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Review

Cultural concepts of distress and complex PTSD: Future directions for research and treatment

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ABSTRACT

Complex post-traumatic stress disorder (CPTSD) was introduced as a new diagnostic category in ICD-11. It encompasses PTSD symptoms along with disturbances in self-organisation (DSO), i.e., affect dysregulation, negative self-concept, and disturbances in relationships. Quantitative research supports the validity of CPTSD across different cultural groups. At the same time, evidence reveals cultural variation in the phenomenology of PTSD, which most likely translates into cultural variation with regard to DSO. This theoretical review aims to set the ground for future research on such cultural aspects in the DSO. It provides a theoretical introduction to cultural clinical psychology, followed by a summary of evidence on cultural research related to PTSD and DSO. This evidence suggests that the way how DSO symptoms manifest, and the underlying etiological processes, are closely intertwined with cultural notions of the self, emotions, and interpersonal relationships and interpersonal relationships. We propose directions for future research and implications for culturally sensitive clinical practice.

In 2018, complex post-traumatic stress disorder (CPTSD) was introduced in the International Classification of Diseases 11th revision (ICD-11) as a new diagnosis alongside a revised post-traumatic stress disorder (PTSD) diagnosis (World Health Organization, 2018). ICD-11 PTSD consists of three core symptom clusters: re-experiencing of traumatic events in the present; deliberate avoidance; and a current sense of threat. In addition, significant functional impairment is required for a PTSD diagnosis. CPTSD includes the same symptoms and three additional symptom clusters, collectively referred to as *disturbances in self-organisation* (DSO), which include affect dysregulation, negative self-concept, and disturbances in relationships. The DSO describe symptoms "that can sometimes result from multiple, chronic or repeated traumas from which escape is difficult or impossible (e.g., childhood abuse, domestic violence, torture, war imprisonment)" (Brewin et al., 2017, p. 3).

The cross-cultural applicability of PTSD diagnostic criteria has been subject to debate in the literature (e.g., Friedman, Resick, & Keane, 2007; Hinton & Lewis-Fernandez, 2011). This debate was fostered by evidence from qualitative research showing variations in PTSD phenomenology across different cultural groups, i.e., African, Latin American, Middle Eastern and Asian populations (Rasmussen, Keatley, & Joscelyne, 2014). The ICD-11 Working Group on the Classification of Disorders Specifically Associated with Stress acknowledged this evidence. Although there was large consensus on universal PTSD and CPTSD core features, the working group stated that there might be some degree of cultural variation in the presentation of these disorders (Maercker et al., 2013).

This paper aims to shed light on such cultural variations in symptoms related to CPTSD, or more precisely, the DSO. We aim to set the conceptual ground for future research in this field, based on contributions from cultural (clinical) psychology. For the purpose of this review, we use the following definition of "culture," as proposed by the *Lancet Commission on Culture and Health*: "Culture, then, can be thought of as a set of practices and behaviours defined by customs, habits, language, and geography that groups of individuals share" (Napier et al., 2014, p. 1609). In general, with "cultural groups," we are referring to populations other than the Western, educated, industrialized, rich, and democratic (WEIRD, Henrich, Heine, & Norenzayan, 2010) societies, as well as migrant populations within WEIRD countries.

1. Etic and emic approaches to study PTSD across cultures

Two contrasting methodological approaches have been used in cultural psychology: the etic and emic approach (Pike, 1967). In the etic approach, researchers take an outsider perspective; the same constructs

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and measures are applied across cultural groups, and results are compared across groups by means of quantitative methods. By contrast, the emic approach takes the viewpoint of the insider; using qualitative methods, researchers describe the views, thoughts, or behaviors of the studied group without applying predefined concepts and categories. Thus, in emic research, no direct comparisons can be drawn.

In epidemiology, etic research applies the same diagnostic criteria across different cultural groups. For instance, in the World Mental Health Surveys (Kessler et al., 2007), prevalence rates of mental disorders were assessed with the Composite International Diagnostic Interview (CIDI, World Health Organization, 1990) across 28 countries. The CIDI measures the presence or absence of mental disorders defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV, American Psychiatric Association, 1994), and ICD-10 (WHO, 1992). In the World Mental Health Surveys, PTSD lifetime prevalence varied cross-nationally (Koenen et al., 2017). The PTSD prevalence rate was particularly low in China (0.3%), and, most remarkably, 0.0% among a Yoruba-speaking sample in Nigeria (Gureje, Lasebikan, Lola, & Makanjuola, 2006).

Emic research collects and describes *cultural concepts of distress* (CCDs), a term that was introduced in DSM-5 (American Psychiatric Association, 2013). CCDs include i) culture-specific *idioms of distress*; ii) *explanatory models*; and iii) *cultural syndromes* (Lewis-Fernández & Kirmayer, 2019). Idioms of distress encompass verbal and nonverbal expressions of suffering. Explanatory models refer to etiological assumptions, which are often based on mind–body concepts and spiritual beliefs. And cultural syndromes describe the co-occurrence of symptoms within a syndrome that is distinct from diagnostic categories listed in ICD or DSM. A vast amount of evidence has been collected on such CCD related to trauma (Kohrt et al., 2014; Rasmussen et al., 2014).

Although the etic and emic perspective may seem to be mutually exclusive at first glance, they rather complement each other: Etic research – i.e., the application of the same constructs and measures across cultures – will provide the indications for cultural similarities and variations, whereas emic research – i.e., qualitative methods assessing cultural concepts of distress – will help us to better understand them (Chentsova-Dutton, Ryder, & Tsai, 2014). And vice versa, emic research can be used to develop diagnostic categories that are valid across cultures.

As outlined by Lewis-Fernández and Kirmayer (2019), a true "global nosology" distills phenomenological information from different cultures and reduces this information to universally applicable core features:

> Psychiatric disorders are very different from CCDs both in their semiotics and their pragmatic function. One way to conceptualize their relationship is to think of psychiatric disorders as what is left when CCDs are subjected to a process of abstraction and decontextualization that emphasizes the formal, structural (nomothetic) aspects of the presentations over the idiosyncratic, narrative (ideographic) components. (p. 789).

2. Cultural validity of the CPTSD diagnostic concept

CPTSD as an own diagnosis was first proposed by Herman (1992) for survivors of prolonged and repeated trauma who showed affective changes, pathological relationships and pathological changes in identity, among other symptoms (Maercker, 2021). Subsequently, the diagnosis "Disorders of Extreme Stress Not Otherwise Specified" (DESNOS, Herman, 1992) was introduced to the Appendix in DSM-IV (American Psychiatric Association, 1994). DSM-IV field trials (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005) of this diagnosis were conducted using the Structured Interview for Disorders of Extreme Stress (SIDES, Pelcovitz et al., 1997).

de Jong, Komproe, Spinazzola, van der Kolk, and Van Ommeren (2005) examined the cross-cultural validity of the DESNOS concept across three post-conflict samples in Algeria, Ethiopia and Gaza. At that time, data from populations other than WEIRD societies were lacking. The study by de Jong et al. (2005) showed that the factor structure of the SIDES was not stable, indicating that the theoretical concept of DESNOS was not the same across the three samples. In addition, they found that some features were less prevalent in the studied samples than in the DSM-IV trials, such as suicidal ideation, risk taking, victimizing others, as well as feelings of guilt and shame. The authors provided meaningful insights about cultural and contextual aspects that might explain these differences. Based on these results, the authors proposed "the construction of a universal core module to capture the consequences of extreme stress across cultures, with local modules that fit culture-specific expressions of extreme stress" (de Jong et al., 2005, p. 20). In this context, they also proposed distinguishing three different types of symptoms: core symptoms that are the same across cultures (type A); symptoms that are unique to a culture but reflect universal underlying problems (type B); and expressions of culture-specific processes that have specific symptoms (type C). In addition, the authors suggested including type B and C symptoms in local modules. The newly developed CPTSD diagnosis was developed with the aim of providing the core symptoms that are invariant across cultural groups (type A).

In contrast to the DESNOS study by de Jong et al. (2005), there has been substantial evidence across different cultures that the new CPTSD diagnosis in ICD-11 represents an independent diagnostic construct. The distinction between PTSD and CPTSD has been demonstrated in more than 10 studies testing its factorial structure in clinical and nonclinical samples in the UK, USA, Denmark, Austria, Germany, Israel, Bosnia and Uganda (Brewin et al., 2017). Further evidence regarding the factorial structure of CPTSD also suggests that this is an independent diagnostic construct in Eastern Asian countries (Ho et al., 2020) as well as among three community samples in Nigeria, Kenya and Ghana (Owczarek et al., 2020). More recently, using network analysis, Knefel et al. (2019) and Knefel et al. (2020) confirmed that the structure of CPTSD was similar in population-based samples from Germany, Israel, UK and USA, and in a cross-cultural comparison of clinical samples from Austria, UK and Lithuania, respectively. And Nickerson et al. (2016) found support for the proposed two-factor structure (i.e., PTSD and DSO) in a sample of 134 severely traumatized refugees in Switzerland.

Thus, etic research indicates that CPTSD as a diagnostic construct is valid across different cultural groups, and that the core symptoms of CPTSD are universally applicable. From this evidence, it seems pertinent to conclude that the complex phenomenology of mental disorders in the sequelae of multiple, chronic or repeated trauma was successfully reduced to what de Jong et al. (2005) considered type-A symptoms. Or, in the words of Lewis-Fernández and Kirmayer (2019), these symptoms reflect the formal, structural aspects of CPTSD after "a process of abstraction and decontextualization" (p. 789). What remains to be done is more emic research to define what de Jong et al. (2005) named as type-B and C symptoms, or what Lewis-Fernández and Kirmayer (2019) define as "the idiosyncratic, narrative (ideographic) components" of CPTSD (p. 789). If the DSO are universal aspects of CPTSD, we can start exploring cultural variations in how these three symptom areas are expressed, and what they mean across different cultures.

3. Culture and CPTSD: theoretical background

Chentsova-Dutton and Maercker (2019) suggest using the concept of cultural scripts to study culturally shaped responses to traumatic stress. Cultural scripts are schemas, thus thoughts, cognitions, emotions and behaviors that are sequentially arranged and causally interlinked (Chentsova-Dutton & Maercker, 2019; Chentsova-Dutton & Ryder, 2019). They include both mental representations (e.g., beliefs, values, expectations) as well as observable, structured practices (e.g., consensually understood behaviors). Normative scripts are ways of feeling, thinking or behaving that are "socially approved." By contrast, *deviant cultural scripts* involve mental representations and practices that are still

comprehensible, but understood as abnormal and undesirable (Chentsova-Dutton et al., 2014) (Chentsova-Dutton & Ryder, 2019).

A subset of deviant scripts pertains to mental disorders. Such deviant scripts

> shape where we draw the line between health and illness, how we recognize a problem, what we call it, and how we talk about it (or avoid talking about it). They inform us about possible causes, signs and symptoms, seriousness, and anticipated course. Finally, they provide us with guidance about whether to seek help, how to do so, and what treatments might be most effective. (Chentsova-Dutton & Ryder, 2019, p. 373).

As the term suggests, deviant scripts *deviate* from normative scripts and can thus only be fully understood in reference to the latter (Chentsova-Dutton et al., 2014).

Cultural scripts can be used as a starting point for studying CPTSD, and particularly the DSO, across cultures. The three DSO symptom clusters in CPTSD lie at the heart of what has been investigated in cultural psychology during the past decades: notions of the self, emotion expression and interpersonal relationships (Heine & Ruby, 2010). Insights from such basic research are most relevant for a better understanding of psychopathology, as pointed out by Chentsova-Dutton and Maercker (2019): "The ways in which mental illness disrupts psychological functioning should be considered against cultural referents of what it means to be a normally or an ideally functioning person" (p. 3). Hence, concepts and empirical research brought forward in cultural psychology related to nonpathological notions of the self, emotions and interpersonal relationships can be used to better understand the DSO in a cultural context.

In the following, we review evidence from etic and emic research related to CPTSD. Etic and emic research will complement each other in this field of research. Chentsova-Dutton et al. (2014) bring it to the point by the following statement: "Cross-national differences raise but do not answer questions about underlying processes, about *why* a difference is observed" (p. 340). In this sense, we aim to present both literature that raises potential questions, as well as literature that provides initial answers to such questions. Even though affect dysregulation comes first in the description of the DSO (Brewin, 2020; Maercker et al., 2013), we start with negative self-concept to develop our argument.

4. Negative self-concept

This symptom cluster is reflected in persistent "beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event" (Brewin, 2020, p. 2). Negative beliefs about oneself are intimately related with normative assumptions of what constitutes a valuable person and an appreciated member of society. To take a closer look at how culture relates to negative self-concepts, we first provide a short overview of cultural aspects in the self-concept itself. Thereafter, we review evidence related to DSO-related cognitions (i.e., negative beliefs about oneself), followed by a subsection on self-related emotions (i.e., shame and guilt).

4.1. Cultural aspects in the self-concept

In etic research, much emphasis has been given to studying notions of the self and how the self interacts with the social world, which has found expression in the dichotomies between *individualism* vs. *collectivism* (Hofstede, 1980) or the *independent* vs. the *interdependent* self (Markus & Kitayama, 1991). The independent vs. interdependent self-concept provides two different cultural mandates: In independent cultural contexts, the main mandate is autonomy, self-esteem and uniqueness, and people's behavior is guided by their own attitudes, motivational goals or values. In interdependent contexts, "the notion of personhood does not coincide with the boundary of the skin" (Kirmayer, 2007, p. 242). According to this view, a person is fundamentally a social being, and the self is defined through a strong commitment with the family and the community at large. The corresponding cultural mandates are relatedness and having harmonious relationships (e.g., Kitayama, Karasawa, Curhan, Ryff, & Markus, 2010; Markus & Kitayama, 1991).

Heine (2001) describes cultural differences regarding the self-concept based on the comparison between East Asian and US American culture. This comparison emphasizes the flexibility vs. consistency of the self, with East Asians being more likely to view selves as changing across different situations, whereas the self is experienced as relatively stable across situations in the US. In addition, East Asians conceptualize the self as being malleable, and the individual is required to be responsive to the needs of others by changing aspects of the self. By contrast, in the view of North Americans, the social world is malleable, and the individual has the control to shape it, which is reflected in the concepts of personal control and agency.

Evidence also shows that not only the self-concept itself, but also the construction of self-regard or self-esteem, varies across cultures. Heine, Lehman, Markus, and Kitayama (1999) describe the need for self-regard, or having positive feelings towards oneself, as an important aspect of North American culture. By contrast, in East Asian culture, self-criticism is seen as an important way to motivate the individual to do his or her best to improve, and to adjust the self to better fit the social environment. Self-esteem or self-regard, expressed in positive feelings towards oneself, would be seen as a sign that one is not doing enough to become a better person.

Cultural differences in the conceptualization of the self have a potential effect on psychological processes related to PTSD and CPTSD. In East Asia, Ho et al. (2020) found that a higher proportion of young adults met criteria for CPTSD (3.6%) than PTSD (1.9%), which stands in contrast to other studies where the prevalence of PTSD was equal or higher than CPTSD (Ben-Ezra et al., 2018; Cloitre et al., 2019). The authors posit that DSO symptoms may be more common in East Asian cultures, due to the higher tendencies to agree with negative self-statements (Y.-H. Kim et al., 2008a). Despite promising results confirming the two-factor structure of PTSD and CPTSD, the authors conclude that "more research with nationally representative and clinical samples is needed to confidently determine the validity of this model in Asia" (Ho et al., 2020, p. 7).

4.2. Negative beliefs about oneself

Self-related cognitions are shaped by normative cultural scripts, and by *intersubjective* knowledge. At the *intersubjective level*, people are asked which beliefs and values they *perceive to be widespread* in their respective cultural group (Chiu, Gelfand, Yamagishi, Shteynberg, & Wan, 2010). Intersubjective perceptions can differ from individual values and beliefs (i.e., what I personally value or think), but also from culturally shared knowledge or values (i.e., what most people in my group of reference *actually* value or think). Perceived deviation from intersubjective normative scripts may lead to negative appraisals of oneself. Thus, the negative appraisal itself ("I am a bad person") is most likely universal, but the meaning of this negative appraisal ("I am a bad person *because…*") is culturally shaped.

To account for cultural differences in self-construal and their potential impact on PTSD symptomatology, Jobson (2009), developed the "Threat to the Conceptual Self" (TCS) model. This model is older than the proposal for a new CPTSD diagnosis in ICD-11 and therefore focuses on PTSD only. Nevertheless, it delivers valuable theoretical contributions to cultural considerations regarding negative self-concept in CPTSD. The TCS is based on theories regarding memory and the self (Conway, 2005), cultural concepts of the self (Markus & Kitayama, 1991), and cognitive processes in the development of PTSD (Ehlers & Clark, 2000). In accordance with Ehlers and Clark (2000), the TCS posits that PTSD is accompanied by a current sense of threat, which can be

either external or internal. The external sense of threat is caused by the perception of the world as a dangerous place, whereas internal threat is described as "a threat to one's view of oneself as a capable/acceptable person who will be able to achieve important life goals" (Ehlers & Clark, 2000, p. 320). Jobson (2009) particularly focuses on this internal sense of threat and its relevance for PTSD symptomatology. The internal sense of threat in the aftermath of trauma may touch on different aspects of the self-concept, depending on one's cultural background.

In accordance with this assumption, Jobson and O'Kearney (2009) showed significant interactions between culture and PTSD symptomatology: Among trauma survivors with independent self-construal, three cognitive variables differentiated between those with PTSD and those without PTSD: greater mental defeat; fewer control strategies; and greater permanent change. By contrast, among trauma survivors with interdependent self-construal, no significant differences between those with and without PTSD were found regarding these cognitive appraisals. The authors conclude that "appraisals of personal responsibility, autonomy and control have greater impact on post-trauma psychological adjustment of trauma survivors from independent cultures than for trauma survivors from interdependent cultures" (p. 260).

More recent empirical evidence showed that disruptions in self-concept (i.e., self-discrepancies and trauma-themed self-concept) in the aftermath of trauma correlated significantly with negative self, world and self-blame appraisals among British participants, but not among Asian immigrants (Engelbrecht & Jobson, 2020). However, this was not confirmed in a second study by the same authors. In this second study, those with PTSD had greater self-discrepancies than those without PTSD in both groups, thus no cultural differences were observed. These results are limited by the fact that Asian immigrants may have lived in the UK for several years and thus have undergone a process of acculturation. The authors conclude that more research is needed on the relationship between interdependent and independent self-construal, negative self-concept, and PTSD.

In the TCS, Jobson (2009) further posits that the independent vs. interdependent self-construal has important implications for memory processes in the context of PTSD. Autobiographical remembering reaffirms the self as either an independent or interdependent entity (Wang & Conway, 2004). Thus,Jobson (2011) compared trauma survivors from individualistic vs. collectivistic cultures with regard to their autobiographic memories. In support of her hypothesis, she found that among trauma survivors in individualistic cultures, those with PTSD showed lower *levels* of autonomous orientation in their autobiographic memories than those without PTSD. By contrast, in collectivistic cultures, trauma survivors with PTSD showed *higher* levels of autonomous orientation in their memories than those without PTSD. One possible interpretation of this result is that "People who deviate from cultural expectations in terms of autonomous orientation in autobiographical remembering may be more vulnerable to developing PTSD" (Jobson, 2011, p. 180). This is in line with the concept of deviant scripts and their relevance for psychopathology (Chentsova-Dutton et al., 2014).

In addition to such etic research approaches, insights from emic research grasp aspects of negative self-concept that are not directly comparable across different cultural groups. A mixed-methods study in Austria revealed five main themes reporting positive and negative emotions and attitudes towards oneself in the context of CPTSD (Weindl & Lueger-Schuster, 2018). Statements expressing positive beliefs about oneself referred to autonomy, control and self-esteem, e.g., feeling confident and proud of oneself, expressing one's opinion at all times, not caring about other persons' opinion or a general feeling of self-satisfaction. By contrast, negative beliefs included feeling like a loser or failure, e.g., with regard to one's intellectual capacities, the ability to grasp opportunities, or to hold on to a position. One important aspect was expressed as follows: "Participants reported that despite their efforts they had always felt incapable of feeling satisfied with themselves: 'I am never satisfied with myself. There is always something to find a mistake in'" (Weindl & Lueger-Schuster, 2018, p. 8). As aforementioned, never being satisfied with oneself would be normative in East Asian cultures.

In summary, evidence so far indicates that notions of negative beliefs about oneself are culturally shaped. Future research will show to what extent this has a direct impact on the etiology of PTSD, and corresponding prevalence rates, as raised by Ho et al. (2020). And even if negative beliefs about oneself are a pancultural aspect of CPTSD, there is most likely cultural variation in the content of such negative beliefs, and the meaning assigned to it. Emic research in different cultural groups can be used to shed light on such cultural variation.

4.3. Shame and guilt

Shame is primarily a social emotion linked to social standing and personal reputation. The *social self* refers to one's identity in relation to the social environment, and shame occurs in situations of threat to the social self, such as negative judgment, defeat, low rank, rejection and social exclusion (Budden, 2009). A difference between external and internal shame has been postulated by Gilbert (2003). External shame arises from being shamed by others and is intersubjective in nature: "it is what one thinks is in the minds of others about the self that is the source for this type of shame" (p. 1213). By contrast, internal shame refers to the inner experience of the self as being devalued and unattractive. Guilt, in contrast to the self-focus of shame, arises from the motivation to avoid doing harm to others: "Guilt is not rooted in 'threat to the self,' or need for rapid defenses of the self. Rather, for guilt there must first be some concern with the welfare of others, such that the (distress) experiences of others matter" (Gilbert, 2003, p. 1206).

Evidence from anthropological research shows that across cultures, deviations from normative cultural scripts are sanctioned by shame and disgrace (Gilbert, 2003). Although shame is a pancultural human emotion, there are important differences in notions of shame. Fessler (2004) examined shame in an emic study among Malay people in the Indonesian province of Bengkulu on the southwest coast of Sumatra, and among middle-class participants in California. In both samples, shame was experienced in embarrassing situations or when social rules were violated. *Malu* (shame) was among the most prominent and frequently experienced emotions among Malay people, but among the least prominent emotions in California. Among the latter sample, shame was strongly linked to feelings of guilt, a link that did not emerge in the Malay sample. By contrast, in Bengkulu, *malu* was experienced in situations of subordination, i.e., in the presence of a more powerful member of society. In California, no reporting of shame in situations of subordination occurred. Drawing on literature from other parts of the world, the author concludes that shame in the face of subordination is prominent in many cultural groups, but not in "Western" individualistic societies.

In their study regarding the cultural validity of DESNOS, de Jong et al. (2005) found that shame and guilt were less prevalent in the samples under study than in the DSM-IV field trials. The authors explained that in the studied groups, guilt was related to actual behavior that is conceived as right or wrong, and shame was related to actual social or living conditions such as being poor or walking around in ragged clothes. Thus, the SIDES (Pelcovitz et al., 1997) seemed to have a lack of conceptual equivalence for shame and guilt. Findings such as the emic study by Fessler (2004) shed light on the reasons for this lack of validity: Being poor or walking around in ragged clothes indicates subordination in relation to wealthier and more powerful members of society, a concept that seems to be more relevant in collectivistic cultures. By contrast, guilt was not a common emotion among Malay people, and the ethnographic work showed that they did not have a clear concept of guilt.

The International Trauma Questionnaire (Cloitre et al., 2018) asks about notions of failure and worthlessness, but not about shame and guilt, which may have contributed to the increased validity of the instrument when compared to the SIDES. However, this is an assumption, and more research is needed to better understand specific notions of

shame and guilt across cultures. In addition, shame seems to arise from norm violations across cultures, but normative scripts about appropriate behavior are culture-specific. For this reason, it is vital to explore the type of norm violations in specific cultural groups that may foster shame in victims. As an example, victims of child sexual abuse are shunned for bringing shame to the family among Muslim Pakistani communities in Britain (Gilligan & Akhtar, 2006). Another example is reported by Fessler (2004) from the Malay study, where a young woman committed suicide out of shame because she became pregnant out of wedlock. Thus, in the context of CPTSD, it is most relevant to explore normative scripts in particular cultural groups through emic research. Such research will help to better understand notions of deviations from normative scripts and how they relate to negative self-concepts, shame and guilt.

5. Affect dysregulation

The second DSO symptom is characterized by difficulties in affect regulation, which "may take the form of hyperactivation, the tendency to experience intense emotions that cannot readily be moderated, or of hypoactivation, in which there is an absence of normal feeling states, or of both" (Brewin, 2020, p. 4). If we conceptualize psychopathology as deviance from the normative, our reference points with regard to affect regulation are culture-specific, normative aspects in emotion expression, experience, and regulation. In the same line of thinking, Mesquita and Walker (2003) suggest that emotional disturbances are "relative to the cultural emotion norms and practices that form their context" (p. 778).

In their seminal review, Mesquita and Frijda (1992) disentangled universal from culture-specific facets in emotions, drawing on a cognitive model of emotions. According to this model, antecedent events are encoded and appraised, which leads to emotional behavior through physiological reaction patterns. Emotions can be voluntarily regulated, either through inhibitory control or enhancement. According to this review, certain event types (e.g., loss of a person or rejection from the social group) universally arouse emotions. Evidence also indicates cultural similarities regarding event appraisal (e.g., the pleasantness or unpleasantness of a situation, whether it is considered unfair, or the significance of the situation for one's relationship with others). And there is evidence showing a universal human set of emotional reaction modes, e.g., response inhibition or expression control.

At the same time, there is clear indication of cultural variation in normative cultural scripts related to *emotional practices* (Mesquita & Walker, 2003). Such emotional practices are shaped by one's self-concept, and by the way social relationships are lived. In the following, we review literature on cultural aspects in emotion regulation in the context of post-traumatic stress. In accordance with the cognitive model of emotions and emotional difficulties (Mesquita & Frijda, 1992; Mesquita & Walker, 2003), we structure this evidence along the following elements: antecedent events, appraisal of events, valence of emotional states, and emotion regulation.

5.1. Antecedent events

With regard to antecedent events, there is no question that multiple, chronic or repeated trauma such as childhood abuse, domestic violence or torture, universally cause severe distress in humans, with primary emotions of fear, helplessness and horror (Grey, Holmes, & Brewin, 2001). Evidence also shows that symptoms of PTSD result from traumatic events across culturally diverse samples (Hinton & Lewis-Fernandez, 2011). At the same time, there is indication of cultural variability with regard to the meaning attached to such traumatic events. Budden (2009) argues that sexual abuse, combat or torture do not only cause physical threats, but they also threaten the integrity of one's social self. During such events, people experience acute domination and subjugation, along with violation of salient cultural norms and values, which results in deep feelings of failure, humiliation, loss of self-respect, or a feeling of disappointing others (Wilson, Drožđek, & Turkovic, 2006).

Although these emotional reactions seem to be universally prevalent, cultural norms and values pose important implications for how such events are experienced, appraised and encoded. Thus, the threat to the social self depends on how this social self is conceptualized. Members of independent, individualistic cultural groups perceive the loss of agency and control as much more threatening than members of interdependent cultural groups, where agency is not given much importance (Jobson & O'Kearney, 2009; Mesquita & Walker, 2003). By contrast, in an emic study in Nepal, Kohrt and Hruschka (2010) found that trauma survivors conceptualized negative events as karma, related to past life sins, which caused feelings of guilt. In other cultural groups, such as Japan, social image (e.g., maintaining face) is important, and still other groups place much emphasis on honor (Mesquita & Walker, 2003). Boiger, Güngör, Karasawa, and Mesquita (2014) showed that in cultures of honor, such as Turkey, both anger and shame are experienced frequently. Thus, if interpersonal trauma violates cultural norms related to karma, honor, or social image, this threat to the social self may be perceived as damaging as the threat to life and limb.

5.2. Valence

When it comes to the valence of emotions, it is most relevant to consider culture-specific, normative scripts related to desirable emotional states. The diagnostic criterion of affect dysregulation in CPTSD merely describes deviance from the normative by stating that it may take the form of hyperactivation or hypoactivation (Brewin, 2020). Tsai, Knutson, and Fung (2006) showed that European Americans ideally wanted to experience more high-activation positive feelings (such as excitement), whereas East Asians valued low-activation positive emotions, such as serenity and feeling peaceful. Such desired emotional states are assumed to be congruent with cultural values of autonomy and uniqueness on the one hand, and social harmony and relatedness on the other (Mesquita, De Leersnyder, & Albert, 2013). Similarly, Eid and Diener (2001) found that feeling proud was rated as more desirable in two independent cultural groups (i.e., European Americans and Australians) than in two interdependent cultural groups (i.e., Chinese and Taiwanese), whereas the opposite pattern emerged for the feeling of guilt.

More recent empirical evidence confirms this assumption by showing that, having the "right" emotion is associated with positive well-being (de Leersnyder, Kim, & Mesquita, 2015; de Leersnyder, Mesquita, Kim, Eom, & Choi, 2014), and better health (Consedine, Magai, & Horton, 2005). Evidence also indicates *emotional acculturation* among immigrant populations, which means that more acculturated individuals show emotional patterns that are more similar to the majority group than less acculturated individuals (de Leersnyder, Mesquita, & Kim, 2011; Jasini, De Leersnyder, & Mesquita, 2018). Emotional acculturation translates into better well-being and health: Consedine, Chentsova-Dutton, and Krivoshekova (2014) found that less emotional acculturation was related to greater somatic symptomatology among immigrants in the U.S., with origin from Haiti, the Dominican Republic, the English-speaking Caribbean and Eastern Europe.

Research in cultural clinical psychology has also focused on *alexithymia*, a concept that describes difficulties in identifying and describing subjective feelings, along with an externally oriented style of thinking (Parker, Taylor, & Bagby, 2001). Two studies (Dere, Falk, & Ryder, 2012; Ryder et al., 2008) found higher scores of alexithymia among Chinese than among Euro-Canadians, an effect that was entirely explained by the difference in externally oriented thinking. No significant differences emerged regarding difficulties in identifying or describing feelings. The authors postulate that within Chinese culture, externally oriented thinking is not conceived as a difficulty but rather as "a tendency to not value inner emotional experience as particularly important" (Ryder et al., 2008, pp. 309–310).

5.3. Emotion expression

Matsumoto et al. (2008a) mapped display rules across 32 countries by asking participants what they *should do* if they experienced a particular emotion (i.e., anger, contempt, disgust, fear, happiness, sadness, and surprise), on a scale ranging from emotion expression to hiding. Country scores on individualism correlated with emotional expressivity, which was mostly explained by the expression of positive feelings, such as happiness and surprise, among individualistic countries. Emotions seemed to be universally more expressed towards in-group members than towards out-group members, but individualism was associated with more expression of negative emotions towards in-groups. Another study found that Chinese Americans express fewer emotions than Mexican Americans (Soto, Levenson, & Ebling, 2005).

There is evidence suggesting that cultural variations in emotion expression translate into cultural differences with regard to psychopathology. Chentsova-Dutton et al. (2007) hypothesized that reduced emotional reactivity in the context of depression would occur only in cultural contexts where open expression of emotions was highly valued. By contrast, *heightened* emotional reactivity should occur among cultural groups that value moderation. In line with their hypothesis, they found that, during a sad film, depressed European Americans cried less often and indicated less sadness than did nondepressed European Americans, whereas in the Asian American sample, depressed participants experienced and expressed more sadness during the sad movie than nondepressed participants. No group differences were found in the expression of positive feelings during an amusing film. The authors conclude that the relationship between depression and emotional reactivity may be moderated by prevailing cultural norms in emotion expression.

Emotion expression is also related to cultural norms regarding gender roles, which is relevant for PTSD symptoms in the aftermath of trauma. As an example, in Latin American culture, masculinity is shaped by the cultural value of *machismo* (Nuñez et al., 2016). In a systematic review, Kaiser, Hanschmidt, and Kersting (2020) found a positive relationship between masculine norms that prescribe restrictive emotionality, such as machismo, and PTSD symptoms. And Ventevogel and Faiz (2018) describe clear gender roles regarding emotion expression in Afghanistan: Whereas cultural norms encourage women to express negative emotions, such as sorrow and grief, e.g., through culturally prescribed ways of storytelling and lamenting, masculine honor requires the endurance of (emotional) pain without expressing it openly. The authors show implications for epidemiological studies on PTSD in Afghanistan.

5.4. Emotion regulation

Emotions and emotion regulation processes are not only *shaped* by the self and the social context, but they rather *serve* particular cultural mandates (de Leersnyder et al., 2015). Thus, emotions have a functional role of guiding adaptive behavior in a culture-specific manner:

> while the goal of emotion regulation may universally be proper self-presentation and relationship maintenance, specific cultural models define the norms for self-presentation, as well as the ways to maintain a relationship. Cultural models thus set specific goals for emotion regulation. In this way, emotion regulation ties a person to the most important cultural goals and values. (Mesquita et al., 2013, p. 297).

In other words, emotional phenomena that fit and reinforce cultural concepts of self and relationship will be upregulated, whereas emotions that contradict such models will be downregulated (Mesquita et al., 2013; Mesquita & Walker, 2003).

Emotion regulation processes seem to be unconscious and effortless to a large extent:

> given the functional role of emotions in guiding adaptive behaviour, we contend that effortful emotion regulation must be very limited; it is "culture's last resort" for shaping emotions in a culturally normative fashion, used only when all other means have failed. (Mesquita et al., 2013, p. 297).

This is most relevant for mental health. When individuals perceive deviations with regard to their emotional experiences, they may use behavioral (e.g., situation selection) and cognitive strategies (e.g., reappraisal) towards experiencing more culturally congruent emotions (de Leersnyder, Boiger, & Mesquita, 2013). The less effective these strategies are, the higher the risk for psychopathology.

Emotions are regulated at the individual and at the cultural level (Mesquita et al., 2013). The individual level refers to intrapersonal emotion regulation processes, whereas at the cultural level, emotions are regulated through interpersonal interactions such as parenting behavior, school education, or social support vs. reproach or exclusion (de Leersnyder et al., 2013). At the individual level, two central aspects in emotion regulation have been identified: reappraisal and suppression (Gross, 1998).

Gross and John (2003) showed that reappraisal and suppression were uncorrelated among European American participants, suggesting that people use one or the other strategy. However, in a study including samples from 23 countries, Matsumoto, Yoo, and Nakagawa (2008b) found that reappraisal and suppression were positively correlated among interdependent cultural groups. The authors hypothesize that in these contexts, individuals may use both strategies at the same time, by first reappraising the situation and then suppressing emotions if required to maintain social order. Suppression was generally more prevalent among interdependent than among independent cultural groups.

Emotion regulation strategies do not only differ in terms of prevalence across cultural groups, but also regarding their effect on well-being, relationship quality and psychopathology. In a study by Gross and John (2003) among U.S. participants, using reappraisal (as opposed to suppression) was associated with more life satisfaction, optimism, social support, better self-esteem and lower depression. By contrast, suppression was related to lower life satisfaction, self-esteem, optimism and well-being, and higher depression scores. In addition, suppression was associated with less social support.

Such negative effects of suppression on emotions and relationship quality could not be confirmed among Asian American women in a comparative study (Butler, Lee, & Gross, 2007). In this study, Asian American women reported more habitual suppression than European American women, and habitual suppression was associated with fewer negative emotions. In a subsequent study, emotion expression was inversely related to blood pressure among European Americans, but positively related to blood pressure among Asian Americans (Butler, Lee, & Gross, 2009). These results indicate that expressing (negative) emotions increases stress for Asian Americans, whereas it decreases stress among European Americans. Similarly, Soto, Perez, Kim, Lee, and Minnick (2011) found that suppression was accompanied by negative psychological functioning among European Americans, but not among Chinese participants. In addition, anger suppression seems to be more strongly related to depression among European Americans than among Asian Americans (Cheung & Park, 2010; Kwon, Yoon, Joormann, & Kwon, 2013).

Arens, Balkir, and Barnow (2012) found that among healthy Turkish immigrant women, emotion suppression was associated with less negative affectivity and lower scores of loneliness, but only if there was a balance between frequent use of both suppression and reappraisal. This relationship was not found among German healthy women, or among German and Turkish women with a diagnosis of major depressive disorder. The authors conclude that among healthy members of collectivistic cultural groups, a flexible use of suppression and reappraisal is beneficial for one's well-being, and that depressed individuals may have

specific deficits in using such flexible emotion regulation strategies.

With regard to PTSD, Nagulendran and Jobson (2020) found that among Caucasian Australian trauma survivors, those with a PTSD diagnosis showed higher levels of expressive suppression, thought suppression, and general emotion dysregulation than those without such diagnosis, a difference that was not found among East Asian Australian trauma survivors. The authors conclude that there might be cultural differences in emotion regulation difficulties in the context of PTSD.

Taken together, there is evidence indicating cultural variation in emotion expression and emotion regulation. However, the available evidence does not provide sufficient insights to understand culture-specific aspects of emotion regulation that are disrupted by interpersonal trauma, and to disentangle universal from culture-specific processes. The corresponding CPTSD diagnostic criterion is formulated in a sufficiently abstract manner to embrace all different possible facets and nuances into a universally applicable core feature. In this sense, this criterion contributes to what Lewis-Fernández and Kirmayer (2019) consider a true "global nosology." What remains to be done is the collection of culture-specific evidence, which will contribute to a better understanding of these phenomena, and to more tailored psychological interventions for affective dysregulations in CPTSD.

6. Disturbances in relationships

The third DSO symptom cluster is characterized by "detachment and withdrawal from others" (Brewin, 2020, p. 4). Culture shapes the way intimate, familial and other social relationships are lived (Markus & Kitayama, 1991; Schwartz et al., 2010), which includes normative scripts related to social support (H. S. Kim, Sherman, and Taylor, 2008a). In consequence, the meaning of "disturbances in relationships" also depends on the cultural context to which a person belongs. We first provide a short description of empirical evidence on interpersonal relationships and social support across different cultural contexts in general, followed by findings related to disturbances in relationships in the aftermath of trauma.

6.1. Culture, interpersonal relationships, and social support

As outlined in the previous sections, interpersonal relationships and self-concepts mutually constitute one another. In interdependent cultural contexts, individuals are firmly embedded within strong, lifelong social networks. Concepts such as familism, communalism and filial piety are used to describe interdependent relationships and social networks in collectivistic societies (Schwartz et al., 2010). These contexts are characterized by low *relational mobility*, which is defined as "the general number of opportunities there are for individuals to select new relationship partners, when necessary, in a given society or social context" (Schug, Yuki, Horikawa, & Takemura, 2009, p. 96). Relational mobility is high in independent cultural contexts, where relationships are formed, maintained and terminated as a matter of personal choice. Thus, relational mobility describes the societal context (i.e., networks and social institutions), rather than individual traits.

The social-cultural context has important implications for interpersonal behaviors such as emotional disclosure and social support. In one comparative study by Schug, Yuki, and Maddux (2010), disclosure to a close friend was more frequently endorsed among American than among Japanese participants. These differences were mediated by the level of relational mobility. Among American participants, disclosure to a close friend was done to strengthen personal relationships, which led the authors to conclude that disclosure might be considered as a "social-commitment device" in individualistic contexts. This conclusion is in line with empirical evidence outlined above, showing higher emphasis on emotional expression in independent than in interdependent cultural contexts (Butler et al., 2007, 2009).

When it comes to social support, empirical evidence reveals cultural differences in how this support is provided, and the forms of support that are perceived to be helpful. Among independent cultural contexts, individuals are proactive in seeking social support to enhance their personal well-being. In interdependent cultural contexts, individuals are more cautious in disclosing their personal problems to others, out of concerns of burdening their social network, losing face, or disrupting group harmony. In consequence, people are less likely to seek explicit social support to cope with stress (Kim, Sherman, Ko, & Taylor, 2006; H. S. Kim, Sherman, and Taylor, 2008a).

Taylor, Welch, Kim, and Sherman (2007) distinguish between *explicit and implicit social support*. Explicit social support is defined as "people's specific recruitment and use of their social networks in response to specific stressful events that involves the elicitation of advice, instrumental aid, or emotional comfort" (H. S. Kim, Sherman, and Taylor, 2008a, p. 522). By contrast, *implicit social support* is characterized by

> the emotional comfort one can obtain from social networks without disclosing or discussing one's problems vis-à-vis specific stressful events. Implicit support can take the form of reminding oneself of close others or being in the company of close others without discussing one's problems. (Taylor et al., 2007, p. 832).

Empirical evidence shows psychological and biological benefit of social support that is provided in a culturally congruent manner (Taylor et al., 2007). In a comparative study, relationship quality predicted emotional support among European American participants. By contrast, a high-quality relationship was associated with problem-solving, interdependence and companionship among Asian Americans (Chen, Kim, Sherman, & Hashimoto, 2015). In addition, Ishii, Mojaverian, Masuno, and Kim (2017) found that it was important for European Americans to maintain self-esteem while seeking explicit social support, whereas Japanese emphasized relational concerns when seeking implicit social support. Upon receipt of social support, European Americans reported more self-esteem and pride, whereas Japanese reported more shame and guilt. These results emphasize the mutual constitution of culture, the self and interpersonal relationships.

Strong family relationships have not only been documented among Asian populations, but also among Latin Americans. Campos and Kim (2017) distinguish between *harmony collectivism*, which prevails in East Asia, and *convivial collectivism*, which is more salient in Latino communities. Harmony collectivism is characterized by avoidance of interpersonal conflicts and caution with regard to placing a burden on close others. Relationship closeness is communicated by instrumental support, emotions are not directly expressed, and low-arousal emotions are valued. In such contexts, familial commitment is characterized by mutual duties, obedience and loyalty, which is expressed in the concept of *filial piety*. By contrast, in convivial collectivism, interdependent relationships "are actively built and maintained via open and frequent positive emotion expression, regular social gathering, and pleasant politeness that preserves the honor and dignity of self and others" (Campos & Kim, 2017, p. 545). In these contexts, familial obligations are expected to be emotionally positive and rewarding. Thus, *familism* is kept in high regard in convivial collectivism.

Campos, Ullman, Aguilera, and Dunkel Schetter (2014) showed that familism contributed to psychological health by facilitating closeness and social support across Latino, European and Asian university samples. Of these three cultural groups, Latinos reported the highest levels of familism. Other studies found that familism contributed to lower depression rates and reduced risk of schizophrenia relapse among Latino communities (Campos & Kim, 2017). At the same time, familism and filial piety have shown to be related to heightened psychological distress (Campos & Kim, 2017; Schwartz et al., 2010), and familism was related to suicidal behavior among young Latina women (Zayas & Pilat, 2008). Different possible explanations for these findings have been discussed, e.g., the possibility that familism may require sacrifice that overwhelms individual resources to meet obligations (Campos & Kim, 2017), or, in the case of immigrant populations, the incompatibilities between

people's own collectivist-based value orientations and the individualism characterizing the host country in which they live (Schwartz et al., 2010).

These findings highlight the importance of culture in shaping interpersonal relationships and their association with psychological health and distress. Social support and interpersonal relationships that are congruent with one's cultural concepts and values are beneficial for health, and their absence is related to higher risk for ill health (Campos & Kim, 2017). At the same time, interpersonal relationships bear the risk of affecting one's health in case of conflict or noncompliance with social and familial expectations. This is particularly relevant in the context of CPTSD, which is characterized by a difficulty in feeling close to others. Again, these difficulties are shaped by normative cultural scripts related to interpersonal relationships.

As an example, Friedman et al. (2010) showed that attachment avoidance had more negative effects on relationship outcomes (i.e., conflict, perceived support, relationship satisfaction) in Hong Kong and Mexico when compared to the United States. The authors explain these results by the greater emphasis placed on closeness and harmony in interdependent (vs. independent) cultural contexts. Similarly, Mak, Bond, Simpson, and Rholes (2010) found that perceived support and relationship quality mediated the association between avoidant attachment and depressive symptoms among Chinese and European American participants. Associations between avoidant attachment on the one hand, and perceived support and relationship quality on the other, were stronger among Chinese than among European Americans. The authors conclude that "individuals who live in collectivistic cultures and are highly avoidant may be violating basic norms and expectations of how one is supposed to relate to close others in collectivist cultures" (p. 160).

According to Chentsova-Dutton and Ryder (2019), interpersonal behaviors that are incongruent with culturally normative scripts trigger *interpersonal loops*, through which relationship quality decreases and psychological distress increases. Looping effects describe the process of exacerbating or minimizing certain psychological outcomes through intra- or interpersonal feedback, and "may be central to why transient symptoms can become more chronic syndromes, rather than just isolated (albeit unpleasant) incidents" (Ryder & Chentsova-Dutton, 2015, p. 412). A well-known example of an intrapersonal feedback loop is panic attacks (Clark, 1986). Interpersonal loops occur when the behavior of one person (e.g., avoidance) triggers a complementary reaction in the other person (e.g., frustration), which in turn enhances the likelihood for the initial behavior to be strengthened (e.g., more avoidance). Dysfunctional relationship patterns may be fostered through such interpersonal loops over time (Ryder & Chentsova-Dutton, 2015). In the context of PTSD and CPTSD, such interpersonal loops might be particularly relevant, as is outlined below.

6.2. *Trauma and interpersonal relationships across different cultural contexts*

There is evidence indicating that the third DSO symptom, disturbances in relationships, is subject to cultural variation. In a sample of refugees in Switzerland, most of whom had been tortured, Nickerson et al. (2016) applied two items to measure disturbances in relationships, i.e., feeling of detachment from others, and avoidance of getting too close to others. Feelings of detachment was reported more frequently than avoidance of getting close to others. The authors conclude that the former may represent an internal experience, whereas the latter may indicate a more active strategy, which may lead to interpersonal dysfunction. The authors also reason that "the experience of avoiding getting too close to others may be particularly subject to cultural influence and may have a different meaning in collectivist societies (from which the majority of participants in this study were drawn), compared to individualist societies" (p. 9). This assumption is in line with evidence highlighted above, showing that avoidant attachment has more negative effects on relationship quality in collectivistic than in individualistic cultural contexts (Friedman et al., 2010; Mak et al., 2010).

In their social-interpersonal model of PTSD, Maercker and Horn (2013) suggest three layers of factors that contribute to the development and maintenance of PTSD. Emotional reactions of shame, guilt, anger and revenge are situated at the intrapersonal level. At the interpersonal level, processes such as disclosure and social support have proven to be important determinants of PTSD. And at the cultural and societal level, distant contextual factors, such as the collective experience of trauma, social acknowledgement of injustice, and cultural value orientations may contribute to the prevalence of PTSD and other common mental disorders. As shown throughout this paper, these three levels mutually constitute one another, with looping effects being a powerful process through which symptoms may become exacerbated (Ryder & Chentsova-Dutton, 2015).

Thus, most likely, there is not only cultural variation in the "phenomenology" of disturbed relationships, but social and cultural responses to (C)PTSD symptomatology also actively contribute to the development and maintenance of these disorders. Nickerson, Bryant, Rosebrock, and Litz (2014) suggest that interpersonal trauma severely affects trust and social functioning, and thus the "core processes that facilitate the development and maintenance of healthy interpersonal relationships" (p. 175). We go one step further by postulating that the disruption of functional relational behavior leads to a violation of culturally normative scripts, which, depending on the social-cultural context, leads to negative responses by close others and the larger community, which in turn has even more negative effects on trauma survivors.

There is initial empirical evidence for this assumption. Mueller, Orth, Wang, and Maercker (2009) assessed two interpersonal variables – disclosure intentions and social acknowledgement as a victim – among German and Chinese survivors of crimes. The authors found that both variables were predictors of PTSD symptomatology in both groups. However, the authors also found cultural differences: Chinese crime victims experienced significantly more social acknowledgement as well as significantly less general disapproval from family, friends, acquaintances and local authorities. German crime victims reported more expressive disclosure attitudes (i.e., the urge to talk and emotional reactions while disclosing), whereas Chinese participants reported more reluctance to talk about the trauma. The urge to talk about the traumatic experience was a stronger predictor of PTSD among Chinese participants than among German participants. By contrast, reluctance to talk was a significant predictor of PTSD in the German sample, but not among Chinese participants.

In a more recent study, Hansford and Jobson (2021) found cultural differences with regard to the effectiveness of social support in moderating the relationship between trauma exposure and PTSD. The authors examined independent vs. interdependent self-construal, different forms of social support, and PTSD symptoms among European Australian and Asian Australian trauma survivors. They found that emotional support (i.e., expressing empathy and understanding) moderated the relationship between lifetime trauma exposure and PTSD symptoms in both groups. However, with regard to other types of social support, i.e., appraisal support (i.e., advice or assistance in understanding, defining or coping with the stressor), belonging support (i.e., interpersonal engagement without the need to disclose the stressor), and tangible support (i.e., material aid and assistance), the authors found a moderating effect of interdependence: When social support was perceived to be low, higher levels of interdependence were associated with a stronger relationship between lifetime trauma exposure and PTSD symptoms. The authors conclude that, among individuals with interdependent values, social support has a more beneficial effect on mental health than among individuals with independent values. At the same time, *lack* of social support has a more detrimental effect among individuals with interdependent values than among individuals with independent values.

In summary, empirical evidence indicates that cultural aspects play

an important role when it comes to interpersonal relationships in the aftermath of severe and prolonged trauma. Severe interpersonal trauma seems to disrupt core processes that enable functional relationships (Nickerson et al., 2014). If relationship behaviors of trauma survivors violate normative cultural scripts, e.g., avoidance of relationships in collectivistic cultural contexts (Friedman et al., 2010; Mak et al., 2010), this may have negative consequences in their social network, which may contribute to an exacerbation of CPTSD symptoms through interpersonal loops (Chentsova-Dutton & Ryder, 2019; Ryder & Chentsova-Dutton, 2015). This might be particularly relevant in cultural contexts where symptoms of mental disorders are highly stigmatized (Kohrt & Hruschka, 2010).

7. Directions for future research

In this paper, we aimed to highlight the importance of considering cultural aspects in the phenomenology and etiology of CPTSD. DSO symptomatology has consistently been found to be a single factor in validation studies of this diagnostic concept across different cultural groups (Brewin et al., 2017; Ho et al., 2020; Knefel et al., 2019; Knefel et al., 2020; Nickerson et al., 2016; Owczarek et al., 2020). Nevertheless, more research is needed on the cultural nuances regarding the subjective experience and expression of the DSO symptoms, as well as on the culturally shaped intra- and interpersonal processes that foster or hinder the development, maintenance and healing of CPTSD. None of the validation studies have provided a more detailed discussion of cultural aspects – e.g., different patterns of factor loadings, or correlation between factors. Where such cultural differences are mentioned, the authors suggested to conduct future research (e.g., Ho et al., 2020; Nickerson et al., 2016).

We found that, compared to symptoms of common mental disorders such as depression, anxiety, and PTSD (Haroz et al., 2017; Kohrt et al., 2014; Rasmussen et al., 2014), little research exists on potential substantial cultural variations in the DSO symptomatology, which is most likely due to the novelty of this diagnostic construct. In this paper, we argue that emic research approaches are needed, in addition to etic research that is currently being conducted, in order to better understand cultural phenomena related to CPTSD (Chentsova-Dutton et al., 2014). So far, research has focused mainly on PTSD, rather than CPTSD. In addition, with the exception of research conducted on interpersonal processes and mental health among Latin American communities (Campos et al., 2014; Campos & Kim, 2017), most research compares European American or Canadian participants with East Asians. There is a lack of research among other cultural groups, such as South-Eastern Europe, the Middle East or different regions on the African continent.

We also found that most of the relevant studies used the well-known dichotomy between collectivism and individualism to assess cultural differences regarding the DSO. In our view, this is an insufficient conceptualization of culture. More research is needed using concepts of culture that correspond to current definitions (Napier et al., 2014).

With regard to the negative self-concept, Ho et al. (2020) came to the conclusion that more research is needed to determine the validity of the DSO among Asian populations, particularly due to their higher tendencies to agree with negative self-statements (Y.-H. Kim, Peng, and Chiu, 2008b). In addition, more research is needed on negative self-appraisals in the context of independent and interdependent self-constructs (Engelbrecht & Jobson, 2020; Jobson, 2009; Jobson & O'Kearney, 2009). Emic research can contribute to a better understanding of culture-specific assumptions in terms of what constitutes a valuable person and respectable member of the society, against which one's own self-appraisals are evaluated measured (e.g., Weindl & Lueger-Schuster, 2018). In addition, emic research is needed on cultural variations with regard to negative self-related emotions, such as shame and guilt (Fessler, 2004), in the aftermath of trauma (de Jong et al., 2005; Gilbert, 2003).

Concerning affect dysregulation, more research is needed on the specific meaning of traumatic events against the background of cultural values (e.g., threat to the social self and one's honor, Kohrt & Hruschka, 2010). In addition, evidence shows cultural differences in desired emotional states (Eid & Diener, 2001; Tsai et al., 2006), emotion expression (Matsumoto, Seung Hee, and Fontaine, 2008a), and emotion regulation (Butler et al., 2007, 2009), particularly in the context of psychopathology (Chentsova-Dutton et al., 2007; Cheung & Park, 2010; Kwon et al., 2013). Again, most research on emotion regulation is etic in nature, based on the comparison between European American and Asian participants, with some exceptions (Arens et al., 2012; Consedine et al., 2014). More etic and emic research is needed to better understand normative and deviant scripts related to emotion (dys-)regulation in the context of CPTSD across different cultural contexts.

And lastly, interpersonal relationships are shaped by cultural context and concepts of the self (e.g., Schug et al., 2009; Schwartz et al., 2010), with important implications for mental health (Campos & Kim, 2017). In the context of (C)PTSD, culture has a relevant impact on interpersonal processes such as disclosure and social acknowledgement as a victim (Mueller et al., 2009), or social support (Hansford & Jobson, 2021). Traumatic events may disrupt functional relationship behavior among victims (Nickerson et al., 2014), with culture-specific responses by their social network, e.g., more negative effects of attachment avoidance in collectivistic cultural groups (Friedman et al., 2010; Mak et al., 2010). Interpersonal loops may contribute to manifestation, exacerbation and chronicity of symptoms (Chentsova-Dutton & Ryder, 2019; Ryder & Chentsova-Dutton, 2015). This is particularly relevant in interdependent cultural contexts, where closeness, harmony and relatedness are held in high regard. Thus, more dyadic and systemic research is needed to better understand such interpersonal loops across different cultural groups.

8. Implications for psychological treatments of CPTSD

At present, there are no validated treatments for CPTSD (Karatzias & Cloitre, 2019), due to the novelty of the diagnostic category. However, there is substantial research in the area of PTSD (Lewis, Roberts, Andrew, Starling, & Bisson, 2020), and evidence shows that treatments for PTSD are effective across different cultural groups (Barbui et al., 2020). Karatzias et al. (2019) conducted a systematic review and meta-analysis on the effectiveness of PTSD treatments for CPTSD. They found that cognitive-behavioral therapy (CBT), exposure, and eye movement desensitization and reprocessing (EMDR) had moderate–large effects on negative self-concept and disturbed relationships. They reported a lack of evidence regarding effects of treatments on affect dysregulation. The authors also found that benefits of trauma-specific interventions were smaller when compared with nonspecific treatments, which suggests that a large part of the effectiveness was achieved through nonspecific factors.

Emerging evidence also suggests that multicomponent interventions can be particularly useful with complex traumatization (Coventry et al., 2020). With that in mind, Karatzias and Cloitre (2019) propose a modular approach for treating adults with CPTSD. Such modular approaches can be flexibly adapted to the needs of patients, which is particularly relevant in the context of cultural adaptation (e.g., Murray et al., 2014). For emotion regulation, Karatzias and Cloitre (2019) suggest focused breathing, emotional awareness and self-soothing exercises. For negative views of the self, compassion-focused interventions have been shown to be effective, in addition to cognitive reappraisal of self-worth. And for interpersonal difficulties, the authors suggest improving communication skills, cognitive flexibility around interpersonal expectations, and interventions addressing problems with anger and intimacy.

One multi-component programme, the Skills Training in Affective and Interpersonal Regulation combined with Modified Prolonged Exposure (STAIR/MPE), which focuses on improving emotion regulation and interpersonal problems, showed good effects among survivors of child sexual abuse (Cloitre et al., 2010). Most importantly, the

treatment condition that combined skills training for affect regulation and exposure showed the best effects when compared to exposure or skills training only. However, the outcome of this trial was PTSD and not CPTSD, thus the results cannot directly be applied for the latter. There is a need for further validation of the STAIR/MPE and other manuals for the treatment of CPTSD.

In addition, there is a particular lack of culturally adapted interventions for people with CPTSD from diverse cultural backgrounds, such as displaced populations (Nickerson et al., 2016). Manuals for the treatment for PTSD that include interventions to improve emotion regulation strategies have emerged recently. As an example, Skills-Training of Affect Regulation – A Culture-sensitive Approach (STARC, Koch, Ehring, & Liedl, 2020) is a 14-session culture-sensitive transdiagnostic group intervention to improve affect regulation in refugees. In addition, Culturally Adapted Cognitive Behavioral Therapy (CA-CBT, Hinton, Rivera, Hofmann, Barlow, & Otto, 2012), which includes emotion regulation strategies, has been successfully adapted for different cultural groups, e.g., Cambodian, Latin American, Chinese, and Vietnamese populations (Hinton et al., 2012), for Egyptians (Jalal, Samir, & Hinton, 2017), as well as for Afghan refugees in Germany (Kananian, Ayoughi, Farugie, Hinton, & Stangier, 2017; Kananian, Soltani, Hinton, & Stangier, 2020; Kananian, Starck, & Stangier, 2021). STARC and CA-CBT do not focus on CPTSD specifically, but rather use emotion regulation as a transdiagnostic aspect to improve refugees' mental health. However, since Karatzias et al. (2019) found positive effects of nonspecific therapies on CPTSD, these approaches can be recommended for treatment of patients from diverse cultural backgrounds.

There is an ongoing debate in literature on the extent to which psychological interventions developed in WEIRD societies (Henrich et al., 2010) require cultural adaptation to be effective for the treatment of mental disorders among culturally diverse groups. Evidence indicates a benefit of cultural adaptation of psychological interventions (e.g., Hall, Ibaraki, Huang, Marti, & Stice, 2016). According to Resnicow, Baranowski, Ahluwalia, and Braithwaite (1999), cultural adaptation can range from surface adaptations (e.g., materials, illustrations or case examples) to adaptations of the deep structure of an intervention. In the realm of psychological interventions, such deep structure adaptations include adaptations of the specific therapeutic elements (e.g., narrative exposure, cognitive restructuring), as well as of the common factors (e.g., the shape of the therapeutic relationship, or the explanatory model and treatment rationale delivered to the patient) (Heim & Kohrt, 2019).

There is a lack of methodologically rigorous evidence on the relative importance of these different adaptations and their specific benefit in terms of improved acceptability and effectiveness of psychological interventions (Heim et al., 2021). Heim and Kohrt (2019) suggest using cultural concepts of distress as a starting point for adaptation. In the context of CPTSD, this would imply using cultural concepts related to the DSO for the adaptation of treatments. As an example, with regard to specific factors, it is vital to consider culturally valued emotions (Eid & Diener, 2001; Tsai et al., 2006), and cultural display rules (Matsumoto, Seung Hee, and Fontaine, 2008a; Mesquita et al., 2013) when adapting psychological interventions to improve emotion regulation strategies. Regarding negative self-concept and interpersonal relationships, it might be equally important considering cultural aspects, as outlined above.

We recommend discussing perceived normative cultural scripts with patients, e.g., about what is perceived to be a "valuable person in society," or how closeness or intimacy is expected to be expressed and lived. Cultural interpreters can help to explore such normative scripts. This information may help therapists gain more detailed insights into what is perceived to be normal in the patients' cultural surrounding, which allows for defining therapeutic goals that are adapted to the patients' needs and context. In addition, this information can help in shaping interventions (e.g., emotion regulation skills) and psychoeducation in a way that they become more meaningful and acceptable for patients.

With regard to common factors, and particularly the therapeutic relationship, Campos and Kim (2017) point to the importance of considering cultural expectations regarding social relationships in general. Responsiveness to such expectations may be crucial to patient–provider communication. One study comparing European Americans and East Asians (Japanese) showed that willingness to seek help from professional health services is mediated by willingness to seek social support from one's own social network (Mojaverian, Hashimoto, & Kim, 2013). In addition, cultural competence in the interaction with patients is crucial (Kirmayer, 2012). In the context of CPTSD, relationship avoidance may pose a particular challenge for the therapeutic relationship. Thus, cultural competence is even more important, and a profound understanding of the patients' cultural background is a vital aspect in this process.

And finally, it is important to consider the treatment setting. Based on our review of literature, we are convinced that more dyadic and family interventions are needed, particularly for members of interdependent cultural groups (Maercker & Hecker, 2016). The main focus on the individual and his/her symptoms stands in contrast with the interdependent view of the self, which includes the family and the community. On the other hand, it is important to take into account mental health-related stigma and potential discomfort in showing emotions in a group or family setting (Simiola, Neilson, Thompson, & Cook, 2015), especially if social support is culturally conceptualized as comfort obtained from social networks without disclosing or discussing one's problems (Taylor et al., 2007). Again, such dialectics require cultural competence of the therapist, but also more research with different cultural groups, in order to determine optimal conditions for the treatment of CPTSD.

In addition to etic and emic research concerning the phenomenology of the DSO in the cultural context, we recommend conducting more rigorous research on the effect of cultural adaptation of interventions on treatment effectiveness and acceptance (Heim et al., 2021). Evidence outlined in this review suggests that considerable cultural differences exist in symptom presentation and in the etiological factors that contribute to the development and maintenance of PTSD and CPTSD. Adapting treatments to these culture-specific factors may enhance commitment and provide more meaningful interventions for patients from diverse cultural backgrounds.

9. Concluding remarks

More than 40 years have passed since Arthur Kleinman's fundamental critique of the *category fallacy* (Kleinman, 1977), which he considered to be

> perhaps the most basic and certainly the most crucial error one can make in cross-cultural research … studies of this kind go on to superimpose their own cultural categories on some sample of deviant behavior in other cultures, as if their own illness categories were culture-free" (p. 4).

In the meantime, emic research on cultural aspects in mental disorders has considerably advanced (Haroz et al., 2017; Kohrt et al., 2014; Rasmussen et al., 2014), cultural concepts of distress have been introduced in DSM-5 (American Psychiatric Association, 2013), and cultural clinical psychology has delivered theoretical models to better understand how cultural and societal contexts shape mental health and mental disorders (Chentsova-Dutton & Ryder, 2019; Ryder & Chentsova-Dutton, 2015).

The ICD-11 Working Group on the Classification of Disorders Specifically Associated with Stress, which included experts from different parts of the world, proposed the new diagnostic category of CPTSD as a universal human response to severe or prolonged interpersonal trauma (Maercker et al., 2013). The aim of this new CPTSD diagnosis was far from "superimposing" a diagnostic category on different cultural groups.

It was rather an attempt to distil the common, universal features of human reactions to such severe traumatic episodes, thereby contributing to what Lewis-Fernández and Kirmayer (2019) consider a true "global nosology." Research so far seems to confirm that this aim was met. This is a major achievement, especially when looking back to the lack of validity of the DESNOS diagnostic category among Algerian, Ethiopian, and Middle Eastern trauma survivors, more than 15 years ago (de Jong et al., 2005).

However, the journey does not come to an end at this point. Our theoretical review sets the ground for future research in cultural clinical psychology and transcultural psychiatry, which will bring together evidence on culture-specific features of the new CPTSD concept from around the world. This evidence will hopefully contribute to the development and evaluation of culturally adapted psychological interventions for the treatment of CPTSD. So far, cultural adaptation research has mostly focused on common mental disorders such as anxiety, depression, and PTSD. It is time that cultural adaptation research starts targeting severe mental disorders such as CPTSD. The etiological processes involved in the development of CPTSD are highly complex and, as shown in this review, closely intertwined with the social and cultural context in which trauma survivors live. Research in this field offers new opportunities to better understand the complex interplay between culture and psychopathology. In this sense, we are moving further towards a more inclusive and comprehensive understanding of those people in the world who have endured the most traumatic situations one can imagine. In the end, our aim is to provide them support, and to listen to what they have to say.

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Declaration of Competing Interest

None.

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