what extent do you feel that physical pain prevents you from doing what you need to do?	1	2	3	4	5
4(F11.3)	How much do you need any medical treatment to function in your daily life?	1	2	3	4	5
5(F4.1)	How much do you enjoy life?	1	2	3	4	5
6(F24.2)	To what extent do you feel your life to be meaningful?	1	2	3	4	5

		Not at all	A little	A moderate amount	Very much	Extremely
7(F5.3)	How well are you able to concentrate?	1	2	3	4	5
8 (F16.1)	How safe do you feel in your daily life?	1	2	3	4	5
9 (F22.1)	How healthy is your physical environment?	1	2	3	4	5

The following questions ask about **how completely** you experience or were able to do certain things in the last two weeks.

		Not at all	A little	Moderately	Mostly	Completely
10 (F2.1)	Do you have enough energy for everyday life?	1	2	3	4	5
11 (F7.1)	Are you able to accept your bodily appearance?	1	2	3	4	5
12 (F18.1)	Have you enough money to meet your needs?	1	2	3	4	5
13 (F20.1)	How available to you is the information that you need in your day-to-day life?	1	2	3	4	5
14 (F21.1)	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5

		Very poor	Poor	Neither	Good	Very good

				poor nor good		
15 (F9.1)	How well are you able to get around?	1	2	3	4	5

The following questions ask you to say how **good or satisfied** you have felt about various aspects of your life over the last two weeks.

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
16 (F3.3)	How satisfied are you with your sleep?	1	2	3	4	5
17 (F10.3)	How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5
18(F12.4)	How satisfied are you with your capacity for work?	1	2	3	4	5
19 (F6.3)	How satisfied are you with yourself?	1	2	3	4	5
20(F13.3)	How satisfied are you with your personal relationships?	1	2	3	4	5
21(F15.3)	How satisfied are you with your sex life?	1	2	3	4	5
22(F14.4)	How satisfied are you with the support you get from your friends?	1	2	3	4	5
23(F17.3)	How satisfied are you with the conditions of your living place?	1	2	3	4	5
24(F19.3)	How satisfied are you with your access to health services?	1	2	3	4	5
25(F23.3)	How satisfied are you with your transport?	1	2	3	4	5

The following question refers to **how often** you have felt or experienced certain things in the last two weeks.

		Never	Seldom	Quite often	Very often	Always
26 (F8.1)	How often do you have negative feelings such as blue mood, despair, anxiety, depression?	1	2	3	4	5

Did someone help you to fill out this form?.....

How long did it take to fill this form out?.....

Do you have any comments about the assessment?

.....

.....

THANK YOU FOR YOUR HELP

Appendix J: Permission granted by World Health Organization Quality of Life Group

User Agreement for "WHOQOL-100" and/or WHOQOL-BREF and related materials

This agreement is between the World Health Organization ("WHO") and JARROD WHITE. WHO hereby grants the User a nonexclusive, royalty-free license to use the World Health Organization Quality of Life Questionnaire and/or related materials (hereafter referred to as "WHOQOL-100" or "WHOQOL-BREF") in User's study outlined below. The term of this User Agreement shall be for a period of 1 year, commencing on (date) 10 September 2016.

The approved study for this User Agreement is:

Study Title	Understanding models of Trauma and Recovery
Principal Investigator	JARROD WHITE.
Sample characteristics	Holocaust Survivors > Melbourne, Australia Sudanese Refugees
Sample size	40
Treatment Intervention	—
Total number of assessments	1
Assessment time points	
"WHOQOL-100" or WHOQOL-BREF version – *Please specify language version(s) you would like to receive.*	WHOQOL-BREF
Other measures	HTQR, MILQ, OLQ

Harvard Trauma Questionnaire
Meaning in life Questionnaire
Orientation to life Scale

This User Agreement is based upon the following conditions:

1. User shall not modify, abridge, condense, translate, adapt, recast or transform the WHOQOL-100 or BREF in any manner or form, including but not limited to any minor or significant change in wording or organization, or administration procedures, of the WHOQOL-100 or BREF. If User thinks that changes are necessary for its work, or if translation is necessary, User must obtain written approval from WHO in advance of making such changes.

2. User shall not reproduce WHOQOL-100 or BREF, except for the limited purpose of generating sufficient copies for its own uses and shall in no event distribute copies of the WHOQOL-100 or BREF to third parties by sale, rental, lease, lending, or any other means. In addition, User agrees that it will not use the WHOQOL-100 or BREF for any purpose other than conducting studies as specified above, unless agreed in writing by WHO. In any event, the WHOQOL-100 or BREF should not be used for research or clinical purposes without prior written authorization from WHO.

3. User agrees to provide WHO with an annual update regarding activities related to the WHOQOL-100 or BREF.

4. User agrees to provide WHO with a complete copy of User's raw data and data code books, including the WHOQOL-100 or BREF and any other instruments used in the study. This data set must be forwarded to WHO upon the conclusion of User's work. While User remains the owner of the data collected in User's studies, these data may be used in WHO analyses for further examining the psychometric properties of the WHOQOL-100 or BREF. WHO asserts the right to present and publish these results, with due credit to the User as the primary investigator, as part of the overall WHOQOL-100 or BREF development strategy.

5. WHO shall be responsible for preparing and publishing the overall WHOQOL-100 or BREF results under WHO copyright, including:

a. the overall strategy, administrative set-up and design of the study including the instruments employed;

b. common methods used by two or more Users;

c. the data reported from two or more Users ;

d. the comparisons made between the data reported from the Users;

e. the overall findings and conclusions.

6. User shall be responsible for publications concerning information developed exclusively by User and methods employed only by User. Publications describing results obtained by User will be published in User's name and shall include an acknowledgement of WHO. User agrees to send to WHO a copy of each such paper prior to its submission for publication.

7. WHO may terminate this User Agreement at any time, in any event. Should WHO terminate this User Agreement, User shall immediately cease all use of the WHOQOL100 or BREF and destroy or return all copies of the WHOQOL-100 or BREF. In the event of such termination, all other collateral materials shall be destroyed and no copy thereof shall be retained by User. Notwithstanding the return or destruction of the WHOQOL-100 or BREF and its collateral materials, User will continue to be bound by the terms of this User Agreement.

8. It is understood that this User Agreement does not create any employer/employee relationship. User and its affiliates are not entitled to describe themselves as staff members of WHO. User shall be solely responsible for the manner in which work on the project is carried out and accordingly shall assume full liability for any damage arising therefrom. No liability shall attach to WHO, its advisers, agents or employees.

Please confirm your agreement with the foregoing by signing and returning one copy of this letter to WHO, whereupon this letter agreement shall become a binding agreement between User and WHO.

WHO:

[redacted]

Dr. Somnath Chatterji
Health Statistics and Health Information Systems (HSI)
World Health Organization
Avenue Appia
Geneva 27
CH 1211 Switzerland

[redacted]

Date: 31/08/14

USER: Jarrod White

By:
Title: Doctorate (Clin) Psychology candidate
Institution: MONASH UNIVERSITY
Address: Cnr Wellington Road & Blackburn Road, 3800
Date: 31/08/14

Appendix K: List of presuppositions

Scientific theories, knowledge, and explanation

- Trauma means trauma as outlined in the DSM
- Symptoms of PTSD, if mentioned, necessarily relate to PTSD
- When a traumatic event occurs it impacts the mind
- Depression means depression as outlined in the DSM
- Symptoms of depression, if mentioned, necessarily relate to depression
- The symptoms of PTSD are consequences (ie bad things) that occur as a result of trauma
- Trauma occurs as a result of a traumatic event
- Recovery is possible following traumatic events
- The mind and body are separate
- The soul is separate from the mind
- Somatic symptoms are physical
- The mind refers to the mind as understood in European and American tradition
- The mind and body are one - there may be an entirely different interpretation of mind and body
- It is possible to explain the effects of a traumatic event on an individual
- Trauma stems from an event
- There is a normal way to react to tragedy
- Meaning in life is either in having a purpose or understanding the surrounding world
- Avoidance is a symptom of PTSD
- Traumatic memory is maladaptive
- Traumatic memory is involuntary

Judgments around the truth or falsity of claims being made by the participants

- The experiences the participants endured were "traumatic"
- Participants understand meaning in life in the same way as European and American discourse
- Participants will be able to comprehend the world around them
- Participants will be willing to disclose their experiences
- Participants will be willing to discuss traumatic events
- Depictions of traumatic events are accurate, unhindered by the passage of time
- Participants will will be willing to disclose horrific traumatic events i.e. rape
- Participants discuss effects in terms of good and bad, positive or negative
- Participants will discuss individual, person-centered effects of traumatic events
- Experience once happened, is set and has been maintained since the event
- Interpretation of an event, once made, is set and has been maintained since the event
- The stressful experiences participants discuss are embedded in the genocide of their people, or the war and conflict they experienced
- Participants understand how others in their cultural group respond
- Individuals can express explicitly effects of an experience/ effects that an experience has on their mind
- Participants remember what happened
- Remembering the past is important
- Recovery means going back to the way things were
- Meaning in life is an important component of recovery
- Stress means the same thing in different groups

Personal views and experiences of the researcher that would cloud descriptions of the phenomenon itself

- There is a need to comprehend why events occur
- Meaning in life means the same thing to participants as it does to myself (interviewer)
- Participants understand purpose in the same way as myself (the interviewer)
- A complex is a negative thing
- Participants have had enough time pass to no longer be reliving the event
- Looking down means that the participant is contemplating or avoiding eye contact

Appendix L: Example initial summary of interview

5 - XXXX

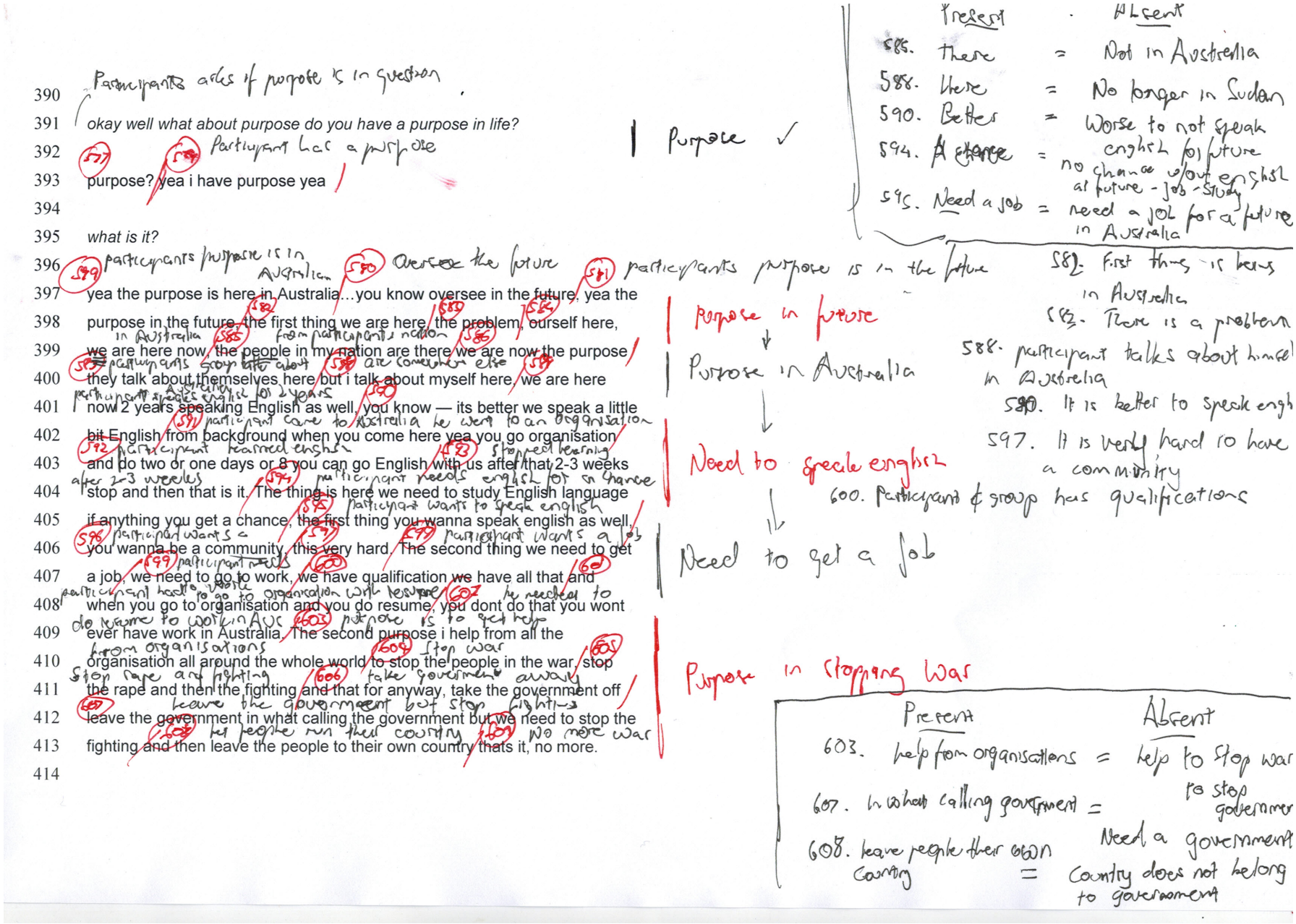
XXXX was a survivor of XXXX. XXXX appeared more emotional than the other survivors had been to date. The passion in his voice felt palpable. His tone shifted from mellow and calm to tense and loud at different times. It appeared as though the wounds were still present for XXXX as the feeling he expressed was raw. XXXX has anger at the Germans. He also expressed anger at the World. The emotion on this account had not seemed to leave him as when he spoke about the world he did so with a loud emphatic tone. His eye contact during this time of the interview was minimal. XXXX reported being upset with the world for not helping during the war.

XXXX explained that being left on his own, isolated, and losing his family were the most difficult things that happened to him during this time. The way XXXX spoke was as if he was still fighting for his pride. His testimony was expressed as a means for him to continue the fight against what had happened. He reported being proud to be Jewish and still devastated that war and conflict is reoccurring in the world. He expressed being unable to comprehend how it is that the world has not learnt from what happened during the Holocaust. XXXX still has a shattered understanding of this world. He was angry at the world – “Little did we know that the world knew everything”. He presented with an apparent sadness to this point. XXXX came prepared to the interview with documents, papers, and props. He expressed that his purpose was to tell the world “don't forget us, take revenge”.

At one point during the interview, XXXX had a look of confusion on his face, as though he was lost in the past when he retells it. He explained that it is not easy to talk about the past. He explained that he resurrects his murdered family every time he tells the story and and buries them again every time he finishes. The point of being able to do this is in “never again”, a slogan that outlines his purpose.

XXXX explained, “you will never forget it”. It is quite clear that XXXX lives with the memory every day as he explained. XXXX explained that recovery is not possible as one cannot go back to the way things were before the event, and cannot be the person they were before the event. This, he said, is impossible. XXXX explained that recovery is talking about the past.

Appendix M: Example excerpt of DPA used to arrive at essential psychological structures


Participants asks if purpose is in question
okay well what about purpose do you have a purpose in life?
Participant has a purpose
purpose? yea i have purpose yea
what is it?
participants purpose is in Australia
Oversee the future
participants purpose is in the future
yea the purpose is here in Australia…you know oversee in the future, yea the
purpose in the future, the first thing we are here, the problem, ourself here,
we are here now, the people in my nation are there we are now the purpose
they talk about themselves here but i talk about myself here, we are here
now 2 years speaking English as well, you know — its better we speak a little
bit English from background when you come here yea you go organisation
and do two or one days or 8 you can go English with us after that 2-3 weeks
stop and then that is it. The thing is here we need to study English language
if anything you get a chance, the first thing you wanna speak english as well,
you wanna be a community, this very hard. The second thing we need to get
a job, we need to go to work, we have qualification we have all that and
when you go to organisation and you do resume, you dont do that you wont
ever have work in Australia. The second purpose i help from all the
organisation all around the whole world to stop the people in the war, stop
the rape and then the fighting and that for anyway, take the government off
leave the government in what calling the government but we need to stop the
fighting and then leave the people to their own country thats it, no more.
Purpose ✓
Purpose in future
Purpose in Australia
Need to speak english
Need to get a job
Purpose in stopping War
Present = Absent
588. There = Not in Australia
588. Here = No longer in Sudan
590. Better = Worse to not speak english for future
594. A chance = no chance without english at future - job - study
595. Need a job = need a job for a future in Australia
Present = Absent
603. help from organisations = help to stop war
607. in wahen calling goverment = to stop goverment
608. leave people their own country = Need a government / Country does not belong to goverenment
591. First thing is here in Australia
592. There is a problem
588. participant talks about himself in Australia
590. It is better to speak engh
597. It is very hard to have a community
600. Participant & group has qualifications

Appendix O: Example of essential psychological structures relevant to study 1

M/U number	Essential psychological structure	Relevant Y/N
186	participant did not que	n
187	participant wound healed	y
188	participant recovered from wound	y
189	participant laughed	n
190	personal experience of cruelty did not effect participant	y
191	death of father effected participant	y
192	participants father was deported before participant	n
193	participant deported first day of ghetto liquidation	n
194	participants father was deported last day of liquidation	n
195	participants father sent to a camp	n
196	father's camp was 80km from participants camp	n
197	Klouga was the name of participant's fathers camp	n
198	Klouga	n
199	Germans evacuated estonia	n
200	soviet troops were close	n
201	germans were losing the war	n
202	1944	n
203	participant was evacuated	n
204	participant was evacuated with other members	n
205	participant was evacuated to germany	n
206	Klouga too close to russia	n
207	klouga not evacuated	n
208	participant to explain what germans did	n
209	germans forced prisoners	n
210	germans told prisoners to place logs	n
211	no oil in estonia	n
212	germans found oil	n
213	participant explained oil to be in shale rock	n
214	participant explained shale rock to be found	n
215	participant explained that jews mined for shale rocks	n
216	petrol can be produced from the shale rock	n
217	oil can be found in shale rock	n
218	there were a lot of logs	n
219	participant explained that wooden logs supported structure	n
220	prisoners were forced to put logs on the ground	n
221	germans forced jews to lie on logs	n
222	jews lay on the first level of the structure	n
223	prisoners put another set of logs on top	n
224	a pyramid was built	n
225	structure was set on fire	n
226	participants father perished in the fire	n
227	participant will never forget a memory	y
228	the memory will always stay with the participant	y
229	participant will never forget memory of father perishing	y

Appendix P: Example of essential psychological structures relevant to study 3

M/U	Essential psychological structure	Abstract coding	Relevant Y/N
579	participants purpose is in australia		y
580	oversee the future	participants purpose is in the future	y
581	purpose is in the future		y
582	first thing is being in Australia		y
583	there is a problem		y
584	participant and his group are in australia now	sudanese refugees are now in Australia	y
585	the people from the participants nation are in Sudan		y
586	participant and his group are the purpose	Sudanese refugees now have a purpose with others still in Sudan	y
587	particpants group talk about themselves in australia	sudanese refugees discuss life in australia	y
588	participant talks about himself in australia		y
589	participant speaks english for 2 years		n
590	it is better to speak english	it is important to speak english to have a future in australia	y
591	when the partcipant comes to australia he goes to an organization		y
592	the participant learns english		y
593	after 2-3 weeks the participant stops learning		n
594	the participant needs english for a chance	need english to survive in australia and have a future here	y
595	the participant wants to speak english as well as others		y
596	participant wants a community	it is important to have a community	y
597	a community is very hard to have		y
598	participant wants to get a job	need to get a job to have a future here	y
599	participant needs to work		y
600	the participant and his group has qualifications	sudanese have qualifications from prior to coming to australia	y
601	participant had to go to organisation for resume		y
602	he needed to do resume to have work in Australia		y
603	Second purpose is to help from organisations world-wide	purpose in obtaining help from organisations around the world	y
604	stop war	purpose in stopping war	y
605	stop rape and fighting	need organisations to help stop the fighting and rape	y
606	take the government away		n
607	leave the government but stop the fighting		y
608	give the country to the people		y

Appendix Q: Example interview summary with general psychological themes

5 - XXXX

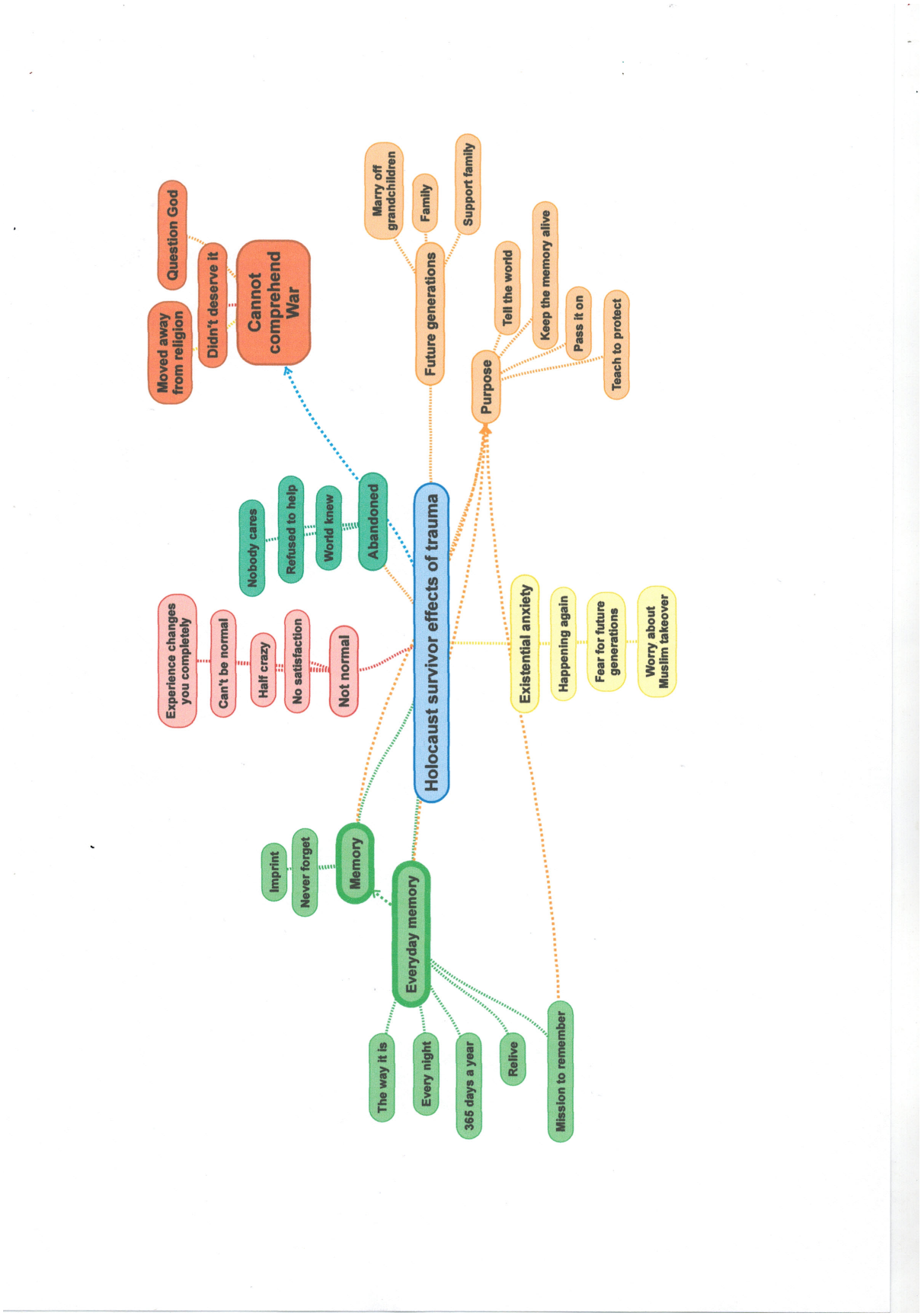
XXXX was a survivor of XXXX. XXXX appeared more emotional than the other survivors had been to date. The passion in his voice felt palpable. His tone shifted from mellow and calm to tense and loud at different times. It appeared as though the wounds were still present for XXXX as the feeling he expressed was raw. XXXX has anger at the Germans. He also expressed FEELING ABANDONED by the World. The emotion on this account had not seemed to leave him as when he spoke about the world he did so with a loud emphatic tone. His eye contact during this time of the interview was minimal. XXXX reported being upset with the world for not helping during the war CHANGED RELATIONSHIP WITH THE WORLD.

XXXX explained that being left on his own, isolated, and losing his family were the most difficult things that happened to him during this time. The way XXXX spoke was as if he was still fighting for his pride. His testimony was expressed as a PURPOSE IN MEMORY for him to continue the fight against what had happened. He reported being proud to be Jewish and still devastated that war and conflict is reoccurring in the world. He expressed being UNABLE TO COMPREHEND CONTINUED WAR AND CONFLICT, and how it is that the world has not learnt from what happened during the Holocaust. XXXX still has a shattered understanding of this world. He was angry at the world – “Little did we know that the world knew everything”. He presented with an apparent sadness to this point.
XXXX came prepared to the interview with documents, papers, and props. He expressed that his purpose was to tell the world “don't forget us, take revenge”.

At one point during the interview, XXXX had a look of confusion on his face, as though he was lost in the past when he retells it. He explained that it is not easy to talk about the past. He explained that he resurrects his murdered family every time he tells the story and and buries them again every time he finishes. The point of being able to do this is in “never again” PURPOSE IN MEMORY, a slogan that outlines his purpose.

XXXX explained, “you will never forget it” EVERYDAY MEMORY. It is quite clear that XXXX lives with the memory every day as he explained. XXXX explained that recovery is not possible as one cannot go back to the way things were before the event CHANGED IDENTITY, and cannot be the person they were before the event. This, he said, is impossible. XXXX explained that recovery is talking about the past.

Appendix R: Mind maps with themes



Sudanese effects of trauma
Ongoing conflict
Beyond evil
Not in Qu'ran
Cannot comprehend war
Purpose
Looking forward
Kids
Future generations
Peaceful
A whole new life
Oversee the future
stop the war
Keep moving on
justice
Too serious
Put others in bad situation
Don't directly ask for help
Burden
Cannot escape
Stems from hopelessness
Cannot do anything
Cannot protect family
Cannot protect country
Powerless
Existential anxiety
Can happen again
Turned upside down
Uncertainty
Memory
Stuck
Can control
Can't forget
Stays forever
Part of you
Thinking too much
Can't eat
Thinking about past
Become sadder
Traumatise you more
Drive yourself crazy
Worry/stress
Somatization
Sick
Headache
Heart attack
Crying in heart
Sleepy muscles
Heart pumping
Nausea
Taste as metaphor