LITERATURE REVIEW

Intergenerational Trauma and PTSD: Historic Wounds Necessitate Treatment Based on Individual Culture

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Intergenerational trauma and post-traumatic stress disorder (PTSD) and their effects are familiar to millions of people around the world. Broad sociological and systemic mechanisms continue to inflict trauma and reduce community healing by usurping access to curative cultural networks. This paper evaluates research showing that traditional therapies, although relevant to some demographics, are ineffectual or harmful when wrongfully applied to underrepresented groups. Diagnostic tools are similarly narrowly effective. Symptomatology should account for cultural differences, and therapy incorporating individual cultural beliefs should be more widely implemented. When personal spirituality and culture is encouraged throughout treatment protocols, individuals more successfully reach recovery. Practitioners are most helpful to this process as they work to personally understand their patients' culture and spirituality.

Keywords: PTSD, trauma, intergenerational trauma, spirituality, culture

Many cultural, ethnic, racial, and socioeconomic groups have experienced extreme trauma from exposure to war, murder, rape, imprisonment, separation from families, or other grievous hardships. Historical records across the world detail the atrocities of various wars: between 1900 and 1990, 43 million soldiers and 63 million civilians were killed—World War II being responsible for at least 70 million deaths alone. Fifteen years ago, there were 30 wars going on worldwide, many of which are still in progress (Hedges, 2003). While soldiers experience devastating trauma, civilian trauma is often underestimated. During times of war, civilians are shot, raped, driven from their homes, held hostage, forced to watch the murder of loved ones, and experience starvation and famine (Kessler et al., 2017). The United

Nations High Commissioner for Refugees (UNHCR, 2019) reports an estimated 70.8 million people are currently facing forcible displacement. This is an average of 37,000 people per day who escape conflict, the highest levels on record (UNHCR, 2019). The World Health Organization (WHO) estimates, from surveys of 125,718 participants from 24 countries, that 70.4% of respondents have experienced 3.2 serious lifetime traumas on average (Kessler et al., 2017). Of concern is revictimization, dangerous because psychological consequences of an initial trauma indicate increased risk for future victimization (Benjet et al., 2016).

Initial trauma for one group can have long-lasting implications for subsequent generations. Israeli research indicates that not only is a trauma passed on intergenerationally, but it is cumulative (Kellermann, 2013; O'Neill et al., 2018). As historical wounds become built into the same mechanisms that transfer culture and memory, cumulative trauma is passed to multiple generations (Isobel et al., 2019; Atkinson, 2013). Duran (2006) refers to this kind of unresolved trauma as a "soul wound" because such a wound is unconscious and

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persists in the human psyche (p. 17). Accompanying this trauma is internalized oppression, the internalization of negative beliefs about one's own group which can revictimize, creating painful emotional and psychological legacies (DeGruy, 2005). Intersecting identities, such as sexism, poverty, and racism, result in multiple external and internal injuries when combined with trauma (Bryant-Davis, 2007). Parents themselves can unwittingly pass hundreds of years of trauma on to their children by demonstrating their love in unhealed, destructive ways. DeGruy calls this pattern "poison in the cookies" (as cited in Reynolds, 2015, para. 6).

This effect is not merely emotional or behavioral, but also biological (Yehuda et al., 2016). In recent years, researchers have supported the idea that sperm changes epigenetically in response to stress, and these changes are passed on transgenerationally, some specifically affecting the brain's ability to mediate stress-related disorders (Pang et al., 2017). Post-traumatic stress disorder (PTSD) affects early maternal care efforts and may also inhibit the development of healthy brain stress responses in children (Pruessner et al., 2004). These trends in brain research, and the general understanding that even loving parents can negatively impact healthy development in their children, support the assertion of Caldji et al. (2000) that "Children need not be beaten to be compromised" (p. 1165). Worse, trauma and stress also increase susceptibility to addiction, which in turn prolongs and increases trauma for the next generation (Garami et al., 2019). When left untreated, trauma can become the catalyst for cycles of wounding and re-wounding through generations.

Treatment is crucial to improving the course of these cycles. Recovery requires intervention (Isobel et al., 2019; Raymond, 2019). Culture-specific and race-specific trauma theories need to be developed (Comas-Díaz, 2000). Rather than blaming maladaptive practices on tradition or culture, treatment should incorporate an understanding that behavior, even poor behavior, is an "adaptive solution to an intolerable situation" (Fralich-LeSarre, 2013, p. 15). Unfortunately, most current definitions of trauma have been built on a European perspective, overlooking residual, heritable effects of cultural wounding and the myriad ways it presents pathologically (Isobel et al., 2019).

This imperialistic and Euro-centric understanding of behavior results from and perpetuates the harmful foundations of colonialism. As a result, most current workable PTSD theory and treatment are not culturally relevant for many victimized populations (Comas-Díaz et al., 2019). Because intergenerational trauma does not exist in a vacuum—a wounding of a culture is a wounding of an individual—more professionals who are already intimately acquainted with the social and spiritual nuances of a culture must be trained. Practitioners should be more adept at incorporating various personal cultures and traditions of clients within their healing principles. Duran (2006) agrees: "ethical codes cannot make a soul healer out of anyone" (p. 21). Mental health professionals, or "soul healers," must use culturally congruent trauma theory and interventions (Brave Heart, 2003).

PTSD continues to be a major concern within the psychological community, but treatment of the worldwide intergenerational trauma epidemic requires more approaches accounting for specific cultural history and spirituality, which are critical to developing effective prevention and intervention strategies. Colonialism has diminished the prevalence of culturally relevant treatment pathways and methods for understanding intergenerational trauma even for the most well-meaning of providers. Intergenerational trauma afflicts pre-eminently; thus, many treatment possibilities should be explored. This review will explore several aspects of intergenerational trauma itself and address current treatment protocols with the emphasis that conventional Eurocentric trauma interventions are inadequate for diverse populations. This review will also discuss why mechanisms inherent within culture are important to healing, what psychological theories can bridge more equitably to deserving—but underrepresented—populations, and how research and methods can be integrated within culture, rather than around it.

Nature of Trauma

The American Psychological Association (APA, 2019b) defines trauma as resulting from a person's emotional response to a terrible event like an accident, rape, or natural disaster. Immediately after the event, shock and denial are typical. Longer-term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea (APA, 2019a). Responses to trauma also include sensitivity to environmental sensations such as sights, sounds, or smells; changes to behavior patterns manifested in purposeful social isolation, disengagement, or increased interpersonal conflict; and poor thought patterns demonstrated by difficulty concentrating or making decisions (APA, 2019a). The US Substance Abuse and Mental Health Services Administration (2019) notes

that trauma can be experienced directly but can also develop after witnessing it, learning about it, or by repeated interaction with the malignant details of traumatic events. Meta-analyses have found that risk factors such as sex and gender, race, ethnicity, childhood abuse, low socio-economic status, and family behavioral health disorders increase rates of PTSD (U.S. Department of Health and Human Services, 2019, p. 8).

Complex trauma, which involves multiple forms of trauma and/or multiple occurrences of trauma, is also a predictor for high rates of PTSD (US Department of Health and Human Services, 2019, p. 96) in addition to Severe Mental Illness (SMI) (Mauritz, et al., 2013). In fact, Mauritz et al., (2013) found that dissociative disorders are correlated (r=.82) with traumatic experiences because complex trauma causes division in a person's internal systems that create psychological identity. Dissociation, and other lesser-known symptoms, reduces the likelihood an atypically presenting trauma disorder is diagnosed and treated (Isobel et al., 2019).

Race and Trauma

Racial trauma, an effect of racism, manifests after an experience with racial discrimination. This can be in the form of humiliating events, experience of harm and injury, or witnessing harm befalling others, and is also correlated with racial and ethnic health disparities (Comas-Díaz et al., 2019). Effects of trauma become multiplicative when intersecting identities complicate effects of adverse events (Sweeney et al., 2018). This was evidenced after Hurricane Katrina by the added suffering of People of Color in New Orleans, Louisiana, U.S. when rescue groups distributed aid unequally and engaged in racially-based victim blaming (Bryant-Davis, 2007). Furthermore, initial victimization of a racial group, whether remembered or suppressed, extends from the victim to family members such as spouses, children, or grandchildren. This multigenerational transmission of racial trauma is unintentional and can build cumulatively, eventually impacting culture and society (O'Neill et al., 2018).

Colonization has perpetrated racial trauma all over the world. When People of Color are subjected to colonization or imperialism, they are likely to experience personal pain in the form of identity conflicts, alienation, depression, shame, rage, and spiritual distress (Haskell & Randall, 2009; O'Neill et al., 2018; Schnyder et al, 2015). Their oppressed group as a whole also experiences deep suffering from a broken sense of self and culture— something Comas-Díaz (2000) terms "racial torture" (p.

1321). Comas-Díaz (2000) suggests that because colonization-caused racial terrorism is protracted and ethnopolitical, to simply term the resulting PTSD as a mental disorder is a "medicalization of a sociopolitical problem" (p. 1321). Such medicalization is dangerous and has been used to repress racial groups. One example is the US's 19th-century habit of accusing slaves of having "drapetomania [. . .] an uncontrollable urge to escape slavery, destroy property on the plantation, be disobedient, talk back, fight with their masters, and refuse to work." (Comas-Díaz, 2000, p. 1321). These racist ideas can lead People of Color to horizontal hostility, a by-product of not being able to express hate to oppressive groups, or internalized oppression, an internalization of negative beliefs about one's own group (DeGruy, 2005).

Governments can Perpetuate Trauma Cycles

For generations, Native Americans have experienced oppression under US government policies which led to genocide and the subsequent destruction of Native American tribal identity, culture, and ethnic traditions (Strong & Van Winkle, 1996; Zephier Olson & Dombrowski, 2020). Federal policies mandating the relocation of tribes out of their homelands have disproportionately harmed tribal family structures and removed Native children to White American homes or boarding schools (Brave Heart, 2003). Such practices are correlated with adverse health outcomes like PTSD, alienation, alcohol abuse, drug addiction, and identity development (Brave Heart, 2003).

While it is in error to view all Native American tribes with a lens of victimhood, systematic reviews have found a correlation between boarding schools, poor family bonding, and substance use (Zephier Olson & Dombrowski, 2020). When early interpersonal traumas combine with an inability to rely on community and culture, the result is often unresolved traumatic pathology which is easily transmitted to subsequent generations (Ringel, 2005). Albert Bender (2015), a Cherokee historian and attorney specializing in Native law, suggests "the intergenerational trauma felt by all Native people, but particularly by Indian youth, is the result of the historical policy of genocide exemplified by endless massacres, the forced removals and military campaigns that continued to the end of the 19th century" (as cited by Wolynn, 2016, p. 32). Bender goes on to say that these traumatic experiences are at the forefront of the minds of many Native young people and that youth suicide rates are so high that "a week without a suicide is now considered a blessing on many reservations"

(Wolynn, 2016, p.33). In some parts of the country, tribal youth suicide rate is 19 times higher than rates impacting other American youth (Bender, 2015).

The Rape, Abuse, and Incest National Network (RAINN) found that Native Americans are victims of sexual violence—the perpetrators of which are mostly non-indigenous people—twice as often than other ethnic demographics (RAINN, 2019b). Unfortunately, they are also less likely to report this kind of sexual trauma. There are a few reasons for this: lack of funding for tribal law enforcement, tense interactions with law enforcement of non-indigenous groups, rare access to sexual assault forensic equipment, and most notably, policies protecting non-indigenous perpetrators from being prosecuted in tribal courts (RAINN, 2019a). Justice, a process often painful for the victim, should lead at least to some resolution. Without external reinforcement of a victim's dignity, whether in the courts or out, trauma continues to fester.

Biology of Trauma

There is substantial and growing evidence that trauma persists in the biology of our bodies. Animal research indicates epigenetic changes within germ cells that can shape future generations even before conception (Bale, 2015). In his book *It Didn't Start with You*, Wolynn (2016) suggests that because precursor cells of gametes exist at birth, then mature and combine at adulthood to create new life, a child's cellular environment shares history between mother and grandmother. Trauma-caused epigenetic changes affect noncoding DNA, which is responsible for many social, emotional, and psychological traits and is negatively impacted by stressors (Wolynn, p. 29). Developing sperm can also change epigenetically and affect subsequent generations (Wolynn, p. 26). When a man is exposed to stress, the genetic code of his developing sperm change, predisposing his children to an elevated risk of brain disorders and psychiatric illness (Pang et al., 2017). Sperm continues to be susceptible to trauma and reactive epigenetic changes almost to conception (Wolynn, p. 26). Some of these epigenetic changes have been observed in people who experienced famine; their children and grandchildren were more likely to have restricted diets (Hackett et al, 2012). Hackett, of the University of Cambridge, goes so far as to say that genes can retain memory of past experiences (Hackett et al., 2012). Research about Holocaust descendants also shows that gene changes can be passed to descendants. Epigenetic changes were discovered on the same part of the same gene affecting cortisol in both parent and child,

"providing insight into how severe psychophysiological trauma can have intergenerational effects" (Yehuda et al., 2016, p.372).

Trauma in Childhood

Trauma has the most severe impact during the first decade of life (O'Neill et al., 2018). Extreme stress correlates with deficiencies in the brain's physiology, indicating that many children experiencing early trauma may suffer long-term attachment problems, poor expectations of interpersonal relationships, reduced learning and attention, and damaged ability to self-regulate (O'Neill et al., 2018). Children with such challenges will experience more symptoms of PTSD and are likely to become parents who perpetuate the same issues within their own children (Isobel et al., 2019; O'Neill et al., 2018). Chronic stress, especially in early childhood and adolescence, is also a risk factor for later addiction. When a young person is traumatized and does not have the necessary coping skills, the brain's stress reward circuits are activated. This can result in a physiology that enhances drug cravings, reinforces behaviors supporting maladaptive experience and reward, and increases the risk of drug relapse (Garami et al., 2019).

Native Americans who were sent to boarding schools as children and were likely victims of abuse on school grounds show higher rates of disrupted attachment in relationships as adults (Haskell & Randall, 2009; Zephier Olson & Dombrowski, 2020). The dismantling of cultural identity and family ties integral to this boarding school tradition creates twice the loss—these Native American children were not only subjected to extreme forms of trauma but had no way to begin a process of identity restoration and healing (Zephier Olson & Dombrowski, 2020). In total, the systemic brutalization of Native and Indigenous tribes across regions has led to weak cultural identity, spiritual oppression, and lack of positive Native adult role models, furthering cultural disconnect and exacerbating trauma through generations (Brave Heart, 2003). Society may view unhealthy social patterns in racial groups and attribute this to the people themselves having inherent racial or ethnic failings. This assumption is in error: blaming behavior on superficial observations of culture is wrong, especially when the behavior is an adaptive solution to trauma (Fralich-LeSarre, 2013). Even though maladaptive behaviors should not be explained as a cultural trait inherent to Native or Indigenous tribes, treatment of the behaviors must be centered on strong cultural identity (Kulis et al., 2002).

A more beneficial, more nuanced treatment response, then, is to increase availability of cultural protective factors and community connection with Indigenous individuals and families in treatment. This could be approached by allowing the individual to integrate tribal spiritual and healing practices with therapeutic measures offered by the practitioner (Borowsky et al., 1999; Cwik et al., 2015). Speaking to a profound strength, Indigenous tribes have maintained reparative cultural traditions, healing practices, and patterns of familial connectivity despite centuries of trauma. This richness of culture is a desired source of comfort and healing even for modern American Indian adolescents (Cwik et al., 2015). Integration of culture, when promoted by practitioner treatment flexibility, allows diverse clientele to more fully subsume effective approaches to healing. Until treatment options are less Eurocentrically based and more regionally or culturally friendly, considerable adaptability within current psychological systems is necessary.

Discussion

This literature review was conducted as a means of pursuing answers to four central questions. First, why do conventional Eurocentric trauma interventions show differing success rates between cultures? Second, what mechanisms inherent within culture are important to healing? Third, what psychological theories can bridge more equitably to deserving—and underrepresented—populations? And fourth, how can future psychological research and methods be integrated within culture, rather than around it?

A careful review of peer-reviewed journal articles was conducted within EBSCO psychological databases using keywords such as: intergenerational trauma, PTSD, historic trauma, culture, spirituality, and protective factors. Articles were carefully screened through the analysis of theoretical frameworks, conceptualization of issues, and cultural representation. Any article which made especially salient or unusual points was flagged and the corresponding cited references were investigated. At times, references were found to be mis-cited either because the research was not generalizable to the original paper's claim or because only general nods to the desired subject were present. These articles were excluded. In general, the reference sections of peer-reviewed papers were helpful in directing this literature review toward further relevant information. Some researchers created important terms or phrases to describe pathologies; this wording is quoted directly (ex: "soul wound," "poison in the cookies," or "soul healer").

In the interest of representation, heavy emphasis was placed on articles written by people from the populations for which they purport to speak. Some of these researchers are Dr. Dixon Chibanda, Dr. Maria Yellowhorse Brave Heart, Alfred Bender, Dr. Joy DeGruy Leary, Dr. Lilian Comas-Díaz, and Dr. Rachel Yehuda. Further study of their works, and others, will yield momentum and inspiration for continued theory development regarding treatment and culture.

Culturally Based Treatment

There are no widely practiced theoretical guidelines focusing specifically on treatment of complex intergenerational trauma. Any interventions should be individualized, accounting for the client's personal and cultural symptoms (U.S. Department of Health and Human Services, 2019, p. 96). Because "racial trauma erodes cultural identity," healing needs to happen culturally and spiritually, with increases in health equity across societies (Comas-Díaz et al., 2019). Counselors should be trained to understand privilege, cultural oppression, and cultural traditions and work with the client to implement culturally specific treatment plans. Furthermore, counselors should know to take racial trauma seriously without minimizing or intellectualizing it (Bryant-Davis, 2007, p. 139). Addressing the intergenerational trauma response takes specific expertise in individual psychological mechanisms, but also a willingness of practitioners to adapt to important traditions within each cultural group (Duran, 2006; Fralich-LeSarre, 2013).

One problem facing Native American populations is that standardized diagnostic measures applicable to many tribal cultures have not been developed. This in itself is a tall order—there are more than 500 tribes in the U.S. alone, each with its own rich traditions (National Congress of American Indians, 2020). However, current treatment methods are grossly insufficient and progress needs to be sought after. Predominant symptomatology and other defined markers are likewise unsuitable and even harmful, perpetuating misguided diagnoses and unserviceable characterizations of disorders (Duran, 2006, p.20). Depression and schizophrenia are over diagnosed among Indigenous groups because practitioners are unfamiliar with tribal mourning and grieving patterns (Robin et al., 1996), while other disorders are missed because of mistrust between tribal and non-tribal people. For centuries, the US government denied grief practices and other tribal rituals, leading tribes to be plagued by unresolved trauma (Weaver &

Brave Heart, 1999). A restoration of tribal community and spiritual connections are necessary for trauma recovery to begin (Duran, 2006, p.18). Assessment tools should be culture-specific; clinicians who know and respect tribal customs can mitigate some cultural misunderstandings which exist in current treatments (Robin et al., 1996, p. 240). Brave Heart (2003) asserts that culturally congruent trauma interventions in consideration of Native spirituality and history are crucial to reducing rates of PTSD and intergenerational trauma within those groups.

Culturally and spiritually sensitive solutions applicable to many ethnic or cultural groups must be developed before lasting recovery is possible. In the 1970s, popular opinion in the White American scientific community focused on cultural deprivation among African American communities, inappropriately using Eurocentric cultural norms as a diagnostic tool (Fralich-LeSarre, 2013). Things have not significantly improved: unintentional transmission of racial trauma by White counselors to their Black clients is common. Current cultural deprivation theories have become more sophisticated but amount to what is essentially an insufficient re-wording of the same issue (Fralich-LeSarre, 2013).

Impact of Culturally Based Treatment Initiatives

Few areas across the world are free from traumatic histories inherited by current populations. Zimbabwe is no exception. This region in southern Africa was able to maintain equilibrium—if not peace—for thousands of years between conflicting kingdoms such as the Mapungubew, Mutapa, Rozvi, and Ndebele (Zimbabwe, 2021). However, it was devastated under British colonial rule (Chigudu, 2021) beginning in the late 1800s. British imperialist Cecil Rhodes enslaved Black Africans for diamond mining, forced nearby geographical areas into one imperialist domain, Rhodesia, which was named after himself (Chigudu, 2021; Zimbabwe, 2021). White colonists, who made up only 3% of the population, seized control over almost all commerce and industry (Zimbabwe, 2021). While war and conflict were not new to the region, the consequences of colonialism were far worse. This colonial rule controlled Black Africans through complicated passport systems and indentured servitude, destroyed ties to culture and community, and caused countless deaths among Black children and adults alike (Chigudu, 2021). Political unrest, including the reclaiming of power by Black Africans, has been consistently overshadowed by a draconian perspective that perhaps Zimbabwe is better off under imperialist rule after all (Chigudu, 2021). Thus, Zimbabwe's significant history has caused the proliferation of multigenerational psychological trauma. Suicide, PTSD, and depression rates in Zimbabwe are high, much higher than the 12 psychiatrists in a country of 16 million people could ever handle alone (Nuwer, 2018).

One psychiatrist came up with an unorthodox solution: train local grandmothers in talk-therapy and place them strategically within hurting communities. The grandmothers learned western techniques and terminology such as suicidal ideation and depression but insisted on discarding the words in favor of more culturally understood concepts such as kufungisisa, or "thinking too much" (Nuwer, 2018), a Shona term for depression. The program found that incorporating these and other traditional Shona spiritual concepts helped reduce participants' mental load after consistent therapeutic visits (Abas et al., 2016). The training methods the grandmothers employed were established on evidence-based cognitivebehavioral techniques, augmented with indigenous concepts, local knowledge, and wisdom (Nuwer, 2018). To date, over 400 grandmothers have been trained in the program and have improved the mental health over 30,000 people by teaching self-sufficiency in problem solving. Interestingly, the grandmothers themselves received mental and physical benefits from their active altruism (Chibanda et al., 2016).

By 2009, excited by the early success of the grandmother program, Zimbabwe's government health department began to refer many patients from different community action centers. Chibanda et al., (2016) found in a randomized control trial that after 6 months of following this new program, participants who had visited with the grandmothers saw significant positive gains in mental health. A youth-friendly friendship bench program also showed promise with adolescents, who reported a reduction of loneliness and an increase of positive affect and optimism (Broström et al., 2021). Following initial successes, a broadened treatment approach was implemented in several African nations (Chibanda et al., 2020) and the program has been expanded across the world, having trained people of all ages, sexualities, and ethnicities. These trainees—who are rich in shared experience and can speak personally of trauma and recovery—provide access to care and a warm solution to loneliness, misunderstanding, and isolation (Nuwer, 2018).

Trauma, Spirituality, and Culture

Trauma survivors engage in psychological defenses as a

protective force against intergenerational effects, or "soul wounds" (Duran, 2006, p. 17), and shattered illusions of safety (Alberici, 2018; Shilony & Grossman, 1993). Over time, if not treated, the survivor is likely to engage only with their protections and avoid stimuli that will reengage them with traumatic factors (Alberici, 2018; Catherall, 1986). For this reason, many trauma survivors find it easier to function in isolation because interaction with people is likely to be complicated and triggering (Catherall, 1986). This biological, neurological, and emotional urge to defend against future pain is understandable; once a person's schema of security is destroyed, they protect themselves from future knowledge of their own vulnerability (Catherall, 1986; Stenson et al., 2021). It is important to develop better ways of diagnosing intergenerational trauma disorders such as PTSD, but mental health professionals also have a deep responsibility to integrate the research, the cultural and social systems, and the individual's construct of their own trauma in pursuit of relevant treatment.

These individual and cultural differences require flexible integration of research and protocol. Traditional Cognitive Behavior Therapy (CBT; Bhar & Beck, 2009) is not itself useful for many victims of racial or political violence but adding racial and trauma-focused narratives to CBT has been effective with some refugees (Kira, 2010). A study reviewing PTSD treatment in the Hispanic population found that symptoms are best improved when implementing culturally sensitive strategies meant for the patients' specific subgroups (Quintana, 1997). In Japan, PTSD patients are usually reluctant to discuss specifics of their traumas and cannot relate to rationale-driven CBT (Schnyder et al., 2016). Recent research on scales evaluating PTSD and complex PTSD conducted in Nigeria, Kenya, and Ghana shows differences in measurable cutoff levels between countries (Palgi et al., 2021). This suggests that cultural differences in types of experienced trauma and inner perceptions of traumatic distress are apparent between countries, can impact results of evaluative measures, and should be addressed when recommending treatment.

One explanation for these differences is event centrality, or how deeply an individual feels the trauma has harmed their identity (Boals, 2018). Even after controlling for comorbidities, the Centrality Event Scale (CES) can explain some variance in PTSD symptoms and is associated with severe symptoms in several populations (Boals, 2018; Rubin et al., 2014). An increased CES score is also associated with a significant effect on the Post Traumatic Stress Disorder Check List (Rubin et al., 2014).

Therapy strategies developed to confront some of these geographical and cultural differences in PTSD indicators do exist. Bronfenbrenner's ecological model (1979), which shows that the individual is influenced by an ecosystem of people, systems, laws, and culture (Bronfenbrenner & Morris, 2006) has inspired Multisystemic Therapy (MST) and Structural Ecosystems Therapy (SET; Kira, 2010). Individuals and families treated with therapies such as MST and SET showed sustained improvement over 4 years compared to 70% of those treated under traditional models (Kira, 2010). Another treatment option is dialectical behavior therapy (DBT), which was developed to treat PTSD in diverse populations (Wagner et al., 2007). The friendship bench program is also an excellent model (Chibanda et al., 2016). Palgi et al.'s newly developed Subjective Traumatic Outlook (2021) scale includes subjective experience as a predictor for PTSD. This scale is built on the understanding that an inner psychological concept of the trauma may serve as a mechanism connecting the event with the disorder (Mahat-Shamir et al., 2019). When clinicians understand that social ecology and culture influences individual and societal meanings of trauma, their work is enriched (Schnyder et al., 2016). Because trauma is varied and people differ, outcomes are multiplicative. There is no standard formulation of treatment that applies to all people, but some methods are flexible enough to work in many capacities.

Trauma Healing Through Meaning-Making

What, then, creates the link between trauma and healing or trauma and disorder development? Park and Ai (2006) found empirical support for the positive connection between the meaning-making framework spirituality offers and other positive outcomes after exposure to trauma. "Meaning-making" restores a sense of control and order by reframing the event in the context of a broader life purpose. In contrast, rape survivors who repressed their pain and memories of the event had a higher risk of PTSD (Boeschen et al., 2001). PTSD appears to develop from negative appraisals of the event and its effects. Meaning, or a sense of purpose, protects against trauma: a study on activists and non-activists who were tortured found that the activists had lower incidence of PTSD although they were subjected to worse torture (Basoglu et al., 1997). Adults who sought spiritual support after multiple traumas had a well-developed positive growth mindset and were insulated against PTSD (Harris et al., 2008). Victor Frankl, renowned holocaust survivor and psychiatrist, developed logotherapy in response to

the need for structured meaning-making in his patients. Logotherapy suggests meaning can be found in creative activities, experiences, and broader perspective (Finch, 2013). Modern CBT strategies focus primarily on attitude, but spirituality and culture are rich and rewarding avenues to find meaning through trauma. Religion, a version of practiced spirituality which shapes a sense of meaning with cultural tradition and community, is also protective (Pargament, 2013; Park & Slattery, 2013). Religious traditions and rituals offer healing, protection, and purpose to its spiritual believers, leading to resilience among a supportive community (Currier & Eriksson, 2017).

Spirituality, though underutilized and difficult to empirically measure, is protective against mental distress and PTSD even after extreme trauma (Pargament, 2013). This could be due to spirituality's inherent quality of meaning finding or identity with a higher purpose. The connection between PTSD and spirituality has been studied but the findings are mixed. This could be due to the difficulty of defining spirituality as a construct and the simplicity of the studies. However, some studies have shown greatly reduced rates of Post-traumatic Stress Syndrome (PTSS) in Wesleyan missionaries who experienced high levels of trauma, and Muslim Iranian veterans for whom a higher religiosity measure correlated with better health and a lower risk of PTSD (Aflakseir & Coleman, 2009; Park & Slattery, 2013).

Many African tribal traditions—varied as they are—offer healing in the form of rituals and community. Tribal cosmologies, which employ sacred rites that embrace the past and prepare for the future, often promote healing energy (Radomsky, 2017). Unfortunately, as a clear example of imperialism, most literature describing these practices is colored by the superficial interpretation of non-African researchers. Early European settlers described tribal leaders and healers as "charismatic charlatans coercing others through clever manipulations of esoteric knowledge and granted inappropriate worth by a credulous and anxiety ridden people" (Peek, 1991, p.12). Indigenous healing traditions are still seen this way by many researchers in the scientific field. Ironically, these same words could be used to describe scientists and researchers themselves, who may promote their quantitative ideals prominently and indiscriminately.

Conclusion

Native psychologists theorize that intergenerational trauma, or Duran's (2006) "soul wound," (p. 17) occurs on a spiritual, physical, familial, and community level. Euro-centric therapy ideologies emphasize physical and cognitive pathology, but Native tradition encourages the belief that a person is more than cognition, and an entire other spiritual, personal realm exists where healing needs to take place (Duran, 2006, p. 20). A therapy program which only emphasizes cognition will fail when applied to people who thrive on a rich cultural spiritual awareness. Indigenous experts argue that historic trauma occurs at a community and personal level, further complicating the mind-body-spirit path to healing (Duran, 2006, p.21). Practitioners who do not understand these community-culture-individual connections may inadvertently blame the victim and further traumatize patients. Duran (2006) maintains that "to face the reality of [trauma's] history and the present moment" (p. 22) is to begin making diagnoses within context and create a successful intervention. The path to this kind of healing is more complex than current definitions allow, but it must be in order to embrace all aspects of trauma.

While the medical community has made great strides in diagnosis and treatment of biochemical and physical effects of trauma, healing must also occur with regard to culture and spirituality. Manifestations of trauma are found in many areas including community violence, spiritual abuse, family dysfunction and suicide rates (Amendola, 2020; Gray et al., 2021; Hinsberger et al., 2016; Panchuk, 2020). Treatments must be capable of addressing these issues with cultural reverence at the source of the pain. A qualitative study with residents from Vancouver's Downtown Eastside found that although all participants experienced multiple forms of Adverse Childhood Events (ACE), and through self-medication had developed illicit Substance Use Disorders (SUD), none had been offered trauma-informed healthcare or psychological treatment for their PTSD (Torchalla et al., 2015). This addiction-first or symptom-first method to treatment can be deeply inadequate and even harmful. Healing from maladaptive behaviors such as addiction cannot be reached without understanding of individual trauma experience. Spirituality, community, and beliefs should be the basis for intervention strategies (Duran, 2006; Fralich-LeSarre, 2013). Culture underpins identity. Practitioners are often the gatekeepers between trauma and healing. Treatment theories need to be flexibly built on ethnicity and culture by those who can have an empathetic—not just clinical—understanding of the personal nature of complex trauma, racial trauma, and intergenerational trauma.

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Conflicts of Interest

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