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The Cultural Context of Trauma Recovery: Considering the Posttraumatic Stress Disorder Practice Guideline and Intersectionality

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The American Psychological Association's (2017) Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults endorsed by the American Psychological Association notes that attention to cultural context is a required component of trauma-informed mental health care provision. Despite the inclusion of this statement, the Treatment of PTSD Guideline does not give adequate attention to culture in the defining of trauma, review of the trauma literature, the criteria adopted for evaluation of PTSD treatments, and, resultantly, the determination of treatment recommendations. Culture plays a significant role in the vulnerability to, experience of, and recovery from mental health sources of distress, including interpersonal trauma (Bryant-Davis, 2005). Approaches to trauma-focused psychotherapy that are ethically sound call for a prioritizing of cultural competence (awareness, knowledge, and skills), as well as cultural humility (Harvey & Tammala-Nara, 2007). Trauma survivors, however, hold multiple identities simultaneously that influence their conceptualizations of trauma, therapy, and the recovery process (Brown, 2008). Intersectionality refers to the way in which a multiply marginalized person experiences cultural identity and oppression that is qualitatively different than the experience of trauma survivors from dominant cultural groups (Crenshaw, 2005). The realities of racism, sexism, heterosexism, and classism, as well as their influence on the trauma recovery process, are examined, while noting the minimal attention that has been given to additional forms of oppression such as religious intolerance and able-bodyism. This critical review of the literature will examine the theoretical and empirical literature, which has examined the framework and strategies that have been cultivated in service to trauma survivors who have been traditionally underserved. Attention will be given in particular to benefits, limitations, and critiques of evidence-based interventions, as well as benefits, limitations, and future research needs of both culturally modified interventions and culturally emergent trauma interventions.

Clinical Impact Statement

Question: What factors should clinicians consider when addressing posttraumatic stress disorder with culturally marginalized clients? ***Findings:*** Marginalized communities may present posttrauma symptoms in unique ways, and their cultural worldview and socialization should be considered in the selection of interventions to address their posttraumatic stress disorder. ***Meaning:*** Clinicians who adopt a culture-blind view of trauma assessment and treatment are missing critical components of a client's life and recovery journey. ***Next Steps:*** Researchers should be intentional about sampling culturally marginalized community members in the evaluation of empirically supported interventions, and more qualitative and quantitative studies of culturally emergent interventions is needed.

Keywords: PTSD, guidelines, culture, intersectionality

Psychological recovery from traumatic experiences must acknowledge and integrate the sociopolitical and sociocultural realities and resources of the survivor (Bryant-Davis, 2005; Bryant-Davis & Wong, 2013). Contrary to trauma training that focuses almost exclusively on the individual's thoughts, feelings, and behaviors, culturally responsive trauma models expand their frame to include the cultural context and the sociopolitical history of the survivor and their community (Comas-Díaz, 2014). Considering the complexities of cultural identities, Crenshaw (2005) developed the term *intersectionality* originally to address the ways antisexist and antiracist scholars and activists rarely consider the experiences of women of color who often experience structural and political violence. Intersectionality, in its contemporary form, includes the various aspects of oppression, which co-occur within an individual based on their multiple identities and social locations. Intersectional oppression may include the simultaneous experience of racism, sexism, heterosexism, able-bodyism, ageism, classism, religious intolerance, transphobia, and/or xenophobia. Trauma recovery care must attend to the multiple layers of identity within each person, consider-

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ing race, ethnicity, culture, gender, age, migration status, disability, sexual orientation, and religion and/or spirituality (Brown, 2008).

The current Treatment for PTSD Guideline (American Psychological Association PTSD Guideline, 2017) provides a critical review of the literature on posttraumatic stress disorder (PTSD) treatment models; however, they offer insufficient attention to the influence of culture on PTSD conceptualization and treatment. Marginalized community members are more likely to experience interpersonal trauma, to develop severe PTSD, and to face barriers to safety, justice, and mental health services; the neglect of these populations in the PTSD guidelines contributes to the cultural incompetence found in the field. (Alcántara, Casement, & Lewis-Fernández, 2013; Hernandez, Plant, Sachs-Ericsson, & Joiner, 2005; Institute of Medicine, 2003). The cultural context of trauma recovery is particularly important, given the higher risk of trauma and PTSD occurrence within marginalized communities (Lanktree & Briere, 2017). Psychologists traditionally are less likely to seek out members of marginalized communities during the development and evaluation of evidence-based interventions. Persons who experience multiple forms of oppression are at increased risk for the development of PTSD and are less likely to have access to evidence-based treatments. In addition, the interventions that emerge from their cultural groups are less likely to have the resources for large-scale evaluative studies. Finally, studies on evidence-based treatments very rarely examine the application of these models with societal traumas such as history trauma, intergenerational trauma, and oppression.

This article will provide a brief overview of the following: (a) the PTSD guidelines (2018) statement on addressing culture and cultural oppression, (b) culturally modified empirically supported PTSD treatments, (c) a critique of the inclusion criteria used to evaluate PTSD treatments for the guidelines, and (d) culturally emergent or indigenous psychological interventions for PTSD, including those developed to address the societal trauma of oppression (APA, 2017). Finally, the author will examine future research needs and implications of the reviewed literature. Given that PTSD is one of a few disorders that points directly to one's experience within the context of their lives, it is especially important to attend to the context of a survivor's recovery including but not limited to the bidirectional influence of family, community, and society; this requires a socio-interpersonal framework of PTSD (Maercker & Hecker, 2016).

Addressing Intersectionality in Current APA Treatment of PTSD Guideline

Psychologists need to recognize the cross-cultural dimensions of trauma and the sociopolitical and sociocultural underpinnings that shape the experience of trauma and trauma recovery (Dyregrov, Gupta, Gjestad, & Raundalen, 2002). The Treatment of PTSD Guideline (American Psychological Association PTSD Guideline, 2017) highlights the role and dynamics of intersectional identities for one page of the 139-page document, with only four supporting citations provided on that page. The summary statement makes four major points: (a) Survivors have intersecting identities that therapists should acknowledge, (b) therapists need to be aware of the ways in which their experience and identities differ from the survivors with whom they work, (c) therapists should have an openness and respect for the diverse cultures of their clients, and (d) therapists of trauma-surviving clients should consider sociocultural factors such as access to care, cultural congruence of treatment models, and comprehension of empirically supported interventions by culturally diverse clients. In addition, while noting Comas-Dias' work on barriers to treatment, there is no direct mention of oppression, discrimination, culturally modified empirically supported PTSD treatments, PTSD resulting from traumas that target a person as a result of their cultural group membership, or culturally emergent treatments. These points of erasure are unethical, in that they fail to equip mental health professionals and students to appropriately acknowledge, assess, and address individual and collective traumatic stress among marginalized survivors.

A Critique of the Treatment of American Psychological Association PTSD Guideline (2017) includes the fundamental assumption of a universal trauma response called PTSD without consideration of the possibility that PTSD is culture-bound and may not fully represent the ways in which trauma effects culturally marginalized survivors (Marsella, 2010). This assumed universality aligns with the already rejected goal of color-blind psychology, which usually translates to a psychology based on research with White middle-class, heterosexual, male, college-educated research participants that is then applied liberally to all groups of people. In addition, the lack of a presented trauma-event person model, which attends to the ways culture shapes the experience of trauma and treatment, is a major gap found within the guidelines (Marsella, 2010). This article will address these factors with the aim of offering recommendations for serving trauma survivors with PTSD who live at the intersection of multiple webs of oppression. Some critiques of multicultural psychology question the rationale of psychologists who dedicate their life's work to studying the psychology of specific cultural groups. The cultural erasure in the current Treatment of American Psychological Association PTSD Guideline (2017) provides an additional rebuttal to these critiques and adds to the call for multicultural psychologists, liberation psychologists, feminist psychologists, queer psychologists, and community psychologists to continue doing the sacred work of decolonizing psychology through the creation of space for the voices, experiences, needs, strengths, and treatment of diverse populations.

Culturally Modified PTSD Treatments

Although there are studies on cultural modifications of PTSD-focused treatments in various countries (Damra, Nassar, & Ghabri, 2014; Perera-Diltz, Laux, & Toman, 2012), due to space constraints, the focus of this review will be limited to research conducted within the United States. The treatments recommended in the guidelines focus primarily on various cognitive and cognitive-behavioral interventions. Cultural modifications of trauma-focused cognitive-behavioral therapy have been explored for Latinos, African Americans, Christians, children with medical conditions, and lesbian/gay/bisexual survivors (Al-Kharafi, 2018; Gibbs, 2014; Gray, 2018; Partridge & Walker, 2015; Perales, 2018). Integrating cultural values and experiences within trauma interventions can result in improved accessibility, retention, congruence, and efficacy among minority group members (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009). Culturally modified treatments have been found to have higher client satisfaction and stronger treatment

response than nonculturally modified versions of the same treatment (Castro, Barrera, & Steiker, 2010; Meyer, & Zane, 2013).

Cognitive processing therapy (CPT) is one of the recommended treatments in the PTSD guidelines; however, there are limited studies that examine culture considerations. A study comparing non-Latino, Latino Spanish-speaking, and Latino English-speaking trauma survivors revealed findings that illuminate the importance of attending to culture and intersectional identity (Marques et al., 2016). A critical component of CPT is the identification of "stuck points" by the therapist. In this study, the content of stuck points was similar across the three groups, but therapists were able to identify less stuck points for Latino clients. In addition, content analysis of stuck points for Latinos highlighted the role of religion, family, poverty, and community violence. Training for CPT needs to include attention to potential barriers to identifying stuck points as well as consideration of the contextual themes that are more salient among Latino trauma survivors with regard to intersectional factors, such as migration status, language, socioeconomic status, and level of neighborhood safety. Cultural modifications for Latinos, which result in improved appropriateness and accessibility, include Spanish translation, attention to regional differences in language, literacy level, and exposure to community violence (Valentine et al., 2017).

Prolonged exposure (PE) therapy is another model endorsed in the PTSD guidelines, which psychologists have culturally modified. Clinicians working with 9/11 survivors found they could not provide appropriate care if they ignored the social, cultural, political, and economic realities that shaped the lives of those for whom they provided treatment (Marshall & Suh, 2003). Although trauma psychologists have traditionally treated cognitions as individually based, researchers now know that our reality, cognitions, the experience of emotion, and the expression of emotion are constructed in part by our culture. In addition, individual trauma models overlook the realities of collective trauma and the cultural experience of mass suffering, such as that experienced by African American, Jewish, Muslim, Armenian, and transgender survivors. For these survivors, the rebuilding of social systems is a required component of recovery. Following Maslow's hierarchy of needs, safety and stability are prerequisites to psychological progress on interpersonal connectedness and fulfillment (Marshall & Suh, 2003). Clinicians can enhance PE by understanding the world of the client prior to the trauma from a social and anthropological perspective and the culturally contextualized meaning of the trauma to the individual (Bracken, 2001). In addition, collaboration with primary care physicians, faith leaders, and community leaders is the basis for continuous modification of assessment and intervention strategies, which will build on the client's strengths and resources (Marshall & Suh, 2003). Culturally modified PE should be conducted in the client's preferred language, include assessment of cultural factors such as undocumented status, and be addressed in treatment as integral parts of the client's recovery (Benuto & Bennett, 2015).

There are cultural modification recommendations established for applying cognitive psychotherapy with Asian American clients (Boehnlein, 1987). Boehnlein (1987) endorses trauma-focused cognitive psychotherapy as a culturally congruent intervention, as it integrates direct questioning and dialogue about religious beliefs, values, and personal trauma history. The modifications require clinicians to attend to migration experience, loss of cultural connections, acculturation, language, loss of status, family and cultural role expectations, religious belief systems, pessimistic views of fate, and intergenerational conflict. Culturally modified trauma treatment with Asian American survivors honors the client by not limiting their identity to their trauma but instead by creating space for the person's context and community.

Chinese Taoist cognitive psychotherapy is an integrative approach that builds on Taoist principles while utilizing the didactic approach of cognitive therapy (Zhang et al., 2000). The principles incorporated are caring for yourself without harming yourself or others, doing your best, not competing with others, not being selfish, knowing when to stop and be satisfied, knowing harmony and humility, and holding softness to defeat hardness. The clinician facilitates the process of exploring the traumatic event, identifying cognitive distortions and their consequences, and learning the Taoist principles as a way of regaining purity of mind.

Modifications of trauma treatment with African Americans include attending to resilience while incorporating spirituality, movement, art, and music (Bryant-Davis & Comas-Díaz, 2016). Modifications should also attend to socioeconomic status, accessibility of services, cost, and discrimination, by providing interventions that are geographically accessible, community-based, cost-effective, and attuned to the realities of complex trauma (Dutton, Bermudez, Matás, Majid, & Myers, 2013). In addition, for African American children who experience PTSD at higher rates than White children, integrating trauma-focused cognitive-behavioral therapy, trauma-focused art therapy, and Afrocentric therapy can provide a culturally congruent treatment alternative (Gibbs, 2014). Cultural awareness training of clinicians and culturally matched treatment dyads when possible are also recommended. Although not culturally modified specifically to African American culture, modifications have been made to mindfulness-based stress reduction with low-income African American female trauma survivors to increase its accessibility. These modifications included shortening the number and duration of classes, being sensitive to the religious concerns of participants, increased logistical support via weekly reminder calls, not including laying down activities that can be triggering to complex trauma survivors, and ensuring participation is voluntary and not a mandate of a treatment program (Dutton et al., 2013; Kabat-Zinn, 2003). The participants reported positive experiences of the group and particularly appreciated not having to discuss their traumatic experiences.

Sloan, Berke, and Shipherd (2017) have outlined cultural modifications of dialectical behavioral therapy (DBT) with transgender and gender-nonconforming clients to address chronic invalidation and discrimination. Cultural modification of DBT begins from the stage of assessment in noting that transgender clients should not have their symptoms of distress from chronic invalidation equated with borderline personality disorder. Chronic invalidation and discrimination can result in emotional and behavioral dysregulation, so although skills training may be helpful, it must be rooted in an acknowledgment of oppression. Balancing change and acceptance, culturally modified DBT can be used to empower transgender clients to navigate systems of oppression including medical systems, to build and maintain healthy social networks, and to build a positive sense of self despite the chronic invalidation from the larger society. Mindfulness can be used to tolerate distress associated with transition as well as to increase gender-affirming activities, patience with process, loving kindness toward self, and distress tolerance related to past trauma, while decreasing judgments of self.

Cultural modifications with sexual minority (lesbian, gay, and bisexual) trauma survivors include attending to factors that may intensify PTSD symptoms. Specifically, daily heterosexism experiences as well as internalized heterosexism predicts PTSD severity. Psychologists working with sexual minority clients with PTSD symptomology should explore experiences of discrimination, which may increase negative views of the self, which may maintain or worsen PTSD (Dworkin et al., 2018). Integration with gay affirmative therapy increases attention to coming, stigma, social support, and discrimination, working toward affirmation (Gray & Rose, 2012).

Cultural adaptations are additionally needed to apply ethical treatment to trauma survivors living with disabilities (Bryant-Davis, 2005). Cognitions, affect, behavior, and relationships should be viewed in context, which requires acknowledgment of ableism, health care disparities, access to psychotherapy, culture, risk factors, resiliency factors, and intersectional social identity and roles (Brown, 2008). Clinicians must be aware of their biases, assumptions, and socialization around ability status and its intersection with various types of trauma.

Modifications also exist for mainstream psychotherapy interventions that did not receive the highest endorsement in the guidelines, such as eye movement desensitization and reprocessing therapy (EMDR) and psychodynamic therapies. Gaztambide (2015) explored the birth of psychoanalysis from the Jewish experience of oppression and marginalization. From this vantage point, he connects psychoanalysis and psychodynamic treatments to liberation psychology that inherently honors the other, the discarded, the rejected aspects of the self, and the oppressed of society. Applied with attention beyond the individual psyche, psychodynamic treatment can attend to issues of social justice and oppression that the client experiences and observes. In the Torah, the Prophets, and the Christian gospel, divinity is revealed through and to the oppressed (Gaztambide, 2015). The excellence, humanity, and sacredness of the enslaved, the oppressed, is centered in these philosophical frames, and this is foundational to psychodynamic construction. Preference is given to the repressed, in the psyche and in society, and this aligns with liberation for the client and the larger community. The client is encouraged to acknowledge and integrate the hidden aspects of the self and the hidden members of society. Considering the hidden among the hidden, Jackson and Greene (2000) have explored the use of feminist psychodynamic therapy with African American lesbian and bisexual women. Greene (2004) acknowledged the criticism of psychodynamic therapies historically as sexist, heterosexist, and Eurocentric but noted there are multiple approaches to psychodynamic treatment including approaches that center and affirm African Americans, sexual minorities, and other culturally diverse people. Culturally appropriate psychodynamic therapists acknowledge power, privilege, social injustice, social identity, immigration, skin color, spirituality, gender, and therapist shame and guilt (Tummala-Narra, 2011; Greene, 2006).

Modifications to integrate religion, spirituality, and culture have been explored with EMDR, which has strong empirical support in the literature with diverse populations; the modifications call for clinicians to attend to and integrate themes congruent with a client's faith traditions and belief systems (Abdul-Hamid & Hughes, 2015). Cultural modifications of EMDR related to being a racial and ethnic minority challenge clinicians to maintain space and sensitivity to issues of discrimination, poverty, clinician bias, misunderstandings due to language usage, family responsibility, role conflict, racial identity, and identity confusion (Rittenhouse, 2000). With American Indian survivors, clinicians may consider the use of sage and crafts as well as the salience of taboos, beliefs, and rituals (Gray & Rose, 2012). Integration of culture in EMDR also requires intentionally attending to immigration, bilingualism, discrimination, marginalization, microaggressions, racism, and sexism to adopt an antioppression stance (Levis & Siniego, 2017).

A Critique of APA PTSD Guidelines Assumptions

As described by the authors, the American Psychological Association PTSD Guideline (2017) recommend treatments based on quantitative methods, with priority given to manualized treatments with outcomes documented in large randomized control studies. Critiques of cognitive-behavioral trauma interventions include the emotional difficulty of exposure methods for survivors of complex trauma, the potential cost-prohibitive fees, and the reality of those who complete the prescribed sessions and continue to live with PTSD (Dutton et al., 2013). Based on the evaluation methods of the guidelines' authors, the treatments that are highlighted are primarily cognitive, which is reflective of the Cartesian philosophy "I think therefore I am." Non-European cultures embrace a philosophy of "I am because we are," (closer to collectivistic on the individualistic/collectivistic continuum), yet the interventions promoted by the guidelines for the most part ignore the sociocultural and center the mind of the individual.

Ginwright (2018) laid out several critiques of trauma-focused treatments, the core of the recommended PTSD interventions. The first of which is the tendency to define the person through their trauma while overlooking the strengths, resources, culture, and sociopolitical identity of the survivor. Another is that these interventions center the pathology in the individual who has been harmed without attending to larger family, community, and society as a site in need of intervention and prevention (Ginwright, 2018). The American Psychological Association PTSD Guideline (2017), following a medical model, make the culminating point of treatment the cessation of posttrauma symptoms, which falls short of the possibility of interventions that aim toward well-being and growth.

Psychologists developed cognitive and cognitive-behavioral treatments independent of culture for the most part (Marshall & Suh, 2003). Critics argue that framing people according to a diagnosis, such as PTSD, is clinically "limiting and naïve" (Ren, 2012, p. 988). For many cultural communities, the site of greatest trauma is not psychobiological changes but those in the spiritual domain. Addressing thoughts while ignoring the soul wound, the community wound, and the community solution is insufficient. Scientific methods have difficulty handling complex, nuanced notions such as spirituality and culture, so they are left out of many models for the convenience of the research despite the impact on the culturally marginalized survivor. In addition, scientific foundations are more likely to fund studies that are easily replicable, manualized, and monitored for fidelity, which results in the devaluing of culturally emergent, spiritually integrative, and artistically based interventions, whose flexibility is not an addition but a core component of their approach. It is unethical to facilitate a recovery

process for a person while only welcoming the parts of themselves that are easy to control (Ren, 2012).

Culturally Emergent Trauma Treatments Including Those for Racial Trauma

Culturally rooted, or indigenous, approaches to trauma recovery have been explored minimally in the psychology literature but are based in healing practices that often predate the field of psychology. Indigenous psychologies are based in self-determination, and community- level healing in addition to the individual, and cultural approaches to healing (Liu, Aho, & Rata, 2014). One may adopt the frame that interventions which emerge outside of the West are indigenous psychologies or one may argue that Western-Born interventions such as CBT are indigenous models themselves that emerge from Western culture.

To appropriately address trauma among multiply oppressed survivors, the psychologists must attend to the client's community, spirituality, meaning, and responsibilities to observe the impact on a client from a perspective that incorporates the sacred meaning of relationship, nature, children, ancestors, and spirit (Ren, 2012). Indigenous trauma therapy emerges from the culture of the survivor and their community and flows from cultural proverbs, values, beliefs, stories, spirits, and resilience. Practitioners must approach the work with humility, empathy, and respect for the client and their culture, recognizing that cultures have therapeutic pathways despite the lack of empirical validation for their contribution. Indigenous psychologists challenge clinicians to immerse themselves in the spirit and culture of survivors and to become "rooted and grounded" in them to emerge appropriately and effectively. To address trauma among culturally marginalized communities, some have developed integrations between Western psychology models (acceptance and commitment therapy and DBT) with indigenous psychology beliefs, practices, and rituals for spiritual well-being (Gallagher, 2019; Hill, Lau, & Sue, 2010).

There are core differences between culturally emergent healing tools and evidence-based Western interventions. The primary one is the Western model, based on working with the individual, usually in a clinic for a limited number of minutes and limited number of sessions. Culturally based psychologists have argued for the decolonization of psychology through the development of models that recognize the value of group and family-based interventions, as well as interventions that respect spirituality, creativity, and engagement in social justice.

Culturally emergent interventions have been developed to address racial trauma, intergenerational trauma, and soul wounds, which have traditionally not been included in the PTSD diagnosis or mainstream trauma psychology treatments (Comas-Díaz, Hall, & Neville, 2019). Persons from marginalized communities have lived with the violation of oppression, enslavement, attempted genocide, mass incarceration and deportation, poverty, raids, systemic discrimination, colonialism, and neo-colonialism (Hartmann, Wendt, Burrage, Pomerville, & Gone, 2019). Racial trauma is exacerbated by intersectionality because persons live with multiply oppressed statuses such as African American Muslim women, Jewish transgender men, undocumented Latinas who are differently abled, and homeless Asian American gender-nonconforming adolescents. Symptoms observed in persons who have experienced racial trauma include PTSD symptoms; however, racial trauma, intergenerational trauma, and intersectional oppression are not identical to PTSD. A critical difference is that most trauma interventions are aimed at helping people recover from traumatic events in their past, whereas racial trauma and oppression are ongoing realities that persist over time and even across location and that are therefore continuous and cumulative (Kira, Lewandowski, Chiodo, & Ibrahim, 2014).

African Americans and Latinos are reported to have higher risk of developing PTSD, and the clinical outcomes among these populations is poor (Sibrava et al., 2019). Although Western notions of trauma have highlighted interpersonal violence such as sexual assault, war, and child abuse, little research has focused on the potentially traumatizing impact of acts of oppression such as racism. In fact, frequency of racial discrimination has been found to predict the PTSD diagnosis status among African Americans and Latinos (Sibrava et al., 2019). In addition, American Indians who self-medicate with alcohol note the critical role that oppression and discrimination play in downgrading their mental health (Skewes & Blume, 2019). These findings demonstrate the need for clinicians who conduct trauma therapy to attend to oppression, discrimination, and racism as potential sources of traumatic stress symptoms (Skewes & Blume, 2019).

Several culturally emergent models to healing trauma have evolved and been explored in the literature. Womanist and mujerista psychologies focus on healing Black women and Latinas, utilizing empowerment, creativity, spirituality, self-development, activism, and resistance of internalized oppression (Bryant-Davis & Comas-Díaz, 2016). Treatment includes awareness raising, building connections with others, redefining one's self, self-expression, resistance of oppression and internalized oppression, and activism.

Based on the concept of harmony and interconnection of all living things, the Ubuntu model of therapy utilizes African values and practices noting that emotional distress is rooted in spiritual wounds, the family and not the individual is the focus, and attention must be given to god(s) and ancestors (Van Dyk & Nefale, 2005). Ubuntu therapy involves the client telling their story and the clinician analyzing the problem on three levels: their connection to God, to themselves, and to others. The treatment plan will then determine if the best ways to work toward reconnection on the three levels is individual, family, or group, with the aim of creating inner and outer harmony. Regardless of the number of persons present in the room, the therapist adopts a systemic approach, with awareness of cultural roles, values, and conflicts that are often intrapsychic and intergenerational. For trauma in particular, dancing is utilized as the wound is embodied; therefore, the healing, culturally and spiritually, too must be embodied.

Emotional emancipation circles are group interventions that focus on the use of a narrative approach to diminish the potentially traumatic impact of anti-Black discrimination and dehumanization to cultivate resistance to the lie of White supremacy (Community Healing Network, 2018). These evidence-informed groups focus on participants sharing their stories of racism, becoming aware of the impact of historical and contemporary racism on themselves and their relationships, and learning emotional wellness skills to foster their growth and honor their dignity and humanity.

American Indians have used retraditionalization, or reconnecting with cultural heritage, as a source of healing through ritual, crafts, nature, and music (Gray & Rose, 2012). Use of the medicine wheel has been particularly relevant for trauma recovery

because it incorporates mind, emotion, body, and spirit as the survivor walks the wheel to retrain the neurological system and to transform the traumatic event into opportunity for initiating one into their purpose (Gray & Nye, 2001). Healing American Indian historical trauma requires a framework that acknowledges individual and collective trauma, colonialism, structural violence, and interdisciplinary approaches to wellness (Hartmann et al., 2019). Approaching healing with two spirit American Indian survivors requires the therapist become aware of their biases and assumptions, affirm the spiritual and not just sexual identity of their client, and acknowledge the diversity that exist within cultural groups (Garrett & Barret, 2003). Originating in Japan, Morita therapy, based in Zen Buddhism, focuses on the uncontrollability of internal experiences and the controllability of actions as well as the conflict between drives for fulfillment and drives for safety. Morita therapy for trauma focuses on inclusion of ecological settings, an initial rest stage as crucial to recovery, consciousness raising, and learning to live creatively with the realities of uncertainty (LeVine, 2018). Most recently, the Healing Racial Ethno Trauma framework has been proposed, which utilizes trauma-informed treatment and liberation psychology with the aim of cultivating justice and hope (Chavez-Dueñas, Adames, Perez-Chavez, & Salas, 2019). The stages are establishing sanctuary, or safety for the survivor, exploring the effects of the trauma, strengthening connections with the self and others, and finally developing resilience as an agent of change. Although most Western models of therapy focus on coping and reducing distress, cultural-based trauma models have a component of resistance of the trauma of oppression, whether with activism, internally, socially, or spiritually. Along those line, Bryant-Davis and Ocampo (2006) lay out a model for healing wounds from racism and other forms of oppression utilizing the following steps: acknowledge, share, safety and self-care, grieve, shame and self-blame/internalized racism, anger, coping strategies, and resistance strategies. This is a modification of Herman's stage work for trauma recovery with the additions of addressing the possibility of internalized oppression, and the potential pathway of resistance as an act of radical healing.

Conclusion

The Treatment of American Psychological Association PTSD Guideline (2017) provides a vigorous review of psychology interventions that evidence effectiveness through randomized control studies based in a medical model of trauma, but these interventions in their original form treat people from a culture-blind perspective. The recommendation of these interventions without full examination of their cultural limitations provides a disservice to mental health professionals and to marginalized trauma survivors themselves. Culture blindness is erasure, and erasure does not ethically serve trauma survivors whose multilayered identities encompass cultural resources and cultural oppression that bring vulnerability, strength, and meaning to their identity and their experience of trauma and recovery.

The following recommendations are made because these relates to the APA Treatment of American Psychological Association PTSD Guideline (2017):

(1) The original task force issue a joint statement on the recognition that it overlooked important cultural considerations when drafting the PTSD guidelines. In addition, they state their support for the creation of either a modification of their guidelines or the creation of new guidelines crafted by psychologists who are immersed in the work of serving and/or conducting research with culturally marginalized trauma survivors.

(2) The APA calls for and provides resources for a task force to work on a revision to the Guideline (APA, 2017) and/or support the creation of a new task force of multicultural psychologists to create a Trauma Treatment Guideline for Trauma Survivors from Systemically Oppressed Groups.

(3) The newly created task force start their document with a discussion of the terms trauma and PTSD because it relates to culture, power, and privilege regarding the acknowledgment of diverse forms of trauma, including such constructs as terrorism, historical trauma, racism, sexism, heterosexism, hate crimes, and societal trauma.

(4) The newly created task force deconstruct notions of evidence-based treatments and acknowledge the strengths and limitations of the ways in which the criteria are determined.

(5) The newly created task force include the growing literature on cultural modifications of evidence-based and empirically supported PTSD treatments.

(6) The newly created task force include a review of the diverse culturally emergent treatment approaches to addressing trauma among marginalized communities.

A growing body of literature examines cultural modifications of the first- and second-tier interventions endorsed by the guidelines. These modifications require the clinician to attend to the sociocultural realities that permeate the client's internal world, external world, and the therapeutic world with the clinician. Initiating process and being aware of process themes that emerge related to discrimination, migration, language, skin color, gender, sexual orientation, religion, spirituality, age, identity, roles, responsibilities, stigma, and cultural strengths need to be a part of both assessment and intervention.

Attention to intersection also means holding space for the complexity of people's lives. For example, African American women endorse higher levels of religiosity than women of other ethnic groups. Although African American women endorse religious coping as helpful in reducing distress in the aftermath of intimate partner violence, African American women who have been sexually assaulted experience a positive relationship between religiosity and PTSD severity (Bryant-Davis, Ullman, Tsong, & Gobin, 2011). The layers of identity also intersect with the type of trauma, and culturally attuned clinicians do not gloss over these aspects of meaning that shape recovery.

As Greene (2000) discussed, there are margins within margins. Marginalized groups are neglected in the trauma psychology literature, and there is urgency in changing this. When oppressed communities appear in the trauma literature, it is usually as an afterthought because psychologists seek to take their U.S.-based

interventions around the world. Less scholarship exists on culturally emergent, indigenous interventions for trauma survivors. More research on neglected populations is needed, which includes Armenian American elders, Muslim immigrant adolescents, as well as women of color with disabilities, religious minorities, and same gender loving trauma survivors (Kira et al., 2014; Mangassarian, 2016); certain traumas have also been neglected in the literature, such as police brutality, which is pervasive and protected by privilege, power, and silence.

Finally, this critical review of the literature calls for attention to policy reform. Intersectional identity, cultural oppression in all of its forms, needs to be a mandated part of trauma training, practice, supervision, research, and consultation. Interventions, which ignore the cultural realities of those they seek to serve, are shortsighted at best and harmful at worst. Neglecting culture allows for a simplified cookie-cutter approach that can be mass-marketed in ways that support capitalistic, bureaucratic, medical models of treatment. Although some empirically based interventions evidence effectiveness with diverse trauma survivors, attending to the soul and culture of those who have been systematically invalidated would enrich the field of trauma psychology.

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