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Culture, Trauma, and the Treatment of Posttraumatic Syndromes in a Global Context

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Understanding how cultures create social psychological mechanisms to assist victims of natural and human-induced traumatic events requires knowledge of cultural systems and the nature of traumatic experiences. The purpose of this article is to present a holistic cultural view of trauma and posttraumatic syndromes in the light of theoretical assumptions and operating principles in Western psychology and trauma interventions currently applied in the global context. It reviews the literature pertaining to culture, trauma, and posttraumatic syndromes, including concepts of trauma archetype and trauma complex, and presents ten hypotheses about posttraumatic interventions in culturally diverse populations. A cross-cultural analysis of posttraumatic interventions revolves around the question of "What works for whom under what conditions?" It is suggested that healing and recovery is person-specific within culturally sanctioned modalities of counseling and interventions that include traditional practices, rituals, communal ceremonies, and conventional medical treatments. A set of core questions are

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proposed to guide future research and the development of culture-sensitive trauma theory and practice.

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, treatment, interventions, counseling, and medical care. To understand the relationship between trauma and culture requires a "big picture" overview of both concepts (Marsella & White, 1982). 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 cleansings, childhood abuse, domestic violence, terrorism, etc.) that contain specific stressors (e.g., physical or psychological injuries) that tax coping resources and challenge personality dynamics (e.g., ego strength, personal identity, self-dimensions) and the capacity for normal developmental growth (Green, 1993; Wilson, 2006; Wilson & Lindy, 1994). Traumatic life events can be simple or complex in nature and result in simple or complex forms of posttraumatic adaptation (Wilson, 1989, 2006). 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 than coping with the aftermath of the worst tsunami disaster in humankind's history as in 2004 that caused massive death of thousands, and destruction of the environment and the infrastructure of cultures. Hence, it is important to know 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. Problems that require mental health and counseling interventions involve 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 (Marsella, Friedman, Gerrity, & Scurfield, 1996; Moodley & West, 2005). The integration of extreme stress experiences 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. It is therefore essential to understand the psychology of trauma and trauma recovery broadly.

This article begins with a discussion of issues in trauma intervention in the global context, including cultural assumptions and other operating principles in the treatment of posttraumatic syndromes. The discussion is followed by a review of the literature on culture as it relates to trauma recovery, with conceptual, research and practice implications for the advancement of the trauma field.

The Treatment of Traumatic Stress in Global Context

The ubiquity of traumatic events throughout the world has raised global awareness of posttraumatic reactions as an important psychological condition that results from a broad range of traumatic experiences (e.g., wars, ethnic cleansings, terrorism, tsunamis, catastrophic earthquakes, etc.). Economic globalization has “flattened

the world" (T. L. 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, it cannot automatically be assumed that advances in Western psychotherapeutic techniques can be exported and applied to non-Western cultures

In an influential and important critique of mental health programs in war-affected areas (e.g., Bosnia, Rwanda, etc.), Summerfield (1999) explicated seven fundamental operational principles 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 operational principles are stated 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 principles, it is assumed, could safely be generalized to non-warzone countries in which there are catastrophic

natural disasters (e.g., tsunamis, earthquakes) 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" (Summerfield, 1999, p. 1461). Moreover, Summerfield 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).

These observations by Summerfield (1999) raise a number of critical points when it comes to the proper and efficacious treatment of posttraumatic syndromes in simple and complex cultures in the world.

The term "posttraumatic syndrome" should not be regarded 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), post-traumatic 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, 2006). 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, 2006). 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, 2006), 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. We need to understand both functional and dysfunctional reintegration in trauma recovery.

Knowledge of healing practices for traumatized persons poses challenging questions to anthropological and Western empirical approaches to diagnosis, assessment, and criteria of behavioral change. It cannot be assumed that psychotherapeutic techniques scientifically validated for use in Western cultures have generalizability to non-Western cultures, despite the fact that in terms of PTSD treatment, in particular, evidence suggests that the reduction of dysregulated affective states, "exposure" treatments designed to desensitize the disruptive effects of distressing traumatic memories, is useful in ameliorating anxiety, depression, and states of emotional liability associated with PTSD (Wilson, Friedman, & Lindy, 2001). In non-Western cultures, such therapeutic techniques, the customary settings in which they are utilized with patients (e.g., office, hospital, clinic), and their dependence on verbal expressions in response to the therapists questions about the trauma experience could be out of synchrony with cultural norms or traditional cultural healing practices. The understanding of global applications of different therapeutic procedures to assist persons suffering from posttraumatic syndromes requires clarity and knowledge (clinical and empirical) of what "works best" to restore integrative psychological functioning — to enable persons to continue healthy, normal, and adaptive coping within the cultural contexts of such parameters. The assumption is that by examining empirical and clinical knowledge, it

becomes possible to further identify useful, pragmatic, and communally validated practices to alleviate suffering among persons adversely impacted by trauma. Moreover, native or indigenous healing practices require evaluation and respect as to reports of efficacy in treating a broad range of posttraumatic symptoms and phenomena (Wilson, 1989).

First, local clinical knowledge in certain parts of the world is also folk knowledge, accumulated wisdom about the types of experiences that facilitates the restoration of well-being and recovery from posttraumatic syndromes. Second, empirical knowledge in the Western context is that which typically uses controlled experimental research designs to determine what effects on clinical outcome treatments generate. Western cultures place a premium on the merits of tightly controlled research designs, especially randomized clinical trials, double-blind studies, manualized treatment protocols (e.g., cognitive behavior therapy) and similar techniques. However, in non-Western cultures such studies may not be possible, intelligible, or acceptable within the culture itself in terms of its prevailing religious, ideological, or indigenous belief systems. The accumulation of global knowledge about the treatment of posttraumatic syndromes will require the convergence of empirical and clinical information so as to develop a conceptual matrix of therapeutic techniques that identifies therapeutic interventions what work for whom and under what conditions, in response to different types of traumatic events. Such a conceptual matrix would identify such categories as: (1) the client population; (2) traditional healing practices; (3) therapeutic contexts; (4) medical practices; (5) shamanic practices; (6) assumptive belief systems about illness and health; (7) perspectives on the psychobiology of traumatic stress (i.e., mind-body relationships); (8) the implicit psychological and behavioral principles; (9) the range of healer roles and practices; (10) individual vs. collective practices; and (11) religious and spiritual involvement in healing and recovery.

Culture and Treatment of Posttraumatic Syndromes

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 (Marsella & White, 1982). 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 underlying traditional healing practices across different cultural groups. Consider for a moment four very different cultural views of healing: Native American; African (Zulu); Indian (Ayurveda); and traditional Chinese medicine. What does each of 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 the person's 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 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, Bhugra, 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 (TCM), "mental illnesses are said to result from an imbalance of yin and yang forces, a stagnation of the *qi* and blood in various body organs, or both" (So, 2005, p. 101). Furthermore, "the driving forces behind this relationship are the entities of *qi* (vital energy) and *li* (order). The oft-cited concepts of yin and yang, oppositional yet complementary in nature, are characteristics … along the meridians (channels) that correspond to specific organs of the body" (p. 101). Thus, TCM views health and illness as related to a balance of vital forces, and that disruptions which affect their critical balance can result in physical or mental illnesses.

Table 1 summarizes and compares these four 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, (6) healing empowers vital energies contained within the person. By comparing different traditional cultural views and their underlying assumptions, 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 practical question remains as to what posttraumatic interventions should be applied in culturally different contexts and under what conditions.

Table 1. Cultural Convergence: Similar Principles?

Principles	Native American	African (Zulu)	India (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 (2006).

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 requires us to explore assessment, diagnosis, and treatment within a sensitive cultural framework that reflects knowledge and understanding of a culture. Indeed, the World Health Organization (2002) 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. 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., cognitive behavioral therapy, psychodynamic). Fourth, there is 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" behavioral consequences of trauma (and therefore traumatization), such behaviors can only be meaningfully defined by cultural norms and expectations about what is "normal" and "abnormal." Human grief reactions, for example, are universal to death and loss but that does not make them pathological (Raphael, Martinek, & Wooding, 2004). Acute adjustment reactions for a short period of time are entirely expectable after a tsunami that destroyed towns, cities, even cultures and more than 250,000 people. But that does not make adaptational requirements pathological or a PTSD symptoms of an illness per se for the survivors. Sixth, it can be justifiably assumed that throughout centuries of human evolution, adaptive mechanisms and wisdom have existed in culture to deal with the human effects of extreme trauma. 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, 2006). These considerations allow us to now explore a number of hypotheses about the relation of culture to trauma and 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-spe*cific. 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 & Drožđek, 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 & Drožđek, 2004).

7. The rapid growth of globalization in the 21st 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, 2006).

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.

These 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 is the most validated psychotherapy for PTSD in the United States. But is cognitive behavioral therapy 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 impact the psychobiology of the organism. Clearly, posttraumatic adaptations fall along a continuum from pathological to resilient (Wilson, 2006). 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 resilience in the face of adversity, and the resumption of normal psychosocial functioning (Wilson, 2006).

By examining the continuum of culturally sanctioned modalities of posttraumatic adaptation, the second and third assumptive principles 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., shaman, mental health specialists, herbalist, medicine persons, physicians), ceremonies, and other modalities to facilitate recovery from distressing psychological conditions, including those produced by trauma. Where such modalities of treatment do not exist or are inadequate, they will be developed and

implemented as it is critical for a 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. 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, 2006). Personal identity within a cultural context includes a sense of continuity and discontinuity in life-course development that shapes personality and the coherence of the self-structure. Thus, there is no sense of personal identity without a cultural reference marker to counterpoint and define those events that seemed 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. 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 post-traumatic consequences (e.g., physically disabled, disease infected, atomic radiation exposure, mentally ill, etc.).

The question 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, 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, 1995).

A further understanding of the relation of culture and trauma can be analyzed with knowledge of the trauma archetype (Wilson, 2004, 2006). The trauma archetype represents universal forms of traumatic experiences across time, space, culture, and history.

Table 2 presents a summary of the dimensions of the trauma archetype that has eleven separate but interrelated dimensions. The trauma archetype is a primordial type of human experience in which a

Table 2. 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 (post-traumatic 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-deintegration, 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 (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).

psychological experience is encoded into personality dynamics. It gives birth to trauma complexes (see Table 3) which, in turn, represent 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;

Table 3. The Trauma Complex

1.	The trauma complex is a feeling-toned complex which develops in accordance with the trauma archetype.
2.	The trauma complex is comprised of 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 vs. transcendent which are universal variants in the search for meaning in the trauma experience.

Source: Wilson (2004).

(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.

The conceptualization of trauma archetypes and trauma complexes has much utility when looking at trauma and culture, as these concepts 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, 2006).

First, it is necessary to understand, in culture-specific ways, the phenomenal reality of a person. Wilson and 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 affected 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 affected by psychological trauma.

An Agenda for the Development of Culture-sensitive Trauma Theory, Research, and Practice

The concept of posttraumatic stress and the multidimensional nature of cultures require 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 sub-cultures 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.

When addressing 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 (L. J. 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 et al., 1996; Wilson, 2006; Wilson & Drožđek, 2004)? If so, what are the differences and commonalities in therapeutic approaches to dealing with trauma?

Table 4 presents 21 core questions concerning the relation of culture to traumatic life experiences and posttraumatic adaptation. These core questions serve to frame future conceptual and research work toward a culture-sensitive trauma psychology.

Table 4. 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 species?
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 structure?

Table 4 (Cont'd)

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 for 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 (2006).

1. *Is the experience of psychobiological 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. 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 posttraumatic stress disorder (Breslau, 1999).

2. *Are the emotional reactions to 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 (L. J. 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 mythical 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 metaphorically returns to his "rest" and "sleep"?

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?* 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, torture, political oppression, motor-vehicle accidents, murder, etc.) necessarily viewed as a trauma in another culture? Second, what sets of expectations for resilience 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 World War II 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?

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. Wilson (2004, 2006) have 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.

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? Wilson (2006) has delineated eleven dimensions (see Table 2) of the trauma archetype and how they influence posttraumatic personality dynamics and adaptive behavior.

7. *Does culture determine 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 among 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, 2006).

8. *Are there cultural-based syndromes (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 & White, 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 institutionalized mechanisms to assist persons who experience psychic trauma?* This question attempts to identify the specific ways that cultures evolve and develop institutionalized and non-institutionalized 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 exit. It is possible 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 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 that 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, 2006). 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. 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 individual 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 re-entry into society after an adverse journey into the abyss of trauma (Wilson, 2006). 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*, Campbell (1992) 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, 1977). 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 understand 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 Wilson (2004, 2006) has coined to describe the "black hole" of psychological trauma: a vast chasm of dark, empty space in which terror and fear of annihilation exists. There are five dimensions of the abyss experience which include: (a) the confrontation with evil and death; (b) the experience of soul death with non-being; (c) a sense of abandonment by humanity; (d) ultimate aloneness and despairing; and (e) 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. In the mythology of cultures, 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 psychic 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 "cast light" as to the meaning of the trauma experience and provide 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 cultures 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. *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 etic (universal) measurements of trauma and PTSD (Dana, 2000). 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.

18. *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 of medications to treat PTSD in culturally diverse populations (M. J. 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).

19. *Is the unconscious manifestation of posttraumatic states the same in all cultures?* This core question is complex and fascinating because it demands a method to assess unconscious processes cross-culturally (Dana, 2000) 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, 2006).

20. *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. Wilson (2006) has described in detail the process of traumatogenic experiences with an ontogenetic framework of self-metamorphosis. Understanding mythological and epigenetic frameworks of how trauma alters the trajectory of the life cycle has important implications for counseling and psychotherapy.

21. *What cultural 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, 2006).

Concluding Comments

So what does globalization portend for trauma treatment in the 21st century as the world "flattens" due to technological advances and commercial homogenization? In brief, the ready availability of scientific data on international databases for PTSD (e.g., http://www.ncptsd.va.gov/) may 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., 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 a "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, 19th- and 20th-century conceptualizations of counseling and psychotherapy are culture-bound in nature and origin. The 21st century will witness the development and emergence of global conceptualizations of what constitutes trauma and how it gets healed. A matrix of databases will be developed 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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文化、心理創傷及全球對心理創傷後症候群的治療

要了解文化如何塑造出協助天災人禍受害者的社會和心理機制，就必須掌握文化系統的知識及心理創傷經驗的性質。本文基於西方心理學的理論假設及運作原則，以及現時世界各地的心理創傷介入方法，旨在整全地展示心理創傷及心理創傷後症候群的文化觀點。文章首先檢閱有關文化、心理創傷及心理創傷後症候群（包括創傷原型及創傷情意結）的文獻，繼而展示在不同文化中心理創傷後介入的十項假設。對心理創傷後介入的跨文化分析圍繞一個問題：「在甚麼條件下哪些方法對誰人有效？」本文建議，在文化認許的輔導和介入形態（包括傳統方法、儀式、宗教典禮、醫藥習俗）下，治療和康復方法仍是因人而異。本文提出一套關鍵問題，期望能為切合不同文化的心理創傷理論及實踐的未來研究及發展作出一點指引。