

CHAPTER SAMPLER

# Counseling and Psychotherapy with People of Color:

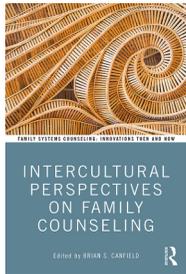
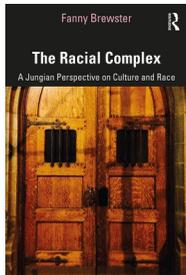
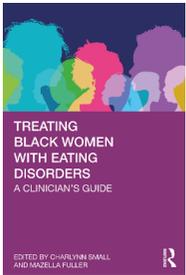
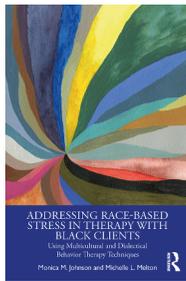
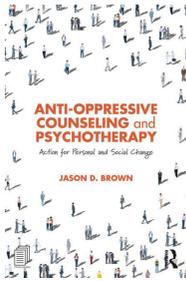
## A Chapter Sampler for Mental Health Professionals



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# 1

## OPPRESSION AND MENTAL HEALTH

This chapter introduces the topic of global inequality and presents some evidence of its existence with social, economic and political examples across Canada and the United States. A colonial analysis of historical relations between original Indigenous peoples and European immigrants to North America explores the beginnings of oppression. The arrival and establishment of settler societies represented the views of white, European, Christian males. This analysis illustrates concepts of diversity, privilege and disadvantage. It is followed by an introduction to psychological studies of stigma, prejudice and micro-aggressions.

Why is social inequality relevant to professional counseling and psychotherapy?

- We live in an unequal society. Each of us is born within a hierarchy. Position in the hierarchy is advantageous to some and disadvantageous to others. Social positions have a substantial lifelong effect on individuals.
- Inequality produces oppression. Problems exist at both the structural level and the personal level as well as in between. Social problems manifest as personal problems (e.g. gender differences in employment position and income). Personal problems manifest as social problems (e.g. employment and income opportunities and outcomes differ by gender).
- Oppression is reflection of a group's and individual's status relative to others. It puts one member of a particular group at a distinct advantage over members of another group. Differences exist in power, influence and control. These differences manifest as unequal opportunities and unequal outcomes.
- Forces of oppression are structural (e.g. market, globalization, colonization) and reflected in policies and practices between nations. These forces are national (e.g. government policy, ownership, participation) and reflected in

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policies and practices within nations. The forces are also local (e.g. location, services, capital) and reflected in policies and practices within communities. These forces are personal (e.g. esteem, agency, identity) and reflected in personal meaning.

- Counseling and psychotherapy focus on individuals. The practices operate from the basis that problems exist or are accessible within the individual. Such problems manifest as imbalances, excesses or deficiencies of known properties of the mind.
- An anti-oppressive (AO) perspective broadens the view of individuals to the forces that exist outside and recognizes the profession and the professional positioned within systems of oppression.
- From an AO perspective, mental health is personally and structurally determined. Personal problems manifest as imbalances, excesses or deficiencies of known aspects of a community or society.
- AO Counseling and Psychotherapy (AOCP) locates a portion of the responsibility on context that can be influenced by a collective. AOCP views interpersonal circumstances and the social context as legitimate targets for change. The professional and client engage in both internal and external change to address the problem.

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## Inequality

In 2017, Oxfam reported that “8 men owned the same wealth as the poorest half of the world”, and Credit Suisse reported that those in the top 1% of global wealth together owned more than the rest of the globe (Anand & Segal, 2017). Today, the United States holds 33% of global wealth, while Canada holds 3%. There is clear evidence of global economic inequality. The country one is born in and the income distribution of that country are highly predictive (Milanovic, 2015). However, differences within nations are widening to a greater extent than the gaps between nations (Milanovic, 2016).

Within nations, an index known as the **Gini coefficient** reflects the income distribution. It is one of the most widely used measures of inequality. On this measure, a score of 0 represents maximum equality and 100 represents maximum inequality. In Canada, the Gini coefficient for 2010–2015 (United Nations, 2016) was 33.7 and the US was 41.1 (Bogliacino & Maestri, 2016). According to the World Bank (2015), the nation with the highest Gini, of 176 ranked nations, was South Africa at 63.4 and the nation with the lowest Gini was Ukraine at 25.5. Internationally, Canada ranked 68th and the United States 117th, reflecting a major gap between their least and most wealthy citizens.

The relationship between inequality and social problems is linear and positive, such that the greater the inequality, the greater the indices of violent crime, obesity, mental illness, imprisonment and teen births (Wilkinson & Pickett, 2010). With greater equality, there is a greater sense of cohesion, trust, cooperation and social stress (Wilkinson & Pickett, 2017).

The connections between low population and personal health status are evident in developmental trajectories (Pless, Hodge, & Evans, 2017), as well as within regional and local communities with higher concentrations of risk factors (Fazel, Geddes, & Kushel, 2014). There is ample evidence that policies associated with improved access to education, health care, housing, employment and other services within disadvantaged or underserved areas and populations have a positive leveling effect (Allen, Balfour, Bell, & Marmot, 2014). In the sections that follow, connections between economic, social and political inequality are described.

## Economic

The *Vertical Mosaic* (Porter, 1965) was coined to reflect the prominent layers of social arrangement. While the book was written 50 years ago, the concept remains and is the subject of discussion and debate. Recently (Porter, 2015), scholars have

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written about the vertical mosaic in relation to gender and race inequality, citizenship and social justice as well as social class and power. To illustrate, poverty lines in Canada and the United States reflect significant differences between individuals and families along the continuum from least to most wealth.

**Low Income Cut Offs (LICO)** in Canada are relative measures of poverty that identify the threshold at which families are spending more than 20% of their income than the average on food, clothing and shelter. They are calculated by number of people in a family and by community size. According to the LICO measure, there are several demographic groups that are overrepresented and therefore at risk for poverty (Canada, 2010; Tweddle, Battle, & Torjman, 2015):

### 1. Children

- 9.1% nationally
- 23.4% of lone parent
- 39.3% in recent immigrant families

### 2. Women

- 9.9% nationally
- 29% of all unattached
- earn 71.4% of what full-time men earn on average

### 3. Unattached adults

- 58.1% of 18–24 years
- 31.6% of 45–54 years
- 39.3% of 55–64 years

### 4. Indigenous peoples

- 42.8% of all unattached
- 25% of adults in urban families
- 27.5% under 15 with family
- 63% for 16–24 years

### 5. People with disabilities

- lower average income, \$28,503 vs. \$37,309 (national average)
- 43.9% 15–64 NOT in labor force vs. 19.8% (national average)

### 6. Recent immigrants

- 32.6% of families
- 58.3% of unattached
- 54.7% of refugees

The **US poverty line** is based on pre-tax income and proportion spent on cost of a minimum diet, adjusted annually for inflation and reported based on family size, composition and age. The US (Department of Health and Human Services, 2015) poverty rate is quite restrictive but still includes 14.5% (45.3 million people).

- The child poverty rate was 19.9%: for African-American children 36.9%, Hispanic 30.4% and white children 10.7%.
- Nearly half of all female-headed lone-parent families (45.8%) lived in poverty.
- Working age individuals with and without disabilities had discrepant poverty rates of 28.4% vs. 12.4%.
- Women were 35% more likely to live in poverty than men.
- 19% of immigrants vs. 13.5% non-immigrants live in poverty.
- Among 18–44-year-olds, 15.3% of males and 21.1% of females live in poverty, with rates increasing among those who identify as gay or lesbian, at 20.5% and 22.7%, higher for individuals who identify as bisexual, at 25.9 and 29.4%, compared to 20.1% and 21.5% for those who do not identify as a member of the LGBTQ2+ community.
- About 40% of homeless youth identify as LGBTQ2+ (Macartney, Bishaw, & Fontenot, 2013).
- In the UK, poverty rates for Muslims are 50%, relative to those who are Jewish (13%), Sikh (27%), Hindu (22%), Anglican (14%) or Catholic (19%), with 18% as the national average (Heath & Li, 2015).

## **Social**

Social indices of inequality are reflected in victimization statistics. In Canada (Statistics Canada, 2017), hate crimes occurred most frequently based on race or ethnicity targeting—in order of occurrence: Black, East Asian and South Asian individuals. Religion was the second most frequent target of hate crimes, with individuals who were Jewish or Muslim most frequently the targets. Sexual orientation was the third most frequent target of hate crime. In the United States, hate crimes reported to police, in order of frequency (Federal Bureau of Investigations, 2016), occurred on the basis of race/ethnicity, religion, sexual orientation, gender identity and, finally, disability.

In another illustration of social inequality, approximately 70% of incidents of abuse of woman go unreported, and of those that are, one-third are sexual assaults and beatings. Women with disabilities in Canada are 1.4× more likely than women without a disability to experience abuse. In 2013 (US), the rate of serious violent victimization for persons with disabilities (14 per 1,000) was more than three times higher than the age-adjusted rate for persons without disabilities (4 per 1,000).

## ***Political***

Political indices of inequality are reflected in voting behavior and representation of elected officials. In the United States, voting rates vary by ethnicity. In the last presidential election (2016), 65.3% of eligible white voters voted, 59.6% of Black voters and 47.6% of Hispanic voters (US Census, 2017). Canada is closer to the goal of building a diverse parliament that represents its population. A cabinet ratio of 48.3% women, 16.1% visible minorities and 6.5% Indigenous comes close to matching a Canadian population that was 50.9% women, 22.3% visible minorities and 4.9% Indigenous (Wherry, 2015).

## **Positions Against Social Inequality**

An argument upon which this text is based is that unequal opportunities and outcomes diminish population and personal mental health. This context creates conditions in which mental health problems are more likely to be triggered, exacerbated and maintained. Three additional arguments against inequality are reflected in the following moral, economic and political positions.

A **moral argument against inequality** is that it is unfair and therefore unjust (Marquez, 2018). This is a value position that begins with the idea that no life is worth more than any other life. However, unequal life chances, unequal opportunities and unequal outcomes exist and must be addressed.

An **economic argument against inequality** is that few have the means to purchase enough to keep the economy functioning. According to the OECD (2014), economic growth decreases when inequality increases (Dabla-Norris, Kochhar, Suphaphiphat, Ricka, & Tsounta, 2015). The poorest 40% of the population are most affected when inequality rises. Greater inequality leads to less education by those at the lower end of the distribution, which diminishes economic potential.

A **political argument against inequality** is that it reduces political interest and involvement in elections. The most well off do not have the voting numbers to continue to lead democratic systems. However, those who are not represented in political office and have no candidates may choose not to vote.

## **Legacies of the Settler Societies**

Social inequality in the United States and Canada is reflected in colonial history following the arrival of Europeans and creation of settler societies. At the time of contact, Europeans arrived within nations that were self-sufficient and connected to the land. It has been noted that

archaeological evidence is mounting to the point where it can now be argued with growing conviction, if not absolute proof, that the pre-Columbian

Americas were inhabited in large part to the carrying capacities of the land for the ways of life that were being followed and the types of food preferred.  
(Dickason, 1992, pp. 26–27)

England and France were the primary colonizers in North America during the 1600s. This European expansion led to white **settler societies** in what became Canada and the United States.

Colonial views included a belief that the existing inhabitants “had no real history” and that the land was “empty of mankind and its works”. In this view, the people of the Americas “lived in an eternal, unhistorical state” (Mann, 2005, p. 9). Land ownership and a lucrative fishery and fur trade, as well as timber, tobacco, wheat and potash, were imposed for the benefit of the colonies and colonists (Rosenbloom, 2018). Although assimilation efforts were made in multiple ways, there has been consistent effort by Indigenous peoples to partner with and, eventually, resist colonial influences.

There was some diversity among the European settlers. For example, the need for cheap labor opened immigration to the colonies, but at a lower status than the proletariat in the colonies. Following British defeat of the French in 1760, French subordination began to emerge. Those “at the helm of the colonial, then dominion states, and those shaping civil society drew from imperial and home-grown philosophies about the appropriate character, physical appearance, roles and behavior of settler women and men” (Stasiukis & Jhappan, 1995, p. 97). These ideas were evident in colonial beliefs of racial and ethnic superiority, rigid gender and sexual roles, and the need for a young, Christian workforce.

### ***Race and Ethnicity***

In race and ethnicity, “settler and post-settler society citizenship is best conceptualized and described by examining the linked processes of what is called the aboriginalization (of indigenous minorities), the ethnification (of immigrant minorities) and the indigenization (of settler majorities)” (Pearson, 2002). Loyalists from the United States included European, Indigenous and Black soldiers who, in return for their freedom, supported the British. Nova Scotia was the first place in Canada where the experiences of racism and segregation were documented. The underground railroad provided a means from the US to Canada, where individuals would be inexpensive labor, but “free”. Over time, communities of those who fled the United States developed. Newcomers in the late nineteenth and early twentieth centuries arrived from Europe, China, Japan and India. The minister and politician JS Woodsworth, in his book *Strangers Within Our Gates*, described these immigrants as “non-assailable elements that are clearly detrimental to our highest national development, and vigorously excluded” (1909, p. 279).

### *Gender and Sexuality*

Men “founded” North America. They held top positions in production and decision-making. The Company of One Hundred Associates (New France) claimed all land and took over all but fishing industries. To do this, they needed management and skilled labor, who were male. “Women were represented as little more than breeders to reproduce the nation, the empire and the future of the race” (Stasiukis & Jhappan, 1995, p. 99). For example, the “Daughters of the King” were women from France who came to marry settlers. **Nuclear families** formed the basis of settler societies. Laws and customs regulated male–female sex and marriage to shape these units with clearly defined gender roles and purposes (Wells, 2015). Individuals without family membership could be relegated to the margins of a settler society (Phillips, 2009).

### *Employment and Ability*

The **British “poor laws”** of the late 1500s distinguished between those who were worthy and unworthy of assistance (Roberts, 2016). In the colonies, this responsibility was transferred, and those who could not work were left to live in the margins, while any who could work were put to work. The Charity Aid Act assigned responsibility for the poor to charity and churches. Ability determined whether one was capable of working or not. Those who were capable of working were “able”, and those who were not were “disabled” (Martel, 2016). While they were provided with some assistance, their value to the colony was limited.

The person naturally disabled, either in wit or member, as an idiot, lunatic, blind, lame etc., not being able to work . . . all these . . . are to be provided for by the overseers of necessary relief and are to have allowances . . . according to . . . their maladies and needs.

*(Ward & Flynn, 1994, p. 30)*

### *Age*

At the time, depending on their parents’ wealth, children were either protected and educated or became part of the workforce (McCusker & Menard, 2014). Workers that became too old or experienced injury became liabilities and were replaced. For women, who needed only be 13 years old to legally marry in England in 1875, their roles as child-bearers and parents began early. There were no protections for children from the workforce or regarding their treatment until the Society for Prevention of Cruelty to Animals was created in 1824 and in 1891 the Society for Prevention of Cruelty to Children (Flegel, 2016).

## **Religion**

Missionaries were sent by the colonizers to convert the Indigenous peoples (Fisher, 2018). This effort brought new hierarchies. Beliefs in God and church extended into rites of passage and Christian ceremonies such as marriage, baptism and burial (Woolford, 2013). Interestingly, it was the submissive role of women within the church that met the greatest resistance among Indigenous women (Smith, 2015). Values of self-reliance and hard work were viewed positively and as a means to economic reward (Bayley, 2008).

## **Colonialism Today**

The legacies of the settler societies are evident today. A fundamental driver of colonial interest was and continues to be control. Efforts to control movement of Indigenous peoples through the reserve system and forced relocations; spirituality through the outlawing of traditional practices; families and parenting through adoptions and residential schools; and governance through the Indian Agents were applied (Smylie & Firestone, 2016). Other methods have been used and are still practiced today (Moane, 2014), including violence (via law enforcement), political exclusion (via scrutiny of voters), economic means (via ownership and taxes), sexuality (via motherhood, marriage, birth control), education (via access, content omissions, media control) and ethnic fragmenting (e.g. competition, tokenism and immigration). Stages of colonization in the United States and Canada include 1) denial and withdrawal, 2) destruction and eradication, 3) denigration, belittlement and insults, 4) composure under the surface, accommodate and tokenize, 5) transformation and exploitation (Laenui, 2000, p. 1).

## **Social Privilege**

The notion of inequality confers both privilege and disadvantage. Many of us, as students and beneficiaries of higher education, possess some level of privilege. Many of us also experience levels of disadvantage. It is important to recognize the complexity of these ideas and that each person as well as each group has experience with both. The degree to which one is more or less advantaged or disadvantaged is of limited value in this discussion because accumulations and intersections of identity and social group membership exist. What is important is to make the concept of privilege explicit.

What is privilege? It has been defined as four qualities (Lucal, 1996; Robinson & Walker, 1999), including: 1) special advantage that is not universal, 2) something bestowed and not earned, 3) something related to a preferred status and 4) something that benefits only those who possess it and no others. An adapted version of a “check your privilege” (Holm, Gorosh, Brady, & White-Perkins, 2017)

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activity follows. It is important as a learning opportunity to reflect on your own and others' experiences and to recognize the effects each of us has on others.

### *Privilege and Responsibility Exercise* (Holm et al., 2017)

\*Modified for therapists

- If I want to move, I can rent or buy in an area I can afford and want to live.

Race/ethnicity, religion, SES, sexual orientation

- If I ask to talk to the person in charge, I will be facing a person similar to me.

Race/ethnicity, gender, sexual orientation

- If I walk towards a security checkpoint in the airport, I can feel that I will not be looked upon as suspect.

Race/ethnicity, religion

- If I walk into a restaurant I can expect to be treated with dignity and respect.

Race/ethnicity, physical/mental ability, SES, sexual orientation

- When I enter my workplace, it is a familiar layout and furnishings to what I'm used to.

Race/ethnicity, SES

- I have no trouble getting to and from work and in and out of my office.

Physical/mental ability, SES

- I have never seen vandalism or had someone say something to me in public that was offensive.

Race/ethnicity, physical/mental ability, SES, sexual orientation

- If I walk through a parking garage at night, I don't have to feel vulnerable.

Gender, age

- I can buy posters, postcards, picture books, greeting cards, dolls, toys and magazines featuring people who look like me.

Race/ethnicity

- People like me are featured in history books that elementary school children read.

Race/ethnicity, physical/mental ability, SES, sexual orientation

- I feel confident that my clients feel that I am qualified upon first impression.

Race/ethnicity, age, gender

- My employer gives days off for the holidays that are most important to me.

Religion, ethnicity

- I can work whenever needed and know that my children will be cared for.

Gender, SES

- I can speak in a roomful of professionals and feel that I am heard.

Age, race/ethnicity, gender

- My age adds to my credibility.

Age

- My body stature is consistent with an image of success.

Gender, ethnicity/race

- I can bring my partner to a professional or community gathering without thinking about it.

Sexual orientation

- I can feel confident that if a family member requires counseling they would be treated with dignity and respect even if they don't mention my profession.

Race/ethnicity, physical/mental ability, SES, sexual orientation

- I have no medical conditions or cultural/religious dietary restrictions that require special arrangements or that makes others see me as different.

Religion, physical/mental ability

## Oppression

Oppression is the result of unchecked “entitlement, sanction, power, immunity and advantage or right granted or conferred by the dominant group to a person or group solely by birthright membership or prescribed identities” (Black & Stone, 2005, p. 245). It happens through force or deprivation, and at primary (e.g. personal), secondary (e.g. beneficiaries of oppression) or tertiary (e.g. oppressed group seeks approval from dominant by victimizing members of own group) levels (Hanna, Talley, & Guindon, 2000). Types of oppression include **exploitation** (e.g. using the efforts of some for another group's benefit), **marginalization** (e.g. pushing a group to the margins, as not valued enough to exploit), **powerlessness** (e.g. the haves and the have nots), **cultural imperialism** (e.g. making the culture of the ruling class the “norm”) and **violence** (e.g. fear of themselves or their property being attacked) (Romney, Tatum, & Jones, 1992).

Power differences are integral to the creation and experience of oppression. The “matrix of domination”, for instance, includes four domains of power: structural, disciplinary, hegemonic and interpersonal (Mosedale, 2003). **Structural power** is the power of the institutions and laws that are prominent within a society. **Disciplinary power** is the influence held by those who act in roles created by the institutions and laws of a society. **Hegemonic power** refers to the dominance of a set of ideas or views over all others within a society. While structural, disciplinary and hegemonic power operate at a high level of influence and deal with oppression via governance and education, justice and social services as well as health systems, **interpersonal power** is what occurs between individuals within a society.

Oppression can be viewed as the “causes of the causes” of ill health, including systemic forces such as globalization, imperialism and neoliberalism. Oppression

is associated with diminished health outcomes. At the level of individual experience, these forces intersect and lead to psychological distress (Pascoe & Richman, 2009; Williams & Mohammed, 2009). For example, internal and external sexism and racism among African-American women is associated with psychological distress (Szymanski & Stewart, 2010). In another example, stressors including heterosexist events, racist events, heterosexism in communities of color, racism in sexual minority communities, race-related dating and relationship problems, internalized heterosexism or homophobia, ‘outness’ to family and ‘outness’ to the world accounted for one-third of the distress experienced by LGBTQ Asian Americans (Ray, 2016).

### **Stigma and Prejudice**

Stigma and prejudice are “societal-level conditions, cultural norms, and institutional policies that constrain . . . opportunities, resources, and well-being” (Hatzenbuehler & Link, 2014, p. 2). They produce similarly negative psychological effects but for different reasons. Stigma concerns conditions that are not commonly experienced, such as HIV or Fetal Alcohol Spectrum Disorder, while prejudice is based on more ‘usual’ issues like race, gender or class. Two psychological consequences of stigma are: 1) anticipation of reaction to self (e.g. vigilance and anxiety) and 2) internalization of stigma—directing negative attitudes from society toward self, which is also called “appropriated” stigma. Prejudice occurs as a result of interpersonal treatments of individuals who are marginalized by another who is not marginalized. There are multiple studies of the negative psychological effects (e.g. Bostwick, Boyd, Hughes, West, & McCabe, 2014; Velez, Campos, & Moradi, 2015; Calabrese, Meyer, Overstreet, Haile, & Hansen, 2016).

In an important study linking social policy to mental health (Hatzenbuehler, 2014), it was found that diagnosed psychiatric disorders in the LGBTQ community were higher in states with no protection versus those with legal marriage, even after perceived discrimination was controlled for. In the state of Massachusetts before and after same-sex marriage was legalized in 2003, there was: 1) a reduction in depression and hypertension for gay and bisexual men from 12 months before to 12 months after and 2) less health care demand as well as 3) health care cost savings. A comparison on prejudicial attitudes showed higher mortality in high stigma communities, with a 12-year difference between these and the lowest stigma communities. Among LGBTQ youth in neighborhoods with higher rates of hate crimes, there were higher rates of suicide ideation and attempts than among LGBTQ youth in lower hate crime neighborhoods (Hatzenbuehler, 2014).

Stigma and prejudice affect mental health in five ways. First, the effect may manifest as an activation of stress processes among those discriminated against by others in encounters, leading to mistreatment in jobs, education and health care. Second, structural problems with access, such as denial of health services or benefits, affect mental health. Third, unconscious forms of prejudice occur without

awareness of the one acting in a discriminatory manner but with the notice of the individual being discriminated against. Fourth, there may be internalized prejudice and stigma by those who are discriminated against. Fifth, mental health may be affected due to vigilance by individuals fearing discrimination, leading to stress and compromised social interactions (Stuber, Meyer, & Link, 2008).

## Micro-Aggressions

Sue (2010) distinguishes between modern and aversive racism. Modern racism is right wing, conservatives who talk about traditional values or family values. Aversive racism is what liberals practice when they are conflicted between values of equality but harbor negative feelings. Aversive racism is not conscious. It is difficult to identify, yet very harmful. It is also not apparent to those holding the beliefs so difficult to address by others and self. One way that aversive racism manifests is through micro-aggressions. Indeed, the personal, structural and relational are all interconnected; “inasmuch as a person who is constantly exposed to hearing language which stigmatizes him/her is distressed by that experience, this is as real a form of oppression as structural discrimination” (Hopton, 1997).

As defined by Sue et al. (2007, p. 273).

Microaggressions are the everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, which communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership. In many cases, these hidden messages may invalidate the group identity or experiential reality of target persons, demean them on a personal or group level, communicate they are lesser human beings, suggest they do not belong with the majority group, threaten and intimidate, or relegate them to inferior status and treatment.

Three forms of micro-aggressions can be identified (Sue, 2010): **micro-assault**, **microinsult** and **microinvalidation**. Micro-assault is explicit denigration that is deliberate and conscious, held and expressed when the person feels safe to do so or is just overwhelmed. Microinsult is subtler and not recognized by the person doing it but is apparent to the other, such as talking over someone or diverting one’s attention when they speak. Microinvalidation is communication that invalidates another’s experience.

The examples below focus on color blindness and denial of individual racism (Sue et al., 2007, p. 276).

*Color blindness: Statements that indicate that a White person does not want to acknowledge race. For example, “When I look at you, I don’t see color.” In effect, this is denying a person of color’s racial/ethnic experiences.*

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*Denial of individual racism: A statement made when Whites deny their racial biases. "As a woman, I know what you go through as a racial minority." The meaning of this is that your racial oppression is no different than my gender oppression. I can't be a racist. I'm like you.*

### Conclusion

Social inequality is a major cause of compromised mental health and wellness. Each individual is located within groups of differences that have a legacy in the settler societies of North America. These groupings, including sex and gender, race and ethnicity, age, religion, class and ability, refer to characteristics that are organized hierarchically. This social hierarchy is largely a European import that has produced categories of difference within which each of us is embedded. AOCPP is situated in this unequal environment, and its practitioners are mindful of the ways that social categories operate in their own professional and personal lives, the lives of their clients and on their interactions. This awareness creates understanding of contextual and interpersonal forces that affect mental health and the necessity of challenging oppression at different levels.

### Web Links

Joe Gone—Historical Trauma, Therapy Culture, and the Indigenous Boarding School Legacy

<https://vimeo.com/104030869>

Canada Continues to Be a Settler Society

<http://newcanadianmedia.ca/item/5199-canada-continues-to-be-a-settler-society>

Psychotherapy and Traditional Intervention Strategies: Being an Effective Helper

[www.ccpa-accp.ca/wp-content/uploads/2015/06/2014conf.PeterMenzies.pdf](http://www.ccpa-accp.ca/wp-content/uploads/2015/06/2014conf.PeterMenzies.pdf)

Strategies for Responding to Colonization and Oppression

[www.ohtn.on.ca/strategies-for-responding-to-colonization-and-oppression/](http://www.ohtn.on.ca/strategies-for-responding-to-colonization-and-oppression/)

Temptations of Power and Certainty

[www.kennethstewart.com/temptations-of-power-and-certainty.html](http://www.kennethstewart.com/temptations-of-power-and-certainty.html)

### Key Terms

Gini coefficient 7

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## Discussion Questions

1. In what ways have you and your family experienced social disadvantage and advantage? Do you believe that these have changed over time or across generations? Why or why not?
2. Take a walk through your community or neighborhood and a commercial or retail establishment. In what ways is diversity reflected? What is absent? What are the messages about who is “in” and “out”?
3. In what ways is being a professional a privileged position? How could this have an effect on clients who already face significant social disadvantage? How could you counteract this?

# Assessment and Diagnosis of Race-Based Stress

## ■ Introduction

In its simplest form, assessment is used as a basis for identifying problems, planning interventions, evaluating and/or diagnosing, and informing clients and stakeholders. The practice of assessment entails the collection of information in order to identify, evaluate, and address the concerns of clients. It is noteworthy that providers attend to client–provider communication, notions of stigma, and cultural mistrust to minimize the negative affect such phenomenon can have on clinical judgment, the therapeutic relationship, and the types of diagnostic inferences made during the clinical interview. The integration of ethical, multiculturally competent assessment, formulation, and diagnosis necessitates the consideration of subjective evaluation of cultural, social, and environmental context. Such consideration requires the evaluator to not only utilize means/methods to measure symptoms or conditions, but the influences and effects of disease and health interventions on quality of life as well.

Effective assessment of an individual's perception of their life, within the context of the culture and value systems in which they live, is integral for accurate intervention. Inattentiveness to cultural considerations in the interview may engender over-identification or under-identification of psychiatric disorders across cultural groups or inadvertently promote stereotypes that impair clinical

decision making (Alcantara & Gone, 2014). In the absence of more substantive sociocultural contextualization, clinicians may commit a false overgeneralization or impose Western psychiatric categories on other cultural groups without evidence or their cross-cultural validity.

Assessment instruments, structured, and semi-structured interview measures have been developed to address unintentional biases in the interview/assessment process. However, an instrument is only as “woke” as its developer. Through the decades of advocacy on the importance of diversity and inclusion in the provision of mental health services, practitioners and researchers have made gains in developing interview process and measures that assist in assessing a person’s quality of life and overall well-being. The *Diagnostic and Statistical Manual of Mental Disorders*’ (5th ed., American Psychiatric Association, 2013a) Cultural Formulation Interview (CFI) is one such example. However, this structured interview, while comprehensive, does not directly address the experience and impact of racial discrimination on a person’s well-being. This is a significant limitation that may perpetuate institutionalized barriers to effective treatment for persons of color.

In the role of assessor or evaluator, you will do well to have an assessment practice that is sensitive to the nuances of the realities of human difference. Your capacity to understand a theory of difference can allow for more accurate identification of problems, diagnoses, and plan interventions. Consequently, you will be better able to empower clients because you are using cultural and personal factors relevant to their sense of self in the therapy work. In this chapter, we will present tools for effective assessment of race-based stress. We will also provide a model of conceptualizing mental health symptomology, quality of life concerns, and diagnostic considerations.

## ■ Exploring Psychometrics of the Self

Considerations of multiculturally competent assessment typically focus on determining the appropriate measures or methods that are generalizable to minoritized populations, language competencies

of clients, and the appropriateness of diagnostic categories for cultural minority groups. It is also critical that practitioners pursue the understanding of the “psychometrics of the self.” This concept, coined by Cimbara and Krishnamurthy (2018), implores providers to reflect on their implicit perceptions, reactions, biases, beliefs, values, assumptions, and areas of ignorance (blind spots that are tied to one’s sense of self as an individual). Consequently, this examination brings better awareness of the impact our identities have on clinical work and allows for a more accurate assumption of who the client actually is. Such examination may allow for more creative responses and interventions for our clients by bringing into focus the ways in which the strengths and resiliencies inherent in identities inform, transform, and can also be distorted by distress and dysfunction (Brown, n.d.). Mental health providers, then, have better awareness of what they represent to their clients and what those clients represent to them. Inaccurate evaluations of self and fluctuations in the presentation of self to the client (e.g. either from session to session or from client to client), increase the likelihood that providers will impose a Western-based, medically oriented perspective on clients, whereby missing the nuances afforded by the client’s subjective cultural realities.

As an example, let’s take a look at a dialogue between Dr. Francis, a White cis-male therapist, and James, a Black cis-male client.

James: It’s just always on my mind whenever I’m in my car. I think it has to do in part with my being so involved with educating the young black men on what to do if they are stopped by the police. I feel so on edge. It wears on me all the time.

Dr. Francis: I can hear it in your voice and see it in your body language. You seem weary just talking about this. I am wondering how this experience is also affecting your home and work life.

James: I don’t really talk about it at home. They already know what it’s like to drive while Black. At work [chuckles], we steer clear of any conversation about race. It just gets too intense and I’m always the one trying to make them

see sense! They want to make it all about how “it wouldn’t have happened if they just would have complied,” and crap like that. But when I call out their White privilege, they get mad and make it seem like I’m racist.

Dr. Francis: I can understand that being upsetting. But let’s get back to understanding how you’re feeling on edge all the time. Can you describe more of the symptoms?

James: I mean, I just feel tense like I can’t relax. I have to constantly be aware of where I am and how others are reacting to me being there.

Dr. Francis: Ok. Ok. Now we’re getting somewhere. When you start feeling this tension, this hyperawareness, what goes through your mind? What thoughts come up?

James: I dunno. I just feel uneasy, like they think I’m a threat because I’m a tall Black man.

Dr. Francis: Ok. So, what else? If people think you are a threat, what does that mean to you?

James: ... It means I’m not safe because they’re going to make an issue about me just existing in the space. If I move too quick, or speak too loud, or look too long ... it’s always a problem to them.

Dr. Francis: I see. It makes sense to me then, why you would feel uneasy. It’s what you’re thinking! What you’re saying to yourself, about yourself. It seems to me that you are using a sort of thinking filter here that distorts reality. And, in doing so, you’re the one sitting in the angst and distress. It’s not the environment or the people in your immediate surroundings. It’s how you’re thinking about it and them. And, my best guess is, this sort of thinking habit you have is developed from a skewed sense of self. So, that’s the bad news. The good news, is now that we’ve identified it, we can change it!

The exchange between Dr. Francis and James exemplifies a professional attempting to apply a therapy modality to a client’s experience. Though well meaning, and perhaps appropriately applying the intervention, Dr. Francis’ assessment of the concern

excluded James's subjective cultural reality. This exchange also raises questions about Dr. Francis' awareness of himself as a cultural being, his privileges as a White cis-male, and his implicit perceptions, reactions, biases, and assumptions. It may be assumed that Dr. Francis, in continuing his treatment planning, may be imposing his world view and perspective on James under the guise of psychological science. If so, Dr. Francis would be violating ethical standards and best practices in standards of care.

### Practices for Exploring the Psychometrics of the Self

The following tasks, activities, and exercises have been informed by the literature (Baca & Smith, 2018; Hook, Davis, Owen, & DeBlaere, 2017; Pope, Sonne, Greene, & Vasquez, 2006) to include a developmental, multiculturally oriented perspective. The purpose of these exercises is to encourage a mindful awareness of the complex, and at times messy, intrapersonal and interpersonal engagements that exists in real life, how we respond to them, and the need for openness, honesty, courage, and constant questioning. However, the practices presented are not exhaustive. It is also encouraged that providers actively engage in supervision, therapy, and consultation to become more accurate self-evaluators.

#### **Questions for Self-Reflection**

- Have you had experience trusting those who are very different from you? How has this impacted your life, personally and professionally?
- Generally, are you too hard on yourself? Too easy on yourself (e.g., typically finding ways to avoid feedback and self-reflection)?
- Do you get "tired" or "bored" with some people and not others?
- With whom do you become avoidant?

- Do you “tolerate” some people?
- Do you find yourself “biting your tongue” with certain people?
- When have you found yourself using a tone that is patronizing or infantilizing with people?
- Whose strengths do you celebrate?
- With whom do you share your warmth and affection?
- When do you find yourself saying things that are harsh, sarcastic, and cynical?
- During your professional training/practice, what were some of the negative stories you were told/taught (implicitly or explicitly) about various cultural groups?
- Have you ever felt jealous of a client?
- Have you ever regretted bringing up a topic, disclosed something, or taken a stance? If so, what was it, and why did you regret it?
- During your professional training/practice, in what ways, if any, could openness, directness, and honesty be a liability? What, if anything, could not be questioned?
- Have you ever blushed or become embarrassed when you were in a therapy or evaluation with a client? Why?
- During your professional training/practice, what were some negative past experiences with individuals from different cultural groups?
- What are some of your own internalized, personal struggles with your cultural identity(ies) or cultural beliefs, values, and attitudes?
- What, if anything, could a client say or do to you that would be uncomfortable or embarrassing to you during the session?
- What, if anything, could a client say or do to you that you’d be uncomfortable or embarrassed putting in the client’s chart?

- Have you ever worked with a client you hated? If so, could you work effectively with that client?
- If there are certain kinds of clients who make you uncomfortable, how would you describe them? How, if at all, does your discomfort affect your ability to work effectively with them? To what extent is your discomfort acknowledged or reflected in your notes?

Creating an intentional reflective practice increases self-validity and self-reliability as a mental health provider. In doing so, we as professionals can create a stable treatment environment that is responsive to fluctuations in client presentations as well as accurately assess differences between clients. However, reflection is only part of maintaining competence in assessment and evaluation. Using the awareness garnered from reflective practices, professionals can neutralize the intellectual, emotional, and relational components that maintain biases and increase professional liability. Hook et al. (2017) recommend the following such practices:

- Address the intellectual component of bias (i.e. stereotypes, overgeneralizations, and confirmation biases) by doing research, thinking, reflecting, and journaling.
- Address the emotional component of bias (i.e. anger, fear, suspicion, etc.) by exploring deepest thoughts and feelings about cultural groups you may hold bias towards. Utilize consultation, supervision, and/or therapy to assist in such exploration.
- Address the relational component of bias (i.e. avoidance of cultural groups) by developing positive relationships with member(s) of that group.

## ■ What Exactly Are We Assessing and Why?

Existing literature and research have established statistically significant relationships between perceived experiences with racism and a range of psychiatric and emotional reactions

including adjustment, stress reaction, and mood and anxiety disorders (Carter, 2009; Williams et al., 2018). However, the literature also suggests that mental health professionals may not be adequately incorporating considerations of race, culture, racism, and discrimination in evaluations. This lack of consideration may be due to limited understanding or guidance in assessing and addressing the unique lived experiences of racial minorities.

To further complicate matters, racial encounters are often inexplicable and are not often discussed with mental health professionals. The lack of disclosure from clients may be due to lack of a shared language about race, culture, and discrimination. However, it has also been noted that racial encounters may not be discussed within affected communities or family groups in much detail. Whether or not this behavior is attributable to external factors or learned coping habits, mental health professionals have a duty to accurately assess strengths, liabilities, and dysfunction impacting the lives of clients. In doing so, providers must consider and critically assess client self-definitions, client-context (i.e. physical and psychological settings and environments that clients are immersed in), and apply evidenced-based concepts of distress and dysfunction, like race-based stress, to best serve their clients.

Carter and Forsyth (2009) and Carter (2007) provide a framework to best assess and conceptualize race-based stress and race-based traumatic stress, highlighting that distress is an outcome of exposure to racial discrimination, racism, and discrimination in general. First, the authors provide a distinction between stress and traumatic stress which has significance when determining the presence of pathology or disorders. Stress is defined as the appraisal of an event as positive, unwanted, negative, and/or taxing that requires one to adapt or cope in some way. The authors distinguish trauma as a more severe form of stress that circumvents a person's ability to cope. Further still, traumatic stress is a form of stress resulting from emotional pain as opposed to a life-threatening event or a series of events as the core stressor. The distinction between stress and trauma is important in planning for the most effective interventions. For example, the experience of stress may be best addressed using emotional regulation and interpersonal

effectiveness skills. Trauma reactions and experiences may be better managed using distress tolerance skills. Choosing the best intervention strategies will be further presented in Chapter 6. At the assessment and diagnosis stage of mental health care, you will do well to be able to understand and articulate differences between the experience of stress and trauma.

In using the definitions and distinctions between stress and trauma, Carter (2007) defines race-based stress and trauma reactions as *racial encounters that must be sudden, unexpected, and emotionally painful*. This is the first tier to be met for accounting for trauma reactions. How encounters with racism are experienced depends on many factors associated with an individual's background, health, and cognitive processing. The person who interprets and appraises his racial encounter as extremely negative (emotionally painful), sudden, and uncontrollable, may exhibit signs and symptoms associated with the stress and possible trauma of racism. Reliance on a dispositional (i.e. intrapsychic) approach may hold your client responsible for situational factors outside her or his control. Employing the notion of injury may better capture the external violations and assaults inherent in racism/race-based encounters that create stress, distress, and trauma for clients. In doing so, providers are better able to assess and identify reactions that integrate the situational (external) and dispositional (internal) elements in the context of an individual's life history and experiences, including racism.

To increase validity and reliability of assessing for the mental health effects of racism and racial discrimination, it is useful to have types/classes of racism rather than using broad social definitions or systemic descriptions. Carter (2007) proposed the following three types of racism for assessing race-based stress: racial harassment (i.e. often indirect and avoidant including barring access, exclusion, withholding information, etc.), racial discrimination, (i.e. typically hostile and direct, including verbal and physical assaults, hostile work environment, and being profiled), and discriminatory harassment (i.e. aversive and hostile including isolation at work, denial of promotion, question of qualifications, etc.). Being able to assess for and recognize these

classes of racism further empowers the professional and the client to delineate the racial encounter beyond calling it racism/discrimination and better understand the negative, and at times lasting, impact on mental health. In essence you will be able to create specific language around the unique experience and implement more precise and targeted interventions.

In their research on race-based stress, Carter and colleagues have found that there are specific symptom clusters that clients report following negative racial encounters. The reports of symptom clusters allow clinicians to establish diagnostic criteria to classify the impact on mental health and well-being. For example, criteria have been defined to include the reporting of two or three symptoms (i.e. reactions that are arousal or hypervigilance, intrusion, or re-experiencing an avoidance or numbing). Other symptoms expressed are important but not necessary for determining race-based trauma injury, including depression, anger, physical reactions, and low self-esteem. The severity of the impact on functioning can then lead to formal mental health diagnoses and effective treatment planning.

One particular tool that may be useful in the assessment of racial trauma is the University of Connecticut Racial/Ethnic Stress and Trauma Scale (UnRESTS). This semi-structured interview allows the mental health professional to facilitate conversation with the client about experiences with racism while building rapport (Williams et al., 2018; Williams, Pena, & Mier-Chairez, 2017). This instrument provides professionals with specific questions and instructions to navigate the assessment of racially charged topics. UnRESTS's semi-structured nature gives providers flexibility to follow-up to get more detailed descriptions of experiences. The format of the interview is broken into sections to include introduction to the interview, racial and ethnic identity development, experiences of direct overt racism, experiences of racism by loved ones, experiences of vicarious racism, and experiences of covert racism (Williams et al., 2018; 2017). Lastly, the instrument also provides guidance for making a diagnosis of post-traumatic stress disorder (PTSD) by aligning information gathered with the current DSM-5 criteria. We believe

this is a crucial instrument to assess and treat Black clients for experiences of racial discrimination.

## ■ Assessment Instruments

The use of testing instruments/tools during assessment should be in an effort to obtain a more complete picture of the types of verbal, perceptual, and motor behaviors clients engage in their everyday lives. Every reaction to test stimuli or questions is a projection of the private world and personal characteristics of the client. Integration of data with interpretations (that are relevant to the client) constructs the assessment.

There has been a compendium of instruments developed over the past 10–12 years that measure perceived racism and/or discrimination. Understanding the available measures is important for assessing and comparing racism/discrimination across health care environments, documenting the presence or degree of racism/discrimination, and measuring changes in levels subsequent to interventions (Kressin, Raymond, & Manze, 2008). Commonly used instruments to assess exposure to racism and its impact are:

Race-Based Traumatic Stress Symptom Scale (RBTSSS)

General Ethnic Discrimination Scale (GEDS)

The Racial Microaggressions Scale modified (RMAS)

Schedule of Racist Events (SRE)

Racism and Life Experience Scales (RaLES)

Experiences of Discrimination (EOD)

Perceived Racism Scale (PRS)

Everyday Discrimination Scale (EDS)

Perceived Ethnic Discrimination Questionnaire (PEDQ)

Multidimensional Inventory of Black Identity (MIBI)

Index of Race-Related Stress – Brief Version (IRRS-B)

Racism Experiences Stress Scale (EXP-STR)

While the above instruments have been developed to assist in the assessment of the impact of racial discrimination, they are not without critiques and limitations. For example, few measures are theoretically based, with most assessing only general dimensions of racism and focused specifically on the experiences of African American patients (Atkins, 2014). Additional measures are needed for detailed assessments of perceived discrimination that are relevant for a wide variety of racial/ethnic groups. The literature also recommends future research and instrument development to assess how racism/discrimination affects health care decision making and treatments offered.

We recommend that if professionals choose to use an instrument to assess for race-based stress/trauma, special care is taken to consider the psychometric properties of the measure. In essence, the measure chosen should assess whether racist/discriminatory events/actions occurred and the extent of impact on the functioning of the individual experiencing them. Additional instrument measures can also address whether the racist/discriminatory events/actions experiences affect the individual's interaction with his or her health care provider, client's view or acceptance of the provider's treatment recommendations, or the provider's offer of care.

### ■ Making the Case for DSM Diagnosis(es)

Although the presented framework for race-based stress and trauma and the highlighted assessment instruments provide conceptual clarity, it is important to acknowledge that the DSM-5, does not include consideration of the racial-cultural context in listed diagnoses, particularly PTSD (Carter, 2007; Carter & Forsyth, 2009; Williams et al., 2018). The criteria for a diagnosis of PTSD requires an index trauma event, including either exposure to actual or threatened death, serious injury, or sexual violence that can either be experienced directly or witnessed by the individual, learning the event occurred to a family member or close friend, or repeated exposure to aversive details of the event (American Psychiatric Association, 2013a). A trauma stressor, as conceptualized in the

DSM-5, does not include racial discrimination events, especially if there is no direct evidence of physical violence. Therefore, a Black client who reports experiencing a negative racial encounter, and demonstrates symptoms consistent with PTSD, would likely have the severity of their symptoms dismissed because the event would not be considered catastrophic enough to meet DSM-5 criteria for the diagnosis (Carter & Forsyth, 2009). Researchers have called for the inclusion of racial discrimination events to be recognized as legitimate trauma stressors, thereby being acknowledged as contributable to an authentic, diagnosable, treatable form of PTSD.

To make the case for a diagnosis(es) using DSM-5 criteria, understanding the sequelae race-based stress and trauma is also important in knowing what to ask and how to conceptualize information gathered from interviews and assessment instruments into a diagnostic formulation. As discussed previously, DSM-5 definition of a trauma event will need to be broadened beyond a simple, circumscribed event such as death, threatened death, serious injury, or actual or threatened sexual violence. Instead, it is important to acknowledge discrimination and racism as a complex trauma experience arising from repeated or prolonged exposure to assaults on the personhood and integrity of the victim (Williams et al., 2018). The impact of these experiences is best understood using with the stress sensitization hypothesis that suggests repeated exposure to external and endogenous stressors results in the progressive amplification of a response. In other words, every personal or vicarious encounter with racism (i.e. overt, covert, and cultural) contributes to a more insidious, chronic experience of stress. Over time, the accumulation of stress inflicts psychological and physiological injuries, increasing the likelihood of a pathological response to future exposure to negative racial encounters and prevents the natural abatement of symptoms (Harkness, Hayden, & Lopez-Duran, 2015; Williams, et al., 2018). In this way, ongoing exposure to racism and discrimination reshapes individuals' sense of themselves, their identity and identity group, and their place in the world. Exposure may also manifest in distressing memories, intrusive thought or ruminations, distress over reminders of encounters, avoidance behaviors, depression,

anxiety, feeling unsafe, hypervigilance, poor sleep, difficulty concentrating, anger, guilt, low self-esteem, and even suicidal or homicidal ideation.

Compounding the subsequent psychological distress of racism further, the literature has indicated that there are social costs for sharing personal experiences of racism or discrimination including being perceived as less likable, viewed as a complainer, and accused of attempting to avoid personal responsibility (Williams et al., 2018). In addition to the negative mental health impact of racism, victims are also then burdened with the dissonance between their personal reality of encountering racial stressors and conflicting social messages that indicate racism is not a valid explanation for their experiences. Mental health providers can perpetuate the experience of invalidation by rigidly adhering to the DSM criteria that do not account for the psychopathological impact of racial discrimination. It is therefore incumbent on you to consider, conceptualize, and articulate how racial trauma, whether direct or indirect, has similar behavioral health consequences to those for individuals who have experienced traumatic events such as death, threatened death, serious injury, or actual or threatened sexual violence.

### Case Example 1

Mr. Davis is a middle-aged male who identifies as African American. He presented to a community clinic for a mental health assessment. When Mr. Davis meets with the clinician, he described increased irritability and stress and feeling overwhelmed with life. He described starting a new job where he is the only African American and only person of color in the office. He further described feeling “paranoid” around his co-workers and increased difficulty completing tasks at work. Given Mr. Davis’ report of symptoms and current psychosocial stressors, the assessing clinician utilized

the UnRESTS semi-structured interview to gather more detailed information about Mr. Davis' racial identity, history, and current experiences of direct and covert racism and racial discrimination. Using the questions and prompts in the UnRESTS, Mr. Davis reported that during his first week at work, he was getting into his car in the parking lot when two men came up behind him, slamming him into the side of his car, pushing his head down on the roof, and putting "something" on the side of his neck, while stating "Run yo pockets fool!" Mr. Davis described being terrified in the moment and attempted to comply with the assailants. After what felt like "forever," Mr. Davis stated the two assailants started laughing and released him. Still afraid, Mr. Davis turned and saw two of his new White co-workers laughing and stating "welcome to the team bro." Mr. Davis then became angry and pushed one of the co-workers declaring that what they did was not funny. Mr. Davis then stated the co-workers began to mock him with statements like "What? You can't handle a joke," "You should be used to that coming from the inner city," and "Don't be so uppity." The co-workers then continued to joke and mock Mr. Davis's reaction before walking away. Since that incident, Mr. Davis learned that there was another co-worker involved who video recorded the event and shared it around the office. Mr. Davis made a complaint to his direct supervisor, whose response was:

It was just a prank. You're taking it too seriously. They didn't mean any harm. They were just trying to bond, don't take it personally. You're not one of those people who like to pull the race card because they're too sensitive, are you?

Over the following four months, Mr. Davis described increased distress at work, intrusive thoughts about the event, disturbed sleep, attempts to avoid all co-workers,

hypervigilance, difficulty concentrating at work, increased startle response, self-blame, anxiety, and depression. After learning more of Mr. Davis' recent experiences following the event, the assessing clinician was able to use the UnRESTS to identify and confirm DSM-5 PTSD symptoms attributable to Mr. Davis' report of a racial trauma event.

It is also important to note that not all traumas result in a diagnosis of PTSD. The same can be said for race-based stress experiences. In such cases, you can still acknowledge the deleterious impact of racial stress on the Black client and then complete a differential diagnosis of other diagnoses or disorders. When the racial stress is not the primary focus, but still a significant factor on functioning, clinicians should consider DSM-5's Use of Other Specified and Unspecified Disorders, as well as Other Conditions That May Be a Focus of Clinical Attention (American Psychiatric Association, 2013a).

The Other Specified Trauma- and Stressor-Related Disorder category may be used with the client who reports symptoms of trauma with clinically significant distress, but full criteria is not met. This diagnosis allows the clinician to communicate the presence and impact of racial encounters by highlighting the reported symptoms, even when Criteria A of PTSD cannot be directly identified. For example, if a client describes symptoms of intrusive thoughts, mood reactivity, and distorted thoughts following repeated exposure to watching videos of Black people being killed by police, Criteria A of PTSD would not be met. Vicarious experiencing of racialized violence through media is specifically noted as not meeting criteria (American Psychiatric Association, 2013a). However, the client's psychological distress is clinically significant. In this case the diagnosis of Other Specified Trauma- and Stressor-Related Disorder, with a specifier of Race-based Traumatic Stress Reaction would be appropriate.

Being able to make a diagnosis is not only helpful in creating a shared language, but also validates the client concerns or

presentation. In turn, clinicians and treatment teams will have a more accurate clinical picture. However, diagnoses may also be stigmatizing to the individual. It is important to make distinctions between clinically significant symptoms that indicate psychopathology, warranting a diagnosis and treatment, and not overpathologizing clients, especially when there are environmental and/or psychosocial elements that sustain distress. In such cases, the DSM-5's Other Conditions That May Be a Focus of Clinical Attention may be useful. More specifically, the conditions and problems under Other Conditions That May Be a Focus of Clinical Attention are not mental disorders but are meant to draw attention to the scope of additional issues that may be encountered in routine clinical practice and to provide a way for clinicians to document these issues (American Psychiatric Association, 2013a).

The conditions or problems that would best capture race-based stress reaction that have not resulted in other clinically significant symptoms are Social Exclusion or Rejection and Target of (Perceived) Adverse Discrimination or Persecution. Social Exclusion or Rejection category allows clinicians to document when social power imbalances create or result in recurrent social exclusion or rejection by others including bullying, teasing, intimidation, verbal abuse, or exclusion from activities of peers, co-workers, etc. (American Psychiatric Association, 2013a). Target of (Perceived) Adverse Discrimination or Persecution can be used when the client, based on their minoritized group membership or identity, reports experiences or perceived discrimination or persecution. Again, this category can be added to the diagnostic impression when experiences of racial discrimination warrant clinical attention. Carter's (2007) delineation of classes of racial encounters described previously (i.e. racial harassment, racial discrimination, and discriminatory harassment) align with both Social Exclusion or Rejection and Target of (Perceived) Adverse Discrimination or Persecution that warrant clinical attention. Clinicians are encouraged to give consideration to these diagnostic categories when completing diagnostic formulations when a clear mental health diagnosis is not present. It can also be useful in justifying a clinical treatment.

## Case Example 2

Mrs Johnson is a 60-year-old Black woman who is seeking treatment for worsening depression and increasing stress. During the intake interview to establish care, she discloses a history of diagnosis and treatment of Major Depressive Disorder using both medications and psychotherapy interventions. Mrs Johnson endorsed symptoms consistent with a diagnosis of Major Depressive Disorder and relayed that her symptoms began to worsen approximately six weeks before the scheduled appointment. She was unable to identify any particular trigger but described increase responsibilities at home due to a change in her husband's health and difficultly managing new "wifely and grandmotherly duties." Mrs Johnson also described feeling more isolated at work following a "charged" conversation with her younger White co-workers about the removal of confederate monuments and statues. She distinctly recalls one of her co-workers calling her a racist, and stated that since Mrs Johnson lived through the civil rights movement, she should know better. The interviewer then administered the Perceived Ethnic Discrimination Questionnaire (PEDQ) and UnRESTS. Data for both measures indicated additional experiences with microaggressions, exclusion from social gatherings at work, coworkers withholding information, etc., which has led to increased experience of stress and loneliness. Although Mrs Johnson is experiencing racial stress, it does not meet the level of criteria for PTSD or Other Specified Trauma- and Stressor-Related Disorder. She does, however, meet criteria for Major Depressive Disorder, Recurrent, Moderate. Her experiences of race-based stress do appear to be a contributing factor to her depressive symptoms. It would then be appropriate to use Social Exclusion or Rejection to document the influences of such experiences on current symptomology and level of functioning.

### Case Example 3

Mr. Warren is a 25-year-old African American gay cisgender male graduate student. He presented to the campus counseling center for a walk-in supportive counseling session. Mr. Warren disclosed to the therapist that he has been involved in the campus gay/straight alliance group called Prism. Mr. Warren described recent tensions in the group, particularly with their all-White student leadership. Specifically, he stated that recently he advocated for the replacing of the club logo with the new Pride flag, which incorporates the black and brown stripes to represent inclusion of LGBTQIA people of color. Mr. Warren stated he was passionate in his advocacy through highlighting the history of the exclusion of people of color from the LGBTQIA community. The response he received was surprising in that the leadership and some of the other White group members rejected his idea and the notion that the LGBTQIA community has been biased. Mr. Warren then tried to argue his point but was then “accused of causing factions in the group” and that his proclamations were unnecessary and unhelpful. Since that time, he and other Prism members of color have been left off email announcements. Additionally, his ability to accurately/appropriately represent LGBTQIA to the public has been openly questioned by the group leadership. In response, Mr. Warren described feeling hurt, but also motivated to speak truth to power, even if it is to a group he feels “should already know.” At this time, he reports some increase in stress but believes he is able to utilize adaptive coping skills to manage. Mr. Warren did not endorse any other mental health symptoms. The therapist validated his thoughts, feelings, experiences, and use of adaptive coping skills. Mr. Warren was also provided some psychoeducation about microaggressions. As the supportive therapy session closed, Mr. Warren expressed appreciation for the

psychoeducation about microaggressions and relief that he “isn’t the crazy one.” Mr. Warren did not meet DSM–5 criteria for PTSD and did not endorse clinically significant distress that warrants any other diagnoses. In this case, use of Target of (Perceived) Adverse Discrimination or Persecution is appropriate for charting and billing purposes.

## ■ Summary

An overarching goal for addressing race-based stress in Black clients is to improve quality of life. To meet this goal, accurate assessment of mental health functioning and symptoms must include considerations of race and racial discrimination/harassment, and cumulative cultural traumas. Integrating appropriate assessment instruments can facilitate conversation in provider–client dyads and lead to accurate diagnostic formulation, case conceptualization, and effective treatment planning. Mental health professionals should also consider the psychometric of the self to identify and address potential biases that may impact the provision of mental care. It is recommended, then, that professionals establish intentional self-reflection into clinical practice as well as routine consultation or supervision.

# 8 An Integrative Approach to Understanding and Treating Disordered Eating in African American Women

*Carolyn Coker Ross*

## **Introduction**

Black<sup>1</sup> women are sometimes assumed to be less susceptible to body dissatisfaction based on the notion that African American culture embraces larger or curvier body types than the dominant culture does. Eating disorders are becoming a major health concern for Black women. While some research suggests that anorexia nervosa is less common in Black women than in White women (Striegel-Moore et al., 2003), recurrent binge eating occurs at higher rates in Black women than in White women (Striegel-Moore, 2000). How can clinicians do a better job of detecting and treating eating disorders in Black women? Improving care for Black women starts with conceptualizing disordered eating not solely as a preoccupation with appearance but also as a strategy for coping with stress, depression, and trauma (Thompson, 1992).

Stress, trauma, and insecure attachment contribute to the development of eating disorders in African American women (Cortés-García, Takkouche, Seane, & Senra, 2019; Tasca & Balfour, 2014). These early adversities exert their effects through their impact on brain development, architecture of the brain, and gene expression and are more intersected in African American communities. Early adversity has been linked to later impairments in learning, behavior, and both physical and mental well-being. Newer research on the impact of childhood maltreatment on adult health is challenging us to move beyond the notion of “genetic predispositions” to understand the influence of environment and early experiences and how, when, and to what degree different genes are activated. Understanding this interaction can explain the mechanism through which gene–environment interaction or epigenetics affects lifelong behavior, development, and health (Bagot & Meaney, 2010) and may also explain the transmission of these effects from generation to generation. The effects of stress, attachment disorders, and trauma in childhood can persist into adulthood, putting individuals at higher risk for depression, obesity, and eating disorders. Once a child has been maltreated, the trajectory of their long-term potential may be hijacked, putting them at risk for lifelong consequences in the areas of educational achievement, economic productivity, health status, and longevity (Shonkoff et al., 2011). Because early adversities, stress, and

insecure attachment are more prevalent in African Americans (as will be discussed in what follows) (Slopen et al., 2016), these factors should be evaluated when treating African American clients who present with eating disorders.

## **Stress**

Problematic eating patterns in African American women may develop in response to stress, and existing eating disorders may be worsened by stress. In order to understand the underlying causes of eating disorders in African American women, it's important to understand the effect of stress on children and adults. Stress can begin before birth through exposure to maternal stress. Both prenatal stress and early life stress can increase the risk of developing an eating disorder, addiction, and obesity (Su et al., 2016; Thomas, Hu, Lee, Bhatnagar, & Becker, 2009). Exposure to early life stress can result in more difficulty managing stress and regulating emotions throughout life, as well as a predisposition to mood disorders, impulsive and compulsive disorders such as eating disorders, attention deficit hyperactivity disorder, and addictions (Enoch, 2010; Warren et al., 2014). The relationship between childhood adversity and eating disorders is mediated by emotional dysregulation (Trottier & MacDonald, 2017).

Both animal and human studies have shown that fetal exposure to maternal stress can affect responsiveness to stress in later life. This effect has been shown in animals to be passed down through subsequent generations. Prolonged stress after birth without the buffering protection of supportive adult relationships is called toxic stress. Toxic stress in childhood includes events studied in the Adverse Childhood Experiences Study and includes abuse, neglect, exposure to violence, and having a parent with mental illness or a substance use disorder (McEwen, 2005)

Childhood experiences stimulate neurodevelopment. Having a range of experiences stimulates different parts of the brain, leading to balanced brain development. Noted child trauma researcher Perry (2002) has stated:

The simple and unavoidable conclusion of these neurodevelopmental principles is that the organizing, sensitive brain of an infant or young child is more malleable to experience than a mature brain. While experience may alter the behavior of an adult, experience literally provides the organizing framework for an infant and child. Because the brain is most plastic (receptive to environmental input) in early childhood, the child is most vulnerable to variance of experience during this time.

(p. 88)

A young child's brain is like a sponge—taking in and using experiences that are helpful to the growing brain and also ones that are not. This spongelike quality of the young child explains why chronic or severe stress can be so toxic

to the brain. Chronic severe stress (toxic stress) causes the release of stress hormones that shape and mold the developing brain, which is very sensitive to the chemical influence of stress hormones. Chronic stress results in increased size and function of the emotional parts of the brain (the amygdala and orbitofrontal cortex) and decrease in size and function of the prefrontal cortex and hippocampus, which govern memory, executive, function and learning (Slopen et al., 2016). Early traumatic experiences can lead to hyperactivity of the stress response. Depending on the severity of the trauma or on the type of trauma, there can be a significant dysregulation of the stress response. Physical or sexual abuse before age five has a more significant impact on children (Cicchetti, Rogosch, Gunnar, & Toth, 2010) than it does on those who were older at the time of their abuse or on children who were victims of emotional abuse or neglect.

Some stress is normal, and it helps children learn to react to future challenges. However, when a child is exposed to repeated experiences of abuse and neglect, those experiences can lead to toxic stress and can disrupt the child's brain development. Further, other parts of the brain may be weakened by early traumatic experiences (i.e., the parts of the brain having to do with emotional self-regulation, impulse control, judgment, social interactions, and abstract thinking; "Preventing Adverse Childhood Experiences | VetoViolence," 2019).

Because of the hyperactivity of the stress response system, survivors of trauma are typically hypervigilant, always on the lookout for the next threat. This continual feeling of tension is uncomfortable, so trauma survivors often engage in adaptive behaviors in response to the discomfort. Binge eating, emotional overeating, and eating addiction are common reactions, particularly among Black women. Some African American women with past or present trauma may have used food as the only reliable source of pleasure or comfort in their lives.

Socioeconomic factors can also be a source of stress. Black women are more likely than their White counterparts to experience poverty ("Poverty in the U.S. | Poverty Solutions," 2019), a major, pervasive source of stress. African American women are also confronted with the stressors of racism and microaggressions—a form of covert racism. Microaggressions can be defined as "brief, everyday exchanges that send denigrating messages to people of color because they belong to a racial minority group" (Sue et al., 2007, p. 273).

In a study of Black undergraduates, 63 percent reported experiencing at least one episode of overt racism in the previous year, and 96 percent experienced several episodes of microaggressions. Both were also predictive of depressive symptoms (Donovan, Galban, Grace, Bennett, & Felicié, 2012). Black women are greatly affected by discrimination and sexual harassment in the workplace, and they may have limited avenues for effective recourse. While reports of sexual harassment of White women have declined overall (from the 1990s to the 2010s), harassment of Black women has stayed at basically the same level for more than 20 years. Black women are 3.8 times more likely to report sexual harassment as White women (Cassino & Besen-Cassino, 2019; Krieger et al., 2006).

These results show that the lived experience of Black women is vastly different than that of their White counterparts. The race, class, and gender inequities that these studies report is illustrative of the ways in which treating Black women with eating disorders is different than treating White women with eating disorders.

Independent of other factors, children exposed to toxic stress in childhood are more likely to have behavioral problems, to struggle academically, and to have health problems. The hair-trigger response or state of being on constant red alert that accompanies childhood exposure to stress may make some children appear overly reactive to even mild stressors and less able to cope with future stresses. In adulthood, the adoption of unhealthy or risky behaviors can be seen as a coping mechanism that may explain why exposure to childhood adversities and toxic stress is associated with tobacco use, substance use disorders, obesity, and eating disorders in adults (“Persistent Fear and Anxiety Can Affect Young Children,” 2019; Gunnar & Quevedo, 2007).

Beyond childhood, toxic stress causes wear and tear on the body that lasts into adulthood and is associated with medical conditions including heart disease, diabetes, lowered immune function, autoimmune diseases, poor wound healing, and depression (Cohen et al., 2012). Black women and children have greater exposure to stress both prenatally and during their lifetime that comes from numerous environmental sources including racism, microaggressions, and other unique cultural factors. Culturally competent care must include an understanding of the significant physical and mental disorders that result from stress.

## **Individual Trauma**

The Adverse Childhood Experiences (ACE) Study has catalogued the impact of trauma that occurs before age 18. The ACE study was started by Kaiser Permanente in San Diego; now it is jointly run with the Centers for Disease Control. This study of more than 17,000 participants looked at abuse (physical, emotional, or sexual), neglect (emotional and physical), and household challenges (witnessing domestic violence, household substance abuse, mental illness in the household, parental separation or divorce, and having a family member who is incarcerated). The ACE study is groundbreaking because it is the first of its kind to explore and validate the link between adverse childhood experiences and the development in adulthood of physical and mental health disorders (Child Abuse and Neglect Prevention | Violence Prevention | Injury Center | CDC, 2019).

The essence of the impact of trauma—whether it is from abuse, neglect, loss, or violence—is a loss of an essential part of ourselves—a sense of safety, trust, or security. A history of trauma is particularly important to ascertain in African Americans who present for treatment of eating disorders. Across all racial groups, Black and Hispanic children have been exposed to more adversities than White children. Nine percent of African Americans have been diagnosed with PTSD (vs. 6.8% of Whites; Alim et al., 2006; Slopen et al., 2016).

Lifetime prevalence of PTSD after trauma was 51% in a study of African American patients in primary care offices, and it was higher in females than in males (Alim, Charney, & Mellman, 2006).

Socioeconomic status is another contributing factor to the exposure to trauma. Children from low-income families have an even higher risk of exposure to frightening or threatening experiences than do other children. Low-income children, of whom Black children are disproportionately high, were 18% more likely than children from higher-income families to have been exposed to one adversity, 15% more likely to experience two adverse experiences, and 74% more likely to have three or more exposures. When looked at through the lens of race, Black children were 45% more likely than White children to have two adverse exposures and 21% more likely to have three or more. These statistics reflect the intersection of race and income; more children in low-income homes are African American, and children from these homes are more likely to experience trauma (“Toxic stress and children’s outcomes: African American children growing up poor are at greater risk of disrupted physiological functioning and depressed academic achievement”; Morsy & Rothstein, 2019).

The ACE study has found that two-thirds of all American households have at least 1 ACE, and one in five have three or more ACEs. This is significant, because clinicians now know that ACEs are common. There is also a strong dose–response relationship between the number of adverse events before the age of 18 and social, mental, and behavioral outcomes. ACEs affect all types of families, all races, all communities, and all socio-economic levels. Finally, the study found that a history of more than one early-life adversity is associated with a higher risk for eating disorders, substance use disorders, and depression, and it is also associated with more than 40 other disorders including heart disease, stroke, and diabetes.

## **Historic or Intergenerational Trauma**

Trauma ultimately can define our behaviors, actions, and sense of self. Beyond childhood trauma, research shows the destructive effects of trauma being passed down from generation to generation in the expression of our DNA and in our cultural nurturing. Intergenerational trauma was initially studied in the children and grandchildren of Holocaust survivors in the 1960s. Offspring of Holocaust survivors showed a variety of trauma response pathology and experienced themselves as “different or damaged” by their parents’ experiences (Sotero, 2006, p. 96). Studies on families of Holocaust survivors show an association between eating disorders and Holocaust exposure (Zohar, Giladi, & Givati, 2006), and they show the transmission of trauma coping pathology and insecure attachment through three generations (Bar-On et al., 1998).

More recent studies involving historical trauma have focused on American Indian/Alaska Native (AIAN) populations. Brave Heart describes historical trauma as “the cumulative emotional and psychological wounding over

one's lifetime and from generation to generation following loss of lives, land and vital aspects of culture" (Sotero, 2006, p. 96; Brave Heart & DeBruyn, 2001). Brave Heart also developed a lexicon of terminology to describe the AIAN experience, including "historical unresolved grief," to describe how the losses they suffered had never been mourned, and the "survivor's-child complex" to describe the similar dynamics among children of survivors and their descendants.

This definition of historical or intergenerational trauma fits African Americans who were taken to North America from Africa and the Caribbean. They lost their cultures; many lost their lives in the Middle Passage and later on slave plantations. Additionally, they were separated from their families, children, and spouses by slaveowners and experienced innumerable traumatic experiences that have continued through racial oppression, family separation, and mass incarceration of Black men. In his 1952 semiautobiographical novel *Go Tell It On the Mountain*, the esteemed African American author James Baldwin asked the question: "Could a curse come down so many ages? Did it live in time, or in the moment?" (Halloran, 2018, p. 46).

Baldwin's reference to intergenerational trauma is echoed in research through discussions on the long-term impact of slavery on African Americans. For instance, DeGruy (2017) articulated a condition called posttraumatic slave syndrome (PTSS) to reflect a condition that exists as a consequence of centuries of chattel slavery followed by institutionalized racism and oppression. Chattel slavery was based on the belief that Black persons are inherently and genetically inferior to Whites. The systemized trauma of slavery, racism, and oppression is a cultural process that became part of the collective identity of African Americans (Eyerman, 2004). Generations after slavery was abolished, children were witness to their parents' or grandparents' daily degradation at the hands of the dominant culture. For example, while Black Americans may have been granted the right to vote, they often did not have the freedom to vote and many times were turned away at the polls because of gerrymandering and other obstructive political practices. For many, the legacy of slavery has led to feelings of inferiority that are passed from generation to generation and that keep individuals from reaching their full potential. Other examples of systematic oppression include the ongoing deaths of Black men at the hands of the police and the excessive incarceration of Black men, which has continued the fragmentation of the Black family that began during slavery. There are also deprecating accounts of African Americans in the media, disrespect in the school system, and daily microaggressions.

DeGruy described three outcomes of the trauma of slavery: low self-esteem, ever-present anger (or sensitivity to disrespect, also called "shame-proneness"), and racist socialization. She goes on to explain intergenerational trauma transmission as being a result of parental modeling. Racist socialization can show up in the belief that light-skinned Black persons are superior to darker-skinned individuals or that straight hair is better than kinky hair. This can contribute to body image issues in Black women with eating disorders. Low self-esteem

and depression also found in Black women with eating disorders is further evidence of the long-term impact of living as a Black woman in America. Many use food as a way to deal with the stress and emotions associated with the Black experience.

The injuries from slavery have led to individual and collective injury that shows up in low self-esteem, self-destructive behaviors, interpersonal conflict within the home and community, and often maladaptive beliefs and behaviors (Gump, 2000). The trauma can also become a family legacy, whether survivors talked about it or kept it silent, even to children who were born after the trauma.

Posttraumatic slave syndrome, then, begins with the ways in which individuals and the Black community have coped over many generations. Some of them were positive, such as resilience demonstrated by the strong Black woman syndrome (SBWS). African American women learned from their mothers and grandmothers to be strong, suppress emotions, and hide vulnerability. The SBWS also involves a determination to succeed even with limited resources. Within the SBWS was also the obligation to help others. While the SBWS is evidence of great resiliency, it can come at the cost of strained interpersonal relationships, health consequences due to the delay in seeking self-care, and stress disorders such as anxiety, depression, obesity, and adverse maternal health outcomes. The SBWS may also explain the reticence in the Black community to seek care for mental health problems, including eating disorders (Woods-Giscombé, 2010).

Many Black women identify with the SBWS, not out of choice but because they have had to be strong. They may be raising their children as single parents; some are even raising their grandchildren at the same time they are working full time and volunteering at their church. The stress involved can lead to overeating and other eating disorder behaviors as survival behaviors, or they may have started using food to deal with childhood or adult traumas for which they may never have received treatment. While White individuals with eating disorders may have experienced trauma in their past, or even intergenerational trauma, it is important to recognize that past traumas are compounded with the stressors in everyday life of being Black. Stress and trauma (past, present, or intergenerational), along with insecure attachment, which will be discussed next, all present differently in Black women with eating disorders and work in concert to make it even more difficult for Black women to give up survival behaviors that have provided a source of comfort and security when the world around them may feel unsafe and insecure simply because they are Black.

## **Attachment**

When a child's interactions with their caregiver are inconsistent, unreliable, or insensitive, this interferes with the development of a secure and stable mental foundation. While there are few studies that explore race and attachment styles, one study (Bakermans-Kranenburg, Ijzendoorn, & Kroonenberg, 2004)

shows that in almost all ways, Black families are different than White families. For example, Black mothers in this study tended to be almost four years younger than their White counterparts, and income was almost half that of White families. These differences might explain why Black mothers tended to be more stressed and why Black children were already showing attachment difficulties by the age of two. As well, a distinct relationship has been found in research between childhood trauma and insecure attachment in African American women. Research shows that a history of emotional abuse can lead to more insecure attachment styles in African American women (Gaskin-Wasson et al., 2016).

Other unique cultural factors may also influence the development of attachment bonds in African American children. For example, living in a dangerous neighborhood, as is the case for some Black women who may present for treatment, can be related to greater psychological distress and poorer long-term adjustment. When evaluating adults with eating disorders who may have insecure attachment and depression, it is important to be aware that they may also have higher rates of childhood physical, psychological, or sexual abuse. The interaction between attachment insecurity and psychopathology is also fostered by stressful life events and poverty (Mikulincer & Shaver, 2012).

One of the deficits in studying attachment in African Americans is that the mother is usually used as the attachment figure. However, in Black culture, it is not uncommon for extended family members to provide or share the care of children in the family, and there may be more than one attachment relationship. These strong kinship ties can provide resiliency and security when a primary caregiver (mother or father) is not able due to illness, mental health issues, or addiction. Despite changes in the family structure in the United States, extended African American families are still resources of strength, resilience, and survival (Hall, 2007).

Therefore, when assessing attachment styles, it is important for clinicians to look beyond just a primary caregiver to caregivers in the extended family such as grandparents or aunts when evaluating African Americans who present with an eating disorder.

## **Connecting the Dots**

The most significant impact of life experiences is on the brain. As mentioned, trauma can be exacerbated by prenatal or postnatal toxic stress and by attachment insecurity. This stress leads to dysregulation of brain neurotransmitters such as serotonin and dopamine, and the brain reward circuits are also affected.

The disruption in the brain's reward mechanism is just one of the mechanisms in which the brain is changed by life experiences in childhood that are carried over into adulthood.

Blum coined the term reward deficiency syndrome (RDS) to describe a failure in the brain's dopamine reward system (Blum & Badgaiyan, 2015). RDS is observable when a person has difficulty experiencing feelings of pleasure

or satisfaction with normal pleasurable activities, including eating normally. Specifically, people with RDS have abnormally low levels of dopamine D<sub>2</sub> receptor activity, caused by genetics or early adverse life events. The brain thus has a harder time “hearing” the pleasure signal carried by dopamine, leading the person to want to “turn up the volume” by doing more of the pleasurable thing. Low D<sub>2</sub> receptor activity in the brain may make a person more prone to emotional eating and to bingeing. Stress is a major environmental factor contributing to changes in the brain that may lead to RDS.

Finally, attachment insecurity can compound the effects of trauma and stress, leading to emotional dysregulation, which is thought to mediate the development of eating disorders in people who have childhood maltreatment. Research since the 1960s in Holocaust survivor families, families of Vietnam vets with PTSD, and others originally postulated that the effects on children had to do with the difficulties of living with a parent or parents who had been traumatized. Newer studies during the “age of the brain” in research have looked at the impact of trauma on the brain’s development—the number of nerve cells and neurocircuitry of the brain.

Studies in the 1980s identified potentially heritable changes in the expression of genes that can be triggered by life experiences. It is known that when the brain has been affected by trauma, stress, and attachment insecurity, the DNA does not change. If the genetic code does not change, how can trauma, attachment insecurity, or stress be passed from generation to generation? A new field of study called epigenetics helps answer that question. Epigenetic changes are changes in the *expression* of a gene. For example, not everyone who has the genetic predisposition to addiction or eating disorders will develop an addiction or an eating disorder. The expression of the gene for an eating disorder, for example, may be turned on by trauma, early child maltreatment, prenatal stress, and toxic childhood stress. Now that this gene has been “turned on,” it may also be passed from generation to generation. More studies are needed to validate the mechanism of epigenetic changes, but there is no doubt that trauma psychopathology as well as resilience can be passed intergenerationally.

## **Summary**

Disordered eating and eating disorders are not really about food at all. They are about how food is used to tamp down or amp up emotions, to numb negative emotions, or to distract from the pain of past experiences. African American women may adopt cultural values that put them at higher risk for emotional eating and that make it more difficult for them to seek and accept help for the problem. In particular, they may hold themselves to the “strong Black woman” standard. In a study of a demographically diverse sample of African American women, researchers found that participants reported reluctance in expressing their emotions, felt a responsibility to meet everyone else’s needs before their own, and hesitated in seeking assistance from others (Woods-Giscombé,

2010). Like a beach ball held under water, emotions that are repressed may resurface with a vengeance, often in another form. Many participants in this study reported stress-related compulsive behaviors such as emotional eating and smoking.

Parents who have experienced trauma not uncommonly have children who experience trauma. As well, a child's response or adaptation to the original trauma may make them even more vulnerable to future traumatic experiences. African American children living in urban environments are at high risk for repeated trauma exposures. They are more likely to live in poverty, to experience interactions with the police and the justice system, to be placed in foster or substitute care, to be exposed to family and community violence, or to become homeless. In addition to individual trauma experiences, African American children have to cope with the legacy of historical trauma of slavery and the intergenerational effects of racism and continued racial disparities. Research is now confirming that the direct experience of racism or microaggressions and other race-based stressors is predictive of emotional distress, psychiatric symptoms, and the development of PTSD ("Complex Trauma: In Urban African-American Children, Youth, and Families," 2019).

Though slavery was abolished in 1865, its intergenerational effects persist. While African American clients who present with eating disorders are the same in many ways as other patients we treat, they are also different. Being open to learning about these differences is important in healing current and past trauma and ensuring a more stable recovery from an eating disorder. The Centers for Disease Control (CDC) has identified the promotion of safe, stable, nurturing relationships (SSNRs) as a key strategy for the public health approach to child maltreatment prevention. Establishing therapeutic relationships and helping patients improve other relationships in their lives that model the CDC guidelines can also go a long way toward healing intergenerational trauma.

African American women are disproportionately affected by stressful and traumatic life experiences that increase their chances of developing an eating disorder, particularly binge eating, compulsive overeating, or disordered eating. Their struggles with food and eating may be overlooked by clinicians who think of eating disorders primarily in terms of anorexia, perfectionism, and preoccupation with beauty standards defined by extreme thinness. Clinicians should compassionately investigate experiences of stress, trauma, or depression that may contribute to their clients' disordered eating.

### **Treating the Whole Person Using Integrative Medicine**

Integrative medicine has much to offer African American women when it comes to recovery from eating disorders. Problems such as eating addictions or compulsive overeating arise in a context of complex, interconnected factors, so it makes sense to take an integrative approach to their treatment. A client cannot change a difficult past, but she can change how she cares for herself in light of her experiences. Similarly, she cannot change her body, but she can

transform her relationship to her body. Unlike other compulsive behaviors, eating is not something a person can be abstinent from. Consequently, African American women must establish a new, healthy relationship with food.

Healing from an eating disorder involves five levels of change:

1. Letting go of superficial behaviors such as dieting, restricting, and obsessing about food, because these behaviors do not solve the problem of out-of-control eating; they only function as a distraction from the underlying emotional issues.
2. Learning new ways to effectively cope with stress and beginning to acknowledge and express the painful emotions that may have been driving the eating disorder.
3. Developing body awareness, reconnecting with sensations, and learning to see the body as a source of wisdom rather than as a recalcitrant adversary that has to be “whipped into shape” or “kept in line.”
4. Letting go of core beliefs (such as “It’s not safe to trust other people”) that no longer serve a positive purpose and cultivating new beliefs that are accurate and functional in the present (such as “I can trust that certain people in my life truly want the best for me”).
5. Discovering ways to satisfy the profound human need for authenticity and meaning, because these experiences are essential to a good life and also because they serve as natural positive reinforcers that help heal the brain’s reward system.

Clinicians can help clients recover from disordered eating by guiding them through these five levels of healing.

While disordered eating is not fundamentally about food, diet and nutrition do matter. People with food sensitivities (intolerances) often have cravings for the very foods to which they are sensitive. Incomplete digestion of both gluten and dairy protein stimulates the production of opioid-like substances (casomorphins and gluteomorphins) that contribute to food cravings and addiction. Food sensitivities can be identified through an elimination diet, although this can be problematic for people with a history of food restriction, and for that reason, blood tests may be preferable.

Stress, food sensitivities, and a proinflammatory diet can all damage the intestinal lining and lead to intestinal permeability (“leaky gut syndrome”), allowing toxins into the bloodstream. They can also cause an imbalance in gut flora. Proper digestion of food and absorption of nutrients are key to good health. Healing the digestive system can improve both mental and physical symptoms, including cravings, bingeing, and obesity (Crawford, Cadogan, Richardson, & Watts, 2008).

When it comes to diet, one size does not fit all. Food intolerances may arise when a population changes its foodways more quickly than its genetic regulation of digestive enzymes can adapt. For instance, African Americans have high rates of lactose intolerance because their ancestors adopted dairy relatively late compared to Europeans. Thus, many African American women

have found it helpful to model their dietary choices on the African ancestral diet. This involves prioritizing legumes, nuts, grains, vegetables (such as leafy greens, yams, and sweet potatoes), and healthy spices; it also means emphasizing fish and plant proteins over red meat and eggs. Such a diet may improve overall health and reduce the risk for obesity and depression.

Finally, it's important to consider the role of sleep. Sleep helps balance appetite by controlling the hormones ghrelin and leptin that regulate feelings of hunger and fullness ("More Sleep Would Make Most Americans Happier, Healthier and Safer," 2014).

Lack of sleep is, by itself, associated with weight gain, emotional eating, and food cravings. Chronic sleep deprivation contributes to obesity, high blood pressure, diabetes, and addiction. Insufficient sleep may also cause fatigue that makes it difficult to burn off extra calories. Clients can be encouraged to practice good sleep hygiene and to seek help for insomnia or sleep disorders including sleep apnea. Sleep apnea can be both a cause and a result of weight gain.

There are still biases among clinicians who fail to recognize and diagnose eating disorders in African Americans. This can present an obvious barrier for African Americans being able to receive treatment. The second barrier to care is recognizing the significance of trauma as the root of both eating disorders and addictions and, therefore, the need for trauma treatment for individuals with eating disorders. Finally, for African Americans, it is important to understand the context of intergenerational trauma, racism, and systemized oppression as part and parcel of what may lead to the development of eating disorders. This complexity must be understood, however, in order to break the cycle of childhood maltreatment that is at its root. Helping families resolve traumas is imperative, where possible, in helping African American clients with eating disorders heal.

As clinicians, we are more effective in helping our clients when we take a holistic view of their lives. It is critically important that all clinicians work to understand the whole experience of their Black female clients, including their physical health and their emotional lives. Clinicians should also understand the many ways in which the stresses of racism, discrimination, poverty, trauma, family disruption, and adverse childhood experiences can contribute to disordered eating in African American women. In essence, it is imperative that we recognize the potential causes and symptoms of eating disorders in our African American clients so they do not suffer alone.

## Note

1. Throughout this chapter, the terms "African American" and "Black" are used interchangeably to describe women of African ancestry.

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# 3

## THE RACIAL COMPLEX

### Common complexes

In *The Structure and Dynamics of the Psyche*, Jung wrote the following in his description of the complexes:

Today we can take it as moderately certain that complexes are in fact “splinter psyches.” The aetiology of their origin is frequently a so-called trauma, an emotional shock or some such thing, that splits off a bit of the psyche. Certainly one of the commonest causes is a moral conflict, which ultimately derives from the apparent impossibility of affirming the whole of one’s nature. (*Collected Works*, vol. 8, para 204)

We understand from Jung’s definition of the complexes as just described that the complexes were originally a part of the psyche as a whole. Due to what Jung labels “so-called” trauma, we develop what eventually become complexes. It is important to note that he says the complexes are most likely caused by a moral conflict that keeps us from having a sense of wholeness. I think it brings together our understanding of how complexes—actual traumatized aspects of our psyche—reinforce a disconnection with the archetype of the Self. It is only through the conscious affirmative working of an alienated ego burdened with psychological complex issues that the aspect of psyche that seeks balance, through compensatory activity, can become more energized. I would call this, as Jung did, the archetype of the Self.

We come to know complexes as we have lived and studied these for almost one hundred or so years since first Wundt, Pierre Janet, Freud, and later Jung, helped us look into the unconscious, into psyche, seeking to better know ourselves.

Our attempts to understand our human nature leads us into that place not just of a Self archetype but also as Jung labeled it, the Shadow. (When used as an archetype

reference then Shadow is capitalized, otherwise lowercase.) Today, as our understanding of Jungian psychology has grown, we also have a greater understanding of the Shadow as archetype functioning within us on an individual level as well as a collective level. I believe that our complexes hide behind and within Shadow and whatever archetypal core energy encompasses them until they choose to no longer remain hidden. Jung himself says:

The complex can usually be suppressed with an effort of will, but not argued out of existence, and at the first suitable opportunity it reappears in all its original strength.

Jung says that the complexes play “impish tricks.” These are some of the examples he provides in this essay of the *Collected Works* on the complexes in *A Review of the Complex Theory*.

As time has passed we have learned much more about our complexes in terms of labeling them and seeing how they might trap us.

This is true of particularly strong ones that can engage all of us at some point or another—for example, a guilt complex, a money complex, a sex complex.

Probably most known are the parental complexes, especially our mother complex. The emotional weight of our complexes tends to haunt us in our wake state as well as in our dreams.

Jung states that “unconsciousness helps the complex to assimilate even the ego” resulting in “a momentary and unconscious alteration of personality known as identification with the complex. He later says that this identification was spoken of as possession—being driven by the devil or “hag-ridden.” This is more of the serious nature of the complex that we might encounter, and there is no attempt on my part of make little of our mother or father complexes—they bring us, and keep us in analysis, working on them for literally years.

## The racial complex

I was first drawn to Jung’s mention of what I have termed the *racial complex* through his comment in the *Collected Works*, in which he said the following:

Just as the coloured man lives in your cities and even within your houses, so also he lives under your skin, subconsciously. Naturally it works both ways. Just as every Jew has a Christ complex, so every Negro has a white complex and every American (white) a Negro complex. (*Collected Works*, vol. 10, para 963)

At the time of these words Jung had begun writing about America’s ethnic situation—what he believed were the problematic racial differences between whites and blacks and the cause(s) of such differences. Though he did not say very much in this particular paper, titled “The Complications of American Psychology” (1934), he emphasized the negative “fall-out” from the influence of the “primitive”—African and Native Americans—on white American society. It seemed important

to expand on Jung's initial writing about the racial complex—Negro and American, because in referring to African Americans he only identified their desire to become white—to change ethnicity.

Embedded in Jung's minimalist comment is so very much that speaks to our unconscious processes of race and racism in America. As with much of Jung's work from decades ago, it rests with others who have an interest to deconstruct, refine and examine for applicability his theories to our 21st-century lives. I believe that within us and at times holding us are psychological complexes. I also believe that a complex that is devoted to raciality, racism and ethnicity does exist. At the time of Jung's bare reference to what I have termed a racial complex he could only identify an Africanist wish to be white and the white torture of African Americans living under the former's skin. His focus was initially on skin color differences as a determining factor for defining intellectual functioning, spiritual beliefs and interpersonal behaviors. I think that many of our American Jungian community have probably been uncomfortable with Jung's words from the 1930s, these words with their negative racial commentaries generally about African Americans and specifically about those of Africanist lineage. As a result, I believe that we have, like the larger collective, cultural racial complexes.

As an Africanist individual I do not have a white complex as Jung stated because I wish to be white. I have a cultural racial complex that embodies all that I have inherited due to this life—personal associations, the lives of my ancestors and archetypal patterns of all that has come before.

In discussing how Freud became the modern day discoverer of the unconscious, Jung addresses the issue of complexes. He says:

The *via regia* to the unconscious, however is not the dream, as he thought, but the complex which is the architect of dreams and of symptoms. Nor is this via so very "royal," either, since the way pointed out by the complex is more like a rough and uncommonly devious footpath that often loses itself in the undergrowth and generally leads not into the heart of the unconscious but past it.

I can appreciate Jung's idea and image of the complex as a devious footpath because it suits one of my ideas regarding a racial complex. I would like to return to shadow for a moment—the place where we hide in the "undergrowth" all the things we cannot tolerate seeing, feeling, experiencing. I think our racial complexes also can live in that dark place of shadow. It can become that rough footpath that keeps us falling down and leading us astray. African Americans I believe have known more on a conscious level regarding this fact because of being at the negative symptomatic end of the racial complex. The also very complicated racial relationships in American society have been well documented while there is still so much more to tell. Within the last 150 years we have more intensely begun to open up Pandora's Box regarding ethnic issues and racism in America. Actually, today I believe we have more of a dialogue than ever before. But if we are to believe Jung, these conversations will not eliminate our racial complexes.

I agree with Jung. One important circumstance for this is that complexes, as psychic material from the unconscious, develop and have a free will of their own.

I think the only control we can exercise—through free will—on these autonomous split off parts of psychic material is first learning about them, and unveiling them further through shadow work—seeing into our cultural individual and group defenses and by engaging in ego strengthening in support of discovering places where we project our weaknesses onto an Other.

What exactly are our racial complexes? As an African American I have a white American complex—or so Jung believed. How does it haunt me? How am I hag-ridden?

When I was a child my grandmother used to talk about haunts or hags riding people, and the things one needed to do in order to not incur the wrath of haunts or spirits. She also used to speak about the healing remedy for getting rid of haunts. Let's say my racial complex with its white complex haunting me lives in my unconscious self—lower case /s/. How might I be uncomfortable in my own skin, certainly with my identity?

How does my ethnicity cause me a repetitive experience of the psychological trauma of identity tied to race as an individual as well as tied to an American group identity? Growing up African American means that there are racial lessons to be learned at a very early age. The lesson of skin color differences bring with them sociological and psychological wounds and trauma of racism. This is a fact of living in America.

It is a personal experience as well as a known part of our American societal history. It is certainly my own cultural collective group experience.

The suppression, repression and amnesia of racial complexes has contributed to the wounding of our American psyche in terms of how we have continued over centuries to inflict physical and psychological pain, because of a constructed idea regarding differences due to ethnicity.

Collective cultural trauma shows itself as having a cultural racial complex that has been formed and nurtured by first slavery, and down through decades the racist aspects of American life. Jung's idea of the theory of Opposites has done much in probably an unintended way to promote American racism. Samuel Kimbles has spoken eloquently regarding the racial issues inherent in groups that have their own cultural rituals and rites of passage. One of the landmark rites was the passage of Africans to the Americas as slaves. This event I believe remains a very uncomfortable discussion topic for many Americans even though we have not even begun to see deeply into the psychological trauma still being experienced by the descendants of slaves. American slavery was a horrific event that lasted for centuries. Unfortunately, in our unconscious amnesia, we continue to live out our fears through racial complexes expressed many times through racist actions. Jung says, "Complexes are something so unpleasant that nobody in his right senses can be persuaded that the motive forces which maintain them could betoken anything good" (*CW* vol. 10, para 211). There is no wonder we have avoided within our area of Jungian psychology a depthful discussion of racial complexes.

## Dissociation in the s/Self relationship

Identity is crucial to our psychological health and well-being. We understand that from the very beginning of our biological and I would say psychic lives, including the DNA of the archetypes, we need recognition in the form of identity. Due to the issue of racial relations in America, we are taught early on about ethnic differences. Jung pointed to something that was present in our shadowed collective unconscious that was, and continues to be, acted out through negative racial acts.

I believe that when we cannot recognize or see ourselves because of a complex taking over ego consciousness, then we are limited in developing a connection between our ego selves and the archetypal Self. This dissociation in the s/Self relationship, in the situation I am referencing, belongs to the traumatic event of slavery and all that has followed in terms of racial identity problems as part of a racial complex in America. We have seen the struggle to find the “right” identity for African Americans—within African Americans themselves as well as in the collective at large. First called black African, then colored, nigger emerged and has re-emerged, black—the negative one and the one of beauty of the 1960s—finally we have arrived at African American, again. Our American collective has struggled with finding its identity in terms of how we will, and must be treated, because of skin color differences, and all that goes along with the cultural meaning of such a circumstance. The psychological trauma of being Other has its impact on people of color. We can be Other but a part of our consciousness makes the Other—the white person, also an Other. One of the aspects of white privilege and its cultural white racial complex is that it perceives itself as the only thing that can confer qualities such as “otherness.” In the case of African Americans, these qualities, both consciously and unconsciously in the shadow, would have us be “primitive” and not rational minded or reasonable human beings. We would be unintelligent and slow to learn. These beliefs come from racial complexes that have lived unexplored within shadow for many centuries since the arrival of slaves in the 1600s.

The cultural collective that is African American has as a group been bound, not just by the act of physically being bound for centuries, but also the psychological suffering of being individuals held within a racist societal structure. This structure has controlled and promoted through conscious habits the educational, financial and emotional deprivation of this cultural collective.

I believe that this external imposition of a negative racial construct has supported the deepening of a negative racial complex within individuals and in group psychic consciousness. Lynching and development of groups such as the Ku Klux Klan are examples of this type of a negative group consciousness—a cultural complex that erupts into American society. Jung has stated that complexes are split off parts of psychic material originally caused by trauma. I have considered a specific complex, that of the racial complex partly because it has not been discussed in any manner within historic Jungian psychology circles with the exception of Jung’s reference to it in 1934 and American psychiatrist John Lind in 1909 with his publication of the article, in the first issue of the *Psychoanalytical Review*.

I would look to Jungian practitioners to open up a dialogue on one of Jung's theories emerging from his work on the Word Association Experiment. The racial complex is one such under-developed theory. I feel that it is left to us Jungians to begin these conversations. I have considered a written discussion of the racial complex because I believe we are caught in this complex, in a constant struggle with it, while attempting to forget about its existence. The pain of such a complex, as Jung noted, left us no peace. The very real suffering of racial discrimination and even physical death due to one's identity can cause severe emotional trauma. It can feel like the never-ending waves of a tsunami because thus far it has not come to an end. The days of mass lynching of African Americans have passed. However, the words alt-right, states rights, voter suppression and white nationalists all date back to a time when psychological and physical trauma were daily events for Africanist people. I believe the African American has not only the collective fear of such events held in an Africanist psyche but also the individual anxiety at the continuous possibility of being physically harmed due to skin color.

As I stated earlier I think there has been a reluctance to discuss a racial complex in our Jungian collective. Jung himself predicts that this could happen due to the very "devilish" nature of complexes—they only appear to be adequately suppressed by the ego only to come back stronger. Jung identified the Germanic group cultural complex that could be seen in the rise of Nazism leading to the Second World War. This rise of a group of people who participated in the murder of millions showed a distinct manner in which complexes can take hold of us. Individuals made up the armies, medical staff and administrators that formed Hitler's Nazi party. The victims of the trauma of this persecution were also individuals. Sometimes, I think we can lose sight of the importance of the individual—not just in terms of a process of individuation, which the Self promotes, but when dealing with complexes, as with the suffering that can occur. The numbers of those who have been tortured or murdered are so great that it is difficult to comprehend them and stay within our own ego's psychological place of comfort.

When complexes haunt us, we lack peace of mind. The trauma of racism and its effects does not disappear but accompanies one on a daily basis. I propose that any racial complex of African Americans will be closely "identified" with this type of trauma. I think it is important to stress what Jung knew: complexes do not disappear. They are uncovered. They are considered and worked with until we can learn how to live with them in some way that creates less continuous psychic and emotional pain. How can we do this—create less pain originally caused by an initial traumatic event such as the African Holocaust? I believe that we must first open ourselves to conversations about historical collective trauma and intergenerational psychic pain lived out in every day contemporary life. Silence will only harm us. The re-occurring trauma experienced as a racial complex moves in relationship with the self and the shadow. I propose that this relationship creates anxiety and a fear specific to the trauma that initially caused such a complex to develop and becomes repeatedly realized through the generations.

The tension and anticipatory anxiety caused by issues of racial identity, discrimination and fear of physical harm could only intensify psychic pain and a separation or dissonance with the Self. I would imagine that the psychological

work to reconcile the s/Self would be complicated—as Jung said of American psychology when addressing the issue of ethnic differences in America. In the final paragraph of his essay on complexes Jung says that he has only given us the “essential features of the complex theory.”

He does not provide the solutions that are created by the complexes but does say, “Three important problems would have to be dealt with: the therapeutic, the philosophical, and the moral. All three still await discussion.” (*CW* vol. 8, para 219)

I believe that my discussion of an African American cultural racial complex, brought about by the trauma of the African Holocaust, and racism, is one avenue for looking at our deeply complicated American collective as well as individual problems in all three of these areas that Jung have posited—the therapeutic, the philosophical and the moral.

Complexes do not go away. We bring them into consciousness out of the shadow. We make the unconscious conscious. In the further comprehension of Jungian theories and concepts it is incumbent upon us to explore, discuss and examine those things that continue to haunt us. This the true work of being aligned with depth psychological work. I believe myself and others like me follow in a depth psychological way when we pick up the slender threads of the beautifully woven tapestry of consciousness and begin to create a different pattern with a familiar fabric. I think about the development of ideas regarding cultural racial complexes as being in alignment with this proposition.

Two aspects of racial complexes, exposed through racism, are emotional suffering and the pain of invisibility. These aspects combined with the struggle for identity are only a part of what I consider needs healing within the parameters of negative racial complexes. I can recognize these aspects because I have seen them played out in my own life, my family and my cultural collective. I have seen the results of negative racial complexes exhibited in the broader collective.

How do we begin to think about healing these places of psychic pain—of long standing psychological suffering? Most of us wish for and strongly desire a state of inner peace, a harmonic connection between our ego and our unconscious, in this case our archetypal Self. But Jung gives us almost a warning as regards our complexes as we seek harmony.

I think the beauty of Analytical Psychology is that it can oftentimes provide the answer to our suffering. The remedy is in the poison. I believe that Jungian psychology is a psychology of discovery. The path will usually be in the form of a labyrinth—it will of course *not* be easy. The acceptance of this fact and the actual experience of both the suffering and joy of life—both the pain of the complex, and the numinosity of the divine Self, *can* continue to offer us hope.

## **In community**

An aspect of my more recent Jungian-oriented work has been its expansion into speaking and facilitating group processes regarding racial relations for group dream

work, Jungian clinical analytical training and community of individuals broadly interested in Jungian psychology and its practice. At a recent gathering at Antioch University, Los Angeles, a group of individuals—alumnae, students, faculty, Jungian analysts and community members met on a Sunday. We met in order to deepen our experience of one another within a multi-ethnic community of mostly strangers who were willing to think and feel through raciality, American depth psychology, racism and the racial complex.

Through the hours of being together we learned about our own biases—our individual racial complexes, our inner cultural hurting places and how to gain more courage in asking questions about our Jungian community, depth psychology, and racial issues. We began with the question I have asked in the second section of this chapter: what is a racial complex? It is not too simple of a question to return to here as I wish to bring in the voices of community.

Jungian psychology is known for its mostly structured format of a one to one interaction in the clinical practice. I believe that the Jungian material we seek to expand upon in terms of the racial complex suggests a gathering of many who are willing to enter a collective space. One of the difficulties with the racial complex and its archetypal shadowed material is its staying hidden. Jungian community gatherings and discussions, supports adding a format in service of deepening our conversations, on a topic that has hidden from consciousness for a very long while in American Jungian psychology. When we gather I will typically hear that those attending are eager to find answers and raise questions in a circle of others where vulnerability is allowed and no topic is forbidden. This definitely would be a Jungian circle coming together to discuss racial issues.

Within our group that day in response to the questions: What is a racial complex? What does this question mean to you as an individual? Some of the following participant responses were offered:

Paradox  
On-going trauma  
Skin color  
3rd Culture  
Historical trauma  
Who am I  
Self-Vanishing  
Am I deserving?  
Shame  
Projections  
Emotions  
“Reading” the Other’s signals  
Vulnerability  
Owning feelings  
Suppressed humanity  
“Sloppy” work

The openness with which we worked together in our group process reflects the difference in how we have been able unable to communicate about racial relations within our Jungian community. A part of the reason for *The Racial Complex* book is to further open our discussions within and without the area of Jungian psychology.

Group process allows us to share a part of our conscious selves as well as unconscious material—complexes, in a way that does not make us fearful to speak of shame, of ourselves or of others. As our group delved into the question of the nature of the racial complex we can see from the shortened list above that skin color, emotions, trauma and identity are each recognized as a part of this complex. Group participants related their own individual experiences with the “normal” of being a particular skin color—whether white, black or yellow, and the painful emotional encounters with others who find their skin color offensive.

The racial complex like any complex carries emotions. Jung named the complex as being emotion-toned for the reason of its carrying within it emotionality. This emotionality as previously discussed is not only fear due to ego consciousness—a loss of control over complex domination—but also the ego’s fear of what this selected complex carries for the person of color. Regarding the emotions would be fear of death—African Americans have been killed in one form or another because of their skin color over hundreds of year. So within the anxiety of a racial complex for a black person is the ego’s fear of a literal dying. Skin color and emotions are very much tied together as aspects of an African American racial complex.

The identity of black skin, brown skin, yellow skin signifying “Other,” has carried its racial discrimination and resultant penalties for centuries.

Since complexes do not go away in our psyches, can endure for a lifetime—perhaps because of archetypal energies inter-generationally over many lifetimes, it seems very possible that the racial complex of a person of color is bound by the emotion of fear.

This fear has been solidified over generations by lynching, Jim Crow acts of violence and sexual assault against black women. In looking at the common complex and the ways in which it functions, how do we amplify its attributes in terms of the racial complex? For example, in considering how a complex is as Jung says “unteachable,” how do we imagine this would be actualized in a racial complex? Is there a way in which we can “teach” ourselves to behave in a non-racist manner towards someone that we “hate” because of skin color? Can we “teach” our racial complex to “behave” in the face of our own fear of ourselves and of another? How do we teach ourselves not to be afraid when physical violence and death is such a real possibility because of skin color?

I believe that suppressed humanity and shame as highlighted by group members and therefore within this book’s discussion belong together. They can also be discussed as separate affects but cohesions of the racial complex. How do we define shame? What is suppressed humanity? As I listened to a young woman speak of what it felt like to be black, to have “a suppressed humanity,” in that moment it was as if I could feel her “disappear.” Someone from the above list spoke referencing the question of her racial complex in terms of self-vanishing. I could see in those moments of our discussion and feel within the phenomenological space the

quality of making one's self disappear due to shame and the suppression of self that merged together in a number of complexes driven by an autonomous cultural racial complex. Complexes are not singular entities and as elements of the psyche do not exist by themselves without influence by other psychic energies in the unconscious. A multiplicity of them may and will generally interact with each other at any time that one may be constellated. In speaking of complexes Jung says the following regarding shame:

It is not immediately apparent that fear could be the motive which prompts consciousness to explain complexes as its own activity. Complexes appear to be such trivial things, such ridiculous "nothings," in fact, that we are positively ashamed of them and do everything possible to conceal them. (*Collected Works* vol. 8, para 207)

The irony of shame becoming activated in the psyche of an African American individual tied to a racial complex is informative and yet not surprising. Racism demands that within the ethnically different relationship, one individual must overtly carry shame. All of the lessons of American racism dating back to slavery adhere to the rule that people of color must be the carriers of shame. This is a harsh irony. When viewed within the context of a white/black racial complex, who has more to be ashamed of on a cultural level?

When we consider shame within the psyche of an African American woman or man can we think about "deserving"—also from the above list? An emotional positioning within the psychology of having the intergenerational trauma of the affects of slavery addresses worthiness and deserving of the best—deserving of anything. The tradition of slavery and the years following speak to giving the worst—the cast offs, to people of color. How does shame hide in the psychic space of shadow for all these hundreds of years? When a racial complex is triggered by a sense of worthlessness that appears in behaviors or feelings of shame and being undeserving of good, can we not help but see patterns of self-destruction.

Who speaks for our worth and how do we better learn the inner language of self-value?

These were questions raised at our Sunday gathering in our discussion of the racial complex. The racial complex within African Americans promotes a sense of polarity. This polarity is reflected in the American cultural collective in all-American ethnic groups. We have discovered the falsity of declaring us as being a Melting Pot. We are not that but rather more like Jambalaya. We arrived to America in different ways and have survived within our cultural groups through adversity—some of us more than others. I believe that we have learned to live out Jung's theory of Opposites in a sociological as well as psychological manner through our racial complexes. The polarity that was spoken of by the woman participant was addressing not only her inner sense of being segregated from within—being split off from the Self perhaps—but feeling alienated in a home, town, school to which she felt she should belong. She feels a polarity because her racial complex when activated connects with a sense of

isolation and rejection by an Other that refuses to accept *her* cultural differences. In the world of Opposites and polarity, there can only be one “Other” that is acceptable. History, cultural emotional pain, collective racism have all defined for the African American individual experiencing a negative racial complex constellation, which Other is acceptable. This decision as repeatedly experienced, like the endurance of any complex, lives in the racial complex.

In our Sunday discussion, different voices kept returning to the word *trauma*. We also spoke of historical trauma. These are words that continue to return into our daily conversations not only in the room that day at Antioch University, but also in the media, our family rooms and our social settings. We can't seem able to stop speaking of our trauma. I feel that as people of color it took us so very long to arrive at this destination in this time when we can almost touch, not yet fully embrace our historical trauma. It sometimes still hurts too much as an individual and as someone belonging to the culture of ancestral slavery. The centuries that we were born into and lived in human bondage are a part of our historical, inter-generational trauma. We have barely begun to feel ourselves and hear our own voices awakening to this trauma. It does not appear that we are ready or prepared to relinquish this historical trauma. This history and all the historical lies told and truths omitted in American history have added to an American collective racial complex that also exists within each of us who have experienced living on American soil even those who have arrived as immigrants—white, brown, or yellow. In America there are “racial rules” for every “colored” body.

African American historical trauma includes the African Holocaust. We are not forgetting because we are only now waking up to another consciousness of remembering. This history of ours, that includes such a fierce hypocritical denial by the racist structure of American society, has supported and encouraged the development of a racial complex that though I am only discussing here with a focus on whites, actually belongs to all Americans. Jung's perspective on the racial complex in terms of whites was that the “negro” was under the skin of whites.

This image of African Americans as irritant has persisted through the centuries with Africanist people as “the problem.” This denial of us as worthy, a part of humanity, deserving of a non-enslaved life, has become a sometimes repressed, sometimes active part of American consciousness. I believe it is a part of why we struggle with racism and display all the symptoms of racism through our attitudes and behaviors. In the collective there has been centuries-long denial of racism and racist actions all flourishing underneath white privilege. In the burying of Africanist people needs, wellness, prosperity, the repression of their goodness, what arises in the unconscious actions of a white Other signals the presence of trauma in the form of a racial complex in the personal unconscious.

The historical trauma of the African Holocaust I believe resonates so much more loudly now than ever before in our awakened consciousness because we have had so many centuries of denial regarding its existence. The stories and narratives of slavery were not considered important in telling the history of the Americas. The cursory telling of the lives of millions who died in the Middle Passage and as part of North

American slavery created a quilt of comfort under which American collective tragedy could reside in shadow.

What about white guilt?

This was part of a question posed by a group member. I would ask what about a white guilt complex in duality with a white racial complex? How do these complexes present themselves in terms of race, racism, behaviors and attitudes?

Another woman addressed her own personal issue of not believing that she could own anything—that nothing could ever really belong to her—ever, not even her own feelings. She was afraid everything could be taken away from her. She believes this is a part of her racial complex as a black woman. The first response to her came from a white man. He said that he doesn't think about such a thing, ever—because he was raised as a white American male to think of ownership of *anything* as a natural way of functioning.

Is this a part of white privilege—part of a cultural white racial complex? What do centuries of slavery and ownership of millions—human beings, land, money—do to the complexes and collective unconscious patterns of psyche that reflect ethnicity?

I view the Sunday that we spent together at Antioch University as a continuation of Jung's work on complex theory. I don't think that we can have only one location—solitary rooms for all the questions, concerns and rhythms of psyche that present in our individual experiences or within our 21st-century collective. I do believe that we must occupy every space that we can with inner and outer conversations because the tenacity of our racial complexes are relentless in their ability to survive, remain strong, and cause emotional pain.

In *The Complications of American Psychology* Jung states the following:

Racial infection is a most serious mental and moral problem where the primitive outnumbers the white man. America has this problem only in a relative degree, because the whites far outnumber the coloured. Apparently he can assimilate the primitive influence with little risk to himself. What would happen if there were a considerable increase in the coloured population is another matter. (*CW* vol. 10, para 966)

Perhaps the *racial infection* to which Jung refers is actually our racial complexes. We as Americans have certainly *all* been infected no matter the size of population.

Apparently, one of the most relevant fears of some who have a cultural white racial complex, one hundred years after Jung wrote the above words, was that the colored population *is* increasing. What would happen if there was a considerable increase in the *colored*, black and brown population?

# Dying to get out

## Challenges in the treatment of Latin American migrants fleeing violent communities

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In this chapter, we explore the intersection of migration and trauma via three clinical vignettes that capture the complex nature of the psychological experience of immigrants fleeing violent communities as well as the therapeutic challenges that emerge in treatment. The three cases we present reflect work with individuals who experienced significant personal and social trauma in their lives prior to making the decision to migrate. All three came from impoverished communities in Mexico where violence was rampant and where community violence was overlaid onto personal experiences of familial deprivation, conflict, and loss. While economic opportunities no doubt played a role in their decisions to migrate, the overwhelming character of their experiences in their home communities were also decisive in these deliberations. Further, though these patients presented for treatment due to concerns in their daily lives at the present, the violence of their pasts was for each a crucial and defining aspect of therapy and the seemingly unrelated concerns they presented.

### **The context of modern immigration**

The population of immigrants in the United States has exploded, growing four-fold since the 1960s (Pew Research Center, 2016a). Today there are more than 42 million immigrants living in the United States, almost two-thirds of them from Mexico (Pew Research Center, 2016a), with roughly eight million immigrants classified as “unauthorized” (Pew Research Center, 2016b). What is often missed in explorations of the psychology of immigration and therapeutic work with immigrants is the fact that many, especially those coming from Mexico, Central America, and Africa, are coming from communities ravaged by violence. This means that in addition to the more familiar themes that we associate with the psychological experience of migration, such as loss and mourning (Ainslie, 1998; Akhtar, 2011; Grinberg & Grinberg, 1984; 1989) and the stressors of encountering a new and unfamiliar culture (Ainslie, Tummala-Narra, Harem, Barbanel, & Ruth, 2013; Akhtar, 1996), clinicians working with immigrant populations must increasingly be aware of, and sensitive to, the very real possibility that their patients have witnessed and/or been victims of unspeakable violence in

their communities of origin, including victimization through domestic violence, criminal organizations, or violence that is state sponsored (see Holland, 2006 and Volkan, 1993).

Such realities have increasingly blurred the historic convention of distinguishing between immigrants and refugees as motivated by different considerations. Historically, refugees have been understood to be individuals fleeing political violence and catastrophic circumstances, whereas immigrants have been viewed as driven by economic hardship. Increasingly, however, immigrants are fleeing communities in countries that have devolved into civil war, or where broad swaths of those countries are, for all intents and purposes, ungovernable failed states with no rule of law. People who leave countries facing such conditions are likely to have been motivated to leave their communities of origin driven by both economic concerns and by the cataclysmic social conditions where violent crime, including high murder rates, is rampant. People fleeing countries experiencing such violence and tumult arrive in places like the United States and Western Europe having been immersed in extremely traumatic experiences yet without the protections afforded by refugee status. Treatment providers are unlikely to consider the traumatic experiences that these individuals have experienced, as they fail to appear on most standard assessments (Kaltman, Green, Mete, Shara, & Miranda, 2010).

Considering that these patients fall into the space between categorizations of “immigrant” and “refugee,” it is important that their unique constellation of needs be recognized. In the following cases, we wish to illustrate the complexity of therapeutic work with these immigrant patients, especially when that complexity is shaped by a confluence of personal and collective trauma and the utility of psychoanalytic frameworks for meeting their needs.

## **Case #1**

Sylvia was a Mexican woman in her late 40s, a mother of five who had lived in the United States for about 15 years. She was connected to counseling services through the Texas crime victims’ compensation program. Four months previously, Sylvia was the victim a nearly fatal attack that left her with significant physical and emotional scars. Sylvia was born and raised in what she described as a poor and very rural community made up of small farms, outside of Nuevo Laredo, Mexico. Sylvia’s community of origin can be characterized as “violent” because of the violence perpetuated within it, but, perhaps more importantly, because of the failure of systems to provide justice and protection to those, like Sylvia, who were victimized. The events of her early life and the failure of her community to hold and protect her were recurrent themes in our work, nearly half a century later.

Sylvia was the youngest of 11 children and described her early childhood as marked by poverty and the sense that her family did not have sufficient resources. She reported that her father had left the family before she could remember. In her early childhood, before the age of 5 or 6, Sylvia was sexually abused by her maternal uncle, though she had limited memories of this event. Yet, the difficult

conditions of her early years were cushioned by the love of her mother, a woman who reportedly worked tirelessly and lovingly to support her children.

However, Sylvia's life changed dramatically around age 9 when her mother was murdered by a spurned would-be lover. Sylvia alternately recalled being told this news by her eldest sister and discovering it by seeing a photograph of her mother lying in a pool of blood in the newspaper, an image that haunted her. There was never justice for Sylvia's mother; her killer was never prosecuted and continued to live in the community. Following her mother's death, Sylvia was sent to an orphanage run by nuns for the remainder of her childhood, an experience she described as "cold," "hungry," "cruel," and loveless. Although she maintained contact with her siblings, Sylvia recalled that after her mother's death she was "alone" in the world. Despite her negative experiences at the orphanage, she developed a strong Christian religious conviction.

In her late teens, Sylvia met and married her husband. Through this marriage, she achieved financial stability that she had sorely needed. She and her husband had five children, and motherhood came to be a central aspect of Sylvia's identity. However, from the beginning the marriage was tempestuous, abusive, and violent. Sylvia reportedly experienced severe episodes of depression, attempting suicide at least twice during their marriage. After more than 15 years together, Sylvia left her husband, although they did not divorce. She reported that living alone with her children outside Nuevo Laredo for the following few years was the happiest time of her life, in which she finally felt she had a place of her own. However, after her elder daughter immigrated to the United States, Sylvia was persuaded to move as well, first to Laredo and then to a larger city in central Texas.

Moving in with her elder daughter's family, including three young children, and Sylvia's youngest, still-teenaged, daughter, she found herself overwhelmed with childcare responsibilities and with little of the freedom she had enjoyed during the years after her separation. In particular, she felt restricted by her financial dependence on her daughter and son-in-law. As a result, Sylvia sought employment to provide herself with more independence and the sense of purpose she missed from working. She secured a job as a bartender at a bar in a blue-collar, Spanish-speaking neighborhood. Although Sylvia felt ashamed about working at a "low class" bar, which was at odds with her identity as a mother, she reportedly loved working as a bartender: the money, the camaraderie with her co-workers, and the chance to listen to her customers and give them advice.

The attack that precipitated Sylvia's seeking therapy occurred before her regular shift at work. Her memories of the attack were limited; she recalled clearly getting out of the car to go to work that evening and receiving a call, which she later saw as portent, from her son-in-law encouraging her to stop working and to leave her job. Sylvia couldn't recall what instigated the attack itself, except that the coworker who attacked her had caused problems before, and she recalled a "flash" of memory of the other woman jumping across the bar at her "like an animal," smashing a bottle and attacking Sylvia's face, body, and hands with the

broken end. Sylvia recalled seeing herself, her body as if from above, lying in a pool of blood.

Four months after the attack, Sylvia presented to her first session at the community mental health agency where I was a practicum student as extremely dysregulated, unable to fill out her paperwork, quick to disassociate, hyperventilate, and experience panic attacks, suicidal and desperate for someone to talk to about how poorly she felt. Sylvia bore scars on her face, wrist, and arm and along her thigh running from her waist to her knee. These scars, she felt, were mocking reminders of what she had been through. The depth and relentlessness of Sylvia's despair and its embodied presentation, howling sobs, quick and shallow breathing, hunched posture, and ceaseless pacing, affected and overwhelmed me. Sylvia reported symptoms associated with complex PTSD: chronic suicidal ideation, tumultuous interpersonal relationships, a fragmented sense of self, flashbacks, panic attacks, and a pervasive sense of loss of safety, meaninglessness, and despair.

Sylvia's transference toward me was idealizing and very, even overly, positive. She called me her "beautiful, studious angel" and would tell me that therapy was the only place in which she could be herself. In my countertransference, I often felt a sense of helplessness, that treating her was wrestling a windstorm. Yet I also found her charming, sharp and funny, and abidingly strong. Her presentation was so turbulent, so easily, seemingly almost willingly, dysregulated, that our sessions were fragmented and our progress slow. In addition, despite her praise for therapy, Sylvia had chronic difficulty getting to session and arriving on time. She acknowledged that she was her own biggest barrier to treatment: failing to fill the car with gas, putting off leaving her house, forgetting to check her voicemails.

Despite our uneven progress, Sylvia was immensely compelling and her case filled with meaningful interplay between her present and past. From the beginning of treatment, Sylvia introduced her presenting issues as not just the recent assault that had nearly taken her life but also, and even more so, her unresolved feelings revolving around the death of her mother. The two events were so inextricably intertwined that at moments I could not tell which of the two she was talking about or whether the thoughts and feelings she expressed referred to both. I came to understand that these two events meant the same thing to Sylvia, the loss of safety in the world, and were symbolized by the same image of Sylvia and/or her mother lying, dying in a pool of her own blood.

She repeated constantly the question "why?" Why had this happened to her? she asked. Why had God permitted that her mother be taken, that her own life be threatened? Her fears about her own potential loss of life were transfigured into a persistent, nagging suicidal ideation, held back only by her deep conviction that suicide was punishable by an eternity in hell and by Sylvia's sense that her suicide would do to her children what her own mother's death did to her. She alternated between asking why she hadn't fought back, even killing her coworker, and asking why her coworker hadn't done them both a favor and finished the job. Between furious questions of "why," she would raise her head, smile slyly, and ask me "Am I crazy?" or crack a dark joke. Despite the chaos

Sylvia brought into the room, in these moments of stillness I felt connected to her, admiring her strength, her humor, feeling deeply for all that she had been through.

The line between reality and dream, in addition to that between past and present, was often blurred by Sylvia's frequent experiences of portentous dreams, visitations, visions, nightmares, and flashbacks, experiences that often featured the key figures of her mother and her attacker. This symbolic content played an important role, helping me to see through content that was often difficult to parse. Sylvia reported experiencing visitations from her mother in her dreams. She had experienced similarly mystical dreams in the past, including dreams foretelling the deaths of two of her brothers. In the visitations, her mother appeared and offered her love and comfort. Yet Sylvia seemed unable to accept the love and comfort her mother offered her. Sylvia described her mother's arms reaching out to embrace her but the thought of the embrace, rather than providing comfort, re-awoke her sense of fear and provoked extreme emotional dysregulation.

As therapy progressed, it became apparent that in all her relationships Sylvia experienced similar difficulty accepting the love she craved; in her relationships with her children and with befriended neighbors, bids for love and attention turned to bitter fights. Fights, particularly those with her children, in turn produced bitter self-recrimination for proving her failure as a mother. In session with me, she invested in and praised our relationship, sometimes leaving needy, breathless voicemails only to fail to show up for the appointment and thereby the care she sought.

A key metaphor from our treatment came from Sylvia's visions of two dolls, the good, beautiful doll and the ugly, bad, unlovable doll. Sylvia reported that these two dolls had been two of her few possessions when she lived in the orphanage. She identified herself as the ugly doll, thrown to the floor, undeserving of love. She fragmented herself into "the ugly doll" and the "good mother." I came to appreciate her tempestuous presentation as the result of spending her week denying the "ugly doll" in order to perform the role of the "good mother," only to vent the pain, hate, and suffering of her denied self in the consultation room with me. Sylvia would gesture to a corner of the room and tell me she was seeing the doll, lying there, unable to be picked up, and she would spew verbal abuse at it.

In many ways, that is how our therapy ended: my care and regard for her could not convince Sylvia to pick the doll up, to use her capacity as the "good mother" to care for the part of herself who needed mothering the most, model it though I tried. After eight months of therapy, I moved agencies and brought Sylvia to the new agency as my client. In our first session she was desperate to see me and I was relieved she had made it, half expecting the change of venue to shatter her already tenuous attendance record. But she missed our second session, later citing a new job that conflicted with our time. I detected a familiar pattern: a job was significant progress for Sylvia, yet it became the barrier to further treatment. In

our third session, she broke into a tirade of racist insults, turning to me and noting, "I've offended you, haven't I?" Sylvia didn't return my calls after she missed the next appointment. I didn't have the opportunity to ask her if she was trying to push me away or to pick up the doll again.

## Case #2

Working in a primary care setting often proved challenging due to the time and session restrictions, even as it provided opportunities to access and provide integrated treatment for underserved patients.

Gloria was a 26-year-old mother of three who had emigrated from Mexico. Gloria's primary care physician referred her for therapy when she presented with concerns of depression and "anger management difficulties." The clinic provided Gloria with psychiatric consultation for anti-depressants, one-on-one counseling sessions with her therapist, and parent-child therapy with another psychologist – all in one location.

Gloria had migrated to the United States eight years earlier with her husband and oldest daughter after the violent murder of her sister-in-law. Gloria still recalls the trauma of witnessing her sister-in-law's dead body in the family dining room, her home's white walls stained with blood. Her sister-in-law's murder remains unsolved. In addition, Gloria's family faced recurring threats from local gangs. Gloria described being "hunted" by local gang members who were seeking to extort families and small businesses in the community. Leaving everything behind, Gloria and her family fled the corruption and violence that defines contemporary life in many Mexican communities.

Gloria had seen therapists at the community clinic on two previous occasions prior to this course of therapy. Since her initial visit in 2009, clinic psychiatrists had diagnosed her with depression; unspecified, then major depressive disorder, generalized anxiety, with a possible personality disorder. Over the years, Gloria had been on a variety of anti-depressants, but none seemed helpful and she therefore was reluctant to stay on her medications. Significantly, Gloria's two former therapists had described her as a "guarded" patient who assiduously avoided speaking about her previous life in Mexico.

Gloria returned to therapy for a third time, now presenting with concerns that she was experiencing distressing difficulties feeling close to her three young children; her eldest daughter had to come with Gloria and her husband, while the two younger girls were born in the U.S. Gloria feared that her daughters would see her as a "bad mother."

This time Gloria's experience in therapy was markedly different from the prior two therapies. She appeared to be highly motivated and very engaged with therapy. For example, although she lived 40 minutes away from the clinic and had very limited resources, she never missed an appointment and always arrived early. Her only absence was a three-week hiatus during major Immigration and Customs Enforcement (ICE) raids in the community, which resulted in her feeling that it

was too unsafe to leave her home. She often had to bring her 2-year-old toddler to her sessions, but preferred that to having to miss an appointment.

During parent-child sessions, I observed that Gloria's children appeared to adore her. They were often affectionate toward her, but she was very rigid and unable to reciprocate their overtures. Gloria could observe herself, and in her individual therapy appointments she reported that she was painfully aware of what was taking place but felt unable to respond. The circumstance left her feeling deeply frustrated. In her individual sessions, she voiced the wish to be able to be more responsive, to find this "genuine love," a love she said she had never felt. "It has to be genuine," she would say.

Another complication in her treatment was that it was clear that Gloria did not respond well to the short-term, Cognitive Behavioral Therapy modality that was the clinic's primary approach to therapy; it was too directive and did not fit well with what I could sense she needed. My supervisor and the clinic allowed me to approach this therapy with a non-structured, narrative focus. This was a big change for Gloria, but she responded to it well, as reflected in her dedication to the work we were doing together.

In Gloria's prior two treatments she had been very reluctant to talk about her past experiences, but in the current therapy she was gradually able to bring her past into her therapy. Gloria found a way to connect with me and reveal her vulnerability and I learned quickly that the therapy sessions were providing her with a space to show the vulnerability she was hesitant to reveal to the outside world.

As we slowly delved deeper, Gloria began to discuss how her own mother had abandoned her in infancy because she was a product of rape. Her mother left her with her maternal grandparents in rural town in Mexico. Gloria described her grandmother as a very cold and distant woman. Thus, no one filled the emotional void left by her mother's abandonment and rejection. In addition, Gloria reported that her grandfather had sexually exposed himself to Gloria and her cousins at an early age. Gloria was also sexually abused by an older male cousin and a family friend between the ages of 8 to 12. At one point she had attempted to tell her mother and her grandmother about these experiences, but nothing was ever done to protect her.

Gloria was, for a long time, not able to understand how these experiences had impacted her emotional life and, in turn, her ability to connect with her children and others. She reported that as a child she had never felt a bond with anyone in her family, and gradually she came to see that this was the pattern that she was now repeating with her own children and husband.

Gloria felt a tremendous amount of guilt about her difficulties in these relationships. This included her mother, whom she attempted to re-engage, but continued to feel as if nothing was there. She described this effort as a formality born out of *respeto* (respect) for her mother, but lacking the real emotion she desired. There were many variations. She also felt guilty that she had never allowed her sister-in-law, the one who had been murdered in their home prior to Gloria and her family

leaving Mexico, to get close to her, a connection she knew her sister-in-law had very much wanted. Gloria felt haunted by her relational failures at every turn, failures that left her feeling depressed and full of self-criticism. "There's nothing good about me," she would say in her appointments.

Gloria had succeeded in erecting an emotional wall around herself, beginning with her maternal abandonment, her grandmother's cold indifference, and the sexual abuse that had victimized her. Her sister-in-law's murder was simply the final blow. For Gloria, to be vulnerable was to expose herself to profound loss and anxiety. It was too much to risk.

We took it session by session. The therapy focused closely on the therapeutic relationship, constantly reflecting on what was taking place between us. There was an obvious pattern in which she would reach out to me in some way, only to immediately pull back into her defended, guarded position. It was evident that our relationship was enormously important to her (and, in countertransference, I felt very maternal and caring toward her). Even though we were close to the same age, in the transference I became the mother that did not reject her or abandon her, but rather the "good object" that stood with her, was interested in her, and that "genuinely" cared about her. At times when she felt hopeless that she could not "mend" or that she was just "a bad mother," I reassured her that I was here for her and that I would not give up on her; that I would carry the hope for her until she could carry it herself. The therapeutic alliance became the primary therapeutic tool upon which she leaned. This was the reason she never missed appointments and the reason she arrived early, eager to start the day's therapy.

In one session, when she'd been bringing in the many sad and traumatic aspects of her childhood and reflecting on the many facets of the abandonments she'd experienced, she became flooded with emotion. She said she feared she was incapable of loving others like a mother should love her children or a wife should love her husband. She couldn't find that tender place within herself from which she knew such feelings came. She was acutely aware in that session of the wall she had built and the emotional cost to her of such protection from vulnerability. It was one of the few times I saw her cry in the 11-month treatment.

I was a practicum student at this clinic and I was to rotate to another site at the end of the year. An extremely difficult moment in the therapy centered on the termination. It was the clinic's policy that Gloria could be transferred to another therapist, but Gloria's response was what one could have anticipated given her history of abandonment and given that she'd finally allowed herself to feel close to me. Even as Gloria expressed her dismay, we were able to reflect on how our therapeutic relationship had shown her that she could, indeed, feel close to others and the implication of this for her relationship with others. We also explored what she valued about our relationship, and the fact that although she might be scared about the termination, she would have these genuine moments as a reminder of what she could have with others in her life. I, too, felt a great deal of sadness in the termination as well as some guilt: I was abandoning her as she'd been abandoned by others whom she needed and relied upon. However, this loss was different. We

both knew it and, most importantly, we could talk about it – something that had never been possible before. Gloria’s story was a journey of grief, guilt, abandonment, and trauma – all which had plagued her ability to connect with others, especially her own children. However, it was clear that she’d made significant strides in working through these feelings by the time I left the clinic.

### **Case #3**

Arturo was referred by local nongovernmental organization (NGO) as a young man “struggling with his transition to life in the United States,” as well as symptoms of depression and anxiety. The appointments were carried out in Spanish, both patient and analyst being native speakers. Arturo was 19 years old and dressed in ill-fitting work clothes furnished as uniforms by his place of employment. He was slight in height and frame, and he avoided eye contact. He seemed frail and quite vulnerable. In the initial appointment, Arturo appeared quite dissociative, and it was with great difficulty that he attempted to describe his situation. One of the things he discussed was that he suffered from great anxiety and felt very isolated and alone, notwithstanding some sources of support: a girlfriend and her family, as well as the church that they all attended. Arturo was not a religious person, but this church community was very welcoming of people in his circumstance and it was through the church that he had met his girlfriend and her family. People in the church community actively reached out to him and had helped him find work, and he described his girlfriend and her family as embracing of him (they were American citizens of Mexican ancestry).

Notwithstanding the efforts to support him, Arturo was acutely aware of the fact that he experienced great difficulty allowing his girlfriend, her family, and others in the church community to get close to him. He described himself as chronically feeling hyper-anxious, easily distracted, and very disconnected. The latter, in particular, was creating substantial conflict in his relationship with his girlfriend, a circumstance that worried him considerably. He was afraid that he was going to lose his girlfriend, yet he found it difficult to behave in a way that met her needs within the relationship. This was reproduced in the sessions, as he found it difficult to relax and connect with me, sharing his experiences only with great difficulty, skittish in his eye contact, and requiring a great deal of effort to draw him out. In the countertransference, I experienced him as “orphaned” (the image had come to mind for me during our first appointment), and notwithstanding his avoidant, detached style, there was nevertheless a pull toward wanting to take care of him that may have been the same quality that helped his girlfriend, her family, and the church community reach out to support him as well. He was likeable even though he kept himself at a remove.

Prior to his migration to the United States, Arturo, his mother, and two younger siblings had lived in a poor, working-class neighborhood in the border city of Nuevo Laredo, Tamaulipas, across the Rio Grande River from Laredo, Texas. Arturo’s mother was a poorly paid public school teacher. Arturo’s father had

abandoned the family when Arturo was six and it had been years since he had had contact with him. Nuevo Laredo was a dangerous city, especially in neighborhoods such as the one where Arturo and his family lived. More than a decade into the raw violence that has swept parts of Mexico and claimed close to two hundred thousand lives, Tamaulipas remains one of the most violent and ungovernable areas in the country.

In the first appointment, Arturo indicated that he'd "had to leave Mexico," without further elaboration. It wasn't until his second appointment that the reasons for his leaving were fleshed out. When he was 15 years old, Arturo and two friends had left his house where they'd been playing video games and walked to the corner store to buy a soda. As the boys emerged from the store, a group of men brandishing guns forcibly seized them, placed bags over their heads, and bound their hands with duct tape. They were subsequently beaten while being held in a room in a safe house somewhere in the city. Neighbors witnessed Arturo's kidnapping and immediately notified Arturo's mother. The kidnappers soon contacted her, demanding an exorbitant ransom that she was unable to pay.

Nuevo Laredo was under the control of the Gulf Cartel and their armed wing, a group of ex-military gone to the dark side known as Los Zetas (the Zetas would soon split off from the Gulf Cartel and become the most feared cartel in Mexico). The streets of the city had been a bloody battleground since the early 2000s, when the Sinaloa Cartel had attempted to seize control of Nuevo Laredo, which was prized because of its easy access to United States drug markets, given that the border crossing at Laredo, Texas is, by a significant margin, the busiest truck crossing on the U.S.-Mexico border with approximately two million trucks per year (U.S. Department of Transportation, 2016). The result was open warfare in the city streets, including an ambush of federal forces as they arrived to reduce the violence, the murder of a newly elected mayor within hours of assuming the post, and attack on the city's newspaper with bazookas and AK-47s. But in the poor neighborhoods, local gangs terrorized defenseless civilians with assaults, kidnappings, and extortions. It is likely that Arturo was the victim of just such a local gang; at least that was his own theory.

The three boys were kept in the safe house for a week. In the interim, Arturo's mother contacted her brother who, according to Arturo, had "communication" with the Zetas or a street gang that was closely affiliated with them. Through his contacts, Arturo's uncle arranged for his release, without payment. On the day he was let go, the kidnappers entered the room where the boys were being held, sacks still over their heads and hands now zip tied. They took off the bag over Arturo's head and, in that moment, the kidnappers executed the two other boys with a gunshot to the head. Perhaps they acted out of frustration: their kidnapping was unraveling, as none of the boy's families had money and they'd now been forced to free one of them. Whatever the cause, the violence was reflective of what has become commonplace in a handful of Mexican states where drug-related violence runs unabated – communities where ordinary citizens live under constant threat

and high levels of vulnerability with no recourse (law enforcement is either non-existent or in collusion with the criminals who victimize the citizenry).

A terrified Arturo made his way home and told his mother what had he'd endured over the course of that week and about the assassination of his two friends in front of him. Arturo and his mother believed that he continued to be at risk, so they immediately pulled together a bag of his clothes and a little cash, and Arturo made his way across the Rio Grande River, illegally crossing into the United States. He remained in Laredo for 18 months, living with an aunt before making his way to San Antonio, where employment was more plentiful and where he had another relative. He spent two years in San Antonio before moving to Austin where he was now working in the service industry.

I only saw Arturo for five sessions. During each, the sense that this was a very traumatized young man remained salient. I understood his avoidant quality as clearly defensive – a product of the overwhelming trauma of his kidnapping. That trauma was in turn overlaid on a familial history of poverty, neglect, and abandonment. Arturo found every session difficult, and yet he seemed to also value them, as he put considerable effort into getting to appointments. He worked six days a week, and public transportation to my office was difficult to manage given that he lived and worked at the other end of the city from my office – it took Arturo an hour and a half each way to make his appointments. The focus of our brief contact was to help him understand that the difficulties he was experiencing in allowing his girlfriend, her family, and others in his church community to get closer to him were rooted in the overwhelming violence he'd experienced, layered over a family where there had been little affection or closeness – three children abandoned by their father with a single mother who worked and had no alternative but to leave them at home alone until she returned from work each day. His mother had no emotional reserves left to give much to her children in terms of love and affection beyond keeping the household afloat financially on her meager income. Without a doubt, his anxiety and depression were partly shaped by these experiences, although the overwhelming nature of his kidnapping and the death of his two friends was a specific, traumatic event and pivotal in driving him to leave home. It had also left a deep and as yet unprocessed psychological wound. After the fifth session, Arturo left me a voicemail saying he would not be able to make his appointment the next few weeks due to work conflicts and illness in his girlfriend's family. He said he would check back with me when he was ready to resume, but I did not hear from him again.

In my view he had used these sessions, in part, as a place to share his history with another person who listened to it with empathy and understanding. That, alone, was meaningful. These were experiences that lived within him that prior to these appointments had not been shared with anyone else. He'd been alone with them for years. While his presentation was emotionally quite flat and detached, it was not dissociated. He *wanted* to tell me what he'd lived through. My stance was to be receptive and, where appropriate, to suggest the connection between these experiences and his current struggles – gingerly and in ways that were “useable.”

Similarly, four years after his kidnapping, Arturo had never discussed this experience with anyone, save with his mother the day of his release. He voiced relief to have a place where he could talk about it. Remarkably, he had not seen the connection between this traumatic experience and the difficulties he was having allowing himself to get close to his girlfriend and to others.

Everyone who had contact with Arturo, including the NGO that referred him for treatment, thought that he was just one more undocumented immigrant fleeing economic hardship for a better life in the United States. The caseworker's description that he was "struggling with his transition to life in the United States" only captured his circumstance in the most superficial terms (partly, of course, because Arturo himself had not shared with her a fuller picture of his background and the experiences he'd endured given their traumatic character). None imagined that Arturo had survived a profoundly traumatizing horror as a young teenager.

## Discussion

The literature on the psychology of the immigrant experience rarely enters the terrain of trauma, and yet increasing numbers of immigrants are driven to leave their countries of origin because they live in communities ravaged by violence, often violence that has affected them directly. It is our view that clinicians working with immigrant populations should always be alert to the possibility that their patients arrive with both personal and collective experiences of trauma that may create significant therapeutic challenges. In addition, some of these patients' current conflicts may activate or deeply resonate with prior trauma that they have experienced. Arturo's difficulties relating to his girlfriend, her family, and his church community were clearly a product of the profound trauma he had experienced as an adolescent prior to leaving Mexico. This is also clear in Sylvia's fusion of the near-lethal attack at her place of work in the United States post-migration, with the murder of her mother when she was a child, as reflected in the collapsed symbolic representation of seeing her bloodied self as at one with the image of her mother's bloodied body, as well as in her therapist's struggle to distinguish the emotional reference points ("is she talking about herself, her mother, or both?"). For clinicians working with immigrant patients who come from conflict-laden communities and who have experienced overwhelming violence in addition to substantial personal/familial conflict, the emotions are often difficult to distinguish and, indeed, as with Sylvia, are at times fused.

Similarly, Gloria's struggle with her attachment to her children and others in her current life was an extension of her mother's abandonment and rejection from the very beginning of Gloria's life. Gloria's grandmother's coldness and emotional neglect meant that she was unable to fill the vacuum created by the loss of her mother and, instead, further exacerbated the impact of this early maternal abandonment. Finally, her extended experiences of sexual abuse as a little girl also played a role in fostering her protective detachment. This detachment, with such deep roots in Gloria's childhood, was now surfacing as a conflict-laden

concern, as she struggled to feel close to her three children, her husband, and others in her current, post-migration life.

Immigrant patients with multiple personal and social traumas often require therapeutic approaches that are more flexible and relationally driven and where there is a focus on creating a space within which these patients can eventually discuss and explore the traumatic content that so haunts them, in addition to exploring other life experiences. For example, Sylvia entered therapy in a state of acute crisis, dysregulated to the point that she could not fill out the paperwork during intake. However, her therapist succeeded in creating a therapeutic space within which Sylvia could eventually feel safe enough to explore her mother's murder and the near-lethal attack that had been the impetus for her seeking therapy. The turbulent character of some of the sessions was offset and absorbed, to some extent, by the positive, idealizing transference that Sylvia developed toward her therapist, and it helped sustain the therapy during these difficult times. Similarly, Gloria had previously seen two therapists who viewed her as guarded and closed-off before finding a therapist who was willing to set aside the time-limited CBT framework that her agency preferred for a more open-ended, non-directive narrative approach, where attention to understanding Gloria's life-defining experiences and how these surfaced within the therapeutic relationship was the focus of the work.

It is our observation that psychodynamic approaches that are characterized by this open-endedness, with attention to creating a "useable" therapeutic space and where the observation of transference and countertransference elements helps to shed light on and facilitates the use of the therapeutic relationship in constructive ways, are all key to working with immigrant populations who have experienced trauma. But just as importantly, such accepting, unstructured, narrative-based approaches appear to be more culturally sensitive to the needs of people for whom time-limited, overly structured, directive therapeutic approaches are not a good fit.

Finally, all three cases illustrate the brittle nature of the therapeutic frame when working with immigrant patients with multiple traumatic experiences. Sylvia and Gloria both responded with great difficulty to their terminations, and neither was able to follow her therapist to the therapist's new site, despite good working alliances and despite the therapists' best efforts to continue the work. The break in the continuity of the work was simply too much for these two patients. In the case of Arturo, simply being in therapy posed an extreme hardship given his long work hours and the inordinate amount of time it took him to reach his appointments. Nevertheless, in retrospect, his therapist felt that he should have been more thorough in addressing Arturo's challenges in making it to appointments. Perhaps such an exploration might have provided some strategies for facilitating his continuation. On the other hand, it is also possible that the appointments were themselves challenging, emotionally, for Arturo given that the process challenged his defenses. Nevertheless, Arturo's treatment also exemplifies another common feature of work with such immigrants: the fact that they work long hours (often at

more than one job), frequently with the pressure of earning enough money to help support family in their country of origin, all the while earning low wages. Such conditions can sometimes make therapeutic commitments difficult to sustain.

However, as seen in these three cases, the logistical difficulties posed by treatment for immigrant patients are not a prescription for overly structured or time-limited approaches, but rather require clinicians to develop and use flexible, relational approaches to reach through the structural barriers that may appear to “wall off” these clients. In addition, psychoanalytic frameworks provide critical tools for working with these populations on a variety of levels. First, they provide an indispensable theoretical lens for conceptualizing these patients’ experiences and their impact on their sense of themselves and others, as well as the psychological resources, including defenses, that they have available to manage them. Second, psychoanalytic approaches lend themselves to the kind of open-ended, narrative-based engagements that immigrants from Latin America (and probably elsewhere) find more palatable, engaging, and culturally familiar. This is especially important when contrasted with interventions focusing exclusively on behavior change or the alteration of thoughts as is common in CBT treatments, which tend to be somewhat ahistorical and less interested in broader life contexts and experiences that may help explain the origins of the patient’s feelings and struggles. Psychoanalytic approaches not only create a context that invites these broader cultural and historical elements into the treatment, it sees these as indispensable to therapeutic understanding.

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# 2

## COUNSELING MUSLIM COUPLES AND FAMILIES IN THE UNITED STATES

*Khalid A. Alfallatah*

### **Introduction**

As the counseling field engages in intercultural practice considerations, the need for researching different cultures increases. With more than 3 million Muslims living in the United States and about 1.5 billion others around the world the need for more research is increasing (Lipka, 2017). The Muslim population in the United States is growing and researchers in the mental health field are conducting more research related to this population (Ibrahim et al., 2015). This chapter provides an overview of Islamic family concepts along with a case study that will help readers better understand multiple ways of implementing clinical interventions when working with Muslim couples and families in the United States.

Many Muslim societies tend to be collectivistic and individualism is discouraged (Ali et al., 2004). The Quran repeatedly encourages showing respect to parents and discourages children from raising their voice on their parents. When major conflicts arise, practicing Muslim children who engage in arguments with their parents and raise their voice feel very guilty and find it very difficult to express their emotions to their parents.

Muslim clients will vary in the degree of their adherence to religious principles and practice. The variation of the degree of assimilation may create family conflicts. Recent immigrants may be considered more religious than individuals born in the United States (Ali et al., 2004). Conflicts between children and parents may arise regarding religious and spiritual Islamic issues. Therapists may need to assess the level of religiosity of both parents and their children to gather more data about the family.

Another aspect that should be noted by clinicians is that there are multiple factors that may prevent Muslim clients from seeking therapy. Research has revealed that one of the reasons Muslims hesitate to seek treatment is their fear of being stigmatized within the Muslim community. The fear of being stigmatized drives some clients to prefer using family/friends advice over seeking professional help.

Another barrier stems from the fear of being seen as inferior, or for looking ridiculous, or for being sensitive to their culture being criticized, which means not wanting to add to the negative stereotype about the Muslim culture if the problem becomes known to others outside of the culture. Furthermore, there is a gap in the literature in providing guidance for therapists about the best ways to approach Muslims living in the United States (Sauerheber, Nims, & Carter, 2013).

After understanding some of the barriers that can stop Muslim clients from seeking therapy, the understanding of the therapeutic relationship with Muslim women is essential. Alotaiby aimed to answer the following questions: What is the experience of marriage and family therapists with respect to issues of power inequality in the therapeutic relationship with Muslim women? And what do therapists do to make their practice applicable to work with Muslim women? The phenomenological study was conducted by interviewing 11 therapists that worked with Muslim couples and clients.

The results of this study revealed important themes (that are important for therapist to know) such as: (a) recognition of limitation and privilege; (b) accountability and accommodation.

The first theme described the recognition of limitations and privilege within the Muslim clients. An important sub-theme construct identified was accessibility. Therapists in this study shared that the accessibility factor appeared to have an influence on the therapeutic relationship. Accessibility was viewed differently by participants. For example, some therapists noted utilizing an interpreter to overcome the language barrier in cases where clients did not speak English. Others suggested that having a co-therapist from the same culture would support a stronger therapeutic relationship. It is important to note that some therapists might find it challenging to understand the Islamic culture and religion; however, a full understanding of the Islamic religion is not required for a successful therapeutic outcome.

The second sub-theme in this study was privilege, gender, and women's issues. In this category, therapists shared how their cultural backgrounds influenced their perception of clients throughout these experiences. Some therapists shared their feelings about being at a place of privilege in relation to race and socioeconomic status noting that they had to work on their own biases while building the therapeutic relationship. While it was hard for some therapists to relate to the difficulties some of the clients suffered, it was easier for others to relate to some aspects of the power and hierarchy paradigm, in which therapists could identify with what they shared with the clients through this experience.

Although therapists in this study noted that they were not experts in their clients' faith, nor did they have the experience some of the difficulties that their clients go through such as intense security checking while traveling or going through airports, some were able to connect with their clients by sharing some of their own experiences.

Gender is a very important factor to be aware of when interacting with clients of Islamic faith. Recognizing your own bias and perceptions about gender is of great importance to the therapeutic relationship with Muslim clients. The ability to relate to Muslim clients will help in forming a stronger relationship. Alotaiby noted that rather than seeing the client as only a Muslim woman, a therapist in her study, reflected on the humanity of the client, which had the greatest influence on the relationship with the client.

Another theme revealed in this study was accountability and accommodation. The main construct in this theme is adjustment to practice. What this sub-theme refers to is the ability to make certain adjustments when working with certain clients, for example, incorporating the cultures of the clients into the treatment. Some therapists reported they did more home visits, and ate with the clients, which it is not commonly something they would have done. Another therapist reported that she made assessments to incorporate the client's religion into the treatment.

## **Substance Abuse Interventions for Muslim Clients**

Many studies had focused and researched the effectiveness of 12 steps programs on recovering addicts. The studies identified the effectiveness of multiple support groups such as A.A., Alanon, and N.A. and other support groups on individuals in recovery. Multiple factors such as family relationships and functioning in society were explored. However, very few studies have been conducted to explore the effectiveness of Milati Islami (MI), an Islamic-based 12-steps program for addicts. A thorough literature review will be conducted to explore the topic.

With the increase of substance use in the Muslim population in the USA, especially among the younger generation, looking at the effects of support groups such as Milati Islami becomes essential. Muslim addicts might feel more responsible when it comes to their relationship with their family. They might also feel responsible when it comes to their relationship with their higher power. These feelings could cause negativity and difficulty for addicts and their families. By understanding more about the 12-steps programs such as MI, researchers can help strengthen family relationships in addition to providing addicts with better conceptualization about their relationship with their higher power.

In a single month an estimated 20 million Americans aged 12 or older use an illegal drug as reported by the National Survey on Drug Use and Health (Alcohol and Drug Information). Less than 30% of all 2013 arrestees reported ever

receiving any drug or substance abuse treatment. Among this population, more than 80% of arrestees noted that they have been arrested at least once prior to their current arrest (Alcohol and Drug Information). This cycle of drug use and arrest is a potential waste of human productivity and growth. The mental health field has to evaluate and advocate for a variety of support groups that can help client have different options when seeking treatment and support systems.

## **Family Relationship**

There are no set rules that can measure the effects of having an alcoholic family member on adolescents in the family household. However, a significant improvement can be made when addicts and family members work on improving their self-concept.

A study aimed to investigate the associations between structural features of the self-concept and certain aspects of psychological adjustment among adolescents growing up in alcoholic families. In this study a sample of 60 adolescents from alcoholic families living in two large cities were examined. The three aspects of wealth, stability, and certainty of their self-concepts were evaluated using a set of questionnaires. The strongest association found in the study between richness of the self-concept and depression. That means that the more stable the self-concept, the lower the level of depression (Polak, Puttler, & Ilgen, 2012). In this research the emphasis on the self-concept helped improve depression. One of the main goals of support groups such as MI, A.A., and N.A. is to help members gain a better understanding of themselves (Ali, 2014). It remains essential to explore the effectiveness of the 12-steps programs on families with an addicted member.

The self-concept idea talked about in the previous research is not foreign to faith-based support system organizations. Research aimed at exploring the support system provided by faith-based organizations to families of clients undergoing substance use treatment explores the effects of such interventions. The research suggested that religious behaviors affected A.A. members, where belief did not (Kaskutas et al., 2003). Religious behaviors such as seeking family reconciliation and working on family issues can be very helpful for clients. Clients can be religiously motivated to work on family relationship issues. This suggests the importance of research in the literature about the effects of religious behavioral rituals on client's recovery. The research noted that one of the best methods of assessments when working with a substance abuser is to conduct a family assessment. It is recommended when working from a faith-based model to help families find hope and unity (Ali, 2014).

## **Relationship with Higher Power**

The concept of higher power has its definition in the 12-steps program. The third step refers to the higher power as "God as we understand him" (Alcoholics

Anonymous, 2001). The literature addresses 12-steps programs and their diversity. Some programs are family-oriented and others are for specific age groups. There are also faith-based 12-steps programs such as Milati Islami (MI), which is Islamic based. There are some similarities and differences between MI and A.A. One major difference is that MI is based on an Islamic doctrine. A research aimed to explore the MI support group and compare it to the A.A. support group the research also addresses some Islamic concepts regarding addiction. All intoxicants are prohibited in Islam (Ali, 2014). Therefore a practicing Muslim client with substance use disorder may feel that their relationship with their higher power “Allah” is damaged. Therefore the existence of the MI support group can help Muslim clients restore that relationship.

The 12 steps in MI are different but similar than the Alcoholic Anonymous 12 steps. The first step of A.A. is about admitting ones powerlessness over alcohol and that one’s life had become unmanageable. In MI 12 steps it states that “We admitted that we were neglectful of our higher selves and that our lives have become unmanageable” (Ali, 2014). The MI version puts the responsibility on the person and used the word neglectful instead of powerless. In the Islamic faith, admitting neglecting can be a motivation for repentance.

In the second step, the A.A. 12-steps version noted that one came to believe that a power greater than oneself could restore their sanity. However, in the MI 12 steps it stated that “We came to believe that Allah could and would restore us to sanity” (Ali, 2014). Throughout the steps it can be noted that the MI steps are designed to address the specific needs of Muslim individuals with substance use problems.

More research needs to be conducted to examine the effectiveness of MI on clients that are practicing the Islamic faith and are substance users. This possible gap in the literature is worth of research and investigation as it can be considered an avenue that advocate and support Muslim clients.

## Case Example

Jasmine is a 22-year-old Lebanese American Muslim female born in Orlando Florida. Her parents came to the United States from Lebanon and had her a year after their arrival. Jasmine is an only child. Her 45-year-old mother is a high school teacher at a local Islamic school. Her 50-year-old father is a physician at a local hospital. Jasmine described her family as being traditional and religious. She noted that she is a practicing Muslim and that she considers her faith to be important. Jasmine stated that she had multiple family conflicts in the past and that she is currently experiencing anxiety about wearing the hijab in public. She noted that with the increasing number of hate crime incidents against Muslims in the United States that she is considering to take off her headscarf “hijab.”

Hijab is an Arabic word that means protection, cover, and barrier. Muslim women in America may at sometimes find it difficult to wear their Islamic hijab

in public. Some Muslim women may decide to wear the hijab, niqab, or burqa, whereas others may decide to stop wearing them because of negative reactions and actions from others (Cole & Ahmadi, 2003). Those decisions of either wearing or taking off the hijab may lead to family conflicts within the Muslim family. Jasmine noted that her parents are opposed to her decision to stop wearing the hijab. She said that although she understands their point of view, she has concerns about her safety and discomfort.

### **Case Conceptualization, Clinical Assessments, and Interventions**

Researchers to gather data about families over generations have long used genograms. Murray Bowen's family systems theory was one of the first theories of family systems functioning (Brown, 1999). Multigenerational transmission is an essential concept of the Bowen family systems theory. This concept explains how patterns and roles are passed from one generation to another. The theory not only focuses on family patterns as an evaluation process, but as a therapeutic intervention. When family members are able to learn more about the history of their family and times in which they got stuck, they are better able to look at and take responsibility for their own part in conflicts (Brown, 1999). Many researchers have developed and expanded on Bowen's work to be able to better understand the multigenerational transmission concept and other essential concept of the theory.

When conceptualizing Jasmine's case, the therapist must take into consideration multiple aspects. First, an examination of Jasmine's spiritual genogram is essential. The spiritual genogram is a tool developed to help clients gain different perspectives on ways in which their spiritual and religious history continues to affect their reactivity, reactions, and family processes (Frame, 2000).

The spiritual genogram can be used at any process of therapy and is used as an assessment strategy to gather data. After developing the appropriate client-counselor bond, trust, and getting the client's consent, the counselor would conduct the spiritual genogram. The counselor must make sure that using this tool is appropriate by assessing the presenting problem and the client's willingness to address religious and spiritual concerns (Frame, 2000).

The spiritual genogram involves four steps. Creation of the spiritual genogram, questions for future reflection, connection with one's family of origin, and integration into the global therapeutic endeavor are the four steps of the spiritual genogram (Frame, 2000). Understanding and implementing the four steps of the genogram are essential for acquiring a better understanding of the systemic perspective of the collected data.

The first step of creating the spiritual genogram is very important in that it helps in obtaining necessary information in the family's religious and spiritual history. In this stage, the therapist and client draw a three-generational family map including as much information as possible about family members. Important

information such as significant events, births, marriages, divorces, and deaths are noted. Noting family member's religiosity, spirituality, and major significant religious and spiritual personal and community events is noted.

Events such as mosque vandalisms, threatening letters to the congregation, changing in the racial/ethnic or class composition of the congregation and/or other important events should be noted. Gathering information about client's perspective on family member's level of religiosity and spirituality is gathered. An example of an event could be a conflict between a mother and daughter when the daughter married outside her religion. Another example would be a conflict between a father and a son when the son changed his religious affiliation. The creation of the spiritual map/genogram is considered the first step of the assessment process.

The second step of the process is the questions for further client reflection. In this stage, the therapist asks questions with the intention of having the clients reflect on the role that religious/spiritual beliefs, experiences, rituals, and practices have on their presented issue. The questions aim to help clients externalize religious issues and reduce emotional reactivity in their relationships. In the next session, the therapist invites clients to share their insights about their responses and further reflect on the family dynamic in relation to religious and spiritual issues in the family (Frame, 2000). Some clients may not have all answers to those questions, which is a good place to proceed to step three, "connecting with one's family of origin."

In the third stage clients connect with their families of origin. This is an opportunity for clients to gain access to information from extended family members to clarify religious and spiritual events and elicit the meaning that family members attribute to those events (Frame, 2000). The additional information is added to the original genogram and the fourth stage is introduced.

In the fourth stage the therapist seeks to integrate the spiritual genogram created and the information gathered to process it with the family. In this process the family explores the effects of reflecting on their own past beliefs, experiences, and family-of-origin issues (Frame, 2000).

The process of exploring family's religious and spiritual journey helps the family reflect on issues that may contribute to the family's presenting problems. The application and use of the spiritual genogram will be integrated to address specific religious and spiritual Islamic concepts. Understanding essential issues about counseling families of Islamic faith can give a deeper understanding of the process of integrating the spiritual genogram when working with Muslim families.

Using the spiritual genogram with Muslim families would be helpful in gathering more data about the family and helping them reflect on their religious and spiritual presenting problem. Using the four stages of the spiritual genogram would help the therapist to make an assessment on family member's level of spirituality and religiosity.

The spiritual genogram may assist Muslim families to have a deeper understanding of the effects of different levels of religiosity and spirituality on conflicts in the family. The spiritual genogram can also be used to help Muslim families cope with stressors. Research aimed to investigate coping skills of Muslim women survivors of domestic violence. Researchers found that Muslim women who used spirituality were able to cope with ongoing domestic violence. The research indicated that religious coping mechanism included listening to Quran, prayer and meditation (Hassouneh-Phillips, 2001).

When integrating the spiritual genogram with Muslim families, it is important to take into consideration the diversity of the Muslim population. Muslim families may share a universal religion, but they exhibit diversity in relation to ethnic and racial history and heritage. In the third stage of the spiritual genogram where clients are connecting with families of origin, the intergenerational issues must be taken in consideration. The therapist would help clients reflect on how religious values and cultural norms were and are talked about (Sauerheber, Nims, & Carter, 2013).

Generational patterns can help families gain more awareness of their degree of differentiation and their level of emotional separation from their family of origin (Kerr & Bowen, 1988). The religious, spiritual, and cultural values passed down from one generation to the other affects the development of a differentiated person within a family system (Bartle-Haring, Glebova, & Meyer, 2007). Using this process with Muslim families can help clients get a better understanding of each member's contribution to the presenting problem.

When counseling Muslim families, a good assessment of their level of religious, spiritual, and cultural values is essential. The assessment along with counseling skills and techniques creates an appropriate environment to foster a healthy therapeutic process.

The use of the spiritual genogram and the process of integrating that tool in relation to conflicts among Muslims facing social injustice, stereotyping and family conflicts can be beneficial in helping those families move forward. The need of an academic discussion about whether the spiritual genogram can work across cultures and believes is a good area of future research. Researching whether or not family levels of spirituality or religiosity may affect or play a role in hindering or expediting the therapeutic outcome is recommended. With the rising number of Muslims in the USA and worldwide, the need to explore different interventions and the implications of them becomes more prevalent to the counseling field.

## Conclusions and Recommendations

Counseling Muslim couples and families in the USA is an area that needs to be explored. Researchers focused on multiple factors which seem to help clinicians gain a better understanding and better results with their Muslim clients.

Understanding that Muslim clients will vary in the degree of their adherence to religious principles and practice will help clinicians in planning appropriate interventions and create treatment plans collaboratively with their clients.

In addition to that, it is important that clinicians are aware of their own biases and perceptions about Muslim clients. Researchers revealed that some barriers that can stop Muslim clients from seeking professional help stem from the fear of being seen as inferior or for being sensitive to their culture being criticized, which means not wanting to add to the negative stereotype about the Muslim culture if the problem becomes known to others outside of the culture. With all the stereotypes about Muslims in the media and more, Muslim clients are very sensitive to any bias that might be presented by therapists which could jeopardous the therapeutic relationship.

Religion is often an integral part of Muslim clients and needs to be addressed by the multiculturally aware counselor. This will help therapists gain better understanding of how clients perceive themselves, others, and the world. That will also help guide therapeutic interventions. An example of that would be to explore if your client feels that joining the Milati Islami instead of a general 12-step programs is a better option for them.

It is also important to consider that for many Muslims, following their parents' wishes is considered to be a very important good faith indicator. Therefore, in situations where the child has a fundamental difference in opinion with their parents, that feeling of guilt and shame may be present. The therapist must be culturally competent and take into consideration that aspect in treatment planning and in therapy. Asking questions and being client-oriented would be the best way to have a successful therapeutic outcome.

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