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Ethnocultural Aspects of PTSD: An Overview of Concepts, Issues, and Treatments

Anthony J. Marsella[1]

Abstract

The present article offers an overview discussion of ethnocultural aspects of PTSD, with special attention to major conceptual issues, clinical considerations, and therapy practices. The historical circumstances leading to the widespread acceptance of PTSD among conventional mental health professionals, and the subsequent criticisms that emerged from scholars, humanitarian workers, and ethnocultural minorities are presented as an important background to the current controversial status of the concept, especially with regard to arguments regarding the ethnocultural determinants of PTSD. The concept of culture, its definition, and its developmental socialization process, are presented as foundations for understanding the many influences cultural variables have on the perception, experience, clinical expressions, and treatment responses to trauma. A "trauma event-person ecology" model identifies the different factors that serve to shape the outcome of trauma within and across cultures. A therapy outcome equation is presented that summarizes the complex calculus of variables and considerations impacting different outcomes. The many healing principles used by different Western and traditional approaches are also identified, calling attention to the importance of fitting patient to therapist to therapy to present and past circumstances. The article concludes that in spite of what appears to be common neurological processes, correlates, and consequences in the initial response to trauma exposure, ethnocultural variables exercise major influence on perceived causes, symptom manifestations, clinical parameters (i.e., onset, course, and outcome), interventions, and societal responses.

Keywords

PTSD, trauma, culture, ethnocultural, traditional healers, healing, healing principles, cultural competence

Introduction

As studies expanded beyond initial concerns for PTSD among Vietnam War veterans (e.g., Figley, 1990; Kukla et al., 1990) toward explorations of trauma disorders in other populations including refugees, war and disaster victims, children, women, elderly, and minorities (e.g., Bracken, Giller, & Summerfield, 1995; DeVries, 1996; Green, et al., 2003), questions inevitably emerged regarding the existence of ethnocultural variations in the etiology, diagnosis, expression, and treatment of PTSD and related stress disorders.

Initially, some of these questions were ignored or dismissed by conventional psychiatry and other mental health specialties because within existing medical models, it was assumed that trauma was a universal human experience—both in terms of omnipresence of stressful traumatic events, and the well-accepted human neurological response to stressful trauma events involving the brain's emotional centers (especially the hypothalamus-pituitary-adrenal axis (HPA), the amygdala, and various endocrine functions). Later research revealed the even greater central nervous system (CNS) complexities involved in trauma and stress responses, and the destructive consequences of acute and chronic trauma and stress exposures including lower threshold for anxiety, hippocampal atrophy, and cingulate cortex atrophy. But, as the evidence of neurological consequences continued to mount, it did not dampen the emerging findings of widespread ethnocultural variations across clinical parameters (e.g., onset, manifestation, course, and outcome) and the need to explore the causes of these variations.

Although the results of numerous studies in cross-cultural psychology, psychological anthropology, and transcultural psychiatry (e.g., Marsella, 2000a, Marsella & Yamada, 2000; Marsella & Yamada, 2007) revealed extensive ethnocultural variations in psychological and behavioral disorders—including depression, anxiety, and psychotic disorders—the possibility of ethnocultural cultural variations in PTSD was

[1]University of Hawaii, Honolulu

Corresponding Author:
Anthony J. Marsella, Professor Emeritus, Department of Psychology, University of Hawaii, Honolulu, Hawaii.
Email: marsella@hawaii.edu

not widely accepted. Reasons for this resided in the fact that the possibility of ethnocultural variations challenged both (1) basic assumptions about the universal substrates (i.e., biological) of psychiatric disorders, and (2) basic assumptions about an emerging PTSD scientific and professional complex that held certain premises about trauma to be universal.

If ethnocultural variations in trauma and PTSD existed, this would call attention to the plasticity of the human mind and brain, especially the role of cultural factors in causing and shaping disorders and diseases. This relativity would contradict the "disease" model of psychiatry that sought to re-position psychiatry as a medical specialty replete with well-defined disorders with identifiable symptomatology and treatment protocols that had emerged from the neo-Kraeplinian approach that was favored by influential psychiatrists in the 1980s (e.g., Blashfield, 1984). Thus, there was, and likely remains today, opposition to ethnocultural determinants of trauma, PTSD, and related-stress disorders. At the same time, resistance to the resistance arose among advocates for re-considering and re-thinking the favored trauma and PTSD models.

Resistance to Western Assumptions about Trauma and PTSD

Principles of the Western Model

Summerfield (1999), a Western physician who has devoted much of his life to humanitarian services, reported that Western ideas about trauma and PTSD had become codified in a series of principles that were applied indiscriminately in non-Western settings, especially following natural and man-made disasters. Summerfield (1999) listed seven principles that he claimed constituted the coda of cannon of the group:

> (1) Experience of war and anxiety 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 frameworks (i.e., PTSD); (3) large numbers of victims traumatized by war need professional help; (4) Western psychological approaches are relevant to violent conflict worldwide; victims do better if emotionally ventilate and "work" through their experiences; (5) there are vulnerable groups and individuals who need to be specifically targeted 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; (7) local workers are overwhelmed and may themselves be traumatized (Summerfield, 1999, 1452-1457).

Homogenizing the Concept and Cure

The critiques of the conventional Western approaches continued to be published with ever more strident statements about the abuses of accepted Western notions about trauma and PTSD. For example, Bracken, Giller, and Summerfield (1997) wrote:

> Trauma projects which seek to objectify "suffering" as an entity apart, converting it into a technical problem to which are applied technical solutions like Western talk therapies, are discounting indigenous knowledge, capacities, and priorities. Such projects aggrandize the Western expert who defines the problem (e.g., PTSD) and brings the cure; too often it is the same problem and the same cure, whether to Cambodia, Rwanda, or elsewhere. (Bracken, et al., 1997, pp. 430-442)

Tyranny of Western Expertise

Michael Wessells (1999), one of the most active and knowledgeable disaster professionals in psychology, identified the problems that can emerge when Western disaster professionals intervene in developing countries:

> In emergency situations, psychologists hired by NGOs or UN agencies often play a lead role in defining the situation, identifying the psychological dimensions of the problems, and suggesting interventions. . . . Viewed as experts, they tacitly carry the imprimatur of Western science and Western psychology, regarded globally as embodying the highest standards of research, education, training, and practice. . . . Unfortunately, the dynamics of the situation invite a tyranny of Western expertise. The multitude of problems involved usually stems not from any conspiracy or conscious intent but rather from hidden power dynamics and the tacit assumption that Western knowledge trumps local knowledge. . . . Local communities have specific methods and tools for healing such as rituals, ceremonies, and practices of remembrance. Since they are grounded in the beliefs, values, and traditions of the local culture, they are both culturally appropriate and more sustainable than methods brought in from the outside (Wessells, 1999, pp. 274-275).

By the turn of the 20th Century, resistance to Western assumptions about trauma and PTSD had grown to sizeable proportions, and numerous reports continued to indicate that PTSD evidenced widespread variations across ethnocultural boundaries (e.g., Marsella, Friedman, & Spain, 1993; Marsella, Friedman, Gerrity, & Scurfield, 1996; Wilson, 2008; Young, 2005). The demand for greater sensitivity to the variations increased. Many of the reports were accumulating from international clinical research studies associated with numerous natural (e.g., earthquakes, hurricanes, floods) and human-made disasters (e.g., war, terrorism, accidents; e.g., Bracken, et al., 1995; Marsella & Christopher, 2004; Marsella, Johnson, Watson, & Gryczynski, 2008; Nader, Dubrow, Stamm, 1999; Norris, 2008).

The limited success of many efforts to address and resolve the psychological and behavioral problems occurring amid these crises pointed to the problems associated with the Western context of trauma and PTSD, especially the accepted notions of universal causes, manifestations, and treatment responses. Of special note were reports by some researchers that exposure to trauma events could actually result in improved mental health for so called victims. This phenomenon was termed "post-traumatic growth (PTG)," a finding that fit well with the belief among some non-Western people that a crisis is also an opportunity, and that endurance and courage in the face of stress are admirable and valued (Tedeschi, Park, & Calhoun, 1998).

Culture-Bound Disorders

Yet another challenge to the "universal" view of trauma and PTSD emerged from the growing interest in the concept of culture-bound disorders. Although this concept was quite old in anthropology and transcultural psychiatry, conventional psychiatry had resisted the idea, and for many years simply saw disorders in non-Western cultures as variants of Western disorders or "exotica" undeserving of attention. However, under growing pressure from minority psychiatrists, "culture-bound disorders" had gained increased credibility in psychiatry and they were finally listed in the American Psychiatric Association's (1994) *Diagnostic and Statistical Manual (DSM-IV),* albeit on the last pages of the Manual.

In response, questions quickly arose about whether PTSD might be a culture-bound disorder. The controversy over PTSD had now joined the controversies associated with culture-bound disorders creating a complex discussion of both concepts (see Marsella, 2000b, for a detailed discussion of the issues surrounding "culture-bound disorders"). A reasonable point of view is that all disorders are culture-bound, including all Western disorders since they emerge, are experienced, and responded to within a cultural context. The question must be asked: Can any psychological disorder escape cultural influence? The answer is: No!

Today, the number of publications on ethnocultural aspects of trauma—especially PTSD—has grown to sizeable proportions (e.g., Marsella, et al., 1996; Marsella & Wilson, 2008; Wilson & Tang, 2007) and is rapidly increasing as researchers and clinicians continue to explore and incorporate cultural variables (e.g., concepts of personhood, ethnic identity, religious status, gender status and roles, cultural history, conceptions of health and disorder) in their clinical and research efforts.

The Concept of Culture

Definition

Given the previous controversies and debates, it is important to discuss the concept of culture, including a definition and explanation of culture's role in the construction of our realities. Culture can be defined as:

> Shared learned behavior and meanings acquired in life activity contexts that are passed on from generation to another for purposes of promoting survival, adaptation, and adjustment. These behaviors and meanings are dynamic, and are responsive to change and modification in response to individual, societal, and environmental demands and pressures. Culture is represented *externally* in artifacts, roles, settings, and institutions. Culture is represented *internally* in values, beliefs, expectations, consciousness, epistemology (i.e., ways of knowing), ontology, and praxiology, personhood, and world views. Cultures can be situational, temporary, or enduring. (See Marsella & Yamada, 2000, p. 12; Marsella & Yamada, 2007, p. 801)

Cultural Socialization

The essential point about the concept of culture is that culture constructs our reality. It is the template that guides our perceptions. How does this occur? Table 1 describes the cultural socialization process indicating how all behavior is shaped by culture. Culture structures our perception and experience of reality, and it shapes, often in very profound ways, the perceptual and experiential templates we use to describe, understand, predict, and control the world around us. This is true for both "normal" and "disordered" patterns of behavior (Marsella & Yamada, 2007). This cultural construction can be considered "spectacles" that frame our views of reality, constantly guiding us as we seek to make meaning of the world before us.

Unfortunately, our understanding of trauma responses and traumatic events is complicated by the problem of *ethnocentricity* in which different groups come to believe that only their construction of reality—their cultural world view—is accurate or true. This has led to some problems, especially among well-intentioned Western help providers. The "power" assigned or assumed by Western mental health sciences and professions because of Western economic, political, and military dominance does not mean that their views are accurate; rather, they are simply a dominant view that can be problematic. Among the mental health sciences and professions, ethnocentric inclinations have led to errors and biases and abuses in the diagnosis, assessment, and treatment by Western personnel working with non-Western or ethnic and racial minority groups of patients. At this time, ethnocentric assumptions about trauma and traumatic events continue to remain a barrier to the accurate understanding of trauma disorders and other forms of psychopathology and maladjustment.

Today, however, the incorporation of ethnocultural factors into our understanding of PTSD is widespread. Within the context of the previously given definition of culture and the acknowledged limitations imposed by ethnocentricity, it is

Table 1. Steps in the Cultural Construction of Reality

1. There is an inherent human impulse to describe, understand, and predict the world through the ordering of stimuli
2. The undamaged human brain not only responds to stimuli, but also organizes, connects, and symbolizes stimuli, and in the process, generates patterns of explicit and implicit meanings that help promote survival, adaptation, and adjustment
3. The process and product of these activities are, to a large extent, culturally contextualized, generated, and shaped through sensory, linguistic, behavioral, and interpersonal practices that constitute the cultural socialization process
4. The storage of stimuli as accumulated life experience, in both representational and symbolic forms in the brain, and in external forms (e.g., books), generates a shared cognitive and affective process that helps create cultural continuity across time (i.e., past, present, and future) for both the person and the group. To a large extent, individual and collective identities are forged through this process
5. Through socialization, individual and group preferences and priorities are rewarded or punished, thus promoting and/or modifying the cultural constructions of reality (i.e., ontogenies, epistemologies, praxologies, cosmologies, ethoses, values, and behavior patterns)
6. "Reality" is, thus, "culturally constructed." Different cultural contexts create different realities via the cultural socialization processes

now recognized by many scientists and professionals that virtually every aspect of trauma-related mental disorders is shaped by cultural determinants (Drožđek & Wilson, 2007; Marsella, Friedman, Gerrity, & Scurfield, 2001; Wilson, 2008; Wilson & Tang, 2007). This means that we need to train professionals and scientists to grasp the implications this has for diagnosis, assessment, and therapy.

Universal Arousal With Cultural Mediation

What, then, is the current state of our knowledge about cultural aspects of trauma-related disorders, traumatic events, and traumatic stress treatments? The biopsychosocial response to stressors associated with traumatic events appears to be universal. That is, when faced with stressors, the brain, CNS, and related hormonal systems are activated to prepare either for fight, flight, or freeze. This involves the well-known activation of the sympathetic CNS that initiates the hypothalamic–pituitary–adrenal (HPA) axis changes that prepares the organism to address the stressor. But here, culture—as the psychological construction of reality—acts as a perceptual and experiential template for responding to traumatic stressors by rendering "interpretations" with regards to such concerns, as of the nature and cause of the stressor, and the pattern of responses that it may elicit.

Figure 1 offers an ecology interactional model that recognizes and acknowledges the spectrum of external and internal causal forces that shape expression and outcome of trauma and PTSD. As Figure 1 indicates, external and internal forces shape trauma, PTSD, related stress disorders, and culture-bound disorders. The model offers a general perspective that incorporates a wide range of determinants to accommodate to conventional Western assumptions and non-Western views.

Ethnocultural Competence

In recent years, competency has become a popular term. It has been used to refer to the mastery of computers, foreign languages, writing, and a score of other areas. Ethnocultural competence refers to the abilities, capacities, and skills to accurately understand the importance of cultural factors in the conduct of research, teaching, and clinical services. In our global era, with the inevitable encounters that are occurring in health and medical care settings, professionals and other service providers are faced with the complexities of communicating, understanding, assessing, diagnosing, and treating patients from differing ethnocultural traditions. Oftentimes, the encounters involve contrasting and even conflicting cultural encounters (e.g., Nigerian doctor —Korean patient). The importance of developing cultural competence skills has now become an essential requirement (e.g., Dana & Allen, 2008). Table 2 (Marsella, 2009) displays a self-evaluation form for assessing cultural competence with regard to a specific client. Although perfect cultural competence is never attainable, especially when crossing cultural boundaries, competence may be assessed by reference to knowledge of a different culture's important features. Depending on the extent of this knowledge, it is possible to either increase or limit the accuracy and effectiveness of clinical decisions. It is clear that working amid "cultural blindness" is likely to lead to many risks for the patient.

Ethnocultural Influences on Clinical and Societal Dimensions

Culture influences the clinical parameters of the diagnostic criteria for PTSD and related stress disorders that may occur in response to "traumatic" events, including (e.g., Marsella, 1982; Marsella, et al., 1993; Marsella & Wilson, 2008):

- Patterns of onset
- Idioms of distress
- Manifestation of symptoms (e.g., guilt, anger, anxiety, somatic)
- Patterns of re-experiencing, avoidance, and dissociation symptoms
- Disabilities and impairments
- Course, progression, and outcome
- Patterns of culture-bound disorders that do not meet Western diagnostic criteria

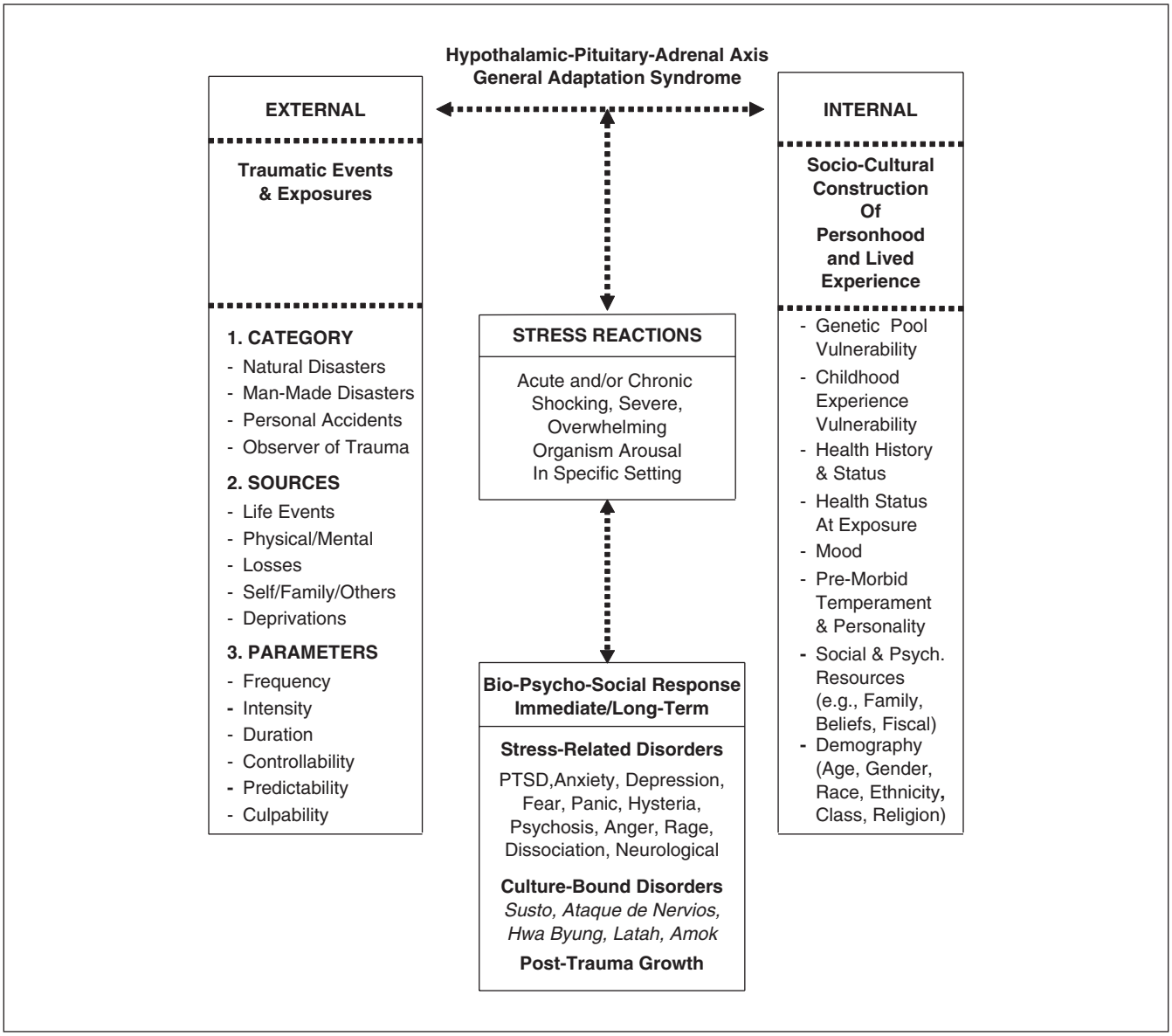

Figure 1. The complex trauma & PTSD ecology: An interactional model

Culture also shapes various psychosocial aspects of responses to "traumatic" events, including:

- Meaning and implications of phenomena such as nightmares and visions
- Role of beliefs in destiny or fate in determining the perception of the event and responses
- Disabilities and impairments independent of symptomatology
- Perception of personal responsibility for the event and response (i.e., culpability)
- Vulnerabilities to trauma (e.g., genetic pool and social network, status, and structure).
- Thresholds for arousal via perception and interpretation of stressors

Culture also shapes various dimensions of PTSD via certain societal determinants:

- Genetic pools available for breeding
- Types and parameters of exposure to various stressors (e.g., natural, human-made, interpersonal, situational)
- Patterns of coping and social resources used to mediate responses to traumatic events and PTSD
- Religious and related belief systems

Table 2. Cultural Competence Self-Evaluation Form (CCSE)

Select your client's ethnocultural group: _____
Rate yourself on the following items of this scale to determine your "cultural competence" for this client.

Very true of me	True of me	Somewhat true of me	Not true of me	Unsure about me
4	3	2	1	U

1. _____ Knowledge of group's history
2. _____ Knowledge of group's family structures, gender roles, dynamics
3. _____ Knowledge of group's response to illness (i.e., awareness, biases)
4. _____ Knowledge of help-seeking behavior patterns of group
5. _____ Ability to evaluate your view and group view of illness
6. _____ Ability to feel empathy and understanding toward group
7. _____ Ability to develop a culturally responsive treatment program
8. _____ Ability to understand group's compliance with treatment
9. _____ Ability to develop culturally responsive prevention program for group
10. _____ Knowledge of group's "culture-specific" disorders/illnesses
11. _____ Knowledge of group's explanatory models of illness
12. _____ Knowledge of group's indigenous healing methods and traditions
13. _____ Knowledge of group's indigenous healers and their contact ease
14. _____ Knowledge of communication patterns and styles (e.g., nonverbal)
15. _____ Knowledge of group's language
16. _____ Knowledge of group's ethnic identification and acculturation situation
17. _____ Knowledge of how one's own health practices are rooted in culture
18. _____ Knowledge of impact of group's religious beliefs on health and illness
19. _____ Desire to learn group's culture
20. _____ Desire to travel to group's national location, neighborhood

Total score: _____80-65 = competent; 65-40 = near competent; 40 below = incompetent
Total No. of Us: _____ (If this number is above 8, more self-reflection is need)
Therapist: _____ Age: _____ Gender: _____ Religion: _____ Ethnicity _____

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- Language used to encode, interpret, and respond to traumatic events and PTSD. (Languages may access or label experiences in different ways)
- Standards of normality, abnormality, and deviance, including tolerance for certain behaviors

Cultures Under Constant Stress and Trauma

Last, there is a need to recognize that there are cultures that persistently encounter traumatic circumstances. For example, cultures undergoing cultural disintegration, collapse, acculturation, fragmentation, destruction, abuse, and a score of other conditions brought on by oppression, insecurity, war, disaster, and a history of political subjugation and tyranny exact a harsh toll on their members. Under these circumstances, members are forced to live in conditions of deprivation, fear, hate, anger, and helplessness that leave permanent psychic and physical scars. Cultures, in these circumstances, may foster and sustain constant trauma presenting their members inescapable pressures. The issue of "pathogenic" societies needs to be understood since life in these contexts can destroy any hopes of resiliency and recovery (e.g., Edgerton, 1991; Leighton, 1959). These considerations all raise further questions about the interface between culture and traumatic life events.

Culture, Treatment, and Healing

Culture Influences Treatment and Healing

All cultures have different patterns, rituals, and treatment protocols for dealing with survivors of disaster, trauma, and extreme stress. Depending on the culture, these mechanisms may include what Western health and medical professionals—psychological experts would classify as, nontraditional or alternative modalities of treatment or assistance. Included within this group of "healers" are shamans; medicine "men and women" of non-Western practices; herbal therapies; physical and somatic (bodily) treatments of many varieties; aboriginal dances and incantations, recitations (Drožđek & Wilson, 2007; Incayawar, Wintrob, & Bouchard, 2009; Marsella & Higginbotham, 1983; Moodley & West, 2005; Winkleman, 2010). Table 3 displays examples of non-Western and traditional health systems, healers/practitioners, and therapies. It should be noted that traditional and non-Western medical systems have existed for many centuries and continue to constitute viable treatment alternatives that probably have been used to treat trauma-related disorders and impairments.

Lin (2000) offers a valuable example of the uses of non-Western therapy and healing approaches to trauma-related disorders. In response to an earthquake in Taiwan, Lin described an instance where a Western counselor's emphasis

Table 3. Examples of Traditional and Non-Western Health, Healers, and Therapy Systems

Examples of Healers/Therapists
- Curanderos (Latino)
- Dukhuns (Indonesia)
- Herbolarios & Hilots (Philippines)
- Kahunas (Hawaii)
- Mudangs (Korea)
- Santerias (Latino)
- Shamans (Widespread)
- Temple Masters and Priests (Buddhism, Taoism)
- Voudoo Trance Healers
- Examples of Non-Western Health Systems
- Ayurveda (India, Hindu)
- East-Asian (Chinese Korean, Japanese, Tibetan)
- Indigenous (Australian Aboriginal, American Indian, Sub-Saharan Africa, Native Hawaiian and Pacific Island)
- Shamanistic Systems (World Wide)
- Unani (Arabic)

Examples of Non-Western Therapies
- Expressive Therapies (Art, Chanting, Dancing, Singing)
- Ho'oponopono (Hawaiian)
- I-Ching (Chinese)
- Meditation (Widespread)
- Morita Therapy (Japanese)
- Naikan Therapy (Japanese)
- Sweat Lodge/Vision Quest (American Indian)
- Voudoo (Caribbean/Africa)
- Yoga (India, Hindu)

on "talk" therapy was ineffective because of its culturally-inappropriate applications (i.e., the need to share feelings, emotions, and suffering with a counselor).

> I do not know how to communicate with the experts. He told me that I have some kind of disease in my mind but I think I am okay. He kept asking me to express my feelings toward the earthquake, but I feel embarrassed if I tell people my own feelings. . . . I went to a Master in the temporary temple and she taught me how to deal with the situation. How to calm my anxieties through worship and helping others. How to accept grief as an arrangement of the gods. You know that our people have done so many wrong things." (Lin, 2000, pp. 10-11)

It is essential that all therapists grasp the fact that the codification of experience occurs in many different modalities of functioning, and these modalities each have their own accessing points. For example, our experience of the world can be encoded "cognitively/verbally, imagistically, affectively, viscerally, and/or proprioceptively."(Marsella, 2008). Although some experiences are coded within one modality, other may be encoded in several or even all. Therapists too often rely on the verbal mode to access and to heal experiences and for many non-Western patients; the verbal mode is neither preferred nor useful. If healing is to occur, a variety of approaches that tap different modalities in which experiences—especially traumas—are encoded, may be needed. The fundamental issue for all forms of psychopathology is essentially the issue of the variations in the cultural mediation of the linguistic and sensory mediations of disorder. Marsella (1982) wrote:

> We cannot separate our experience of an event from our sensory and linguistic mediation of it. If these differ, so must the experience differ across cultures. If we define who we are in different ways (i.e., self as object), if we process reality in different ways (i.e., self as process), if we define the very nature of what is real, and what is acceptable, and even what is right and wrong, how can we expect similarities in something as complex as madness (Marsella, 1982, p. 363).

A Therapy/Healing Calculus

A global perspective of psychic trauma is critical to healing, mental health delivery services, medical practices, therapies, and other professional services. (e.g., Kirmayer, Lemelson, & Barad, 2007; Marsella & Wilson, 2008). The critical question that remains is: "What forms of care and treatment work best for a given patient, with a given therapist/professional, using specific therapy methods and techniques?"

Within this context, an outcome equation for trauma and PTSD that looks at outcome as function of a number of critical therapy/healing encounter variables can be created (Marsella, 2005):

$$\text{Outcome} = F \text{ of } V_1 \text{ (Client Characteristics)} \quad V_2 \text{ (Client Problem/Symptoms)} \quad V_3 \text{ (Therapist Characteristics)} \quad V_4 \text{ (Therapy Methods)} \quad V_5 \text{ (Healing Principles)} \quad V_6 \text{ (Settings)} \quad V_7 \text{ (Time Available)} \quad V_8 \text{ (Costs)} \quad V_9 \text{ (Crisis State)}.$$

In other words, we may need to attend to the many complex variables that can influence the outcome of treatment for trauma and PTSD; we cannot assume that there is uniformity in the disorder, the client, therapist, or the therapy techniques. The reflexive response among therapists to apply their preferred therapies (e.g., cognitive-behavioral therapy) without consideration of the many other variables that determine outcome may well account for continuing problems we face in healing trauma and PTSD (e.g., Marsella, 2005). A complex healing calculus must be considered, and this is especially important across cultural boundaries when a score of intervening factors can impact outcome.

And herein lies the rub (with deference to Shakespeare): training programs become oriented around particular therapy systems. Often, there is a favored system that is taught as "gospel." This situation ignores the critical issues defined in the calculus formula presented. Furthermore, it assumes that every student is not only capable of rendering the "gospel"

therapy, but that it is appropriate for their character, temperament, values, and personality style (e.g., Could Albert Ellis ever be Carl Rogers?).

Alternative Healing Principles

Variable 5—healing principles—in this equation is particularly important. Early in my career (Marsella, 1982) as I conducted research in different countries and among different ethnocultural groups, I began to identify the wide range of healing principles that were used in different therapy methods and techniques. Eventually, I came to see that therapy/healing efforts around the world use a variety of different healing principles. All of them are powerful sources of solving problems and across a lifetime, many different ones might be applied depending on the circumstances. In brief, no single principle is the best, and no single therapy is the only therapy to be used. Table 4 lists examples of key healing principles found among various therapy/healing systems.

Table 4. Examples of Healing Principles Used in Different Therapy Approaches

(In the therapy process—both Western and traditional—a number of different healing principles can be offered, acquired, instilled, elicited, experienced, and explored. These can provide immediate, short-term, and long-term improvements and solutions to problems associated with trauma)

1. Beliefs and values (gains new beliefs and values that are salutogenic)
2. Catharsis (expressing emotions of anger, hate, fear, etc)
3. Confession (confess troubling experiences)
4. Penance (engages in behaviors to express sorrow and responsibility for actions)
5. Empathy experience (communication of shared feelings and understandings)
6. Verbalization of problems (helps clarification and identification)
7. Faith (establish different kinds of "faith" (e.g., religion, family, society)
8. Forgiveness (forgiveness toward self and/or others)
9. Hope (expectation of a desired outcome)
10. Information (obtaining information about many different aspects of problems)
11. Insight (gaining a sudden awareness of the sources of a problem—"aha" reaction)
12. Interpretation (explaining things within a new light or meaning)
13. Locus of control (moves locus of control regarding problems)
14. Unconscious (unconscious memories become conscious, offering new insights)
15. Authority permission (therapist provides permission/acceptance for certain actions)
16. Mobilization of endorphin and immune system
17. Skill sets (acquires new skill sets for social and cognitive functioning)
18. Reduction of negative emotions (e.g., uncertainty, guilt, shame, anxiety, fear).
19. Acceptance (increased acceptance of situation, self, and others)
20. Identification (new sense of personal and/or group identity—indigenous groups).

Some Closing Thoughts

After initial resistance and hesitancy to include cultural factors in the conceptualization, diagnosis, assessment, and treatment of trauma, there is now a widespread recognition of its importance for understanding trauma responses and traumatic events. However, resistance to considering ethnocultural determinants of PTSD continues to exist as evidenced by the adherence to clinical and research protocols that do little to offer centrality to ethnocultural factors. Much of this resistance is a function of a scientific and professional PTSD subculture replete, with its own organizations, conferences, funding sources, journals, thousands of books and hundreds of thousands of articles, that serves to isolate different views and conclusions. Although arguments can be made in favor of the progress that has occurred, problems in diagnosis, therapy, and prevention continue to exist. These problems can be found in both conventional psychiatric assumptions and models of care, and in the pursuit of ethnocultural determinants. For this to occur, it is necessary to adopt a multicultural and multidisciplinary approach. For the latter, it is important to draw linkages across different levels (macro–micro–psycho–social–biopsychosocial) of human existence.

Although progress toward more integrated viewpoints is slower than is warranted, there is some reason for optimism. Of special note is the fact that Western psychiatric notions about psychopathology continue to draw increasing criticism both within the West and across the world. There is a growing recognition that Western economic, political, and cultural hegemony does not constitute grounds for a universal acceptance of its health and medical concepts and practices. In addition, responses to both national and international disasters are offering contact situations in which Western professionals are witnessing limitations in their approaches. Across the world, even in the face of a common trauma, scientists and professionals find variations in the perception of the trauma's causes, psychological and physical consequences, and response to treatments.

Although traumatic events are a universal part of human experience, there are many different ethnocultural determinants that shape its behavioral, psychological, and social consequences. Thus, I am compelled to conclude with that closing remark common to so many articles: "More research is needed." More research, indeed, but specifically research that recognizes and responds to the powerful role of culture.

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