

Nepali Concepts of Psychological Trauma: The Role of Idioms of Distress, Ethnopsychology and Ethnophysiology in Alleviating Suffering and Preventing Stigma

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Abstract In the aftermath of a decade-long Maoist civil war in Nepal and the recent relocation of thousands of Bhutanese refugees from Nepal to Western countries, there has been rapid growth of mental health and psychosocial support programs, including posttraumatic stress disorder treatment, for Nepalis and ethnic Nepali Bhutanese. This medical anthropology study describes the process of identifying Nepali idioms of distress and local ethnopsychology and ethnophysiology models that promote effective communication about psychological trauma in a manner that minimizes stigma for service users. Psychological trauma is shown to be a multifaceted concept that has no single linguistic corollary in the Nepali study population. Respondents articulated different categories of psychological trauma idioms in relation to impact on the heart-mind, brain-mind, body, spirit, and social status, with differences in perceived types of traumatic events, symptom sets, emotion clusters and vulnerability. Trauma survivors felt blamed for experiencing negative events, which were seen as *karma* transmitting past life sins or family member sins into personal loss. Some families were reluctant to seek care for psychological trauma because of the stigma of revealing this bad *karma*. In addition, idioms related to brain-mind dysfunction contributed to stigma, while heart-mind

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distress was a socially acceptable reason for seeking treatment. Different categories of trauma idioms support the need for multidisciplinary treatment with multiple points of service entry.

Keywords Posttraumatic stress disorder · Trauma · Psychosocial · Stigma · Nepal

Introduction

“PTSD does not exist in Nepal,” declared an expatriate humanitarian worker in Kathmandu. This statement could imply that the 17 symptoms comprising the current diagnosis of posttraumatic stress disorder (PTSD) cannot be identified among Nepalis. Another interpretation is that a PTSD-like construct is not present in local languages and conceptualizations of suffering, emotions, behavior and perception.

If the person were referring to the first interpretation—that one could not find the symptoms comprising PTSD among Nepalis—then he would have been wrong. Marsella et al. (1996, p. 531) have commented, “We are not aware of any ethnocultural cohort in which PTSD could not be diagnosed, although prevalence rates have varied considerably from one setting to another.” Similarly, every study in Nepal that has looked for PTSD has found it: 53% prevalence among internally displaced persons (Thapa and Hauff 2005), 55% among child soldiers (Kohrt et al. 2008), 60% among torture survivors (Tol et al. 2007), and 14% among Bhutanese refugee survivors of torture (Shrestha et al. 1998). However, the mere identification of PTSD symptoms in a population has questionable therapeutic utility. Observation of PTSD symptoms does not, in and of itself, immediately reveal optimal clinical care or other interventions. Understanding personal or social meanings and experiences of distress associated with traumatic events also is necessary for effective treatment.

The second interpretation of the humanitarian workers’ statement has greater potential to be of value to those in the healing professions. The question of whether or not a *local construct* for PTSD or psychological trauma exists is crucial to identify persons who are locally recognized as needing support, employ existing healing practices, understand the social significance for persons labeled locally as having psychological trauma and determine if persons with the label are stigmatized and deprived of care. All of these factors become important when considering how to alleviate suffering for survivors of traumatic events. Hinton and Lewis-Fernandez (2010) have identified seven forms of clinical relevance for idioms of distress: indicators of psychopathology, indicators of risk for destructive behavior, indicators of life distress, indicators of past exposure to trauma, indicators of psychosocial functioning, causes of distress and targets for therapeutic intervention.

Compared to the number of epidemiological studies of PTSD, there is a dearth of studies of these local conceptual frameworks influencing diagnosis and treatment of psychological trauma in non-Western settings (Lemelson et al. 2007). Such studies are not trivial. When trauma-healing programs do not address local psychological

frameworks, there is risk of unintended consequences such as denigration of local support systems, pathologizing and stigmatizing already vulnerable individuals and shifting resources from social and structural interventions (Argenti-Pillen 2003; Kleinman and Desjarlais 1995; Summerfield 1999, 2002). Proper identification and understanding of local concepts and idioms not only reduces the risk of harm, but also enables improved treatment such as selection of culturally-appropriate therapeutic interventions (Hinton and Lewis-Fernandez 2010).

Investigating the presence of local PTSD-like constructs within non-Western frameworks of emotions, behavior and perception is additionally important because of the history of changing psychological trauma concepts within Western culture. Young's (1995) description of the evolution of the category of PTSD in Western culture reveals that PTSD was not a universal and ever-present way of framing specific experiences and psychological consequences. Rather, PTSD is only the most recent incarnation of describing, identifying and treating a manifestation of psychological suffering in Western ethnopsychiatry. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) diagnostic construct of PTSD, which only first appeared in 1980, is not simply the progression of scientific knowledge but, rather, the confluence of political, economic, legal and medical institutional forces.¹ Furthermore, the release from military duties and compensation of those psychological affected by combat exposure have played a significant role in PTSD's current place in Western psychiatric nosology (McNally 2003; Summerfield 2001; Young 1995).

Since the DSM codification of PTSD, trauma psychiatry has burgeoned and extended into work with non-Western populations. In the 1980s, mental health researchers began to use the PTSD label in their work with Southeast Asian refugees (Kinzie et al. 1990; Mollica et al. 1987, 1990). PTSD epidemiological studies now appear to be standard practice in settings of war and natural disasters as illustrated by the numerous Centers for Disease Control and Prevention (CDC) studies documenting widespread PTSD, depression and other mental health problems in Bosnia, Pakistan, Afghanistan, Burma and Thailand (Lopes Cardozo et al. 2000, 2003, 2004a, b; Thienkrua et al. 2006). Psychological trauma intervention programs are now commonplace, ranging from targeted clinical interventions to psychosocial programs for large numbers of affected populations (Bass et al. 2006; Bolton et al.

¹ Young (1995) argues that the psychiatric lens of PTSD originally was developed primarily to understand the mental health problems and frame treatment of returning American veterans from Viet Nam. Young ties the growing interest in psychological trauma during the 1860s to increasing use of railway transport and British Parliament's passing in 1864 of legislation to financially compensate victims of railway injury. In addition, Summerfield (2001) correlates the growing interest in psychological trauma with changes in personhood related to entitlement, expected success and absence of suffering. PTSD legitimizes victimhood, moral exculpation and disability pension. Bremner (2002) also suggests that personality has changed from a warrior class, where life was filled with violence and people endured severe hardship with great courage and strength, to a "postwarrior" class where trauma overwhelms individual resources. From automobile collisions to overhearing sexual jokes in the workplace, identifying with the psychological trauma discourse provides the foundation for compensation. Summerfield (2001) views PTSD as the product of compensation pursued on the basis of individual rights: "An individualistic rights conscious culture can foster a sense of personal injury and grievances and thus a need for restitution in encounters in daily life that were formerly appraised more dispassionately."

2003, 2007; Jordans et al. 2009; Layne et al. 2000; Mohlen et al. 2005; Neuner et al. 2008; Tol et al. 2008; Verdelli et al. 2008).

One explanation for the global proliferation of PTSD as a way of framing suffering is that it is a useful lens in many settings to identify those in need of care and to select types of intervention goals. For example, Tol et al. (2007) have shown that PTSD has a direct relationship with severity of disability among torture survivors in Nepal. Another argument for the spread of the PTSD trope is legal advocacy for survivors of human rights violations. PTSD has been used as medical and scientific evidence of human rights violations (Physicians for Human Rights 1996, 2001, 2008); a diagnosis of PTSD is evidence that an individual's rights have been infringed upon through torture and other forms of political violence. In the political asylum system, PTSD is nearly requisite as "evidence" of torture (Bracken et al. 1995; Silove 2002; Smith Fawzi et al. 1997; Summerfield 1999).

Drawing attention to the psychological suffering of specific groups also is used to mobilize funding for nongovernmental and humanitarian organizations. Breslau (2004), in a special issue of *Culture, Medicine and Psychiatry* (Vol. 28, No. 2) on the "Cultures of Trauma," critiques how researchers, humanitarian aid workers and local political forces dictate the application of the PTSD label. He claims that applying PTSD labels in non-Western settings reflects the politics of humanitarian aid and local political forces attending to the global resource procurement. Breslau argues, for example, that research into the prevalence of PTSD among Bhutanese refugees in Nepal (Shrestha et al. 1998) is a political endeavor, which, by highlighting torture, misses the broader suffering in refugee camps. He argues that this results from the nature of medical labels tied to privileged resources and spotlighted by the humanitarian community.² Ultimately, what has been missing in many of these debates for or against the use of the PTSD label is the relation between the psychiatric category and the local experience of distress. Without research on local idioms and frames of understanding trauma, one cannot effectively assess how importing or rejecting the PTSD label impacts well-being, treatment seeking and stigma.

Idioms of Distress Ethnopsychology, Ethnophysiology and Stigma

Nichter (1981) defines *idiom of distress* as "an adaptive response or attempt to resolve a pathological situation in a culturally meaningful way." These idioms can include somatic complaints, possession and other culturally significant experiences. Idioms of distress typically necessitate culturally prescribed healing and resolution. Idioms of distress related to frightening experiences include *susto* in Latin America

² Argenti-Pillen (2003) describes how the new breed of "fearless women" in Sri Lanka who engage in trauma intervention programs are also the women who traveled throughout the country pursuing claims for disappeared husbands and son, thus illustrating a specific political context in which the construct becomes employed. An outspoken critic of the trauma and violence literature, Summerfield (1999) states that (1) trauma is not necessarily widespread in conflict settings, and (2) war is a social experience requiring healing through social means, not Western mental health intervention. Summerfield refers to the work of Somasundaram (1996) in Sri Lanka, which states that "none of the subjects considered themselves psychiatrically ill, and just saw their symptoms as an inevitable part of the war."

(Rubel et al. 1984), *kesambet* in Bali (Wikan 1989), *rus* in Micronesia (Lutz 1988), *rlung* in Tibetan medicine (Clifford 1990), *yadargaa* in Mongolia (Kohrt et al. 2004) and soul loss in many cultures. In Thailand, *lom*, *wuup* and *rook klua lai tai* are idioms representing cultural conceptualization associated with panic (Udomratn and Hinton 2009). Hinton and Lewis-Fernandez (2010) describe a range of anxiety-related idioms of distress in Cambodian and Caribbean Latino cases. Bolton (2001), employing a constellation of methods, identified a number of local idioms that clustered into a “mental trauma” syndrome comprising symptoms of PTSD, depression and other psychological complaints in Rwanda.

The limitation of idioms of distress is that they may easily become a vocabulary list without a cohesive framework detailing the significance of these terms and how they fit into a broader understanding of suffering and wellbeing in a given cultural context. One solution to this is conducting rich ethnography as exemplified by Wikan’s (1989, 1990) work on the term *kesambet*, which positions the fright idiom within broader expectations of self-expression, emotions and social relations. Her ethnographic work thus places the idiom within an *ethnopsychological* framework of understanding life and well-being. White (1992) defines ethnopsychology as the study of how individuals within a cultural group conceptualize the self, emotions, human nature, motivation, personality and the interpretation of experience. It is a local lay psychology used to understand experience.

A complement of ethnopsychology is *ethnophysiology*. Hinton and Hinton (2002) describe ethnophysiology as “the culturally-guided apperception of the mind/body rather than actual biological differences,” and they provide examples of the hydraulic model of anger in Western culture and the pneumatic model of wind to explain panic in Cambodian culture. Thus, the way a cultural group interprets experience is related to how the group conceptualizes the body and its processes. Hinton et al. (2006) find that cultural concepts related to the mechanisms of mental and bodily events contribute to the types and experiences of anxiety disorders. Young’s (1976) work in Ethiopia describes the experience of depression as an overheating problem related to the heart’s control of *jimat* (cords) that move and motivate the body. Much of Tibetan, Mongolian and Chinese concepts of mental health can be understood in terms of the humoral energies: *rlung*, *khii* and *qi*, respectively (Clifford 1990; Janes 1999; Kohrt et al. 2004).

Among the Mandinka, Fox (2003) identifies four posttrauma syndromes: two are disorders of the heart, one affects the mind, and the last affects the brain. These syndromes operate cumulatively, with fear leading to disturbance of the heart. If the heart problems are severe, this leads to dysfunction in the mind and, ultimately, the brain. Ethnopsychology helps to reorient understandings of traumatic events. Kenny (1996), using the example of *susto*, suggests that cultural conceptualization and understanding of the self determine which types of events are considered misfortune.

Ethnophysiological understandings have important implications for intervention as well. Hinton et al. (2009b) outline a framework for “concentric ontology security” explaining how interventions can engage different elements of the self depending on the presentation and primary complaints of individuals, specifically in relation to nightmares.

Idioms of distress reflect and influence the stigma associated with illness. Stigma worsens the experience of an illness and often leads to lack of access to care, social isolation and internalized feelings of shame, inferiority and fatalism (Weiss et al. 2006). For some conditions, the impact of stigma may be more devastating than the condition itself. Stigma is understudied in relation to PTSD in any cultural setting. For example, both HIV and PTSD are relatively new diagnostic entities introduced to medicine in the early 1980s. Both have approximately 13,000 journal publications (Medline search, 14 February 2009). However, whereas there are 199 publications with ‘HIV’ and ‘stigma’ in the title, there is only one with “PTSD” and “stigma” in the title. Summerfield’s (2001) comment exemplifies this conception of PTSD not being stigmatized: “[It is] rare to find a psychiatric diagnosis that anyone liked to have but post-traumatic stress disorder was one.”

Despite a poverty of stigma literature related to PTSD in Western cultural settings, one cannot assume that psychological trauma is not stigmatized in non-Western contexts. In Cambodia, French (1994) describes the difficulty mobilizing support for amputees injured by landmines. The trauma resulting in amputation is seen as the result of poor *karma*, the sins of an individual in past lives. Similarly, Miller’s (2009) film, *Unholy Ground*, dramatically demonstrates how traumatic experiences are seen as an individual’s fate transmitted through karma. Therefore, one of the objectives of this study is to examine the meaning of trauma idioms and perceived causation in relation to assess the relationship of psychological trauma with stigma.

Psychological Trauma in Nepal

The timing of research on local psychological trauma concepts is particularly important in Nepal. The country recently emerged from a decade-long civil war that resulted in the death of 14,000 people, thousands of disappearances, the displacement of over 150,000 people, the conscription of more than 10,000 children into armed groups, and more than 100,000 incidents of torture (Human Rights Watch 2007; INSEC 2008; Singh et al. 2007; Tol et al. 2010). In response to this, psychosocial programming has grown rapidly to address a putative burden of psychological trauma (Kohrt 2006). In addition, thousands of ethnic Nepali Bhutanese refugees who are survivors of political violence are emigrating from Nepal into the United States, where they will encounter a medical system in which PTSD is a dominant clinical trope. A recent systematic multidisciplinary review of psychosocial, mental health and political violence literature in Nepal revealed that the dearth of social science understandings of trauma is a major impairment to epidemiological studies and intervention for Nepalis and ethnic Nepali Bhutanese refugees (Tol et al. 2010).

Previously, research on idioms of distress in Nepal has shown that *jham-jham* (numbness and tingling) and *gyastrik* (dyspepsia) are common complaints associated with psychological distress, particularly depression (Kohrt et al. 2005, 2007); however, the idioms are not interchangeable with a specific psychiatric disorder. Sharma and Van Ommeren (1998) have catalogued idioms of distress among ethnic Nepali Bhutanese refugees in Nepal by drawing on clinical

experiences and case note surveys. Their list includes *dukha laagyo* (sadness), *dar laagyo* (fear), *jharko laagyo* (irritation), metaphors in relation to being uprooted from one's homeland and somatic complaints such as *jiu sukera gayo* (drying of the body) and *kat kat khanchha* (tingling and burning sensations). All of these idioms overlap with psychological trauma but none exemplifies one-to-one synonymy with PTSD.

Ethnopsychological/ethnophysiological models of the self have been outlined for Nepali frameworks of mind–body relations (Kohrt and Harper 2008). In Nepal, the self is considered an assemblage of the *man* (heart-mind), *dimaag* (brain-mind), *jiu/saarir* (corporeal body), *saato/atma* (spirit/soul) and *ijjat* (social status/honor), all of which are connected with *samaaj* (the social world). Within this ethnophysiological framework, afflictions of the brain-mind are highly stigmatized. To date, research has not examined the interplay of idioms, these ethnopsychological models and psychological trauma.

This paper addresses this gap in the research through an exploration of local constructs of psychological trauma, Nepali idioms of distress and vulnerability to suffering. Nepali ethnopsychology and ethnophysiology provide schemata on which to formulate employing idioms in intervention, with attention to stigma reduction and prevention. The findings are incorporated into recommendations for humanitarian psychosocial workers, psychologists, psychiatrists and other professionals in the mental health and humanitarian fields.

Methods

This study was conducted in Nepal using semistructured interviews, free lists, comparison tasks and observant participation to identify types of events considered traumatic, idioms of distress related to these traumatic events, emotions associated with psychological trauma and perceptions of causation and vulnerability related to traumatic events. All participants were Nepalis. The first author and a Nepali research assistant conducted all interviews in Nepali. All participants completed an informed consent form. The study was approved by Emory University Institutional Review Board and the Nepal Health Research Council.

Free-list and emotion comparison tasks were conducted in 2005. The sample composition for the research tasks was limited to persons residing in Kathmandu because it was unfeasible to travel in rural areas during the time of the People's War, which did not conclude until the end of 2006. Thirty-five individuals participated in the free-list and emotion questionnaire portion of the study. Thirty-three participants had complete data for emotion comprehension ranking, 32 for emotion-term similarity analysis and 30 for free lists. The sample included 19 women and 16 men, including 18 Newar, 8 high-caste Hindu, 4 low-caste Hindu and 5 from other ethnic groups (Gurung, Magar, Rai, Tamang). Twenty were married, and 15 were single. Age ranged from 18 to 72 years, with a mean of 33 years. Education level ranged from 0 to 18 years, with a mean of 10 years [School Leaving Certificate (SLC) pass]. This sample was selected for heterogeneity of ethnicity, age and level of education to allow for an assessment of terms and concepts that were mutually intelligible and salient

across Nepali demographic groups. All participants completed the surveys in Nepali regardless of their ethnolinguistic group. For participants who spoke another ethnic language, such as Newar or Magar, we inquired about their proficiency in Nepali. All of these respondents said that they had been educated in Nepali and that they were as proficient or more proficient in Nepali than in their ethnic language.

The survey, comprising free lists and an emotion questionnaire, was administered to the lay public participants to identify local concepts of psychological trauma. In free-list tasks, participants were asked to list types of traumatic events, the effects of traumatic events on one's life, terms used to describe suffering and traumatic events (idioms of distress), emotions associated with trauma and gender differences in the impact of trauma. The emotion questionnaire, which included comprehension ranking and dyadic comparisons, was administered to produce a general model of similarity and understanding of terms identified in the free-list tasks. This enabled us to identify commonalities of understanding to complement the idiosyncratic individualized responses provided in free lists and semistructured interviews. The emotion questionnaire includes a list of emotions derived from free lists. To identify how confidently people understood emotion terms, participants rated emotion terms on a scale of 1–5, with 5 signifying "I completely understand the emotion term" and 1 signifying "I completely do not understand the term." Intermediate numbers represent degrees of partial understanding.

After rating their level of understanding of emotion terms, participants rated similarity among emotion term pairs to determine the conceptual similarity. To assess overall consensus on these ratings, we fit a cultural consensus model using an ordinal data type in UCINET 6 (Hruschka et al. 2008). We used correspondence analysis to represent visually the conceptual similarity between trauma-related emotion terms in a two-dimensional space (Moore et al. 1999; Romney et al. 1997, 2000). In such a graph, those items that participants consistently rated as more similar are closer together in the graph. In the graph, 95% confidence ellipses reflect the certainty about each emotion term's average location in the two-dimensional space (SYSTAT 2007).

Semistructured interviews were conducted to gain more in-depth information on concepts of psychological trauma. This was done with practitioners to elicit narratives of care, the practitioners' beliefs surrounding psychological trauma and their perceptions of clients' beliefs and attitudes. Semistructured interviews with clients were used to understand the traumatic events, models of causation, psychological and social sequelae and terminology used to describe the event and related emotions. Semistructured interviews were conducted with 32 individuals from 18 organizations involved in psychosocial programs. The organization participants included program administrators, counselors, other health professionals and clients. Semistructured interviews also were conducted with religious leaders regarding causality of traumatic events. Semistructured interviews lasted approximately two hours. Semistructured interviews were conducted in Kathmandu and rural areas of Western Nepal from 2005 to 2008. Observant participant was conducted in Nepali nongovernmental organizations (NGOs) and clinical health settings in both Kathmandu and rural areas from 2006 through 2008. Observant participation was used to identify language of clinical discourse, which may not have been reported in individualized interviews and free list

tasks. Observant participation also elucidated common presenting symptoms and referral patterns.

Findings

Traumatic Events

Participants were asked a range of questions to elicit categories of traumatic events such as (i) the worst events that happen in people's lives, (ii) the worst events they have heard through conversations with others, television, radio, news and other media, and (iii) other events that dramatically alter a person's life in negative ways. Probes included violence, accidents, natural and manmade disasters and other threats to life.

Four general themes dominated the categories of events described. (i) Counselors, program administrators and other health professionals focused on events involving *a threat to one's life or a family member's life*. (ii) Clients placed more attention on chronic, ongoing events that impair livelihood, specifically *failure or lack of success in specific domains of life*. (iii) *Spiritual and supernatural events* were considered major traumatic events. (iv) Finally, *conflict-related events* featured prominently; clients of one NGO felt that trauma only resulted from political violence.

Threat to Life and Limb

Mental health professionals endorsed a range of events related to loss of life and well-being including domestic violence, road accidents, marital rape, burns and fires, plane crashes, snake bites, falling from heights, animal attacks, witnessing of accidents or violence and death of a loved one. Physical illness, even without the threat of death, was related to psychological trauma. Physical wounds were thought to cause suffering and impairment in life. Major diseases like HIV/AIDS and cancer were thought to be traumatic. Respondents stated that drugs and alcohol can cause mental trauma, and traumatized people are more likely to drink alcohol.

Both male and female participants reported that the loss of a husband or son causes psychological trauma for women, but participants did not report the converse of losing a wife or daughter as traumatic for men. This gender difference was explained in part by the restrictions placed upon widows versus widowers (Bennett 1983; Kohrt and Worthman 2009). Widows cannot own property or remarry. Thus, they suffer significant livelihood instability. In contrast, widowers are able to maintain their wealth and property and free to remarry after losing their wives.

Failure to Meet Expectations

The majority of clients responded to inquiries about the worst experience in life as those events where "reality does not meet expectations." Failed expectations in life domains included being unsuccessful in love, failing the SLC exams at the end of 10th grade, experiencing a major loss in business, unemployment, poverty and

generally not being satisfied in one's desires. Too much ambition or too high expectations caused suffering in one's life. If someone works too hard, he or she will suffer. For those suffering from failure in some area of life, it was recommended to not think about it or "forget it." For women, central issues were producing male children and maintaining good relations among household members. For men, being unsuccessful in professional life or having one's social status damaged were examples of the most negative experiences in life.

Men returning from work in Persian Gulf countries reported that they did not return at the level of success and prosperity for which they had hoped; they identified this as the worst experience of their lives. These migrant workers had intended to return home as wealthy businessmen. However, they often found that they had been deceived by international manpower agencies, and they returned even more impoverished than when they left. Furthermore, homecoming is a very important process for most Nepali groups. Individuals are welcomed back from journeys with ceremonies that may include animal sacrifices, public festivals and other activities (Kohrt forthcoming). The lack of a proper return and reintegration into the community has also been identified as a major source of distress for returning child soldiers in Nepal (Kohrt and Koenig 2009; Kohrt et al. 2010). Similar distress arising from negative homecoming experiences was observed for U.S. military returning from Viet Nam (Fontana et al. 1997; Johnson et al. 1997).

Spiritual Causes

A man working as a psychosocial counselor at an NGO explained that spiritual events, such as cursing, possessions and 'evil eye,' are thought to play a dominant role in some forms of trauma (e.g., *bigar*, *naag*, *devtaa*, *tunamuna* and *aakhaa laagyo*). *Boksi* and *bhut laagyo* (struck/possessed by witches or ghosts) can cause trauma. Food and water can cause suffering if it is cursed (*tunamuna*).

Conflict-Related Trauma

Conflict events included having family members 'disappeared,' being detained, witnessing the brutal killing of a family member, witnessing bomb explosions, watching one's house and land being burned, experiencing destruction of livestock, losing money and savings, being kidnapped or witnessing relatives being kidnapped, being forced to join armed groups, being forced to leave one's children, having one's family dispersed across the country, lacking food and shelter, lacking access to health care or education, being forced to move repeatedly and having constant feelings of insecurity. One NGO worker said that war is the *only* true cause of psychological trauma, thus demonstrating a tight linkage of the trauma narrative and political violence for some humanitarian workers.

Trauma Idioms of Distress

Free-list responses from laypersons, NGO workers, and mental health professionals revealed a range of terminology and idioms of distress. Table 1 lists the idioms

Table 1 Nepali idioms related to psychological trauma

| Nepali idiom (transliteration) | English translation |
|--|---|
| <i>Aatincchu</i> | Startled |
| <i>Aitin laagyo</i> | Sleep paralysis, spirit-induced attack while sleeping |
| <i>Bejjat</i> (also <i>naak khatne, ijjat gayo</i>) | Loss of social status; social shame |
| <i>Birsane nasakne darghaatana</i> | Accident/event that cannot be forgotten |
| <i>Dar laagyo</i> (also <i>bhaya, traas</i>) | Struck by fear |
| <i>Dukha laagyo</i> | Struck with sadness |
| <i>Jhajhalko aauchha</i> | Flashbacks, flashing memories |
| <i>Maanasik aaghaat</i> | Mental shock |
| <i>Maanasik tanaab</i> | Mental tension |
| <i>Maanasik yatana</i> | Mental torture |
| <i>Manko gaau</i> | Wound/sore/scar on the heart-mind |
| <i>Manmaa asar parchha</i> | Effects on the heart-mind |
| <i>Manmaa kuraa khelne</i> | Words/thoughts playing in the heart-mind; worrying |
| <i>Paagal, baulaahaa</i> | Crazy, mad, psychotic |
| <i>PiDaa</i> | Suffering, anguish, torment |
| <i>Saato jaanchha</i> | Soul/spirit loss |

participants most commonly reported as responses to traumatic events. Idioms included fear responses, sadness, suffering and worrying. Idioms associated with supernatural phenomenon were *saato gayo* (soul loss) and *aitin laagyo* (spirit induced sleep paralysis). NGO and mental health professionals used the English terms “depression,” “trauma,” and “PTSD” as responses to these events. No lay participants mentioned these English terms.

Participants explained that these idioms differed by phenomenology and triggers. Fear-related idioms ranged from terror to anxiety:

Dar is fear of something specific that lasts only briefly such as upon seeing a snake or ghost. *Traas* is terror. It is feeling insecure about something that is there all time, but you cannot do anything about it. It is something that cannot be controlled. *Bhaya* is also a fear, but it can be addressed by working hard or preparing, such as for a test. (24-year-old female NGO worker)

Pir is constant, generalized fear, whereas *chinta* refers to something specific, such as fear of leaving the house to go to work. *Chinta* is momentary, brief, and related to something specific. (40-year-old female Nepali language instructor)

With regard to depression and sadness, the 24-year-old female NGO worker added:

Dukha is considered sorrow, but “depression” [stated in English] is a state where one cannot do anything. They are unable to get motivated to do work. *Riis* [anger] is something that comes from small things, but *traas* [terror] and *aaghaat* [shock/trauma] come from big things.

NGO workers and mental health professionals routinely employed the term *aaghaat*, which refers to shock, impact or clash. Some qualified the term as *maanasik aaghaat* (mental/psychological shock) to distinguish mental shocks from physical shocks (*aaghaat*). However, counselors explained that clients and the public often are not familiar with the term *aaghaat*, especially in the psychological context. Counselors felt more comfortable employing *piDaa* (pain, anguish, agony, torment, suffering) or *maanasik piDaa* (mental anguish) and other idioms when speaking with clients and the public. A client at a center for Maoist victims stated,

We have the most *piDaa* [suffering] and the most *maanasik samasyaa* [mental problems] of anyone in the entire world.

Some participants, both lay and professional, reported that dramatic negative life events could lead to symptoms of madness, psychosis and mental illness. These events could make someone *paagal* or *baulaahaa* (mad, psychotic, crazy). Some participants added that it is not the event per se that is the problem but, rather, individuals who “think too much” about the events and bad life experiences who are most likely to become *paagal* or *baulaahaa*. Health professionals employed the term *maanasik rog* (mental illness) rather than *paagal*. *Maanasik rog* was distinguished from *maanasik piDaa*. A woman working as a psychosocial counselor for an NGO explained:

For *maanasik rog* [mental illness], these individuals can disclose things to counselors. They often have difficulty sleeping, their appetite is decreased, and they have problems studying. For *maanasik aaghaat* [mental shock] or *piDaa* [suffering, torment], individuals do not trust counselors. They do not get relief after two or three sessions. They do not want to talk. They act like statues. They act as if they are not in the real/physical world.

In contrast, a psychiatrist at a mental hospital explained that *maanasik piDaa* could present as psychosis:

People with *piDaa* [trauma/suffering] are *paagal* [mad]. If a loved one dies, then their relatives may go mad. People believe that others should avoid utensils and water they have touched or else they will contract the madness.

A client at one of the treatment centers recounted an anecdote of a neighbor who became crazy:

This woman had a husband who was always unfaithful. She began to have strange behavior. She spoke to herself without stopping but would not speak when spoken to. She did not eat. She was *pura baulaahaa* [totally crazy]. She ran away and was naked in a village. Her hair was unkempt. This lasted eight or nine years. One day she was startled by the loud noise of a jeep driving nearby. She suddenly realized how in disarray she was and that she was naked and so she became embarrassed. She then returned to her normal behavior.

Although this woman recovered, it was generally felt that madness from psychological trauma was permanent. A psychiatrist at the mental hospital explained,

Maanasik aaghaat has a long period of effect, often life-long and permanent. He/she will be abnormal for the rest of his/her life after the traumatic event.

Counselors reported that clients had symptoms of uncontrollable irritation and angered easily at small things. Counselors thought that those with *maanasik aaghaat* (mental shock) could do anything in anger; they can kill others or kill themselves.

Memory is a central feature of presentation. *Birsane nasakne darghaatnaa* (unforgettable events) and *manko ghaau* (wound/sore/scar on the heart-mind) both refer to inability to forget such events. *Manko ghaau* refers to a scar/sore/wound on the heart-mind. A 24-year-old NGO worker explained how hearing stories of rape left such a scar on her heart-mind:

I was “depressed” [stated in English] after hearing [the stories of rape survivors]. I could not sleep. Things kept racing in my mind, and I could hear our conversation over and over again. It left a *manko gaau* [a scar on my heart-mind] that will never heal.

In this instance, a distressing experience scars the heart-mind, which is the organ of memory, just as the body becomes physically scarred through physical trauma. This scar in the heart-mind then prevents the individual from forgetting about the event, as a physical scar is a reminder of other types of trauma. The analogy extends even further: just as severe physical trauma can lead not only to a scar but also to impaired functioning of an arm or leg, severe psychological trauma damages the heart-mind, leaving a scar that prevents normal functioning of the organ of memory. Thus, when one tries to use heart-mind to recall other events, they only come up with remembering the traumatic event. An 18-year-old girl from rural Nepal whose family was attacked by Maoists explains that the event is constantly replaying itself in her heart-mind:

I can’t believe that it happened. The incident *manmaa raakhiraakhne* [is always on my heart-mind]. I can’t forget; I remember it all the time.

Similarly, other survivors of trauma reported *manmaa kura khelne* (having worries playing in their heart-minds) that caused insomnia. Some clients ruminated about killings they had witnessed. Caregivers and psychological trauma survivors all endorsed insomnia and nightmares. A few trauma survivors describe *jhajhalko aauchha* (flashbacks, flashing/flickering memories), feelings of the event happening again. One psychosocial counselor for torture victims finds that none of his clients reports the PTSD symptom of “difficulty remembering parts of the event.” Most survivors have no problem remembering the event, on the contrary, they report being unable to forget the event.

An Ayurvedic doctor described how his patients would think of the past event, then subsequently “go into a panic condition.” One young man who had been beaten along with his family by Maoists described intrusive memories of his traumatic event:

I worship and pray and while I am doing those activities, I do not think about the incident. Nevertheless, as soon as I go out into the street with office work if I see an accident, the exact scene of my beating repeats itself over and over

again. I cannot concentrate on the work that I have to do and what is going on in front of me. I do not want to remember my tragedy but seeing bad scenes forces me to remember.

Memories of the event impair recall of other issues and decrease concentration. One NGO program administrator described a teacher who would forget what he was teaching in the middle of lessons; he stated, “Psychological trauma causes people to lose memory power.”

Somatic complaints were common. Health professionals identified somatic complaints as the primary presentation of psychological trauma: headaches, back pain, gastric problems, painful urination, visual disturbances, palpitations, high blood pressure and fainting attacks. An Ayurvedic doctor commented that persons with psychological trauma have “a poor immune system, weak nervous system, runny nose, and low blood pressure.” One psychosocial counselor described a connection with psychological trauma causing physical problems; “*Maanasik tanaab* (mental tension) has an effect on the body. One is more susceptible to illness.” Counselors reported that clients appear comfortable discussing physical health problems. However, they do not typically self-disclose about traumatic events until it is uncovered through the medical history. Other common symptoms included not having enough energy to work.

The last category of idioms referred to loss of social status through traumatic events. Participants explained that social honor is lost, *ijjat gayo*, or that social shame is incurred *bejjat*. The idiom *naak khatne* refers one’s nose being cut as a metaphor for social shame. Participants explained that social status could be lost from traumatic events to oneself or one’s family because it demonstrated poor *karma*—and thus was the person’s or family’s fault—or was related to loss of honor such as through being a victim of rape. The role of *karma* is discussed further below.

Trauma and Emotions

The second phase of the research examined people’s conceptions of emotion terms related to suffering from trauma, specifically their comprehension of terms and how they viewed the relationships of these terms. The comprehension results of the 22 emotion terms are presented in Table 2. Terms such as *dukha*, *chinta*, *dar*, *riis* and *pir* were well understood by the general population. *PiDaa* was also relatively well understood. *Aaghaat*, however, was the least intelligible emotion term for the general public sample. The general population also poorly understood two English terms used by Nepali health professionals: depression and trauma.

A cultural consensus model fit the judged similarities between common emotion terms [eigenvalue ratio = 13.1, mean first factor loading = 0.61 (SD = 0.15), all factor loadings > 0]. Figure 1 represents the first two dimensions of a correspondence analysis of similarity ratings. Emotion terms related to fear and fright form a distinct cluster (*bhaya*, *dar* and *traas*). *Riis* (anger) and *paagal* (madness) form a distinct and moderately overlapping cluster. A third cluster encapsulates negative emotional states related to suffering: *chinta* (worry), *pir* (anxiety/sorrow), *piDaa* (anguish/suffering) and *dukha* (sorrow/hardship). The final four terms lie

Table 2 Emotion term comprehension (ranked in decreasing order of comprehension)

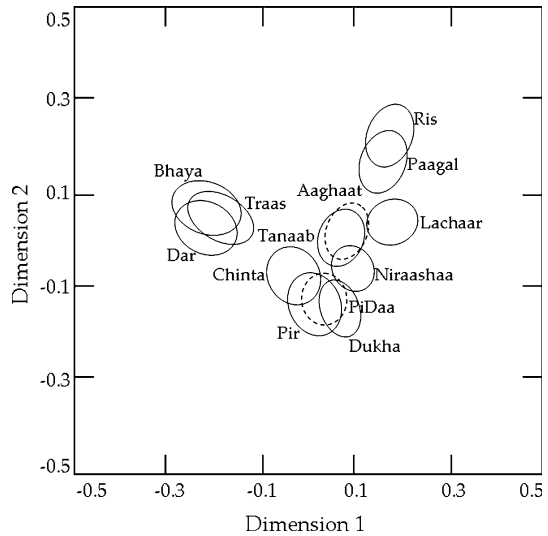
| Nepali word | Mean | SD | English corollaries ^a |
|------------------|------|------|--|
| <i>Mayaa</i> | 4.61 | 0.97 | Love, liking, affection, compassion |
| <i>Dukha</i> | 4.45 | 0.94 | Trouble, grief, sorrow, misfortune, hardship |
| <i>Chinta</i> | 4.42 | 0.97 | Anxiety, worry, trouble |
| <i>Dar</i> | 4.39 | 1.06 | Fear, dread, awe, terror |
| <i>Riis</i> | 4.33 | 1.05 | Anger, wrath, ill temper, resentment |
| <i>Pir</i> | 4.21 | 1.27 | Trouble, anxiety, sorrow, anguish |
| <i>Niraashaa</i> | 4.18 | 1.04 | Disappointment, despair frustration, sadness |
| <i>Sukha</i> | 4.15 | 1.06 | Happiness, joy, pleasure, comfort, tranquility |
| <i>PiDaa</i> | 4.09 | 1.26 | Pain, anguish, suffering, agony, torture, pang |
| <i>Laaaj</i> | 4.09 | 1.35 | Shyness |
| <i>Eklopan</i> | 3.91 | 1.47 | Loneliness |
| <i>GhriNaa</i> | 3.88 | 1.45 | Disgust |
| <i>Paagal</i> | 3.82 | 1.38 | Madness, insanity, derangement |
| <i>Hadaad</i> | 3.79 | 1.43 | Hasty, impetuous, rash |
| <i>Bhaya</i> | 3.73 | 1.46 | Fear, awe, fright, dread, trepidation |
| <i>Aatanka</i> | 3.52 | 1.62 | Terror |
| <i>Traas</i> | 3.48 | 1.48 | Fright, terror, fear, alarm |
| <i>Tanaab</i> | 3.27 | 1.72 | (Mental) tension |
| <i>Laachaar</i> | 3.18 | 1.70 | Helpless, having no means, forlorn, destitute |
| <i>SurTaa</i> | 3.00 | 1.71 | Sorrow |
| <i>Hataas</i> | 2.91 | 1.59 | Despair, loss of hope |
| “Depression” | 2.52 | 1.50 | <i>English term administered</i> |
| <i>Aaghaat</i> | 2.30 | 1.42 | Trauma, shock, impact |
| “Trauma” | 1.61 | 1.20 | <i>English term administered</i> |

^a English translations adapted from Nepali-English dictionaries (Gautam 2001; Schmidt 2000; Singh and Singh 1991)

somewhere between the anxiety/suffering cluster and the madness/anger cluster. These are *laachar* (helplessness), *aaghaat* (trauma), *tanaab* (mental tension) and *niraashaa* (despair).

Notably, the common clinical term, *aaghaat*, lies somewhere between its presumed synonym for trauma, *piDaa*, and the more stigmatized term, *paagal* (madness). Indeed, the judged similarity between *paagal* and *aaghaat* is significantly greater than the judged similarity between *paagal* and *piDaa* (mean similarity = 3.44 vs. 2.59, Wilcoxon matched-pairs signed-rank test, $p < 0.05$). This suggests that the term (*maanasic aaghaat*) identified by mental health professional and NGO workers as synonymous with psychological trauma (*maanasic piDaa*) is viewed by the general public as having some similarity to madness/psychosis (*paagal*).

Fig. 1 Correspondence analysis of trauma-related emotion terms with 95% confidence ellipses around each term (dimensions 1 and 2). Aaghaat and PiDaa are represented with dashed-line ellipses



Vulnerability to Traumatic Events

Mental health professionals and clients discussed vulnerability at two levels: vulnerability to negative life experiences and vulnerability to express emotional and psychological symptoms after experiencing negative events. Previously, Sharma and Van Ommeren (1998) found that many Bhutanese refugees explained their suffering in terms of *karma ko phal*, the fruit of sins in prior lives. Respondents in our study explained that karma dictates vulnerability to negative life events. Karma is the concept of good or bad deeds determining prosperity or suffering. Karma thus dictates who does and who does not suffer from traumatic events. A 56-year-old male Hindu priest in central Nepal explained the relationship of karma with traumatic events:

Ghatanaa bhaeko chha, yo karma ko phal ho. [An accident has happened; it is the result/fruit of karma.]

Naraamro nagarnu hai, paap ko phal dekhalaai hai. [Do not do bad things; you will see the consequences/fruit of your sins.]

Karma is related to the experience of traumatic in two ways. First, an individual may have committed sins in a prior life and suffer the consequences as traumatic events in this life. When asked specifically whether sins committed in this current life can lead to traumatic events in this same lifetime, multiple Hindu priests explained that this did not happen. Instead, the sins committed in this life lead to traumatic events in future lives or in the lives of family members.

Second, sins committed by one's family members in this life and sins committed by one's deceased ancestors can also result in the experience of traumatic events for other family members (*pariwaariko karma*, the family's karma). One Hindu priest

explained that sins of the mother or father lead to the family's suffering. For example, a sinful parent will have children who are mute, are deaf, experience accidents and die at an early age. The Hindu priest explained,

Mero purkhaa ko paap maile bhogdaichhu. [I must bear the sins of my ancestors.]

Therefore, the experience of traumatic events can be highly stigmatizing because people believe that the trauma survivor must have been a bad person in a prior life or that his or her family members and ancestors were bad people. Not surprisingly, traumatic events are often covered up within the family because the events reflect badly on them as well as the individual who experienced the event.

Women are considered to have been less pious than men were in their previous lives, and consequently they are born female and at greater risk of traumatic events. Similarly, persons from low castes are considered to have poorer karma, and thus they are fated to experiences more negative events during their lifetime.

Regarding vulnerability to expression of psychological distress after negative life events, an Ayurvedic doctor referred to constitutional differences:

Individuals are most susceptible to effects of trauma during the third trimester of pregnancy. If the mother is traumatized during this time, the child will be affected for his or her lifetime. To avoid this, pregnant women should only pay attention to the fetus, and ignore what is happening around them. Mothers who are strong and dedicated will not have traumatized children. Mothers with *naasaa kaamjor* [dry or weak nerves] are at risk of having children with psychological trauma. If trauma occurs after birth, it has much less effect on a person's life. However, if the trauma is severe, such as torture, then the person will have psychological difficulties for their lives that cannot be cured. Trauma from *graha* [unseen/astrological causes] can have lasting effects. Emotional, artistic, and mentally active people are most at risk of psychological trauma because they are of "nerve-type" and get frustrated easily.

Participants also described susceptibility based on how strongly one's *saato* (spirit or soul) is attached to the corporeal body. Souls are seen as less securely attached among children. Children lose their *saato* from frightening events, and this causes behavior changes, such as *piDaa* and nightmares. The loss of soul makes them more susceptible to illnesses ranging from diarrhea to respiratory infections. Traditional healers can treat *saato* loss. It is thought that adults lose their souls less easily than children do, and thus typically do not suffer from *saato* loss. Among adults, women are considered more vulnerable than men are to *saato* loss. One adult woman described an incident when she suffered *saato* loss.

I was walking along a street. Then I saw men driving on motorcycles. They were driving around a man and beating him. I saw blood everywhere. Then *saato gayo* [my soul left]. I do not know how I got back to where I was going. I could not do work that afternoon. My *saato* returned later that evening, but I had problems sleeping for more than a week.

Model for Ethnopsychology of Trauma, Idioms of Distress and Therapeutic Implications

Figure 2 is a schematic attempting to represent psychological trauma within the context of this Nepali sample and other ethnographic work in different communities throughout Nepal (Kohrt and Harper 2008). At the left in the schematic is vulnerability to negative life experiences. Psychological trauma is rooted in concepts of vulnerability wherein individuals with poor karma who did not fulfill their religious path in prior lives or have sinful ancestors are more likely to suffer from traumatic events in this life. This vulnerability is important to keep in mind when considering therapeutic interactions because karma attributes a degree of culpability to people with negative life experiences.

Traumatic experiences occur along a continuum. At one end of the continuum are chronic stressors and repeated burdens such as poverty, lack of education and failure to achieve ones’ goals. At the other end of the spectrum are specific acute events that an individual may describe as “unforgettable.” We find that the term *birsane nasakne dargatana* (unforgettable accidents/events) captures individualized experiences that produce psychological distress. In an epidemiological study, Thapa and Huff (2005) also found that the role of lasting memory was central in eliciting traumatic experiences; they reported that nearly all persons with high PTSD

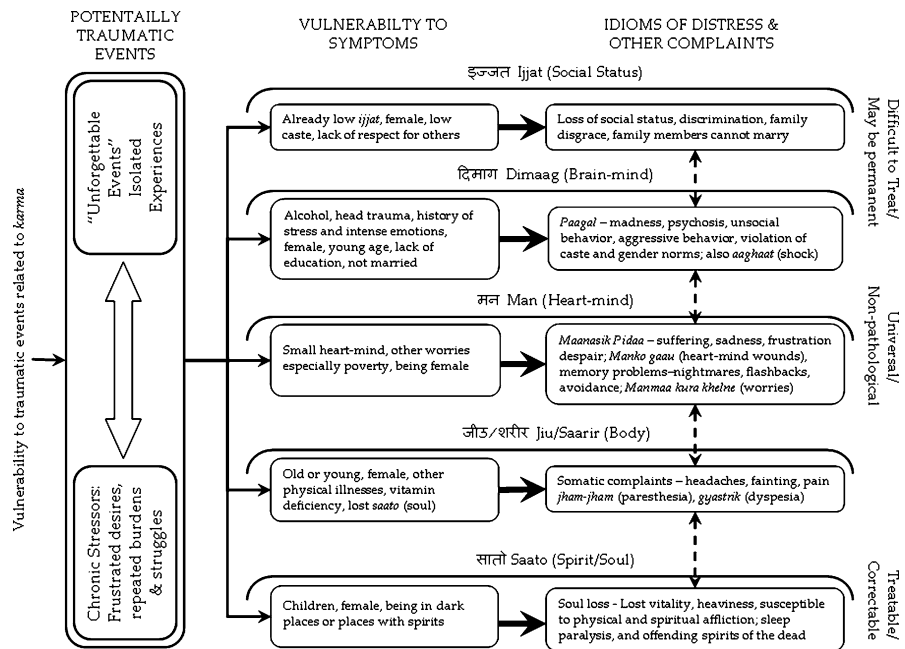


Fig. 2 Ethnopsychological model with idioms of distress for psychological trauma

symptomatology endorsed the phrase *dukha lagne ghatanako gahiro chap baseko* (having deep and long-lasting impression of the terrifying event). However, they did not report what percentage of people endorsed the phrase who did not have high PTSD symptom severity. In the model, individuals who suffer either chronic stressors or acute unforgettable events have differential susceptibility to psychological symptoms. Because children have *saato* (spirit/soul) that are attached weakly, they are more likely to have soul loss and fright. Women are more susceptible than men are because of being considered constitutionally weaker. Finally, individuals with small or weak *man* (heart-minds) are also more likely to suffer psychological distress (McHugh 1989).

The emotional and psychological consequences of negative life experiences, both chronic and distinct, can be mapped on the ethnopsychological framework of *man* (heart-mind), *dimaag* (brain-mind), *jiu/saarir* (physical body), *saato* (spirit/soul) and *ijjat* (social status/social face). Referring to the emotion model in Fig. 1, the three clusters map onto these different elements of the self. The anxiety/suffering cluster (*chinta*, *pir*, *piDaa*, and *dukha*) reflects disturbance of the *man* (heart-mind). The fright cluster (*dar*, *bhaya*, and *traas*) is strong sudden emotions that disrupt the *saato*'s attachment to the body. The cluster of madness and anger (*paagal* and *riis*) reflects disturbance of the *dimaag* (brain-mind).

There are two categories of symptoms related to heart-mind disturbance. One category includes the general emotions of suffering, sadness and worry. The other category is memory-related phenomena because the heart-mind is the organ of memory. As reported above, memory symptoms are described through the ethnophysiology of scars on the heart-mind. This scarring of the organ of memory leads to flashbacks, rumination and other intrusive recollections of the event. Desjarlais (2003, p. 148) describes this among the Yolmo ethnic group of central Nepal:

Among the Yolmo [people] significant events, hurtful ones especially, can leave a mark, a trace, at times a *maja* or 'scar'... within a person's *sem* [heart-mind], much as words can be carved into stone or sounds engraved within a phonographic record.

In urban and rural clinical settings, patients often focused on the inability "to forget" certain life experiences as one of their main complaints. The constant remembering of specific events in the heart-mind (i.e. intrusive memories) caused physical and psychological distress. Common to these complaints was a sense that one could not control when these memories would intrude and that, once the thoughts started, individuals could not stop thinking about them or abate physical and psychological sequelae. Patients consistently expressed the desire "to forget" these events. One patient stated, "My goal is not to remember the suffering." A male patient beaten by Maoists recounted:

When I saw it all happening, I did not think it was real. I did not think this was happening to me. Even now, I cannot believe that it happened to me. All I want to do is forget that it happened. But, I cannot forget.

Pettigrew and Adhikari (2009, p. 420) describe this phenomenon among the Tamu-mai (Gurung) ethnic group in western Nepal:

[Forgetting fear] should also be described as ‘not remembering’ or more specifically, no longer having intrusive memories. Since the end of the insurgency people have talked a lot more about forgetting fear. While people sometimes talked about past fears, fear was not a currently experienced emotion in the sense that it was during the insurgency. “Forgetting fear” was also a coping strategy that allowed villagers to put the past behind them.

Disturbances of the *dimaag* (brain-mind) represent a more severe tier of problems. Brain-mind disturbance symptoms include madness, psychosis, aggression and unsocial behavior. The association of madness and anger is common in Nepal, with the inability to control one’s anger seen as a symptom of madness and mental illness (Kohrt and Harper 2008). The community stigmatizes brain-mind problems more than heart-mind problems because of a fear of contagion and consideration of these brain-mind problems as permanent, whereas heart-mind disturbances may be transient.

One of the key findings from the cultural consensus analysis and the semistructured interviews was the interpretation of *aaghaat*. Whereas NGO and health professionals used this term to describe trauma as mental shock, the public often did not understand the term. More importantly, laypersons identified *aaghaat* in the *paagal* and *riis* (madness and anger) cluster of brain-mind disturbance. Thus, *aaghaat*, when used by a health professional, has a potentially negative effect for those seeking care and their families because the term is associated with highly stigmatized conditions.

To summarize, a Nepali ethnopsychology and ethnophysiology of trauma comprises vulnerability to traumatic events, with blame placed on sins in past lives and sins of family members for the experience of these events. Events that cause suffering cover a range of experiences from chronic inability to meet one’s needs to discrete “unforgettable” events. The events produce suffering based on different elements of the self. Events that disturb the heart-mind cause sadness, despair, anguish and worry. Moreover, disturbances of the heart-mind lead to intrusive memories of the event. Events can disturb the brain-mind, causing anger and/or madness. The frightening component of the event leads to rupture of the soul from the body with the concomitant effects of soul loss such as vulnerability to physical illness. The physical body may be damaged by a traumatic event leading to headaches, body pain, gastrointestinal problems, vision changes and other somatic complaints. The experience of these events threatens one’s social self or social honor. Because traumatic events typically imply poor karma, experiencing traumatic events is associated with a loss of social status.

Idioms of distress and ethnopsychology/ethnophysiology can be incorporated into care for psychological trauma in a number of ways. Mental health care professionals, psychosocial workers and other care providers will encounter survivors of trauma in a variety of settings. The framework described below fosters a multidisciplinary approach in which individuals address needs at the point of service entry and make referrals to other sources of care. First, when trying to

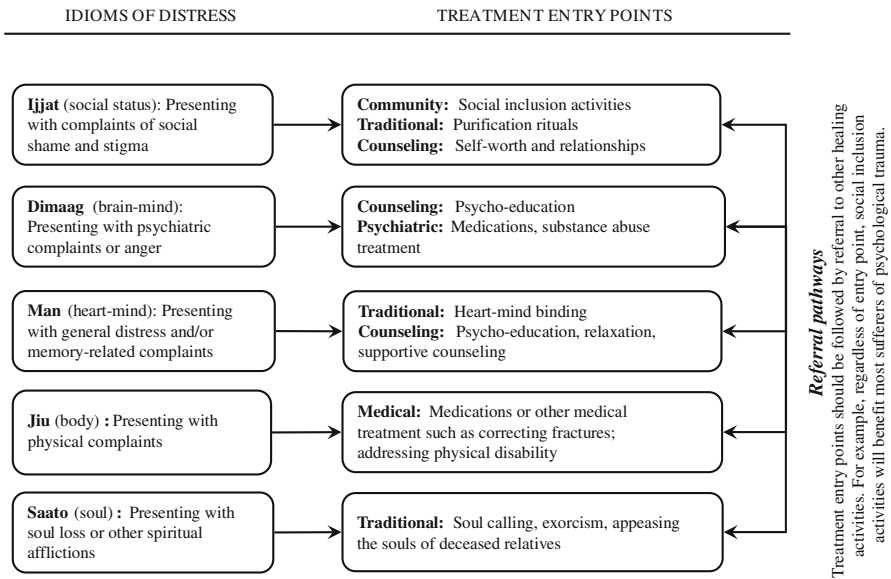


Fig. 3 Treatment entry points for psychological trauma based on presenting idioms of distress

elucidate exposure to traumatic events, one of the most effective pathways may be focusing on the inability to forget certain events. In clinical settings, the phrases *Tapaaiko kunai birsane nasakne dargatana bhaeko chha?* (Have you had any events/accidents that you cannot forget?) and *dukha lagne ghatanako gahiro chap baseko* (having deep and long-lasting impression of the terrifying event) are effective for eliciting traumatic experiences.

The type of symptoms most distressing to the individual should dictate initial treatment and referrals. Figure 3 illustrates entry points for psychological trauma based on presenting idioms of distress. For example, if individuals or their families are most concerned about physical problems such as headaches, vision changes or other somatic complaints, they are likely to first present to a health post worker or physician. In these cases, it would be beneficial to adequately address the possibility of underlying physical pathology as well as identify acceptable referrals for additional support. One of the dangers is ignoring possible treatable physical illnesses that are underlying or comorbid with psychological distress (Kohrt et al. 2005).

If a person presents with psychotic complaints or signs of mental illness, it would be more appropriate to highlight a combination of psychiatric care and counseling for treatment. If a survivor of trauma has a substance abuse problem, as was described by counselors in this study, then psychiatric inpatient substance abuse treatment may be necessary. Among Cambodians, anger may be a better indicator of trauma exposure than PTSD (Hinton et al. 2009a), and therefore screening for anger may be an effective approach to begin considering intervention to alleviate trauma-

related distress. In this Nepali sample, anger was the most proximal emotion to psychotic behavior. Thus, anger should similarly be a potential screen for trauma, especially among those presenting to psychiatrists.

In contrast, disturbances of the heart-mind are not seen as physical or mental pathology but, rather, as a form of natural distress in response to certain types of events. Therefore, heart-mind problems may best be served by encouraging support from friends and family, supporting traditional healing, if desired, and provision of psychosocial counseling. One form of traditional healing done by *dhami-jhankri* (shamans) in Nepal is *man badne*, which means to bind the heart-mind. This is seen as a way to control the distressing processes or bad memories and has been reported as a form of healing sought out by former child soldiers (Kohrt forthcoming). Counseling in Nepal has been developed around the construct of the heart-mind, rather than a treatment for mental illness related to brain-mind dysfunction (Kohrt and Harper 2008). The literal translation of the Nepali term commonly used by psychosocial NGOs for “counselor” is *manobimarshakarta* (person who advises on matters of the heart-mind).

If the main complaint after a traumatic event is soul loss, it may be appropriate to recommend a traditional healing ceremony. Because the soul brings vitality to the body, the return of the soul is necessary before one’s body, heart-mind or brain-mind can begin to heal. Traditional healing for return of the soul can be done alongside medical treatment to heal the body (Kohrt and Harper 2008). Traditional healing for many forms of suffering, not only fright or traumatic events, has been described in many ethnic groups in Nepal (Desjarlais 1992; Maskarinec 1995; McHugh 2001; Nicoletti 2004; Peters 1981).

If a primary concern is loss of social status related to experiencing traumatic events, this could be remedied through a number of mechanisms. One option is traditional or religious healing. Religious healing can be seen as a way to account for poor karma. Performing offerings or rituals for sins in a past life may prevent the experiences of future traumatic events in one’s current life. These rituals also improve social perception and increase social support of sufferers (Desjarlais 1992; Maskarinec 1992; Peters 1981). Often if a child is identified as having bad karma or having been born in unfavorable astrological context, rituals can be performed to prevent a life of repeated traumatic events. Loss of social status also can be addressed through community-based social inclusion activities. Many sufferers of traumatic events are afraid they will be excluded from interaction with others. If social inclusion activities can be facilitated for trauma survivors, this could help ameliorate fear of exclusion. In addition, counseling can focus on the feelings of low self-worth and perceived interpersonal disruptions. Counselors, through supportive listening, can present a stable social connection for trauma survivors, as well as providing psychoeducation and problem-solving skills (Jordans et al. 2007; Tol et al. 2005).

Ultimately, regardless of whether a trauma survivor presents to a psychosocial counselor, physician, traditional healer or psychiatrist, it will be beneficial to support pluralistic healing for psychological trauma. Individuals may present with somatic complaints, but treating these uncovers evidence of heart-mind disturbances or soul loss. As Fig. 3 illustrates, the practitioner can refer the individual and their

family to other types of healers, in accordance with their religious, spiritual and health-behavior beliefs. Likely, the individual and his or her family will already be seeking multiple forms of support.

One of the crucial aspects of care is reducing and preventing stigma. Psychosocial NGOs in Nepal and elsewhere have cautioned against employing terminology that may stigmatize program participants (IASC 2007). In Nepali, the term *kalanka* refers to a physical blemish or spot, as well as to slander, vilify or misrepresent to harm another person (Turner 1931). In Nepal, mental health problems historically have been associated with *kalanka*. This is particularly true for psychological problems perceived to be the result of brain-mind dysfunction (Kohrt and Harper 2008). Thus, it is crucial to consider how interventions inadvertently may exacerbate stigma and lead to barriers to care. One specific conclusion that can be drawn from this research is the problematic use of the idiom *maanasik aaghaat* (mental shock/trauma). While health care providers perceived this as a possible linguistic corollary for psychological trauma, the lay public did not always understand the term, and when they did, it was perceived as referring to the highly stigmatized condition of brain-mind dysfunctions such as madness and uncontrolled anger. If a health care professional or NGO worker was to label someone as having *maanasik aaghaat*, the individual and his or her family may perceive this as an incurable condition. Therefore, we would recommend language such as *maanasik piDaa*, which is more informative and less pathologizing than *aaghaat*.

Another aspect of stigma is the cultural model of trauma causality in Nepal, which may differ from Western conceptions. Hinton and Lewis-Fernandez (2010) point out that effective evaluation and treatment of disorders necessitate understanding the stigma linked with idioms of distress. Summerfield (2001) and others have suggested that PTSD is a desirable label because it removes culpability from the individual and often is associated with receipt of monetary or other support through government policies or lawsuits. In contrast, traumatic events in Nepal can be perceived as the result of personal infractions in past lives and sins of one's family and ancestors, which are transmitted through karma into this life. Thus, people may be ashamed to report experiencing traumatic events. In addition, families may be reluctant to acknowledge or seek help for traumatized family members because it reflects badly on the family's and ancestors' religious piety. In addition, the experience of a traumatic event may differentially stigmatize certain family members. We found that mothers often blamed themselves or were blamed by others for traumatic events occurring to family members. Dahal's (2008) work among war widows in Nepal finds that families and communities often blame and ostracize widows for the deaths of their husbands. The issue should be considered in both public health approaches and individualized care.

Despite claims of PTSD's desirability in the Western context, most mental health workers in Western settings likely will have seen clients who also blame themselves for traumatic events without invoking the concept of karma. Western therapeutic approaches for these clients may be a worth considering for Nepali survivors of trauma as well. As mental health care and psychosocial support resources grow in Nepal, it will be important to address stigma hand in hand with development of care systems. If stigma is not a major focus of the mission to make mental health care

and psychosocial services available to trauma survivors, there is a risk that newly established services will go unused or that interventions could make trauma survivors more vulnerable through stigmatization.

Conclusion

This research revealed that psychological trauma is not a unitary construct in Nepal. Rather, psychological sequelae of negative life events are expressed through an array of idioms of distress. The Nepali ethnopsychology/ethnophysiology both overlaps and diverges from DSM psychiatric classification of PTSD. In Nepal, the response to negative life events includes multiple possible manifestation such as general distress and inability to control memory reflected as a disturbance in the heart-mind, behavioral manifestations of anger and madness reflecting dysfunction of the brain-mind, a fright response resulting in loss of the soul, physical impairments with damage to bodily systems and a threat to personal and familial social status.

Our findings suggest that exploring a range of idioms of distress incorporated into a broad understanding of local ethnopsychologies and ethophysiology can foster effective communication with clients. This is more helpful than trying to identify single terms to approximate the concept of psychological trauma. Similarly, others also have advocated that trauma treatment across cultural settings should comprise strong holistic interventions that keep PTSD in mind but also intersect more broadly with issues of guilt, somatic complaints and other manifestations of distress (McKenzie et al. 2004).

A primary limitation of this study was the presentation of only one ethnopsychological/ethnophysiological model. Ethnic composition influences ethnopsychological models significantly. The analysis of emotions presented here is based on interviews primarily with a sample representative of the ethnic heterogeneity of the capital Kathmandu. Therefore, the model produced illustrates how psychological trauma is communicated within this specific demographic. It is not representative of rural, low-caste or non-Newar ethnic minority (*Janajati*) groups who more commonly reside outside the capital. Therefore, the model does not speak to all ways of viewing psychological trauma in Nepal. Pettigrew and Adhikari (2009) provide a description of the understanding of fear among *Tamu-mai* (Gurungs) in western Nepal that sheds light on possible ethnic diversity in traumatic experience. Ultimately, there is not one single totalizing ethnopsychology of trauma in Nepal because of the range of ethnic, linguistic and socioeconomic groups. Rather than relying solely on the model provided here, we offer this study as a framework for practitioners working with trauma survivors in Nepal and elsewhere. We suggest that they develop their own ethnopsychological models when caring for specific populations.

Another limitation is the rapidity of change and trends in the health and development fields. In both Western and other settings, the terminology for psychological trauma is shifting continuously. For example, Dwyer and Santikarma (2007) have written about the labeling transition from “crisis clinics” to “trauma

clinics” in Indonesia. Public mental health campaigns should address the public interpretation of the evolving terminology for psychological trauma. The public interpretation of terminology may have unforeseen consequences in a world of rapidly changing vocabulary for distress. We found that clinicians’ attempts to employ a linguistic corollary for PTSD led to use of a relatively unfamiliar term (*aaghaat*) that the public found stigmatizing. Rapidly shifting idioms, within both lay and professional language, further necessitate grounding within ethnopsychology/ethnophysiology, which likely follows transformations that are more gradual. From an intervention and clinical standpoint, the alleviation of suffering starts with local frameworks, needs, concerns and processes of identification. Ultimately, healing begins with understanding, and understanding begins with listening to local models as expressed through idioms of distress.

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