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Are We Lost in Translations?: Unanswered Questions on Trauma, Culture and Posttraumatic Syndromes and Recommendations for Future Research

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Introduction

As discussed throughout this publication, the relation of 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 and care. To understand the relationship between trauma and culture requires a "big picture" overview of both concepts (Marsella & White, 1989). However, because of the complexity of both, reactions to trauma and cultural phenomena, a "big picture" raises also many questions.

What are the dimensions of psychological trauma and what are the dimensions of cultural systems as they govern patterns of daily living? How does culture influence an individual's reaction to trauma? How do victims across the world make sense of their experiences in situations of extreme stress? In this regard, Smith, Lin and Mendoza (1993, p.38) 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 . . ."

How do cultures create social-psychological mechanisms to assist its members who have suffered significant traumatic events? 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). As shown throughout this publication, these different approaches

can and sometimes must be combined with each other in order to diminish the suffering of trauma victims. Intercultural trauma treatment can be based on the combination of various "cultural wisdoms" and not on their exclusion from the healing process.

In this chapter, we will discuss the issues of convergence and divergence between healing principles across cultures, raise some fundamental questions on relationships among trauma, culture and posttraumatic syndromes, and propose some directions for future research. In this trajectory, not only the knowledge on psychology and anthropology, but also mythology has been a valuable source of inspiration.

What can we Learn From the Myths?:The Mythology of the Hero, Traumatic Encounters and Personal Transformation

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. Their analysis is a rich source of inquiry as to the interplay between culture, traumatic events and their transformation by facing challenges to existence itself.

The mythologist Joseph Campbell (1949, 1992) researched the universality of myths in many of the worlds' literature, including the myth of "the Hero" who journeyed into "zones of danger" only to emerge transformed in mind, body and spirit. Figure 17.1 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 survivors' journey include:

- A life journey that can begin at any point in life-cycle development
- The encounter within 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

As discussed by Campbell (1992), 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 their 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.

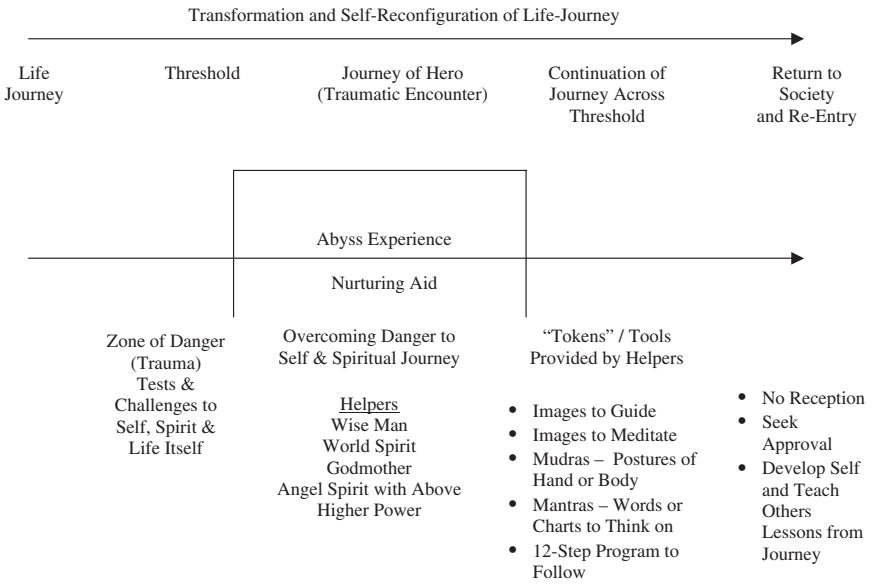

FIGURE 17.1. Mythology and the journey of the hero: The abyss experience and transformation of psychic trauma©.
Source: John P. Wilson, 2005©

The mythological journey of the Hero is also the journey and psychological sequel 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. There are five dimensions of the Abyss Experience which include: (1) the confrontation with evil and death; (2) the experience of soul death with non-being; (3) a sense of abandonment by humanity; (4) ultimate aloneness and despairing; 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 sense of the numinous. 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 (1992) notes that there are three prototypical patterns of reentering the society: (1) no reception; (2) the search for approval, validation and confirmation of one's journey, travails and suffering; and (3) the need to share their story of survival and teach others in generative ways.

Upon re-entry into the culture of origin, the trauma survivor, like mythical Hero, encounters some or all of the following reactions to their 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 trauma experience

The above mentioned can also be observed in "modern" trauma survivors entering a different society and culture of their own after being forced to migrate.

According to Campbell (1992), 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) to 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.

Campbell (1992) further outlines the four functions of mythology as follows: (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.

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.

To be clear, in this discussion as well as throughout the book, the authors are 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, 2005). Given the capacity of traumatic events to impact adaptive functioning, including the inner and outer worlds of psychic activity (Wilson, 2004), 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 argued elsewhere (Wilson, 2005), the history of scientific research on PTSD is badly skewed (perhaps for reasons of historical necessity) towards the study of psychopathology rather than on human growth, self-transformation, resilience and optimal functioning.

When we address the question of how 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 (Wilson, 2005; Wilson &, 2004; Marsella, Friedman, Gerrity, Keane, & Scurfield, 1996)? If so, what are the differences in therapeutic approaches across cultures to dealing with trauma? To answer this question requires further examination of the core questions pertaining to culture and the patterns of posttraumatic adaptation.

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, Kinzie (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 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.

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).

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, Obeyeskere (1985, p. 134) 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?" 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 posttraumatic stress disorder (Breslau, 1999).

2. Are the emotional reactions to psychological trauma the same in all cultures?

Scientific evidence, especially neurobiological studies, have documented that affect dysregulation, right hemisphere alterations in brain functioning, and strong kindling phenomena are universal in PTSD (Schore, 2003; Friedman, 2000). 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. Does culture (i.e., cognitive-affective belief systems) act as a perceptual filter to the cognitive appraisal and interpretation of psychic trauma? If so, how do internalized belief system and culturally shaped patterns of 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, incestual relations; traffic deaths; political oppression; motor-vehicle accidents; murder, etc.) necessarily viewed as a trauma in another culture? 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'?

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 post-event processing and cognitive interpretation of the traumatic stressor itself?

4. 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, Wilson (2004, 2005) has discussed the unique nature of trauma archetypes and trauma complexes 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. Dimensions (see Table 17.1) of the trauma archetype and how they influence posttraumatic personality dynamics and adaptive behavior have been delineated (Wilson, 2005).

5. 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 sub-culture (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)?

6. 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, institutionalized and non-institutionalized healing methods for victims of trauma that cultures develop. This question is of significant research interest as it defines the areas in which commonalities overlap and in which culture-specific differences exit.

TABLE 17.1. 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 vs. abject despair and meaninglessness paradigm.
11. The Trauma Archetype may evoke spiritual transformation: individual ⟶ journey / "encounter with darkness: ⟶ return / transformation / re-emergence, healing (J. 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: John P. Wilson, 2004©

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 (Wilson, 1989; Mails, 1991). 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.

As we will discuss later, it is our belief that each person's posttraumatic syndrome is a variation on a culturally sanctioned modality of adaptation which can be "treated" by either generic or culturally-specific practices.

7. Is it possible to 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 etic (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.

8. 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 few comparative randomized clinical trials (RCT) of medications to treat PTSD in culturally diverse populations (Friedman, 2001). Yet, studies have shown that some anti-depressant medications are more efficacious in symptom reduction than others for non-Western populations with severe PTSD (Kinzie, 1988; Lin, Poland, Anderson, & Lesser, 1996).

9. 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 trauma experiences in similar ways, perhaps in trauma complexes that are, in turn, shaped by cultural factors (Wilson, 2005).

10. 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 and other reactions to trauma as important psychological conditions that result 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 towards 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 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. 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 five very different cultural views of healing: Native American; African – Zulu; Indian (Ayurveda), traditional Chinese medicine (TCM), and Western. What do each of these 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.

TABLE 17.2. Cultural convergence: similar principles?.

Principle/Assumption	Native American	African (Zulu)	India (Ayurveda)	Chinese (TCM)	Western Industrial Culture
1. Harmony in relations (earth, people, society)	Yes	Yes	Yes	Yes	No
2. Vulnerability within person	Yes	Yes	Yes	Yes	Yes
3. Balance of biological and mental forms	Yes	Yes	Yes	Yes	No
4. Illness is imbalance, loss of harmony	Yes	Yes	Yes	Yes	No
5. Health is restoration of balance, harmony	Yes	Yes	Yes	Yes	No
6. Healing empowers vital energy	Yes	Yes	Yes	Yes	Yes

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 persons' 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, according to the western medical terminology, depression, PTSD, dissociation, and altered maladaptive states of consciousness and being (Jilek, 1982; Mails, 1991; Wilson, 1989; Poonwassie & Charter, 2005).

South African (Zulu)

The Zulu culture in South Africa employs a view of mental and spiritual life that is intricately interconnected. Bojuwoye (2005, p. 63) 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". 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 persons' 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, p. 115) 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". 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 (TCM), "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.

Western Approach

The Western Judeo-Christian postmodern industrial culture overemphasizes individualism at cost of integrative tendencies. An individual feels balanced when there is a balance within him/herself. The harmony of the individual in relation to its surroundings, the society or the earth is less important than in other cultures. Consequently, illness is not viewed as a result of a loss of harmony, but as an individual problem, caused by disturbances and misbalance on the level of individual biology. Therefore, healing focuses on treatment of the individual mirroring the culture's preference of reductionism over holistic approach.

Cultural Convergence and Divergence in Healing

Table 17.2 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, in all cultures healing empowers vital energies contained within the person. By comparing different 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.

Western Scientific Colonialism: Does it Make Sense?

In an influential and important critique of mental health programs in war-affected areas (e.g., Bosnia, Rwanda, etc.), Derek Summerfield (1999, pp. 1452–1457) 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 can be applied worldwide as 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".

This same set of assumptions could safely be generalized to non-warzone 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 with large claims that there was an epidemic of 'post-traumatic 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).

More fundamentally, the question can be raised whether it is appropriate to refer to Western healing techniques as therapies and treatments, while we use terminology like traditional healing and rituals when describing non-western approaches. Are the western approaches just well structured rituals (in terms of focus and time management) embedded in the western culture, where efficiency, self assertiveness, highly individualized control over life and individual-centered worldview are the most important values and traits? At the same time, non-western approaches focus more on re-establishing harmony in relationship between the individual and the world around him/her, which fits better in a non-western worldview. Besides this, the question is whether western techniques like cognitive behavior therapy (CBT) or eye-movement desensitization and reprocessing (EMDR) must be praised for their efficiency, while there have been accidental reports of fast recovery after just one session of maraboutage or another non-western healing approach.

Western healers favor approaches that are evidence based, and often define non-western alternatives as mambo-jumbo practices. At the same time, there have been almost no studies of non-western healing approaches. Opportunity to do scientific research is a privilege of rich societies, as most of the western societies are. Therefore, the exclusion of non evidence based approaches from those that

should be applied in intercultural trauma treatment does not seem appropriate. It reflects yet again the western scientific colonialism.

These views raise a number of critical questions when it comes to the proper and efficacious treatment of posttraumatic syndromes in different 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 (WHO, 2005). 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 a posttraumatic stress symptoms an illness *per se* for the survivors. Sixth, it can be justifiably assumed that throughout centuries of human evolution, cultures have developed adaptive mechanisms and wisdom 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 10 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. While the impact of trauma seems to be universal on a biological level, both attribution and conceptualization of traumatic experiences are culture-bound.
2. Healing and recovery from psychic trauma is *person-spe*cific. There are multiple pathways and forms of treatment within a culture. Help-seeking behavior is culture-bound.
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 & Thomas, 2004; Wilson & Drožđek, 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 & Droek, 2004).
7. The rapid growth of globalization and mass migrations in the twenty first Century are creating new evolutions in a "world-universal" culture and the possibility of fusing cross-cultural modalities of treatment and recovery.
8. 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.

9. Western 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).
10. The pathways to healing are idiosyncratic and universal in nature across cultures. The pathways of healing vary in form, purpose, duration, social complexity and utilization by a culture.

The 10 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 be applicable to assisting victims of the 2004 tsunami who live in a non-English speaking culture in Ache, 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?

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, 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, 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, Sonnega, & Bromet, 1995). As Wilson and Drožđek (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, (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, non-institutionalized 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. 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).

Final Remarks

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 posttraumatic stress disorders (e.g., P.I.L.O.T.S.@ncptsd.org)

enable 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). 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.

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