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KNOWING DIFFERENCE OR WE'RE ALL DIVERSE HERE

In this chapter, I explore some models for thinking about diversity and human difference, with particular attention to how those models inform psychotherapists' understanding of trauma. I also begin the process of looking closely at what it means that each psychotherapist represents something culturally meaningful to her or his clients as clients do to their psychotherapists, and these representations affect the process and outcome of psychotherapists' therapeutic work.

During my time on the faculty of a doctoral program in clinical psychology I took the lead in teaching a course with the well-meaning and benign-sounding name "Assessment and Treatment of Diverse Populations." When I took over the class on my arrival on campus and looked through the syllabus prepared by the prior instructor, I was unsurprised to find that this had been a class focused on rules for treating members of specific North American groups of people of color and other so-called minority groups; there was 1 week for African Americans; 1 week for Asian Americans; 1 week for lesbian, gay, and bisexual (LGB) people; and so on.

This model, referred to in the introduction to this volume as the etic strategy for understanding difference, has been so prevalent in psychology's

discourse about cultural competence, difference, and diversity that I would be unsurprised if many psychotherapists picking up this book expected to find just that approach. The epistemologies of diversity in psychology have, until recently, been about deviance from an unspoken norm, the one in which "even the rat was White," to use Guthrie's (1976) not-quite-humorous words and in which a generic male human was seen to cover the experiences of all humans, including those who, unlike males, could and frequently did menstruate and give birth (Weisstein, 1970).

If one becomes deeply immersed in knowledge of a particular culture it may be possible to parlay the etic model into culturally competent trauma work in that culture alone. Psychotherapists who are intimately familiar with the norms, customs, languages, spiritual traditions, and histories of particular American Indian nations may be extremely well equipped to work with American Indians from those nations as clients. Trauma has been ubiquitous in the lives of this community, although there are large enough cultural and historical variations from nation to nation that deeply knowing Nez Pierce history does not mean deeply knowing Duwamish history or Dine history or Cherokee history, despite common themes of genocide and forced relocation. But even the most culturally steeped American Indian psychotherapist may not know what to do when the trauma for a particular client is one that happens outside the very broad parameters of the many and common traumas of this community. If, for instance, the client is a two-spirit person who has been gay bashed by other tribal members, the psychotherapist may not have all of the epistemic foundations necessary with which to assist the client in recovery with that particular form of within-group oppressive trauma.

What I have found useful in making sense of human diversity and people's multiple identities within that diversity is a model first proposed by psychologist Pamela Hays (2001, 2007). Hays invited her readers to see themselves and their clients through an intersecting web of what I refer to as "social locations" or "social identifiers." I define these as components of identity that are constructed in the context of social, interpersonal, and relational realities and that commonly inform the development of identity. Hays developed an acronym, ADDRESSING, for her epistemic system; this stands for age, disability (acquired and/or developmental), religion, ethnicity, social class, sexual orientation, indigenous heritage, national origin, and gender/sex.

Along with her acronym Hays proposed a series of strategies for developing culturally competent practice no matter whom psychotherapists are treating. A point that she made and that seems particularly germane to working with trauma survivors is that knowing the histories of cultures and societies, not simply the histories of the individuals with whom psychotherapists work, is a foundation of culturally competent practice. Understanding that social locations, the places in the social network where people are interpersonally situated, develop within a particular historical period and are also the

inheritors of other historical periods, allows for careful, critical examination of psychotherapists' assumptions about each of these potential components of identity. Many of these histories contain deeply embedded experience of trauma that go on to be the lens through which members of these cultures encode today's experiences. Inter- and transgenerational transmission of traumatic experiences cannot be well understood unless the histories that created those experiences are part of a psychotherapist's understandings of the world.

I often add to Hays's list, which she described as foundational but not all inclusive, such other social locations as vocational and recreational choices, being (or not) partnered, being (or not) a parent, attractiveness, body size and shape, state of physical health (different from disability), phenotype (similar to ethnicity in some instances, but not isomorphic with it), and experiences of colonization (which frequently but not always overlap with indigenous heritage in the Hays model). Readers are likely to have awareness of other social locations that neither Hays nor I have identified, and I encourage readers to consider including them in their understanding of themselves and their clients. ADDRESSING is useful because it invites psychotherapists to think broadly about the locations of diverse experience in each human.

Each person, client and psychotherapist alike, will have some relationship to most if not all of these social locations, and many of these locations will form core components of identity. Bias, oppression, and stereotype can be leveled at people on the basis of any one of these social locations; thus each person will have either been a target of such bias, will have practiced such a bias, and/or, as a result of being a target, will have internalized bias into identity. If a person has not her- or himself had such experiences, the experiences may have happened in the history of family and culture and may have left their psychological and relational traces. The presence of bias interwoven into the experience of social location in the context of social and cultural histories informs the meanings that those locations have for people's identities. This interweave of history, culture, trauma and identity also creates specific vulnerabilities as well as resistances to the experiences of trauma in the present day. It is important to explore each of these factors in greater depth and to begin the process of seeing where and how an enhanced comprehension of those factors can facilitate culturally competent, culturally sensitive, and culturally aware trauma treatment. The discussions in this chapter are introductory, and each topic explored here is addressed in great depth later in this volume.

A BRIEF WORD ABOUT TERMINOLOGY

A preliminary word about terminology to be used here and later in this volume to refer to groups of people who are usually referred to as minorities is

helpful in understanding this discussion. I have come to eschew the use of the term *minority group* for a number of reasons having to do both with the message given to people by being called minority (e.g., perhaps less than) as well as the inaccuracy of the term (some minorities are now or are about to become numerical majorities).

Rather, I refer to *target* groups and *dominant* groups. Target groups are those social groups that have historically or continue currently to be targets of discrimination, bias, oppression, and maltreatment. Dominant groups constitute those social groups currently defined as the norm within a given culture. Thus, in the United States today, dominant groups include U.S.-born, English-speaking persons of European descent who are biologically male, heterosexual, affiliated however loosely or historically with some variety of Protestant Christian faith, married with children, middle-class, aged 25–49, with a college education or more, no current disabilities, not fat, normative in their gender expression, and adhering to conventional standards of attractiveness. Target groups constitute all others. Most persons have some mixture of target and dominant group status; even a person who today is entirely in the dominant group may move out of it as a result of aging beyond 49, acquiring a disability, losing his income and becoming poor, marrying a person of a target ethnicity, or converting to a non-Christian faith, to describe some very common trajectories for changes to social status. Movement among and between dominant and target social locations and finding ways to share both within one skin are other aspects of how identity develops. Understanding people's dominant and target statuses can emerge through exploration and examination of the most common categories of social location.

I also use the term *social location* as a broad concept that refers to a variety of different types of experience that can affect identity. The ADDRESSING model, for instance, lists many of the social locations that most commonly affect a person's sense of self as well as the ways in which others may respond to them. Even though some social locations have a biological component (e.g., gender, which is based in biological sex), all of them are to some degree or another socially constructed and variable from culture to culture. Although this terminology may be unfamiliar to some readers, my hope is that by using it I am inviting readers to reconfigure how they think about identity so that they eventually understand that it entails far more than a person's current or easily visible categories in the world.

ENTERING THE ADDRESSING MODEL

To understand how the ADDRESSING model can inform a psychotherapist's work, it is useful to explore in-depth each of the social locations identified by that model. This discussion will begin to interweave the topic of trauma into each ADDRESSING variable.

Age

Age is a social location with two components: one's actual age, which speaks to issues of developmental capacities, tasks, and needs, and one's age cohort, which informs the cultural contexts and norms surrounding one's life experiences. One's actual age is also a risk factor for certain kinds of bias; both children and older adults are targets of ageism, and because ageism is internalized, persons in adolescence and young adulthood frequently are affected by that internalized bias regarding their presumed future status as older people. To practice culturally competent trauma therapies, it is essential to understand the age (or ages, in the case of long-lasting trauma processes) at which trauma has happened and consequently to apprehend what developmental tools were available to the person for response to the trauma. The impact of trauma on succeeding developmental processes is also understood through the lens of age, because data suggest that traumagenic interference with one set of tasks affects, if not entirely inhibits, the successful accomplishment of other later developmental tasks. A very useful decision rule about age and severity of trauma impact is that younger persons are those most likely to experience longest term and most pervasive consequences of trauma exposure; this contradicts the common sense belief that the very young are very resilient and adaptable in the face of trauma and the very old are more vulnerable and reflects the reality that the foundational developmental tasks of childhood are more easily disrupted by trauma than are those of later life. I return to this topic and its ramifications for trauma therapy later in this volume.

Disability

As Olkin (1999) noted, it can be difficult to strictly define what constitutes a disability. She suggested that psychologists consider two continua, one of health and one of disability, which intersect in a variety of ways. Thus disability refers to changes and challenges to function at the level of the body that interfere with certain functions of life. Some conditions could disable an individual in some circumstances but not in others. Take severe myopia, for example. I am writing this sentence while looking through the lenses of my glasses. I am profoundly myopic and cannot see clearly much further than the end of my nose without those lenses; I have not been able to do so since about age 6. Living in a society that has developed corrective lenses means that I am not disabled from any function by my myopia, and I would not describe it as a disability. However, for an individual living in a pre-corrective-lens society this condition might be disabling and even life threatening, because my uncorrected eyes cannot tell what is lurking just down the road or looming beneath my feet.

Some disabilities come with few or no effects on general health. For example, a person may be deaf as a result of the failure of the auditory nerve

to develop during gestation but may otherwise be in excellent health. A person might, however, be deaf because she or he had meningitis that damaged the auditory nerve and that has had various other long-lasting health consequences. A person might be born with spastic quadriplegia due to cerebral palsy and have quite severe disabilities of use of language and motor control arising from oxygen deprivation during the labor and delivery process; health problems that emerge for this person are not inherent in her or his condition but rather in the psychosocial consequences of having difficulty with voluntary movement and relying on others to move one's body so as to avoid decubitus sores from pressure.

Olkin (1999) has suggested looking to issues of function and the effects of a condition on a range of functions, noting that it is useful not to think of a "disabled person," but rather "a person disabled from" with the functions specified by a particular condition. A person might be disabled from reading by neurological difficulties, by visual difficulties, or by posttraumatic anxiety but not disabled from walking, speaking, hearing, or engaging in daily self-care functions, for example. Thus, an individual born without disabilities may as a result of cardiovascular disease become disabled from walking or cognitively impaired in later life. A person who suffers traumatic brain injury after adolescence or a war veteran who experiences traumatic limb amputation in combat has acquired a condition that can be disabling. Acquiring disability later in life can be traumagenic for some individuals.

Disability as a social location has both developmental and acquired components. Developmental disabilities as defined by Hays (2001, 2007) are those that develop in utero or very early in life so that they are long-lasting and core components of an individual's experience. Acquired disabilities can loosely be defined as those that occur or develop far enough into the life cycle that they are experienced or perceived as a change to the person. Thus, neuromuscular disorders that express themselves in childhood such as muscular dystrophy would be developmental, whereas a similar set of symptoms of muscular weakness arising in adulthood as the result of myasthenia gravis would be classified as acquired.

There is an important interaction of this social location with the previous one, age. The presence of a developmental disability informs a person's encounters with normative developmental tasks; the acquisition of a disability later in life informs the use of formerly acquired skills and may uncover the presence of tasks of emotional and cognitive development that were less than adequately accomplished. Because of the impact of both medical technologies and also the legal system on the lives of people who are on the high end of the continuum of disability, age cohort is also an extremely meaningful signifier in the lives of people with disabilities.

Disability is also a social construct. One can see this in the lives of people who identify as culturally Deaf (using the capital letter *D* to denote this cultural identification). Such persons do not see themselves as having a

disability despite the fact that the inability to hear is so defined by the larger culture. Rather, they define themselves as an oppressed linguistic minority who, like other oppressed groups, have been forced until recently to learn the language of the majority culture rather than their own (Padden & Humphries, 1988). The spirited protests held by some students and faculty during the mid-1980s at Gallaudet University illustrate this defining process, with the protestors insisting that this unique university of Deaf culture have a president who was Deaf as well. Deafness is a physical condition defined as a disability in most laws, and persons who are deaf and those who are Deaf may request accommodations from schools and employers such as provision of sign language interpreter services under those laws.

However, many Deaf people do not personally identify as having a disability and define themselves as occupying a cultural location that must be defended from incursions by the larger dominant hearing world. This, too, is a function of social factors other than the ability or not to hear; age cohort as well as family history of deafness plays a large part in whether a person who does not hear self-defines as having a disability. A deaf child born to and raised by hearing parents is more likely to be defined by self and family as a person with a disability. A deaf child born to the deaf children of deaf parents, as a third generation "Deaf of Deaf" (to use the term from the Deaf community for those deaf by heritage as well as sensory capacities), is likely to see her- or himself as a person with a different language and culture, not a person with a disability.

I join with Olkin (1999) and Hays (2001, 2007) to suggest that culturally competent therapy with people with disabilities and their families requires what Olkin refers to as a "minority" rather than a "deficit" model. What is true is that people with disabilities have some (or several) aspects of their bodies that function differently than those of a majority of other humans. Frequently, however, the challenges for these individuals lie not in those physical differences but in the barriers created to fullest possible function by cultural institutions and practice. *Ableism*, bias against persons with disabilities, is pervasive, and because most people with disabilities do not come from families in which the parents are also people with disabilities, children with developmental disabilities almost always grow up in social environments distorted by ableist bias.

Trauma enters the issue of disability in a host of ways. Because of the risks inherent in applying a deficit versus a minority model, psychotherapists must be careful not to assume that the presence of the disability is itself traumatizing or stressful. This is especially true for people whose disabilities are developmental and for whom this way of being in their bodies is well-known and not associated with abrupt loss or change. Harriet McBryde Johnson (2005), an attorney, memoirist, and disabilities rights activist, exemplified this stance in her memoir *Too Late to Die Young: Nearly True Tales From a Life* (2005). Although her neuromuscular condition is progressive and has

increasingly disabled her from using her legs and hands as she has grown older, her relationship with her body is one of deep familiarity. She knows that she is a person with a disability, but that is not a source of trauma to her; her stresses come from the barriers erected by others to her pursuit of her life.

Her story stands in contrast to those of individuals who are disabled by events or conditions that were inherently traumatic or a source of loss: accidents leading to paraplegia or quadriplegia or life-threatening illnesses such as cancer or multiple sclerosis. Such persons, prior to loss of their able-bodied status, may have held strong, even if not conscious, biases about the lives of people living with disabilities, and these biases now inform their understanding of the events that led to a change in function. Thus they may conflate being a person with a disability that made its appearance in the middle of their nondisabled life and life narrative and experience that entire change as traumatic.

Finally, as I discuss in further detail later in this volume, being a person with a disability can be a risk factor for some kinds of trauma exposure. The manner in which a particular trauma attacks a person at the location of disability and those aspects of identity affected by disability will both inform the experience of trauma. They will also shape that which may be useful in the healing process.

Religion and Spirituality

Religion and spirituality are the next social locations in the Hays (2001, 2007) model. Even atheists have a belief system; although they may balk at calling it a spiritual system, it will be one that allows for the making of meaning. All traumatic stressors are assaults on meaning-making systems, and most traumas will have lasting transformative impacts on the survivor's ways of making meaning. There is a pervasive interaction between trauma and issues of meaning making, with religion being equally a source of trauma, a location at which trauma is directed, and a source of coping in the aftermath of trauma.

Culturally competent practice necessitates inquiry into and comprehension of a survivor's religious, spiritual, and existential systems currently and prior to and during the trauma. Changes across time arising from trauma exposure and recovery are common, and the meanings ascribed to those changes by a trauma survivor will often become central to understanding some of that survivor's coping strategies in the face of trauma. It is also important for psychotherapists not to conflate religious identification with spirituality and existential meaning-making systems. Although for some people these are isomorphic, for many others they are completely separate, as is the case for the person who attends a Methodist church with his family on holidays and the occasional Sunday but describes his spirituality as being about his relationship to nature.

Some religious affiliations constitute target groups; which groups are targeted depends on history and context. For example, although the Mormon Church is currently a large, successful religious denomination, its founding history is full of stories of hate crimes perpetrated on the founders of the church by dominant culture Protestant Christians. In Utah today where Mormons constitute the dominant religious and cultural group and the numerical and political majority there continues to be a consciousness of target group status in the group's early history. Similarly, an individual raised in a cultural context in which her or his faith is dominant may develop religious target group status when she or he moves from that context into one in which her or his faith is no longer dominant; this is a common aspect of immigration to the United States from countries where Islam, Buddhism, or Hinduism are the dominant faiths, for example. The trauma of having one's faith marginalized can lead to distress that sometimes does not appear to be psychological but represents what happens when anxiety leads to rigidification of previously more fluid coping strategies.

Ethnicity and Culture

Ethnicity, the next factor in the Hays (2001, 2008) model, subsumes several factors. Ethnicity is commonly used in North American discourse to refer to persons of color, as in the phrase *ethnic minorities*. Hays asserts, and I concur, that ethnicity is not the same as phenotype. Phenotype refers to biology, the physical characteristics such as eye color and shape, hair color and texture, skin pigmentation, and so on, which are used as place markers for the construct of race, a concept that is then conflated with ethnicity. Ethnicity, however, is an intersection of a multiplicity of factors that include phenotype, culture, and language. Many Euro-American individuals are unaware that they have an ethnicity because they conflate that term with phenotype and may find a question about that topic confusing when coming from a psychotherapist. They may answer, "I'm White. I don't have an ethnicity." It can be helpful to give examples: One can be a "hyphenated" American of some sort (Armenian-American, Irish-American, or Norwegian-American); one can be of indigenous Euro-American ethnicity (Southerner or Northeasterner); or as one of my students phrased it, one can be "Heinz 57. A mutt," denoting a mixed and hybrid ethnicity of European descent whose distal origins have been lost in transmission over time.

A person's cultural identification, ethnicity, phenotype, and ancestry may not be isomorphic. Some fourth and fifth generation Americans of Japanese and Chinese descent are disidentified with their parents' and grandparents' cultures of origin. Statistics indicate that members of these groups are very likely to marry Euro-Americans rather than phenotypically similar persons and to identify culturally with Euro-American dominant culture. "I'm a White guy whose great-grandparents came from Japan" is the self-description

of an acquaintance who although phenotypically Asian appearing and with a Japanese last name has no identification with any Asian culture, speaks no Japanese, and describes himself as fully assimilated into the Euro-American culture of which his spouse is a member.

Thus, ethnicity is a many faceted phenomenon containing a range of potentially traumagenic experiences that evolve out of family history and personal experience. Persons of non-European phenotypes and some of Eastern or Southern European phenotypes have been the targets of racist bias both historically and currently. Individuals who identify with ethnicities that are primarily defined by phenotype (e.g., race) may experience exposure to racism even when they are phenotypically more similar to the Euro-American dominant group. Consider, for example, Walter White, the famous African American activist who had fair skin and hair yet clearly was targeted by and affected by White racism.

Ethnicity has also been a source of other sorts of trauma exposures that may be unknown to the client because assimilation was a family response to trauma, but whose effects have been transmitted intergenerationally. Public figures such as former Secretary of State Madeline Albright and former U.S. Senator George Allen are two recent examples of offspring of Holocaust survivors who had no knowledge of their parents' Jewish origins until those histories were exposed to them in their middle adulthoods. In each case the family had used assimilation and religious conversion as self-protective strategies so that dynamics related to trauma in the family's history were buried and unavailable for understanding by either of these individuals.

Historical trauma, easier to identify in groups in which such trauma is relatively recent, is also present in the lives of most of the large immigrant groups who came to North America prior to the imposition of immigration quotas. Although the potato famine of Ireland that engendered the large immigration of Irish people to North America is 2 centuries past, the experiences of colonization and conquest by the English, the banning of indigenous Gaelic language, the disenfranchisement of the Roman Catholic religion, and other aspects of Irish historical trauma that preceded the famine are all components of Irish cultural identity that may be detectable in clients of Irish descent even when, at the point she or he enters therapy, that client's understanding of her or his ethnicity is consciously limited to her or his relationship to St. Patrick's day celebrations.

Social Class

Social class is the great invisible social location in the United States. Although national statistics increasingly point to growing income disparities between the richest Americans and all others and some social commentators speak of the disappearance of the middle class due to diminished availability of well-paying jobs outside of the learned professions, most Americans who

are not abjectly poor are likely to describe themselves as being middle class. *Classism*, the bias against poor people as well as against those who work with their hands, is pervasive in American culture in which an analysis of class issues has rarely been a component of the public discourse.

Social class is also a complex variable. It may or may not reflect actual income level; some commentators on class have noted that middle-class status reflects the presence of social capital, defined in part by such factors as availability of literature in the home, parental or other close familial education, and a value placed on education for its own sake, even when financial means are absent or strained. A person of great wealth may have little or no social capital. Additionally, in North America barriers between classes are permeable, with social class not marked by accent, as is the case in Europe, or hereditary participation in a landed aristocracy (although informal aristocracies of wealthy visible families have long existed in the upper classes of U.S. society and now can be seen to form through families of celebrity). A person may live in many different social classes during her or his lifetime, with trauma sometimes being a factor contributing to loss of class status.

Social class is conflated with several other social locations. Persons with disabilities are more likely to be very poor, with some estimates being that 80% of people with disabilities are un- or underemployed as a result of systemic barriers to participation. For instance, a person with disabilities and a doctorate in psychology who requires multiple medications and the use of a wheelchair for mobility and also has a personal care attendant may be unable to find a job that both pays sufficiently to have a high quality of life and also provides adequate health insurance coverage; she or he can only afford access to necessary care if she or he remains on disability income payments, which then creates needs-based eligibility for that care. If she or he does find work that pays more than $700 monthly, she or he places all benefits in jeopardy (Panzarino, 1994). Additionally, if this person uses paratransit services to go to and from a job, she or he risks being terminated for repeated tardiness because a common complaint of persons who use paratransit systems is that they are rarely on time, sometimes being as many as several hours behind schedule. All of these factors can conspire in the life of a person with a disability to leave her or him impoverished no matter what her or his educational level, talents, or capacities. This person may thus be middle class in values and social capital but financially poverty stricken.

Age also interacts with social class. Very young children are more likely to live in poverty than any other group of Americans. In the past, older age was also associated with poverty, and this continues to be the case for many aging women and aging people of color. In those instances earlier discrimination in the workplace created a cascading effect from lack of financial resources earlier in life leading to reduced savings for retirement and smaller Social Security payments as a result of lower paying work. However, with the inception of so-called welfare reform in the 1990s, chil-

dren in the United States are more likely to be living far below the poverty level than ever before.

Trauma interacts in a variety of ways with social class. Access to and expectations of care and safety are enhanced for middle-, upper-middle-, and upper-class persons. As I describe later, certain types of traumatic experiences, because they are more inconsistent with the lives and expectations of middle- and upper-class persons, are potentially more likely to be emotionally challenging for these individuals. Social class also directly affects the sorts of services and resources available to trauma survivors including insurance coverage for health and psychological services. Poverty creates risks for exposure to certain kinds of traumatic stressors including, given the all-volunteer nature of the U.S. military, combat trauma exposure.

Sexual Orientation

Sexual orientation describes the direction and expression of an individual's sexual and romantic desires. It is conceptualized on two continua, one of other-sex attraction and one of same-sex attraction (realizing, of course, that there are actually more than two sexes but that the other sexes generally sort into malelike and femalelike categories that allow the use of this continuum paradigm for sexual orientation). Each human being is to some degree high, medium, or low on each of these continua. Persons who self-identify as heterosexual are commonly higher on the other-sex attraction continuum; persons who self-identify as lesbian or gay are commonly higher on the same-sex attraction continuum; and self-identified bisexual individuals fall at roughly similar places on both continua. Persons' expressed sexual behavior is commonly, although not always, indicative of their desires; persons with strong same-sex and weak other-sex attraction may engage in sexual and romantic relationships with members of the other sex and not necessarily identify as lesbian or gay, for example. Not all of these relationships reflect some kind of suppression of true sexual self or self-hatred; they can also be about a strong relational connection with one particular other-sex individual.

Each person has a sexual orientation; for some individuals this is fixed throughout the lifetime, as appears to be true for most gay and heterosexual men. For others, including some lesbian and heterosexual women and some bisexual women and men, sexual orientation is experienced as more fluid. The best available data suggest that the origins of sexual orientation are poorly understood for persons of all orientations but that attempts to change orientation, the direction of desire, in individuals for whom this is not already to some degree fluid are generally unsuccessful and may be harmful to those persons. A discussion of the issue of sexual orientation conversion, or reparative therapies, is beyond the scope of this chapter but is addressed as a trauma

risk factor in greater detail when sexual orientation issues in trauma are more fully discussed later in this book.

People who are lesbian, gay, or bisexual (LGB) are targeted by *heterosexism* (the systemic privileging of heterosexual ways of being and relating) and *homophobia* (fear and hatred of persons believed to be LGB) and are subject to a variety of forms of legal and attitudinal bias and discrimination. Currently most states in the United States ban marriages between members of the same sex; although same-sex sexual behavior is no longer criminalized in the United States, it was until quite recently. Persons who are LGB are forbidden to serve in the U.S. Armed Forces if their sexual orientation becomes known under the infamous "Don't ask don't tell" policy. (Readers might find it ironic that Israel, officially a theocracy, recognizes same-sex marriages from other countries, which the United States does not, and allows openly LGB people to serve in the military. Israel also makes survivor pensions available to the partners of those who serve, who are also likely to have been military veterans.) There are 17 U.S. states that have laws forbidding discrimination on the basis of sexual orientation in housing, employment, and public accommodations, but this means that the majority of states do not have such laws. Some states, most notably Virginia, do not even allow gay people to make nonmarital legal contracts such as medical powers of attorney for use in emergencies regarding their domestic partnerships.

Sexual orientation interacts with all other social location variables, both those already discussed and those to follow. Briefly, for purposes of this chapter, what is important in terms of beginning to approach culturally competent trauma treatment is for psychotherapists never to assume the sexual orientation of clients, regardless of such apparently obvious cues as the presence of an other-sex spouse or same-sex partner. Routine inquires into how a person self-identifies are an important part of conveying to clients that a psychotherapist is open to however they describe themselves. Psychotherapists who have personal difficulty with individuals of a given sexual orientation and have been unable to work through that aspect of countertransference should refer clients to other psychotherapists, as the risk of harm to clients from a psychotherapist's homophobia, biphobia, or negativity about heterosexuality can be great.

An aspect of sexual orientation that is rarely considered is that of what its practitioners refer to as *kinky* sex. This includes individuals who, along with attractions to persons of a particular sex or sexes, are aroused by such activities as bondage and discipline, the infliction or receipt of pain, various forms of role-playing involving dominance and submission, sexual behavior in relatively public settings known as *play parties*, or sex involving fetishistic elements such as clothing of particular fabrics (leather, rubber, vinyl, and velvet appearing to be among the most common). Sexually kinky individuals are gay, lesbian, bisexual, and heterosexual. Some have multiple partners for purposes of sexual activity; some will be monogamous with one partner;

and still others may be polyamorous (or *poly*), with committed relationships to more than one person that are not open to sexual activities with others outside the sexual partnership.

Although there are estimates available regarding the numbers of LGB persons in the U.S. adult population (generally ranging from 3% to 10% depending on how these counts are made), no data exist regarding sexually kinky individuals. Working with this group of persons requires a particular degree of cultural competence that includes a high level of open-mindedness about sexual activities of consenting adults. Again, as is true with a client of any sexual orientation, psychotherapists who have poorly contained countertransferences toward kinky sexuality should consider referring clients to other psychotherapists.

Trauma intersects with sexual orientation in a large number of ways, and not all of these are related to a client's membership in a sexual minority. For example, sexual assault of heterosexual women by male acquaintances and spouses is related to the risk factor of being heterosexual and female and thus in close relational proximity to the group of humans most likely to commit sexual assaults. For LGB people, however, trauma of some sort is a constant; working with LGB clients thus requires knowledge of both LGB issues and trauma in its many guises.

Indigenous Heritage and Colonization

Indigenous heritage refers to people first known to be dwelling in a location prior to its colonization. In the United States, this includes American Indians, Alaska Natives and Inuits, Native Hawaiians, and Samoans (this definition begs the question of whether these individuals were themselves colonizers of other now-vanished groups). World-wide indigenous people include Africans from formerly colonized countries, the indigenous dwellers of Taiwan who were colonized first by the Han Chinese and then by the Japanese, the Ainu of Japan, aboriginal peoples of Australia, and the Karen and Hmong peoples of Southeast Asia. Some settings also have semi-indigenous groups, originally European colonists who were then themselves secondarily colonized by ultimate conquerors such as Acadians in Louisiana, Spanish Americans and mixed-race Mexicans in the part of Spanish America that became California, Texas, New Mexico, and Arizona, all of whom experienced secondary colonization by English speakers.

What persons of indigenous heritage all have in common is a history of colonization by a group that invaded and stole land; imposed a different language, religion, customs, and ways of dress; often enslaved people for use in labor to produce trade goods; and frequently committed actual genocide. To say that trauma is an ever-present component of the lives and heritage of indigenous peoples is a great understatement. Historical, intergenerational, and present-day interpersonal trauma, called post-colonial trauma syndrome

by some, are common in the lives of indigenous individuals (Duran, Duran, Brave Heart, & Yellow Horse-Davis, 1998). Poverty is commonly associated with indigenous status; the poorest place in the United States is the Pine Ridge reservation, the rural ghetto of the Lakota people. But most other social location variables cut across indigenous status as well.

National Origin, Immigration, and Refugee Status

National origin reflects the issue of immigration. Except for those people indigenous to North America, all Euro-Americans and Asian Americans and many African Americans living here are descendants of immigrants or themselves immigrants (differentiated from the experiences of people of African descent who if descended from slaves were not immigrants but rather victims of kidnap and enslavement). Each succeeding wave of immigrants has been greeted with hostility; the anti-Irish sign festooning New York City in the 1820s contained sentiments not unlike the anti-immigrant slogans being preached today by the vigilante groups who troll for undocumented people crossing the U.S. border with Mexico.

But the meaning of immigration has changed over time as well. When my Jewish grandparents fled their native Poland in the early 1900s they knew with certainty that they would never return, because Poland was an unsafe place for Jews. My partner's maternal great-grandfather who hid in a ship coming from Hamburg after running away from his home somewhere in the Austro-Hungarian Empire had a similar expectation of no return, although the issue was not as much one of safety. Immigration in the preairplane world was mostly a permanent phenomenon that had loss embedded deeply into its fabric.

Many of today's voluntary immigrants often come to the United States with the reasonable expectation of visiting home and extended family again once this is financially feasible. The losses of immigration still exist for voluntary and legal immigrants, but their configuration is different. More like the immigrants of the past are refugees fleeing unsafe places in their homelands; my dentist, a Baha'i born in Iran, cannot return home so long as the present government, which has criminalized her faith, is in power, despite Iran's being the place where the Baha'i faith was founded. Refugees thus have the usual losses of the immigration experience today but are also likely to carry with them specific experiences of trauma and danger that impelled their departure from their homeland. Persons who are undocumented also bear more resemblance in their experiences of immigration to those of earlier generations than to legal immigrants of today in terms of danger and risk associated with the immigration experience.

African Americans present a special experience of national origin. Persons of African descent whose ancestors came to the United States before the slave trade was banned in the early 1800s are all the descendants of those who survived the brutal Middle Passage of the slave trade. Although many

also have Euro-American and American Indian ancestors as a result of sexual assaults and intermarriages and thus can be both indigenous and immigrant in their heritage as well, being transported to this continent in chains is a very different migration experience even than coming voluntarily as an indentured servant who shared phenotype and legal status with the master. Similar to the experiences of these persons are modern-day people who are trafficked into the United States and other industrialized nations for purposes of low-paid work or the sex trade. Trafficked people are in essence enslaved and come to the United States as a result of trickery or because they have been sold to pay a family debt. The meaning of migration for these individuals is not that of the voluntary immigrant, legal or otherwise.

Cultural competence around issues of national origin requires psychotherapists to consider carefully the various meanings of immigration and migration to their own and their clients' identities and then to explore how and where those experiences have engendered encounters with trauma. As is becoming clear, immigration intersects with every other social location; even persons of indigenous heritage in one place may become immigrants to another place, bringing with them their particular histories of living in their colonized countries of origin.

Gender and Sex

The final social location described by Hays (2001, 2008) is, ironically, the one that is generally primary in people's identities—gender. Gender is not sex. Sex is a term that describes the biological makeup of the body. As noted earlier, persons may be one of several sexes, with external genital morphology that matches or varies from chromosomal makeup or reproductive organs. One in 2,000 live births is of a person who is intersexed, meaning that the infant in question has genitals that are either ambiguous or inconsistent with reproductive and/or chromosomal sex. Generally, however, individuals in the United States regardless of actual sex are sorted into the two categories of male and female (the issue of intersex is addressed at greater length later in this volume).

Gender is the social construct built on the sex of the body. It is a series of schemata and roles that are both internalized and enacted and that begin to be imposed on children from almost the first moment at which the sex of a fetus is determined. Because of the very early imposition of rules regarding appropriate gender expression, gender is frequently phenomenologically experienced as isomorphic with sex and gender expressions as hardwired in the anatomy of the body. This position appears to be largely mythological, with careful meta-analysis of the sex difference literature determining that effect sizes for almost all sex differences are small and insignificant (Hyde, 2005).

Gender, no matter its origins, is quite a powerful determiner of identity and is generally the first identity that a person experiences, usually emerging

with clarity for a child between ages 18 months and 3 years. Developmental capacities for greater and lesser flexibility of categories and less and more critical thought about rules frequently govern the gender expression of younger humans, particularly very young children. Younger individuals are thus quite rigid about gender roles and rules. Gender interacts with every other social location, because no matter what a person's social locations, that person has a gender.

Individuals whose preferred gender expression is at variance with that to which they have been assigned on the basis of sex are defined as *transgender*. Transgender itself operates on several continua, which may or may not include the desire to surgically or hormonally modify the body to bring it into line with gender expression. Overtly transgender individuals are frequently mistaken for being gay or lesbian, given stereotypes of cross-gender expression in sexual minority persons; however, transgender individuals come in the range of sexual orientations, which may or may not remain constant if and when a person has sexual reassignment surgeries.

Cultural competence in psychotherapy requires psychotherapists to have an awareness of their own gender schemata and the rules that they impose on the gender expressions of others. Gender nonconformity is a frequent risk factor for trauma exposure; however, what is less well understood is that particularly rigid forms of gender conformity also risk trauma exposure as well. Gender expression additionally appears to mediate response to trauma exposure, and posttraumatic symptoms are frequently expressed in manners reflecting an interaction with gendered ways of being in the world already utilized by a trauma survivor.

REPRESENTATION AND PRIVILEGE IN CULTURALLY COMPETENT PRACTICE

As noted previously, I have added several other possible social locations for consideration in the development of cultural competence for myself; each psychotherapist will, in deepening cultural competence, find social locations in her- or himself and her or his clients that enhance understanding of identity and its relationship to trauma. Culturally competent practice involves the psychotherapist's awareness of her or his own personal relationships to each of these variables of social location. Because of the manners in which trauma differentially impacts each of these social locations and their various intersections, a particular component of identity will have itself been a source of personal trauma or distress for many persons. Psychotherapists must also be aware that their various social locations, particularly those easily apparent to clients, will also have meanings that will color the therapy relationship. What psychotherapists represent to their clients and what clients represent to their psychotherapists through the lenses of their collective

multiple identities affect therapy profoundly. The ability of psychotherapists to be aware of those issues of representation is core to cultural competence in practice.

The 19th century African American suffrage activist Anna Julia Cooper said, "When and where I enter, then and there the whole race enters with me" (quoted in Giddings, 1996, p. 13). Cooper's statement is true for each psychotherapist and each client. When and where psychotherapists enter the exchange of therapy, into the room with them marches their personal and cultural histories. They will represent things to their clients and their clients to them. This, I suggest, is more than simply issues of transference or countertransference, because the things psychotherapists represent are frequently alive and well in the social environments in which psychotherapists and their clients live and are not simply past experiences that are symbolically or unconsciously evoked or transferred into the therapeutic environment. These dynamics, even when symbolic, are not merely nonconscious representations of personal history; they are the interpersonal and political realities in which therapy takes place.

Culturally competent practice with trauma survivors or others requires a heightened awareness of what it is psychotherapists represent and what is represented to them. Culturally competent practice requires the sophisticated capacity to know when the dynamic in the room is about the psychotherapist's social locations, when it is about other representations, and when it is within the set of more usually considered dynamics of therapy as understood by the psychotherapist's particular theoretical orientation. This is especially the case when one or the other person represents a component of personal or historical trauma to the other.

A basic assumption of culturally competent practice is that psychotherapists can never and should not assume the trust of their clients. Trauma is itself destructive to trust; survivors of interpersonal trauma may take years to believe that psychotherapists will not become one of their perpetrators. Psychotherapists working with trauma survivors represent humans who were the source of trauma; psychotherapists' specific social locations and identities may enhance or decrease their overall role as a threat stimulus. As several of my clients have told me, it is only because my dog, who works with me, appeared to trust me that they then decided to accelerate their own process and view my actions as more likely to be truly benign rather than a trick designed to pull them closer to me so I could harm them further.

When certain kinds of difference are present, psychotherapists' clients will have even more reasons founded in experience and reality to view their psychotherapists with suspicion and uncertainty, not to believe that their psychotherapists' professional training trumps their life training as biased humans. In fact, for many members of target groups the mental health disciplines have been a source of pathologizing and disempowerment, making psychotherapists less worthy of trust than some other types of healers. When

psychotherapists represent current or historical trauma to their clients and are aware of it, however, they increase the possibility of earning trust when they tell the truth about their acceptance of their role as representative of their culture. Acknowledging and validating the presence and stinky leavings of historical elephants in the therapy office can communicate to clients that psychotherapists are willing to tell truths that are uncomfortable for them as psychotherapists and not simply to invite their clients to experience their own discomfort. I return to this theme repeatedly throughout this volume as I explore the specific ways in which representation affects the therapy process in trauma treatment.

Cultural competence also requires attention to the phenomenon of dominant group privilege. Privilege is the collection of unearned advantages attendant on being a member of a dominant cultural group. There are usually corresponding undeserved disadvantages conferred on members of target groups. Some examples of how privilege manifests itself include the following:

- You can drive any car you want without worrying that you will be stopped so long as you are obeying traffic laws.
- You can marry the person you love and receive survivor benefits if they die first.
- You can walk into any store wearing anything you want pretty well assured that you will not be followed or harassed.
- You believe that if you are the victim of a crime that you can call the police and be helped by them.
- Your culture's holidays are always days off from work or school.
- You can be imperfect and few people will generalize from your imperfections to those of everyone in your group.
- You can swear or dress in second hand clothes or not answer letters without having people attribute these choices to the bad morals, the poverty, or the illiteracy of your group.
- If your day, week, or year is going badly, you need not ask in each negative episode or situation whether it has overtones of bias or whether you're being paranoid. (McIntosh, 1998)

Privilege lends power to one's biases; if I am a lesbian biased against heterosexual people, I may suffer from being prejudiced but I lack the social power to declare all marriage between other-sexed persons illegal. The heterosexual person biased against me has the privilege and power to legislate against me. Acknowledging one's privilege can be a trust-engendering and relationship-building action in therapy. Ignoring it or pretending that it does not matter will eventually undermine trust and endanger the working alliance of therapy.

When I sit across the room from persons of African descent, they cannot know that my ancestors arrived in this country in 1919, nor does it mat-

ter whether I personally benefited from slavery. What they know, and I must also know and be able to acknowledge, is that I have benefited from the unearned privilege associated with my phenotype of European-appearing skin and that they, in turn, have experienced undeserved social disadvantage associated with their phenotype of darker skin than mine. I know that my grandfather, who came off the boat in 1919 speaking no English, found work as a carpenter in Cleveland more easily because of the color of his skin than did a similarly experienced African American carpenter born and raised in the city to which my grandfather came.

I also know that when he built his home in a middle-class suburb in the 1950s no one questioned his right to be there. When the first two African American families tried to build their homes in that same suburb in the same time frame, their applications were held up for years by a zoning board raising one petty question after another. A carpenter with a seventh-grade education designed and built that first home; an architect with a master's degree in his subject designed, built, and finally was able to live in that second home with his daughter, who became the first African American girl in my scout troupe but not until the city did everything it could to make him and his family feel unwelcome. If I cannot find a way to convey to my African American client that I know this truth about the realities of phenotype privilege, she or he has no reason to go past a certain point of vulnerability with me because I will not have communicated an awareness of the power of my social location of privilege.

Other groups—heterosexual persons, middle- and upper-class persons, those not yet disabled, and so on—also benefit from unearned privilege and, when engaged in the intimate exchange of psychotherapy, will bring the effects of that privilege into the dynamics of the relationship. Privilege can protect against distress in the face of trauma, or it can be a factor leading to distress; disadvantage can instill resilience that is protective, or it can create vulnerabilities that spread the effects of a trauma exposure beyond their initial impact. The dynamics of power and powerlessness arising from privilege intertwine with trauma, and when they are treated as nonexistent, they will impinge on therapy for trauma survivors. Not yet being a survivor of trauma is, after all, very much a form of privilege that is unearned; being able to keep one's survivor status private and avoid the shame associated with disclosure, something that redounds to the role of the psychotherapist within the usual boundaries of the process, is also a form of privilege, associated as it is with the power of the psychotherapist's role.

Privilege is not a reason for guilt on the part of the dominant group psychotherapist. Individuals are not responsible for having inherited unearned privilege. I did not choose my phenotype or know the unearned advantages it would give me. In fact, guilt from privileged persons about their privilege invariably becomes an additional burden for the disadvantaged others, who then often feel compelled to do the work of reassuring

dominant group members that they are not a bad, oppressive individuals, and become deflected from their own agendas. Rather, psychotherapists with some dominant group membership (and it is difficult to have none; the heterosexual Christian married-male African American has one set of privileges stemming from the first four social locations in his identity; I, a lesbian Jewish cannot-get-legally-married female Euro-American have a different set of privileges stemming from the last of my listed social locations) need to commit to personal work to become aware of their privilege and how it manifests in their worldviews and their work to achieve and maintain cultural competence.

A component of that work is leaving guilt and shame behind. I have privilege; my job is to know how to live responsibly with that reality, not to deny it or pretend that I can jettison it. Similarly, psychotherapists with social disadvantage must become aware of the effects of internalized oppression and exclusion on their psyches as they enter the relationship with clients who may have more access to privilege than they and notice how they or their clients may subtly disempower these psychotherapists as the dynamics of power and dominance from the larger society infiltrate the therapy office.

As McIntosh (1998) noted, any dominant group privilege, be it of gender, sexual orientation, ethnicity, social class, and so on, is generally operating at a nonconscious level. It is the nature of privilege to make itself invisible to those benefiting from it but very visible to those who do not have it. Internalized oppression may be similarly invisible because it has become a part of the consciousness and sense of self of the oppressed individual (Pheterson, 1986), a negative ascription about one's own group that feels true because it has been reinforced in oppressive social contexts for so long. In each instance, the psychosocial impact of culturally based hierarchies will have a residence in the therapy room and, if not brought into awareness and consciousness by the psychotherapist, may be detrimental to an effective healing process. Add trauma to the mixture and the potentials for problems may increase because trauma is itself a factor disadvantaging a person and frequently one that undermines power and privilege in ways that are confusing to all parties.

This perspective can be particularly important given that psychotherapists frequently constitute the privileged persons in the therapy room, with the power of the therapeutic role outweighing privilege or disadvantage that might operate in the social world outside of therapy. Because therapy is an elite profession requiring in most cases postgraduate study and thus the luxury of time and financial resources and the capacities to navigate educational systems designed by and for the privileged, few psychotherapists do not come from dominant groups holding social privilege. When the psychotherapist is not a trauma survivor and the client is addressing issues of trauma, then dynamics related to privilege will obtain even when all other aspects of social

location are shared by client and psychotherapist. Ultimately, privilege is about unearned ease and the inequitable access to resources inherent in certain kinds of personal and structural power. Because trauma is about disempowerment and the loss of safety and ease, a psychotherapist's awareness of power dynamics will strengthen the work with trauma survivors no matter what a psychotherapist's general orientation to treatment might be. Awareness of privilege and disadvantage become important components of knowing what one represents because the social locations that enter the room with a psychotherapist generally carry messages about the privilege or disadvantage stemming from those markers of social realities.

The psychotherapist working from a culturally competent standpoint takes the position of an ally. Allies are not advocates, nor does an alliance stance require a deviation from the frame of one's theory of psychotherapy (Mio & Rhoades, 2003). Rather, alliance is the stance of externalizing the problem that has been placed on the client's shoulders and making it a collective problem; specifically as relates to the issue of privilege, an alliance perspective places the primary responsibility for responding to issues evoked by a psychotherapist's dominant group privileges in the hands of the psychotherapist. It is a stance of moral nonneutrality as regards the traumatic event, a stance that, as Ochberg (1988) pointed out long ago, is required in work with trauma survivors for whom moral neutrality is the functional equivalent of silently standing against the survivor. It is a stance of willingness to identify and validate the realities of systems of oppression that operate in the lives of target group people who are also survivors of trauma (Dass-Brailford, 2006).

This can be particularly crucial when working with trauma survivors who are a superordinate target group cutting across and through all other identities and social locations in part because of having been the targets of a traumatic event, rendering them members of a group stigmatized in Western cultures. Trauma is a feminizing event; trauma renders its targets weak, helpless, confused, and emotional, all characteristics that are associated with the target group of femininity. Many of the meaning-making systems of our cultures impute blame to the trauma survivor for what has happened; notice that even in the case of supposedly morally neutral natural disasters a discourse of "why did they live there in the path of the tornado/flood/hurricane/windstorm/earthquake fault" can be seen and heard in postdisaster public discourse. When the psychotherapist is her- or himself a trauma survivor, she or he is in the room not in that identity, holding the privilege of the psychotherapist position. As a therapeutic ally, the culturally competent trauma psychotherapist acknowledges the presence of stigma in the room, attends to her or his inner pulls to assume the privilege of *normalcy*, (which is a characteristic almost always ascribed to members of the dominant group, even in those contexts not officially dedicated, as is indeed true in the psychotherapeutic context, to defining people as normal or abnormal), and tells the truth

to clients about the reality of their situations rather than attempting to minimize the experience of the trauma or failing to respect that the client has already made attempts to cope with its aftermaths. The culturally competent therapist contextualizes the experience of trauma in light of historical, systemic, and institutionalized dynamics of oppression and targeting, highlighting the interaction between trauma and those other phenomena in the client's experience of pain and of recovery.

It can be helpful to differentiate clearly between privilege or its lack and trauma. All trauma strips privilege from people; not all disadvantage is traumatizing. Oppression, as I discuss later at length, is a risk factor for becoming traumatized, with some writers arguing that all oppressive systems are inherently traumagenic. Nonetheless, oppressed people frequently also have available to them systems of resilience and coping that mitigate the traumagenic effects of oppression. Culturally competent therapists have the task of enlightening themselves and their clients about the complicated interrelationships between oppression, trauma, and resilience as well as between privilege, trauma, and resilience. As I discuss later in this volume, there are times when privilege increases a person's risk of experiencing an event as traumatic.

THE COMPETENT TRAUMA SURVIVOR

Alliance with a client and cultural competence also reflect a competency-based stance on clients (Bertolino & O'Hanlon, 2001). From this position a psychotherapist strives to see the people with whom she or he works as having already been making numerous biological, psychological, psychosocial, and spiritual attempts to solve the problems engendered by trauma exposure. Gilfus (1999) referred to this stance as a "survivor-centered epistemology," which she defined as "first and foremost the acknowledgment of the survivor as a complete human being with a cultural and historical context, capable of expert knowledge in her or his own right, to be viewed through the lens of a loving perception" (p. 1253).

Some of these strategies for responding to the unbearable pains of trauma will have succeeded magnificently for varying periods of time; some will have succeeded poorly if at all. But all of these strategies are evidence of the survivor's intentions and desires to deal with what trauma invited into her or his life. The Vietnam veteran nurse with whom I worked in the 1980s began drinking to silence her nightmares and flashbacks. In alcohol she had a strategy that worked very well for a decade or so, then began to break down as her dose increased and interfered with her other life functions, and worked even less well as even the increased dose no longer kept her intrusive symptoms at bay (Brown, 1986). It is important to note that because active alcoholism is more stigmatized in women than in men, her coping strategy led to more

social isolation and rejection from her family than similar behaviors might have for a man. However, she was not helpless or a failure, although she believed herself to be both when she began to work with me. She had been actively trying to cope with her distress for almost 2 decades and was mostly in need of a method that worked better and lasted longer so that she could recover from the trauma and pick up the pieces of her life left by her initial coping strategy. Just as generally culturally competent practice rests on respect for the diversity of ways in which humans inhabit life and the world, so culturally competent trauma practice respects and honors the diversity of attempts that trauma survivors have made to solve the problems of distress and disruption that trauma has brought into their lives.

Some coping strategies will have worked not as well as wished for or lasted not very long. The heterosexual Euro-American man who was beaten in the parking garage at his office and then developed an unwillingness to leave home solved the problem of being in unsafe places by never leaving his safe home. However, he quickly replaced the problem of unsafe places with the problem of never being able to go to work. Because he was male in a culture that has no official social role for a man not working outside the home, his solution worked more poorly for him than it might have for a similarly traumatized woman, especially if she was heterosexual and married, two social locations that make it permissible for an adult not to work outside the home if she is female, but stigmatize that strategy for a man.

Nonetheless, both of these people and every single trauma survivor that psychotherapists encounter in their work will have created some sort of self-help strategy: avoidance, dissociation, overwork, abuse of substances or food or exercise, prayer, art, petting the dog, giving birth, or being celibate. They have arrived at psychotherapists' offices alive, if sometimes only barely so. Frequently the strategies that they have used reflect one or more of their social locations, both at and after trauma exposure; some of their strategies will have been learned from other people residing in a shared traumatized context, be it familial or cultural. Some of the reasons that they will have come into therapy also reflect their social locations and the capacities of their emotional and psychosocial environments to support their strategies or not. A stance of alliance is one that recognizes psychotherapists' client's desires to problem solve buried in what are now symptoms of distress and dysfunction and honors that problem-solving capacity in an overt and respectful manner as a component of the therapy process. Similar to Rogers's (1957) thesis that all humans are possessed of the drive to self-actualize, so I find useful the notion that humans have the will to solve the problems of their lives. As I discuss later, a component of culturally competent treatment for trauma involves exploring effective strategies developed not only by psychotherapists but by other similar survivors who are often the best experts on what works.

In summary, cultural competence in work with trauma involves two sets of knowledge and two sets of emotional skills that must then be skillfully combined into one set of strategies for understanding and interacting with those who seek psychotherapists' care. In the remainder of this volume I explore further how to think about diverse experiences and their relationship to trauma so as to deepen that combined set of skills in clinical practice.