International Journal of Intercultural Relations 70 (2019) 67–77

Contents lists available at ScienceDirect

International Journal of Intercultural Relations

journal homepage: www.elsevier.com/locate/ijintrel

Intercultural attention in trauma treatment: Western trauma treatment negotiated and modified in Sudan

Marie Røren[a], Reidar Jessen[b], Shai André Divon[a], Sigrun Marie Moss[b,*]

[a] Norwegian University of Life Sciences, Norway
[b] University of Oslo, Norway

ARTICLE INFO

Keywords:
Transcultural treatment
Trauma
Western methods
Cultural specificity
Sudan

ABSTRACT

Western therapeutic methods have increasingly been implemented in non-Western contexts as treatment for traumatic stress reactions. There is a growing awareness of the need for such implementations to incorporate cultural specificity, and discussions are needed on the suitability of Western psychological approaches and theories in different parts of the world. The objective of this paper is to explore the intercultural applicability of trauma treatment through a case study in Sudan. We look at how Western methods are applied and potentially modified in Sudan to fit social-cultural realities – and how specific contexts affects treatments. Such data from a non-Western context is invaluable to the discussion of transcultural aspects of mental health care. This paper presents interview data, where counsellors in a trauma centre in Sudan were asked how they are implementing Western methods, and how these treatments are negotiated and potentially modified to fit the context. The interviewed counsellors emphasise the contextual factors influencing the treatment and the need to modify therapeutic methods to the specific cultural setting. Three themes are discussed: stigma towards mental health and sexual assaults; the negotiation of treatment alongside traditional healers; and the modification of treatments to the cultural context. The findings suggest that although Western methods can be useful in non-Western settings, these need to be carefully modified to the context as well as to each individual client. The study offers valuable insights into such modifications.

Introduction

Research within psychology in general and clinical psychology in particular, has predominantly been conducted with Western participants (Henrich, Heine, & Norenzayan, 2010). Subsequently, various mental health treatments, including for trauma, have been developed based on experience and knowledge accumulated from Western participants. This feeds into the ongoing debate on transcultural aspects of mental health care, where assumptions about the universality of human biology often take precedent over contextual socio-cultural constructions affecting human cognition (Bracken, Giller, & Summerfield, 1995, p. 1076). Critics emphasise that culture is a key determinant affecting the perception of trauma, and as such, methods should be tailored to specific contexts (Kienzler, 2008). While many assert that culture should not be a hindrance to the reception of effective treatment (for example see National Institute for Clinical Excellence (NICE, 2005), few offer advice on how to incorporate cultural aspects to enhance the effectiveness of treatments. In most cases methods are applied with limited knowledge of the transferability across different social

* Corresponding author at: Department of Psychology, University of Oslo, Postboks 1094 Blindern, 0317 Oslo, Norway.
E-mail addresses: marie_roren@hotmail.com (M. Røren), reidarjessen@gmail.com (R. Jessen), shai.divon@nmbu.no (S.A. Divon), s.m.moss@psykologi.uio.no (S.M. Moss).

https://doi.org/10.1016/j.ijintrel.2019.03.002
Received 17 October 2018; Received in revised form 20 February 2019; Accepted 14 March 2019
Available online 21 March 2019

and cultural settings, making it crucial to gather data from non-Western contexts where Western methods are used. Considering how these methods are applied and potentially modified to fit social-cultural realities – and how specific contexts impact treatments – is invaluable to the understanding of the intercultural use of these methods. To contribute to this discussion, this study focuses on how trauma treatment is conducted at a trauma centre in Khartoum, Sudan, looking mainly at how trauma counsellors in Sudan negotiate and modify Western trauma treatment to fit the Sudanese context.

Trauma treatment and cultural modification

Cultural transferability in mental health treatment is a debated topic. In essence, psychotherapy is a concept that operates between the medical and social sciences (Menninger, 1948). While the techniques and methods of psychotherapy are diverse, they aim at addressing the expressions of mental distress by focusing on the underlying cognitive and affective processes that manifest as physical symptoms and impairment in daily life functioning. These concepts link between the universality of humans and the unique socio-cultural constructions at play affecting us (Kleinman, 1980; Wittkower & Fried, 1959). In this space, the treatment of mental illness is a bridge between medicine, psychology and psychiatry, and culture (Kleinman, 1980). Such a bridge presents various challenges to therapists applying diverse techniques and methods to improve the well-being and address the mental health of patients across cultures. These challenges are exacerbated by the origin and history of mental healthcare in Western European cultures (Kleinman, 1977; Wittkower & Fried, 1959), characterised over time and across cultures by uneven power relations, problematic practices, and at times not the most conducive organisation of services (Bhui & Bhugra, 2007; Kirmayer & Young, 1998; Swartz, 1998; Wittkower & Fried, 1959). With the emergence of post-colonial discourses and the awareness of social and political dimensions of psychiatric practices (Kirmayer, 2007), a criticism anchored in power and hierarchy revealed variations in diagnostic practices conducted by therapists within and across cultures. It led to a realisation within mental health research and practise that there is room for a greater awareness of the anthropological aspects of psychiatry (Kleinman, 1991).

Two important questions arise from the juncture between mental illness and socio-cultural settings. The first regards the impact of the socio-cultural context (i.e. the role of local rules, norms, and conventions) on the prevalence, identification, and treatment of mental illnesses. The second regards the extent to which one can identify universal components of sociocultural interactions leading to mental illness, and by extension the universality of treatment methods (Cox, 1986; Swartz, 1998).

For decades, mental health workers have applied Western psychological interventions in non-Western settings and for non-Western refugees settled in Western countries (Ehntholt & Yule, 2006; Hinton, Rivera, Hofmann, Barlow, & Otto, 2012; Otto & Hinton, 2006; Tol, Jordans, Regmi, & Sharma, 2005). A common approach is to rely on the fundamental treatment principles while modifying certain aspects, such as paying attention to the way in which symptom interpretations and treatment procedures interact with culturally-specific beliefs, as well as making efforts to integrate treatment services within the community. McFarlane and Kaplan (2012) reviewed 40 outcome studies on the efficiency of psychological interventions for non-Western adult survivors of torture and trauma, and found a significant reduction in psychiatric symptoms. They included studies of treatment procedures that were conducted with refugees living in countries of resettlement, people displaced to or seeking asylum in a Western country, and survivors in their country of origin. However, they emphasised that the improvements in most of the studies were measured in terms of reduced psychiatric symptoms, and not daily functioning, relationships, distrust, sense of justice, or other more context-specific psychosocial aspects. In their view, the lack of attention to contextual factors such as ongoing violence, political leadership, and asylum status makes it difficult to draw conclusions regarding the efficiency of these psychological interventions with non-Western clients. There has been growing focus on the issues involved in the export of Western psychological trauma interventions to non-Western contexts and participants (see for example Marsella, 2010; Nicholl & Thompson, 2004). Several studies have demonstrated the need for increased emphasis and sensitivity to the powerful influence of culture on the expression of symptoms (e.g. Ofori-Atta et al., 2010). The argument is that although posttraumatic stress is experienced across the world, symptoms manifest in diverse ways; therefore, one cannot assume that the Western diagnosis has the same meaning in other cultures. Nor can one assume that posttraumatic stress affects populations in the same way within societies that are differently organised (Miller, Kulkarni, & Kushner, 2006). The growing awareness of these issues, highlight both the possibilities that lie in psychotherapy and other mental health methods, whilst increasingly also appreciating the need for cultural and contextual knowledge (see Marsella, 2010).To contribute to the discussion of the applicability and suitability of Western-developed trauma treatment, we look at how such a treatment is administered and applied with Sudanese clients at a trauma treatment facility in Khartoum.

A case study of trauma treatment in Sudan

The present study explores the use and modification of Western treatments of counsellors working with trauma victims in Sudan. The chosen trauma centre applies Western approaches, and works mainly with victims of sexual violence. We ask how the counsellors are working with trauma in Sudan; what challenges they are facing, and whether and how they are adapting or modifying the Western methods to fit the Sudanese context. The present study does not explore the effectiveness of the treatment offered; instead, through interview data, it focuses on the counsellors' experience of working with trauma in Sudan. In this study we have taken a broad approach to examining trauma treatments in non-Western contexts, allowing the respondents to explore factors that influence how they conduct trauma treatment at their centre. In this article, Western trauma treatment refers to the psychotherapy tradition developed in Western countries. There are hundreds of different therapeutic approaches. The clinic in Sudan applied various methods, including Narrative Exposure Therapy for individuals, group and family therapy and community work. The clinicians had different professional backgrounds. We acknowledge that the differences between the approaches may be relevant in understanding

the cultural applicability of the approaches. However, this study is positioned within the tradition of common factors in psychotherapy (see Wampold, 2015). From this perspective, different therapeutic methods have some general principles in common. The focus here is on the cultural applicability of some general principles of psychotherapeutic work, rather than the specific methods. The study is an important contribution to the discussion of the impact of cultural specificity when it comes to Western-developed trauma methods applied in non-Western settings.

Some research has been conducted on mental health treatment in Sudan, including studies on barriers to mental health services (Ali & Agyapong, 2016) and studies of the treatment offered at traditional healers centres (Sorketti, Zainal, & Habil, 2012). Several studies have also focused on trauma and well-being in Sudanese refugees in different locations (e.g., Meffert et al., 2014; Tempany, 2009). To the best of our knowledge, however, no published work within psychology has focused on trauma counsellors and their own narratives on the use and modification of Western-developed methods in Sudan. Before detailing the methodology of this study, we provide a brief context introduction on Sudan.

The Sudanese context

The National Congress Party (NCP), under President Omar al-Bashir, leads the Sudanese government. The regime gained power in a coup in 1989. Formally a democratic consociationalist republic entertaining a multi-party system, Sudan is an authoritarian, Islamist state led by the President and his allies (Gallab, 2014). The long north-south civil war in Sudan ended in 2005, and South Sudan seceded in 2011. Sudan is still the site of multiple conflicts. The extensive security apparatus, loyal to the NCP, often imprisons and abuses dissidents (e.g. see Human Rights Watch, 2016), and the government is actively demobilising the population to avoid collective uprisings against the regime (see Moss, in press). It is a religiously strict society, and as argued by some, increasingly so, as elements of Selafism is clashing with the traditional Sufism (Ahmed, 2015). The societal structures grant limited social and judicial room for punishing offences against women and minorities, especially when it comes to sexual abuse. As the trauma centre in question mainly receives cases of sexual assaults, this social context is highly relevant and greatly affects treatments.

Mental health is not a priority in Sudan, with limited funding and extensive stigma against mental health issues (Ali & Agyapong, 2016, see also Omar et al., 2010 for mental health priorities and stigma in other African countries). Faced with mental health challenges, rather than seeking psychological or psychiatric help, people often seek the help of traditional healers. The latter mainly operate in relation to religion, seeing mental health issues as connected to issues of belief.

Methodology

Sample

The relevant trauma centre was located through an existing cooperation between a Sudanese institution in Khartoum and a European institution. The Sudanese institution provides free voluntary psychosocial support to individuals, families, and communities affected by traumatic events. The counsellors use Western-developed methods to treat trauma. The first author contacted the Sudanese institution, which agreed to partake in this study. Semi-structured interviews were conducted with seven counsellors at the trauma centre in 2016, with the purpose of understanding their experiences of working with trauma treatment. All seven respondents were female: six from Sudan and one European. Five respondents held a Master degree within the field of trauma and counselling acquired at Sudanese universities, and two were educated as clinical psychologists in Europe. They do not have training in traditional practises. The sample of counsellors in this study is not representative, therefore precluding statistical generalisations. This was never the aim of the study, which focuses on the experiences of the counsellors. The sample thereby allowed us to analyse narratives from people handling the negotiation of treatment in a setting where stigma is a reality, and where traditional healers play a prominent role in society.

Interview schedule

The study was presented as an exploration of trauma treatment in Sudan. Questions focused on the counsellors' education and work experience within traumatology; the treatments used by the counsellors, if and how counsellors modify methods to fit contexts; aspects of Sudanese culture and society that may affect the perception of trauma, including family involvement in the treatment process, religious beliefs, and traditional healing; and aspects relating to structural factors such as justice mechanisms in Sudan. Counsellors were also invited to discuss additional topics as they saw fit. All interviews took place at the trauma centre and were conducted in English. Interviews lasted about 40 min, and were conducted, recorded, and transcribed by the first author.

Data analytic strategy

As our goal was to explore how the trauma counsellors were working with Western methods in Sudan, we conducted a broad thematic analysis (Braun & Clarke, 2006), covering the breadth of the material rather than a more narrowly focused analysis. This can be fitting when working with relatively unexplored topics or with populations seldom focused on (Braun & Clarke, 2006), such as in this study. Using an inductive approach to the analysis, codes and themes were developed from the data. We positioned the analysis within social constructivism (Burr, 2015), seeing the counsellors' accounts as socially produced. The participants' narratives are seen as subjective, but valid accounts of the phenomena at hand. In the analysis, we read the transcribed interviews several times. Each

researcher underlined and searched for relevant themes for trauma treatment. Codes and themes were compared at three different points during the process. These were discussed, systemised, and organised into a hierarchal relationship, going back and forth between the analysis and the transcripts.

Ethical considerations

Given the sensitivity of collecting information on mental health care and treatment, strict ethical guidelines were approved by an internal evaluation, and further approved by the Norwegian Centre for Research Data before the fieldwork in Sudan. An information letter was sent by email prior to data collection to all potential respondents. Participants were notified that they could withdraw their participation in the research at any point. Before each interview, participants signed an informed consent form. No specific information about patients was collected during this study.

Reflexivity

The first author collected the data in Sudan. Having read about cultural sensitivity with regards to trauma treatment, it was easy to be influenced by the arguments that such modification of the treatment is both necessary and difficult. The participants at times talked of these challenges in a different way than expected, and even showed defiance in some of the conversations. For example, some of them obviously felt strongly for the opposite argument, along the line of others telling them that these methods cannot be used in Sudan, but that they were showing those people that they were wrong. As the counsellors were all trained in Western methods, it should not be very surprising that they were defending their methods. These were arguments the first author had to adjust to, and continuously work on her reflexivity in the handling of the data – both related to this aspect, but also with regards to the project at large.

Findings

It was clear from the analysis that the counsellors saw Western treatment approaches as useful. Nevertheless, most emphasised the need to modify these approaches. While discussing working with trauma treatment in Sudan, all counsellors brought up a variety of factors influencing their work. The analysis resulted in three main themes, each divided into two subthemes. The first theme relates to stigma and the consequences of this, both regarding stigma towards mental health and towards sexual assaults. The second theme concerns traditional healers, and how trauma treatment competes – but simultaneously needs to be administered alongside this. The third theme regards the balancing of universality and modification in the trauma treatment.

Theme 1: stigma

Stigma is an important factor discussed by all the counsellors as impacting trauma treatment at different levels. It is mentioned with reference to two different aspects: stigma towards mental health issues in general and stigma towards sexual assaults. As most of the centre's cases involve sexual assaults, the multilevel stigma related to this in Sudanese society is highly consequential for the trauma counselling.

Stigma towards mental health

The counsellors all pointed out that mental health issues are not discussed openly in Sudan, nor widely recognised as health problems. Some counsellors emphasised that trauma is not prioritised by the Sudanese government due to lack of awareness and a general preference for medicine over psychotherapy. One counsellor said: "Mental health is not something that is very much appreciated by the government, or even by the minister [of health], and does not have a lot of funds." (**Int. 1**). Mental health issues are stigmatised in the society at large as well: "the common belief is that if you go to therapy that means that you are insane and then you might as well be in a hospital." (**Int. 5**). The same counsellor continued:

> "[My client] struggled to come to us because her mother had said to her…"why are you going there, are you mad?" So this is the common belief, it is a sort of stigma. So she came for the session, said what she wanted to say and then she will not come back.

This makes the therapy challenging, as people will be reluctant to come in the first place and are often unlikely to return after one session. Another counsellor concurred and said that the stigmatisation of mental health issues hinders people from seeking treatment, although the situation is improving:

> Four or five years ago very few would come and say that they had some type of psychological problem. It is more [common to do] so among people that are educated. We have had some clients that come with sunglasses or ask to come after everyone else has left in order to try to hide their identity. **(Int. 2)**

This need to hide one's psychological problems also takes other forms, as explained by this counsellor:

> Sometimes parents come here with a cover story. They say that the child's performance in school is very low, that the child is depressed and so on. They give you all the symptoms and problems, but not the real reason. I think this is because of the stigma issue. This has a lot of effects because if something is hidden for you as a counsellor and you cannot see it then you cannot

intervene to try to fix the problem. **(Int. 3)**

Another counsellor said that stigma was also something they had to consider when starting the centre: "Even when we opened the trauma centre we didn't call it trauma centre, we called it counselling centre, because people said 'if you call it trauma centre then nobody will come to you.'" **(Int. 1).** The counsellors emphasised that working with trauma in Sudan requires an acknowledgement of this stigma: "Understanding our culture means understanding that there is a stigma [towards mental health]" **(Int. 1).** Counsellors also indicated that education might play a role when it comes to stigma, suggesting that stigma might be more common among less educated people.

Stigma towards sexual assaults

Counsellors indicated that the main societal discourse around sexual assaults in Sudan is that the victim is to blame. Victims are often criticised for wearing inappropriate clothing, for immoral behaviour, and for wrong decisions. One counsellor explained:

> We [Sudanese] are blaming victims more than perpetrators: 'why did you go down that street…' We are a very masculine community and you have to protect yourself and wear dresses that covers yourself. It is a part of the cultural system where these ideas are very strong. **(Int. 4)**

The stigma does not only come from the larger society, but often also from within the family. One counsellor shared the story of a client who was raped twice:

> She cannot say anything to her family about what happened to her, because her family believes that a girl who is raped deserves this because she wears the wrong clothes or because she has been out too late in the evening.
> Whenever they see on the TV or read in the media that some girl has been raped, abused or sexually harassed the mother and the sister would say that she deserves this because she has been acting like a prostitute. So my client wonders: 'how can I tell my family that I have been raped?' **(Int. 2)**

This stigma is echoed in the justice system, where victims of sexual assaults risk being seen as the criminal, as discussed by many of the counsellors:

> …we have in our justice system in Sudan many cases of women who seek justice because of rape who have been legally turned from victims into criminals. **(Int. 5)**

This, the counsellor continued, is connected to zina, the punishable offence of having sexual intercourse before marriage. Further, a few of the counsellors indicated that some view sexual assaults as normal – something that happens to everyone:

> … sometimes maybe the mother will say: 'it happened to me also… I never talked about it and look at me now. It is not really a problem.' They do not regard it as a problem. It is nearly normal. One girl said to me that when she told her sister what happened to her she just said: 'that also happened to me. It happens to all of us, so you should not regard it as a problem.' **(Int. 6)**

The lack of acknowledgment by family members and others means that the trauma may become internalised. The counsellors underlined that this represents a challenge for psychological treatment, as described by one counsellor:

> What is striking is how alone they are with it. That their families do not acknowledge that it happened, so there is no one to turn to in the family because of the cultural shame around it. So the trauma becomes very internalised. **(Int. 7)**

The counsellors also frequently mentioned the issue of virginity and marriage. In the Sudanese society, virginity is generally upheld as a requirement for females entering into marriage: "Being raped or sexually abused means that you will face challenges getting married." **(Int. 4).** Another counsellor explained the important role of the family in this process:

> The family can also inhibit a traumatised person. First it depends if they encourage a person to seek help or not so they can have therapy. For example, if a girl is raped, this is stigmatized, not to be the rapist, but to be raped. Especially for girls, because… no one will marry her. **(Int. 5)**

This strong societal stigma makes it challenging for the clients to open up about these assaults in therapy:

> …women that have been raped will not come and simply say that they have been raped. They might say things like; 'he ruined me, he did bad things to me.' So most of the time they will not tell you directly what happened, maybe with time… It is also important that you understand that this is also related to the person's concern about virginity. This is a big, big issue in our culture. Because virginity is… connected with marriage. Among many here it is believed that if you are not a virgin then you are not a good woman… This also leads to issues concerning raped women being rejected by their husbands, and their families… This results in a series of traumas for these women. **(Int. 5)**

Women thereby risk shying away from treatment as well as disconnecting from much-needed social networks. This, according to the counsellors, frequently leads the victims of sexual assaults to choose isolation in fear of alienation and stigma, and makes it very difficult for them to reach out and get treatment.

Theme 2: negotiating treatment alongside traditional healers

All the counsellors underlined the relevance of traditional healers in relation to mental health treatment processes in Sudan. People often use traditional healers, who are mostly associated with Islam in contemporary Sudan. There are two aspects regarding traditional healers influencing the trauma treatment: competition with formal mental health treatment, and the necessity of dual treatment.

Competing with traditional healers

Most of the counsellors indicated that in Sudan, people generally prefer traditional approaches to mental health care, and thereby would often shy away from more formal mental health treatment:

> The majority of Sudanese… would not go to mental doctors because this is associated with taboo and it is stigmatising. It is less stigmatising to see a traditional healer…. People go there based on a more general understanding of not feeling good. Seeking the traditional healer, the illness can be seen as a failure of performing your religious practice for instance (**Int. 4).**

This extract echoes the stigma issues in the previous theme. Another counsellor concurred:

> People believe in them [traditional healers] very much. And I find clients especially from rural areas hard to work with because they believe so strongly in this and they are not very educated. They simply believe that these traditional healers are the one person in their society that knows best. If they have any problem…then they will go to the traditional healer. So they can control them totally, because they believe so strongly in them (**Int. 6).**

These sentiments expressed by the counsellors, especially towards people in rural areas and the less educated, may indicate a degree of bias by the counsellors towards patients. The counsellors are trained in Western trauma treatment, therefore this bias may be a product of the counsellors being grounded in their expertise and experience. Their training in Western methods is thus potentially reflected in their interpretations. We return to this issue in the discussion.

One counsellor added that trust and familiarity are essential for the special place traditional healers have in society:

> The thing with traditional healers is that there is a trustful relationship… They use methods that are more familiar to the clients, more than us. This is a challenge to us. This is another reason why it is so important to us to understand the culture so that we have a more acceptable way of relating to people. **(Int. 5)**

The counsellors experience competition with traditional healers due to stigma and through a lack of cultural legitimacy, as many Sudanese feel a closer connection to traditional treatment. As a concrete example of why traditional healers often are chosen, several counsellors mention that mental health issues are often perceived as being a punishment from God, and people therefore seek traditional healers for help:

> All rural areas have people that believe very strongly… that the illness that happened to them is a result of God and the traditional healer is the only one that can treat them. If not, then [their illness] will not be treated. They believe that no one else can treat them. (**Int. 6)**

Seeing their afflictions as punishments from God allows people to explain their reality in ways that make sense to them, and as a function of that, seek the correct prescription for improvement. Counsellors say they must consider this in the treatment, and at times attempt to build the treatment around the discourses and frames of meaning clients draw from. One counsellor explained that the clients frequently say:

> 'I accept this that happened because this is something from God.' We try to use this acceptance in a positive way. We try to make sure that there is no denial, but saying that 'you are right – it happened, but we can try to make things better.' We try to work in a way so that this type of statement does not become a hinder in order to change and adjust in a better way to get over the bad experiences. But these types of religious statements can sometimes be the reason people do not seek help, because they believe that what happened to them was sent from God. (**Int. 5)**

The counsellors say it can be challenging for clients to acknowledge that they have experienced traumatic events. By incorporating the clients' view that this was a punishment by God, the counsellors attempt to integrate religious aspects to improve the therapeutic framework and goals. Traditional healers clearly enjoy a widespread legitimacy among many Sudanese, while clinics and their methods often represent something unfamiliar. The counsellors say that they often lose this "competition", but that they make an effort to integrate clients' belief systems into the treatment in an attempt to cater for the needs of the clients and to make the approaches a better fit to the context.

Necessity of dual treatment

Most of the counsellors emphasise the necessity of accepting dual treatment – as most clients see traditional healers while undergoing treatment at the trauma centre. The counsellors said they would lose legitimacy with clients if they would not accept this dual treatment. Finding a balance between the acceptance of traditional treatments and the implementation of Western methods is thereby an important component of therapeutic work in Sudan. One counsellor explained:

> The hospitals here now work in collaboration with traditional healers because they know that people believe in these things. We

cannot tell people not to because then they will not come back here. We cannot tell them that the Sha'ir does not understand anything. If people say that they are going to the Sha'ir …we need to say: 'yes it's okay, but please do also come back here.' (**Int.1)**

The acceptance of traditional healers by counsellors also enhances their credibility by association:

I don't mind working with them, because here the traditional healers have a huge amount of respect. If we just separate ourselves from them then we will never reach our goal. Actually we do cooperate with them. (**Int. 3)**

This demonstrates how counsellors attempt to capitalise on the trust that many clients have in traditional healers to enhance their own bond with clients and establish a therapeutic alliance. Several of the counsellors said that dual treatment often works well:

Right now we do have a child were the parents believe that she is possessed by something evil. We work with her to help her manage many of her symptoms, and the parents also take her to the traditional healer. It looks like it is working. (**Int. 3**)

Most counsellors view traditional practices as less advanced than clinical methods, but still valuable in a cultural sense. As many Sudanese believe in traditional practices, most counsellors say they need to relate to it and use it the best they can. However, some counsellors disagree that traditional and clinical methods can be combined:

Those who go to local healing they will continue their life in the same way even if you intervene. Like for me personally, I tried to tell my family that I don't believe in that shit [traditional healers], that this way of doing things is not in line with… the way I have studied this field. Then they tell me that it is education that is screwing me up. It is very difficult to change the way people relate to this. When people go to traditional healers then this completely blocks their minds from mental health [treatment], they just go there because they believe in that healer. I don't see these two ways of healing as compatible. (**Int. 4)**

This counsellor clearly sees traditional healers as an obstacle to the treatment process. Another agrees:

…sometimes they come to us at the same time as they go to traditional healers. This is very challenging. I have a client like this and it is challenging because she believes more in the traditional healer than she believes in us - because the traditional healer is closer to our culture. Those traditional healers say: 'if you go for psychotherapy then you will not improve, you should only follow us.'… So I really struggle with this type of clients. Sometimes they will just say: 'I will not do this because my Sha'ir told me not to. I will not come to the therapy.' (**Int. 6**)

All counsellors stated that some traditional healers engage in maltreatment of their patients, including confinement, beatings and starvation. Maltreatment is where all counsellors drew the line. One counsellor indicated that she accepted dual treatment as long as…

…the traditional healer is treating the clients right, because some of the traditional healers may beat the child… But as long as they do not use methods like this then we can accept that our clients use their services. (**Int. 3)**

Another counsellor explained:

Many go to the Sha'ir every month or on special occasions, before weddings or to get pregnant. Regarding mental health, they go to the Sha'ir and he reads verses and this is okay. But if he tells you that you cannot drink water, salt, sugar or tie the client up, we cannot agree with that. (**Int. 2)**

The counsellors stressed their responsibility to monitor treatments offered by traditional healers, and to try to intervene if their clients are being maltreated.

These two themes – stigma and traditional healers – constitute the main contextual factors discussed by the counsellors. The counsellors negotiate culture and tradition, and often attempt to integrate it with their treatment methods. On the one hand, the first and the second themes can be seen as the contextual factors that are answered by the modification described in the third theme. At the same time, the negotiations with traditional healers and local understanding of illness described in the second theme constitute factors which impact the implementation of Western trauma treatment in Sudan. Similarly, stigma issues also require modifications of treatment approaches at times, as the Sudanese context limits the access to social support after rape for example.

Theme 3: balancing universality and modification

The third theme focuses on how counsellors find a balance between using textbook elements – often with reference to universal human processes – and modifying methods to suit the Sudanese context. Correspondingly, this theme is divided into universality and modification.

Universality

Despite underlining the need for context specific modifications, counsellors often emphasise the universal aspects of human psyche that need to be considered and valued when working with clients:

Some things can be used directly, other things we only have to change some words when we translate for it to better suit our culture. If some technique does not work, then I just change it for a different technique. We never think that this cannot work in our culture, but we do modify for technique to work better… People say that it [Western trauma treatment] cannot be done in other cultures, but now we are showing them that it can be done. (**Int.1)**

Despite warnings and concerns about the possibility of implementing Western approaches in Sudan, this counsellor clearly believes in shared, universal aspects making Western approaches relevant in Sudan. However, the counsellor simultaneously emphasises the need to slightly modify the approach to better fit the cultural context, as well as the importance of being flexible and considering other techniques if needed. Another counsellor also pointed to the universal and shared aspects of human emotions:

> The thing with therapy is that you can always connect with someone in the sense that we are all human beings with feelings and emotions. They may sometimes be culturally specific, but they are still feelings that you can recognise, like being sad or frightened or angry (**Int. 7**).

According to this line of reasoning, the universal aspects allow for the implementation of Western-developed approaches across different cultures. Some counsellors question whether 'Western theories' is a helpful term:

> I would like to point out that I do not prefer the term Western theories, but rather scientific theories. Now, I use all the methods that I learnt in the UK. But of course, in any type of mental health we need to consider the context where we apply it. But this will not change the scientific bases of the practice. (**Int. 5**)

The counsellor emphasises that there will always be a need for modification, but that the core elements of the treatment remain applicable.

> …when I graduated there were three girls doing their research at the military hospital [in Khartoum] using CBT [Cognitive Behavioural Therapy] on the patients the same way it was written in the books and it worked. So I don't think that Western approaches cannot be used in our culture. Unless you do not understand the culture. You have to be able to put yourself in the client's shoes, and understand how the client thinks and how he feels. Sometimes it is more about the relationship you have with the person, and not so much about the different ways of making interventions. Sometimes basic counselling will be enough. **(Int. 1)**

Here, both universality and contextual needs are emphasised. The quote further demonstrates the importance of understanding various aspects of the clients' cultural background and life situation in relation to the specific context. One core component that emerges from the responses above is a distinction between universal elements, namely emotions such as fear, anger, sadness etc. and the ways in which emotions can be fleshed out, explained and dealt with through therapy. Social contexts and cultural settings are key, and here the background and cultural knowledge of the counsellor comes in.

Modification

As seen in the above quotes, in addition to emphasising universality, most counsellors indicate that it was necessary for them to modify or adjust treatments to better fit the Sudanese context.

Perhaps the most noticeable outcome of the effects of cultural norms, livelihood reality, and stigma in relation to mental health care in Sudan, is that clients that decide to go to therapy, will often show up for one session only. Others will only participate in therapy for very short periods of time. Several contextual factors contribute to this, including stigma and the availability of alternative treatments (as specified above). The first meeting between a client and a therapist thus becomes a crucial juncture where the therapists attempt to effectuate maximum impact, as well as ensure that clients return to subsequent meetings. As such, a deep knowledge of socio-cultural institutions and contextual challenges in Sudan are essential for maximum effect during the first session, as well as attempting to convince clients to return to subsequent treatments.

The counsellors emphasised the importance of observing how clients frame their problems against the context of their social background, in order to effectively adjust their methods to fit with Sudanese socio-cultural norms and narratives. For example, counsellors may engage in customary greetings, ensure they are wearing appropriate clothing, and refrain from touching their clients. The following quote illustrates some of the challenges associated with devising a clinical strategy to fit socio-cultural contexts:

> Many times we have to modify the methods and treatments to make them fit our culture and our clients. If we do that then these [treatments] are suitable because it is the same symptoms. What we do with PTSD, trauma and especially rape victims - they benefit a lot when you… work specially with resilience, and encourage them and empower them. We never talk about their stories, we never ask, unless she wants to talk about it. We try to make them relax and to feel comfortable, and then they will start opening up. For the relaxation technics and grounding technics we need to modify. For example, there is a relaxation song where you use a metaphor where you have to climb some stairs, before you go down to a beach, there you meet an eagle, a dolphin and a horse, before you have to climb a tree. The first time we tried this with our client she tried to relax, but then she was like; 'why are there stairs leading to the beach? There is no beach here, I cannot walk on the beach.' And when I said there is a dolphin, she said; 'is there a dolphin in our river?' And even when I mentioned the eagle she said, 'I am fat, I cannot ride an eagle…' So then we need to modify. (**Int. 2)**

According to the counsellor, standard trauma treatments fit the client if they display the symptoms described in Western literature. However, as indicated in this case, the counsellor attempts to modify the techniques to fit the Sudanese clients, in order to make it work. A cultural and personal adaptation is necessary. Most counsellors shared similar stories, referring, for example, to how flowers in many Muslim countries are not incorporated into people's customs in the same way as in many Western countries, and thereby do not carry the same metaphorical usage:

…in narrative exposure therapy we use the metaphor of stones and flowers…But I think sometimes we can use something else besides the flowers, from the local area. I can ask a patient; 'What would you like to use in order to represent a nice event?' Then they will choose something that they can more easily relate to than the flowers. The metaphor should mean something to the client. **(Int. 5)**

These modifications are examples of cultural adaptions which indicate the importance of in-depth knowledge of socio-cultural institutions. As discussed above and mentioned by many of the counsellors, clients mostly show up for a single session only. This makes it crucial to be able to accommodate elements in therapeutic techniques to achieve the most effective impacts possible.

The counsellors also make references to clients' religious and cultural context:

Here sometimes we use certain beliefs in therapy. We know that this is a part of our culture, our belief-system. I have one client who follows Islam very strictly…. So I use Islamic therapy. I read from the Quran and use expressions like: 'the prophet Mohammed said…' Because this is the most appropriate way for her. So we switch things a bit …to suit the client. Even if it is like you said that the methods came from a Western context, so I might take something that is ours and then rather use things that fit our culture. We [in Sudan] believe in our grandparents [ancestors], so sometimes I use this also: 'our grandparents say…' - if the client believes in this. (**Int. 6)**

This demonstrates how this counsellor incorporates directly and indirectly contextual aspects in treatment. While 'Islamic therapy' is not a formal type of treatment, the quote above indicates that the therapist has identified a need to link treatment to faith, and enhance the effectives and impacts by linking religious beliefs to mental health therapy. In essence, the therapist incorporates traditional elements, that is, elements that would usually be addressed by traditional healers, with mental health education to create a more relevant treatment for a subject. In sum, counsellors emphasise both the universal aspects of mental health challenges and subsequent therapeutic approaches as well as the need to adapt these approaches to the specific socio-cultural context. According to the interviewed counsellors, modifying their approach to therapy helps them achieve better outcomes in the Sudanese context. These modifications indicate that successful therapy in a Sudanese context requires a deep knowledge and understanding of socio-cultural institutions as a basis for the application of any cognitive based mental health therapeutic method.

Together these three themes reveal important factors that influence how trauma treatment is negotiated in this institution in Sudan. The counsellors adapt Western methods according to the context, and must find a balance between the method and contextual factors influencing the treatment. A narrative emerged based on the themes: The first theme describes stigma as an obstacle to the counsellors' commitment to Western approaches. The second theme, working alongside traditional healers, represents both an obstacle and an opportunity to the counsellors' work with local people in Sudan. The negotiation of traditional healers and local understandings of illness in the second theme also describes how counsellors modify Western trauma treatment in Sudan. The third theme explores in more detail the counsellors' work, their attention to the intercultural aspects, and how they modify their trauma treatment to this context.

Discussion

The present study explored how counsellors work with trauma in Sudan, what challenges they face, and whether they modify Western methods. Their answers demonstrate that they find Western trauma treatments useful in Sudan, but with modification of several aspects to suit the local context. The first theme explores stigma towards mental illness and victims of sexual assaults. This brings to attention the social norms that maintain victimhood, and excuses perpetrators instead of holding them accountable. The article here provides insights into the world of therapy in countries where sexual assaults in particular are highly stigmatized. The second theme explores the need to negotiate treatment alongside traditional healers. While the counsellors, at times, view traditional treatment as competition and even as harmful practice to the clients, they recognize the strong positions these healers occupy in Sudanese society (see Ae-Ngibise et al., 2010 for similar findings in Ghana). The article shows how counsellors need to tread gently alongside other beliefs and traditional practises (see also Arias, Taylor, Ofori-Atta, & Bradley, 2016; Ofori-Atta et al., 2018). The first and second themes constitute important contextual factors that directly affect treatments. Both demonstrate the difficulties counsellors face, as well as how they use creativity to modify the treatments to the local culture, rather than adhering rigidly to the treatments or practices. This adaptive, creative approach is the focus of the third theme, which demonstrates how the treatment is often altered and adjusted to fit socio-cultural factors. Taken together, the article demonstrates the counsellors' attention to contextual and cultural factors in their trauma treatment. The article also illustrates the various ways counsellors work with clients. Some ground their work in indigenous frameworks (e.g. Islamic therapy) while bringing in adapted western techniques and methods. Others again begin with a universalized approach by applying western methods, and then modify them when clients do not relate to them (western based metaphors, stories, etc.).

While the study did not focus on the effectiveness of the treatment offered by the interviewed counsellors, it does demonstrate when and how counsellors modify treatment methods. As such, the findings of this study support the literature calling for the modification of Western trauma treatments applied in a non-Western context to fit socio-cultural contexts (see for example Copping, Shakespeare-Finch, & Paton, 2010; Marlowe, 2010; Tempany, 2009). Marsella (2010, p. 17) writes: "ethnocultural variables exercise major influence on perceived causes, symptom manifestations, clinical parameters (i.e., onset, course, and outcome), interventions, and societal responses", hence learning from counsellors working in non-Western settings is invaluable. Another contribution of this study is the focus on mostly Sudanese counsellors in Sudan, rather than interviewing Western health personal, avoiding at least partly what Wessells (1999, p. 274) termed the potential "tyranny of Western expertise."

Flexibility is at the heart of this socio-cultural adjustment of therapy, and allows amending methods and approaches to fit contexts and the individual needs. Social support, for example, is seen as an important component of trauma treatment. Such support assumes a different role in Sudan. As indicated above, family involvement may not be possible for Sudanese trauma victims due to stigma, particularly in cases of sexual assaults (see Ofori-Atta et al., 2010 for similar accounts from Ghana). These observations are supported by a testimony in a Human Rights Watch report from 2016, where a female activist who was raped and beaten by the National Security Forces, also suffered from the stigma: "I became a victim again. It wasn't enough the government subject me to all this but society and my colleagues also labelled me an indecent girl." Counsellors in our study need to strike a continuous balance between traditions and the roles of the local community and family on the one side, and interventions informed by psychological knowledge on the other.

The ability to balance cultural specificities with universal aspects of the human psyche, described most in depth in the second and third theme, is necessary for successful modifications of psychological interventions. All counsellors in our study emphasised the need to modify the treatments to suit the specific context, but also agreed that modified Western methods fit well with the Sudanese context. Some of counsellors opposed the differentiation between Western methods and other methods, referring instead to scientific or modern methods. Many argued that there will always be a need to modify approaches to better fit individuals and contexts. Here the counsellors emphasised that modifications of methods are not only important when applied across cultures, but are also a necessity within cultures. These findings are in line with how the literature on implementation of Western treatment methods in non-Western context has developed the last years, from discussions between defenders and critics, to a more nuanced position highlighting both the possibilities but also the need for modification. In this way, this study describes how this modification can be done, as long as one has the cultural competence needed (Kienzler, 2008; Miller et al., 2006). One counsellor (Int.1) remarked: "People say that it [Western trauma treatment] cannot be done in other cultures, but now we are showing them that it can be done." She was emphasising that the methods worked in Sudan, and was clearly frustrated that people suggested this could not be done. She is thereby not ignoring cultural differences, but emphasising that therapeutic approaches developed in the West can also be used elsewhere (see Bracken et al., 1995).

Counsellors highlighted the need to combine treatments founded on universal psychological processes with culturally modified language and techniques. This view is in line with Miller et al. (2006), who suggested using social constructivism as a bridge between the two perspectives. This approach is critical towards the universal applicability of a Western approach, while at the same time conceding the benefits of some universal features in the response to traumatic events (Kienzler, 2008). Using social constructivism as a bridge underlines the socially constructed aspects of reality and shifts the attention towards how people create meaning and make sense of their world in particular contexts. One example from the present study is the way counsellors modify so-called universal metaphors – e.g. flowers – to better fit the Sudanese context. From this perspective, local idioms of distress and patterns of help-seeking behaviour should be examined, and local mental health priorities and effective intervention strategies identified. Another example is the way counsellors attempt to root techniques aimed to change cognitive and affective processes within cultural and religious narratives. This paper demonstrates how this idea is applied in practice by these counsellors using Western trauma treatment in a non-Western context.

References

Ae-Ngibise, K., Cooper, S., Adiibokah, E., Akpalu, B., Lund, C., Doku, V., & Mhapp Research Programme Consortium (2010). 'Whether you like it or not people with mental problems are going to go to them': A qualitative exploration into the widespread use of traditional and faith healers in the provision of mental health care in Ghana. *International Review of Psychiatry, 22*(6), 558–567. https://doi.org/10.3109/09540261.2010.536149.

Ahmed, E. (2015). Militant Salafism in Sudan. *Islamic Africa, 6*(1–2), 164–184. https://doi.org/10.1163/21540993-00602001.

Ali, S. H., & Agyapong, I. O. (2016). Barriers to mental health service utilization in Sudan – Perspectives of carers and psychiatrists. *BMC Health Services Research, 16*(21), https://doi.org/10.1186/s12913-016-1280-2.

Arias, D., Taylor, L., Ofori-Atta, A., & Bradley, E. H. (2016). Prayer camps and biomedical care in Ghana: Is collaboration in mental health care possible? *PLoS One, 11*(9), 1–16. https://doi.org/10.1371/journal.pone.0162305.

Bhui, K., & Bhugra, D. (2007). *Culture and mental health: A comprehensive textbook*. London, UK: Oxford University Press.

Bracken, P. J., Giller, J. E., & Summerfield, D. (1995). Psychological responses to war and atrocity: The limitations of current concepts. *Social Science & Medicine, 40*(8), 1073–1082. https://doi.org/10.1016/0277-9536(94)00181-R.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa.

Burr, V. (2015). *Social constructionism* (3rd ed.). London, UK: Routledge.

Copping, A., Shakespeare-Finch, J., & Paton, D. (2010). Towards a culturally appropriate mental health system: Sudanese-Australians' experiences with trauma. *Journal of Pacific Rim Psychology, 4*(1), 53–60. https://doi.org/10.1375/prp.4.1.53.

Cox, J. L. (1986). *Transcultural psychiatry*. London, UK: Croom Helm.

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 & Psychiatry, 47*(12), 1197–1210. https://doi.org/10.1111/j.1469-7610.2006.01638.

Gallab, A. A. (2014). *Their second republic: Islamism in the Sudan from disintegration to oblivion.* New York, NY: Routledge.

Henrich, J., Heine, S. J., & Norenzayan, A. (2010). The weirdest people in the world? *The Behavioral and Brain Sciences, 33*, 61–135. https://doi.org/10.1017/S0140525X0999152X.

Hinton, D. E., Rivera, E. I., Hofmann, S. G., Barlow, D. H., & Otto, M. W. (2012). Adapting CBT for traumatized refugees and ethnic minority patients: Examples from culturally adapted CBT (CA-CBT). *Transcultural Psychiatry, 49*(2), 340–365. https://doi.org/10.1177/1363461512441595.

Human Rights Watch (2016). *Good girls don't protest. Repression and abuse of women human rights defenders, activists, and protesters in Sudan*www.hrw.org.

Kienzler, H. (2008). Debating war-trauma and post-traumatic stress disorder (PTSD) in an interdisciplinary arena. *Social Science & Medicine, 67*(2), 218–227. https://doi.org/10.1016/j.socscimed.2008.03.030.

Kirmayer, L. J. (2007). Cultural psychiatry in historical perspective. In K. Bhui, & D. Bhugra (Eds.). *Culture and mental health: A comprehensive textbook* (pp. 3–19). London, UK: Oxford University Press.

Kirmayer, L. J., & Young, A. (1998). Culture and somatization: Clinical, epidemiological, and ethnographic perspectives. *Psychosomatic Medicine, 60*(4), 420–430. Retrieved from: https://journals.lww.com/psychosomaticmedicine/Abstract/1998/07000/Culture_and_Somatization__Clinical,.6.aspx.

Kleinman, A. M. (1977). Depression, somatization and the "new cross-cultural psychiatry". *Social Science & Medicine (1967), 11*(1), 3–9. https://doi.org/10.1016/

0037-7856(77)90138-X.
Kleinman, A. (1980). *Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine, and psychiatry.* Berkeley, CA: University of California Press.
Kleinman, A. (1991). *Rethinking psychiatry: From cultural category to personal experience.* New York. NY: Free Press.
Marlowe, J. M. (2010). Beyond the discourse of trauma: Shifting the focus on Sudanese refugees. *Journal of Refugee Studies, 23*(2), 183–198. https://doi.org/10.1093/jrs/feq013.
Marsella, A. J. (2010). Ethnocultural aspects of PTSD: An overview of concepts, issues, and treatments. *Traumatology, 16*(4), 17–26. https://doi.org/10.1177/1534765610388062.
McFarlane, C. A., & Kaplan, I. (2012). Evidence-based psychological interventions for adult survivors of torture and trauma: A 30-year review. *Transcultural Psychiatry, 49*(3-4), 539–567. https://doi.org/10.1177/1363461512447608.
Meffert, S. M., Abdo, A. O., Alla, O. A. A., Elmakki, Y. O. M., Omer, A. A., Yousif, S., ... Marmar, C. R. (2014). A pilot randomized controlled trial of interpersonal psychotherapy for Sudanese refugees in Cairo, Egypt. *Psychological Trauma: Theory, Research, Practice, and Policy, 6*(3), 240–249. https://doi.org/10.1037/a0023540.
Menninger, W. C. (1948). *Psychiatry: Its evolution and present status.* Ithaca, NY: Cornell University Press.
Miller, K. E., Kulkarni, M., & Kushner, H. (2006). Beyond trauma-focused psychiatric epidemiology: Bridging research and practice with war-affected populations. *American Journal of Orthopsychiatry, 76*(4), 409–422. https://doi.org/10.1037/0002-9432.76.4.409.
Moss S.M. (In press) Leadership strategies of mobilisation and demobilisation in Sudan. In special thematic section: Multiple perspectives in conflict settings: from diversity to pluralism. Journal of Social and Political Psychology.
National Institute for Clinical Excellence (NICE) (2005). *Post-traumatic stress disorder (PTSD): The management of PTSD in adults and childrne in primary and secondary care.* London, UK: NICE.
Nicholl, C., & Thompson, A. (2004). The psychological treatment of Post Traumatic Stress Disorder (PTSD) in adult refugees: A review of the current state of psychological therapies. *Journal of Mental Health, 13*(4), 351–362. https://doi.org/10.1080/0963823041000172980.
Ofori-Atta, A., Cooper, S., Akpalu, B., Osei, A., Doku, V., Lund, C., ... Mhapp Research Programme Consortium (2010). Common understandings of women's mental illness in Ghana: Results from a qualitative study. *International Review of Psychiatry, 22*(6), 589–598. https://doi.org/10.3109/09540261.2010.536150.
Ofori-Atta, A., Attafuah, J., Jack, H., Baning, F., Rosenheck, R., & Joining Forces Research Consortium (2018). Joining psychiatric care and faith healing in a prayer camp in Ghana: Randomised trial. *The British Journal of Psychiatry, 212*(1), 34–41. https://doi.org/10.1192/bjp.2017.12.
Omar, M. A., Green, A. T., Bird, P. K., Mirzoev, T., Flisher, A. J., Kigozi, F., ... Mhapp Research Programme Consortium (2010). Mental health policy process: A comparative study of Ghana, South Africa, Uganda and Zambia. *International Journal of Mental Health Systems, 4*(1), 1–10. https://doi.org/10.1186/1752-4458-4-24.
Otto, M. W., & Hinton, D. E. (2006). Modifying exposure-based CBT for Cambodian refugees with posttraumatic stress disorder. *Cognitive and Behavioral Practice, 13*(4), 261–270. https://doi.org/10.1016/j.cbpra.2006.04.007.
Sorketti, E. A., Zainal, N. Z., & Habil, M. H. (2012). The characteristics of people with mental illness who are under treatment in traditional healer centres in Sudan. *International Journal of Social Psychiatry, 58*(2), 204–216. https://doi.org/10.1177/0020764010390439.
Swartz, L. (1998). *Culture and mental health.* London, UK: Oxford University Press.
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. https://doi.org/10.1177/1363461509105820.
Tol, W. A., Jordans, M. J., Regmi, S., & Sharma, B. (2005). Cultural challenges to psychosocial counselling in Nepal. *Transcultural Psychiatry, 42*(2), 317–333. https://doi.org/10.1177/1363461505052670.
Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry, 14*(3), 270–277. https://doi.org/10.1002/wps.20238.
Wessells, M. (1999). Culture, power, and community approaches to psychosocial assistance and healing. In K. Nader, N. Dubrow, & B. Stamm (Eds.). *Honoring differences: Cultural issues in the treatment of trauma and loss* (pp. 267–282). New York, NY: Brunner/Mazel.
Wittkower, E. D., & Fried, J. (1959). Some problems of transcultural psychiatry. In M. K. Opler (Ed.). *Culture and mental health: Cross-cultural studies* (pp. 489–500). New York, NY: MacMillan.