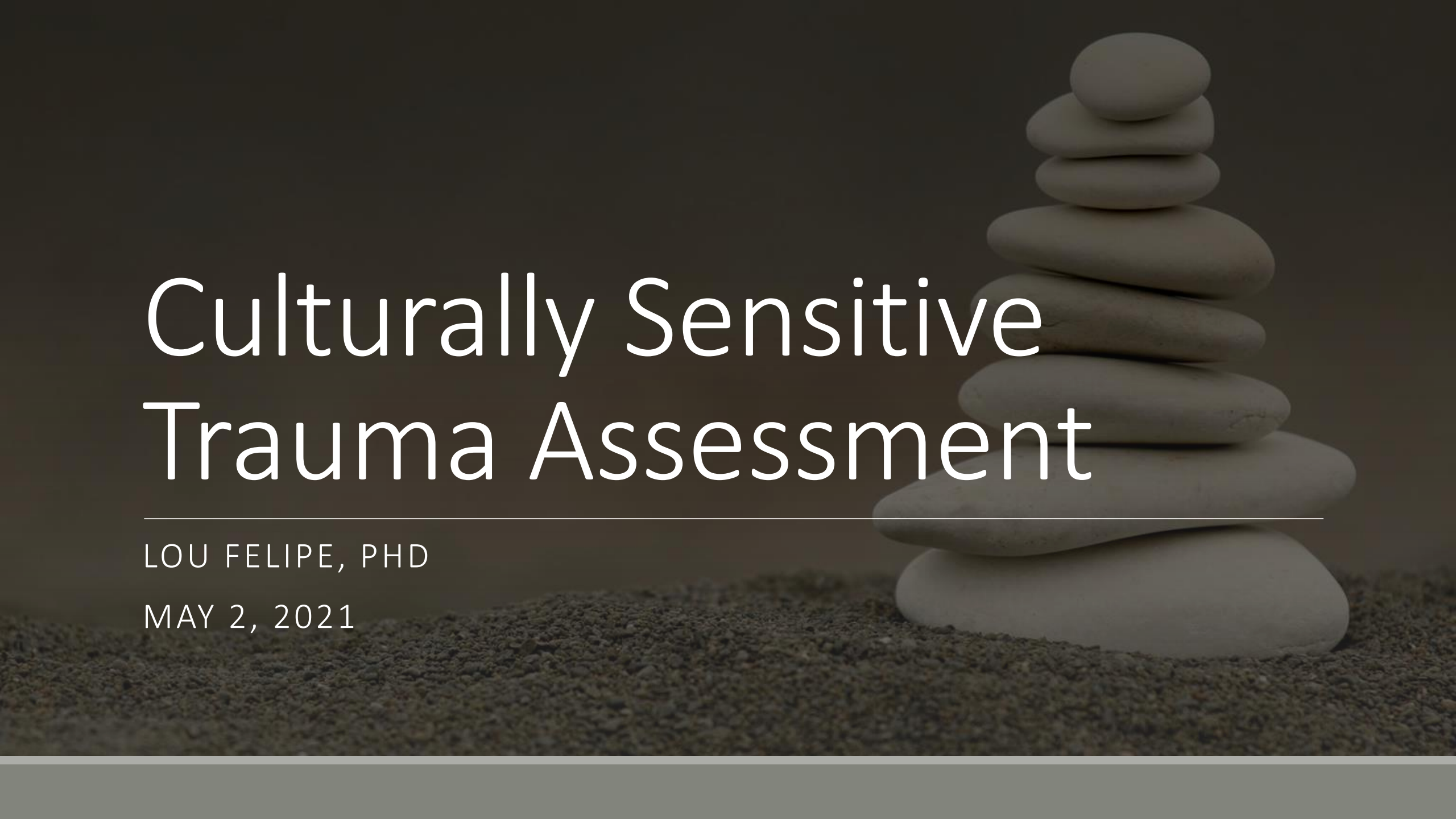
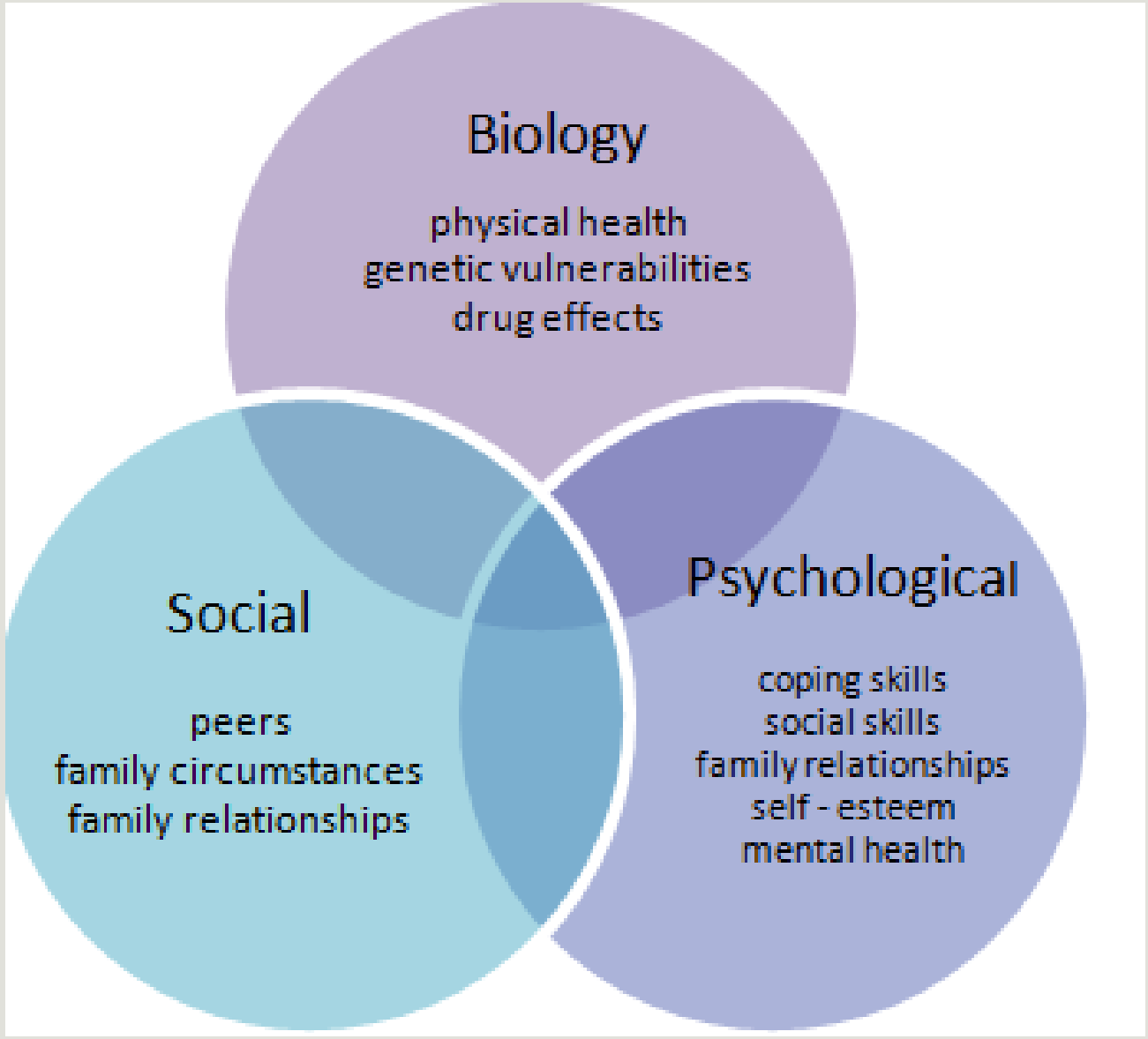


Culturally Sensitive Trauma Assessment

LOU FELIPE, PHD

MAY 2, 2021

Trauma and Stressor-Related Disorders



Biopsychosocial Assessment

Stress, Crisis, and Trauma
(Dulmus & Hilarski, 2003)

Stress, trauma, and crisis on a continuum

- Stress: threatens homeostasis
- Trauma: shatters worldview
- Crisis: instability and disorganization due to lack of resolution

Perception of threat/danger vs. the ability to cope with that threat/danger

Each individual will perceive stressors unique to their own history, culture, context, and personality

Reactive Attachment Disorder

Children < 5yo

Unable to form stable attachments

Usually grossly neglected and/or persistent disregard for basic needs

Symptoms: detachment, unresponsive or resistant to comforting, holding back from others, socially withdrawn, mix of approach/avoidance behaviors

Disinhibited Social Engagement D/O

Usually grossly neglected and/or persistent disregard for basic needs

Symptoms: approaching behaviors with unfamiliar adults

Post-traumatic Stress Disorder (PTSD)

A: Exposure to trauma

B: Reexperiencing

C: Avoidance

D: Negative alterations in cognitions and mood

E: Arousal

F: Duration (lasts for more than 1 month)

G: Causes significant distress or impairment

H: Not attributable to substance use or other condition

Criterion A: Exposure to trauma

Exposure to actual or threatened death, serious injury, or sexual violence in one or more of the following ways:

- Direct experience
- Witness the event
- Event occurred to close family member or friend. When actual or threatened death to someone close, event must have been violent or accidental
- Repeated or extreme exposure to aversive details of the event

Criterion B: Re-experiencing

One or more since the traumatic event(s):

- Recurrent, involuntary, or intrusive distressing memories (repetitive play in children > 6yo)
- Recurrent distressing dreams (frightening dreams without content in children)
- Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the event is recurring (reenactment in play with children)
- Intense or prolonged distress at exposure to internal or external cues
- Marked physiological reactions to internal or external cues

Criterion C: Avoidance

One or both since the traumatic event(s):

- Avoidance of distressing memories, thoughts, or feelings
- Avoidance of external reminders that arouse distress

Criterion D: Negative alterations in cognitions and mood

Two or more of the following:

- Inability to remember an important aspect of the event
- Persistent and exaggerated negative beliefs about self, others, or world
- Distorted sense of blame on self or others
- Persistent negative emotional state
- Diminished interest or participation in activities
- Feeling detached or estranged from others
- Inability to experience positive emotions

Criterion E: Arousal

Two or more of the following:

- Irritable behavior and angry outbursts
- Reckless or self-destructive behavior
- Hypervigilance
- Exaggerated startle response
- Problems with concentration
- Sleep disturbance

Specifiers

With dissociative symptoms

- Depersonalization: feeling detached from one's mental processes or body (outside observer)
- Derealization: unreality of surroundings (being in a fog or bubble)

With delayed expression

- If full diagnostic criteria not met until at least 6 months after the event

Other Stressor-Related Diagnoses

Acute Stress disorder

Same as PTSD, but duration < 30 days

Adjustment Disorder

Identifiable stressor, but not traumatic

Sxs < 6 months

Other Specified and Unspecified Trauma- and Stressor-Related D/O

Specified: list reason full criteria is not met

Unspecified: do not list reason full criteria is not met

4 main symptom clusters

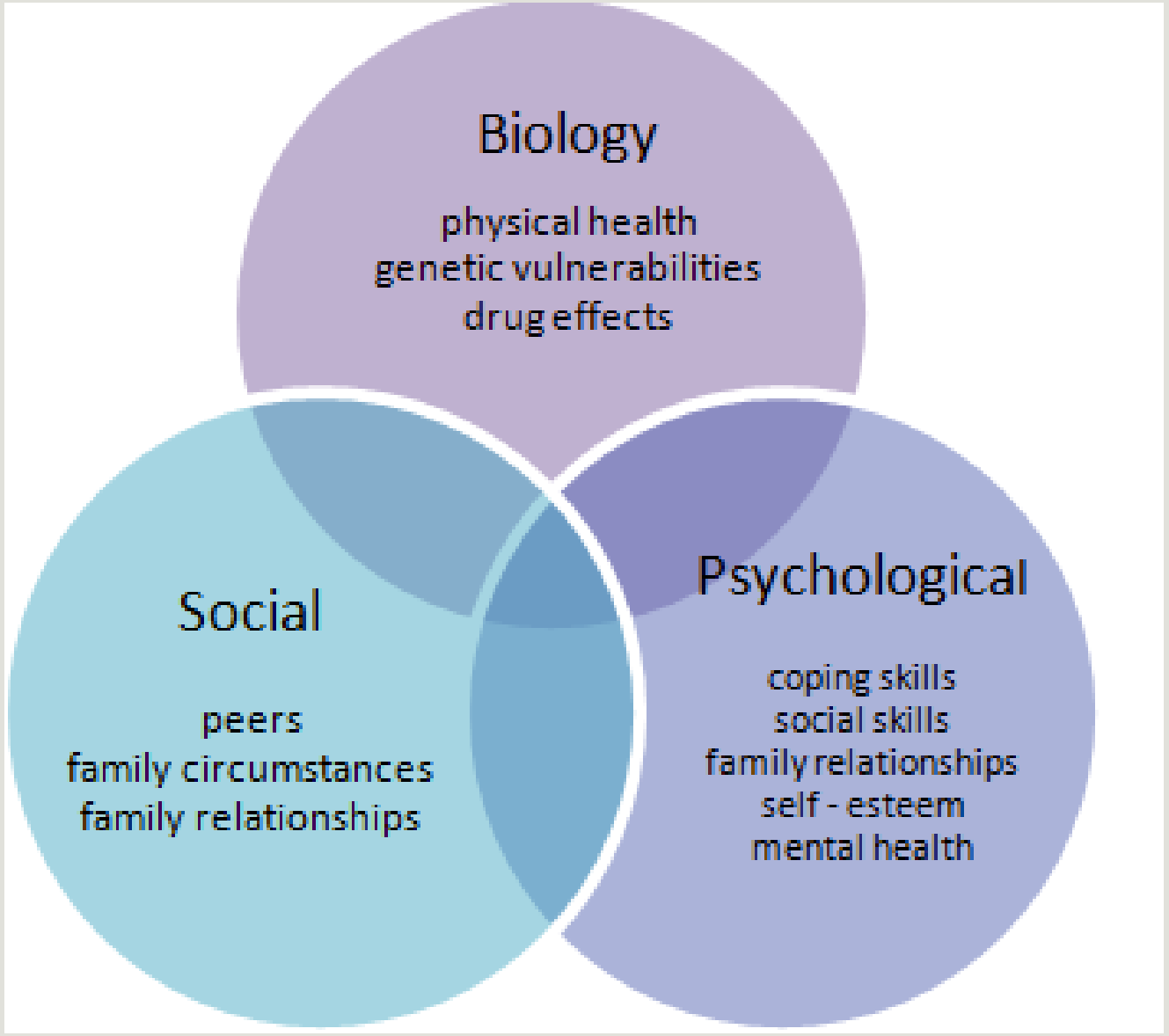
Re-experiencing the traumatic event

Numbing, negative cognitions and mood

Avoidance of the trauma-relevant stimuli

Hyperarousal and hyperreactivity

Developmental Trauma



Biopsychosocial Assessment

Developmental trauma

Developmental Trauma D/O expands understanding of traumatic experiences to include overwhelming experiences of childhood that often occur in caregiver-child relationship

(Blaustein & Kinniburgh, 2010)

Neglect	Psychological maltreatment	Attachment separations	Impaired caregiving systems

The proposal of developmental trauma disorder recognizes that development is dynamic and that developmental tasks build upon one another

(Blaustein & Kinniburgh, 2010; Van der Kolk, 2005)

Attachment Styles

Graphic downloaded from https://www.positive-parenting-ally.com/attachment-styles

Attachment styles	% of sample (also generalized to represent U.S. population)	The child's general state of being	Mother's responsiveness to her child's signals and needs	Fulfillment of the child's needs (why the child acts the way it does)
Secure Attachment	65%	Secure, explorative, happy	Quick, sensitive, consistent	Believes and trusts that his/her needs will be met
Avoidant Attachment	20%	Not very explorative, emotionally distant	Distant, disengaged	Subconsciously believes that his/her needs probably won't be met
Ambivalent Attachment	10-15%	Anxious, insecure, angry	Inconsistent; sometimes sensitive, sometimes neglectful	Cannot rely on his/her needs being met
Disorganized Attachment	10-15%	Depressed, angry, completely passive, nonresponsive	Extreme, erratic: Frightened or frightening, passive or intrusive	Severely confused with no strategy to have his/her needs met

Trauma Challenges Attunement

Children who have experienced trauma often lack capacity to communicate needs or to identify and cope with difficult emotions

They often communicate via behaviors instead of words

- Need to learn how to interpret the function of the behavior

Triggers may elicit intense emotions and/or numbing responses

Complex Trauma

3 criteria defining complex trauma (Cook et al., 2005)

1. Chronic (repeated trauma)
2. Early life onset (first five years of life)
3. Occurs within the caregiving relationship

Among adults, trauma that occurs (Courtois, 2004):

1. repeatedly and cumulatively
2. in certain relationship contexts
3. over a variety of times spans and developmental periods

Stress Response System

FIGHT	• Aggression • Irritability/anger • Trouble concentrating • Hyperactivity, “silliness”
FLIGHT	• Social isolation • Avoiding others • Running away
FREEZE	• Constricted emotional expression • Stilling of behavior • Overcompliance and denial of needs

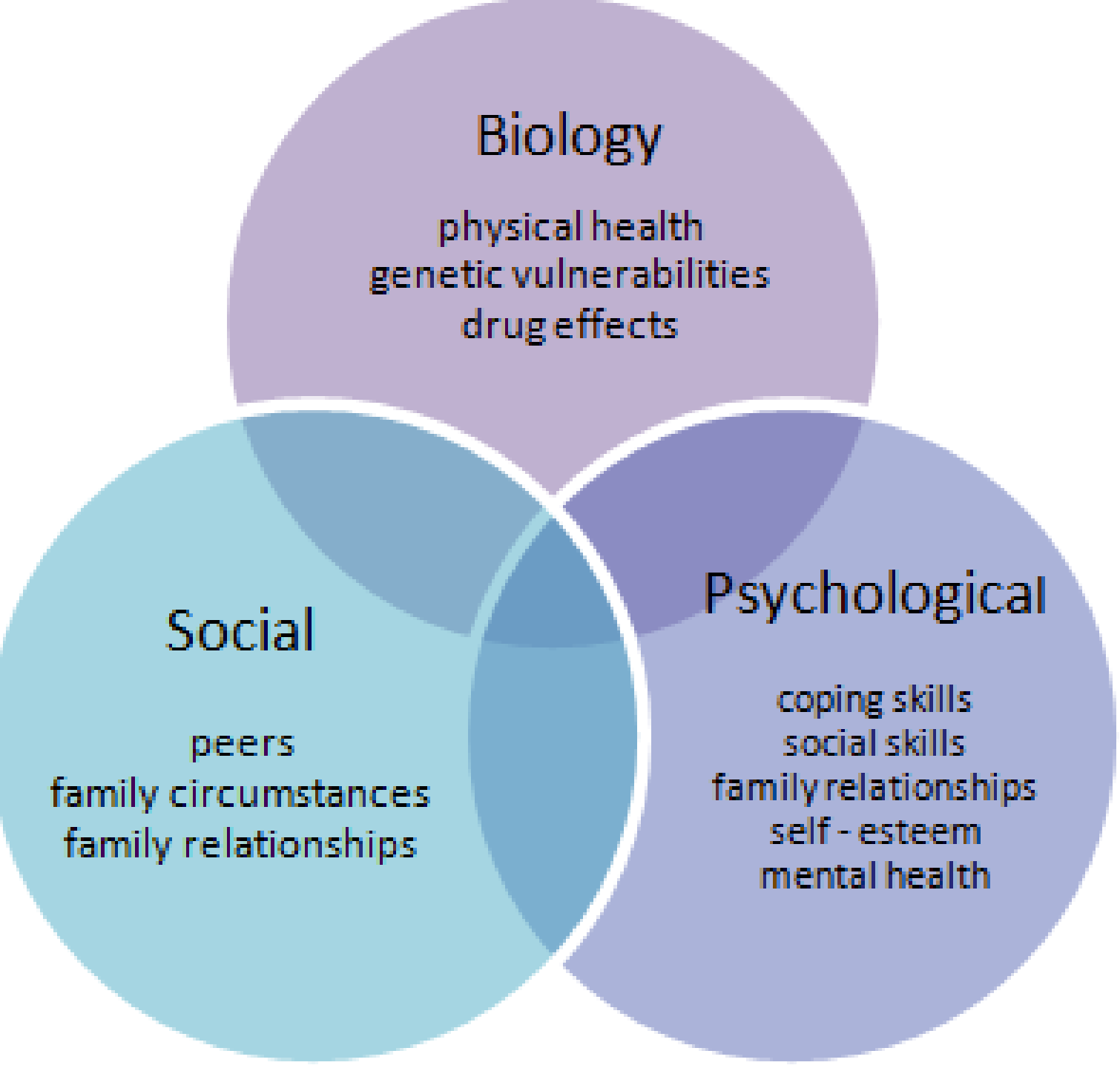
(adapted from Blaustein & Kinniburgh, 2010)

Domains of Functioning Impacted

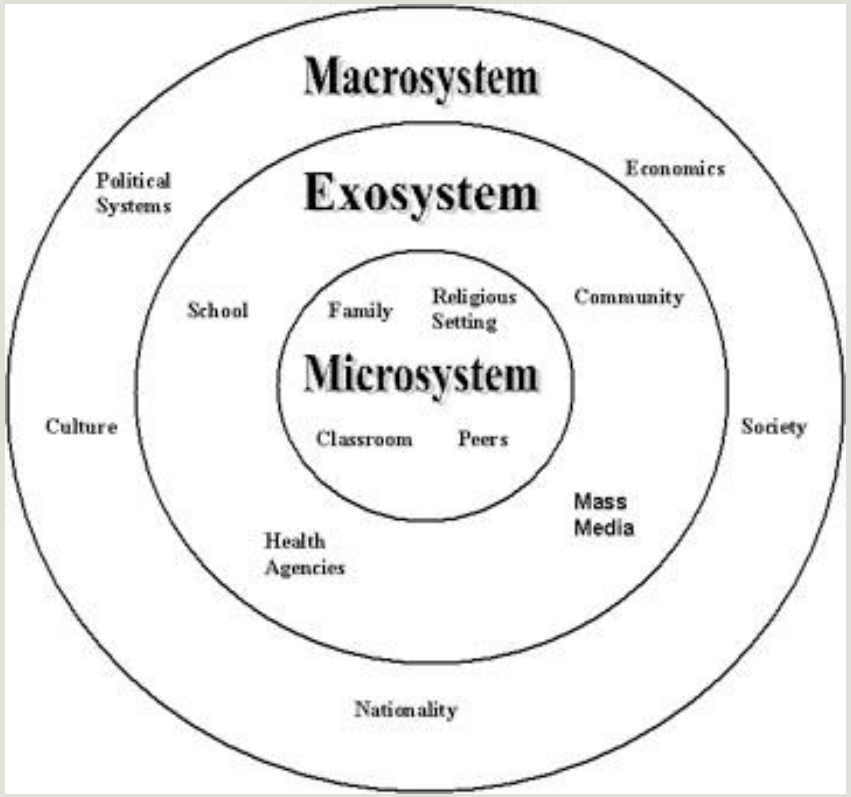
(Cook et al., 2005)

Domain	What it looks like
Attachment	Disrupted relationships (friends, caregivers)
Biology	Delays in development Impaired sensation and movement
Affect Regulation	Difficulties with managing mood
Dissociation	Impaired consciousness, memory
Behavioral Control	Poor impulse control, increased risk-taking
Cognition	Delays in language and learning; impaired memory
Self-Concept	Poor self-image, body-image, identity

Culturally Responsive Treatment



Biopsychosocial Assessment



Bronfenbrenner's Ecological Systems Theory

Microsystem: Immediate interpersonal circle

Mesosystem: Interaction between microsystems

Exosystem: Communities, organizations, neighborhoods

Macrosystem: Cultural frameworks, values, philosophies

Chronosystem: Changes over time

Social Justice Counseling/Therapy

*Social justice counseling therapy is an **active** philosophy and approach aimed at producing conditions that allow for equal access and opportunity; reducing or eliminating disparities in education, health care, employment, and other areas that lower the quality of life for affected populations; encouraging mental health professionals to consider micro, meso, and macro levels in the assessment, diagnosis, and treatment of client and client systems; and broadening the role of the helping professional to include not only counselor/therapist but advocate, consultant, psychoeducator, change agent, community worker, and so on.*

(Sue & Sue, 2016; pp. 134)

Social Justice Counseling/Therapy

Encourages mental health professionals to consider **micro, meso, and macro levels** in the assessment, diagnosis, and treatment of client and client systems

Broadens the role of the helping professional to include not only counselor/therapist but advocate, consultant, psychoeducator, change agent, community worker and so on

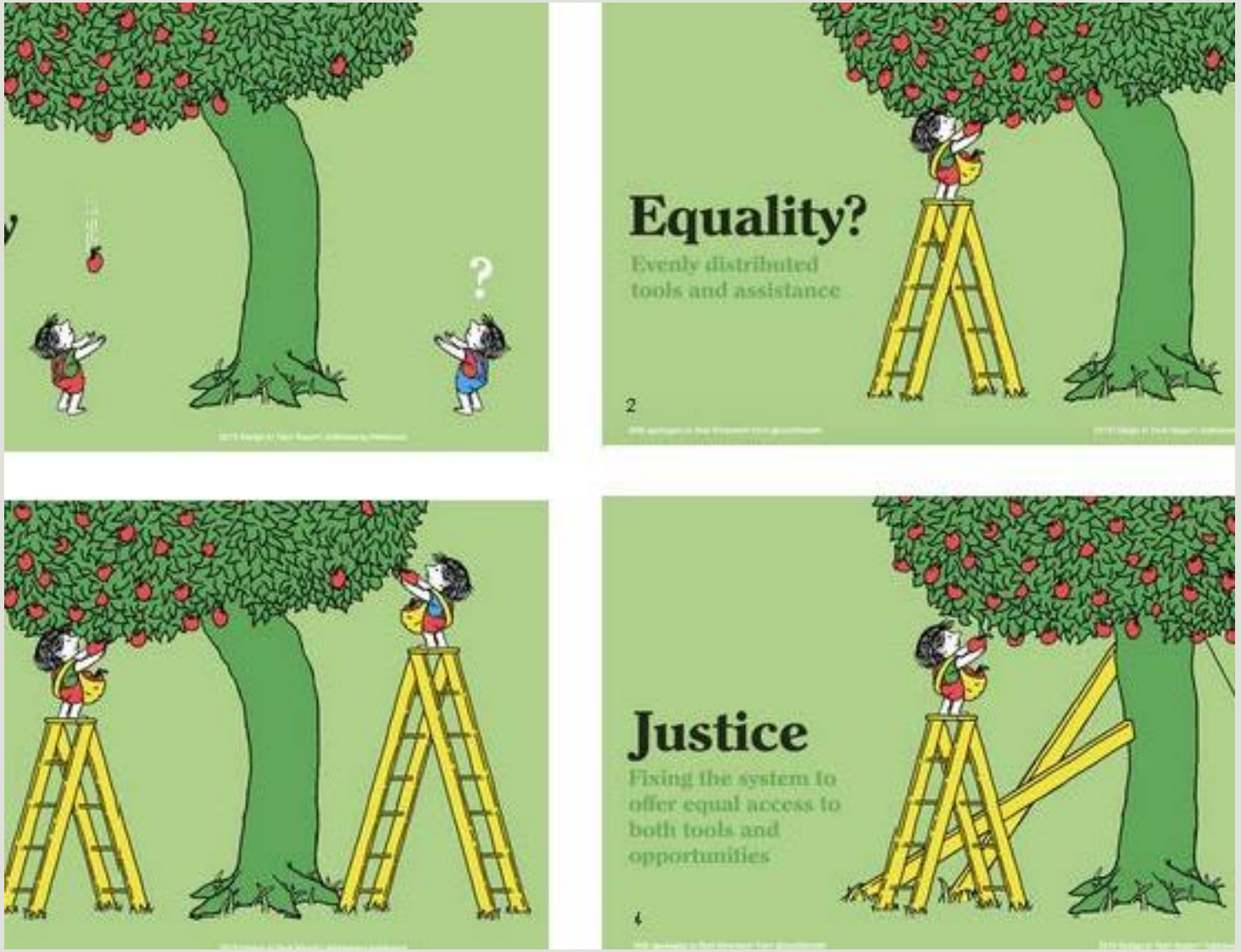
Cultural Competence vs. Cultural Humility

Cultural Competence implies that there is set standard to reach.

- *Cultural competence* is frequently used in research and in practice guidelines

Cultural Humility is a process-oriented approach

- Recognizes that cultural humility is an ongoing practice
- Calls for an exploration of one's relationship with power



Cultural Humility

3 components to cultural humility

1. Lifelong commitment to self-evaluation
2. Fix power imbalances
3. Develop partnerships with people who advocate for others

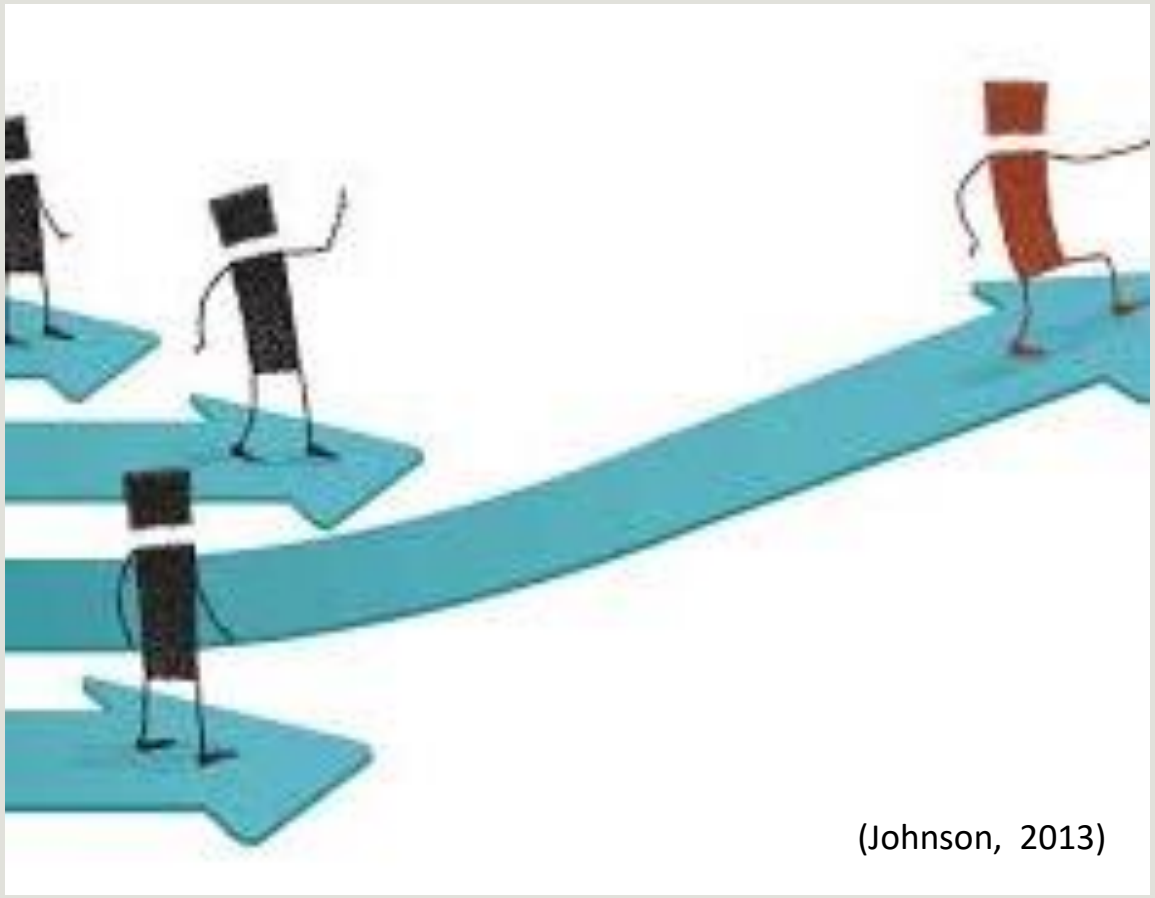
(Tervalon & Murray-Garcia, 1998)

How is Oppression Maintained?

Oppression is upheld and enabled on 3 levels:

1. Institutional (macro level)
2. Personally Mediated (meso level)
3. Individual Level (micro level)

(Jones, 2000)



(Johnson, 2013)

What is Privilege?

"[A]n advantage that is unearned, exclusive, and socially conferred."

Organized along 3 principles:

Dominance

Positions of power typically held by a particular group.

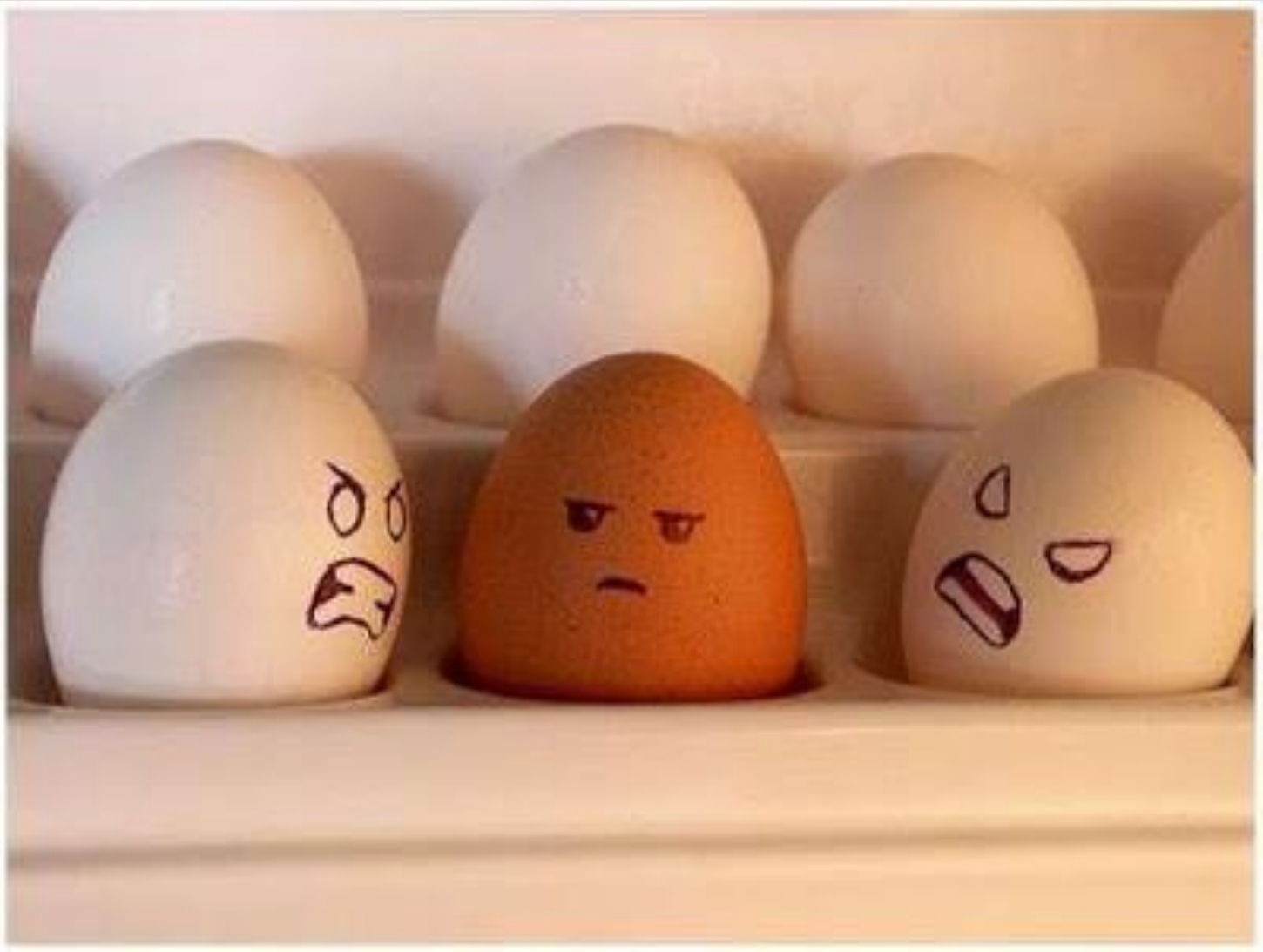
Identification

Who gets to be considered the standard for humanity?

Centeredness

The experiences of a group are placed at the center

“A basic assumption of culturally competent practice is that psychotherapists can never and should not assume the trust of their clients. Trauma is itself destructive to trust; survivors of interpersonal trauma may take years to believe that psychotherapists will not become one of their perpetrators. Psychotherapists working with trauma survivors represent humans who were the source of trauma; psychotherapists’ specific social locations and identities may enhance or decrease their overall role as a threat stimulus” (Brown, 2008; pp 40).



Modern Oppression

Oppression can be expressed in two ways:

- Overtly (Direct, blatant expressions and behaviors)
- Covertly (Indirect, often unconscious expressions)

Despite the subtleties of some these expressions, they still create immense, traumatic effects

Contemporary Oppression

Microaggressions:

"Brief and commonplace daily verbal or behavioral indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults that potentially have a harmful or unpleasant psychological impact on the target person or group" (Sue & Sue, 2013; pp. 153).

“Like drops of acid on a stone…”

Traumatic insults are being perpetrated on various levels (micro, meso, macro level)

These slights and daily and/or frequent impact one’s sense of safety

Over time, these insults eat away at the psyche

Trauma symptoms may present suddenly and dramatically, seemingly without notice

(Brown, 2008)

Insidious Trauma

Characteristics and

Contributing Factors:

Subtle, yet consistent marginalization

In multiple settings

For extended periods of time

Has cumulative, damaging effects


Micro
Aggressions


REDSKINS


Charlie Riedel/AP


delicious for supper too!
AUNT JEMIMA
READY-MIX
for PANCAKES
WHEAT, CORN, RYE AND RICE FLOUR


DESTROY THIS MAD BRUTE
ENLIST
VOGUE
Perfect Fit
DRESSING FOR EVERY SHAPE FROM SIZE 0 TO 16
Plus
87
Swimsuits to Flatter Every Figure
You Are (Not) What You Eat
Debunking Diet Myths
NO-EXERCISE DIET
What Happens When You Quit the Gym
THE POWER OF AN HOUR
How Fast Can You Get Fit?
SHAPE ISSUE
Secrets of the Best Bodies
GISELE & LeBRON
+ the World's Top Models and Star Athletes

ADDRESSING – Multicultural Assessment	
A	Age
D	Disability
D	(Developmental or acquired)
R	Religion
E	Ethnicity
S	Social Class
S	Sexual Orientation
I	Indigenous Heritage
N	National Origin
G	Gender

ADDRESSING Model

Hays, P. (2016). *Addressing cultural complexities in practice, third edition: Assessment, diagnosis, and therapy.* Washington, D.C: American Psychological Association.

Intersectionality

Use of the word “minority”

- Many communities will be numerical majorities

Dominant vs. Targeted identities

Identity vs. Social Location

Minority Stress Model

Describes the role of stress processes in negative physical and mental health outcomes for LGBTQ+ people

Stress processes include:

- Experiences of prejudice
- Expectations of rejection
- Hiding or concealing one's identity
- Internalized homophobia

(Meyer, 2003)

Suicide: Gender Differences

Rates for MDD range from 15-20% among adolescents.

At 15 years, female adolescents have 2x rates of depression than males

Among trans youth, 49% among transfeminine, 62% of transmasculine youth (Becerra-Culqui et al., 2018)

Gender expectations influence disparities in rates: body image, gender role conditioning, greater discrimination for women and GNC youth

LGB Youth Suicide

Suicide is the 2nd leading cause of death among young people ages 10 to 24. (CDC, NCIP, 2010)

LGB youth seriously contemplate suicide at almost three times the rate of heterosexual youth. (CDC, 2016)

LGB youth are almost five times as likely to have attempted suicide compared to heterosexual youth. (CDC, 2016)

Of all the suicide attempts made by youth, LGB youth suicide attempts were almost five times as likely to require medical treatment than those of heterosexual youth. (CDC, 2016)

LGBTQ+ Youth Suicide

In a national study, 40% of transgender adults reported having made a suicide attempt. 92% of these individuals reported having attempted suicide before the age of 25.

LGB youth who come from highly rejecting families are 8.4 times as likely to have attempted suicide as LGB peers who reported no or low levels of family rejection.

1 out of 6 students nationwide (grades 9–12) seriously considered suicide in the past year.

Each episode of LGBT victimization, such as physical or verbal harassment or abuse, increases the likelihood of self-harming behavior by 2.5 times on average.

Current events & Mental health impacts

COVID-19 and health disparities
- Race, ethnicity
- Disability
- Family size
- Socio-economic Status

Political responses to pandemic (country, state, county)

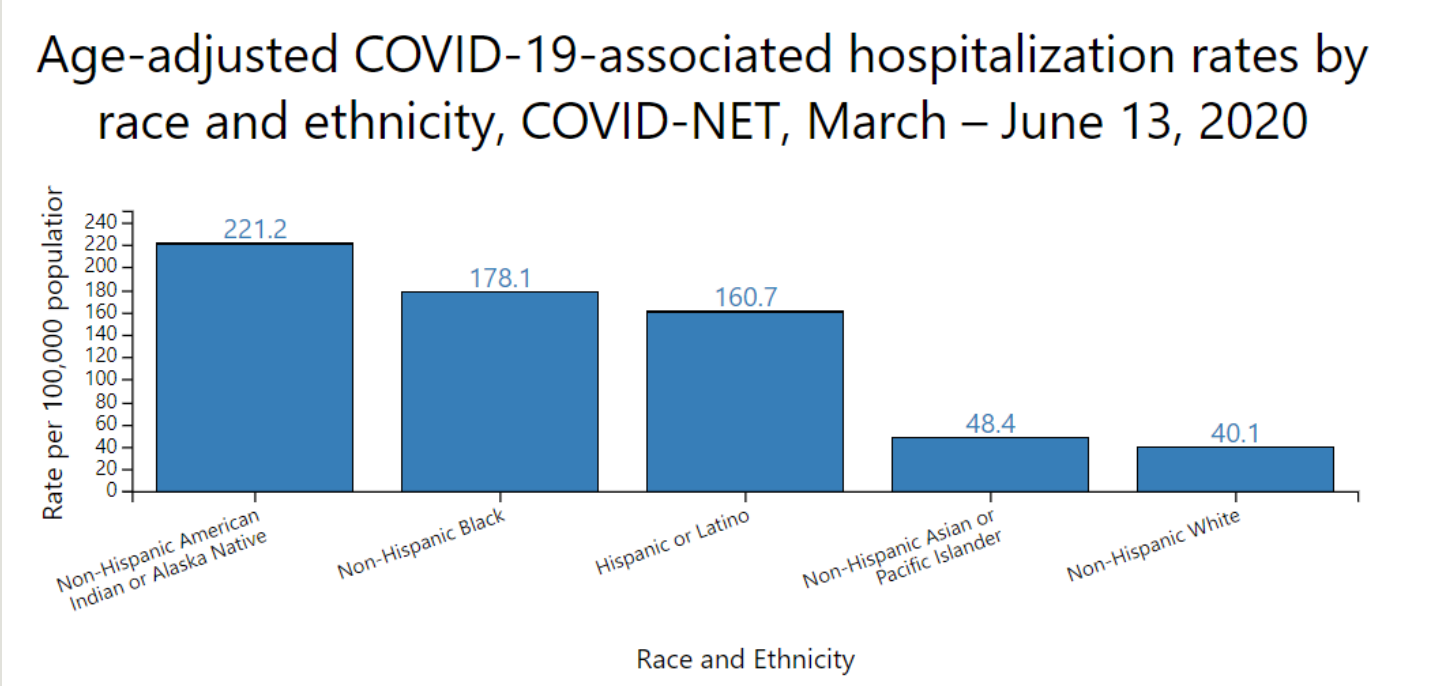
Challenges with returning to school

Social politics – BLM, Protests

Incidents of police brutality

COVID-19 Hospitalization rates by race/ethnicity

- Non-Hispanic American Indian or Alaska Native persons have a rate that is 5 times that of non-Hispanic White persons
- Non-Hispanic Black persons have a rate approximately 5 times that of non-Hispanic White persons
- Hispanic or Latino persons have a rate approximately 4 times that of non-Hispanic White persons



(CDC, 2020)

Vignette

Jessica is a 12 year-old who lives in with her mother and father. Jessica was referred to you, the therapist, by her 7th grade teacher who noticed that Jessica appears more irritable than usual and seems disconnected from her friends. Jessica's grades are decent and have not shifted dramatically, though the teacher has noticed that she is often tardy and is frequently turning in assignments late. After reaching out several times to Jessica's parents, they finally gave you their consent for Jessica to engage in therapy. When meeting Jessica, she mentions that she would prefer to be called "Jess," and she expressed concern about how much the therapy sessions would cost her parents. For several sessions, she seemed defensive and somewhat distant.

Vignette

Jessica is a 12-year-old of Mexican and Salvadorian descent who lives in with her mother and father in Aurora, CO. Jessica was referred to you, the therapist, by her 7th grade teacher who noticed that Jessica appears more irritable than usual and seems disconnected from her friends. Jessica's grades are decent and have not shifted dramatically, though the teacher has noticed that she is often tardy and is frequently turning in assignments late. After reaching out several times to Jessica's parents, they finally gave you their consent for Jessica to engage in therapy. When meeting Jessica, she mentions that she would prefer to be called "Jess," and she expressed concern about how much the therapy sessions would cost her parents. For several sessions, she seemed defensive and somewhat distant. In her last session with you, Jess talked about how she has a girlfriend, and that her girlfriend has relatives that have recently been deported to Mexico.

Vignette

Jessica is a 12-year-old of Mexican and Salvadorian descent who lives in with her mother and father in Aurora, CO. ***She and her family moved to Colorado from Houston, TX in 2017.*** Jessica was referred to you, the therapist, by her 7th grade teacher who noticed that Jessica appears more irritable than usual and seems disconnected from her friends. Jessica's grades are decent and have not shifted dramatically, though the teacher has noticed that she is often tardy and is frequently turning in assignments late. After reaching out several times to Jessica's parents, they finally gave you their consent for Jessica to engage in therapy. When meeting Jessica, she mentions that she would prefer to be called "Jess," and she expressed concern about how much the therapy sessions would cost her parents. For several sessions, she seemed defensive and somewhat distant. In her last session with you, Jess talked about how she has a girlfriend, and that her girlfriend has relatives that have recently been deported to Mexico.