Preface

By John P. Wilson

This book attempts to break new ground in the field of traumatology. As the field has advanced in its scientific knowledge, it has also become more globalized in nature as this body of scientific and clinical information has been utilized in nearly all parts of the world, especially in situations of disaster (e.g., 2004 Tsunami; Hurricane Katrina), wars (e.g., Iraq, Bosnia), political oppression and genocide (e.g., Darfur, Sudan), and to other types of traumatic events. Therefore, there is a need for a reference work that extends beyond the limitations of Western methods of assessing and understanding psychic trauma. It is our hope that this book and its successors will begin a process that eventually will lead to integrative global knowledge of how to employ culturally sensitive ways to understand psychological reactions to traumatic life experiences for culturally and ethnically diverse populations.

The book is organized into three parts. Part I focuses on theoretical and cultural considerations in the cross-cultural assessment of psychological trauma and posttraumatic stress disorder (PTSD). There are six chapters in this section. Part II concerns assessment methods and contains four chapters. Part III examines trauma and cultural adaptation in six unique chapters.

In Chap. 1, John P. Wilson presents a broad conceptual overview of culture, trauma, and the assessment of posttraumatic syndromes in a global context. He raises issues regarding the importance of the field of traumatology to create an agenda for the development of culturally sensitive assessment processes and procedures. In a similar way, he presents 21 core questions for understanding culture, trauma, and posttraumatic syndromes. Wilson also suggests by looking at mythology, universal themes of the relationship between traumatic life experiences and patterns of posttraumatic adaptation can be evaluated from literature and its reflection of human struggles across different cultures throughout time in human history.

In Chap. 2, Lisa Tsoi Hoshmand presents a rich chapter on the understanding and assessment of trauma and its aftermath from a cultural–ecological perspective. As she notes, "the definition of trauma entails the cultural and ecological symptoms that mediate human experience and provide resources for 'coping and meaning making.'" This chapter discusses many critical issues concerning the assessment of trauma from a cultural–ecological perspective. These critical issues include, but are not limited to, the following (1) one cannot assume pretraumatic normality of development for persons living in abnormal, chaotic, persistent, threatening, and unstable environments; (2) the issues concerning culture-specific versus universal adaptations to trauma and extreme stress has not been resolved conceptually and empirically; (3) there are different patterns of response to conditions of prolonged items of a threatening or depriving nature to those of acute, shorter traumatic exposure; (4) knowledge about the understanding of trauma in different cultures is evolving in an era of globalization; (5) it is important to understand and assess both individual and community resilience; (6) understanding the different types of threat to basic needs for human security; (7) developing valid psychometric measures for cross-cultural research as well as clinical protocols, field-based process models, and qualitative methods of assessment. Hoshmand continues her discussion of the need for education and academic applications to help train future clinicians and researchers.

In Chap. 3, Siddharth Shah examines ethnomedical practices for international psychosocial efforts in disaster and trauma. He begins by defining ethnomedical competence and ethnomedicine as the study culturally embedded or alternative beliefs and practices for health care. He details how neocolonial, largely Western practices, have assumed the transportability and relevance to other cultures. Shah challenges the validity of such assumptions and, instead, argues for ethnomedical competence in which there are symmetrical learning processes that are democratic in nature. To illustrate his point, he presents a case history of the 2004 Tsunami in which he learned from a Sri Lankan colleague and spiritual healer named Ranjan, who employed traditional healing practices to aid victims of the disaster. Shah describes the spiritual healers' gifts and techniques and contrasts them with how modern psychiatry would have approached the distressed and traumatized victims of the flood waters. He notes that Ranjan's techniques were applied to wide ranges of psychological problems with clearly observable success which would likely be criticized by Western scientific standards as quackery.

Shah goes on in this chapter to outline the evidence for shortcomings in ethnomedical competence and references recent efforts by the World Health Organization to create standards by which to assess the effectiveness of interventions in situations of extreme stress, disaster, and trauma. Finally, he concludes his chapter with a set of guidelines to counteract

neocolonial processes that might be counterproductive in non-Western cultures.

In Chap. 4, Yael Danieli examines the issues of assessing trauma across cultures from a multigenerational perspective. Drawing on her previous research, Danieli emphasizes the time and process mechanisms in assessing the diverse and complex forms of posttraumatic adaptation. For example, in discussing massive psychic trauma such as the Holocaust, the wars in Bosnia and Rwanda, she argues that "only a multidimensional, multidiscipline integrative framework" can fully understand the effects across families, communities, cultures, and nations themselves. To this end, Danieli revisits the extensive literature as it pertains to the cross-cultural assessment of trauma and PTSD. Further, her analysis includes the importance of resilience and trauma assessment among generations. Moreover, among the most important aspects of assessing traumatic effects is the knowledge of the mechanisms of the transmission of trauma. How does it occur? What are the specific mechanisms and processes? What are the implications of clinical and psychometric assessment? What are its effects on the life-cycle and the next generation? In this regard, she discusses the importance of culture as a transmitter, buffer, and facilitator of healing and recovery from experiences of extreme stress.

In Chap. 5, Richard Dana discusses the increasingly important cross-cultural issues of culture and competence training with special reference to refugee populations. He begins by noting that there are over 20 million displaced persons worldwide. Many of these persons have been victims of torture, trauma, and political persecution. As a consequence they face not only psychological sequela, but also problems associated with resettlement, acculturation, and asylum seeking. By use of two summary tables, Dana lays out a broad range of issues that are central for the assessment of posttraumatic consequences. In the first table, he makes comparisons of ethnic minority mental health practices in Europe and the United States. These identified practices include (1) monitoring/research; (2) specific services; (3) professional training; (4) counseling/psychotherapy; (5) service user involvement; and (6) racial/xenophobia in services. In the second table, an organization is created to identify assessment objectives, domains, and adaptation outcomes. The objectives include psychopathology, holistic health, and acculturation. For each of the objectives there is a corresponding domain of inquiry. For example, for psychopathology, the domain is clinical diagnosis and the *adaptation outcome* is medical model symptom reduction. For holistic health, there are six areas for assessment: core adaptation, posttraumatic growth, strength, resilience, wellbeing, and salutogenesis. Similarly, for the objective of acculturation, there are six areas for assessment: cultural identity, ethnic identity, racial identity, acculturative stress, coping skills, and social support.

By using these two tables as conceptual roadmaps, Dana discusses in detail each component in terms of refugee assessment practices and cultural competency training. He concludes his thoughtful analysis by saying, "there is no consensus within or between host countries on the necessity for culture-specific, research-informed assessment practices . . . culturally competent research and simultaneous development of training resources within relevant professional areas in host societies are of overarching importance for refugees and asylum seekers."

In Chap. 6, Boris Drozdek and John P. Wilson present an overview of the subtle and complex issues of assessing psychological trauma in asylum seekers. Based on the authors' previous research (Wilson & Drozdek, 2004) case histories of clients from Azerbaijan, East Timor, Chechnya, Iran, Sri Lanka, and Bosnia are presented to illustrate the critical issues that face mental health professionals who are trying to holistically understand the clients for whom they have responsibility.

The authors begin by noting that trauma does not occur in a vacuum and neither does the assessment process. Trauma victims in general and asylum seekers in particular, have endured and survived a broad range of traumatic stressors such as war, dislocation, torture, detention, rapes, interrogations, political persecution, etc. Through these experiences they also suffer different types of losses which include their property, houses, jobs, homeland, social status and roles, and in come cases, a loss of self and identity. Thus, the professional conducting the psychological assessment must become familiar with their nature and impact within the phenomenological perspective of the asylum seeker. As the authors note, in many countries in Europe and the Western hemisphere, the individual may only have 48 h to present evidence of being endangered in their country of origin in order to gain official status as an asylum seeker. And, even if granted initial access to the process of seeking asylum, there are many secondary stressors they will endure in the months that lay ahead e.g., seeking financial assistance, housing, and social support. In most cases, there are language barriers and fears of fully disclosing their traumatic events in their native land. Thus, many clients suffer depression, anxiety, and social phobias on top of their posttraumatic sequela associated with traumatic exposure. It is for these reasons that the authors discuss obstacles in communication between a health professional and asylum seekers. Beyond these clearly identifiable communication barriers is the paramount question of how to create a safe treatment environment. Drozdek and Wilson argue that the trauma victim must feel secure and safe in the context of the assessment environment and/or treatment setting. These considerations give rise to the need for understanding explanatory models and cultural relativity. Following a discussion of cultural relativity, the authors raise the question of how to check the accuracy of the trauma history. A set of guidelines is presented with a recognition

that the trauma story unfolds over time and the assessor rarely obtains a complete and full reporting of the traumatic experience, precisely because the event overwhelmed the normal coping resource of the person and requires sufficient time and assistance to process and integrate the extraordinary experiences into the self and personality.

In Chap. 7, Catherine So-kum Tang discusses the assessment of PTSD and psychiatric co-morbidity in contemporary Chinese society. She begins the chapter with an overview of traditional Chinese medicine (TCM), its concepts and practices. The concepts of Yin and Yang, the Wu-Hsing system, Qi and the meridias of the human body are discussed and embedded conceptually with traditional Chinese concepts like yaean, fenshui, and ren. Having created a historical and culture-specific background concerning TCM, Tang next compares the diagnostic manual used in mainland China (CCMD-3) to the DSM-IV and ICD-10. Similarities and differences are highlighted, especially for the category of PTSD. She then proceeds to discuss the recent research in China on PTSD and reviews the questions and assessment procedures that have been employed to study such traumatic events as the SARS virus, the 2004 Tsunami, earthquakes, traffic accidents, and other traumatic events. As Tang notes, 94% of all published research on trauma in English and the five non-Western, non-English publications are not widely known to traumatologists. Her chapter concludes with a highly focused discussion of challenges for a future research and the need to continue to move toward globally standardized measures of psychic trauma, PTSD, and culturally sensitive approaches to diagnosis and assessment.

In Chap. 8, Kathleen Nader presents a comprehensive overview of culture and the assessment of trauma in children and adolescents. She begins with four case histories of children from different cultural backgrounds who experienced traumatic experiences (1) a sibling who witnesses his brother killed in a motor car accident; (2) Liberian soldiers killing villagers; (3) a Native American adolescent whose brother was shot to death; and (4) a school playground shooting of a 7-year-old girl. These case illustrations set the stage for Nader's examination of the many complex factors involved in the cross-cultural psychological assessment of posttraumatic sequela in youths.

Nader first reviews and then discusses the factors associated with the assessment of culturally diverse groups, which include ethnicity, confounding variables, traumatic stressors, the nature of subcultures and their unique qualities. Second, she reviews the literature and national cultures and the special nuances that must be taken into consideration such as differences in emotional expression, reporting practices, parent reporting, self-descriptive interpretations of symptoms and behaviors, culture and personality, gender differences, families and acculturation, risk and resilience factors.

In a systematic way, Nader then lays out the important issues, for the assessment process. This section of the chapter is a step-by-step checklist of critical clinical considerations that are essential when conducting cross-cultural assessments with youths. There is also a presentation about using measures and questionnaires with youths and the problems of translations and back translations of commonly used psychometric instruments. For example, she states, "effective assessment and treatment of youth necessitates cognizance of age as well as culture-related issues and personal qualities. Translating measures or using a translator to question an adult requires understanding the ways in which specific emotional states, behaviors, and other symptoms are described and viewed within the culture." The chapter concludes with a discussion of how assessment procedures have implications for treatment.

In Chap. 9, Charles Marmar and his associates discuss the peritraumatic dissociative experiences questionnaire (PDEQ). To set the proper perspective, it should be noted that during the past two decades, the issues of dissociative reactions in traumatic situations has reached "center stage" in mapping the possible psychiatric sequela in posttraumatic adaptation. Indeed, one would phrase the central question asking simply, "what happens psychobiologically when an individual manifests a peritraumatic dissociative (i.e., concurrent to the event), during a powerful traumatic experience?" In essence, this conceptual question gave birth to the development of the PDEQ and the research that has subsequently emanated from it in many parts of the world and in many diverse cultures.

The authors begin their chapter with a brief but focused background on the PDEQ, noting its birth and refinement on earlier research on Vietnam War veterans in the United States. They review this developmental research and how it culminated in the final version of the instrument and its psychometric properties for the ten-item scale. Once having established its reliability and validity, the authors, collaborators, and fellow researchers began using the scale to study the relationship between self-reported peritraumatic phenomenon and the later development or absence of PTSD. In a condensed historical sense, the research program accelerated rapidly and a plethora of studies began examining scores of the PDEQ and subsequent development of PTSD, thus raising more theoretical questions as to the cognitive/psychobiological processes involved with human response to overwhelming or subjectively perceived threat. Why is it that the tendency to dissociate in the face of perceived threat is empirically and causally associated with PTSD? And is this pattern of relationship the same across cultures?

In the balance of the chapter, the authors review research from Germany, Israel, Japan, Brazil, Turkey, China, and elsewhere. This impressive and growing body of knowledge clearly presents *evidence-based knowledge* of the convergence and coherence of research identification that

peritraumatic phenomenon are beyond cultural boundaries and, perhaps a more universal human form of adaptation and coping with situations of extreme stress.

In Chap. 10, Daniel Weiss presents a comprehensive overview of the Impact of Events Scale (IES-R), one of the most widely used psychometric scales for the assessment of PTSD and PTSD symptoms. This chapter is rich in its complexity and comprehensiveness. Weiss begins his chapter with a review of the history of the scales' development and psychometric properties. As pertains to this book, he notes that the electronic databases reveal 1,147 citations (P.I.L.O.T.S.) and 515 in the psychinfo database of the American Psychological Association. In terms of international use and translation, the Impact of Events Scale – Revised (IES-R) can be found in Chinese, French, German, Japanese, Spanish, Bosnian, Dutch, Italian, Norwegian, Persian, and other languages. Moreover, Weiss illustrates that, as one might expect, it has been used to measure PTSD symptoms for many traumatic stressors, ranging from severe medical illness to war-related problems in many cultures throughout the world.

For these international and cross-cultural studies, there is an analysis of the relevant psychometric statistics regarding reliability, validity, and factor structures of the IES-R scale. In his conclusion, Weiss notes: "The Impact of Events Scale – Revised has generated a number of formal international versions, several informal versions that have appended in the context of a typically oriented peer-reviewed publication, and a number of unpublished international versions. At the level of basic psychometric properties, the published data suggests impressive concordance in terms of internal consistency, test-relevant reliability, and subscale correlations even though the networks used have not employed all aspects of a comprehensive and exhaustive approach that is admittedly challenging and expensive to undertake."

In Chap. 11, Walter Renner, Ingrid Salem, and Klaus Ottomeyer present an impressive quantitative and qualitative study of asylum seekers for three different countries – Chechnya, Afghanistan, and West Africa. The aim of the study was to evaluate cultural differences in PTSD symptomatology using the Impact of Events Scale – Revised (IES-R), the Harvard Trauma Questionnaire, and the Clinicians Administered PTSD Scale (CAPS-1). Additionally, other measures were used to assess psychiatric symptoms beyond PTSD and for their purpose of the Hopkins Symptom Checklist – 25, the Bradford Somatic Inventory and the Social Adaptation Self-Evaluation Scale were employed. Based on item scores but not total scores for the scales, discriminant analyzes correctly classified 92% of the participants. In the qualitative part of the study, clinical protocols were recorded and subjected to classification into five areas (1) factors that prevent or embrace symptoms; (2) factors identified as stressful; (3) symptoms related to PTSD; (4) personal and cultural views of the traumatic events

reported; and (5) other outcomes. The results showed that the Chechnya group had more somatic symptoms and irritability. The West Africa group was distressed over being idle while seeking asylum. The Afghan group expected relief through education and training. They concluded that more studies of an empirical nature are necessary with a framework of culture-sensitive assessment.

In Chap. 12, Roberto Lewis-Fernandez, Alfonso Martinez-Taboas, Vedat Sar, Sapana Patel, and Adeline Boatin examine the cross-cultural assessment of the phenomena of mental dissociation. This comprehensive chapter is noteworthy for its review of the research literature from many parts of the world, extending beyond American and European publications to other cultures in Asia, the Middle East, and elsewhere. The chapter is organized into sections, each of which could stand alone as a condensed review and overview on the multifaceted dimensions for the clinical and scientific understanding of dissociation. These subsections include (1) definitions of dissociation; (2) somatoform dissociation; (3) dissociation and psychosis; (4) trauma and dissociation; (5) normal and pathological dissociation; (6) cross-cultural perspectives and conceptualization of dissociation; (7) assessment methodologies; (8) research with psychiatric populations; (9) community studies of dissociation; (10) case studies; (11) research with academic undergraduate populations; and (12) translations of measures of dissociation. The authors conclude this rich and interesting chapter by noting "that the cross-cultural assessment of dissociation summarized available data on the extent to which global diversity of dissociative phenomena are tapped by existing measures and classifications. To a large degree, the work in Turkey and Puerto Rican communities lends support to the usefulness of standard international assessments in cross-cultural research on dissociation. In nearly every instance, measures developed in one setting still had adequate psychometric properties in another cultural region. At the same time, however, it is clear that in order to fully characterize the dissociative nature of certain forms of pathology, new measures need to be developed."

In Chap. 13, Derek Silove, Zachary Steele, and Adrian Bauman examine a current controversy in the study of war trauma. To state the controversy simply, it is whether or not PTSD or forms of psychopathy are the inevitable outcome of exposure to traumatic events. The other side of the coin is the argument that such sequela is not inevitable and many, if not most victims/survivors, manifest resilience and good long-term adjustment, despite expectable short-term postevent distress.

The authors begin their chapter with a review of the literature regarding the controversy. They note, in this regard that, "this emerging evidence base rather than arriving at premature conclusions on the basis of a priori etic or emic assumptions about the appropriateness of the trauma model in such settings." In this regard, the chapter, by use of a comparative table,

presents 13 sets of propositions and critiques of trauma and PTSD and pragmatic responses to them based on the current, cumulative scientific literature.

Having set the stage about the controversy, the authors next present an illustrative research project on Vietnamese immigrants living in Australia. The chapter details the participants and methodology on a large-scale (N = 1,161) Vietnamese sample and matched Australian controls. The study found many significant findings among which is that "trauma remained the most powerful predictor of mental disorder in the Vietnamese, 11 years after resettlement with exposure to 3+ trauma being associated with an eightfold risk of mental disorder (compared to a fourfold risk in Australians)." After discussing the clinical and applied implications of the research data, the authors conclude that "the data show that trauma and PTSD remain important to the overall mental health of the community 11 years after resettlement in a Western community and that the concentration of trauma-related problems amongst the subgroup with the most severe trauma exposure. For those with lesser exposure, traumatic stress symptoms are moderated by the restorative effects of living in a safe and secure environment."

In Chap. 14, Raphael, Delaney, and Bonner present a clearly conceptualized historical and psychological perspective on the assessment of trauma for Australia's indigenous people, the Aboriginals. This chapter begins with an overview of the cultural and personal losses suffered by the 60,000-year-old aboriginal people, the oldest in the world. As with Danieli's chapter, the authors point out that culture-sensitive assessment must be viewed from a perspective of collective, cumulative traumatization across in time and generations. They note, correctly, that the destruction and decimation of Aboriginal culture involved a large range of traumatic stressors: loss, grief, subjugation, and being social outcasts by the colonial government. The authors quote statistics gathered in recent years that show that rates of mortality and morbidity of nearly every conceivable source and measure that illustrates the levels of cultural loss and forms of psychosocial pathology. Aboriginal people die young and suffer mental health maladies (e.g., depression, alcoholism, suicide, PTSD, domestic violence, etc.) at higher rates than the non-aboriginal cultures. In short, being Aboriginal means being at risk for medical and psychiatric maladies in living.

In terms of assessing traumatic reactions, measures of stressors of daily living show that those with seven or more life-event stressors were 51/2 times more likely to have significant behavioral and mental health problems. However, as with issues of assessment in culturally sensitive ways, there are currently two standardized protocols for the proper assessment of the ways that Aboriginal people process their difficult life-experiences.

In terms of clinical engagement and psychosocial assessments, the authors examine several core issues in work with Aboriginal people which includes (1) culturally appropriate processes, recognizing the limits of ones own belief system and being sensitive to those of others; (2) qualities of the relationship (e.g., trust, context, personal knowledge) to those being assessed and cultural disparities; (3) the diversity of the histories, culture(s), and the context of the evaluation; (4) the necessity for informed collaboration with other professionals; and (5) sensitivity and trust, the creation of empathic attunements with respect for historically significant cultures and background.

As pertains to trauma manifestations among Aboriginal people, the chapter details a broad set of traumatic issues such as trauma and grief, endemic training, maladaptive behavioral patterns, and the need to assess cultural transmissions of trauma constellations. Finally, the authors discuss the interplay between traumatic assessment and clinical approaches to treatment.

In Chap. 15, J. D. Kinzie examines the combined psychosocial and pharmacological treatment of refugees from a cross-cultural perspective. Kinzie brings decades of experience from his work with various refugee populations in Oregon, USA. He begins by noting that the responsible treatment of refugees is complex and difficult. More importantly, he notes that there is relatively little systematic research that has attempted to examine combined psychotherapeutic and pharmacological approaches to the treatment of non-Western populations, who are refugees or, on the other hand, in need of treatment in their country of origin.

Kinzie presents several case histories of patients from the Intercultural Psychiatric Program at Oregon Health and Science University. In this chapter, Kinzie "walks" the reader through the treatment process of the patients, much as a clinical professor of medicine would do in an educational sense with residents in psychiatry. He provides a detailed list of diagnostic, differential diagnostic, and clinical considerations for the proper and successful diagnosis of the patients' problems in relation to the specific traumas they endured prior to asylum seeking as a refugee in the United States. Moreover, he provides accumulated medical and clinical wisdom about the use of medication in conjunction with "customized" psychotherapy approaches adapted for the care of diverse refugee populations. The chapter concludes with a set of seven specific guidelines for combined treatment recommendations.

In Chap. 16, Westermeyer and Her present a fascinating account and history of their professional work with Hmong refugees. They begin their chapter with background information about the Hmong people, known as the "Montash" people in Laos, Vietnam, Thailand, and China, indigenous to the Annamite mountain region of Southeast Asia. After the end of

the Vietnam War, Hmong refugees sought asylum in the US as they aided American military forces during the war.

In presenting a discussion of obstacles to assessment and care, the authors discuss critical issues that include (1) language and the differential semantic meaning of words; (2) interpretation, as there are two major dialects in Hmong language which can post significant problems when using interpreters for psychological assessment and clinical treatment approaches; (3) suspicion and mistrust are features of some Hmong patients, partly due to their abandonment by the US at the end of the Vietnam War. The authors provide several anecdotal illustrations. For example, "when Hmong people die in the United States, is it true that they are cut into pieces and put into tin cans and sold as food?"; (4) belief system differences can impede proper diagnosis and evoke countertransference reactions due to inaccurate understanding of culturally based differences in beliefs; (5) history of traumatic experiences, rooted in the Hmong history with many foreign countries and groups (North Vietnam, Pathet Lao, etc.) are extensive. The authors make an analogy to the experience of Native Americans in terms of genocidal warfare and ethnic cleansing. They point out that the power of these reports may evoke significant distress in the clinical assessor. Further, they note that PTSD is not the only expectable psychological sequela, as other anxiety, depression, and phobic disorders are prevalent.

In the next section of this comprehensive chapter, the authors discuss the need to understand Hmong social organization, i.e., how families and communities are organized and can be mobilized to provide needed social support. As part of this "larger perspective" of Hmong culture is an understanding that opium use was common among the Hmong in their natural culture. However, when they immigrated to the US, suffered from the effects of addiction, the need to find sources of supply, to receive treatment for their withdrawal symptoms, including suffering mood and anxiety disorders, had to be addressed by treatment providers in a culturally sensitive way as not to disgrace their integrity.

The chapter concludes with an examination of childbirth, child rearing, and childhood development as it pertains to how cognitive structures and ideological systems of belief are formed within the Hmong Society. To conclude the chapter, the authors discuss the application of psychotherapies to Hmong patients: behavior modification, interpersonal therapy, and network therapy. Similar to Kinzie's recommendation in Chap. 14, there is also a discussion of the combined use of medication with psychotherapy.

Part I

Theoretical and Conceptual Considerations in the Cross-cultural Assessment of Psychological Trauma

Chapter 1

The Lens of Culture: Theoretical and Conceptual Perspectives in the Assessment of Psychological Trauma and PTSD

John P. Wilson

INTRODUCTION

The relationship between trauma and culture is an important one because traumatic experiences are part of the life cycle, universal in manifestation and occurrence, and typically demand a response from culture in terms of healing, treatment, interventions, counseling, and medical care. To understand the relationship between trauma and culture requires a "big picture" overview of both concepts (Marsella & White, 1989). What are the dimensions of psychological trauma and what are the dimensions of cultural systems as they govern patterns of daily living? How do cultures create social–psychological mechanisms to assist its members who have suffered significant traumatic events?

Empirical research has shown that there are different typologies of traumatic experiences (e.g., natural disasters, warfare, ethnic cleansing, childhood abuse, domestic violence, terrorism, etc.) that contain specific stressors (e.g., physical or psychological injuries) that tax coping resources, challenge personality dynamics (e.g., ego strength, personal identity, self-dimensions), and the capacity for normal developmental growth (Green, 1993; Wilson, 2005; Wilson & Lindy, 1994). Traumatic life events can be simple or complex in nature and result in simple or complex forms of post-traumatic adaptation (Wilson, 1989, 2005). Similarly, cultures can be simple or complex in nature with different roles, social structures, authority systems, and mechanisms for dealing with individual and collective forms of trauma. For example, dealing with an accidental death of one person is

significantly different from coping with the aftermath of the worst tsunami disaster in the history of humankind (2004) that caused massive death of thousands, destruction of the environment and the infrastructure of cultures. In this regard, it is important to understand how cultures utilize different mechanisms to assist those injured by different forms of extreme stress experiences. The injuries generated by trauma include the full spectrum of physical and psychological injuries. In terms of mental health and counseling interventions, this includes a broad range of posttraumatic adaptations that include posttraumatic stress disorder (PTSD), mood disorders (e.g., major depression), anxiety disorders, dissociative phenomena (Spiegel, 1994), and substance use disorders. In terms of mental health care, cultures provide many alternative pathways to healing and integration of extreme stress experiences which can be provided by shamans, medicine men and women, traditional healers, culture-specific rituals, conventional medical practices, and community-based practices that offer forms of social and emotional support for the person suffering the adverse, maladaptive aspects of a trauma (Moodley & West, 2005). But how does culture influence an individual's reaction to trauma? How do they make sense of their experiences in situations of extreme stress? In this regard, Smith, Lin, and Mendoza (1993) state: "Humans in general have an inherent need to make sense out of and explain their experiences. This is especially true when they are experiencing suffering and illness. In the process of this quest for meaning, culturally shaped beliefs play a vital role in determining whether a particular explanation and associated treatment plan will make sense to the patient . . . Numerous studies in medical anthropology have documented that indigenous systems of health beliefs and practices persist and may even flourish in all societies after exposure to modern Western medicine . . . These beliefs and practices exert profound influences in patients' attitudes and behavior . . ." (p. 38).

CASE HISTORY

To illustrate how culture shapes belief systems and influences the perception of traumatic events and their subsequent processing and integration into cognitive structure of meaning and attribution, let us consider the following case example.

In 1985 I attended an intertribal "pow wow" on the Lakota Sioux Indian reservation in South Dakota (Sisseton-Whapeton). The pow wow was a 4-day event for Vietnam War veterans and their families. The event contained Native American ceremonies and rituals to honor the veterans for their military service and sacrifices. These ceremonies included sweat lodge purification (Lakota Warrior "sweat" for healing), the Red Feather induction ceremony, traditional communal singing and dancing, potlatch

sharing of gifts, and ceremonial fires with "talking circles" and communal dinner with the eating of traditional foods.

During this pow wow, I had the opportunity to meet several Lakota Sioux Vietnam combat veterans. Among them was a veteran whom I will refer to as Tommy Roundtree (not his real name). Tommy was a two-tour combat veteran who had been highly decorated for his valor and courage in combat with the 101st Airborne Brigade between 1967 and 1969. Tommy grew up on the Rosebud reservation of the Sioux Nation in South Dakota. He was an athletic, tall, handsome man with black hair and ruddy dark skin. In many respects, he had a "Hollywood" character that resembled the famous actor, Erroll Flynn.

When I met Tommy, he was dressed in traditional tribal clothing and had his face painted. Visibly noticeable were the scars on his chest and back from when he had participated in Sun Dance ceremonies in which the participants were skewered with straps to a pole located in the center of a pow wow arena. The straps are skewered into pectoral and upper back muscles by small bones or sticks. At the climax of the Sun Dance ceremony, which involves dancing and blowing through a small bone, the celebrant, at the critical time, leans back and releases himself from the straps which link him to the pole. The skewers tear the skin and cause bleeding. The Sun Dance ceremony is a physically arduous process and requires stamina, mental concentration and preparation, including a Sweat Lodge purification prior to the actual Sun Dance itself. In traditional ways, it is thought that the ritual aids in the development of spiritual strength. When I observed Tommy's scars, he immediately told me that he had done three Sun Dances during his life, two prior to deployment to Vietnam. I told him that I had read about the ceremony and others that were part of Lakota culture. It was at this point that he said, "You know, John, I would like to talk with you about my Vietnam War experiences, but I am afraid that you will think I am crazy or psychotic if I tell you how I understand what happened to me there and since coming home from the war." I responded that I have great respect for traditional Native American culture, especially Lakotan, and would like to hear his story. He smiled nervously at me as I looked at him straight in the eyes and said, "Well, okay, let's talk."

We found a quiet spot in the pow wow grounds and began to talk. In the background, the pulsating beat of the tom-tom drums could be heard along with the singing of traditional songs. Tommy explained that prior to his deployment to Vietnam, the tribal elders prepared him in various ways for going to war. He was taught to sing his "death song" if fatally wounded. He was instructed as to how to use his native cosmology and natural connection to the earth and its creatures to help him stay alert and knowledgeable about danger and threats. Tommy said, "In Vietnam, I would ask the insects to be my eyes while I slept to look for the enemy;

I asked the trees to signal me if the enemy is creeping towards me." He continued by saying that during active combat with his M-16 automatic rifle, he would sometimes see a blue protective shield surrounding him that deflected enemy bullets away. Tommy said that other times during combat he could hear his grandmother speaking to him, saying not to worry and that he was going to live and be free from injuries or death. He added that his grandmother's voice told him that if he did get shot, to sing his "death song" so that ancestral spirits would be with him to join him and provide care and assistance to the other world (heaven).

Tommy asked me if I thought he was psychotic or delusional. I replied that I did not believe that he was "crazy" or psychotic. However, I asked him how he dealt with his war trauma after coming home from Vietnam. Tommy said, "John, I will show you our way of healing" and arranged for me to participate in a Lakota Sweat Lodge with a sacred pipe carrier of the Sioux Nation. He also arranged for me to observe and participate in several other rituals and ceremonies for healing and well-being. Afterward, he explained to me that his perspective of the Vietnam War was different from that of the white Anglo-American culture that he volunteered for military service to honor agreements his ancestral grandfathers made about fighting for their "land and way of life." He continued by saying that by keeping to the traditional ways, abstaining from alcohol, and working to help others who had adverse residual traumatic war injuries, he could live with harmony and balance in all his affairs in life. This he explained, was the Lakota way, the great circle of life.

THE MYTHOLOGY OF THE HERO, TRAUMATIC ENCOUNTERS, AND PERSONAL TRANSFORMATION

The mythologist Campbell (1949, 1991) researched the universality of myths in many of the world's literature, including the myth of "the Hero" who journeyed into "zones of danger" only to emerge transformed in mind, body, and spirit. Figure 1 presents an illustration of this important myth which includes personal encounters of trauma, disaster, and war. In brief the core elements of the Hero and trauma survivor's journey include:

- A life journey that can begin at any point in life-cycle development
- The encounter with trauma, loss, bereavement, and disaster
- The entry and exit from a zone of danger with powerful or supernatural forces
- The four tests of the human spirit
- Trauma and the great cycle of living and dying
- The return of the Hero and the task of transformation upon re-entry

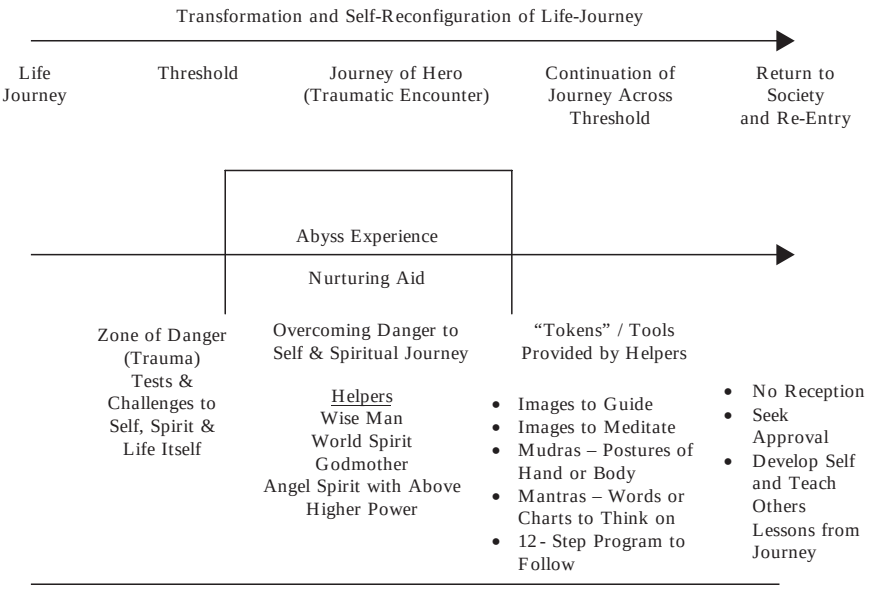

Figure 1. Mythology and the journey of the Hero: the Abyss Experience and transformation of psychic trauma (Source: © Wilson, 2005)

As discussed by Campbell (1991), the mythology of the Hero concerns the travails of ordinary people through extraordinary experiences. In some cases, the myths characterize the life journey, beginning with youthful innocence and naiveté and the eventual encounter with powerful forces of seemingly insurmountable proportions. There are many variations on the themes of this myth and how the individual is transformed by the nature of his or her experience. For example, young men become war-hardened combat veterans; the apprentice shaman enters the "underworld" of spiritual entities; the knight of the king's realm challenges dragon beasts and the search for sacred, lost objects that have secret powers. The mythological journey of the Hero is also the journey and psychological sequela of the trauma survivor. They both encounter dark, sinister, life-threatening forces and then cross a threshold to re-enter normal life and society. The power of life-threatening dark forces constitutes the nature of the Abyss Experience (Wilson, 2005). During the Abyss Experience, the individual confronts the specter of death, extreme threats, and overwhelming immersion into traumatic stressors. Upon re-entry into society after the Abyss Experience, the survivor faces the task of transformation and the psychic metabolism of these experiences. As part of this process, the mythical Hero is assisted by "helper guides" who take the form of wise old men, a spirit guide, a deceased elder relative, an

angelic person or another person who has had a similar experience (e.g., a recovering addict, war veteran, etc.).

After the Abyss Experience, the trauma survivor (Hero) faces the arduous and painful task of re-entry where he or she is met with additional stressors and psychic burdens. Contrary to expectation, the hero or survivor does not receive a warm welcome from those left behind. Campbell (1991) notes that there are three prototypical patterns: (1) no reception; (2) the search for approval, validation, and confirmation of one's journey, travails, and suffering; and (3) the need to share his or her story of survival and teach others in generative ways (Campbell, 1991).

Upon re-entry into the culture of origin, the trauma survivor, like mythical Hero, encounters some or all of the following reactions to his or her journey and life-transforming experiences:

- The absence of recognition of the true nature of suffering, sacrifice, and survival
- The absence of recognition of the perils endured
- The absence of appreciation for personal injuries and changes
- The absence of treatments, health care, or opportunities to engage in traditional healing rituals
- The emergent realization that meaning must be created out of the traumatic experience

According to Campbell (1991), mythology suggests that the heroic survivor seeks to find pathways to healing. Thus, we can identify six consequences of healing pathways within the diversity of culture: (1) restore harmony in mind, body, and spirit; (2) restore vital physical and mental energy; (3) promote well-being through mindfulness and psychic integration; (4) empower personal energy for life-course development; (5) access and utilize treatments available in the culture; and (6) develop healing practices that promote resilience.

TRAUMA, CULTURE, AND POSTTRAUMATIC SYNDROMES: THE CORE QUESTIONS

The concept of traumatic stress and the multidimensional nature of cultures requires a conceptual framework by which to address core issues that have direct relevance to understanding the nature of trauma as embedded within a culture and its assumptive systems of belief and patterns of behavioral regulation. Marsella (2005) has noted that healing subcultures have at least five distinct elements: "(1) a set of assumptions about the nature and causes of problems specific to their world view and construction of reality; (2) a set of assumptions about the context, settings, and requirements for healing to occur; (3) a set of assumptions and

procedures to elicit particular expectations, emotions, and behaviors; (4) a set of requirements for activity and participation levels and/or roles for patient, family, and therapist; and (5) specific requirements for therapist training and skills expertise criteria" (p. 3). These sets of assumptions are useful as they define a necessary conceptual matrix for examining how different cultures handle psychopathology, behavioral disorders, and complex posttraumatic syndromes. To be clear, I am not using the term posttraumatic syndrome as synonymous with PTSD, although it certainly includes the narrow, diagnostic definition of the disorder. Rather, posttraumatic syndromes involve a broad array of phenomena that include Trauma Complexes, Trauma Archetypes, posttraumatic self-disorders (Parsons, 1988), posttraumatic alterations in core personality processes (e.g., five-factor model), identity alterations (e.g., identity confusion), and alterations in systems of morality, beliefs, attitudes, ideology, and values (Wilson, 2005). The experience of psychological trauma can have differential effects to personality, self and developmental processes, including the epigenesis of identity within culturally shaped parameters (Wilson). Given the capacity of traumatic events to impact adaptive functioning, including the inner and outer worlds of psychic activity (Wilson, 2004a), it is critically important to look beyond simple diagnostic criteria such as PTSD (Summerfield, 1999) to identify both pathogenic and salutogenic outcomes as individuals cope with the effects of trauma in their lives. As I have argued elsewhere (Wilson, 2005), the history of scientific research on PTSD is badly skewed (perhaps for reasons of historical necessity) toward the study of psychopathology rather than on human growth, self-transformation, resilience, and optimal functioning.

When we address the question of how individual cultures deal with psychological trauma in its diverse forms, it is useful to examine commonalities and differences among approaches to counseling, healing, psychotherapies, treatments, and traditional practices. If traumatic stress is universal in its psychobiological effects (Friedman, 2000; Wilson, Friedman, & Lindy, 2001), are therapeutic interventions, in turn, designed in culture-specific ways to ameliorate the maladaptive consequences of dysregulated systems of affect, cognition, and coping efforts (Marsella, Friedman, Gerrity, & Scurfield, 1996; Wilson, 2005; Wilson & Drozdek, 2004)? If so, what are the differences in therapeutic approaches to dealing with trauma? To answer this question further examination of the core questions pertaining to culture and the patterns of posttraumatic adaptation is required.

Table 1 presents 21 core questions concerning the relation of culture to traumatic life experiences. These core issues serve to frame the later discussion about the commonalities and differences in culture-specific and transcultural approaches to counseling and mental health care.

Table 1. Core Questions for Understanding Culture, Trauma, and Posttraumatic Syndromes

1. Is the experience of psychobiological trauma the same in all cultures?
2. Are the emotional reactions to trauma the same in all cultures?
3. Is the psychobiology of trauma the same in all cultures?
4. Does culture act as a filter for psychic trauma? If so, how do internalized beliefs, culturally shaped patterns of coping and adaptation govern the posttraumatic processing of traumatic experiences?
5. Are traumatic experiences universal in nature across cultures? Are traumatic experiences archetypal for the specter?
6. If trauma is archetypal for humankind, what are the universal characteristics across all cultures?
7. Does culture determine how individuals respond to archetypal forms of trauma? Are posttraumatic syndromes and Trauma Complexes culture specific in nature?
8. Are there cultural-based syndromes (not necessarily PTSD) of posttraumatic adaptation? If yes, what do they look like? What is their psychological status?
9. How do cultures develop rituals, medical–psychological treatments, religious practices, and other institutionalized mechanisms to assist persons who experience psychic trauma?
10. Are there culture-specific and universal mechanisms to help persons recover from trauma?
11. What does cultural mythology tell us about the experience of trauma?
12. What are the great myths in cultural literature that concern individual and collective trauma?
13. What are the psychological and cultural functions of mythology? How do they relate to the cross-cultural understanding of trauma?
14. What is the Abyss Experience in mythology and how does it relate to the psychological study of trauma?
15. What does mythology tell us about culture-specific rituals of psychic trauma?
16. How do forms of traumatic experiences relate to the universal myth of the Hero as protagonist?
17. How does modern psychology standardize the assessment and treatment of trauma across cultural boundaries?
18. Do pharmacological treatments of posttraumatic syndromes work equally well in all cultures?
19. Is the unconscious manifestation of posttraumatic states the same in all cultures?
20. What are the mythological images of the life cycle and the transformation of consciousness by trauma?
21. What cultural belief systems underlie cultural approaches to healing and recovery from trauma?

Source: Wilson, 2005.

1. *Is the experience of psychological trauma the same in all cultures?* This question addresses the issues of how cultural belief systems influence the perception and processing of trauma. For example, Kinsie (1988, 1993) noted that among Cambodian refugees who had suffered multiple life-threatening trauma during the Khmer Rouge regime, many who suffered from PTSD and depression understood their symptoms in the light of their Buddhist beliefs in karma as a station in life, an incarnate level of being and fate. Hence, Western psychiatric views of suffering and depression may not exist within a Buddhist ideology per se. Personal suffering may be seen from a religious–cosmological perspective of the meaning of life. If a culture does not have linguistic connotations of a pathogenic nature (e.g., PTSD), how then does the person construe acute or prolonged effects of extreme stress experiences? In a discussion of depression and Buddhism in Sri Lanka, Obeyesekere (1985) stated: "How is the Western diagnostic term depression expressed in society whose predominant ideology of Buddhism states that life is suffering and sorrow, that the cause of sorrow is attachment or desire or craving, that there is a way (generally through meditation) of understanding and overcoming suffering and achieving the final goal of cessation from suffering or nirvana?" (p. 134). Hence, sorrow, suffering, depressive symptoms, traumatic memories, disruptions in sleep patterns, and other trauma-related symptoms will likely be construed in a similar manner, especially since depression is a component of PTSD (Breslau, 1999).
2. *Are the emotional reactions to psychological trauma the same in all cultures?* Scientific evidence, especially neurobiological studies, has documented that affect dysregulation, right hemisphere alterations in brain functioning, and strong kindling phenomena are universal in PTSD (Friedman, 2000; Schore, 2003). If there is a common set of psychobiological changes associated with either PTSD or prolonged stress reactions, is the emotional experience universal in nature (e.g., hyperarousal, startle, anger, irritability, depressive reactions) or do cultural belief systems "override" or attenuate the magnitude or severity and intensity of dysregulated emotional states?
3. *Is the psychobiology of trauma the same in all cultures?* This question is similar to the one above. If extreme stress impacts the human organism in the same manner irrespective of culture, does the organism react in exactly the same way? Or, do cultural belief systems act as perceptual filters to the cognitive appraisal and interpretation of traumatic stressors? For example, in the 1988 Yunnan earthquake in a rural, peasant area of China, over 400,000 people

were impacted by the event which had not been previously experienced by most inhabitants. However, among the common explanations for the earthquake was that a great dragon was moving beneath the earth because he was angry with the people (McFarlane & Hua, 1993). Does such a mythical attribution influence the subsequent psychobiological responses to the disaster once it terminates? What if the dragon returns to his "rest" and "sleep"?

4. *Does culture (i.e., cognitive–affective belief systems) act as a filter for psychic trauma? If so, how do internalized belief system, culturally shaped patterns coping and adaptation govern the posttraumatic processing of traumatic experiences?* This question goes to the heart of the culture–trauma relationship. First, how does a culture define trauma? Is a trauma in one culture (e.g., natural disaster, incestuous relations, traffic deaths, political oppression, motor vehicle accidents, murder, etc.) necessarily viewed as a trauma in another culture? Second, what sets of expectations for resiliency in coping does the culture possess? For example, after the July 2005 terrorist bombings to transit systems in London, the general media and political leaders noted that the British people immediately returned to work the next day, rode the buses and subways, and manifest high levels of resilience. The Prime Minister, Tony Blair, made reference to how British resolve was evident during the bombing raids in WWII and that in 2005 such resilient resolve was once again transparent. Is this a cultural norm or expectation? How do cultural beliefs and values influence the postevent processing and cognitive interpretation of the traumatic stressor itself?
5. *Are traumatic experiences universal in nature across cultures? Are traumatic experiences archetypal for the species?* Research on PTSD has identified categories and typologies of traumatic life events and the specific stressors they contain (Green, 1993; Wilson & Lindy, 1994). While there is agreement on the nature and types of traumatic events, a more fundamental question is whether or not they are archetypal in nature. Elsewhere, I have discussed the unique nature of Trauma Archetypes and Trauma Complexes (Wilson, 2004a, 2005) and suggested that the experience of trauma is both universal and archetypal for the human species. However, culture shapes the way that individuals form Trauma Complexes after a traumatic experience and, once formed, articulate with other psychic complexities.
6. *If trauma is archetypal for humankind, what are the universal characteristics across all cultures?* This question is a corollary to the one above. Given that traumatic experiences are archetypal for the species what are the defining characteristics of the Trauma

Archetype? I have delineated 12 dimensions (see Table 3) of the Trauma Archetype and how they influence posttraumatic personality dynamics and adaptive behavior (Wilson, 2005).

7. *Does culture determine (i.e., shape, influence, design) how individuals respond to archetypal forms of trauma? Are posttraumatic syndromes and Trauma Complexes culture specific in nature?* Culture serves as a powerful socializing force, creating and shaping beliefs and regulating patterns of behavior and adaptation. For example, among many Native American people a "good world" is one defined by harmony and balance in "all things" and "all relations" in the environment and amongst people (Mails, 1991). Illness is thought to result from imbalance, loss of harmony, and being dispirited within oneself due to a loss of vital connectedness. Among some aboriginal native people, trauma is simply defined as that which causes one to lose balance in living with positive relations with nature and the human-made world. Moreover, within this cosmology, it was well known that certain events, such as warfare, could cause profoundly altered states of well being (i.e., dispiritedness) and necessitated healing rituals for the restoration of wholeness (Wilson, 1989, 2005).
8. *Are there cultural-based syndromes (cf. not necessarily PTSD) of posttraumatic adaptation? If yes, what do they look like? What is their psychological structure?* This core issue is among the most fascinating to consider and interesting to conceptualize since there may be unique ways that posttraumatic adaptations occur within a culture or subculture (e.g., trance states, dissociative phenomena, somatic illnesses, mythical attributions, etc.). How does culture provide awareness for posttraumatic syndromes to exist and be expressed? Are these forms of adaptation pathogenic or salutogenic in nature (Marsella, 1982)? What are the implications of culture-specific posttraumatic adaptations for culture-specific interventions?
9. *How do cultures develop rituals, medical–psychological treatments, religious practices, and other forms of institutionalized mechanisms to assist persons who experience psychological trauma?* This question attempts to identify the specific ways that cultures evolve and develop institutionalized and noninstitutionalized mechanisms and treatments for victims of trauma. This question is of significant research interest as it defines the areas in which commonalities overlap and in which culture-specific differences exist. As I will discuss later, it is my belief that each person's posttraumatic syndrome is a variation on a culturally sanctioned modality of adaptation which can then be "treated" by either generic or culturally specific practices.

10. *Are there culture-specific and universal mechanisms to help persons recover from psychological trauma?* How have cultures evolved specific rituals, treatments, or ceremonies to facilitate recovery from psychic trauma? For example, most Native American nations use the Sweat Lodge Purification Ceremony to "treat" states of dispiritedness, mental illness, alcohol abuse, depression as well as to instill spiritual strength (Wilson, 1989). The Sweat Lodge purification ritual has a unique structure and process and is embedded within the traditional cosmology of a tribe (e.g., Lakota Sioux). Under the guidance of a trained and experienced medicine person, the Sweat Lodge is used to restore "balance" through purification, sweating, and emotional catharsis (Mails, 1991; Wilson, 1989). This is just one example of many that exist among and between cultures to facilitate "stress reduction" and to alleviate suffering, including prolonged stress reactions after traumatic life events.
11. *What does cultural mythology tell us about the experience of trauma?* The discovery of how cultures deal with trauma can be found in the great mythologies of the world (Campbell, 1949, 1992). Mythology contains themes which converge across cultures, literary forms (e.g., epochs), and style. While it is the case that modern science, especially in the study of PTSD, has generated an impressive body of knowledge, it lacks carefully crafted cross-cultural studies of trauma, healing, and human adaptation (Wilson, 2005). However, from the pre-Greeks to the middle ages to our present time, the great mythologies of the world have chronicled the trials and tribulations of simple, ordinary, "heroic" figures and their individual journey which present profound challenges to life, spirit, body, and human integrity. Joseph Campbell's (1949) study of mythology has identified universal themes of the heroic figure whose journey of self-transformation in the life cycle is also about the universal stories of the trauma survivors. Analysis of the great mythologies is a rich source of inquiry as to the interplay between culture, traumatic events, and their transformation by facing challenges to existence itself.
12. *What are the great myths in cultural literature that concern individuals and collective trauma?* There are many great mythologies in cultures throughout the world (Campbell, 1991). The Great Mythologies are themes and stories about the human condition: adversity, jealousy, confrontation with powerful "zones of danger," the prospect of death, the process of individual transformation by confrontation with unconscious and external forces, and the difficult task of reentry into society after an adverse journey into the abyss of trauma (Wilson, 2005). Analysis of these myths thus illuminates the archetypal nature of trauma and the challenges it sets up for human development, healing, and the maintenance of personal integrity.

13. *What are the psychological and cultural functions of mythology? How do they relate to the cross-cultural understanding of trauma?* In his book, *Pathways to Bliss* (1992), Joseph Campbell outlines the four functions of mythology as (a) spiritual–mystical; (b) cosmological; (c) sociological; and (d) psychological. Each of these functions is revealed within mythology and has direct parallels to the nature of psychological requirements in dealing with the impact of trauma to self and psychological functioning. For example, trauma and traumatic life experiences form a reconciliation with unconsciousness and the meaning of life. This issue concerns directly the mythology of one's own life and the role trauma has played in it. For example, novels and autobiographies of war trauma of former combat soldiers typically characterize the horrific encounter with death, the existential questioning of the purpose of war and how such experiences subsequently shape life-course trajectory (Caputo, 1980). Traumatic experiences often force a self-effacing look at personal identity and consciousness. Trauma serves to put the individual in touch with their unconscious processes, including the disavowed, dark or "shadowy" side of personality. By carefully analyzing the functions of mythology within a culture we can identify how it is that culture shapes posttraumatic adaptation, growth, and the challenges of self-transformation.
14. *What is the abyss experience in mythology and how does it relate to the psychological study of trauma?* The Abyss Experience is a term I have coined to describe the "black hole" of psychological trauma – a vast chasm of dark, empty space in which terror and fear of annihilation exist (Wilson, 2004a, 2005). There are five dimensions of the Abyss Experience which include: (1) the confrontation with evil and death; (2) the experience of soul death with nonbeing; (3) a sense of abandonment by humanity; (4) ultimate loneliness and despair; and (5) cosmic challenge of meaning. For each of these five dimensions there are corresponding posttraumatic phenomena: (i) the trauma experience; (ii) self/identity; (iii) loss of connection; (iv) separation and isolation; and (v) spirituality and numinous sense. In the mythology of culture, these themes and aspects of the Abyss Experiences are always present and yet played out within the unique tapestry of a particular culture.
15. *What does mythology tell us about culture-specific rituals for psychological trauma?* The awareness of the Abyss Experience and the zones of danger through which the mythical hero figure traverses suggest that upon return to society from the zone of danger (i.e., trauma) the individual crosses a threshold of re-entry that often includes being ignored or rejected because of the overwhelming and often horrifying nature of his experience. Mythology suggests

that there may exist a "guide" or nurturant person, who helps a "cast light" as to the meaning of the traumatic experience and clues as to how to recover and integrate the experience without prolonged suffering or maladaptive avoidance behaviors (e.g., excessive drinking, alienation, anomie, emotional detachment, and numbing). It can be seen that culture has to have built-in wisdom as to the pathways to healing and the literature of mythology describes the nature and character of these life pathways.

16. *How do forms of traumatic experiences relate to the universal myth of the hero as protagonist?* The mythical hero traverses a journey and encounters powerful forces (e.g., trauma) which challenge mind, spirit, body, and sense of personhood. The travails of the protagonist are universal images of how psychic trauma creates hurdles in the process of living and finding meaning in life.
17. *What are the mythological images of the life cycle and the transformation of consciousness by trauma?* In mythology, the challenges of trauma can occur anywhere in the life span, from infancy to old age. However, no matter where trauma occurs in epigenetic development, it can influence the configuration of ego identity and transform personal consciousness about oneself, others, the meaning of death and the task of self-transformation. Elsewhere, I have described in detail the process of traumatogenic experiences with an ontogenetic framework of self-metamorphosis (Wilson, 2005). Understanding mythological and epigenetic frameworks of how trauma alters the trajectory of the life cycle has important implications for counseling and psychotherapy.
18. *How does modern psychology standardize the assessment and treatment of trauma across cultural boundaries?* This is a core issue in terms of the "globalization" of knowledge about the relation of trauma to culture. At present, we have no standardized ethic (universal) measurements of trauma and PTSD (Dana, 2005). Similarly, we do not have standardized cross-cultural treatment protocols for persons suffering from posttraumatic syndromes. There exist empirical and clinical voids in the knowledge base as to what "treatments" work best for what kinds of person and under what set of circumstances.
19. *Do pharmacological treatments of posttraumatic syndromes work equally well in all cultures?* This question is intriguing because it posts the controversy as to whether or not the psychobiology of trauma is the same across cultures and therefore treatable by pharmacological agents designed to stabilize the dysregulation in neurobiological functioning caused by extreme stress experiences. However, to date, there are a few comparative randomized clinical trials (RCT) of medications to treat PTSD in culturally diverse populations (Friedman, 2001). Yet, studies have shown that some antidepressant

medications are more efficacious in symptom reduction than others for non-Western populations with severe PTSD (Kinsie, 1988; Lin, Poland, Anderson, & Lesser, 1996).

20. *Is the unconscious manifestation of posttraumatic states the same across cultural boundaries?* This core question is complex and fascinating because it demands a method to assess unconscious processes cross-culturally (Dana, 1999) and to discern if unconscious memory encodes traumatic experiences in similar ways, perhaps in Trauma Complexes that are, in turn, shaped by cultural factors (Wilson, 2005).
21. *What conceptual belief systems underlie cultural approaches to healing and recovery from trauma?* In many respects, this issue deals with the most "pure" consideration of the trauma–culture relationship. How does the culture view "trauma" and employ methods to facilitate healthy forms of posttraumatic adaptation? What set of assumptive beliefs does the culture "bring" to the understanding of trauma? Within a culture, is trauma idiosyncratic or synergistic in nature? Are there differences between individual and cultural trauma? What does damage to the structure of a culture mean in terms of posttraumatic interventions? For example, Erikson (1950) noted that among the Lakota Sioux Indians in the United States, the loss of their nomadic mystical culture oriented around the Buffalo meant a loss of historical continuity and collective identity which was profoundly traumatic once the Lakota were interned on federal reservation lands that deprived them of their cherished patterns of living (Wilson, 2005).

CULTURE AND TREATMENT FOR POSTTRAUMATIC SYNDROMES

The ubiquity of traumatic events throughout the world has raised global awareness of PTSD as an important psychological condition that results from a broad range of traumatic experiences (e.g., war, ethnic cleansings, terrorism, tsunamis, catastrophic earthquakes, etc.). Economic globalization has "flattened the world" (Friedman, 2005) as technologies have changed the face of commerce and international marketplace. In a real sense, globalization has generated trends toward the homogenization of cultures and at the same time heightened awareness of distinct cultural differences. However, when it comes to the issue of cultural differences and posttraumatic syndromes (e.g., PTSD) it cannot automatically be assumed that advances in Western psychotherapeutic techniques can be exported and applied to non-Western cultures (Summerfield, 1999). Further, the literature on cultural competence has brought awareness of

Table 2. Cultural Convergence: Similar Principles?

Principle/Assumption	Native American	African (Zulu)	Indian (Ayurveda)	Chinese (TCM)
1. Harmony in relations (earth, people, society)	Yes	Yes	Yes	Yes
2. Vulnerability within person	Yes	Yes	Yes	Yes
3. Balance of biological and mental forms	Yes	Yes	Yes	Yes
4. Illness is imbalance, loss of harmony	Yes	Yes	Yes	Yes
5. Health is restoration of balance, harmony	Yes	Yes	Yes	Yes
6. Healing empowers vital energy	Yes	Yes	Yes	Yes

Source: Wilson, 2005.

the need for knowledge, sensitivity, and innovation when it comes to mental health treatment in non-Western cultures (White & Marsella, 1989). More recently, Moodley and West (2005) discussed the limitations of verbal therapies and presented a rationale for the integration of traditional healing practices into counseling and psychotherapy. While a discussion of the types of traditional healing practices (e.g., shamanism, medicine healing in aboriginal nations) is beyond the scope of this article, it is worthwhile to point out that there are culture-specific healing practices as well as overlaps in conceptual viewpoints about the assumptions that underlie traditional healing practices across different cultural groups. Let us consider for a moment four very different cultural views of healing: Native American; African (Zulu); Indian (Ayurveda), and traditional Chinese medicine (TCM) (Table 2). What do these Western, African, and Asian cultures assume about traditional healing and the cosmological (cf. one could also say mythological) assumptions they hold about physical and mental health?

Native American

In most North American aboriginal nations, healing is considered from the perspective of relations – balanced relations – between individuals and environment and the world at large (Mails, 1991). When sickness occurs it is generally assumed that there is an imbalance in the nature of "relations to all things" – that a loss of balance and harmony has occurred within the person and illness follows. Healing, then, is the empowerment

of the individual spirit with the great circle of life to restore balance and harmony with nature, others, and the Great Spirit (God). The medicine wheel and traditional shamanic (i.e., medicine) practices are used as a guide to understanding. Through traditional healing practices, rituals and ceremonies, the designated "medicine" person facilitates the restoration of a person's spirit and inner strength in order to restore their vital power to be in good balance, i.e., to have good relations of balance and harmony. More specifically, trauma can cause a loss of centeredness in the person and lead to a loss of "spirit," resulting in various forms of "dispiritedness," which includes depression, PTSD, dissociation, and altered maladaptive states of consciousness and being (Jilek, 1982; Mails, 1991; Poonwassie & Charter, 2005; Wilson, 1989).

South African (Zulu)

The Zulu culture in South Africa employs a view of mental and spiritual life that is intricately interconnected. Bojuwoye (2005) states: "The interconnectedness of phenomenal world and spirituality are two major aspects of traditional African world views. The world view holds that the universe is not a void but filled with different elements that are held together in unity, harmony, and the totality of life forces, which maintain firm balance, or equilibrium, between them. A traditional Zulu cosmology is an individual universe in which plants, animals, humans, ancestors, the earth, sky and universe exist in unifying states of balance between order and disorder, harmony and chaos" (p. 63). In Zulu culture, then, traditional healing practices have respect for this view and attempt to facilitate the restoration of a harmonious state of being in relation to these dimensions of the person's phenomenal world.

Indian (Ayurveda)

Indian healing, in the Ayurvedic tradition, views restorative practices as unifying mind, body, and spirit within the context of social conditions. Kumar, Bhurga, and Singh (2005) state: "According to Ayurvedal principles, perfect health can be achieved only when body, mind and soul are in harmony with each other and with cosmic surroundings. The second dimension in this holistic view of Ayurveda is the social level, where the system describes the ways and means of establishing harmony within and in the society. Mental equilibrium is sought by bringing in harmony three qualities of the mind in sattva, vajas and tamas" (p. 115). Thus, traditional Indian healers use time-honored practices (e.g., touching, laying of hands) to facilitate helping a person restore unity in the psyche. After the 2004 tsunami, such practices were used with success by local healers to aid victims who suffer from the stress-related effects of the disaster in India (Siddarth, in press).

Traditional Chinese Medicine

In traditional Chinese medicine, "mental illnesses are said to result from an imbalance of yin and yang forces, a stagnation of the qi and blood in various organs, or both" (So, 2005, p. 101). He further elaborates that "the driving forces behind this relationship are the entities of qi (virtual energy) and li (order). The oft-cited concepts of yin and yang, oppositional yet complementary in nature, are characteristics along the meridian channels of that compound to the specific organ of the body" (p. 101). Thus, TCM views health and illness as related to a balance of vital forces and that disruptions which effect their critical balance can result in physical or mental illnesses.

CULTURAL CONVERGENCE IN TRADITIONAL HEALING

Table 2 compares the different cultural approaches to healing across five basic dimensions that represent assumptions about the nature of illness and health: (1) harmony in relations (e.g., with earth, others, nature, society; (2) personal vulnerability within the person due to imbalance caused by external forces or inner conflict; (3) the importance of balance in biological and mental processes; (4) illness results from imbalance and loss of harmony; and (5) health is the restoration of balance and harmony in mind, body, and spirit. Thus, healing empowers vital energies contained within the person. By comparing different traditional cultural views and assumptions that underlie we can go further and ask how it is that culture deals with those who are severely traumatized by events of human design or acts of nature.

THE TREATMENT OF TRAUMATIC STRESS SYNDROMES IN CULTURAL CONTEXTS

In an influential and important critique of mental health programs in war-affected areas (e.g., Bosnia, Rwanda, etc.), Summerfield (1999) explicated seven fundamental assumptions that many of these programs embrace as justifications for interventions with programs derived from clinical efforts and research on psychotherapy in Western cultures, primarily the United States and Western Europe. These seven assumptions are as follows: "(1) experience of war and atrocity are so extreme and distinctive that they do not just cause suffering, they 'cause' traumatization; (2) there is basically a universal human response to highly stressful events, captured by Western psychological framework [cf. PTSD]; (3) large numbers of

victims traumatized by war need professional help; (4) Western psychological approaches relevant to violent conflict worldwide victims do better if they emotionally ventilate and 'work through' their experiences; (5) there are vulnerable groups and individuals who react to a specific target for psychological help; (6) wars represent a mental health emergency: rapid intervention can prevent the development of serious mental problems, as well as subsequent violence and wars; and (7) local workers are overwhelmed and may themselves be traumatized" (pp. 1452–1457). This same set of assumptions could safely be generalized to non-war zone countries in which there are catastrophic natural disasters (e.g., tsunami, earthquake) or other conditions of human rights violations by political regimes: "the humanitarian field should go where the concerns of survivor groups direct them, towards their devastated communities and ways of life, and urgent questions about rights and justice" (p. 1461). Moreover he notes that "the medicalization of distress, a significant trend within Western culture and non-globalizing, entails a mined identification between the individual and the social world, and a tendency to transform the social into the biological . . . consultants . . . have portrayed war as a mental health emergency writ large, with claims that there was an epidemic of `posttraumatic stress' to be treated, and also that early intervention could prevent mental disorders, alcoholism, criminal and domestic violence, and new wars in subsequent generations by nipping brutalization in the bud" (p. 1461). This conclusion by Summerfield raises a number of critical questions when it comes to the proper and efficacious treatment of posttraumatic syndromes in simple and complex cultures in the world.

POSTTRAUMATIC INTERVENTIONS: WHAT WORKS BEST FOR WHOM UNDER WHAT CONDITIONS?

To focus the central issues rather sharply, what types of counseling, interventions, treatments, practices, rituals, medicines, ceremonies, and therapies work best for whom and under what set of conditions? This seemingly simple and straightforward question turns out to be extraordinarily complex and multifaceted for several key reasons. First, we do not have sufficient scientific studies across cultures to begin to answer this question. Second, cultural competence has shown the need to explore assessment, diagnosis, and treatment within a sensitive cultural framework that reflects knowledge and understanding of a culture. Indeed, the World Health Organization (WHO) published a global plan for culturally competent practices that included mandates to insure the availability of traditional and alternative medical practices in safe and therapeutically useful ways (World Health Organization, 2002). Third, it cannot be

assumed that well-documented Western psychotherapies for PTSD, for example, are necessarily useful in non-Western cultures, especially therapies that rely heavily on verbal self-reports (e.g., CBT, psychodynamic). Fourth, there are a broad range of individual responses to traumatic events. It cannot be assumed "a priori" that PTSD is an inevitable outcome of exposure to extremely stressful life events. It is entirely possible that the concept of PTSD (cf. Western in conceptualization) is foreign and not readily understood in many cultures that do not utilize psychobiological explanations of illness or human behavior. Fifth, to understand "maladaptive" behavior consequences of trauma (and therefore traumatization) can only be meaningfully defined by cultural norms and expectations about "normal" and "abnormal" behavior. Human grief reactions are universal to death and loss but that does not make them pathological (Raphael, Woodling, & Martinale, 2004). Acute adjustment reactions for a short period of time are entirely expectable after the 2004 tsunami that destroyed towns, cities, even cultures and more than 250,000 people. But that does not make adaptational requirements pathological or PTSD symptoms an illness per se for the survivors. Sixth, it can be justifiably assumed that throughout centuries of human evolution, adaptive mechanisms, that wisdom exists in culture to deal with the human effects of extreme trauma. As noted earlier, the great mythologies of the world chronicle such events and the adaptational dilemmas they present for survivors. Such mythical themes point to the necessity of framing culture-sensitive perspectives on human resilience versus psychopathology (Wilson, 2005). These considerations allow us to now explore ten hypotheses about the relation of trauma to culture to posttraumatic adaptations and how mental health "treatments" can be construed in culturally competent ways.

TEN HYPOTHESES CONCERNING TRAUMA, CULTURE, AND POSTTRAUMATIC MENTAL HEALTH INTERVENTIONS

1. Each person's posttraumatic syndrome, state of psychological distress, or adaptational pattern is a variation on *culturally sanctioned* modalities of behavioral–emotional expression.
2. Healing and recovery from psychic trauma is *person specific*. There are multiple pathways and forms of treatment within a culture.
3. Each culture develops specific forms and mechanisms for posttraumatic recovery, stabilization, and healing (e.g., rituals, counseling practices, treatment protocols, medications, etc.). At any given time, cultures may not have available certain types of treatments that would be beneficial to people. These will either evolve in time or be adapted from other cultures.

4. Based on Trauma Archetypes, cultures contain the wisdom to develop mechanisms to facilitate the processing and integration of psychic trauma. Empathy, as a universal psychobiological capacity, underlies the development and evolution of culture-specific forms of healing (Wilson & Drozdek, 2004; Wilson & Thomas, 2004).
5. The concept of "mindfulness" in states of consciousness (traditionally associated with Buddhism) is a key mental process to self-transcendence and the integration of extreme psychic trauma into higher states of consciousness and personal knowledge. Mindfulness, in this regard, is personal awareness of the impact of trauma to living in one's culture of origin and how trauma has impacted the quality of life.
6. There is no individual experience of psychological trauma without a cultural history, grounding or background. Similarly, there is no individual sense of personal identity without a cultural reference point. Anomie and alienation are commonly produced by severely traumatizing experiences and are associated with forms of anxiety, distress, and depression (Wilson & Drozdek, 2004).
7. The rapid growth of globalization in the twenty-first century is creating new evolutions in a "world-universal" culture and the possibility of fusing cross-cultural modalities of treatment and recovery.
8. Posttraumatic therapies and traditional healing practices, in *culturally specific forms*, can facilitate resilience, personal growth, and self-transcendence in the wake of trauma (Wilson, 2005).
9. The pathways to healing are idiosyncratic and universal in nature. The pathways of healing vary in nature, purpose, duration, social complexity, and utilization by a culture.
10. Healing rituals are an integral part of highly cohesive cultures. Healing rituals evolve in situations of crisis, emergency, and threat to the social structure of society and culture. Healing rituals demand special roles and skills (e.g., shaman, crisis counselor, psychologist, medicine person, priest, etc.) to facilitate efforts for recovery and the psychic metabolism of trauma.

The ten hypotheses concerning the relationship of culture and trauma provide a framework for understanding the diversity of posttraumatic psychological outcomes. As Summerfield (1999) noted, it is prejudicial and scientifically unwarranted to assume that traumatic events at the individual or cultural (collective) level will always produce PTSD and the clinical need to intervene with programs and procedures developed primarily in Western cultures. For example, cognitive behavioral therapy (CBT) is the most validated psychotherapy for PTSD in the USA (Foa, Keane, & Friedman, 2000). But is CBT applicable to assisting victims of the 2004 tsunami who live in a non-English speaking culture in Aches,

Indonesia? Or, the survivors of the 2003 catastrophic earthquake in Bam, Iran, which killed over 30,000 people? Or, the mothers of genocidal warfare in the Sudan in 2005 whose children were murdered or starved to death? Or, Native American Vietnam war veterans living in traditional ways on the Navajo reservation in Arizona? These questions bring into focus critical assumptions that each person's posttraumatic adaptational pattern is a variation on culturally sanctioned modalities of coping with extreme stress experiences that impacts the psychobiology of the organism. Clearly, posttraumatic adaptations fall along a continuum from pathological to resilient (Wilson, 2005). At the pathological end of the continuum we find PTSD, dissociative reactions, brief psychosis, depressive disorder, and disabling anxiety states. In contrast, the resilient end of the continuum includes optimal forms of healthy adaptation, manifestations of behavioral resiliency in the face of adversity, and the resumption of normal psychosocial functioning (Wilson, 2005).

By examining the continuum of culturally sanctioned modalities of posttraumatic adaptation, the second and third hypotheses can be understood more precisely. Healing and recovery is *person specific* and there are *multiple pathways* to posttraumatic recovery, if they are needed. Considered from an evolutionary and adaptational perspective, cultures develop rituals, helper roles (e.g., shamans, mental health specialists, herbalists, medicine persons, physicians), ceremonies, and other modalities to facilitate recovery from distressing psychological conditions, including those produced by trauma (Moodley & West, 2005). Where such modalities of treatment do not exist or are inadequate, they will be developed and implemented as it is critical to culture to have functional and healthy members to carry out the critical day-to-day activities necessary to sustain commerce, family life, and the functions that define the identity and essence of the culture itself. For example, a culture that is sick, self-destructive, and dissolving due to warfare, political conflicts and revolution, and massive natural disaster or illness, will not thrive or maintain itself in a viable way.

The viability of culture in the face of collective trauma illustrates the sixth assumptive principle that there can be no experience of psychological trauma without a cultural history, grounding, or continuity of background. There is no individual sense of personal identity without a cultural reference point (Wilson, 2005). Personal identity within a cultural context includes a sense of continuity and discontinuity in life-course development which shapes personality and the coherency of the self-structure. Thus, there is no sense of personal identity without a cultural reference marker to counterpoint and define those events which seem to shape the formation of identity for the person. As an extension of this viewpoint, it can readily be seen that anomie and alienation (e.g., feeling

detached, separate, cut off, divorced, estranged, distanced, removed) from mainstream cultural processes is a potential consequence of severely traumatizing experiences and typically associated with anxiety, distress, and depression since the traumatic experience can "push" the person "outside" the customary boundaries of daily living. The potential of trauma to dysregulate emotions and set up complex patterns of prolonged stress cannot be dismissed as statistically infrequent (Kessler, et al., 1995). As Wilson and Drozdek (2004) have noted, this is particularly true when: (1) the trauma is massive and damages the entire culture; (2) the nature of trauma causes the person to challenge the existing moral and political adequacy of prevailing cultural norms and values; and (3) the trauma causes the individual to become marginalized within the culture and to be viewed as problematic, stigmatized, "damaged goods," or tainted by their experiences or posttraumatic consequences (e.g., physically disabled, disease infected, atomic radiation exposure; mentally ill, etc.).

The nature of how cultures deal with the social, political, and psychological consequences of trauma raises the issue of the availability of therapeutic modalities of healing and recovery. Stated simply, what does the culture provide to assist persons recover from different types of trauma? Examining this question is instructive since one can analyze the nature of formal, organized, and institutionalized mechanisms for recovery from trauma as well as informal, noninstitutionalized, or officially sanctioned modalities of care and service provisions. While a detailed analysis of these issues is beyond the scope of this article, it is nonetheless important when using a "crows nest" or "helicopter aerial" view of how cultures deal with those who suffer significant posttraumatic consequences of trauma, which include being displaced, homeless, unemployed, physically injured, and emotionally traumatized. Clearly, there are levels of posttraumatic impact to the social structures of culture and to the inner-psychological world of the trauma survivor. There are primary, secondary, and tertiary sets of stressors associated with trauma. In the "big view" of traumatic consequences, they intersect to varying degrees in affecting the patterns of recovery, stabilization, and resumption of normal living (Wilson, 1994).

A further understanding of the relation of culture and trauma can be analyzed from knowledge of the Trauma Archetype (Wilson, 2004a, 2005). The Trauma Archetype represents universal forms of traumatic experiences across time, space, culture, and history.

Table 3 presents a summary of the dimensions of the Trauma Archetype which has 11 separate but interrelated dimensions. The Trauma Archetype is a primordial type of human experience in which a psychological experience is encoded into personality dynamics. The Trauma Archetype gives birth to Trauma Complexes which, in turn, represent

Table 3. Trauma Archetype (Universal Forms of Traumatic Experience)

Dimensions
1. The Trauma Archetype is a prototypical stress response pattern present in all human cultures, universal in its effects and is manifest in overt behavioral patterns and internal intrapsychic processes, especially the Trauma Complex
2. The Trauma Archetype evokes altered psychological states, which include changes in consciousness, memory, orientation to time, space, and person, and appear in the Trauma Complex
3. The Trauma Archetype evokes allostatic changes in the organism (posttraumatic impacts, e.g., personality change, PTSD, allostatic dysregulation) which are expressed in common neurobiological pathways)
4. The Trauma Archetype contains the experience of threat to psychological and physical well-being, typically manifest in the Abyss and Inversion Experiences
5. The Trauma Archetype involves confrontation with the fear of death
6. The Trauma Archetype evokes the specter of self-de-integration, dissolution, and soul (psychic) death (i.e., loss of identity), and is expressed in the Trauma Complex
7. The Trauma Archetype is a manifestation of overwhelmingly stressful experience to the organization of self, identity, and belief systems, and appears as part of the structure of the Trauma Complex
8. The Trauma Archetype stimulates cognitive attributions of meaning and causality for injury, suffering, loss, death (i.e., altered core beliefs), which appear in the Trauma Complex
9. The Trauma Archetype energizes posttraumatic tasks of defense, recovery, healing, and growth, which include the development of PTSD as a Trauma Complex
10. The Trauma Archetype activates polarities of meaning attribution; the formulation of pro-social – humanitarian morality versus abject despair and meaninglessness paradigm
11. The Trauma Archetype may evoke spiritual transformation: individual journey/encounter with darkness: return/transformation/re-emergence, healing (Campbell, 1949). The evocation of a "spiritual" transformation is manifest in the Trauma Complex as part of the Transcendent Experience and the drive toward unification

Source: © Wilson, 2004.

how traumatic experiences are encapsulated in individualized ways in the psyche. Moreover, Trauma Complexes: (1) develop in accordance with the Trauma Archetype; (2) are comprised of affects, images, and perception of the trauma experience; (3) are mythological in form, symbolic in nature, and shaped by culture; (4) contain the specter of the extreme threat of annihilation; (5) articulate with other psychological complexes; (6) may become central in the self-structure; (7) contain motivational power; (8) are expressed in personality dynamics; (9) are primarily unconscious phenomena; and (10) contain forms of prolonged stress reactions, such as PTSD, dissociative, and anxiety disorders (Table 4).

The conceptualization of Trauma Archetypes and Trauma Complexes has much utility when looking at trauma and culture, since these concepts

Table 4. The Trauma Complex

1. The Trauma Complex is a feeling-toned complex which develops in accordance with the Trauma Archetype
2. The Trauma Complex comprises affects, images, perceptions, and cognitions associated with the trauma experience
3. The Trauma Complex is mythological in nature and takes form in accordance with culture and symbolic, mythological representations of reality
4. The Trauma Complex contains the affective responses of the Abyss Experience: fear, terror, horror, helplessness, dissociation
5. The Trauma Complex articulates with other psychological complexes and innate archetypes in a "cogwheeling," interactive manner. This includes the Abyss, Inversion, and Transcendent forms of traumatic encounters
6. The Trauma Complex may become central in the self-structure and reflect alterations in identity, ego processes, the self-structure and systems of personal meaning
7. The Trauma Complex contains motivational power and predisposition to behavior
8. The Trauma Complex is expressed in personality processes (e.g., traits, motives, altered personality characteristics, memory and cognition, etc.)
9. The Trauma Complex is primarily unconscious but discernible by posttraumatic alterations in the self and personality
10. The Trauma Complex contains the polarities of the Abyss Experience: diabolic versus transcendent which are universal variants in the search for meaning in the trauma experience

Source: © Wilson, 2004a, 2004b.

are universal in nature and not "wedded" to the concept of PTSD per se or Western perspectives of psychiatric illness. While a more extensive analysis of Trauma Archetypes and Complexes is not possible here due to page limitations, their relevance to the other assumptions about healing, recovery, and culture-specific forms of counseling, psychotherapy, or treatment is transparent and critical (Wilson, 2005).

First, it is necessary to understand, in culture-specific ways, the phenomenal reality of person. Wilson & Thomas (2004) have presented evidence that sustained empathy, as part of any treatment modality, is essential to facilitate posttraumatic recovery. Among other consequences of sustained empathic attunement, it helps the individual develop states of "mindfulness" as self-awareness of how a traumatic experience has impacted all levels of functioning, especially affect dysregulation (Schore, 2003). Mindfulness as a process of meditation is facilitative of higher states of consciousness and personal awareness of how a traumatic event may have impacted pre-existing beliefs about self, others, and nature. We can consider posttraumatic interventions, treatment, traditional healing practices, etc., as *culture-specific* forms designed to facilitate recovery, resilience, and the resumption of healthy living. The pathways to healing

are idiosyncratic and universal in nature and may vary greatly in their contexts, purpose, length, social desirability, and utilization within the culture. In highly cohesive cultures, there will be the use and prescription of rituals, practices, traditional methods of healing, etc. as they reflect archetypal forms of healing. Where such rituals and treatments do not exist, they will be developed by the culture in response to crises and threats to social structures vital to cultural continuity; hence the need for multiple modalities of treatment and specialists (e.g., counselor, shaman, medicine person, priest, doctor, etc.), who, "through the lens of culture," can assist in recognition of how a person has been changed, if at all, by psychological trauma.

So what does globalization portend for trauma treatment in the twenty-first century as the world "flattens" due to technological advances and commercial homogenization? In brief, the ready availability of scientific data on international databases for PTSDs (e.g., P.I.L.O.T.S. @ncptsd.org) enables clinicians, researchers, and patients to have instant access to information about PTSD, complex PTSD, treatment advances, pharmacotherapies, and much more. Second, the spread of knowledge has spurned unprecedented levels of international cooperation and the formation of international professional societies (e.g., ISTSS, International Society for Traumatic Stress Studies in 1985; Asian Society for Traumatic Stress in 2005) to share scientific data and clinical wisdom and to lobby for political and legislative changes on behalf of trauma victims. Third, globalization, to a certain extent, allows for homogenization, fusion, and experimentation with different modalities of counseling, psychotherapy, traditional healing practices, and modern medicine (e.g., traditional Chinese medicine). In a related way, globalization, driven by economic and political forces, is creating the emergence of "global culture" which enables the prospect of fusing cross-cultural modalities of treatment and subjecting them to scientific measures of efficacy. As this occurs, the answer to the question, "What works for whom and under what conditions?" will take on new meaning in terms of how we conceptualize the prolonged effects of extreme stress experience to the human psyche and as a holistically integrated organism. Beyond doubt, nineteenth- and twentieth-century conceptualizations of counseling and psychotherapy are cultural bound in nature and origin. The twenty-first century will witness the development and emergence of global conceptualizations of what constitutes trauma and how it gets healed. There will be developed a matrix of databases which cross-list cultures and the diversity of techniques employed to cope with states of traumatization. Moreover, as this convergence begins to occur, the scientific "gold standards" of what works for whom under what circumstances will take on meaning that transcends culture but not persons whose human suffering impels humanitarian care.

REFERENCES

Bojuwoye, O. (2005). Traditional healing practices in South Africa: Ancestral spirits, ritual ceremonies and holistic healing. In R. Moodley & W. West (Eds.), *Integrating traditional healing practices into counseling and psychotherapy* (pp. 61–73). Thousand Oaks, CA: Sage Publications.

Breslau, N. (1999). Psychological trauma, epidemiology of trauma and PTSD. In R. Yehuda (Ed.), *Psychological trauma, epidemiology of trauma and posttraumatic stress disorder* (pp. 1–27). Washington, DC: American Psychiatric Press, Inc.

Campbell, J. (1949). *Hero with a thousand faces*. New York: Penguin Books.

Campbell, J. (1991). *Pathways to bliss*. New York: Harper.

Campbell, J. (1992). *Pathways to bliss*. New York: Harper.

Caputo, P. (1980). *A rumor of war*. New York: Holt, Rinehart & Winston.

Dana, R. H. (1999). *Handbook of cross-cultural and multicultural personality assessment*. Matwah: L. E. Erlbaum Associates.

Dana, R. H. (2005). *Handbook of cross-cultural and multicultural personality assessment*. Matwah: L. E. Erlbaum Associates.

Erikson, E. (1950). *Childhood and society*. New York: Norton.

Foa, E. B., Keane, T. M., & Friedman, M. J. (Eds.). (2000). *Effective treatments for PTSD*. New York: Guilford Press.

Friedman, L. J. (2000). *Identities architect*. Cambridge: Harvard University Press.

Friedman, M. J. (2001). Allostatic versus empirical perspectives on pharmacotherapy. In J. P. Wilson, M. J. Friedman & J. D. Lindy (Eds.), *Treating psychological trauma and PTSD* (pp. 94–125). New York: Guilford Press.

Friedman, T. (2005). *The world is flat*. New York: Girraux, Strauss & Co.

Green, A. (1993). Childhood Sexual and Physical Abuse. In J. Wilson & B. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 577–592). New York: Plenum Press.

Jilek, W. G. (1982). Altered states of consciousness in North American Indian ceremonies. *Ethos, 10*(6), 326–343.

Kessler, N. C., Sonnega, A., & Bromet, E. (1995). Posttraumatic stress disorder in the national comorbidity survey. Archives-general Psychiatry, 52, 1048–1060.

Kinsie, J. D. (1988). The psychiatric effects of massive trauma on Cambodian refugees. In J. P. Wilson, Z. Harel & B. Kahana (Eds.), *Human adaptation to extreme stress* (pp. 305–319). New York: Plenum Press.

Kinsie, J. D. (1993). Posttraumatic effects and their treatment among Southeast Asian refugees. In J. P. Wilson & B. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 311–321). New York: Plenum Press.

Kumar, M., Bhurga, D., & Singh, J. (2005). South Asian (Indian) traditional healing: Ayurvedic, shamanic, and sahaja therapy. In R. Moodley & W. West (Eds.), *Integrating traditional healing practices in counseling and psychotherapy* (pp. 112–123). Thousand Oaks, CA: Sage Publications.

Lin, K. L., Poland, R. E., Anderson, D., & Lesser, I. M. (1996). Ethnopharmacology and the treatment of PTSD. In A. J. Marsella, M. J. Friedman, E. T. Gerrity, and R. M. Scurfield (Eds.), *Ethncultural aspects of posttraumatic stress disorder* (pp. 505–529). Washington, DC: American Psychological Association.

Mails, T. E. (1991). *Fools crow*. San Francisco, CA: Council Oaks Books.

Marsella, A. J. (2005). Rethinking the 'talking cures' in a global era. *Contemporary Psychology, November*, 2–12.

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

Marsella, A. J., & White, G. M. (1982). *Cultural conceptions of mental health and therapy*. Boston, MA: G. Reidel Publishing Co.

Marsella, A. J., & White, G. M. (1989). *Cultural conceptions of mental health and therapy*. Boston, MA: G. Reidel Publishing Co.

McFarlane, A. C., & Hua, C. (1993). Study of a major disaster in the Peoples Republic of China: The Yurnan earthquake. In J. P. Wilson & B. Raphael (Eds.), *International handbook of traumatic stress studies* (pp. 493–499). New York: Plenum Press.

Moodley, R., & West, W. (2005). *Integrating traditional healing practice into counseling and psychotherapy*. Thousand Oaks, CA: Sage Productions.

Obeyesekere, G. (1985). Depression, Buddhism and the work of culture in Sri Lanka. In A. Kleinman & B. Good (Eds.), *Culture and depression: Studies in anthropology and cross-cultural psychiatry of affect and disorder* (pp. 134–152). Berkeley, CA: University of California Press.

Parsons, E. (1988). Post-traumatic self-disorders. In J. P. Wilson, Z. Harel, & B. Kahana (Eds.), *Human adaptation to extreme stress: From the Holocaust to Vietnam* (pp. 245–279). New York: Plenum Press.

Poonwassie, A., & Charter, A. (2005). Aboriginal worldview of healing: Incusion, blending and binding. In R. Moodley & W. West (Eds.), *Integrating traditional healing practices into counseling and psychotherapy* (pp. 15–26). Thousand Oaks, CA: Sage Publications.

Raphael, B., Woodling, & Martinale (2004). Assessing traumatic bereavement. In J. P. Wilson & T. M. Keane (Eds.), *Assessing psychological trauma and PTSD* (pp. 492–513). New York: Guilford Press.

Schore, A. N. (2003). *Affect dysregulation and the repair of the self*. New York: Norton.

Siddarth, A. S. (in preparation). Ethnomedical best practices for international psychosocial efforts in disaster and trauma. In J. P. Wilson & C. Tang (Eds.), *The cross-cultural assessment of psychological trauma and posttraumatic stress disorder*. New York: Springer-Verlag.

Smith, M., Lin, M. K., & Mendoza, R. (1993). Non biological issues affecting psychopharmacology: Cultural considerations. In K. M., Lin, R. E. Poland, & G. Nalcasali (Eds.), *Psychopharmacology and psychobiology of ethnicity* (pp. 37–58). Washington, DC: American Psychiatric Press, Inc.

So, J. K. (2005). Traditional and cultural healing among the Chinese. In R. Moodley & W. West (Eds.), *Integrating traditional healing practices in counseling and psychotherapy* (pp. 100–112). Thousand Oaks, CA: Sage Publications.

Spiegel, D. E. (1994). *Dissociation*. Washington, DC: American Psychiatric Association Press.

Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programs in war-affected areas. *Social Science and Medicine*, 48, 1449–1462.

Wilson, J. P. (1989) *Trauma, transformation and healing: An integration approach to theory, research and posttraumatic theory*. New York: Brunner/Mazel.

Wilson, J. P. (2004a). *The abyss experience and the trauma complex*. New York: Brunner-Routledge.

Wilson, J. P. (2004b). The abyss experience and the trauma complex: A Jungian perspective of PTSD and dissociation. *Journal of Trauma in Dissociation, 5*(3), 43–68.

Wilson, J. P. & Thomas, R. (2004) *Empathy in the treatment of trauma and PTSD*. New York: Brunner/ Routledge.

Wilson, J. P. (2005). *The posttraumatic self: Restoring meaning and wholeness to personality*. New York: Brunner-Routledge.

Wilson, J. P. (1994). The need for an integrative theory of post-traumatic stress disorder. In M. B. Williams (Ed.), *Handbook of PTSD therapy*. New York: Greenwood Publishers.

Wilson, J. P., & Drozdek, B. (2004). *Broken spirits: The treatment of traumatized asylum seekers, refugees and war and torture victims*. New York: Brunner-Routledge.

Wilson, J. P., Friedman, M. J., & Lindy, J. D. (2001). An overview of clinical consideration and principles in the treatment of PTSD. In J. P. Wilson, M. J. Friedman & J. D. Lindy (Eds.), *Treating psychological trauma and PTSD* (Ch. 3., pp. 59–94). New York: Guilford Press.

Wilson, J. P., & Lindy, J. (Eds.). (1994). *Counter-transference in the treatment of PTSD*. New York: Guilford Press.

World Health Organization. (2002). *Traditional medicine strategy 2002–2005*. WHO Publication, WHO/EDM/2002.1. Geneva: Switzerland.