Cultural Competence In Trauma Treatment

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Thinking About Cultural Competence

A focus will be on epistemologies rather than on prescriptions of particular techniques.

Development of attitudinal norms

- If you can’t get close enough to step on someone’s toes you’re not close enough to become culturally competent.

Terminology I’ll be using- ”Target” and “Dominant/Agent” groups rather than “Majority” and “Minority”

- Why the language we use and our mindfulness about language is important for culturally competent practice.

- Why Star Trek ethnic groups?
Defining Cultural Competence, Old-Style

Etic epistemologies drive prior definitions of cultural competence

- Competence = acquisition of specific body of knowledge about a specific group
- Parameters of knowledge imposed by external, allegedly “objective” knower (usually researcher from outside the system)
- Knowledge of the “other”
- Not about the person of the psychotherapist
- Not about the subjective experience of the client
Rules and Algorithms

A consequence of etic models

- “The handbook of psychotherapy with Bajorans”

- Rules about how to interact with members of specific groups

- Groups defined so as to enhance apparent homogeneity of the Other group and downplay within-group differences

- Identity as singular for members of the Other

- Competence defined as acquiring and using the correct set of rules for the group

- Psychotherapist’s stance constructed as neutral and free of bias
Positive Effects of Etic Models

- Opened the discourse in the mental health fields about culture and human distress
- Created awareness of lacunae in mental health services delivery to marginalized populations
- Expanded definitions of “human”, punctuated how people had been subsumed
- Developed basic skills and awareness about work with these groups
- Legitimized some discussion of culture and difference within psychology
Problematic Effects of Etic Models

- Created false sense of competence in practitioners (“I know the rules because I read the book, so I am competent to work with Bajorans”)
- Downplayed relational, contextual, and political meanings of mental health interventions by constructing phenomena as interesting cultural artifacts of the Other
- Imposed dominant cultural categories (mental illness vs physical illness) on Other groups, creating an implicit norm for both health and illness for them
- Defined difference as about phenotype (aka “race”) and other biological factors (sex), taking an essentialist, deterministic stance
Ignorance and Humility

A radical proposition

- Culturally competent practice is practice emerging from a stance of humility and knowing what we don’t know
- Genly Ai and the Foreteller
Implications of Emic Models

Intersectionalities of identities

- There’s more to identity than can be known from direct observation, and the intersections are unique.

Knowing a person requires consideration of multiple social locations, each with its own meanings for the particular individual.

Culturally competent practice requires a high degree of emotional competence on the part of the practitioner, because cultural competence is much more about the practitioner’s own attitudes and self-awareness than the acquisition of formal data—what we symbolize to one another.

Cultural competence in trauma treatment requires attention to the themes of trauma in identities, both embedded and recently acquired.
Intellectual and Emotional Competence

Old-style cultural competence = intellectual competence only

21st Century cultural competence = emotional competence + intellectual competence

- Capacity in professional to hold ambiguity of client’s intersectional identities, understand how they inform one another, differentiate identities from social locations, see threads of trauma in identity stories
- Know and own one’s own biases and prejudices -- self-awareness
- Awareness of own cultural identities and their meanings for self, including cultural histories of trauma
- Embrace of one’s own ignorance, human capacities for bias
People of good will (most psychologists) prefer to see ourselves as unbiased

This denies

- The presence of our limbic system (the sub-routine for emotion). We are not Lt. Cmdr. Data.
- Actual lived experiences and encounters with difference which classically condition our responses
- How culture and context lend meaning to those encounters, creating appraisals of our over-learned responses
- The effects of our own shame and guilt on our behavior
What the Myth Misses

- Insider/outsider statuses of clinicians
- Clinicians’ own standpoints and intersectionalities of identities
- Role of power in relationship - who has it, how do they have it
- The power of the non-conscious dynamics of difference in the room
Aversive or Modern Bias

- Work of Dovidio, Greenwald, Gaertner, Banaji, and others exploring non-conscious bias (which is called aversive or modern, as it reflects biases to which the person is consciously averse, and emerged from modern discourses on difference)

- Why aversive? Because it’s incongruent with consciously held beliefs, and thus ego-dystonic and often unavailable to scrutiny

- Disowned material for the 21st Century “mensch”

- Aversive bias is not simply a private affair
  - Substantial empirical data documenting negative effects of aversive bias on interactions with target group members (largely in context of race relations)
Embracing the Reality of Aversive Bias in Ourselves

Aversive bias supports and is supported by denial and undoing

- “I’m not biased, but…”
- Creates crazy-making emotional data for member of target group, leading to distance, disconnection, and distrust

Ironically, overtly racist individuals were rated as more trustworthy than those disavowing racism but holding implicit aversive bias
Assessing Your Own Aversive Bias

Take the Implicit Association Test

- [http://www.understandingprejudice.org/iat/](http://www.understandingprejudice.org/iat/)
- Empirically demonstrate the presence of non-conscious biases, including race, gender
- Challenging, eye-opening activity to engage in as it’s difficult to game the test
- Cultural competence includes a willingness to uncover and confront non-conscious bias in ourselves
Aversive Bias as a Form of Countertransference

When aversive bias is unacknowledged, how might it affect the psychotherapy process?

- Most similar to dynamics associated with shame
- Bias is shameful
  - Shame is defended against in ways problematic to genuine psychotherapeutic relating
  - When shame over bias touches other aspects of shame about self, then its power to distort the therapeutic encounter grows
- How is the clinician at risk for shame around aspects of self?
  - Disowned identities
  - Stigmatized identities
How Shame Affects Us Interpersonally

Donald Nathanson has proposed four common reactions:
- Distancing
- Blaming
- Fusion
- Self-hate

How might these reactions in a therapist affect treatment if their source (bias) is unacknowledged and/or unexamined?

How would therapist’s shame over aspects of identity interact with shame about bias—particularly if therapist is her/himself target of bias?
The “invisible backpack” (McIntosh, 1990) of privilege carried by members of dominant groups

- Unearned, cannot be taken off or gotten rid of
- Confers dominance and potential for oppression
- Denial of privilege frequently accompanies aversive bias, as both involve assumptions that playing fields are level (experience of dominant group made equivalent to human experience)

Privilege or disadvantage have specific effects on mental and physical health and well-being

- Because trauma is a particular form of disadvantage it can and does interact with other experiences of privilege or its absence
What is privilege?

Some examples…

- 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 your marriage is recognized wherever you travel.
- You can walk into any store wearing anything you want pretty well assured that you will not be followed or harassed.
- Your culture’s holidays are usually 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.
- If your day, week, or year is going badly, you need not ask of each negative episode or situation whether it has overtones of bias or whether you’re being paranoid.
Privilege creates

- Ease—your group is the norm and defines what is real
- Safety—your group is not targeted because of its characteristics
- Clarity—no need to decipher and unpack potentially ambiguous situations (and thus no awareness that such multiplicity of meanings chronically resides in target group members’ interpersonal milieu)
- All of which contribute to resilience in the face of psychosocial stressors—but can also become vulnerability when this very just world is challenged by events

Privilege unscrutinized can impair empathic relating by psychotherapists

- “S/he’s just over-reacting” (aka demonstrating Axis II characteristics)
Privilege and Cultural Competence

Acknowledging privilege with compassion towards self is one step toward cultural competence.

Necessary—managing affects of shame and guilt associated with awareness of privilege—component of emotional competence for practice.

Acknowledging privilege creates the possibility of alliance in psychotherapy.
Guilty Awareness as a Problematic Therapist Affect

Guilt over privilege frequently arises for dominant group people of good will, which is clinically problematic
- Resentment
- Boundary violations

Denial of realities of privilege can lead to disconnects between clients and therapists

Guilty awareness of privilege – equally problematic

Failures of accurate assessment and treatment can arise both from denial of privilege and guilt/shame over its existence

Particularly a challenge when ideal is cultural competence- how might this affect therapist functioning?
From Awareness of Privilege to Alliance: Anti-Domination

Having an anti-domination perspective on our work, means acknowledging:

- There are no bystanders to oppression
- One either cooperates with oppression and domination, actively or passively
- Or
- Works against oppression and domination though models of practice that are liberatory and examination of our own aversive bias
- This doesn’t require perfection- simply telling the truth about the power of a bystander to worsen oppressive realities

A particularly salient issue for trauma treatment, as much of trauma arises from the institutionalized and normalized dynamics of oppression.
Changes in Attitude

- Cultural competence ultimately requires learning about our own dynamics of internalized oppression and domination.
- We must be willing to make mistakes that we can learn from—be close enough to step on “toes.”
- Make human diversity core to our analysis of everything we do, rather than an add-on.
- This creates a stance, not only of therapeutic alliance, but of alliance around the larger social context in which trauma occurs, and may be ubiquitous.
Cultural Competence Deepens Empathic Relating

- Embracing and examining bias and privilege deepens the capacity for genuine empathy with our clients
- Research findings- target group clients perceived self-aware dominant group therapists as equal in empathy to therapists from own group
- Beyond the therapeutic alliance to alliances with meaning in the social/cultural/political contexts outside the treatment room, all of which inform (or distort) the nature of the therapy relationship

Clinical examples of how we might manifest this
- Talking about elephants in the room
- Attending to “when and where I enter”
- Acknowledging the intrusions of the real into the treatment room
An Alliance Stance allows us to...

- Evaluate client’s behaviors in context of their culture, rather against a dominant cultural “norm.”
- Knowing that all people in all cultures experience distress, and that it will manifest in forms that are culturally-informed (including the psychological distress of Euro American dominant culture folks)
- RE: Trauma, that PTSD, ASD, and other official trauma-related diagnoses will not contain culturally relevant ways of expressing post-trauma distress for many people; they are the “culture-bound” trauma syndromes of Western diagnosis.
When and where we enter...

When we enter an encounter with a client, we bring:

- Our personal history with this person’s various groups
- Our client’s personal history with our various groups
- Our groups’ collective histories with one another
- The history of mental health disciplines with the client’s group
- Our personal and collective trauma histories
- Being aware of what we represent allows us to be allied more effectively and more culturally competent
When and where we enter trauma

We enter the context of the trauma as well

- What the trauma represents to this person because of their social locations, personal, and cultural histories
- What the trauma represents to us because of our experiences and personal contexts
  - How does this trauma evoke our perpetrator, bystander, and target personal/cultural symbologies?

Being aware of how the trauma in question evokes any of these factors will improve the quality of our interventions and enhance cultural competence
Cultural Competence- Learning our Own Identities

Commonly, this is a buzz-word for being able to work professionally North American ethnic minorities of color.

Also, what is often meant is “doing therapy with everybody else except White people”

Not what is meant by this term from an alliance stance.
Everyone’s Diverse Here

There is a broad range of factors affecting diverse human experiences, cultural competence must apply to *all* of our work.

All of us have all of the dimensions of human diversity, whether we notice them or not (a privilege issue)

- If we belong to a dominant group, we may be unaware of how we are affected by these dimensions—privilege at work
- If we belong to a target/oppressed group, we may be only aware of how we are affected by these dimensions—the impact of the absence of privilege.
ADDRESSING- An Epistemology of Difference

- An emic epistemology of difference developed by Pamela Hays (2007) that
- Moves your thinking away from the “how to treat Bajorans” model
- Attends to the complexities of each person’s identities
- Attends to complexities of professional’s identities
  - Similarities to client/difference from client
  - Loyalties- to own culture, to system, to profession
What It Stands For

- **A**-Age related factors. Actual age and age cohort (generation)
- **DD**-Disability - visible and invisible disabilities, developmental (born with) and acquired
- **R**-Religion and spirituality
- **E**-Ethnic identity - “race”, phenotype, culture
ADDRESSING

S-Socioeconomic status- current and former (and family’s current and former)
S-Sexual orientation-gay, lesbian, bisexual, heterosexual
I-Indigenous heritage/colonization history
N-National identity- immigrants, refugees, temporary residents, undocumented persons, “1.5 gen” and adult children of same
Gender- biological sex, transgender, intersex
Assumptions of the ADDRESSING model

People do not have one identity, but rather live in intersectional identities

- Instead, there are multiple identities and social locations for each person
- Aspects of identity have different salience in different social contexts
- Observers will construct a person’s identity differently than persons construct it themselves
- Cultural competence includes knowing visible identities and not assuming that these are primary, or what they mean for the individual
Power and Empowerment as Culturally Competent Trauma Practice

Four locations of power, each one affected by trauma, each with meanings that will be derived in context of intersectionalities of identities.

Culturally competent trauma practice identifies strategies for empowering trauma survivors on these four variables, attending to how identities may have unacknowledged sources of power that have been disguised by shame and marginalization.

Culturally competent practice also identifies ways in which trauma has attacked or undermined previous or unrealized/invisible sources of strength.
Four Locations of Power: Somatic

The person is in contact with their body; the body is experienced as a safe place; accepted as it is rather than forced to be larger or smaller than it would be if adequately nourished. If its size or shape creates a lack of safety for a person, change of size or shape happens in the service of safety. There is connection with bodily desires for food, sexual pleasure, and rest; no intentional harm to one’s own body or that of others w/no routine violation of values. Does not require the ability to see, hear, walk, or talk, nor is a powerful body necessarily free of pain or illness, nor strong or physically fit. Body modifications reflect move toward power and congruence, and personal construction of self. There is compassion for one’s body.
Four Locations of Power: Intrapersonal/Intrapsychic

The powerful person knows what she or he thinks, thinks critically, can change her or his mind; flexible, not suggestible, yet open to input. Trusts intuition, able to find external data; knows feelings as they are felt, feelings a useful source of information re: here and now. absence of numbness, feelings about current, not past or possible futures. ability to experience powerful emotions, to contain affect, able to self-soothe in ways that are not harmful to self or others physically, psychosocially, or spiritually
A powerful person is more interpersonally effective than not, can have desired impacts on others more of the time than not; no illusions of control; forgives self and others, self-protective; differentiated, yet flexible. capable of forming relationships that work more of the time than not with other individuals, groups, and larger systems; able to create and sustain intimacy, to be close without loss of self or engulfment of other, and to be differentiated without being distant or detached; able to decide to end relationships when those become dangerous, toxic, or excessively problematic; able to remain and work out conflict when that’s a possibility; enter roles in life—parent, partner, worker—most often from a place of choice, intention, and desire, not accidentally, although they welcome serendipity and the opportunity to encounter the new
Four Locations of Power: Spiritual/Existential

The powerful person has systems of meaning-making that assist with responding to the existential challenges of life, and that have the potential to give sense of comfort and well-being; sense of own heritage and culture integrated into identity in ways that allow for better understanding of self; is aware of the social context and can engage with it rather than being controlled by it or unaware of its impact; has a raison d’etre, and is able to integrate that into important aspects of their daily lives; access to capacities for creativity, fantasy, play and joy; has a sense of reality.
Trauma as Component of Identity

How can trauma become associated with identity?

- Developmental trauma occurring at vulnerable points in early identity development
- Cultural histories of trauma
- Post-colonial trauma- particular kinds of cultural histories of all-inclusive overwhelming trauma
- Intergenerational trauma
Identities as Aspects of Trauma Response

- Experiences of target or dominant identities can affect trauma response and capacities in the face of trauma.

- Survivor’s relationship to stigmatized or marginalized identities may increase capacity to deal with trauma.

- But may also lead to inabilities to see injustice in own trauma experiences (the absence of a just world).
Trauma - Not Outside the Culturally Aware Range

- Sexual assault occurs in lives of 1/3 of women
- Sexual and physical abuse and/or neglect occur in lives of 1/3 of children
- Domestic violence occurs in lives of 1/3-1/2 of women in the US
- Discrimination and oppression are daily occurrences in the lives of many people in target groups
- War, genocide, colonization and/or recent family histories of these are common world-wide
Insidious Trauma (Root, 1990)

- Uses lives of target group members as basis for paradigm
- Daily experience is replete with sub-threshold traumatic stressors
- Includes “ordinary oppression”, daily life experiences of exclusion or low-level maltreatment
- Leads to increased vulnerability over time
Insidious Trauma

Requires continuous development of coping strategies which may constitute cultural resiliency factors

When major trauma or tipping point event occurs

- Previous coping strategies may rigidify, leading to worse outcomes, although may also promote resilience due to continuing need to develop coping strategies
The “Criterion A” of Insidious Trauma

What constitutes a traumatic stressor may be a sub-threshold event that represents threat to safety, or one thing triggering a chain of responses to many similar events.

- E.g., being called derogatory name may open cascade of associations
- Risk is of person being seen as “personality disordered” or “over-sensitive” rather than insidiously traumatized
“Isms” As Trauma

Within this definition, various forms of oppression—racism, classism, sexism, heterosexism, etc, can be seen as traumatic

- Directly, via hate crimes or discrimination
- Indirectly, via microaggressions and everyday oppression woven into fabric of society
- Via exposure to aversive racism, sexism, heterosexism, etc which is difficult to pinpoint, thus crazy-making
Loss of the Just World

Janoff-Bulman drew on social psychological constructs to define trauma as the shattering of expectations of the just world.

Three fundamental assumptions:

- The world is benevolent
- The world is meaningful
- The self is worthy

Members of dominant groups are at greatest risk for being traumatized in this way, as these fundamental assumptions underlie dominant status.
The Traumagenic Culture

- Culturally aware models of trauma treatment posit that one obstacle to healing is traumagenic culture.
- Individual change is impeded or difficult when societal and environmental changes do not also occur.
- Understanding the continuing effects of a traumagenic environment on the trauma recovery process will be a crucial component of culturally competent trauma treatment.
Not just human design…

- The DSM suggests that traumas of human origin are more traumatizing (due to assumptions of neglect or malice).

- Critical theory in psychology argues that the traumagenic potential of these and similar acts is heightened, not simply, as the DSM would suggest, because the trauma is of human design, but also because repeated prior life experiences have lent added stigmatizing meaning to becoming the victim of this type of trauma (e.g., rape).

- Institutionalized trauma (expectable outcomes of oppressive cultural norms) also creates a traumagenic environment.

- Traumagenic culture is upheld by myths about trauma which create secondary victimization for many trauma survivors.
Myths and Cultural Competence

Myths about trauma may affect a therapist’s ability to see trauma survivors clearly if

- Cultural norms for affect expression run counter to therapist’s view of “appropriate” response
- Cultural meanings for the trauma lend it “added value” that therapist cannot see clearly
Boundary Conditions for Culturally Competent Trauma Therapies

**Therapist functions as an ally**
- Not neutral
- Joins with client
- Tell the truth about how bad things were
- Recognizes client’s pre-existing and current competencies
  - Reframing symptoms as competent attempts to solve problem of being trauma exposed
  - Brain’s attempts to process the trauma
- Tells the truth about traumagenic context that can impede recovery
Empowerment also means

Seeing clients’ experiences as the intersection of identities with trauma experience and offering that vision to clients

- Does this event re-evoke personal or cultural historical trauma?
- Does it undermine personal or cultural coping strategies?

Taking collaborative approach to work, even if trauma survivor seems very disorganized

- “What is the most powerful thing, however small, that you can do right now?”
Identifying Resilience

Cultures with extensive histories of trauma frequently have cultural resilience and resistance strategies

- Humor
- Rituals
- Stories

Integrating cultural resilience into the recovery process as component of culturally competent treatment
Culturally Competent Trauma Treatment-One Size Does Not Fit All

Trauma has meaning created by
- Social locations
- Identities
- Cultural trauma histories

A biopsychosocial/spiritual-existential phenomenon
- Identities and social locations can cause trauma to attach at any point on this matrix
Ultimately

Trauma recovery cannot take place in the absence of cultural competence by the clinician

- Trauma never happens in a cultural vacuum
  - Even a car accident has meaning in terms of the social locations and intersectionalities of identities of the parties involved
- Adding cultural competence and awareness to the mix of therapy can increase empowerment of clients and potentials for healing
Implications of 21st Century Model for Practice

Our responsibilities—awareness of implicit bias and privilege, capacity to own our bias and contain our shame

Increasing our ignorance as a stance for deepening our wisdom

Functioning as allies

- Being part of the solution, not only part of the problem
- Being aware of how our personal and cultural heritages of trauma, and the effects of these on our intersectionalities of identities, affect how we are as psychotherapists with trauma survivors
Additional Reading


And still more reading


