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Trauma Therapy and
The Need for Cross Cultural Competence

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Abstract

This project addresses the relevance of cross cultural competence for work in trauma therapy. I begin with a review of the literature on approaches to trauma therapy, identifying similarities and differences in key approaches, and comparing outcomes where that information is available. I then review a variety of cross cultural variations in mental health conditions and symptoms, attempting to roughly position each within the ethnic group or groups in which the variation is mostly likely to be found. Finally, I review the very small existing literature examining the impact of culturally sensitive approaches to trauma therapy in several non-Western ethnic groups. I conclude by highlighting the relevance of cross cultural competence for meeting the needs of patients with trauma from cultures around the globe, who must be considered in the context of their own cultural values, beliefs, and expectations in order to yield the greatest therapeutic effects.

Treatments for Trauma

Prevailing Western treatments for trauma survivors are outlined below. For each treatment, I detail the different treatment components. I also highlight similarities and differences between exposure-based treatments and treatments focusing on development of hard skills like relaxation techniques, guided imagery, coping skills and more. After each grouping, I will analyze the effectiveness and outcomes of each treatment and compare and contrast them to the other treatments that were mentioned.

Exposure-Based Treatments

Prolonged Exposure Therapy (PET)

Prolonged Exposure Therapy (PET), as explained by Foa (2011), involves exposing the patient to trauma reminders or triggers in vivo and utilizing imaginal exposure to help the patient confront the negative emotions associated with the traumatic event. In vivo exposure is assigned as homework for the client to complete outside of therapy and then is reviewed in therapy (Foa, 2011). Imaginal exposure refers to having the patient recall the event in their mind or “imagine” the event in order to expose them to their negative emotions (Foa, 2011). This emotional response is normalized by a discussion that follows the exposure in order to help the patient process the emotions that occurred during the traumatic event rather than simply repressing and avoiding confrontation with the negative emotions that are associated with the traumatic event (Foa, 2011). Through these discussions, the patient learns to recognize that thinking about the trauma, and exposure to trauma triggers, are not harmful. Patients can then recognize and correct erroneous beliefs about what is truly dangerous (Foa, 2011). Additionally, discussions allow the patients to confront their erroneous beliefs about the events or triggers (for example, that thinking about the event is dangerous) and to make new insights about their experience (Foa,

2011). Prolonged Exposure Therapy typically requires 8-15 meetings lasting from an hour to an hour and a half (Foa, 2011).

Narrative Exposure Therapy (NET)

Prolonged Exposure Therapy is similar to Narrative Exposure Therapy. In Narrative Exposure Therapy, a therapist works with a client to record their telling of the traumatic event that they experienced (Hensel-Dittmann, Schauer, Ruf, Catani, Odenwald, Elbert, & Neuner, 2011). While constructing this narrative of the traumatic event, the client is encouraged to experience their emotional reactions to the event while remaining aware of their current, safe situation (Hensel-Dittmann, Schauer, Ruf, Catani, Odenwald, Elbert, & Neuner, 2011). This tactic teaches the client that the emotions are associated with their memories and are not permanent aspects of their life (Hensel-Dittmann, Schauer, Ruf, Catani, Odenwald, Elbert, & Neuner, 2011). Additionally, each time the therapist reads the traumatic event narrative during therapy, the client is encouraged to correct it (Hensel-Dittmann, Schauer, Ruf, Catani, Odenwald, Elbert, & Neuner, 2011). This therapy continues until the emotional reactions of the client during the retelling of their narrative diminish, and during the last session, the therapist gives the client their recorded autobiography to keep (Hensel-Dittmann, Schauer, Ruf, Catani, Odenwald, Elbert, & Neuner, 2011). For the therapist, unconditional positive regard, empathy, and active listening are crucial for the treatment approach to have the maximum effect on the client (Hensel-Dittmann, Schauer, Ruf, Catani, Odenwald, Elbert, & Neuner, 2011). This therapy differs from Prolonged Exposure Therapy in that there is no in vivo homework assigned in Narrative Exposure Therapy. However, both therapies focus on working through the trauma in therapy--

one focusing on the narrative written by the client and the other through imagining the scene in the client's mind's eye.

Eye Movement Desensitization and Reprocessing (EMDR)

Eye Movement Desensitization and Reprocessing (i.e., EMDR) consists of having the patient picture the worst part of the trauma and focus on feeling the distress throughout his or her body while rehearsing negative thoughts that go along with the scene in his or her mind (Rothbaum, Astin, & Marsteller, 2005). While the patient pictures this scene in his or her mind's eye, the therapist moves his or her finger, which is 18 inches in front of the patient's eyes, back and forth at least 20 times (Rothbaum, Astin, & Marsteller, 2005). During this process, the therapist checks the patient's self-reported subjective distress level, which can range from 0 to 10 (Rothbaum, Astin, & Marsteller, 2005). Once the distress level has decreased to a 0 or 1, the therapist asks the patient to replace the negative thoughts that were rehearsed with a new belief that the patient prefers to have (Rothbaum, Astin, & Marsteller, 2005). This new belief is rehearsed until the patient believes that it is true to him or her. While similar to the other two treatments in terms of the emphasis on processing the traumatic event during therapy, EMDR differs by having the client focus on the therapist's finger while thinking about his or her traumatic event and by the lack of in vivo homework exposure asked of the patient. Similar to PET, EMDR does involve a focus on belief changes.

Implosive Therapy (IT)

Implosive Therapy differs from the other exposure-based therapies in its focus on teaching relaxation techniques. Implosive Therapy (IT) focuses on teaching the client relaxation

techniques like progressive muscle relaxation and guided imagery in order to help them cope with stressful situations that stimulate their anxiety (Lyons, & Keane, 1989). After the client is able to relax and imagine events relatively well, they are introduced to the rationale behind Implosive Therapy, which exposes the client to anxiety cues that are associated with the trauma in a safe situation in order to extinguish the anxiety that is felt when the cues are encountered (Lyons, & Keane, 1989). IT works on the premise that the cues are conditioned stimuli that can be extinguished (Lyons, & Keane, 1989). For exposure, the therapist starts with the least distressing cues and scenes and works up to the client's most distressing scenes and cues (Lyons, & Keane, 1989). When the therapy begins, the therapist has the patient go through deep muscle relaxation and then starts setting the scene of the trauma by describing what happened before the traumatic event occurred (Lyons, & Keane, 1989). The client is told to focus on cues that elicit their anxiety until their anxiety diminishes (Lyons, & Keane, 1989). The therapist works through the scene with the client while the client imagines it and monitors them for any signs of anxiety; when signs of anxiety present themselves, the therapist asks the client what just occurred in order to determine that cue (Lyons, & Keane, 1989). While the scene is occurring, the client focuses on their cognitive, physiological and behavioral responses to the trauma (Keane, Fairbank, Caddell, & Zimering, 1989). Once the scene is completed, the client implements relaxation techniques to calm themselves from any remaining anxiety before the end of the session (Lyons, & Keane, 1989). The sessions last between 2 to 2.5 hours and occur at least once or twice per week (Lyons, & Keane, 1989). Implosive Therapy differs from the others in that it has a faster exposure to the traumatic cues present in the whole narrative. Implosive (flooding) Therapy has proven effective in reducing the PTSD symptoms of Vietnam veterans (Keane, Fairbank, Caddell, & Zimering, 1989).

When treatment outcomes are compared, PET shows evidence of strong treatment outcomes relative to other approaches. For example, Prolonged Exposure Therapy helps clients improve more than the waitlist or minimal attention condition (Foa, Hembree, Cahill, Rauch, Riggs, Feeny, & Yadin, 2005; Resick, Nishith, Weaver, Astin, & Feuer, 2002). Even patients with exacerbated symptoms during the treatment make improvements comparable to those without exacerbated symptoms (Foa, Zoellner, Feeny, Hembree, & Alvarez-Conrad, 2002). In one study, when outcomes for both exacerbated and nonexacerbated groups were pooled, 68.3% improved to the point where they no longer were considered to suffer from PTSD symptoms, with no significant difference of improvement overall in the two groups (Foa, Zoellner, Feeny, Hembree, & Alvarez-Conrad, 2002). Additionally, patients appear to tolerate Prolonged Exposure Therapy well by not dropping out of therapy prematurely as compared to other treatments. For example, in one study the dropout rate for Prolonged Exposure Therapy was 20.5%, versus a drop out in Cognitive Behavioral Therapy (introduced shortly) of 26.9%, in Stress Inoculation Therapy (also introduced shortly) of 22.1%, and in EMDR of 18.9% (Hembree, Foa, Dorfan, Street., Kowalski, & Tu, 2003).

Narrative Exposure Therapy also shows positive treatment outcomes. This approach has been shown to reduce PTSD symptoms both 6 months and a year after treatment ended; the subjects obtained 10 treatment sessions which lasted an average of 13 weeks ($M=9.28$ days between each session; Hensel-Dittmann, Schauer, Ruf, Catani, Odenwald, Elbert, & Neuner, 2011). In research by Hensel-Dittmann and colleagues, all patients ($n=15$ for NET) in the study originally met criteria for PTSD, had experienced organized violence, and were referred to the treatment by social workers or therapists (Hensel-Dittmann, Schauer, Ruf, Catani, Odenwald,

Elbert, & Neuner, 2011). Four weeks after treatment ended, 82% of the patients in Narrative Exposure Therapy still met criteria for PTSD. However, a year afterward only 63% met criteria for PTSD (Hensel-Dittmann, Schauer, Ruf, Catani, Odenwald, Elbert, & Neuner, 2011). Additionally, Narrative Exposure is well tolerated by asylum seekers that are still living under continual stress in an unsafe situation, with only two participants (13%) dropping out prematurely in one study-- a rate which is lower than for other exposure therapies, where drop-out rates are around 20% (Neuner, Kurreck, Ruf, Odenwald, Elbert, & Schauer, 2010).

Eye Movement Desensitization and Reprocessing has also shown benefits in outcome research. EMDR is demonstrated to be better than usual care or wait list condition (Bisson, Ehlers, Matthews, Pilling, Richards, & Turner, 2007). Additionally, EMDR is as effective at improving and reducing PTSD symptoms as Prolonged Exposure Therapy and maintains the same improvement as Prolonged Exposure Therapy at a 6 month mark (Rothbaum, Astin, & Marsteller, 2005). While the decrease in symptoms at the end of treatment is similar with both approaches, EMDR appears to lead to a faster decrease in PTSD symptoms, and to show a lower drop-out rate than Prolonged Exposure Therapy (0/10 dropouts compared to 3/10 for prolonged exposure). EMDR also leads to drastically lower subjective units of distress than Prolonged Exposure Therapy, even after treatment (Ironson, Freund, Strauss, & Williams, 2002).

Treatments with Hard Skills

Cognitive-Behavioral Therapy (CBT)

Cognitive Behavioral Therapy consists of cognitive and behavioral aspects that work together to enhance the therapy (Blanchard, Hickling, Devineni, Veazey, Galovski, Mundy, . . . Buckley, 2003). In Blanchard and colleagues' study (Blanchard et al., 2003), the patient was first educated about PTSD, its symptoms, and the fact that it is a normal reaction to trauma. The

treatment process was described and education was completed. Then, patients were taught muscle relaxation and instructed to practice the relaxation daily at home by following an audiotape. Next, patients were asked to write a detailed description of their traumatic car accident, including their thoughts and somatic sensations that occurred during the accident. During this therapy, patients were asked to read their written description of the event three times a day to keep thoughts of the accident from being avoided so then they could work through them.

This rehearsal was reduced to once a day once the patients became bored. The readings were also done at the first five therapy sessions. In addition, the patients had in-vivo homework: every week they would progress with an action behind the wheel, ranging from sitting behind the wheel of the car to driving by the site of the accident. During these homework assignments, the patients were instructed to practice their relaxation techniques while paying attention to their thoughts and feelings, identifying and replacing negative thoughts with positive ones and refuting false cognitive assumptions. Lastly, this study had patients counteract the anhedonia and social isolation that occurred due to PTSD; patients were required to complete activities that they had normally enjoyed before the accident and they were encouraged to contact those that they felt socially isolated from after the accident. If needed, the therapy also addressed existential issues based on the possible morbidity of the patient and anger toward other drivers or circumstances (Blanchard et al., 2003).

Stress Inoculation Therapy (SIT)

Originally developed by Meichenbaum and Cameron (1989), Stress Inoculation Training is a type of CBT that has three stages in the therapy process, focusing on the goal of anxiety prevention and control. It focuses first on educating the patient about the problem that should be

addressed (for example, the negative reactions that occur after a trauma trigger), and it also specifies what that problem is so the patient can identify when the problem is occurring (Meichenbaum, & Cameron, 1989). In this stage, the client can either self-monitor their baseline or the therapist can do a behavioral assessment of the client in which they directly observe and monitor their reactions and behavior (Meichenbaum, & Cameron, 1989). Once the baseline data has been obtained, the second stage, which focuses on teaching coping skills to the client, begins (Meichenbaum, & Cameron, 1989). Such skills include problem-solving (to improve coping skills and figure out how to problem-solve through situations in the future), relaxation skills, and social skills (Meichenbaum, & Cameron, 1989). Once these skills are learned, they are implemented in vivo and practiced in stage three (Meichenbaum, & Cameron, 1989).

Modifying Meichenbaum and Cameron (1989)'s original Stress Inoculation Training outline, Foa and colleagues Dancu, Hembree, Jaycox, Meadows, and Street (1999) incorporated Stress Inoculation Training into their work with habituating trauma-related anxiety. In stage two of the process, which consisted of seven sessions, patients were taught coping skills like "deep muscle relaxation, cue-controlled and differential relaxation, thought stopping, cognitive restructuring, guided self-dialogue, covert modeling, and role-play" (Foa, Dancu, Hembree, Jaycox, Meadows, & Street, 1999). The clients were instructed to practice these coping skills outside of therapy (Foa, Dancu, Hembree, Jaycox, Meadows, & Street, 1999). Stress Inoculation Training has shown better outcomes than the wait-list condition (Foa, Rothbaum, Riggs, & Murdock, 1991; Foa, Dancu, Hembree, Jaycox, Meadows, & Street, 1999). For subjects with a diagnosis of PTSD, PET has a higher percentage (52%) of good end-state functioning than SIT (42%) after 1 year; however, SIT (68%) and PET (65%) had similar levels of participants who no longer fulfilled criteria for PTSD one year after treatment (Foa, Dancu, Hembree, Jaycox,

Meadows, & Street, 1999). However, PET had significantly fewer drop-outs than SIT, lower anxiety, greater social adjustment, and lower depression (Foa, Dancu, Hembree, Jaycox, Meadows, & Street, 1999). Additionally, four weeks after treatment ended, patients who had Narrative Exposure Therapy (82% had PTSD) were less likely to meet criteria for PTSD than patients who had SIT (100% still had PTSD; Hensel-Dittmann, Schauer, Ruf, Catani, Odenwald, Elbert, & Neuner, 2011).

Cognitive Processing Therapy (CPT)

Cognitive Processing Therapy (CPT) is a type of Cognitive-Behavioral Therapy that was created by Resick and Schnicke (1993) to specifically address the needs of rape survivors with PTSD. This treatment aids patients in realizing that PTSD is a symptom of not recovering from the trauma that they have endured (Surís, Link-Malcolm, Chard, Ahn, & North, 2013). The treatment takes about 12 sessions. The first seven sessions are focused on educating the client, restructuring their thoughts and writing trauma narratives, while the last five sessions focus on ideas of “safety, trust, power, self-esteem, and intimacy” that might have been distorted following the trauma (Surís, Link-Malcolm, Chard, Ahn, & North, 2013). During the treatment process in the first stage, therapists educate patients about “just world beliefs”, issues with assimilation and overaccommodation, and how thoughts and emotions are linked together (Surís, Link-Malcolm, Chard, Ahn, & North, 2013).

The last five sessions of CPT focus on safety, power, self-esteem, and intimacy. The safety portion describes any situation that the client may feel unsafe in after the trauma, which the therapist helps them work through with rationalization (Resick, Monson, & Chard, 2007). The trust portion focuses on trusting other people, acquaintances, family members and friends as

the trauma (specifically sexual trauma) may have been initiated by someone the patient knew (Resick, Monson, & Chard, 2007). Additionally, it addresses issues trusting oneself because the victim didn't realize this "safe" person would attack them (Resick, Monson, & Chard, 2007). Power refers to a feeling of helplessness that often follows the trauma, and this session focuses on helping the patient see that they do have control over certain areas of their life and that they are not completely helpless. The self-esteem session focuses on helping the client regain their self-esteem by battling negative thoughts the patients may have about themselves following the traumatic event (Resick, Monson, & Chard, 2007). Lastly, the intimacy-focused session emphasizes their ability to self-soothe during stressful events and during reminders of the traumatic event, their closeness to family and friends, and their sexual intimacy--especially for survivors of sexual assault (Resick, Monson, & Chard, 2007). Thus, Cognitive Processing Therapy focuses more on changing the erroneous beliefs of the client and less on the hard skills that are taught in CBT and SIT like relaxation and coping skills.

Cognitive Processing Therapy focused on past trauma has been shown to improve PTSD symptoms in military veterans who suffered from military sexual trauma as compared to Present-Centered Therapy, which focused on helping clients problem-solve their current issues and focus on the present (Surís, Link-Malcolm, Chard, Ahn, & North, 2013). In other research, Cognitive Therapy improved PTSD symptoms as much as Imaginal Exposure Therapy (Tarrier, Pilgrim, Sommerfield, Faragher, Reynolds, Graham, & Barrowclough, 1999). However, Imaginal Exposure Therapy outcomes were improved with the addition of Cognitive Therapy when compared to Imaginal Exposure Therapy alone. In fact, data indicated 60% more improvement in the combined therapy than in the specifically Imaginal Exposure Therapy (Bryant, Moulds,

Guthrie, Dang, & Nixon, 2003). Thus, Imaginal Therapy alone might not be an optimal treatment.

Imagery Rehearsal Therapy

Krakow and colleagues (Krakow, Hollifield, Johnston & Koss, 2001) used Imagery Rehearsal Therapy (IRT) to try to counteract the nightmares that inhibited the sleep of many trauma survivors. In Imagery Rehearsal Therapy, the patient wrote down one specific nightmare that they dreamt and then rewrote the nightmare into a dream they would want to have. Then the patient imaged his or her ideal dream for 10 to 15 minutes which was followed by briefly describing the old nightmare and how the patient changed it into a dream. After a while, the patients were encouraged to simply change the nightmare to a dream mentally rather than write down the nightmare that they experienced. Krakow reports that this treatment diminished PTSD symptom severity and sleep difficulties experienced by the survivors (Krakow, Hollifield, Johnston, & Koss, 2001).

Conclusion

Overall, the exposure-based therapies (PET, NET, EMDR, and IT) are very similar in the fact that the main focus of these therapies is to go over the traumatic memories and narrative and work through it with the client. IT is somewhat similar to CBT, SIT, and CPT in the fact that IT incorporates more of the hard skills, like relaxation training, problem solving skills, and coping skills, that are a more important focus than in the exposure-based therapies. CPT and SIT are two different types of CBT; CPT focuses more on the cognitive aspects of CBT in trying to replace negative thoughts with positive ones. On the other hand, SIT focuses on the behavioral skills in

CBT like relaxation, problem solving, and coping skills. Imagery Rehearsal Therapy is the only treatment focused specifically for patients with insomnia caused by PTSD. Of the exposure-based therapies, EMDR, PET, and NET are all pretty similar in terms of symptom improvement in patients, with EMDR having slightly lower levels of premature drop-outs and a faster symptom improvement than the others. Overall, the exposure therapies seem to reduce PTSD symptomology more than SIT.

Additionally, it is important to note that all of the therapies mentioned above were developed in Western countries and the research outcomes are in Western cultures. As such, it is always unclear how these treatments will translate when working with those of other cultures, since trauma and other mental health manifestations might develop or present differently in other cultures. Moreover, these non-Western cultures have beliefs and stigmas that could negatively influence treatment outcomes, which is why it is imperative to acknowledge the role of cultural differences in considering treatment for trauma.

Cross Cultural Considerations: Culture-Bound Syndromes

Asia

In South Asia, trances or possessions and sexually focused symptoms appear much more commonly than in the U.S. It is normal for people to experience trances or possession during religious or spiritual events (Jacob, & Kuruvilla, 2012), which in Western culture might be considered signs of a psychotic episode. Additionally, this region is characterized by *dhat* syndrome, in which clients are afraid they are losing semen (Sumathipala, Siribaddana, & Bhugra, 2004). In the West, the symptoms of *dhat* would likely be viewed as anxiety, depression, somatization, or neurasthenia and only labeled *dhat* if the clinicians were aware of the South Asian culture (Jacob & Kuruvilla, 2012). The South Asian culture tends to explain neurotic

symptoms as a consequence of beliefs about semen-loss, and these patients face less stigma in South Asian cultures if these sexual beliefs are the focus of treatment rather than the anxiety or depression from which the patient may be suffering (Jacob & Kuruvilla, 2012). Another phenomenon which focuses on sexual beliefs is *koro*, or a fear that external sexual body parts--the penis for men and the nipples for women--will recede into one's body, causing the death of the patient (Jacob & Kuruvilla, 2012). Again, this belief could be interpreted as schizophrenia, affective illness, major depression and anxiety disorders by Western clinicians who are not familiar with the Asian culture (Jacob & Kuruvilla, 2012).

Latin America and Latin Mediterranean (Latinxs)

In Latin American and the Latin Mediterranean, most of the non-Western conditions seem to focus around anxiety. For example, there is a phenomenon known as *Ataque de Nervios* (literally translated as “attack of nerves”) which is caused by stressful life events and which consists of “uncontrollable shouting, crying, trembling, bodily discomfort, aggression and dissociative experiences” (Jacob, & Kuruvilla, 2012). However, Western practitioners would normally interpret these symptoms as indications of generalized anxiety disorder, panic disorder, posttraumatic stress disorder, major depression, dissociative disorders, or subsyndromal conditions (Jacob, & Kuruvilla, 2012).

Spain and Hispanic American Immigrants

Individuals from Spain and Hispanic American immigrants also report unique anxiety related conditions. In addition to *Ataque de Nervios* (found in high rates in Puerto Ricans; Durà-Vilà, & Hodes, 2012) in Hispanic American and Caribbean groups, the population experiences

simply *nervios* (“nerves”); *nervios* consists of nervousness, insomnia, difficulties focusing, irritability, headaches, upset stomachs, tingling over one’s body and dizziness (Durà-Vilà, & Hodes, 2012). *Nervios* is presumed to be triggered and maintained by stressful life events and the emotions associated with these events (Durà-Vilà, & Hodes, 2012). In Hispanic populations, there is also another condition known as *susto* or fright. In this culture, it is believed that *susto* occurs after a very frightening event which separates the soul from the body (Durà-Vilà, & Hodes, 2012). Symptoms of *susto* include sleep disturbances, sadness, loss of energy or motivation, low feelings of self-worth, listlessness, appetite changes (losing weight), and muscle aches and pains (Durà-Vilà, & Hodes, 2012).

Africa

In West Africa, distress is manifested more somatically than in Western cultures. Specifically, in Nigeria, the condition of *Brain Fag* is reported (Ebigbo, Elekwachi, & Nweze, 2014). *Brain fag* is a type of distress that manifests as sensations of worms or ants crawling over the body, painful headaches, problems with vision (e.g., dimness), eye pain, and tearing up. Other symptoms include cognitive impairment--especially with the meaning of written words, problems concentrating, and poor understanding and retention. Weakness, dizziness, trouble writing and pains that travel throughout the body are also common (Prince 1989; Ebigbo, Elekwachi, & Nweze, 2014). *Brain fag* is thought to be due to brain fatigue, as it is worsened and caused by reading or engaging in other intellectual activities (Ebigbo, Elekwachi, & Nweze, 2014).

Southeast Asia and Other Locations

In Southeast Asia and in other places around the world, anger may result in a violent frenzy of action. This condition is known as *amok*; *Amok* or “*running amok*” is characterized by an individual going into an unrestrained violent frenzy due to the influence of a strong emotion like rage (Flaskerud, & Flaskerud, 2012). It normally is a very rare occurrence, but tends to occur in very populated areas and ends with the person’s suicide or death due to self-protection (Flaskerud, & Flaskerud, 2012). It is described by the American Psychiatric Association as:

A dissociative episode characterized by a period of brooding followed by an outburst of violent, aggressive, or homicidal behavior directed at people and objects. The episode tends to be precipitated by a perceived slight or insult and seems to be prevalent among males. The episode is often accompanied by persecutory ideas, automatism, amnesia, exhaustion, and a return to a premorbid state following the episode. Some instances of amok may occur during a brief psychotic episode or constitute the onset or exacerbation of a chronic psychotic process. The original reports of this condition using this term were from Malaysia. A similar pattern is found in Laos, Philippines, Polynesia (cafard or cathard), Papua, New Guinea, and Puerto Rico (mal de pelea), and among the Navajo (iich'aa). (APA, 2000, p. 899).

Cross Cultural Considerations: General Cultural Differences

In this section I focus on reviewing general cultural differences that may characterize communities, and the widely varied cultural norms evident in these communities. These diverse communities have different values that are central to their lifestyles, and these values must be

taken into account, as they could impact Western therapy approaches. This research is relatively new, since research and treatments were created for and in Western cultures.

Latinxs and Hispanics

When Latinxs immigrate to the USA, they tend to have larger than normal families for their socioeconomic status; this phenomenon is referred to as the Latinx Paradox (Withrow, 2008). A core part of the latinx paradox is the strong familial connections that ensure that all members of the family are cared for and supported (Withrow, 2008). This high level of support may account for the high levels of resiliency found in Latinx populations residing in the US (Withrow, 2008). More specifically, there is a cultural value of Marianismo -- based on the biblical Mary -- which focuses on the mother's need to care for her children well, aided to a large extent by familial support (Withrow, 2008).

Along with this concept of Marianismo, the influence of religion in this population is evident in a tendency to seek spiritual healing for problems that are encountered in life (Andrés-Hyman, Ortiz, Añez, Paris, & Davidson, 2006). While the main population is considered Roman Catholic, the indigenous population is more spirit-focused with beliefs that problems are caused by malevolent spirits (Andrés-Hyman, Ortiz, Añez, Paris, & Davidson, 2006). It is important to note that only a small portion of this population are spiritualists, and the mechanism driving religiosity is typically the belief that God's will plans out and drives a person's life and destiny (Andrés-Hyman, Ortiz, Añez, Paris, & Davidson, 2006). Because of the importance of religion in wellness, community support for spirituality and religiosity may improve functioning in this population (Guinn, & Vincent, 2002). Along with spirituality, this community's strong social

support networks may help reduce PTSD symptoms in Latinx populations (Pole, Gone, & Kulkarni, 2008).

Asians and Pacific Islanders

A strong familial network is also evident in Asian and Pacific Islander populations, who show strong respect for authority and tradition (Yamamoto, & Acosta, 1982). In these cultures, the father is perceived to be the head of the household and is elevated above the mother and children, who are expected to obey him and respect him (Yamamoto, & Acosta, 1982). Additionally, Asians are brought up in a collectivistic society which emphasizes social harmony rather than the individualistic thinking that characterizes many Westerners (Leong, & Lee, 2006). Social harmony entails reserving one's emotions in public and around strangers in order to save face and not cause issues with others (Leong, & Lee, 2006). This culture values their interdependence with others and will put their own individual desires aside for the good of the group (Pole, Gone, & Kulkarni, 2008).

Asian Americans are culturally expected to moderate their emotions more than European Americans, resulting in higher negative emotional reactivity when depressed compared to European Americans (for example, crying more than European Americans if upset; Chentsova-Dutton, Chu, Tsai, Rottenberg, Gross, & Gotlib, 2007). Asians and Asian-Americans tend to be spiritual, but they follow Eastern religions like Buddhism or Hinduism rather than the Western religions found most predominantly in the USA (Pole, Gone, & Kulkarni, 2008). Eastern religions emphasize enduring difficult situations and accepting one's destiny (Pole, Gone, & Kulkarni, 2008).

Africans and African-Americans

People with an Africentric worldview or one influenced by the African culture cherish spirituality, harmony with others, the responsibility to help others in their group, passing down teachings through oral stories, awareness and sensitivity to others' emotions, and being true to oneself and one's feelings (Patterson, 2001). Intervention groups that take this Africentric worldview into account help increase ethnic identity and self-identity, which correlates with strengthened resilience (Patterson, 2001; Belgrave, 2002). Additionally, making rape prevention programs culturally significant and inclusive for Africans and African Americans aids in increasing attention and interest in the subject material, as it makes the material more relevant to the participants (Heppner, Neville, Smith, Kivlighan, & Gershuny, 1999). Africans and African-Americans have tight bonds with their extended family, a strong work ethic, and a unity with others that are culturally similar to them when faced with ethnic or racial adversity (Pole, Gone, & Kulkarni, 2008). Moreover, African-Americans tend to rely on spirituality and/or social networks to cope with adverse situations (Pole, Gone, & Kulkarni, 2008).

Cultural Factors in Counseling and Psychotherapy*Self-Disclosure, Mistrust, and Drop-Out Rates*

Therapeutic self-disclosure can help increase the strength of the therapeutic relationship and decrease drop-out from treatment with some populations. For example, African Americans tend to feel uncomfortable self-disclosing to a white therapist and are more likely to drop out of therapy prematurely under these conditions (Constantine, & Kwan, 2003). On the other hand, Caucasian therapists who self-disclose to African American clients help streamline open communication with the client and help the client to be aware of the cultural competencies of the therapist (Constantine, & Kwan, 2003). In general, African Americans tend to mistrust white

therapists and will choose to not seek out mental health services if they get assigned to a white therapist (Nickerson, Helms, & Terrell, 1994); they also tend to terminate therapy earlier when paired with a white therapist compared to a black therapist (Terrell, & Terrell, 1984).

Clients from other backgrounds may also prefer to be culturally matched to a therapist, both due to the ability to communicate with their therapist in a native tongue, and due to increased cultural understanding. Asian clients view their therapist as an authority figure and may need to see the therapist's credentials and learn about their knowledge base in order to decide whether the therapist is credible and whether they should continue therapy (Constantine, & Kwan, 2003). Pairing Asian American clients with a racially matched, culturally similar therapist may serve to strengthen the therapeutic relationship between the two (Gamst, Aguilar-Kitibutr, Herdina, Hibbs, Krishtal, Lee, . . . Martenson, 2003). This matching may also allow therapists to provide bilingual services to their clients (Gamst et al., 2003). Furthermore, therapists who are more similar culturally to their client are more likely to understand the client's perception, their interpretations, their coping style, and are more likely to select the most appropriate treatment for the client (Zane, Sue, Chang, Huang, Huang, Lowe, . . . Lee, 2005).

In contrast to African-American populations, other ethnic groups may prefer a therapist who waits to disclose until later in therapy. For example, Mexican clients work best with the therapist if there is very little early self-disclosure, based on the notion of *formalismo* (i.e., the sense of the therapist as a separate entity who should be respected and kept at a distance)--which involves maintaining a formal distance (Constantine, & Kwan, 2003). Later on in therapy, the client may become more comfortable around the therapist (*familiarismo*) and feel more comfortable with therapist self-disclosure (Constantine, & Kwan, 2003).

Overall, cultural groups tend to have better therapeutic outcomes when culturally matched to their therapist. Asians and Hispanics attend therapy more and have better treatment outcomes when ethnically or linguistically matched with their therapist. African Americans and Whites attend more therapy with an ethnically similar therapist, but their treatment outcomes do not appear to depend on the ethnic matching (Sue, 1998).

Mental Health Stigma

Stigma and gender roles are major factors that limit access to mental health services in many of these cultural groups. For example, there is a high stigma surrounding the use of mental health services in Latinx populations, which leads these groups to seek treatment at primary care facilities rather than with mental health providers (Yamamoto, & Acosta, 1982). This mental health stigma, combined with the belief in the *macho* man (i.e., the “strong” man who can protect his family and does not display emotion), makes it very difficult for Latinx men to enter therapy (Yamamoto, & Acosta, 1982). As in the Latinx population, there is a stigma about mental health problems in Asian populations, resulting in an underutilization of mental health services (Yamamoto, & Acosta, 1982). Men, in particular, avoid mental health services, due to the fact that as the authority figure in their family, they cannot display weakness (Yamamoto, & Acosta, 1982). Similarly, in Laotian and Cambodian populations, women are more open to mental health services and the need for mental health services than men (Thikeo, Florin, & Ng, 2015).

General Therapy Modifications

For Hispanic youth who have close ties to their family system, therapies that emphasize this component may aid in symptom improvement. In 2003, Santisteban and colleagues (Santisteban, Coatsworth, Perez-Vidal, Kurtines, Schwartz, LaPerriere, & Szapocznik, 2003)

compared standard group treatment to a Brief Strategic Family Therapy (BSFT) as an intervention for Hispanic youth with drug use or behavioral problems (conduct disorder and socialized aggression). This study found that BSFT lead to more symptom improvement than the standard group approach (Santisteban, Coatsworth, Perez-Vidal, Kurtines, Schwartz, LaPerriere, & Szapocznik, 2003). Specifically, 36% of the family treatment group decreased their behavioral problems while only 11% of the comparison group did; for drug use, 60% of the family treatment group showed decreased drug use while only 17% of the control group did. The success of the family approach over the group approach likely reflects the fact that the family approach capitalizes on the intimate social networks and strong familial support that characterizes this population.

The strong family networks evident in Hispanic populations are also found in African American communities, where tight knit family units are common. For example, Brief Strategic Family Therapy has been linked with successful prevention for African American and Hispanic youth with drug use and behavioral problems (Santisteban, Coatsworth, Perez-Vidal, Mitrani, Jean-Gilles, & Szapocznik, 1997). In Santisteban and colleagues' study (1997), 47% of the participants improved their conduct disorder symptoms from pretest to posttest while 24% improved their symptoms for socialized aggression from pretest to posttest. A weakness of this study was the fact it was only a one-group, pretest-posttest design. Because there was no control group, the improvement might not be due entirely to the BSFT (Santisteban, Coatsworth, Perez-Vidal, Mitrani, Jean-Gilles, & Szapocznik, 1997). However, these findings were consistent with expectations, given that strong racial and familial networks are evident in both the African American population and the Hispanic populations. Future research would benefit from increased methodological rigor, including the use of control groups.

For those cultures with cultural norms that restrict emotional expression, it is useful to focus therapy on a more tangible path toward improvement rather than focusing on emotion exploration. Shen and colleagues (Shen, Alden, Söchting, & Tsang, 2006) display the impact of focusing on the educational aspects of CBT in treating depression and its symptoms in Chinese immigrants. In this study, the education-based CBT treatment almost doubled the effect size of the treatment as usual (Shen, Alden, Söchting, & Tsang, 2006). Asians and Asian Americans tend to focus on social harmony and on restricting their emotional affect, and for this reason, they tend to do better in therapy with a more direct and evident path rather than in a therapy focused on discussing emotions. It appears that in this study, the CBT focus on educating the patients and assigning homework rather than focusing on discussing emotions and negative thoughts aided their improvement (Shen, Alden, Söchting, & Tsang, 2006).

While there does not appear to be any empirical literature specifically examining this possibility, the benefits of taking a culturally informed approach to therapy in other populations suggest that incorporating Latinx spiritual healings may improve therapy outcomes in the Latinx population. This approach would allow Latinx individuals to better understand and connect through a familiar ritual, and this could decrease their premature termination of therapy. The focus on spirituality and resilience might also increase Latinx comfort with therapy, in general (Comas-Díaz, 2006). This possibility warrants additional research.

Therapy Modifications for Cultural Competency for PTSD Treatments

Culturally-adapted therapy modifications for trauma are helpful for treating diverse populations that don't respond to Western treatments. In a group of Vietnamese refugees with treatment-resistant PTSD, Hinton and colleagues' (Hinton et al., 2004) broke the group into two different groups: those who received treatment immediately, and those who got treatment 2

weeks later (delayed treatment group). They then analyzed patient symptoms every two weeks for a period of 6 weeks and noted the improvement between the first two assessments for the immediate treatment group. As expected, the delayed treatment group improved between the last 2 assessments, after the treatment was applied. This CA-CBT focused on explaining the basics of PTSD and panic attacks, on teaching applied muscle relaxation, on culturally specific visualization (in this case, the focus was on a lotus flower bloom which symbolizes flexibility in their culture), cognitive restructuring of their traumatic memories and interpretations of their somatic symptoms triggered by the traumatic memories, building up a coping mechanism and routine for dealing with reminders of traumatic memories, and exploring the triggers for the panic attacks (Hinton, Pham, Tran, Safren, Otto, & Pollack, 2004). The incorporation of the lotus flower aided the subjects in identifying with the treatment, as it was a specific cultural symbol with which they were able to identify. Culturally Adapted Cognitive Behavioral Therapy (CA-CBT) was accepted by the patients and helped improve their symptoms for depression, anxiety, PTSD, and panic attacks (Hinton, Pham, Tran, Safren, Otto, & Pollack, 2004).

This same CA-CBT (Hinton, Pham, Tran, Safren, Otto, & Pollack, 2004) was used later with Cambodian refugees. In Hinton et al.,'s (2005) study, after the first CBT treatment, 60% of the immediate treatment group were below clinical levels for PTSD and generalized anxiety disorder (GAD), while the delayed individuals showed minimal improvement until they also were given the CA-CBT treatment. For the delayed treatment group, after the treatment, 50% no longer met criteria for PTSD and 45% were below clinical levels for GAD. These outcomes are particularly impressive given that this traumatized group did not respond to previous treatment with medications or to Supportive Therapy (Hinton et al., 2005). Moreover, the symptoms of traumatized Cambodian refugees improved on all measures (Hinton et al., 2005).

CA-CBT (Hinton et al., 2004) was also useful for improving the symptoms of a group of Latinx women who had treatment-resistant PTSD (Hinton, Hofmann, Rivera, Otto, & Pollack, 2011). In Hinton et al., (2011) study, all of the participants in the CA-CBT treatment group improved symptomatically (across PTSD symptoms, anxiety symptoms, and on a *nervios* scale) compared to only 33.3% of participants in the applied muscle relaxation alone. Because this population focuses on somatic sensations, the inclusion of relaxation techniques aided the Latinx women to improve their symptomatology, while the incorporation of the idioms of distress known to this population (*nervios* and *ataque de nervios*) helped the patients understand PTSD and the difference between their idioms of distress and PTSD (Hinton, Hofmann, Rivera, Otto, & Pollack, 2011). The treatment helped these women to understand the causes of the somatic symptoms and how they contributed to PTSD (Hinton, Hofmann, Rivera, Otto, & Pollack, 2011).

Similarly, therapy modifications can aid the therapeutic relationship between African American clients and their therapists and diminish the fear of race-based discrimination in their everyday interactions. For African American clients, incorporating a discussion of racism and discrimination and how that influences their trauma during a session of PE allows the clients and therapists to strengthen the therapeutic relationship. Such a discussion demonstrates to the clients that the therapist takes the racism they experience seriously and is aware of the racism that the clients face (Williams, Malcoun, Sawyer, Davis, Bahojb Nouri, & Bruce, 2014). To specifically target this fear of race-based occurrences, the *in vivo* portion of the prolonged exposure in this study focused on the clients approaching Caucasian men or women and interacting with them in order to prove to the clients that most Caucasian people are not racist (Williams, Malcoun, Sawyer, Davis, Bahojb Nouri, & Bruce, 2014). As in any type of in vivo exposure, the exposures are planned so that the clients interact with Caucasians who are unlikely to be racist (e.g., people

working at the mall or people who attend their church; Williams, Malcoun, Sawyer, Davis, Bahojb Nouri, & Bruce, 2014). Additionally, during the imaginal portion of PE, the therapist asks the clients to describe whether they feel discriminated against or feel racism from another during the scene (Williams, Malcoun, Sawyer, Davis, Bahojb Nouri, & Bruce, 2014). Case studies show the potential efficacy of this modified form of prolonged exposure in this population (Williams, Malcoun, Sawyer, Davis, Bahojb Nouri, & Bruce, 2014), although more group studies are needed.

Due to strong mental health stigmas in some non-Western countries, educating populations on the benefits of mental health is key for recovery from PTSD. For Bosnian clients, mental health stigmas are strong because mental health services are mostly used by people suffering from schizophrenia. As a result, psychoeducation in this population is key (Schulz, Huber, & Resick, 2006). In Schulz, Huber, and Resick's (2006) study, before exposing the clients to their trauma, the therapists helped build up their ability to self-soothe and emotionally regulate themselves so they would be able to deal with the trauma and gradual exposure later on. Additionally, to help Bosnian clients process their emotions and everyday thoughts, therapists had clients fill out an ABC sheet (activating event, belief, consequence) where clients described events that lead to a negative outcome or reminded them of the trauma they had endured, and clients described what occurred to the therapist in session. Then, clients used cognitive processing to restructure how they viewed the safe stimuli that triggered their PTSD symptoms. Thereafter, the therapy followed the general guidelines for Cognitive Processing Therapy, and bilingual therapists or interpreters were used. There were 17 treatment sessions (2 hours each). Improvement in PTSD symptomology and everyday functioning provided evidence of the effectiveness of the treatment process in this population (Schulz, Huber, & Resick, 2006).

Conclusion

In considering Western trauma treatments, typically the exposure-based therapies yielded more symptom improvement than therapies that focused more on teaching the client hard skills like relaxation, guided imagery, coping skills, etc. Of the exposure-based treatments, EMDR had slightly lower drop-out rates and faster symptom improvement than the others, but overall, the exposure-based treatments were very similar in treatment effectiveness for PTSD. Imagery Rehearsal Therapy was the only therapy that focused on patients with insomnia caused by their PTSD and it helped diminish PTSD symptomology in patients.

Understanding culture-bound syndromes can be key to working with patients who present with trauma from non-Western cultures. This cultural knowledge is crucial for therapists to understand both their patients' symptoms and their unique cultural perspectives. Moreover, the different, overlying structures of non-Western cultures and the different cultural norms for each culture can significantly influence treatment outcomes. Thus, cultural understanding is crucial for maintaining the therapist's credibility with the client, for strengthening the therapeutic alliance, and for providing the best possible treatment.

However, there is very little research that specifically looks at culturally appropriate treatments or attempts to modify existing treatments to examine the impacts on symptom reduction for the clients with trauma and other mental health issues. More research on using CA-CBT is necessary, and more modifications should be made for diverse populations to try to help them not only with trauma therapy, but also potentially in other areas as well. For example, future research should look at incorporating more family-oriented approaches for the Latinx, Hispanic, and Mexican populations as family is of paramount importance in these communities.

Additionally, incorporation of Eastern religions into therapy as an option for those in Asian communities may lead to more willingness to undergo treatment.

Because clients from different cultural backgrounds need different styles of therapy in order to have the best outcomes not only in PTSD treatments, but also in other types of treatments, it is imperative that the therapists should take their culture into consideration and modify their therapy to best suit the client's needs. Cultural competency is key for reducing premature dropout rates, fighting the stigma of mental health and strengthening the therapeutic alliance between the therapist and the client. Additionally, the use of bilingual therapists with an understanding of the client's specific cultural background would be ideal in the treatment because they would be most attuned to how the client thinks and the cultural norms from which they come.

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