Cultural Competence in Trauma Therapy

Beyond the Flashback

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CONTENTS

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My research assistant, Tracy Bryan, was an invaluable contributor to this process. Her diligent search for the scholarly literature on culture and trauma was eye-opening for us both (in large part because of how hard it was to find anything that I hadn't read already on this topic, although I'm sure that publishing this book will bring those whose work we didn't find yet in touch with us). Tracy is a gifted writer whose work psychotherapists will all be seeing in a few years, including an article coauthored with me in 2007 on feminist therapy and self-inflicted violence (Brown & Bryan, 2007).

None of this would have been written without the privilege of having known and met many survivors of trauma in my roles as psychotherapist and forensic psychologist. These people have been willing to tell me their stories, have allowed me to be witness and participant in their healing processes, and have taught me everything I know about being a psychotherapist. The people I work with are amazing human beings. Despite confusion, pain, and terror, they have struggled to have lives of dignity and decency, practicing compassion for others, although initially they struggle to do this for themselves. They are my heroes because in the face of endless invitations from life to become violent and abusive or simply callous and nihilistic, they are instead kind and loving. I can name none of them because to all of them I owe a debt of confidentiality, but I thank each one of them; they know who they are.

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Cultural Competence in Trauma Therapy

INTRODUCTION: TRAUMA, A MULTICULTURAL REALITY

Trauma and its psychic aftereffects have a texture. The experience conveys meanings that derive from personal histories; cultural heritages; and the social, political, and spiritual contexts in which the painful event happens. Even such an apparently neutral trauma as a natural disaster or a car accident can have a complex and multidetermined meaning structure, because the emotional impact of trauma is not merely about what happened in the moment but also reflects what occurred before and what transpires next. A psychotherapist's ability to understand how a trauma survivor's multiple identities and social contexts lend meaning to the experience of a trauma and the process of recovery comprises the central factor of culturally competent trauma practice. This volume is an extended discussion of how psychotherapists can develop such understandings that are sophisticated, thoughtful, and reflective of the current paradigms of identity and culture.

At the core, trauma is simply trauma. An assault, an earthquake, and combat are all recognizable as events that threaten safety and shatter assumptions about the nature of the world and one's relationship to it. Trauma of some sort is extraordinarily common even in a supposedly safe place, with research on the U.S. population suggesting that as many as one half of all

residents have experienced exposure to a major traumatic stressor, most commonly some kind of interpersonal violence (Briere & Scott, 2006).

Trauma, no matter how endemic, is never generic and never the same for any 2 people. Each experience of an encounter with a traumatic stressor is unique and is given unique meaning by the life history of the person to whom it occurs. Some of that unique meaning arises from the cultural and group memberships in which a person participates and from the multiple, intersecting identities defining each person's individual sense of selfhood. When the trauma is of human design, the most common type, some of the meaning ascribed to the trauma by its targets will arise from the cultural and group memberships and identities of the perpetrators. The relationships of those reference groups, both in the present day and historically, will also give color, texture, and specificity to the trauma; those social and contextual factors can make a wound deeper, extend suffering, become obstacles to healing, or allow even the worst of psychic wounds to heal quickly.

RESPONDING TO TRAUMA COMPETENTLY

Responding to trauma in a culturally competent manner requires the psychotherapist to understand how those added meanings that derive from context and identity make each instance of trauma unique. It also requires the psychotherapist's awareness of her or his own identities, biases, and participations in cultural hierarchies of power and privilege, powerlessness and disadvantage, as well as personal experiences of trauma. Failure to bring cultural competence to the table can lead to missteps in genuinely helping trauma survivors or worse can result in deepening the wounds of trauma, creating secondary and tertiary traumas that are more painful than the original because they are correctly appraised by victims and survivors as unnecessary wounds.

This volume reflects my long interest in two topics and their convergence in my own work. I have worked since the beginning of my career as a psychologist with survivors of trauma. At first I did so accidentally, not realizing how common trauma was in the lives of people in emotional distress. By the early 1980s I was intentionally engaging with trauma survivors, with a deepening focus on what Judith Lewis Herman (1992) called "complex trauma." Complex trauma represents the inter- and intrapersonal effects of multiple and repeated exposures to varieties of interpersonal violence and violation, an experience that is becoming recognized as far more common in the United States than the one-episode traumatic stressor initially envisioned by diagnostic manuals.

As a psychologist trained in the early 1970s, a period in which trauma was virtually never considered a component of distress, I had to learn to uncover and listen to the hidden and silenced stories of trauma that my cli-

ents carried to me. I frequently did not know what I was seeing and hearing when people told me about trauma. I did not yet know the ways in which people communicated their traumatic experiences before they could name them and use language to talk about them. My training as a psychologist had taught me to ignore or trivialize experiences of trauma or to interpret the distress that people shared with me as evidence of something entirely other than the aftermath of trauma exposure, thus the accidental nature of my specialization. It was only because I had the good fortune to be able to hear those stories that I was then willing to intentionally pursue trauma as a topic.

Additionally, since the beginning of my career I have been involved with the development of feminist practice, which in turn has led me to an interest in broader visions of cultural competence in psychology. Feminist psychology has been uniquely situated within the realm of clinical practice as a result of its attention to issues of power and social location and to how people's experiences of gender, culture, social class, sexuality, and other experiences that denote inter- and intrapersonal power or powerlessness might affect both distress and resilience in response to traumatic stress. Because one core aspect of how trauma functions as a source of psychic wounding is that trauma induces powerlessness and loss both of real control and self-protective illusions of control, a theory of therapy that centers its attention on power is likely to have much useful to say to its practitioners and others about trauma.

Like other similar critical psychologies, including multicultural psychologies, queer psychologies, and liberation psychologies, feminist psychology and the psychotherapists informed by it have also been more likely than psychotherapists of other orientations to knowingly and intentionally encounter the survivors of traumas. This is because feminist psychotherapists' theories exposed narratives of trauma even in eras when such stories were forbidden or hidden in the larger psychological discourse (Comas-Diaz & Jacobsen, 2001; Fox & Prilleltensky, 1997). As psychotherapists open to telling truths about the human experience of powerlessness, critical psychologists created the psychological spaces where trauma survivors could speak their truths. This is what happened for me and many of my feminist psychotherapist friends and colleagues; we communicated our willingness to hear truths, and people told us about their hidden experiences of terror and violation. It is not surprising that almost all of the authors who first wrote about the traumas of interpersonal violence, the most hidden yet pervasive of human traumatic stressors, were pioneers of feminist therapy such as Judith Lewis Herman, Florence Rush, and Lenore E. Walker.

In the wake of Hurricane Katrina (which blew through the U.S. Gulf Coast a month after I proposed this book to the American Psychological Association [APA], making my work more urgent and, sadly, timely), the intersection of culture and trauma has become increasingly visible to everyone in the mental health field as well as to anyone who could turn on a

television or open a newspaper in the United States since the fall of 2005. One of APA's many humanitarian responses to that disaster was promotion of the awareness that the mostly poor, mostly African American and Acadian victims of that storm would need not simply posttrauma support from mental health professionals but specifically required culturally competent posttrauma support that avoided reenacting wounds rooted in racist and classist assumptions about the world (Dass-Brailford, 2006). Even the apparently neutral trauma of a hurricane does not have neutral meaning for its victims; nor do the outcomes of such a trauma fail to aggravate old wounds of oppression and discrimination or underscore and enhance old histories of privilege.

THE SECONDARY TRAUMA OF CONTEXT AND CULTURE

Additionally, as the entire culture gained access to Katrina survivors' stories through such media presentations as Spike Lee's (2006) post-Katrina documentary *When the Levees Broke: A Requiem in Four Acts*, people also got to see how an already devastating yet apparently morally neutral act of nature can be more traumatizing when it is disruptive to culturally based coping and resiliency strategies that were dependent on the presence of coeval communities now scattered to every part of the continent. There is no accident in the fact that this event, experienced by all who lived on the Gulf Coast, has had differential impact on survivors based almost solely on interlocking issues of ethnicity and social class.

Speaking of the impoverished Katrina evacuees sheltering in Houston who had suffered grievous losses of home, family, culture, and connection, former First Lady Barbara Bush commented to a news reporter during her visit to the Houston Astrodome,

> What I'm hearing, which is sort of scary, is that they all want to stay in Texas. Everyone is so overwhelmed by the hospitality. And so many of the people in the area here, you know, were underprivileged anyway, so this [is] working very well for them. ("Barbara Bush Calls Evacuees Better Off," 2005)

Perhaps intending well, she wounded the evacuees and many of those simply hearing her words on TV in a way that the hurricane alone could not have. She seemed to be implying that the lives and experiences of the poor and disenfranchised survivors of the storm were lacking in value. Imagine being told that living as a displaced person in makeshift accommodations is an upgrade for your life. The presence of this secondary, tertiary, and additional trauma connected to the trauma of the flood was revealed to the entire American public. Mrs. Bush appeared to be delivering a clear message to Katrina survivors that what was important about their lives—their unique cultures and communities; their rich traditions; the homes, no matter how small, that

they had struggled to own and to build—were of little value in an American society that regards lives in poverty as lives lacking in worth. The destruction of those communities by the floodwaters was apparently seen by her as a good thing, rather than as the heartbreaking drowning of a culture as rich in traditions as it was poor in cash.

What is striking about this episode was not that it happened nor that secondary institutionalized trauma was heaped on the pain of another traumatic stressor as a result of cultural insensitivity, but rather that it was done publicly and so was visible to all. Secondary trauma inflicted by agencies, researchers, and mental health providers as a result of absence of cultural competence has been painfully common but rarely is committed and broadcast on the national news; it usually happens in private, behind the doors of therapy offices and social service agencies, in shelters that define families to exclude family members not related by blood or law, in funding for posttrauma care that has arbitrary end dates reflecting some generic sense of how long trauma recovery should take, in research that fails to ask about identity while inquiring into symptom frequency and then interprets those numbers out of context. How trauma survivors are responded to by their helpers and the biases held by those who purport to assist them make a difference in whether and how those survivors will heal. When a psychotherapist lacks cultural competence, the capacity to understand the complex human identities that inform each survivor's relationship to trauma, that psychotherapist is at greater risk to unintentionally inflict secondary traumas on clients; cultural competence, conversely, may speed healing by connecting trauma survivors to their own resources and honoring the inner and outer realities informing trauma and its meanings.

The Katrina disaster thus also made more generally visible, but did not invent, the necessity for thinking about trauma within a framework of cultural competence. Human beings are entirely human and share a universal DNA, brain structure, and capacity for language and meaning making, each of which is implicated in the trauma response. Humans, trauma survivors and not, are also entirely the individual, unique, infinite intersections of their cultures, their genders, their ethnicities and phenotypes, and all of the other many factors that contribute to multiple and overlapping identities held by each and every person. Trauma does not happen to a generic human being any more than it is generic itself, and the ways in which humans translate their inner biological states of posttraumatic disequilibrium into outward expressions of distress are strongly affected by culture and context.

To date, few of the excellent psychotherapeutic models that have been developed for working with trauma survivors have intentionally taken into account this diversity and complexity of human identity and experience as it informs the encounter with trauma. Although the list in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM–IV–TR*; American Psychiatric Association, 2000) of so-called "culture-bound syndromes"

is replete with posttraumatic responses framed in culturally specific manners, no editor of that important volume has connected the dots in writing. A trauma-savvy or culture-savvy reader may do so; but in the absence of those intellectual frameworks, the relationship of trauma to such phenomena as *ataque de nervios* is submerged, requiring skills at uncovering and contextualizing to be correctly understood as a form of posttrauma response. Additionally, although psychotherapists working with specific target group populations have occasionally proposed culturally specific paradigms for working with trauma in those settings (e.g., Marsella, Friedman, Gerrity, & Scurfield, 1996), few of those interventions have been mainstreamed into the work of trauma experts in North America; they are special treatments for special populations.

THE DISCONNECTION BETWEEN TRAUMA STUDIES AND CULTURAL COMPETENCE

It is surprising and ironic that this disconnection between the fields of trauma studies and cultural competence exists. Although the mental health disciplines have had at best an uneasy and ambivalent relationship with trauma as a topic, the modern field of traumatic stress studies in psychology and related disciplines was founded largely by social justice activists like me who cut their teeth in the 1960s and 1970s in movements against the Vietnamese War and for women's equality and by European and Israeli colleagues living in the aftermath of World War II and the Nazi Holocaust. The very diagnosis of posttraumatic stress disorder (PTSD) was lobbied into the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.; American Psychiatric Association, 1980) by a somewhat uneasy coalition of antiwar Veterans Administration staff, some of them veterans of Vietnam themselves, and feminist psychotherapists from the front lines of the rape trauma and domestic violence movements. It might have been reasonable to assume that these socially conscious professionals, already deeply attuned to some forms of social injustice, would have looked next to issues of racism, classism, heterosexism, and other forms of oppressive inequality as they tried to enhance their comprehension of how trauma affected human lives; but that never occurred.

Why this next step did not happen has been a puzzle that writing this book has forced me to explore. As is true for most group phenomena, I believe that there are many reasons for this neglect of intentional multiculturalism, most of them benign and stemming from the same source as more general problems of modern aversive racism, classism, and heterosexism in progressive social movements as well as within the discipline of psychology (Bowes, 2007). Interrogating race, class, culture, and sexuality, by which I mean thinking critically and asking difficult questions about assumptions

that are taken as truth in dominant culture, is threatening and induces shame in members of dominant groups, a category including the majority of psychotherapists. The critical analysis of systemic forms of oppression requires those in positions of dominance and privilege, such as psychologists and other psychotherapists, to acknowledge the social locations of greater power stemming from their professional training and status and to see themselves as benefiting from oppression through the privilege inherent in those roles, whether or not they actively oppress others.

This stance of admitting to privilege is not a comfortable position for any psychotherapist whose biases, such as they are, are mostly covert and well hidden from her- or himself, taking the form of what Gaertner and Dovidio (1977, 1986, 2005) have called "modern" or "aversive" bias, a form of bias that is denied by and invisible to its practitioners. Aversive bias has rarely been seen as the sort of very problematic countertransferential problem that it is because so much shame attaches to bias despite its nearly universal persistence. It is much easier for mental health professionals to be in the cultural role of supposedly neutral yet caring bystanders, to see themselves as good people who, because they are not intentionally perpetrating oppression, are thus not involved in it nor necessarily responsible for its alleviation through the mechanism of their work. To tell oneself the truth about how bias lurks in one's all-too-human nonconscious affective responses and one's personal symbologies can be a painful exercise in honesty and self-scrutiny.

Interrogating trauma and asking oneself to look closely at what its endemic nature means about the human condition are equally threatening. When people stare trauma in the face, it becomes impossible to engage in defenses against the reality that horrifying, unpredictable, disruptive things happen routinely in the lives of innocent human beings, and worse, that those things can happen to us, a phenomenon of painful awareness that Pearlman and Saakvitne (1995) have called "vicarious traumatization." Working with trauma requires psychotherapists to get up close and personal with stigma, which can and sometimes does rub off. Trauma therapy is not mainstream to training in any mental health discipline, even though some form of trauma is implicated as a psychosocial risk factor for most Axis I and many Axis II diagnoses (Briere & Scott, 2006). As Alpert (2006) noted in her comments in the inaugural issue of *The Trauma Psychologist*, scientists and clinicians in psychology do not generally familiarize themselves with the literature on trauma; those who do risk being seen as strange or suspect and are perhaps themselves secretly trauma survivors (which reads professionally as somehow less qualified to treat trauma because of bias or unhealed psychic wounds).

Each of these intellectual and clinical enterprises on the margins of society and psychology requires its practitioners to tell uncomfortable and often painful truths about aspects of the social status quo. Trauma and op-

pressive biases are close to the top of the list of what therapists generally do not like to talk about (Pope, Sonne, & Greene, 2006). If therapists do talk about trauma, they wish to speak of these painful and frightening topics from a safe intellectual distance, which is a stance antithetical to that necessary to work psychotherapeutically with traumatized people. From my professional location inside the circle of trauma psychotherapists and researchers who have taken the leadership in the field, most of whom appear to be of European descent whether living in North America, Australia, Israel, or Europe itself, it is apparent that many of us believed by that working with trauma survivors we were already doing social justice work and that trauma was sufficiently generic so as to not necessitate delving deeply into questions of cultural difference.

CULTURALLY COMPETENT TRAUMA THERAPISTS

It has also been true that for many well-intentioned Euro-American clinicians, diversity has been a topic reserved for those who work with special populations and for the clinicians who are themselves members of those very groups. Etic approaches to working with groups, which prescribed certain psychotherapeutic strategies for Asian Americans and certain others for African Americans and so on, although initially revolutionary because of simply raising consciousness about race and culture, eventually had the effect of ghettoizing discourse about ethnicity into the special populations class that was and still frequently is an optional course in the training of mental health professionals. Diversity came to be quite narrowly defined in mental health contexts; it was the study of the *other*, with each group placed in its own box. Race and culture were almost the only forms of human diversity addressed in the mental health realms for many years, and culture was defined in terms of those variables. Although feminist psychologists and other feminist psychotherapists have foregrounded gender, and lesbian, gay, and bisexual-affirmative practitioners began to make sexuality core to some components of the psychotherapy conversation, social class was and remains deeply neglected as a psychological topic (Lott & Bullock, 2007). Disability, immigration status, experiences of colonization, and other social locations have informed people's experiences of identity, and thus of trauma, and they have also largely gone unaddressed within the mental health discourse. Genocide perpetrated against Europeans has been of interest in the trauma field; genocide perpetrated by Europeans against indigenous people as colonial forces invaded the Western Hemisphere and the Global South has for the most part not been a subject of the field's attentions if one simply adds up the number of publications and conference presentations. The descendants and beneficiaries of the colonizers are among those controlling the professional discourse far more often than are the descendants of the colonized.

Trauma psychotherapists and specialists have not been an exception to this norm of disengagement from issues of human diversity within the context of U.S. culture. Ironically, the field of trauma studies has been international from its inception, owing largely to European and Middle Eastern heritages of war, the Holocaust, and ethnic strife of a longevity unknowable in a country as young as the United States. The journals and conferences of the traumatic stress studies field are well populated with materials about trauma from earthquakes in Armenia, wars in Kuwait or firestorms in Australia. Internationalism has been the trauma field's multiculturalism. In the largest published volume currently available on the topic of cultural diversity in trauma studies, the most frequent focus was on cultures outside of the United States or on individuals who refuged to the United States from other cultures. I can find more information about disaster survivors in the developing Spanish-speaking world than on the systemic trauma exposures experienced by persons of the many and diverse Spanish-speaking heritages living in the United States. This focus, although valuable in and of itself, has contributed to a neglect of multicultural competencies as regards issues of diversity in U.S. trauma survivors.

Whatever the causes, the dearth of formal commentary on what constitutes culturally competent trauma practice is not sustainable if trauma practice is to respond to the realities of trauma survivors who seek professional care. In this book I attempt to take one step in the direction of filling that lacuna by interweaving a paradigm for thinking about human diversity with knowledge from the field of trauma therapy to yield a framework for culturally competent practice with trauma survivors. The goal of this book is not to produce psychotherapists with etic knowledge, that is, specific knowledge about how to work with a specific population or their particular trauma histories. Instead, I invite my readers to an epistemology of diversity for understanding trauma and its intersections with humans' multiple and diverse identities.

EMIC VERSUS ETIC DISCOURSE OF CULTURAL COMPETENCE

There are numerous reasons for my decision to frame this volume within an emic discourse of cultural competence. First, etic models are themselves plagued by inattention to within-group diversities. To say "Here's how to work with a Bajoran trauma survivor" (Bajorans being a Star Trek ethnic group with a cultural history of trauma) ignores questions such as, is this a male, female, or intersexed Bajoran? Did this person live through the internment camps or is she or he the child of someone who did so? Did she or he participate in the resistance against the Cardassians (yet another Star Trek ethnic group who serve as a placeholder for perpetrators of oppression)? Did she or he see friends die? Spend time in prison? Refuge to another planet to

seek physical safety? Is this Bajoran lesbian, gay, bisexual, or a transgendered person? Is she or he a strong adherent of the dominant Bajoran faith? As the list of questions grows, so does the complexity of issues facing psychotherapist and client. Yet these complexities are always present whether or not they are acknowledged, and the interplay and interaction between them and the trauma experience will have deep and lasting impact on how a person relates to what has happened and approaches the recovery process.

Etic models reduce people to one dimension of their identity and not always the dimension most strongly felt by trauma survivors themselves. My Bajoran client's trauma may have everything to do with being Bajoran or very little; her or his resources for responding to the trauma may also be affected or not by ethnicity and culture. If I only see the large dangling earring and the red clothing and immediately call up the "how to treat Bajorans" chapter from my inner database, I may miss what is important for me to know about this particular Bajoran's experiences of trauma. And I have not even begun to consider what it means that I am a human of this planet offering my services to this ethnically different human of another planet or to ask what we might represent to one another in symbolic nonconscious layers of our encounter. Representation, both individual and cultural/historical, constitutes two other vitally important dimensions of culturally competent practice.

Consequently, in this book I offer an epistemology of culturally aware and sensitive trauma competence of an emic variety. This strategy for addressing diversity teaches psychotherapists how to think about human difference, to develop algorithms for solving conundrums about diversity, and to consider themselves and their own diverse identities as they populate the social ecology of psychotherapy with trauma survivors. These models do attend to the various components of identity but with the goal of understanding how they merge within each person. The epistemology I use in this volume owes a large debt to the work of Pamela Hays (2001, 2008). Hays's model for understanding diversity in clinical context, which she calls ADDRESSING, is one that intentionally engages with multiple and intersecting identities in client and psychotherapist—age, acquired and developmental disability, religion, ethnicity, social class, sexual orientation, indigenous heritage, national origin, and gender. I draw on the ADDRESSING paradigm as an algorithm for thinking about human diversity and about how psychotherapists working with trauma survivors can understand their clients and themselves in terms of the intersection of trauma and multiple locations of social and personal identity.

TRAUMA IN THE LIVES OF PSYCHOTHERAPISTS

It is important to note that I refer to understanding diversity in both clients and psychotherapists. An assumption about what constitutes cultur-

ally competent practice, which recurs in this book, is that such practice involves knowledge of one's own multiple identities and their meanings. Along with one's sex; gender; and various ethnic, sexual orientation, cultural, and social class identities, there is also the question of how trauma is a part of one's identity. Some readers are trauma survivors. Research by Pope and Feldman-Summers (1992) has shown that approximately 30% of practicing psychologists admit to a history of childhood abuse. When I teach about trauma, I urge those in the audience to begin to speak of trauma survivors as *we* rather than *they*, given the ubiquity of this experience in psychotherapists' lives. Add in other common experiences of trauma such as combat, natural disaster, assault and sexual assault in adulthood, and traumatic loss, and the numbers of trauma survivors reading these lines grow.

Some readers will not have had a personal experience of trauma yet; yet because trauma is potential as well as actual. My colleagues living in New Orleans who reeled shell-shocked in the wake of Katrina, their homes, offices, and schools swept away by the floodwaters, were not trauma survivors (that I knew of, although there is a strong unspoken ban among psychotherapists and academicians about speaking of their own personal trauma histories) on the day that I agreed to write this book in early August 2005. When I saw them at APA's annual conference in New Orleans 1 year later they were trauma survivors, and for some of these people that change was visible and palpable. *Katrina survivor* had become an indelible component of their identities in that short timeframe.

Other readers are the children of trauma survivors, living with legacies of intergenerational transmission of trauma experiences (Danieli, 1998). Readers who are American Indian, African American, Jewish, Khmer, Native Hawaiian, or Armenian, to name but a few groups that have been on the receiving end of genocidal violence, are descendants of trauma survivors and of cultures marked by trauma. Readers who are South Asian may come from families that have been affected by the social upheaval and death attendant on the establishment of India and Pakistan. There is a plethora of additional examples; trauma has been pervasive in human experience.

They are we when speaking of trauma and its survivors. To work in a culturally competent manner with trauma each psychotherapist must be willing to understand her or his own participation, directly or historically, in the realities of trauma. Human beings evolved in terribly dangerous environments, surrounded by predators, and were likely to die before they reached age 40. The capacity for a response to trauma is built into the evolution of the species Homo sapiens; one's specific personal heritage is what creates the texture of one's trauma response.

Each individual is also diverse and possessed of multiple identities. Every person has a sex, a gender, a spiritual or meaning-making system (which need not include a divine being), and a culture with which she or he identifies, however loosely. If one's ancestors came from Europe or Asia to North

America, one is most likely a descendant of immigrants or refugees who arrived here to the chilly welcome that has greeted everyone from the Irish of the 1800s to the Eastern European Jews of the early 1900s to today's South Asian computer engineers and undocumented Guatemalans. Some came as indentured servants, sold into labor. If one's family came from South and Central America, one's ancestors may have crawled under the barbed wire fence at the border. Some ancestors came in steerage; others flew first class on a 747; but all experienced the loss of culture and language that is trauma for some.

Many individuals are also perpetrators. Some are the descendants of slaveholders, of soldiers who shot women and children in this country's genocidal wars against its indigenous people, or of those who imprisoned or tortured others in the countries from which they came. Many people have ancestors who suffered what Shay (1995) has called the "moral injury" of being trauma perpetrators, and in many cases that was traumatic to them and to the family cultures that they created and of which later generations are the inheritors. Some families served in the governments of Batista's Cuba, Stalin's Union of Soviet Socialist Republics, Hitler's Germany, or in South Africa under apartheid. Some individuals' ancestors have been beaten; some individuals' ancestors administered those beatings. Some people's ancestors include both; many African Americans carry the genes of a slaveholder great-great-grandfather who raped their enslaved great-great-grandmother. And people from positions of dominance and privilege can perpetrate oppression on others every day in their current lives without knowing or thinking of it (Vasquez, 2007). Perpetrator and victim consciousness live within people's cultures, families, and psychological realities. They are a component of our constructions of identity

If a psychotherapist does not understand her or his own diverse identities and the ways in which those identities include experiences of trauma, then no training in the application of eye-movement desensitization and reprocessing or prolonged exposure therapy or cognitive reprocessing will allow that psychotherapist to be culturally competent. The absence of cultural competence will detract from a psychotherapist's effectiveness as she or he applies these empirically supported modalities for reducing the distressing symptoms caused by trauma exposure because that lack will affect the quality of the therapy relationship. Research on common factors in psychotherapy has shown that for any intervention, a large percentage of the outcome variance is accounted for by the therapeutic alliance (Norcross & Lambert, 2006). Cultural competence enhances a psychotherapist's capacity to build alliances and enact the common factors of good psychotherapy even with those clients who appear to resemble their therapists in every way. I urge readers to think about trauma's meanings for psychotherapists as well as for the clients.

As noted previously, the field of trauma studies is a place in which it is disingenuous to speak of us, the psychotherapists, and them, the clients. We

are they more often than psychotherapists like to think, and if psychotherapists tell themselves this truth, they come one step closer to cultural competence by acknowledging the ubiquity of trauma in human personal histories.

This is a difficult task with which to engage. At a large international meeting of trauma specialists that I attended in the midst of this writing, I never once heard trauma survivors referred to by other than the distancing third person, except for one distinguished presenter who, already full of gravitas and thus unassailable in his professional credentials, set aside his prepared remarks to speak about his own personal trauma history living in a country perpetually at war. Everyone who knows of this man and his work knows that he was born and raised in Jerusalem. As a Jewish Israeli, his trauma history is implicit in his citizenship. But for him to speak of it directly and explicitly was a violation of unspoken norms.

THE IMPORTANCE OF BEING IGNORANT

In her classic science fiction novel *The Left Hand of Darkness*, Ursula Kroeber LeGuin (1969) has taken her readers to the planet Gethen where all of the humans are intersexed and capable of being both male and female at different times in their lives and of being both and neither most of the time. Through the eyes of her protagonist Genly Ai, a middle-years adult male who is an apparently heterosexual, highly educated human of African descent from the reader's own third rock from a star, she has offered readers the opportunity to imagine how meanings are changed when variables that seem important and essential to their identities and understandings of one another become important and essential in entirely different and almost unfathomable ways.

On Gethen, sex is such a variable. Genly Ai cannot tolerate being unable to know which sex a person is, even though each Gethenian is usually neuter outside of a monthly estrous phase. Sex, and knowing a person's sex, is central to Genly's ways of relating; not trained as a psychotherapist, but rather as an anthropologist and diplomat, he is unable to set this strategy for organizing human experience aside. As a consequence of his insistence on putting Gethenians into boxes that do not reflect their lived realities, he makes continuous and dangerous errors of judgment, which form the themes of the book's drama and tragedy.

Psychotherapists are often like Genly Ai; they struggle with the ambiguity of their clients' identities and attempt to put them into the categories that they know and with which they are familiar. Trauma frequently has the effect of creating new and difficult-to-comprehend identities for clients, the identity of being broken, spoiled, dirty, and damaged. Sometimes those identities appear to make no sense to psychotherapists' preconceived notions of how humans organize identity, but they not only make sense for clients but

also convey important information about the meaning of a trauma experience in someone's life. Culturally competent trauma practice requires that psychotherapists stretch their minds and let go of their categories so that they can open themselves to those parameters of identity experienced by the people with whom they work.

Another theme to be sounded here as I discuss how trauma intersects with identity is that no person has one identity. Drawing on models of identity development created by theorists observing the lives of people with multiple racial identities (Root, 2000, 2004a, 2004b), in this volume I encourage psychotherapists to understand trauma as it impacts each person's multiple identities, both additively and interactively. Each individual has a gender, and each individual has a gender as expressed through social class, age cohort, culture, and so on. When trauma intersects those multiple, overlapping, and sometimes apparently conflicting facets of selfhood, culturally competent practice requires psychotherapists to think not only of the easiest to see or most prominent aspect of identity but also about the intersection with the intersections, a sort of three-dimensional Venn diagram.

This leads me to another important point made by LeGuin. At one juncture in her narrative, LeGuin sends Genly Ai on a visit to a Gethenian religious sanctuary where practitioners of the art of Foretelling live. He approaches a member of the group and proclaims, "I am very ignorant." The Foreteller gently suggests to Ai that he is boasting, for in the philosophy of the Foretellers, ignorance is wisdom. So too with culturally competent trauma treatment; great ignorance, the stance of knowing that one does not know and thus openness to being informed, is a core capacity of the emotional competence informing culturally sensitive work. This is likely equally as difficult as being willing to interrogate one's own identities in relationship to trauma. The culture of modern mental health professions, with its reliance on a stance of empirical logical positivism, assumes that the psychotherapist is the expert who knows how to decode and explain a client's reality. Claiming ignorance is profoundly countercultural for people with doctorates, psychologists like me, or other professionals with advanced degrees and years of training.

Consequently another important goal of this book is to help each reader to become more ignorant, and thus wiser, about working with trauma survivors. After 3 decades of working intentionally with trauma I can say with utter certainty that I know that I have no idea of how any particular person will have experienced and made sense, or not, of her or his traumatic experiences. The clients I have worked with have taught me a great deal about what they have done to survive and thrive, and I have been able to amalgamate that knowledge into forms that function as useful heuristics, but no more than that. I have learned that my capacities as a psychotherapist and my ability to apply one or the other intervention effectively or to use my heuristics on behalf of any specific person are slightly less important than my willingness to stand in a position of ignorance in relationship to my client's suf-

fering as well as her or his resilience, capacities, and struggles to make meaning in the wake of trauma. In that position of ignorance I am able both to join my client in intersubjective experience of ambiguity and noncontrol and also to relinquish my needs to act as if I, the psychotherapist, am immune to the vicissitudes of human existence of which trauma is only one.

AN OVERVIEW OF THIS VOLUME

This book's purpose is to generate in the reader the capacity to deliver culturally competent treatment to survivors of trauma. This book should not be read as a comprehensive text about trauma treatment or a comprehensive text about cultural competence. It is an introduction and an invitation. In attempting to adequately introduce readers to this topic in sufficient depth to be useful, I have chosen to omit large territories in both intellectual arenas. Everything written here presupposes that the reader has a basic familiarity with the diagnosis of PTSD and the ways in which the full range of posttraumatic symptoms can mimic a range of other diagnoses, including depressive disorders, anxiety disorders, and dissociative phenomena.

In chapters 1 and 2, I bring readers into the world of culturally competent models of psychotherapy. Here I go more deeply into Hays's (2001, 2007) ADDRESSING model and offer an extended version of that model that may be particularly useful in working with survivors of trauma. I explore how identity develops in the context of multiple, intersecting, and sometimes conflicting social locations and how trauma occurring at any point of identity development itself intersects with those other identity variables. In these chapters I invite readers to consider how the response to trauma emerges within the context of identity.

In chapter 3, I briefly review some common approaches to working with trauma in psychotherapy and discuss how cultural competence might inform their applications, emphasizing the process of therapy intake and transtheoretical paradigms of working with trauma survivors. I strongly encourage readers who wish to become more familiar with the topic of trauma treatment in general to delve further into sources referenced in chapter 3 regarding general paradigms and published guidelines for treatment of trauma sequelae. Working with trauma is a labor of both head and heart; specific, focused training in working with trauma within either a formal educational setting or through postgraduate continuing education is necessary for effective, ethical, and competent psychotherapy practice with trauma survivors. Ongoing consultation and supervision and copious applications of self-care, all of which are core to competent practice in the realities of trauma, cannot be acquired through reading. Doing culturally competent psychotherapy with any client is similarly not something acquired simply intellectually; this book should be a starting point, something that provokes the reader to think.

An additional goal of chapter 3 is to invite the reader to a competency-based view of trauma survivors. As I say to my clients who are castigating themselves for being symptomatic, "You arrived here alive." It can be difficult for psychotherapist and client alike to see a person who is profoundly impaired by flashbacks, numbness, and hyperreactivity as competent. Many survivors of interpersonal violence believe themselves to have been weak because they did not escape or they succumbed to posttrauma distress. Nonetheless, a competency-based viewpoint about clients constitutes a foundation of culturally competent trauma practice, in part because some of the apparent symptoms of posttrauma response are actually individually and/or culturally informed coping strategies. As psychotherapists know from the behavior change literature, people are more likely to feel hopeful about the possibility of their own transformation when they realize that what therapy is asking of them is not the acquisition of some new and entirely foreign skill but rather the expansion of a skill already in the behavioral repertoire.

In chapter 4, I expose readers to a diversity of paradigms for understanding what constitutes a trauma. I discuss trauma as a biopsychosocial/spiritual–existential phenomenon. I also look at multiple conceptual frameworks for understanding what might constitute a traumatic stressor and how experiences that appear to be normative or the background noise of daily life are potentially components of trauma. Feminist and multicultural models of trauma will be explored as additive to the *DSM–IV–TR* Criterion A definition of what constitutes a traumatic stressor. One of the many critiques of the *DSM–IV–TR* definition of trauma has been that it ignores the normative, quotidian aspects of trauma in the lives of many oppressed and disempowered persons (Brown, 2004), leading psychotherapists to an inability to grasp how a particular presentation of client distress is in fact posttraumatic. In chapter 4, I encourage readers to think beyond PTSD when they conceptualize the range of posttrauma responses, with particular attention to the ways in which various identity factors mediate how distress is experienced internally and expressed interpersonally.

In Part II of this book I look at particular social locations as they intersect with trauma. I examine age, gender, ethnicity, social class, sexual orientation, disability, displacement, health, and spirituality as factors in the experience of and recovery from trauma exposure. Each of these social location variables constitutes a source both of enhanced risk for exposure to trauma for some individuals and importantly a source of enhanced resources and resilience in the face of trauma. Each of these variables can also lend particular meanings to a trauma. I explore some of those meanings and ways to think about how social location can lend excess negative value to a trauma. Each of these variables can also influence how trauma is responded to, and thus in these chapters I explore in greater depth how to think in a diverse and complex manner diagnostically about the ways in which each survivor

communicates about her or his distress. I also revisit the importance of looking at these variables as they intersect in the life of each trauma survivor.

In Part III of this book, I discuss interpersonal and psychotherapist variables. Working with the family, friends, and communities of trauma survivors is an important component of trauma therapy, but one that is frequently neglected in the focus on trauma survivors themselves. For many trauma survivors, these interpersonal contexts are the ones in which healing may occur if psychotherapists notice their importance and bring them, actually or symbolically, into the therapy room. Finally, the person of the psychotherapist working with trauma survivors requires attention. I discuss multicultural considerations arising from Pearlman and Saakvitne's (1995) construct of vicarious traumatization, with particular emphasis on how a psychotherapist's own social locations and multiple and intersecting identities affect the experience of working with survivors of trauma. I conclude with a discussion of future directions for deepening culturally competent trauma treatment, raising questions of where future research might be directed.

As always, my own social locations and identities form the standpoint from which I write. A component of that standpoint is the belief that ethics of authorship require a disclosure of those perspectives, because they create my biases and inform my understandings. I am an upper-middle-class Ashkenazic Jewish lesbian born in the last week of 1952, the granddaughter of immigrants who, arriving in the United States in the early 1920s as adolescents and young adults, never went beyond the seventh grade themselves but who sent all of their children to college. I am an inheritor of a rich intellectual tradition of critical thought; I am also an inheritor of a two-millennium-long history of cultural trauma, the descendant of those who survived. I was trained in the Boulder scientist–practitioner model of clinical psychology and have been a psychotherapist in independent practice since 1979. Most of the trauma survivors with whom I have worked have been individuals with histories of severe, repeated trauma exposure in childhood at the hands of parents and other caregivers, although I have also worked with persons who have survived combat and accidents. Most of the people with whom I have worked clinically are biologically female. In the mid 1990s I was deeply involved in the heated debate about trauma and memory, and some of my interests and allegiances in the field of trauma have been shaped by that experience.

As a long-time practitioner and theorist of feminist psychotherapy, I am deeply informed by that orientation and its emphasis on the role of power and powerlessness in the etiology of distress and dysfunction. I am also, because of that orientation, quite pragmatic about what I do in the office because I am mostly interested in the question of what helps and what works for the person sitting across the room from me. That pragmatism is reflected in my discussion of what works with trauma survivors and can also be seen in my general tendency toward a transtheoretical paradigm for good trauma treatment.

As a psychotherapist writing a book primarily for other psychotherapists I do not try to provide an in-depth review of every possible scholarly source on a topic. Rather, my interest is in inviting the reader to engage in a virtual conversation with me through these pages about how to become aware of opportunities for deepening cultural competence at all points in one's work with trauma survivors. I use clinical case examples as my primary instructional strategy because my own experience as both a learner and an instructor is that ideas stay with me when flesh and blood and emotion are hung on the bones of theory, something that I find is done best through clinical tales. This is a book about working with adult clients. I am not skilled or experienced in working with people younger than age 16. An entire separate book deserves to be written about cultural competence in work with children and younger adolescent trauma survivors.

The clinical case examples in this book represent, for the most part, disguised and merged stories derived from the lives of people who have sat across from me over the last 3 decades. Some examples also reflect and in some instances derive from the published biographical and autobiographical literatures on trauma and on human difference. My goal in including these examples is to give life and breath to the dry bones of theory and to illustrate how aspects of identity intersect, collide, and merge with the experience of trauma.

As McFarlane (2006) recently noted, the field of trauma studies began by attending to the literature created by trauma survivors from ancient times to the present to bear witness to their own lives. That literature, fictional and biographical, has been a source of knowledge for me and for the people with whom I have worked as a psychotherapist. In a few specific instances I have permission from a given individual to tell her or his story more fully. In those cases the client in question has read earlier versions of my discussion of our work together and agreed to my narrative of her or his life and the specific disguises given. However, most of the people discussed here are amalgams of two or more people I know. Having my clients read what I write about them has been another important stage in my process of learning about culturally competent trauma treatment, simply because their review of my manuscripts prior to publication afforded them opportunities to foreground aspects of their identities whose importance I had previously downplayed. These individuals have been my best teachers about trauma and its meanings, about what hurts, and what helps; they have also been my most powerful instructors about competence and resilience in the aftermath of trauma. This book would not exist without those lessons, and although none of them can be named, all of these people have my profound gratitude. They are the real authors of everything written by and about trauma by the "experts."

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CULTURALLY COMPETENT MODELS OF TRAUMA TREATMENT