Systematizing cultural awareness: Toward a model for modification of trauma therapy and an application in Turkey

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Abstract
A cross-cultural team including a U.S.-trained clinical cross-cultural psychologist and two Turkish psychiatrists conducted research on a set of five trauma treatment psychotherapy groups for adult women survivors of sexual abuse in Ankara, Turkey. Based upon observational comparisons between trauma treatment groups in U.S. and Turkish settings, the team developed an approach to assist in adaptation of treatment methods from one cultural setting to another. This is a preliminary effort to develop a conceptual tool to focus the attention of therapists on salient dimensions of culture that may influence the psychotherapy process. This article describes six possible dimensions: (a) relational/individual self; (b) situationalism/universalism; (c) high/low power differential; (cc) high/low gender differential; (d) internal/external control; (e) emotional expressivity/containment; and (f) short-term/long-term time orientation. Comparative cultural examples from trauma psychotherapy group field notes illustrate the use of the tool.

Keywords
cultural adaptation, cultural dimensions, psychotherapy, trauma treatment, Turkey, women

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Clinicians in diverse societies work with people from a broad range of cultural backgrounds. Culture is tied to concepts that are socially and cognitively constructed, experientially grounded, and internally held. In this paper, our approach is grounded in the notion that culture is an ongoing meaning-making process between people (Kirmayer, 2006; Taylor, 2003). Although these meanings and concepts are rarely articulated, culture may deeply impact the therapeutic process, particularly in work with survivors of trauma.

Trauma therapy requires a clear understanding of the way that the body responds to stress, the ways that the nervous system processes information and memories, and also the ways that meanings attributed to experiences impact individuals’ physiological, emotional, cognitive, and behavioral responses to those experiences (van der Kolk, van der Hart, & Burbridge, 1995; Vandeusen & Carr, 2003). Effective trauma therapy must take culture into account because it is involved with the meanings given to experiences and with the complex factors that affect perception of events and behavioral responses to those events. Kleinman has suggested that a therapist should gain an understanding of the “explanatory model” of the individual in treatment in order to address the client’s own view of the trauma experience (Kleinman, 1980).

The research therapy groups discussed in this article allowed exploration of some dimensions of culture that may be important when adapting group trauma therapy methods for individuals from different cultural contexts. The goal of our research was first to adapt for a Turkish urban population a model of time-limited (12 weekly 90-minute sessions) group trauma therapy, used extensively in U.S. settings and based upon literature from that context (Chard, 2005; Dolan, 1991; Ginzburg et al., 2009; Kessler, White, & Nelson, 2003; Talbot et al., 1999; Zlotnick et al., 1997). Second, based upon observational comparisons between groups in U.S. and Turkish settings, we aimed to develop a general method for cultural adaptation of trauma treatment methods from one setting to another. A description of the therapeutic model we used and the data we obtained about effectiveness and perceived therapeutic factors from pre-, mid-, and postgroup assessments are the subject of a separate article (Sayın, Candansayar, & Welkin, 2013). Another article discusses therapeutic metaphors and cultural issues related to the concept of trust in these groups (Welkin, 2013). The focus of this article is on field notes and the qualitative observational model the team began to develop for cultural adaptation of this group trauma therapy.

Both the United States and Turkey are complex societies with heterogeneous populations and high levels of cultural change. This discussion does not presume to capture a general essence of either the United States or of Turkey as “cultures,” or to provide a recipe for doing culturally appropriate therapy for residents of the US or of Turkey. The very notion of such a recipe is unrealistic and potentially harmful as it presumes that there are clear and reliable rules we can use to assure ourselves that therapy will be effective for an individual living in a particular context. Such essentialism does not respect the complexity of individuals’ unique participation in cultural groupings. As anthropologists since Clifford Geertz (1973) have argued, “thick description” that considers the context and meaning of behaviors is key to
meaningful ethnography. This article draws on an ethnographic as well as a clinical approach.

We chose to focus our research on trauma treatment of sexual abuse because this type of therapy involves a high level of social and cultural complexity. Sexuality is charged with complex cultural meanings, emotional intensity, powerful assumptions, and passionately held values. Sex has significant biological, individual, and social dimensions. In addition, abuse is a category of human experience that is strongly bound up with issues of power, social systemic structures, emotion, and the meanings ascribed to behaviors. Trauma treatment for sexual abuse leads a clinician into territories that illuminate the complexity and intensity of human experience.

Our qualitative observational analysis draws upon a variety of social psychological and developmental theories including, most prominently, the cultural theories of Hofstede (2003), Trompenaars (1993), and Kağıtcıbaşı (1996, 2003, 2005). These theorists have attempted to conceptualize dimensions of culture to offer practical tools for cross-cultural comparison and communication. However, Hofstede’s and Trompenaars’ theories have been criticized for their potential to essentialize and construe national cultures as static entities. The anthropological and philosophical literature that cautions cultural observers against the dangers of categorizing fluid, dynamic social interactions into static entities is extensive (Bateson, 1972; Behar & Gordon, 1995; Heidegger, 1962; Kashima, 2001; Kirmayer, 2006; Taylor, 2003). This issue is ever present in our awareness as therapists. However, if the concepts used in our schema are viewed as dimensions of human experience and meaning that may provide useful tools for focusing the attention of practitioners, we believe Hofstede’s and Trompenaars’ models can be useful. We draw upon these social theorists’ work in part because the dimensions they propose overlap, reinforce one another, and have an empirical basis. However, these theories must not be understood as attempts to rigidly categorize cultures or nation states, nor as ways to predict specific behaviors. As always when working with theory, we must distinguish between the map and the territory. The model we describe here may eventually inform a guide for helping practitioners to “keep alive the empathic curiosity that allows one to be thoughtfully alert to difference” (Taylor, 2003, p. 179).

Methods

The research that was the basis for this observational analysis was conducted over a set of five time-limited trauma therapy groups for adult women survivors of sexual abuse in Ankara, Turkey, from March 2009 to January 2011. The approach used in these groups included cognitive behavioral therapy, interpersonal therapy, narrative therapy, psychoeducation, and expressive techniques. In all, 47 women were screened and 32 women completed this group treatment process. Our research team consisted of three clinicians: a U.S.-trained, female, experienced clinical cross-cultural psychologist; a male, Turkish psychiatrist who teaches in a medical school psychiatric residency program and conducts a private practice; and a female, Turkish psychiatrist with experience in group therapy, who is also a
professor in the same residency program. All the clinicians had previously conducted cross-cultural research. The team met before and after each group session (12 sessions for each of the five groups for a total of 60 times) for extensive discussion and peer supervision on group-related clinical and cultural issues. Observations from these discussions in addition to notes about the group process were recorded by one therapist as field notes. These field notes were then analyzed according to themes that emerged and were then discussed again between the three collaborating therapist researchers. This analysis of the experiences of three therapists using different frames of reference gradually developed into an articulation of our ideas about modifying a trauma therapy approach according to cultural issues we perceived in our research groups.

Results and Discussions

Based on our clinical experience, field notes from group therapy sessions, and supporting literature, we here outline six dimensions of culture that may be relevant in the process of adapting trauma therapy interventions for use cross-culturally. Each of these dimensions should be viewed as a spectrum with a variable scale of difference. These categories, while distinguishable, do interact and in many cases overlap. They provide a matrix of qualities to attend to rather than completely separate areas of cultural values and meanings. The focus of this six-dimension model is primarily practical, and we do not argue that the model is complete; other dimensions probably exist. We draw attention to these areas of culture to provide a qualitative, conceptual tool for understanding why and how a clinical model of trauma therapy could be modified to make it effective in different cultural contexts and with different populations.

The dimensions of culture we discuss are: (a) relational/individual self; (b) situationalism/universalism; (c) high/low power differential; (cc) high/low gender differential; (d) internal/external control; (e) emotional expressivity/containment; and (f) short-term/long-term time orientation. These dimensions are based on many theories and a complete discussion of that literature is beyond the scope of this article. For each dimension, we will briefly cite the relevant literature and theory and describe an application to a particular case from our field notes from five 12-session trauma psychotherapy groups.

The first four dimensions can be understood as closely related to one another. These dimensions point to issues of self concept, social positioning, power relations, and the ethical values that underlie individual action and social life. Some of these dimensions reflect related qualities of cultural meaning. For instance, high power differential between people is often associated with a high level of perception of external control over behavior and events. In other words, a person who has a strong sense of deference to authority may also perceive behaviors and events to be outside of their own control. However, the two dimensions may also vary separately. A person can question authority but still feel that most things are outside of his or her own personal control. The important point is not that these dimensions are
completely distinct, but that these dimensions may help a clinician to examine possible influences on a given client’s values in relation to an event, behavior, or experience.

We emphasize that any given person may behave in different ways depending upon the context. No individual can be described exclusively in terms of one side or the other of these dimensions. However, in cultural groups there are social patterns of behavior that emphasize and encourage particular values and types of functioning. Through patterns of interaction, cultures encourage people to hold a certain set of expectations and to ascribe certain kinds of meanings to behaviors. The meanings and expectations ascribed to traumatic experiences have very significant effects on the cognitions and emotions evoked. The ability of a survivor to overcome the effects of trauma and integrate traumatic experiences into a constructive life narrative is shaped by expectations and meanings.

**Dimension 1: Relational/individual self**

This dimension draws on the work of Çağdem Kağtçibaşi (2005), a Turkish cross-cultural developmental psychologist. She describes relational cultures as supporting the development of a strongly connected conceptualization of self, based on secure attachment and a high value on relationships. The relational self involves the sense that one’s identity is firmly connected to other individuals and that being part of groups is fundamental to selfhood. Family, tribe, and other social groups and affiliations are construed as the fundamental features that define a person. Many cross-cultural psychologists describe this view as a “collectivist” conceptualization of the self (Kim, 1994). Kağtçibaşi (2005) emphasizes that a relational self concept can allow for individual autonomy in action and emotion.

An individualistic conceptualization of the self is the contrasting conceptualization of self. Individualism values a highly differentiated and separated concept of self in relation to others. Independence and self-sufficiency are highly valued. The United States and many northern European countries rate very high on measures of individual conceptualization of self (Hofstede, 2003).

For the purposes of our work with abuse survivors, one of the important implications of this dimension is the effect it had on the emotional, interpersonal boundaries of the women with whom we worked. In the aftermath of trauma, the boundaries of a person’s perceived self, field of action, and responsibility are of great importance to the healing process. Researchers have argued that “psychotherapy must address two fundamental aspects of PTSD: the deconditioning of anxiety, and the pervasive effects that trauma has on the way victims view themselves and the world” (van der Kolk et al., 1995, p. 2).

For instance, many of the relatively relationally oriented women in our Ankara survivors groups described themselves as coping with their own distress physiologically and emotionally. Yet many of them said they felt completely overwhelmed when they imagined the impact that knowing about the abuse might have on
members of their family. A more individualistically oriented survivor might more easily separate her distress from that of her family members.

**Dimension 2: Situationalism/universalism**

This dimension is concerned with the way that a person conceptualizes the moral or ethical basis of action. How do we order social life? Is the primary reason for construing one behavior “good” and another “bad” a matter of universal rules and principles, or is it a matter of situations, relationships, and social positioning? Do we act based upon a set of universal principles and rules? Or, do we believe that the most important way to determine right action is based upon the social position a person holds?

The work of Lawrence Kohlberg (1958, 1971) and Carol Gilligan (1982) explores the reasoning processes behind moral decision making. Moral reasoning has a basis in values. The statement, “principled action is the highest form of morality,” represents the universalist pole of this dimension, whereas “rules apply only to the weak” represents the situationalist pole. Trompenaars (1993) discusses something similar to this dimension in his universalism/particularism concept.

This dimension also considers values about quality of life. Is personal achievement valued most highly, or rather an ethic of broader social harmony, altruism, and care? Within the boundaries of a defined group, quality of life tends to be a value for everyone. How broad are the boundaries of the rules of altruism, compassion, and caring for the vulnerable? Is there a universal scope for the rules, or is the focus of concern only the individual, one gender, a family or a tribe? A competitive achievement orientation, or focus on cultivation of personal accomplishment or high social status can be associated with a situationalist ethic. The achievement versus altruism aspect of this dimension is described by Hofstede (2003) as “Masculine versus Feminine” values in a culture.¹

Kagıtçibaşı (2005) points out in her concept of the “autonomous relational self” that a person may value relationships and relatedness and at the same time have a high level of interest in achievement and personal accomplishment. She argues that interdependence does not preclude independent action and personal accomplishment. Values of altruism and social cooperation may or may not be fostered by a high value on relatedness. The boundaries of what is considered worthy of concern are most significant.

In these sexual abuse survivors groups in Ankara, the issue of universalism versus situationalism surfaced when the women spoke frequently about their perception (and frustration) that men have license to have sexual relationships outside of marriage but women do not. This is an instance of situationalism, rather than a universal rule about sexual behavior applicable to both genders.

**Dimension 3a: High/low power differential**

This dimension examines differences in relative social power between people. In low power differential cultures, people have relatively egalitarian social
status in relation to one another. High power differential implies a high level of hierarchical difference in social status. Authoritarian and elitist systems are most compatible with a high power differential point of view. Egalitarian social structures support a low level of power difference between individuals and groups. Hofstede (2003) discusses this concept as “Power Distance” and argues that it varies significantly between cultures and has important implications for the functioning of hierarchies and organizational decision making. Theorists interested in the phenomena of social minorities and the experience of oppression explore this issue in great detail. The work of Leticia Nieto in *Beyond Inclusion Beyond Empowerment*, is an excellent resource on this issue (Nieto, 2010).

In our trauma treatment groups in Ankara one example of the high power differential context was members’ frequent comments on class differences between the group members. In many groups, members discussed their desires to set class differences aside and find solidarity instead as survivors and women: “We’re all women, no matter what our backgrounds are.”

**Dimension 3b: High/low gender differentiation**

This dimension may be conceptualized best as a subcategory of high and low power differential. Hofstede’s “Masculine and Feminine” conceptualization of cultural values (1998) suggests that gender differentiation may increase with power differentiation. However, the issue warrants further research. As Hofstede himself suggests (1998), gender differences are complex and controversial. Cultures vary significantly in the degree to which they expect differences between males and females. Gender roles, gender expressions, and gender identities are more or less differentiated in various cultural groupings. The expectation of highly differentiated genders is discussed in some gender theories as a binary concept of gender (Nestle, Howell, & Wilchins, 2002). Low gender differentiation expectations may make people comfortable with more androgynous appearances and less distinct and defined gender roles. For a more thorough discussion of gender expression and the performative nature of gender, see the work of Judith Butler (1999, 2004) and Riki Wilchins and colleagues (Nestle et al., 2002).

The differences between men and women are a common topic of conversation in women’s sexual abuse or family violence therapy groups. It was common in our Ankara survivor groups to hear women say they believed too much was made of the differences between the genders and for them to connect high gender differential with their abuse: “So what if I am a woman, does that mean I can’t just live my life!”

**Dimension 4: Internal/external control**

This dimension draws upon the social psychological literature around “locus of control” first developed by Rotter (1966). The focus here is on how a person conceptualizes the motivation or impetus for action. Do people view themselves as
having a large degree of control over their own behavior and experience, that is, internal control, or do they believe that they are largely controlled by other people, random chance, or situations outside of themselves, that is, external control? Does autonomous choice form the most important basis of experience or is a person’s behavior contingent upon outside direction, external choices, and circumstances? Are avoidance of uncertainty, direct communication, and a high expectation of personal control preferred, as in internal control? (In Hofstede’s model this concept is linked with “Uncertainty Avoidance” [2003]). Or, as expressed by some members of our groups in some contexts, can a person enjoy the spontaneous and unpredictable experiences that may accompany acceptance of uncertainty, indirect communication, and an expectation of control by factors external to the self?

As therapists, one of the important questions we consider with this dimension is the degree to which a person believes that he or she is able to exercise a high degree of control or choice in their own lives and to what extent they believe they are ruled or directed by other people or by external factors like chance. This issue is especially relevant in trauma therapy. The women in our Ankara groups frequently described themselves as controlled or strongly affected by other people and external factors, especially in the first stages of the therapy work: “What could I do? Everyone expected me to be like this.”

**Dimension 5: Emotional expressivity/containment**

This dimension focuses on the degree to which a culture values or allows outward expression of emotions. Emotions are conceived of in some cultures as experiences or feelings that are best contained internally so that others are less aware of or affected by them. Emotions can also be conceived of as experiences and feelings that can or should be shared and expressed so that others are aware of them. This issue is discussed in Trompenaars’ schema in terms of “Neutral vs. Emotional” stances (1993).

Another aspect of this dimension relates to tolerance of affect or emotion in self and others. The position valuing expressivity perceives benefits that stem from externalizing and sharing emotions. Emotional containment may reflect a greater focus on the importance of self-control and the risks of affecting others through one’s emotional expressions. Tolerance of affect involves both the degree to which a person can tolerate his or her own experience of affect and the degree to which she or he can tolerate the expression of affect by others. Tolerance of affect in self and others may vary independently, but both are linked to expression of affect.

This dimension has significant implications for psychotherapy. In trauma therapy, the degree to which affect can be tolerated and expressed has important implications for the client’s ability to manage and integrate emotions associated with traumatic experience. For instance, borderline personality disorder, a diagnosis common among abuse trauma survivors, is a psychiatric diagnostic category in the DSM defined in part by a very low level of ability to tolerate and manage
emotional experience and expression (American Psychiatric Association, 2000). We discuss more observations related to this dimension as noted in our Ankara groups in a later section.

**Dimension 6: Short/long-term time orientation**

This dimension is drawn directly from Trompenaars’s work (1993) and is not discussed in detail in this analysis. It has been argued that some cultural groups, including many North American indigenous peoples, tend to view events in the frame of a very long time span. This long-term orientation towards time is exemplified by concepts such as the need to consider the potential effects of present actions on the seventh generation in the future.

The Turkish and U.S. groups considered in this research did not show a clear difference in the way that they considered the time frame of actions or behaviors. Generally, the time orientation of both groups appeared to be relatively short, focused on the present and near future and immediate relatives and friends. Thus, our data do not allow for an anecdotal illustration of psychotherapeutic differences between the Turkish and the U.S. cultural groups we considered with regard to this dimension.

**Cross-cultural comparisons**

Observations from the field notes on our Turkish research groups are compared here with observations from many U.S. groups of similar format conducted over many years by the first author without the benefit of a systematic research design and approach. These comparisons are qualitative, descriptive, and represent our own informal observations and interpretations. Bearing this caveat in mind, we observed many more similarities than differences between these contexts with regard to patterns of trauma effects, symptoms, and interpersonal behaviors. A full discussion of the pattern of trauma effects that we observed is beyond the scope of this article; for a more extensive discussion of our observational method using a reflective learning process to work with cross-cultural differences see Welkin (2014). Briefly, the effects we observed showed close similarity to those described by Judith Herman (1997) as “Complex Post-Traumatic Stress Disorder.” As noted by Schouler-Ocak, Reiske, Rapp, and Heinz (2008), the cultural differences between these groups were not so much in the symptoms induced by these women’s traumatic experiences as in the meanings and strategies they employed to address them. This discussion will focus on some differences that illustrate the ways in which culture may affect the experience of trauma.

**Cohesion-relational skill**

Related to Dimension 1 (relational/individual self) in our model, the speed and readiness with which our group members connected with each other and the degree
to which they developed group cohesion was remarkable compared to experiences with comparable groups in the US. With some exceptions, women joined the conversation early (within the first two group sessions) and offered significant information about themselves, their backgrounds, and their abuse, without frequent prompting from the therapists. Group members also offered interactive feedback and supported one another. Overall, group participants seemed particularly eager to join, trust, and offer one another caring. Many women spoke about how isolated they felt in the wider society because of their abuse experiences, and how valuable it was to have a social situation in which the issue of sexual abuse was not a source of stigma for them. Group participants rated group cohesion as one of the top three therapeutic factors in their group experiences on a postgroup test, Yalom’s Group Therapeutic Factors Questionnaire (Sayın et al., 2013).

Many participants quickly made strong bonds with one another, and some members of all five therapy groups continued to meet after the therapists concluded the 12-session process. However, not every group member was firmly drawn into the cohesion. In each group, one or two members stayed outside the strong cohesion, generally leaving the group early. Of our 15 dropouts, seven occurred after the screening appointment but before attending a first group session, three were asked to leave the group because of irregular attendance (after more than three absences), and five never responded to phone calls, so we do not know their reasons for dropping out. Members who stayed peripheral to the group process most often left the group altogether. It was unusual for a group member to stay and accept a position mostly separate from the group cohesion. It is possible that the style of cohesion in these groups (interacting with a relational construction of a sense of self) was related to the pattern of dropouts.

The group cohesion was sufficient to tolerate expressions of difference and conflict, but the level of difference or conflict tolerated may have been limited. The high value on politeness in Turkish social interaction also may have limited conflict expression. Closer examination of this issue is warranted. Strong group cohesion coupled with a tendency for some members to leave the group, perhaps indicative of a low tolerance for remaining separate, can be related to the relational self/individual self dimension in our model. This pattern might reflect a strong relational quality in the values and identity patterns of Turkish families (Kâğitçibaşı, 1996).

**Expression and tolerance of emotion**

Another significant theme can be related to Dimension 5 (emotional expressivity/containment) along with tolerance of affect in self and others. The level of distress expressed by these Turkish group participants, voicing pain, fear, anger, hurt, sadness, anxiety, and other emotions, was marked. It is not surprising that participants would express intense emotion in a trauma treatment group. This is an essential part of the process of trauma therapy. However, relative to the first author’s prior experiences in the U.S., this group displayed a high level of tolerance
for their own emotions. In other words, although pain, difficulty, distress, and
dismay about these feelings were commonly expressed in the group, participants
rarely expressed a perceived inability to cope, a feeling that the emotion was wholly
unmanageable, or a sense that suicide or dying would be better than the feelings
that were being experienced.

The Turkish groups displayed high levels of both expressed emotional intensity
and affect tolerance. The affect tolerance appeared to operate both for each mem-
ber’s own emotions and for the emotions of others. In this case, “tolerance” does
not imply that the women were comfortable or fully accepting of the emotions they
were feeling and describing. Rather, we use the concept of tolerance in this context
to indicate that the women coped with the emotions they and others expressed with
a relatively low level of “acting out” and “acting in” (Yoder, 2005). Although one
woman made a suicide gesture after a period of attending group, there were few
self-harm behaviors among participants, and relatively little alcohol and drug
abuse that the therapists were able to observe. There were also very few occasions
in group when women were verbally aggressively toward one another as a means of
defending against the expressed emotions of others.

This contrasts with the norms of many groups of survivors in the United States
observed by Welkin. In her U.S. groups, expressions of distress and fear at the
intensity of experienced emotions were frequent in trauma therapy. For example, it
was common for survivors in the United States to say “I think this pain may kill
me,” or “I would rather die than feel this way.” Such expressions of an inability to
tolerate fear, sadness, pain, or other strong emotions were not noted in our Turkish
groups. This could be because such direct expressions of distress were curbed to
spare the feelings of others, or it could be that expectations of emotional intensity
were different in this cultural context.

For the U.S. trained therapist, there were times when the intensity of emotion
expressed in the group evoked concern. Welkin expected much more suicidal acting
out and was surprised that the groups could sustain and tolerate such high levels of
affect without displaying defensive stances and conflict. In the literature, there is
clear evidence of cross-cultural differences in levels of emotional expressivity (Lu &
Wang, 2012), but there has been no extensive study of differences in emotional
expressivity between Turkish and U.S. populations. Expectations about levels of
emotional expression could influence both group process and leader–member inter-
actions. Given that one of the primary goals of trauma therapy is to bring emotions
into awareness and integrate them with the narrative and sensations of the trau-
matic experience, this tolerance of emotional intensity was likely therapeutic for
group members.

Issues of power differential

Related to Dimensions 3 (high/low power differential) and 4 (internal/external
locus of control), the adult women participating in our groups described experi-
ences of abuse that were most often perpetrated by family members, close
associates, and people they expected to trust in positions of authority over them. Most of the instances of abuse happened when the women were children or very young adults. The perpetrators of the abuse were people in positions of authority over the women and victims felt an obligation to submit and to be obedient to their abusers (Sayın et al., 2013). This is the typical pattern in abusive relationships according to research in the U.S. and Europe as well (Finkelhor, 1994). Abuse consistently involves the misuse of positions of power and authority.

Mocan-Aydin (2000) identified submisiveness to authority and high power differential as significant cultural differences between Turkish and American or European groups as observed in counseling situations. A habit of submission to authority and expectations in this context that women should be obedient made Turkish women more vulnerable to abuse. In other words, a high power differential, as observed in the Turkish cultural context, may increase vulnerability to abuse. On the other hand, a habit of obedience to others, or a tendency to respect authority, may also increase the strength of the therapeutic suggestions of therapists. A well-trained therapist may have enhanced influence in a cultural context with high power differential. But of course this means that a therapist without adequate training and preparation, who is not appropriately respectful of the needs and integrity of the client, may also be very influential, with potentially negative consequences.

Challenging and questioning of therapists’ authority in our Turkish groups was muted and most often indirect. Group members deferentially called the therapists “hocam” (“my teacher”), a term of respect. They asked for advice often and rarely questioned or disagreed openly with the opinions or interventions of the therapists. In the U.S., questioning and challenging of group leaders’ power and authority is an expected part of the group therapy process (Yalom, 2005). As a therapist in the U.S., Welkin had become accustomed to much more frequent and open challenges of her authority. There were times when the respect and idealization by group members in Turkey became uncomfortable for her.

The level of power commonly afforded to therapists, especially in the context of trauma therapy, must be used with great care and caution. A cultural context of high power differential may significantly increase the potential for secondary trauma resulting from therapy experiences. Therapists must be particularly conscious of the power they hold in their position of authority in cultures with a high power differential.

Mocan-Aydin (2000) also identified a cultural difference in the tendency to adopt an internal or external locus of control. In the U.S., therapists are trained to support an internal locus of control for clients, as described in Dimension 4 (Mocan-Aydin, 2000). The common American cultural ideal is a very high level of internal locus of control which may be linked to other cultural factors within the U.S. (Berry, Poortinga, Segall, & Dasen, 1992). There is also evidence of variation according to racialized identity and social class in U.S. society; some groups tend to be less convinced of the value of an internal locus of control (Berry et al., 1992).
High power differential coupled with an external locus of control expectation in our Turkish groups challenged our U.S. trained therapist’s expectations and assumptions.

**Shame and namus**

One of the issues that clearly distinguishes a Turkish point of view on sexual abuse from dominant attitudes in the U.S. is “namus.” The word namus is most often translated as “honor” and is often described as an Islamic concept, though in fact the values and the traditions of namus and honor clearly predate the advent of Islam. Similar values of honor have been described among groups from the Mediterranean to Central Asia, including Muslims, Christians, Jews, and other groups (Ahmed, 1992; Bağlı & Özensel, 2011; King, 2008).

Namus is involved with the integrity of family honor and social standing. The virginity of unmarried girls and the sexual virtue of women in a family are among its most important determinants. Thus, girls and women are in many ways the primary holders of family integrity and honor. Traditionally, women should protect the virtue of the family, and the standing of all the men and women in it, by maintaining flawless, unquestionable morality and purity in the eyes of the community (Cindoğlu, 2000; Delaney, 1991; Kağıtçıbaşı, 1982; King, 2008).

Men’s honor is more often identified with the term şeref. According to tradition, the protection of the honor of women in the family and the cultivation of high social standing in the community, şeref, are essential duties and obligations of Turkish men (Delaney, 1991). Male honor is not exclusively tied to sexuality. However, a man’s şeref may be damaged by a female family member’s loss of namus. As all of our group participants were female, the concept of şeref was not raised in these groups.

Honor killing is the most extreme custom associated with the protection of family namus. According to King, “Most cultures in which honor killings occur are Muslim-majority, however, examples of honor killings occurring among non-Muslims are easy enough to find that a compelling case cannot be made for a direct linkage between Islam and honor killing” (2008, p. 336). King (2008) argues convincingly that the common denominator of societies in which honor killings are practiced is not Islam but rather patrilineage, or the idea that the male lineage is the sole source of procreation (King, 2008). A longer discussion of namus, şeref, and some implications for survivors of sexual abuse in societies that hold these values is beyond the scope of this article.

In our research groups, discussion of utanc, or shame, was common. Again, this is a natural and necessary part of trauma therapy for sexual abuse. Self-blame, a sense of being “flawed,” “unclean,” “broken,” or “unworthy,” as expressed in these Ankara groups, are routinely expressed by sexual abuse survivors in the United States as well (Herman, 1997). The difference between the cultural contexts was subtle: in the Turkish context, shame was usually discussed in terms of the social stigma that a woman felt as a result of abuse. Frequently, survivors in these
Turkish groups described feeling that they had to protect their families from knowing about or having to experience the embarrassment and shame of the abuse. Many survivors in our groups reported they had never told anyone about the experience, which is not unusual across contexts. However, given that family members are among Turkish women’s most frequent confidantes, it was notable that group members would often say that they had not discussed the abuse even with their closest family members. They often expressed fear that others would be harmed by their emotions or experiences: “I can’t tell my family what happened, it would upset them too much.”

Our urban, relatively educated, and less traditional sample of women in one of Turkey’s most Europeanized cities did not describe being afraid of being murdered in traditional “honor killings.” However, levels of self-blame, and the perception of self as flawed, unclean, bad, or immoral, were marked. These women reported feelings of separateness and difference and deeply feared being excluded from participation in normal social life. In a U.S. context Judith Herman (1997) has described survivors’ sense of separateness and difference as characteristic of complex posttraumatic distress.

Many women had never had boyfriends or had not married. The majority of the women who had married had been divorced and many described themselves as having chosen or been forced into poor marriages due to their own or their families’ shame about the abuse. Many said they did not think they deserved to have relationships with decent, good men: “No good man would have me.” These women were markedly different from other women in their social groups in this way, and they said that they feared this difference.

Using the model we have described, these women’s experience of shame and namus can be related to at least three dimensions of culture: Dimensions 1 (individual/relational self), 2 (situationalism/universalism), and 3 (high/low power differential, with high/low gender differential). Women’s experience of namus is focused on their identity and sense of responsibility for others. Namus is based on a relational sense of identity. In societies that encourage such a relational identity, a person’s construction of his/her sense of self is not based upon his/her individual qualities, as it is in individualistic societies. Instead, sense of self is based on relationships or affiliations with others and groups (Kağıtcıbaşı, 1985). Family, tribe, religious group, ethnic identity, and national identity are some of the many kinds of groups that may be very important in the construction of the sense of self (Kim, 1994). In Turkey, family is the group that forms the basis of most people’s idea of who they are and what is important about them (Kağıtcıbaşı, 1996). To some extent, it can be said that a person is nothing without his or her family. Because abuse so often occurs within families and is damaging to family relationships, it may be especially damaging in this cultural context.

The other key element in the construction of the concept of namus is a social structure that places public power and control over families, women, and children in the hands of men (Kağıtcıbaşı, 1982). This can be related to the high gender differential and high power differential dimensions of culture, it also reflects
Dimension 2, situationalism/universalism, in that rules about sexual purity apply to women but not to men. In effect, women and men are understood to be very different from one another in this society (Olson, 1982). The qualities ascribed to males and females, and the duties and behaviors expected of them are different. Men are assigned superior position of power and must demonstrate control of their family and subordinates in public. They are also allowed great sexual freedom. Women are assigned responsibility and given power in separate and more private spheres, family, and home life (Bağlı & Özensel, 2011; Olson, 1982). The interaction of the values of relational self, situationalism, high power differential, and high gender differential that plays out in the cultural phenomena of namus contributes to the complexity of the consequences of sexual abuse for women in this Turkish cultural setting.

Conclusion

This study of five trauma therapy groups in Ankara, Turkey by a cross-cultural team of Turkish and U.S. therapists suggested that a method of trauma therapy for adult women sexual abuse survivors originally developed in the United States could be modified in practice and used to work with urban women in Ankara, Turkey. Data on symptom reduction among these women and their perceptions of efficacy factors are presented in a separate article (Sayın et al., 2013). The qualitative, observational process of adapting our group therapy method illuminated many similarities and a few differences between the two cultural settings. Patterns of trauma response or symptoms in our groups corresponded to the patterns described by Herman (1997) in her description of “Complex Post-Traumatic Stress Disorder.” More work would be necessary in more diverse settings in Turkey to identify specific cultural enhancement or adaptation methods (Barrera & Gonzalez-Castro, 2006; Walker, Trupin, & Hansen, 2013).

In order to understand and analyze the similarities and differences between U.S. and Turkish cultural contexts for this group trauma therapy, differences in the cultural meanings of certain experiences had to be analyzed. Trauma is a complex psychological, physiological, and social phenomenon and to understand differences in effects of traumatic experiences and in the healing processes in treatment, the team developed a model of six dimensions of culture. This model is based upon concepts of cultural values previously developed in the fields of cross-cultural psychology and organizational development. The model can help to direct the attention of therapists to specific factors in group therapy process that may vary across contexts.

Important limits to this qualitative observational inquiry include the small sample, lack of independent measures, and systematic comparisons by multiple observers. Clearly, this discussion is only a first step. Further observation and systematic testing of these six cultural dimensions as an analytic tool by a range of therapists would be necessary to confirm their usefulness and validity in varied contexts. More generally, we suggest that having an analytic tool for focusing the
attention of therapists when modifying therapeutic approaches from one cultural context to another may provide useful guidance for therapists. Current discussions of “cultural sensitivity” or “cultural humility” often fail to include a clear and systematic way to look for salient cultural differences. Therapists working with trauma, in particular, may find that using a conceptual model helps them recognize unconscious biases and assumptions. We hope that the use of tools like the one we describe in this paper can improve our understanding of the experience of trauma and the process of trauma treatment.

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Note

1. Hofstede’s use of these gendered terms must not be understood as referring to men and women but as metaphorical. In particular, North Americans may have some difficulty reflecting on this dimension because cultural patterns around achievement and altruism there tend to be skewed by a strongly masculinist cultural perspective according to Hofstede’s schema.

References


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