Sbordone, R. J., & Liter, J. C. (1995). Mild traumatic brain injury does not produce post-traumatic stress disorder. *Brain Injury*, 9(4), 405–412.

Schneiderman, A. I., Braver, E. R., & Kang, H. K. (2008). Understanding sequelae of injury mechanisms and mild traumatic brain injury incurred during the conflicts in Iraq and Afghanistan: Persistent postconcussive symptoms and posttraumatic stress disorder. *American Journal of Epidemiology*, 167(12), 1446–1452.

Shalev, A. Y., & Freedman, S. (2005). PTSD following terrorist attacks: A prospective evaluation. *American Journal of Psychiatry*, 162(6), 1188–1191.

Shear, K., Frank, E., Houck, P. R., & Reynolds, C. F., III. (2005). Treatment of complicated grief: A randomized controlled trial. *Journal of the American Medical Association*, 293(21), 2601–2608.

van Griensven, F., Chakkraband, M. L. S., Thienkrua, W., Pengjuntr, W., Cardozo, B. L., Tantipiwatanaskul, P., et al. (2006). Mental health problems among adults in tsunami-affected areas in southern Thailand. *Journal of the American Medical Association*, 296(5), 537–548.

CHAPTER

10

Cross-Cultural Perspectives on Posttraumatic Stress

JAMES D. HERBERT

EVAN M. FORMAN

Most cultures have historically framed reactions to trauma within the context of religion, with priests and shamans offering interpretation of the causes or meanings of traumatic events, while also serving in the role of healer. Within Western cultures, beginning in the mid-19th century, physicians gradually began to expand their purview to include psychological reactions to trauma. This process culminated in the creation of the medical diagnosis of posttraumatic stress disorder (PTSD) in 1980, which completed the transformation of reactions to trauma from the religious domain to a biomedical framework. This transformation, led by American psychiatry, clinical psychology, and related fields, has exerted widespread influence. The resulting "positivistic paradigm," in which human suffering and psychopathology are thought to exist independent of local theories, has resulted in a loss of recognition that cultural factors play an important role in the development and treatment of posttraumatic reactions. Despite such concerns, Western biomedical models of trauma and associated interventions are increasingly exported throughout the world. According to the United Nations, there are currently over 12.8 million internally displaced persons, 9.8 million refugees, and an additional 10.3 million "people of concern" worldwide

(UNHCR, 2006). Many of these individuals have experienced traumatic events per modern diagnostic standards, and clinicians have increasingly targeted Western interventions toward them.

Our central thesis is twofold. First, a variety of social and psychological factors, including factors typically associated with culture, invariably shape reactions to traumatic events, and the likelihood they will be viewed as pathological. While such cultural effects impact many forms of psychopathology, they appear especially important in the case of posttraumatic reactions. Second, an understanding of cultural factors is critical when assessing and treating individuals posttrauma. We begin our discussion of these concerns by briefly considering what is meant by "culture." We then review the predominant biomedical model of posttraumatic reactions, focusing on the diagnostic construct of PTSD. We examine the many ways in which psychological, environmental, and cultural factors shape reactions to trauma, including the prevalence and nature of pathological reactions. We observe that cultural effects can be studied cross-sectionally (by comparing different groups at a given point in time), as well as historically across time (within a continuously evolving culture across time). We explore what insights a historical perspective yields on the question of cultural factors in posttraumatic reactions. Finally, we consider the assessment and treatment of posttraumatic stress, including PTSD, within a culture-sensitive framework.

WHAT IS CULTURE?

Derivation of the word "culture" reflects the idea of fostering and nurturing commonalities among individuals. While cultural anthropologists have not reached consensus on a single definition of the term, the United Nations Educational, Scientific and Cultural Organization provides a useful description: "Culture should be regarded as the set of distinctive spiritual, material, intellectual and emotional features of society or a social group . . . in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs" (UNESCO, 2002).

The term "culture" can refer to broad groups that share certain beliefs and practices, extending across several nations (e.g., "Western culture"), to groups defined by national boundaries (e.g., "French culture"), to

areas within a country (e.g., "Canadian maritime culture"), all the way down to local communities such as social, vocational, religious, or even familial groups. When examining cultural factors that shape reactions to trauma, it is important to keep in mind the wide range of levels that make up such factors. Also, at whatever level one examines, no culture is static. Therefore, in addition to a cross-sectional comparison of cultures at a given time point, one can compare the impact of cultures across historical periods.

POSTTRAUMATIC STRESS DISORDER

In terms of the conceptualization, classification, and treatment of psychopathology, American beliefs and practices have become the dominant perspective worldwide. Since publication of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* in 1980 (DSM; APA, 1980), and with respect to psychological reactions to trauma, the prevailing perspective has viewed posttraumatic reactions within a biomedical context—specifically as the medical condition of PTSD.

Since its introduction in the DSM-III (APA, 1980), interest in PTSD has grown rapidly among scholars, clinicians, and the public at large. Further, the definition of what constitutes trauma, and therefore risk for PTSD, has expanded in subsequent editions of the DSM (e.g., DSM-IV; APA, 1994). Qualifying traumatic events have been extended to include learning about or witnessing another person's exposure to a life-threatening event. Traumatic events no longer need to be outside the range of normal experience, nor do they need to be defined by objective standards external to the individual. Within this definition, the majority of Americans have experienced at least one event that qualifies as a traumatic stressor (Breslau & Kessler, 2001). This gradual and ongoing expansion of trauma has led PTSD to become the dominant framework by which reactions to a wide range of adverse events are understood. Accompanying this development is the ever-increasing medicalization of human suffering (Summerfield, 2004).

There are a variety of consequences when we adopt a biomedical model to understand posttraumatic suffering. First, PTSD is understood as a "natural kind," that exists independent of our theories. As with

other medical conditions, PTSD is assumed to be universal, manifesting itself consistently with a unique symptom profile and etiology across cultures, both at any given time point as well as transhistorically. This is the way biomedical diseases work. However, unlike bone fractures or viral infections that may entail the same causal agents regardless of time or place, conditions such as PTSD are presumably socially constructed and therefore culture-bound.

POSTTRAUMATIC RESPONSES ACROSS CULTURES

An often overlooked aspect of PTSD is the fact that exactly what constitutes traumatic events, and the perceived severity of such events, varies by culture. Summerfield (2004) observed:

> There is nothing quintessential about a particular traumatic experience. The attitudes of wider society (which may change over time) shape what individual victims feel has been done to them, and shape the vocabulary they use to describe this, whether or how they seek help, and their expectations of recovery. The more a society sees a traumatic event (rape, for example) as a serious risk to the present or future health and well-being of the victim the more it may turn out to be. In other words, societally constructed ideas about outcomes, which include the pronouncements of the mental health field, carry a measure of self-fulfilling prophecy (p. 232).

Many events considered traumatic within one culture are not so perceived by others. Consider childhood sexual abuse, which has received intense focus in Western societies as a common traumatic event leading to PTSD. An act of fellatio between a pubescent boy and an older man would be universally condemned as childhood sexual abuse by Western standards. However, such acts are a common rite of passage among traditional Melanesian cultures (Bohn, 1996). Even within American culture, the assumption of inevitable lasting traumatic effects of childhood sexual abuse has been questioned (Rind, Tromovitch, and Bauserman, 1998). Outside the sexual realm, cultural differences continue to be

found. Terheggen, Stroebe, and Kleber (2001) documented that Tibetans ranked destruction of religious symbols as the most traumatic event possible, ahead of other events such as death of a friend or even being tortured.

A biomedical perspective suggests that rates of PTSD might be consistent across populations exposed to similar traumatic events. Contrary to this prediction, prevalence estimates of PTSD vary widely, both within and between cultures. For example, studies of recent immigrants to industrialized countries as well as of nationals within developing countries reveal widely variable rates of PTSD (see Yeomans and Forman, 2009). Similarly, estimates of the prevalence of PTSD within a culture are highly variable depending on factors such as gender and ethnicity. The National Comorbidity Survey found an overall rate of PTSD among American men of 8.2%, as compared to 20.4% among women (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Pole, Best, Metzler, and Marmar (2005) reviewed evidence that Latinos in the United States demonstrate higher rates of PTSD than white or black counterparts.

The observation that posttraumatic reactions in other cultures do not necessarily conform to Western expectations is consistent with emerging culturally sensitive research. Yeomans, Herbert and Forman (2008) used a combination of qualitative interviews by native speakers and standardized instruments to assess posttraumatic reactions among internally displaced people in the central African nation of Burundi. In order to avoid response contamination resulting from expectancies, open-ended interviews by trained native interviewers preceded the assessment of specific symptoms. All of the interviewees had experienced at least one, and typically several, traumatic events. Content analysis of the interview data revealed that the most common reactions concerned material complaints rather than psychological symptoms. Assessment of psychopathology revealed symptoms of somatization, anxiety, and depression, with relatively few specific symptoms of PTSD per se. Similarly, Baron (2002) found that the distress of Sudanese refugees in Northern Uganda focused more on material concerns such as lack of food, poor health care, and the ongoing threat of violence rather than psychological symptoms. The majority did not develop distressing symptoms, and for those who did, these tended to take the form of anxiety, somatic complaints, and depressive symptoms.

In their review of cross-cultural studies, Marsella and colleagues (1996; Marsella & Christopher, 2004) observed that, among the minority of individuals who respond with persistent symptoms, posttraumatic reactions tend to differ across cultures. They noted that the intrusive symptoms of PTSD tended to occur across cultures, while avoidance/numbing symptoms were not consistently observed. Marsella suggested that PTSD symptoms may be highest in cultures in which avoidance and numbing are more common, because these symptoms are key in maintaining other aspects of the disorder.

Culture and Resilience

Western journalists and health professionals who visit survivors of severe natural disasters in pre-industrialized, developing countries are often struck by the resilience of the native population. Writing in the *New York Times*, journalist David Brooks (2008) described his experience visiting the Sichuan Province in Western China following a magnitude 7.9 earthquake that killed approximately 70,000 people on May 12, 2008. Despite scenes of horrific devastation, the local villagers were generally upbeat and optimistic, displaying few signs of psychopathology. Brooks was puzzled by the reactions of the survivors he interviewed, writing:

> These were weird, unnerving interviews, and I don't pretend to understand what's going on in the minds of people who have suffered such blows and remained so optimistic. All I can imagine is that the history of this province has given these people a stripped-down, pragmatic mentality: Move on or go crazy. Don't dwell. Look to the positive. Fix what needs fixing. Work together.

Similar observations were made by researchers studying survivors of the 2004 Asian tsunami (Rakjumar, Premkumar & Tharyan, 2008), responsible for 280,000 deaths and more than one million displacements. These researchers obtained PTSD prevalence rates of only 6.4% among those from a devastated Indian coastal village. They concluded that "coping mechanisms exist at individual and community levels that enhance resilience in the face of adversity and enable normal functioning in the

majority of those affected, without requiring professional intervention" (p. 853).

Sometimes social support and other cultural factors can be more important than the actual traumatic event. Wang et al. (2000) compared the reactions of inhabitants in two villages, both hit by the previously mentioned severe earthquake in northern China. Wang found that the village with the higher level of initial exposure to the earthquake also had a higher level of post-earthquake support. Rather than experiencing higher rates of PTSD in accord with a dose-response model of trauma, the town residents with greater exposure actually had lower rates of PTSD. Evidently, social support factors act as a strong buffer to promote resilience and natural recovery after trauma.

POSTTRAUMATIC RESPONSES ACROSS HISTORY

As discussed above, historical analysis provides another means by which to study cultures. Traumatologists sometimes point to historical descriptions of PTSD-like symptoms to support the universality of PTSD (Parry-Jones & Parry-Jones, 1994). However, a careful reading of the historical literature actually supports the opposite perspective. That is, the normative reactions to trauma vary widely over time, and reflect the dominant cultural theories about the impact of trauma (Herbert & Sageman, 2002). Consider for example, various trauma-related conditions that were diagnosed among railroad workers during the mid-19th century. These conditions, known as "railway spine" and "neurasthenia," were characterized by paralysis of the legs and emotional instability. Originally thought to result from spinal compression during injuries, both epidemiological and anatomical data soon revealed that the condition was actually psychological in nature. Jean-Martin Charcot (1889) went so far as to induce symptoms of railway spine using hypnosis. Analogous to current biomedical theories of PTSD (e.g., Bremner, 2001), Charcot believed his hypnotic inductions produced anatomical brain lesions that resulted in the symptoms of railway spine. Subsequent investigators, however, demonstrated that hypnotic effects were due to expectancies conveyed by the popular culture and the examining physician (Bernheim, 1889; Delboeuf, 1890). When care was taken to avoid conveying expectations

of any particular symptoms, Charcot's hypnotic demonstrations could not be replicated. This led Hippolyte Bernheim and Joseph Delboeuf to emphasize the importance of fostering positive expectancies by means of an intervention they termed "psychotherapy." By the turn of the 20th century, railway spine was widely viewed as a posttraumatic psychological condition rather than a result of physical insult. Nevertheless, the specific symptoms of railway spine, particularly hysterical paralysis, stand in stark contrast to the symptom picture of modern PTSD.

Similar lessons have been learned in military settings (Jones & Wessely, 2005; Shephard, 2000). During the First World War, for example, a large number of psychiatric causalities were evaluated as a consequence of the relentless trench warfare that took place. The most common symptom presentation among psychiatric casualties in that war included mutism, hysterical crying, and intractable trembling (termed *Kriegszitterer* or "war trembling" by the Germans). Strong contrasts were noted between British soldiers' lack of improvement from "shell-shock" and French soldiers' swift recovery. This difference has been attributed to the fact that French soldiers were treated near the front without excessive messages of the seriousness of the condition, whereas British soldiers were evacuated to hospitals in England. During the last two years of the war, the British also adopted a program of rapid psychotherapeutic intervention near the front lines, resulting in dramatic reductions in psychiatric casualties (Shephard, 2000). In anticipation of the entrance of the United States into the war, the American physician Thomas Salmon (1917) further developed the French and English program into a strategy that came to be known by the acronym "PIE," for proximity, immediacy, and expectancy. Posttraumatic casualties were treated immediately and as close as possible to the front, with clear expectancies for full improvement. After a brief rest period, soldiers were given meaningful work, and returned to their units as quickly as possible.

Following the First World War, psychoanalysis became the dominant model of psychopathology in both Europe and the United States, and the powerful role of suggestion in posttraumatic reactions was all but forgotten. The initial campaigns of the Second World War brought alarming psychiatric casualty rates, which at one point even exceeded the rate of troop mobilization (Glass, 1973). When Salmon's PIE was

reintroduced, casualty rates fell dramatically. Shephard (1999) has termed these approaches "Pitiless Psychology," characterized by avoidance of pathological diagnostic terms, initial periods of rest with an expectation of rapid return to battle, and elimination of pensions for war-related neuroses. The lessons of the two World Wars were applied by American military psychology and psychiatry in subsequent conflicts, with significant decreases in combat-related psychological casualties.

The popularity of current biomedical models of psychopathology, combined with a Western ethnocentric bias and a lack of historical perspective, has led to the widespread belief that PTSD constitutes a natural kind—a disorder that is universally observed throughout time and across cultures. To the contrary, our brief historical overview has shown that manifestations of posttraumatic symptoms have changed substantially over time. The lessons of the past century, and in particular of the two World Wars, highlight the critical importance of expectancies in the immediate aftermath of trauma in shaping subsequent pathology or recovery. Such findings call into question the prevailing conventional wisdom regarding the nature of PTSD.

ASSESSMENT OF POSTTRAUMATIC REACTIONS

With an appreciation for the variations that occur in posttraumatic reactions, we can now turn our attention to issues of assessment and treatment. A summary of key points for clinicians to consider is presented in Table 10.1 on the following page.

Assessment of posttraumatic reactions almost always begins with a discussion of the nature, intensity, and duration of a traumatic event. When approaching this task, clinicians understand that some individuals may be reluctant to discuss their traumatic experience. There may be a variety of reasons for such reluctance, including shame, avoidance of painful memories or affect, or the belief that such discussions are irrelevant to the individual's current problems. Clinicians should be aware that a reluctance to discuss difficult topics can be more likely in some cultural groups (for example, Chinese and Latino men) than others (Norris, Weisshar, Conrad, Diaz, Murphy, & Ibanez, 2001; Wang et al., 2000).

Table 10.1 Recommendations for a Culturally Informed Approach to Posttraumatic Stress

Assessment	• Assume neither vulnerability nor resilience. • Avoid framing questions in such a way as to lead the respondent to conform to Western expectations of responses to trauma. • Be aware that some individuals are culturally normed to minimize symptoms. • Cast a broad net in the assessment of symptoms. • Beware of assessment tools that are not carefully translated and validated into indigent languages.
Formulation	• Understand the impact of a traumatic event within the context of the meaning ascribed by an individual's culture. Don't assume that events have the same impact across individuals/cultures. • Acknowledge that the way people cope with traumatic stress may vary depending on a number of factors, including cultural background. • Be aware of unconscious and conscious motivations to present with posttraumatic symptoms, especially of PTSD.
Treatment	• Utilize a phased approach to intervention, with treatment depending on the acute, subacute, or chronic posttraumatic phase. • Do not suggest directly or indirectly that an individual will exhibit chronic symptoms or will develop PTSD. Avoid psychoeducation, or administer only with extreme caution. • Utilize culturally consistent sources of recovery (e.g., community-building and extended social support). • Utilize CBT treatments across cultures, with sensitivity to cultural differences and incorporating relevant cultural practices. • Work to reduce clinician-client power imbalance that may be exacerbated by cultural differences.

When conducting an assessment interview, clinicians must avoid suggestive questions that could shape an individual's memory of the traumatic event (Loftus, 1997) and/or establish morbid expectancies. This requires keen interviewing skills and sensitivity to the individual's current state of mind. In addition, the clinician must be mindful of relevant cultural norms and mores. Resources such as the classic book *Ethnicity and Family Therapy* (McGoldrick, Giordano, & Garcia-Preto, 2005) are useful guides to typical cultural patterns associated with various ethnic groups.

A trusting therapeutic rapport is critical, and questions should be posed in an open-ended manner, especially initially. It is also critical for the clinician to suspend his or her own beliefs about how individuals "should" respond to traumatic events. In fact, it is helpful to go out of one's way to seek evidence that might contradict one's beliefs. Otherwise it is far too easy to succumb to what is known as "confirmation bias" (the highlighting and remembering of belief-congruent information over data that contradicts expectations).

A variety of clinician-rated interviews and self-report questionnaires have been developed to assess posttraumatic symptoms. Although such measures can provide useful quantitative symptom indices, they are not without limitations. All currently popular questionnaires and interview-based measures were developed in English, and few have been translated and validated into other languages. Some attempts at translation have revealed linguistic difficulties, as some common English concepts do not exist in other cultures. For example, there is no word for "trauma" in Kurundi (the language of Burundi, Africa). We are aware of one particular trauma workshop in Burundi that spent hours attempting to translate the word, and finally chose a phrase that means "having one's heart turned upside down" (A. Niyongabo, personal communication, March 15, 2005).

More fundamentally, there is the question of whether the concept of PTSD best reflects the experience of individuals in non-Western cultures. Consider that the most common approach to studying PTSD in non-Western countries typically involves these steps: translate PTSD symptoms into a native language checklist; approach an indigent population; assess the listed symptoms; find the extent to which they are endorsed by traumatized groups; report PTSD rates; and conclude that PTSD exists in that culture. This exercise and the findings that result are then used to support PTSD's presumed universality. An example of such a study was conducted by McCall and Resick (2003). They approached the Ju'hoansi tribe of Kalahari Bushmen, and with the help of village elders, identified individuals who had experienced domestic violence and who were symptomatic. They then presented these individuals with a translation of the DSM symptoms of PTSD. Not surprisingly, 35% of the sample endorsed symptoms of PTSD.

A critical problem with such an approach is that any constellation of symptoms among distressed individuals will inevitably lead to a certain number of positive cases. Consequently, the endorsement of distress symptoms tells us little to nothing about the actual validity of a proposed taxonomic entity. For example, suppose that we claim to have discovered a new diagnostic category, which we will call "post-amputee neurosis" (PAN). We claim that individuals who have lost a limb, especially as the result of trauma, will display a specific symptom pattern consisting of hypersomnia, joint pain (outside of the affected limb), anger outbursts, dissociative episodes, and intermittent periods of deflated self-esteem. Now, we translate a list of these symptoms into local dialects, and approach victims of the civil war in the Darfur region of Sudan. We seek out amputees in particular, read off our checklist, and ask if they have experienced these symptoms. We would not be surprised to find that a significant number endorse some of the symptoms. Moreover, we find that amputees endorse symptoms at a higher rate than non-amputees, and double-amputees endorse more symptoms than single amputees. Would these results validate the existence of PAN? Obviously not. Note that the more distressed the group, the more likely they will endorse symptoms of any form of pathology. And of course, amputees are likely to be more distressed than non-amputees (and double amputees more distressed than single amputees). Consequently, amputees will endorse more symptoms of PAN, or of most anything else on a psychiatric checklist, for that matter.

In order to assess how individuals from different cultures actually respond to trauma, one must avoid decontextualized checklists and instead cast a broader net. As the example of PAN illustrates, the nature of posttraumatic responses assessed in research is largely a function of the methods used. Mackowiak and Batten (2008) recently used the symptom checklist method in an analysis of the lives of four major historical figures (Alexander the Great, Captain James Cook, Emily Dickinson, and Florence Nightingale), and concluded that each likely suffered from PTSD. Of course, an examination of checklists for many different disorders might very possibly have resulted in the conclusion that these individuals fulfilled criteria in each instance. Thus, a depression checklist could lead to a diagnosis of depression, a panic checklist to a diagnosis of panic disorder, and so on. In fact, if one totally ignored historical and

cultural contexts, it is possible that Alexander the Great could be retrospectively diagnosed with severe narcissistic personality disorder for wanting to conquer the world, and a possible psychotic disorder for believing in multiple gods, including one who periodically sent lightning bolts to Earth and another who created love with shooting arrows.

Additional issues may influence the assessment of posttraumatic responses, especially in non-Western cultures (Yeomans & Forman, 2009). Individuals may be motivated to respond with socially desirable responses according to their perceptions of what an appropriate or favorable response might be. Such effects are particularly problematic given the power imbalance that typically exists between Western researchers and indigent populations. Western knowledge is often tacitly held to be superior to local knowledge, regardless of its applicability in a particular context (Wessels, 1999; Peddle, Monteiro, Guluma, & Macauley, 1999). This can result in individuals modifying their reports, and perhaps even their actual experience, to match the perceived expectations of researchers. One example of this effect was found by Yeomans, Herbert, and Forman (2008). In this study, indigent rural Africans with greater exposure to Western PTSD psychoeducation reported more symptoms of PTSD relative to those with less or no exposure.

Actual or anticipated secondary gain can also shape reports of traumatic reactions. Individuals in poverty-stricken societies may be motivated to report symptoms of psychological distress in hopes of obtaining resources directed toward those determined to be most needy (Kagee & Naidoo, 2004). Similarly, resources for individuals in industrialized societies are sometimes contingent upon ongoing manifestation of symptoms. For example, current policy of the American Veterans Administration provides considerable compensation for PTSD-related disability, but payment ceases if symptoms remit (Frueh, Smith, & Barker, 1996). Such contingencies can create powerful incentives to develop, maintain, and report symptoms. This is not to suggest that individuals are necessarily malingering, although deliberate exaggeration of symptoms undoubtedly sometimes occurs. Rather secondary gain may reinforce the actual experience of posttraumatic symptoms. A parallel example exists among petitioners for political asylum for whom success sometimes hinges on the extent to which PTSD symptoms convince a judge of the veracity

of their trauma history. It is important to recognize that these incentives exist for the clinician as well, if for no other reason than wanting to "help" their clients. These concerns have been discussed by Derek Summerfield, a British psychiatrist who views PTSD as a Western "invention" that has been improperly imposed on non-Western cultures (Summerfield, 2001; 2002; 2004; 2005).

Problems with research methods that rely on decontextualized checklists, combined with issues related to perceived social desirability, power differential between researcher and subject, and possible secondary gain, highlight the importance of research methods that strive to avoid these factors in order to provide the most accurate picture of responses to trauma. Examples of good practices include so-called "ethnosemantic" interviews by native interviewers that precede queries about specific symptoms in order to avoid contamination.

CULTURALLY SENSITIVE TREATMENT

Before discussing culturally sensitive treatment guidelines, it is important to review several basic findings that pertain to posttraumatic reactions. First, contrary to the prevailing conventional wisdom among many mental health clinicians, the majority of people who experience traumatic events are actually quite resilient (Agaibi & Wilson, 2005). Most will be initially upset immediately following the trauma, and may experience a variety of symptoms, but will recover within a matter of days to weeks. It is therefore important that interventions acknowledge and address the short-term distress that most people experience, while simultaneously supporting factors that encourage resilience. Second, it is becoming increasingly clear that, in the immediate aftermath of trauma, people are acutely sensitive to suggestions regarding expectations of how one should be responding. Although such messages may come from the culture at large, they are especially powerful when delivered by health care professionals. If one conveys expectations that the trauma is likely to result in persistent symptoms, the likelihood of such symptoms increases. If, on the other hand, a clinician normalizes the traumatized individual's experience as temporary, transient reactions to extraordinary circumstances, with the clear expectation of full recovery, then the likelihood of recovery increases.

Despite this overall pattern of resilience, a minority of individuals continue to experience persistent and clinically significant symptoms. These individuals can benefit from scientifically supported treatments. Yet, even this group should not be subjected to interventions that convey that drawn-out posttraumatic symptoms are the normative reaction to trauma. Clinicians should avoid over-pathologizing an individual's reactions to adversity. Simply framing a reaction as a "symptom" of mental disorder can lead to iatrogenic effects. As an illustration, in our study of Burundian war trauma survivors, those who were randomly assigned to attend an intervention workshop that contained a standard psychoeducational component about PTSD had *worse* outcomes than those assigned to an equivalent intervention without the psychoeducational component (Yeomans, Forman, & Herbert, in press).

Taken together, these facts suggest that a phased approach to intervention is most appropriate, with interventions linked to the stage an individual finds him- or herself in relation to the traumatic event. Therefore, we discuss intervention efforts in three stages: the acute posttraumatic phase, the subacute phase, and the chronic phase (Herbert & Forman, 2006; Herbert & Sageman, 2002).

Acute Phase

The most important priority immediately following a traumatic event is attending to the material needs of the traumatized individual, including safety, food, and medical intervention, as needed. Psychological interventions should focus on restorative and recuperative measures, in the context of supportive, encouraging, and optimistic messages regarding full recovery. The individual's reactions should be normalized, without undue attention. This is not the time for introspective analysis of the meaning behind one's symptoms. Adequate rest is essential and medication can be prescribed as a sleep aid if necessary.

It is important to encourage meaningful activities to minimize morbid preoccupation with the trauma and one's symptoms. This is not to suggest that individuals should be encouraged to avoid thoughts of the trauma or distressing feelings associated with it, or from speaking about it if they wish. Indeed, a growing body of evidence suggests that psychological avoidance can be quite problematic (e.g., Hayes et al., 2004). Rather,

the idea is to encourage an individual to engage in meaningful activities to avoid morbid preoccupation with the traumatic event, to encourage a sense of self-efficacy, and, as much as possible, to restore a sense of normalcy. In this regard, indigenous cultural practices and rituals can be especially helpful. Thus, in certain Native American and Southeast Asian cultures, a specific set of post-trauma rituals has developed to cleanse the spirit and restore the soul (Wilson, 2006). In more collectivist cultures in particular, community-building efforts can be especially relevant. For example, after the 2008 Chinese earthquake, survivors quickly set about burying the dead, clearing rubble, and reconstructing schools and other communal buildings. Such community-building efforts have been empirically demonstrated to powerfully mitigate the effects of trauma in collectivist societies (Wang et al., 2000). More generally, clinicians should promote culturally appropriate forces of emotional and social support, and remain mindful that traumatic experiences and the responses that follow take place within a cultural context.

As important as what to do in the immediate aftermath of a trauma is what *not* to do. There is growing evidence that certain common posttraumatic intervention programs (e.g., Critical Incident Stress Debriefing) are at best ineffective, and at worse can be harmful. Indeed, professional treatment guidelines, such as the United Kingdom's National Institute for Clinical Excellence guidelines, explicitly caution against the use of posttraumatic psychological debriefing (Mayor, 2005). Certainly, clinicians do not want to export to non-Western cultures a treatment model that has failed in its own milieu.

Subacute Phase

Even if morbid suggestions and expectations are carefully avoided, some individuals develop persistent symptoms and require treatment. There is no clear consensus on exactly when normal, transient reactions cross the line to become "symptoms" of a disorder. As a general rule, we suggest that clinicians consider treatment within weeks of a traumatic event if reactions remain highly distressing and cause impairment in functioning, as judged within the context of the individual's social group and culture.

With regard to what treatment is advised during the subacute phase, several studies in Western countries have supported the use of short-term

cognitive behavior therapy. This type of intervention can be delivered a few weeks following a traumatic event to those whose symptoms have not resolved on their own. Research has shown that short-term CBT in the aftermath of trauma can be effective in preventing the development of chronic problems (Bryant et al., 1998, 1999, 2003; Foa, Hearst-Ikeda, & Perry, 1995). It is important to emphasize that this type of intervention should only be used with individuals having significant distress and dysfunction as a result of their symptoms. Thus, unlike debriefing programs that are improperly recommended for all survivors, short-term CBT programs are targeted only for individuals with clinically significant symptoms that have persisted weeks following the event. As in the acute posttraumatic phase, it is important that morbid expectations be avoided, and that indigent cultural practices be respected and incorporated into treatment.

Chronic Phase

In the aftermath of trauma, some individuals continue to experience a chronic symptom picture, with impairment in functioning. A growing research literature supports the effectiveness of several specific, cognitive-behavioral therapy (CBT) interventions for chronic posttraumatic symptoms. However, nearly all of this research has been conducted with Western populations. Thus, the generalizability of these approaches across cultures is uncertain. Nevertheless, there are several promising indicators that the effects of CBT may generalize across cultures. First, the samples of trauma victims in a number of Western effectiveness studies were diverse ethnically and, presumably, culturally. Second, a few studies have specifically evaluated the effectiveness of exposure-based therapy for PTSD with racial minority populations. For instance, Zoellner, Feeny, Fitzgibbons and Foa (1999) compared the responses of African Americans and Caucasians to exposure treatment and found equivalent dropout and improvement rates. Similarly, a published series of uncontrolled case studies concluded that exposure treatment significantly reduced PTSD symptoms among low-income African American women (Feske, 2001). Third, the specific techniques of CBT appear to be based on sound, universal principles concerning anxiety reduction that might be expected to cut across cultural lines (Rosen & Davison, 2003). Fourth, there are a limited, but growing, set of studies of CBT-based interventions

for non-Western trauma victims that echo findings with Western populations (e.g., Paunovic & Öst, 2001). In one study, 43 Sudanese refugees in Northern Uganda were randomly assigned to receive either psychoeducation, psychoeducation plus supportive counseling, or psychoeducation plus narrative exposure therapy. Only those receiving exposure therapy experienced decreases in PTSD symptoms (Neuner, Schauer, Klaschik, Karunakara, & Elbert, 2004).

On the basis of the above, we suggest that clinicians operate on the assumption that standard CBT interventions, especially exposure-based interventions, should be the treatment of choice for chronic posttraumatic symptoms in persons of varying cultural backgrounds. One important caveat is that the intervention program, while retaining its core components, must be adapted to be culturally respectful, sensitive, and appropriate.

ADDITIONAL STRATEGIES AND CONCERNS

Stress inoculation training: Closely related to cognitive restructuring is Stress Inoculation Training (SIT; Meichenbaum, 1993), a multicomponent intervention comprised of relaxation, guided self-dialogue, covert modeling (visualizing the successful confrontation of an anxiety-provoking situation), role-playing, and thought stopping (e.g. subvocally saying the word "stop!" to interrupt distressing ruminative thoughts). Although SIT appears to be effective, some evidence suggests it is not as powerful as prolonged exposure and provides no incremental benefits (Foa, Rothbaum, Riggs & Murdock, 1991; Foa et al., 1999). Moreover, growing evidence suggests that attempting to suppress trauma-related cognitions through such techniques as thought stopping may, in fact, paradoxically increase the frequency and intensity of the thoughts (Harvey & Bryant, 1998).

Acceptance-based therapies: The paradoxical effects of thought stopping point to the more general role of psychological avoidance (i.e. the avoidance of aversive thoughts, memories, images, emotions, etc.; Herbert, Forman, & England, 2009) in the development and maintenance of PTSD. Several models of cognitive behavior therapy such as Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999) directly address psychological avoidance and can be applied in the treatment of PTSD (Orsillo & Batten, 2005; Walser & Hayes, 1998; Walser

& Westrup, 2007). Although promising, little research has yet investigated ACT for posttraumatic disorders.

Imagery rehearsal therapy: Imagery rehearsal therapy (IRT; Davis, 2009; Krakow et al., 2001) is a specific cognitive behavioral intervention that can target nightmares and sleep disturbances associated with PTSD. In addition to standard sleep hygiene interventions, IRT involves having the patient write down a disturbing dream. The patient then modifies the dream however he or she desires, and the modified version is then rehearsed daily in imagination. Initial studies of IRT are promising (Maher, Rego, & Asnis, 2006). At the same time, clinicians should be sensitive to culture views regarding dreams and dream content (e.g., when dreams are thought to involve spiritual messages).

Treatments to Avoid

When clinicians work with patients, it is as important to know what treatments to avoid as what treatments to offer. For example, there is little evidence to suggest that traditional psychoanalytic or supportive psychotherapy are effective treatments for chronic posttraumatic symptoms. Another approach lacking support is that of "psychoeducation," at least as it has been applied during debriefings in Western settings. As previously noted, there is, in fact, some initial evidence that psychoeducation about Western conceptions of PTSD is *harmful* rather than helpful. Recently, concerns with psychoeducation have been extended to a non-Western culture. In this study (Yeomans, Forman, & Herbert, in press), Burundians with severe and multiple trauma histories were randomly assigned to one of two versions of a four-day workshop, or a waitlist control. The two workshops differed only in that one intervention included a psychoeducational component. Results indicated that the psychoeducational component reduced the beneficial aspects of the intervention program, presumably by creating a morbid expectation on the part of the participants.

A number of so-called "power" or "energy" therapies have been aggressively promoted over the past decade for PTSD and related conditions, both in the United States and throughout the developed and developing world (Rosen, Lohr, McNally, & Herbert, 1998). The most prominent of these are eye movement desensitization (EMDR; Shapiro, 2001) and thought field therapy (TFT; Callahan, 1985). These programs

claim to operate via unusual mechanisms, and promise much more rapid and effective treatment than standard therapies, including state-of-the-art exposure-based treatments. The evidence, however, does not support this claim. EMDR has been shown to be effective, but no more so than existing treatments, and in some cases somewhat less so (Davidson & Parker, 2001; Devilly, 2002; Devilly & Spence, 1999). Importantly, the distinguishing feature of EMDR—eye movements or other bilateral, therapist-induced stimulation—does not contribute to its effects, suggesting that EMDR is but a variant of cognitive-behavior and exposure-based techniques (Herbert et al., 2000). Similarly, there is no scientific support for the miraculous claims made regarding TFT and its variants. Despite these negative findings, power therapies have been exported to Third World countries in curious forms and for all manner of afflictions. The interested clinician can do an Internet search for these methods to find various examples (e.g., work in Africa by the Association for Thought Field Therapy). We strongly recommend that therapists avoid the power therapies, in favor of more scientifically supported treatments whose claims are consistent with the available evidence.

By far the most potentially damaging treatment approaches for posttraumatic reactions are programs aimed at "recovering" repressed memories of traumatic events. Such therapies may involve any number of techniques, including hypnosis, age regression, and guided imagery, that are designed to uncover "repressed" traumatic memories, often of childhood sexual abuse. Research has now convincingly demonstrated that traumatic repression is inconsistent with the way memory actually works (Schacter, 1996), and that these highly suggestive techniques can actually create memories of abuse that never actually occurred, which are then experienced as veridical (Loftus, 2003). Therapists should avoid such approaches, and should be especially mindful of the risk of inadvertently creating memories through suggestive techniques.

CONCLUDING POINTS

In the past three decades, a tremendous interest in the psychological effects of traumatic experiences has developed. Creation of the diagnostic construct of PTSD in 1980 served as a catalyst to jump-start research and

clinical innovations into posttraumatic reactions. Such work has yielded important fruit. We have gained a clearer picture of normative reactions to aversive events and factors that impede or promote recovery. Effective treatments have been developed for those with persistent symptoms. And importantly, we have an increasingly clear sense of what not to do.

The picture is not entirely positive, however. Despite these achievements, the construct of PTSD has become reified, commonly viewed as a "natural kind" that exists relatively independent of its sociocultural context. The results of cross-cultural and historical studies argue against this perspective. There is mounting evidence that posttraumatic reactions are shaped by a variety of factors. Among the most critical of these factors is the cultural context, which largely determines not only which events are experienced as traumatic, but the nature and degree of pathology of subsequent reactions. History demonstrates that normative posttraumatic symptoms have changed over time, while cross cultural research shows that despite some commonalities, symptoms appear to differ across cultures even today. In addition, the popularity of PTSD tends to draw attention away from one of the most striking facts about posttraumatic reactions: Most individuals show remarkable resilience even following severe traumatic events. It is critical that mental health professionals focus on promoting such resilience, rather than inadvertently undercutting it through well-intentioned but misguided efforts.

Rather than subsuming all posttraumatic reactions under the rubric of a single biomedical diagnostic label (e.g., PTSD), there is growing evidence that such reactions are best understood in their cultural context. Clinicians will find that their assessment and intervention efforts are most effective when infused with culturally sensitive practices.

REFERENCES

Agaibi, C. E., & Wilson, J. P. (2005). Trauma, PTSD, and resilience: A review of the literature. *Trauma, Violence & Abuse, 6,* 195–216.

American Psychiatric Association (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Baron, N. (2002). Community based psychosocial and mental health services for southern Sudanese refugees in long term exile in Uganda. In J. de Jong (Ed.), *Trauma in war and peace: Prevention, practice, and policy* (pp. 157–203). New York: Kluwer Academic/ Plenum.

Bernheim, H. (1889). *Suggestive therapeutics: A treatise on the nature and uses of hypnotism.* New York: G. P. Putnam's Sons.

Bohn, A. (1996). Festivals and sex. In E. J. Haeberle (Ed.), *Human sexuality: An encyclopedia.* Berlin, Germany: Humboldt-Universität zu Berlin.

Bremner, J. D. (2001). Hypotheses and controversies related to effects of stress on the hippocampus: An argument for stress-induced damage to the hippocampus in patients with posttraumatic stress disorder. *Hippocampus, 11,* 75–81.

Breslau, N., & Kessler, R. C. (2001). The stressor criterion in DSM-IV posttraumatic stress disorder: An empirical investigation. *Biological Psychiatry, 50,* 699–704.

Brooks, D. (2008, Aug. 14). Where's the trauma and the grief? *New York Times.*

Bryant, R. A., Harvey, A. G., Dang, S. T., Sackville, T., & Basten, C. (1998). Treatment of acute stress disorder: A comparison of cognitive-behavioral therapy and supportive counseling. *Journal of Consulting and Clinical Psychology, 66,* 862–866.

Bryant, R. A., Moulds, M. L., & Nixon, R. V. D. (2003). Cognitive behaviour therapy of acute stress disorder: A four-year follow-up. *Behaviour Research and Therapy, 41,* 489–494.

Bryant, R. A., Sackville, T., Dang, S. T., Moulds, M., & Guthrie, R. (1999). Treating acute stress disorder: An evaluation of cognitive behavior therapy and supportive counseling techniques. *American Journal of Psychiatry, 156,* 1780–1786.

Callahan, R. (1985). *Five minute phobia cure.* Wilmington, DE: Enterprise.

Charcot, J. M. (1889). *Clinical lectures on diseases of the nervous system, Vol. III.* Trans. T. Savill. London: The New Sydenham Society.

Davidson, P. R., & Parker, K. C. H. (2001). Eye movement desensitization and reprocessing (EMDR): A meta-analysis. *Journal of Consulting & Clinical Psychology, 69,* 305–316.

Davis, J. L. (2009). *Treating post-trauma nightmares: A cognitive behavioral approach.,* New York: Springer Publishing Co.

Delboeuf, J. (1890). *Le magnétisme animal.* Paris: Félix Alcan.

Devilly, G. J. (2002). Eye movement desensitization and reprocessing: A chronology of its development and scientific standing. *Scientific Review of Mental Health Practice, 1,* 113–138.

Devilly, G. J., & Spence, S. H. (1999). The relative efficacy and treatment distress of EMDR and a cognitive behavioral trauma treatment protocol in the amelioration of posttraumatic stress disorder. *Journal of Anxiety Disorders, 13,* 131–157.

Feske, U. (2001). Treating low income Mexican-American women with posttraumatic stress disorder: A case series. *Behavior Therapy, 32,* 585–601.

Foa, E. B., Dancu, C. V., Hembree, E. A, Jaycox, L. H., Meadows, E. A., & Street, G. P. (1999). A comparison of exposure therapy, stress inoculation training, and their combination for reducing posttraumatic stress disorder in female assault victims. *Journal of Consulting and Clinical Psychology, 67,* 194–200.

Foa, E. B., Hearst-Ikeda, D., & Perry, K. J. (1995). Evaluation of a brief cognitive-behavioral program for the prevention of chronic PTSD in recent assault victims. *Journal of Consulting and Clinical Psychology, 63,* 948–955.

Foa, E. B., Rothbaum, B. O., Riggs, D. S., & Murdock, T. B. (1991). Treatment of posttraumatic stress disorder in rape victims: A comparison between cognitive–behavioral procedures and counseling. *Journal of Consulting and Clinical Psychology, 59,* 715–723.

Frueh, B. C., Smith, D. W., & Barker, S. E. (1996). Compensation seeking status and psychometric assessment of combat veterans seeking treatment for PTSD. *Journal of Traumatic Stress, 9,* 427–439.

Glass, A. (1973). *Neuropsychiatry in World War II. Vol. II: Overseas theaters.* Washington, DC: Office of the Surgeon General, Department of the Army.

Harvey, A. G., & Bryant, R. A. (1998). The role of valence in attempted thought suppression. *Behaviour Research & Therapy, 36,* 757–763.

Hayes, S. C., Strosahl, K., & Wilson, K.G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change.* New York: Guilford.

Hayes, S. C., Strosahl, K., Wilson, K. G., Bissett, R. T., Pistorello, J., & Toarmino, D. et al. (2004). Measuring experiential avoidance: A preliminary test of a working model. *The Psychological Record, 54,* 553–578.

Herbert, J. D., & Forman, E. M. (2006). Posttraumatic stress disorder. In J. E. Fisher & W. O'Donohue (Eds.), *Practitioner's guide to evidence based psychotherapy* (pp. 555–566). New York: Springer.

Herbert, J. D., Forman, E. M., & England, E. E. (2009). Psychological acceptance. In W. O'Donohue & J. E. Fisher (Eds.), *General principles and empirically supported techniques of cognitive behavior therapy* (pp. 102–114). New York: John Wiley & Sons.

Herbert, J. D., Lilienfeld, S. O., Lohr, J. M., Montgomery, R. W., O'Donohue, W. T., & Rosen, G. M. (2000). Science and pseudoscience in the development of eye

movement desensitization and reprocessing: Implications for clinical psychology. *Clinical Psychology Review, 20*, 945–971.

Herbert, J. D., & Sageman, M. (2002). "First do no harm:" Emerging guidelines in the treatment of posttraumatic reactions. In G. M. Rosen (Ed.), *Posttraumatic stress disorder: Issues and controversies*. Chichester, England: John Wiley & Sons.

Jones, E., & Wessely, S. (2005). *Shell shock to PTSD: Military psychiatry from 1900 to the Gulf War*. New York: Psychology Press.

Kagee, A., & Naidoo, A. V. (2004). Reconceptualizing the sequelae of political torture: Limitations of a psychiatric paradigm. *Transcultural Psychiatry, 41*, 46–61.

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry, 52*, 1048–1060.

Krakow B., Hollifield M., Johnston L., Koss, M., Schrader, R., & Warner, T. D. et al. (2001). Imagery rehearsal therapy for chronic nightmares in sexual assault survivors with posttraumatic stress disorder: A randomized controlled trial. *Journal of the American Medical Association, 286*, 537–545.

Loftus, E. F. (1997). Creating false memories. *Scientific American, 277*, 70–75.

Loftus, E. F. (2003). Make-believe memories. *American Psychologist, 58*, 867–873.

Mackowiak, P. A., & Batten, S. V. (2008). Post-traumatic stress reactions before the advent of post-traumatic stress disorder: Potential effects on the lives and legacies of Alexander the Great, Captain James Cook, Emily Dickinson, and Florence Nightingale. *Military Medicine, 173*, 1158–1163.

Maher, M. J., Rego, S. A., & Asnis, G. M. (2006). Sleep disturbances in patients with post-traumatic stress disorder: Epidemiology, impact and approaches to management. *CNS Drugs, 20*, 567–590.

Marsella, A. J., & Christopher, M. A. (2004). Ethnocultural considerations in disasters: An overview of research, issues, and directions. *Psychiatric Clinics of North America, 27*, 521–539.

Marsella, A. J., Friedman, M. J., & Spain, E. H. (1996). Ethnocultural aspects of PTSD: An overview of issues and research directions. In A. J. Marsella, M. J. Friedman, E. T. Gerrity, & R. M. Scurfield (Eds.), *Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications*. Washington, DC: American Psychological Association.

Mayor, S. (2005). Psychological therapy is better than debriefing for PTSD. *British Medical Journal, 330*, 689.

McCall, G., & Resick, P. (2003). A pilot study of PTSD symptoms among Kalahari Bushmen. *Journal of Traumatic Stress, 16*, 445–450.

McGoldrick, M., Giordano, J., & Garcia-Preto, N. (2005). *Ethnicity and family therapy* (3rd ed.). New York: Guilford.

Meichenbaum, D. (1993). Stress inoculation training: A 20-year update. In P. M. Lehrer & R. L. Woolfolk (Eds.), *Principles and practice of stress management* (pp. 373–406). New York: Guilford.

Neuner, F., Schauer, M., Klaschik, C., Karunakara, U., & Elbert, T. (2004). A comparison of Narrative Exposure Therapy, supportive counseling, and psychoeducation for treating Posttraumatic Stress Disorder in an African refugee settlement. *Journal of Counseling and Clinical Psychology, 72*, 579–587.

Norris, F. H., Weisshar, D. L., Conrad, M. L., Diaz, E. M., Murphy, A. D., & Ibanez, G. E. (2001). A qualitative analysis of posttraumatic stress among Mexican victims of disaster. *Journal of Traumatic Stress, 14*, 741–756.

Orsillo, S. M., & Batten, S. V. (2005). Acceptance and commitment therapy for PTSD. *Behavior Modification, 29*, 95–129.

Parry-Jones, B., & Parry-Jones, W. L. L. (1994). Post-traumatic stress disorder: Supportive evidence from an eighteenth century natural disaster. *Psychological Medicine, 24*, 15–27.

Paunovic, N., & Öst, L. (2001). Cognitive-behavior therapy vs. exposure therapy in the treatment of PTSD in refugees. *Behaviour Research and Therapy 39*, 1183–1197.

Peddle, N., Monteiro, C., Guluma, V., & Macauley, T. (1999). Trauma, loss, resilience in Africa: A psychosocial community based approach to culturally sensitive healing. In K. Nader, N. Dubrow, & B. H. Stamm (Eds.), *Honoring differences: Cultural issues in the treatment of trauma and loss*. Philadelphia: Brunner/Mazel.

Pole, N., Best, S. R., Metzler, T., & Marmar, C. R. (2005). Why are Hispanics at greater risk for PTSD? *Cultural Diversity and Ethnic Minority Psychology, 11*, 144–161.

Rajkumar, A. P., Premkumar, T. S., & Tharyan, P. (2008). Coping with the Asian tsunami: Perspectives from Tamil Nadu, India on the determinants of resilience in the face of adversity. *Social Science & Medicine, 67*, 844–853.

Rind, B., Tromovitch, P., & Bauserman, R. (1998). A meta-analytic examination of assumed properties of child sexual abuse using college samples. *Psychological Bulletin, 124*, 22–53.

Rosen, G. M., & Davison, G. C. (2003). Psychology should identify empirically supported principles of change (ESPs) and not credential trademarked therapies or other treatment packages. *Behavior Modification, 27,* 300–312.

Rosen, G. M., Lohr, J. M., McNally, R. J., & Herbert, J. D. (1998). Power therapies, miraculous claims, and the cures that fail. *Behavioural and Cognitive Psychotherapy, 26,* 99–101.

Salmon, T. (1917). *The care and treatment of mental diseases and war neuroses ("shell shock") in the British army.* New York: War Work Committee of the National Committee for Mental Hygiene, Inc.

Schacter, D. L. (1996). *Searching for memory: The brain, the mind, and the past.* New York: Basic Books.

Shapiro, F. (2001). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures* (2nd ed.). New York: Guilford.

Shephard, B. (1999). Pitiless psychology: The role of prevention in British military psychiatry in the Second World War. *History of Psychiatry, 10,* 491–510.

Shephard, B. (2000). *A war of nerves: Soldiers and psychiatrists 1914–1994.* London: Jonathan Cape.

Summerfield, D. (2001). The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category. *British Medical Journal, 322,* 95–98.

Summerfield, D. (2002). Effects of war: Moral knowledge, revenge, reconciliation, and medicalized concepts of "recovery." *British Medical Journal, 325,* 1105–1107.

Summerfield, D. (2004). Cross-cultural perspectives on the medicalization of human suffering (pp. 233–244). In G. M. Rosen (Ed.), *Posttraumatic stress disorder: Issues and controversies.* Chichester, England: John Wiley & Sons.

Summerfield, D. (2005). "My whole body is sick . . . My life is not good": A Rwandan asylum seeker attends a psychiatric clinic in London. In D. Ingleby (Ed.), *Forced migration and mental health: Rethinking the care of refugees and displaced persons* (pp. 95–113). New York: Springer.

Terheggen, M., Stroebe, M., & Kleber R. (2001). Western conceptualization and Eastern experience: A Cross-cultural study of traumatic stress reactions among Tibetan refugees in India. *Journal of Traumatic Stress, 14,* 391–403.

UNESCO (2002). *Universal declaration on cultural diversity.* Downloaded from http://www.unesco.org/education/imld_2002/universal_decla.shtml

United Nations High Commission on Refugees (UNHCR) (2006). *2006 Global trends: Refugees, asylum seekers, returnees, internally displaced and stateless persons.* New York: Author.

Walser, R. D., & Hayes, S. C. (1998). Acceptance and trauma survivors: Applied issues and problems. In V. M. Follette & J. I. Ruzek (Eds.), *Cognitive-behavioral therapies for trauma* (pp. 256–277). New York: Guilford.

Walser, R. D., & Westrup, D. (2007). *Acceptance & commitment therapy for the treatment of post-traumatic stress disorder and trauma-related problems: A practitioner's guide to using mindfulness and acceptance strategies.* Oakland, CA: New Harbinger.

Wang, X., Gao, L., Shinfuku, N., Zhang, H., Zhao, C., & Shen, Y. (2000). Longitudinal study of earthquake-related PTSD in a randomly selected community sample in north China. *The American Journal of Psychiatry, 157,* 1260–1266.

Wessels, M. (1999). Culture, power, and community: Intercultural approaches to psychosocial assistance and healing. In K. Nader, N. Dubrow, & B. H. Stamm (Eds.), *Honoring differences: Cultural issues in the treatment of trauma and loss* (pp. 267–280). Philadelphia: Brunner/Mazel.

Wilson, J. P. (2006). *The posttraumatic self: Restoring meaning and wholeness to personality.* New York: Brunner-Routledge.

Yeomans, P. D., & Forman, E. M. (2009). Cultural factors in traumatic stress. In S. Eshun & R. Gurung (Eds.), *Sociocultural influences on mental health* (pp. 221–244). Boston: Blackwell.

Yeomans, P. D., Forman, E. F., & Herbert, J. D. (in press). A randomized trial of a reconciliation workshop with and without PTSD psychoeducation in Burundian sample. *Journal of Traumatic Stress.*

Yeomans, P., Herbert, J. D., & Forman, E. M. (2008). Symptom comparison across multiple solicitation methods among Burundians with traumatic event histories. *Journal of Traumatic Stress, 21,* 231–234.

Zoellner, L. A., Feeny, N. C., Fitzgibbons, L. A., & Foa, E. B. (1999). Response of African American and Caucasian women to cognitive behavioral therapy for PTSD. *Behavior Therapy, 30,* 581–595.