

Abstract: This article gives a culturally-specific twist to trauma-oriented theories by discussing the way in which African-Americans respond when they are paired with a European American therapist and how their historically-rooted traumas manifest in and outside of therapy. Racism is at the core of African-Americans' common traumatic history and may lead them to develop what are essentially posttraumatic survival strategies, which may inhibit therapeutic engagement. Case examples show what these barriers to therapeutic engagement may look like in therapy, and how culturally sensitive practices can mitigate these barriers.

Key Words: African-American, racism, strengths, trauma

African-Americans' Historical Trauma: Manifestations in and Outside of Therapy

I am a European American man who grew up in a predominantly lower income, urban African American (AA) community. This upbringing inspired my longstanding interest in cross-cultural issues. More recently, I have grown interested in the psychotherapeutic experiences of African Americans (AAs) who are paired with European American therapists.

When I decided to write on this topic, I began to look for a theory that could operate as a basis for my exploration. I reflected on my personal experiences in a lower income, urban AA community and particularly remembered that such interpersonal traumas as child and spousal abuse happened regularly. I also reflected on how many people in my old neighborhood seemed to be constantly trying to heal from pre-existing traumatic wounds or responding pre-emptively to new threats. These reflections lead me to conclude that trauma theory was an appropriate theoretical foundation.

In this article, I will present a general theory of trauma and then discuss child abuse and spousal abuse because these are subtypes of trauma that lower income, urban AAs are at high risk for surviving. I will demonstrate that the effects of chronic child and spousal abuse parallel how AAs (and lower income, urban AAs in particular) are affected by white racism, which has implications for their experiences in psychotherapy with European American therapists.

I will present case examples which demonstrate how I have attempted to work through what may be AA's historically-rooted engagement barriers by intuitively making use of their historically-rooted survival strategies. My hope is that this exploration of theory and practice will inform more culturally-sensitive, cross-cultural treatment.

General Theory of Trauma

Kimmerling et al. (2002) noted that an event is considered a trauma when the event imminently threatens the survivor with serious injury or death, or the survivor *perceives* the threat to be of that magnitude. The severity of a traumatic threat is too much for the mind and body to handle, resulting in overwhelming terror, confusion, and helplessness (Lieberman & Van Horn, 2008). Neurobiologically, this occurs because trauma overwhelms the emotional regulatory system, which would normally allow people to face most everyday stimuli, interpret those stimuli, and respond in ways that promote emotional regulation.

When a traumatic threat overwhelms the emotional regulatory system, the mind and body instinctually go into autonomic survival mode (Lieberman & Van Horn, 2008). People become hyper-aware of subtle changes in their surrounding environments, including fast movements, loud speech or noises, or their physical proximity to others. This hyper vigilance prepares traumatized individuals to take quick and decisive action in order to protect themselves. High levels of arousal are oriented towards self-protection, but they may also lead to health problems (Lieberman and Van Horn, 2008). Maintaining high levels of arousal requires significant physiological energy, which the mind and body supply by re-routing energy that would normally go into other vital systems.

Hyper vigilance and arousal are the core physiological symptom of *posttraumatic stress disorder (PTSD)* (Kimmerling et al., 2002). Posttraumatic symptoms are more likely to manifest and when the survivor is traumatized repeatedly by another person, and particularly when the survivor and perpetrator are intimately acquainted. When the violation of trust is chronic, the symptoms are more severe. Survivors of chronic interpersonal trauma tend to have perpetrators with whom they are intimately acquainted (Briere & Scott, 2006; Hughes, 2006; Herman, 1996; Kimmerling et al., 2002; Lieberman & Van Horn, 2008). Chronic trauma survivors are most often children who are abused by a parent and women who are abused by an intimate partner.

Trauma of Abuse

Both chronically physically abused women and chronically physically abused children are emotionally predisposed to seek proximity with idealized others *who are also most likely to traumatize them again* (Lieberman and Van Horn, 2008; Kimmerling et al. 2002). Lieberman and Van Horn (2008) describe survivors of chronic interpersonal trauma who remain in close proximity to their abusers as being in an *emotional dilemma* or paradox. This paradox leads chronic survivors to experience high levels of confusion and anxiety, which may be expressed by seeking the abuser's approval, bargaining with the abuser, or *acting out in ways that provoke negative responses*.

Chronically abused children typically blame themselves for their abuse, which may lead them to provoke strongly negative responses from otherwise caring others (Hughes, 2006). Their underlying motivation is to reinforce the beliefs that other people

cannot be trusted and that they can only count on themselves. This core survival strategy inevitably leads to primary relational failures, which reinforce abused children's *pervasive shame and unloveability* (Herman, 1996).

Abused children's tendencies to act out represent their best efforts to protect their abusive parent's exalted position (Lieberman & Van Horn, 2008). Abusive parents tend to have the most power in the family, particularly if the non-abusive parent is also abused by the abusive parent. Because an abusive parent is the family's only real source of security, direction, and identity, the abuser cannot be seen as *the problem*; otherwise, the abused child would feel utter, unbearable despair (Lieberman & Van Horn, 2008; McNally, 2007). To prevent this despair, the chronically physically abused child will often act out in ways that provide distractions and even dissociate completely from memories of the abuse. Dissociation may be necessary for survival, but it makes chronically physically abused children more vulnerable to being physically abused again (Lieberman & Van Horn, 2008; McNally, 2007).

Chronically physically abused women tend to provoke abusive behavior of their intimate partner (Kimmerling et al., 2002; Scott-Tilley, Rugari, & Walker, 2008). Abused women may think they deserve the abuse or may misinterpret abuse as a sign of love, devotion, or a deeper sense of connection and interest. This way of thinking is ultimately a survival strategy because it keeps *the abusive nature of the abuse* out of consciousness. Because chronically physically abused women are often emotionally and financially dependent on their abusers, keeping the abuse out of consciousness protects a relationship that is necessary for survival, yet also threatens survival.

Both chronically physically abused children and chronically physically abused women develop survival strategies that may *re-create their victimhood*. Trauma survivors will usually respond to traumatic stimulus by re-creating the trauma, avoiding it, detaching emotionally, or behaving aggressively (Briere and Scott, 2006; Lieberman & Van Horn, 2008). Trauma survivors expect danger at any time and without warning. They may erroneously interpret subtle changes in their environment as threatening, respond strongly and pre-emptively, and remain highly aroused and agitated. This reactive response may create major problems in their romantic relationships, family, and workplace (Lieberman & Van Horn, 2008; Hughes, 2006). Relational failures may lead trauma survivors to isolate, become depressed, and develop problems with drugs or alcohol (Herman, 1996).

Trauma Recovery

The trauma recovery process occurs in stages that parallel Maslow's hierarchy of needs (Herman, 1996). First, the trauma survivor needs to escape physical danger and seek an environment that is safe and stable. Once physical safety has been re-established, the survivors' emotional needs can be met more effectively. The trauma survivors' highest priority emotional need is to re-build a core of trust and safety that was shattered by the trauma. Trust and safety can be re-built through the reassurance, patience, support, and nurture of caring others, including the survivor's therapist. Re-establishing emotional safety gradually allows the survivors' mind and body to re-route energy to deprived systems, facilitating trauma survivor's physiological recovery (Lieberman & Van Horn, 2008).

Chronic trauma survivors' irritability, anxiety, and panic, and their tendencies to be emotionally volatile and reactive can make it extremely difficult for supportive and sensitive others to remain patient and soothing (Herman, 1996). Trauma survivors need to re-connect with their families (Herman, 1996) and work with therapists who will not overly personalize the volatility that naturally follows a traumatic experience (Hughes, 2006).

Family de-briefing. As mentioned previously, trauma survivors' intense emotionality may threaten stability of their most important relationships (Herman, 1996). Though de-briefing after a trauma may not absolve survivor's emotional instability,

de-briefing can help to create a climate of empathy and understanding that will facilitate recovery. When I work with clients who have recently survived trauma, I find it helpful to host family sessions and educate family members in front of the trauma survivor about the effects of trauma, and what emotional state the survivor is likely to be in. I often recommend that loved ones care for the survivor as someone who is physically sick.

Cognitive restructuring. Once survivor's physical and emotional needs for safety and security have been met, they need to *make sense* of their traumas by connecting their traumatic experiences to the traumatic experiences of similar others (Briere & Scott, 2006; Lieberman & Van Horn, 2008). Trauma survivors can re-frame and resolve their experiences through trauma-focused group therapy. During this mentally-oriented phase of trauma treatment, therapists help survivors re-examine erroneous patterns of self-blame and look deeply at cognitive distortions that invariably re-create victimhood. The goal in this phase of treatment is to create a more empathic and realistic narrative of the traumatic event(s), which coaxes trauma survivors to move on with their lives rather than *staying mentally and emotionally trapped in their traumatic pasts* (Kimmerling et al., 2002; Briere and Scott, 2006).

Trauma of White Racism

Naming *white racism* as a trauma for AAs and describing its effects in ways that parallel how women and children are affected by chronic physical abuse takes trauma theories a step further in a culturally-specific direction. Trauma-focused theories cited in the previous section acknowledge that lower income, urban AA women and children are at-risk for chronic physical abuse, but these theories say little about how white racism contributes to their at-risk status. When trauma-focused theories mention the effects of racism and discrimination on AAs, racism is described as if it has an *emotionally injurious effect*. Alternately, Afro-centric theories define white racism as a traumatic threat to AAs, particularly lower-income, urban AAs, because white racism threatens their *collective survival* (Parham, White, & Ajamu, 1999; Lum, 2003).

History of Discrimination

After the Civil War, AA slaves were freed, but they remained social outcasts in the dominant white society. AAs were segregated from employment and educational opportunities, and relegated to living in the poorest, most dilapidated neighborhoods, some of which remain the most notorious inner city AA neighborhoods in contemporary America. The concentration of poverty led to rising crime rates, domestic violence, drug problems, and other social ills that might normally be somewhat addressed through public services. However, in inner city AA communities, the police, social service providers, and other public systems were so often corrupt, abusive, and discriminatory that they are historically distrusted by inner city AAs (Grogan & Proscio, 2000; Ryan, 1971). This puts inner city AAs in the difficult position of living in overwhelmingly impoverished and threatening conditions *and* being cut off from the mainstream resources and protective mechanisms that might offer them some assistance. The compounding effect of these socio-environmental factors is one of the primary reasons why lower educational achievement, unemployment, and underemployment remain at epidemic levels in most inner city AA communities (Parham et al., 1999).

White racism creates socio-environmental conditions that increase rates of social problems that are either traumatic in nature, or are at least *traumatic risk factors*. For example, Parham, White, and Ajamu (1999) noted that inner city AAs remain discriminated against in employment and education, which leads inner city AA families to experience financially-related stress, and contributes to family violence. Urban planners studied inner city communities across the country and found that concentration of the poorest of the poor in any one locality invariably led to rising levels of the aforementioned social problems *and* a general

reluctance to access public services (Grogan & Proscio, 2000). The institutionalized, structural conditions of inner city AA communities create discriminatory socio-environments. Grogan and Proscio's (2000) research offers support for the Afro-centric theories' position on white racism meeting criteria of a trauma for lower-income, urban AAs.

Black Psychology

Although lower-income, urban AA communities are invariably affected by white racism, how AAs may be affected by white racism as individuals depends, at least to some extent, on whether certain key risk factors and protective factors are present. *Black psychology* operates from the premise that AAs have a completely different worldview and value system than whites (Parham et al., 1999). Afro-centric values include interdependence with nature and other living things, a deep sense of spirituality, emotional expression, direct communication, and expressing one's true emotional self through dance, music, and other creative arts (Parham et al., 1999; Robinson, 1995; Lum, 2003).

Positive identification with one's blackness is vital to AAs' development because their black selves are constantly attacked by the pervasive influence of white racism, which sends subtle, yet powerfully negative messages about blackness in the mainstream media and everyday social interactions. Negative messages include association of the color black with badness or evil, stereotypes of African-Americans as aggressive and lazy, and the systematic promotion of the European American mainstreams' values for individualism and competition, rational thought, emotional suppression, and indirect communication as superior to AAs' values and worldview (Parham et al., 1999; Robinson, 1995; Young, 2004). Another example of this racist influence is the way in which AAs are widely discriminated against in key areas of life, including housing, employment and health care, regardless of their education and socio-economic status (Waites, 2004; Parham et al., 1999; Robinson, 1995; Sue, 2000; Lum, 2003). The totality of these circumstances leads AAs to band together and identify collectively as *black people*, showing sensitivity to one another's traumatic suffering (Parham et al., 1999).

Internalized oppression. When AAs overly identify with an oppressed-identity; however, they may become hyper sensitive to racism and overreact in ways that create additional problems (Wilson, 2009). AAs who internalize their oppression are predisposed to acting their oppression out in ways that increase rates of the social problems that have been noted to be epidemics in the most notorious inner city AA communities (Parham et al., 1999). Young (2004) studied AA men who lived in inner city communities and found that they often felt trapped in overwhelming poverty and powerless to change their lives in meaningful ways. Contrary to popular stereotypes, most of these men were goal-oriented, perceptive, and thoughtful; they recognized European American-dominated societies' barriers to their success, which lead them to feel discouraged or saddened. Like chronic physical abuse, internalized oppression correlates with health problems, domestic violence, depression, and PTSD (Lieberman and Van Horn, 2008; Briere and Scott, 2006; Gump, 2010; Walker, 2004; Alleyne, 2004a; Alleyne, 2004b; Robinson, 1995; Lum, 2003; Waites, 2004; Wilson, 2009).

Systemic deficiency. Black psychology differs from mainstream trauma theories because it conceptualizes internalized oppression (i.e., posttraumatic symptoms) as symptomatic of *systemic rather than psychic deficiency*. Whereas trauma theories conceptualize interpersonal trauma as occurring in a more immediate environment (i.e. parent-child or intimate-partner relationships), Afro-centric theories expand the scope of the environment to include larger systemic forces like racism and poverty, and how those forces increase traumatic risk factors. Kozol's (2005) research on inner city AA public schools illustrates this theory of larger systemic deficiency in lower income, urban AA communities.

Kozol (2005) found the vast majority of public schools in lower-income, urban AA communities were woefully understaffed, poorly designed, and underfunded. These schools operated under policies which educational bureaucrats knew were ineffective. AA children often learn kinetically through creative expression, motion, and *doing*. The arts, music, and other expressive arts classes stimulate areas of the brain that are vital to children's academic success. Despite the vital importance of these expressive arts classes, when budget cuts became necessary at the schools under study, arts classes were usually the first to go. They were replaced by standardized testing and more rigorous disciplinary procedures on the grounds that these new policies were the most cost-effective. However, these pedagogically questionable policies tended not to exist in more affluent, predominantly white schools. Kozol (2005) concluded that such disparaging realities led AA public school students to feel alienated from the educational process even though, contrary to popular stereotypes, most of them wanted to succeed and were encouraged to succeed by their parents.

Trauma Recovery

In order for AAs to recover from traumatic wounds inflicted by white racism, they need to develop a sense of security and comfort with their blackness. A positive ethnic identity for AAs includes a *critical consciousness* of European American oppression, an awareness of white racism, and use of Afro-centric values and practices to repel its negative effects (Parham et al., 1999). The difference between critical consciousness and the hypersensitivity is that, when AAs are critically conscious of their oppression, they feel internally secure about their blackness without a reactionary vigilance to potentially racist threats. Robinson (1995) and Young (2004) positively conceptualized AAs who face grim realities as adaptive enough to adopt an attitude that helps them survive. Gaylord-Harden et al. (2006) found that AA youth who had a positive ethnic identity experienced fewer symptoms of anxiety and depression than European American youth even though the AA youth endured more stressful life events. Positive ethnic identity may protect AAs from some harmful effects of social inequalities.

Doing Therapy with African-American Clients as a European American Therapist

Thus far, I have presented a general theory of trauma and have shown that the trauma of white racism strongly influences AAs' development as individuals. I will now discuss how this historically-rooted trauma may manifest as barriers to therapeutic engagement when AAs are paired with European American therapists. I will demonstrate that these engagement barriers can be worked through by making use of AAs' historically-rooted survival strategies during therapy.

This discussion is not meant to imply that AAs are a monolithic people and can therefore be treated clinically as if they are all alike. Rather, this discussion is meant to identify some of the common factors making it difficult for AAs to engage with European American therapists and to present a culturally sensitive, therapeutic approach that addresses these common factors. Lower income, urban AAs are a historically underserved and high risk population, and in my experience, European American therapists are more common than AA therapists. Furthermore, Parham et al. (1999) emphasized that some AA therapists are inappropriate matches for AA clients because AA therapists may have their own unresolved issues with their own blackness. Thus, in order for AA clients to be more fully served, specific cross-cultural competencies for European American therapists need to be developed. Often AAs are reluctant to engage in therapy because of historically-rooted beliefs that one should solve one's own problems or at least solve them within one's family and community (Lum, 2003; Reese, 1998; Waites, 2004). Lum (2003) and Parham et al. (1999) noted that AAs seek therapy only when all other options have been exhausted or their presenting problems are suf-

ficiently overwhelming. AAs often view legitimate therapy-seeking as evidence of personal weakness and hurt pride (Adkins, 2010). When AAs present for therapy, they often interpret fairly normal therapeutic attempts at engagement as trickery (Lieberman & Van Horn, 2008).

AAs' barriers to therapeutic engagement are even more formidable when they are paired with European American therapists (Parham et al., 1999), which is particularly true for lower income, urban AAs (Lum, 2003). Despite Jones' (1982) finding that there is no significant difference in therapeutic outcome for AAs who are paired with either AA therapists or European American therapists, AA clients overwhelmingly prefer to work with AA therapists and up to 50% of them who are paired with a European American therapist drop out after one session (Parham et al., 1999; Duncan and Johnson, 2007; African American Therapists, 2008).¹ It may be that just being in close emotional proximity to whiteness triggers AAs' historically traumatic wounds and activates the self-protective survival strategies which may protect them in high risk social environments, but inhibit therapeutic engagement.

In my practice, it has been helpful to acknowledge (to myself and my clinical supervisors) that many of my lower income, urban AA clients don't engage me as readily as European American clients. When I sense the presence of barriers to therapeutic engagement, I often feel irritated. Through clinical supervision, I have unearthed that this dynamic brings up difficult feelings about my not having been accepted as a European American male growing up in a predominantly AA community.

Resisting oppression. I have sometimes been able to work through this irritation by considering that my lower income, urban African-American client's reluctance to engage with me and my irritable response is reminiscent of a historically traumatic dynamic. I have found it helps to reflect on my personal experiences of growing up in a lower income, urban AA community and remember that it was common knowledge that keeping one's mouth closed to authorities (including counselor types) was necessary to prevent police or social service investigations, which often led to AA families being separated and AA men being incarcerated. Such reflection has led me to re-frame what I instinctively considered to be my lower income, urban AA client's "resistance" to engaging me as their best efforts to *resist oppression*.

Because threats of traumatic oppression (e.g., police brutality) are severe in lower income, urban AA communities, predisposition to resist potentially oppressive forces is vitally necessary for lower income, urban AAs (Benard, 2004; Robinson, 1995). European American therapists may be seen as symbols of oppression because, in addition to historically rooted factors, lower-income, urban AA clients often come to therapy at the pressure of such *systemic forces* as criminal justice and child welfare officials, and concerned family members. A predisposition to resist may successfully repel potential threats, but it may also repel legitimate professional helping efforts.

Expressing resilience. Although AAs' predisposition to resist could be conceptualized as a symptom of trauma, I have found it useful to think of my lower-income, urban AA clients' resistance as expressions of *resilience*. Benard (2004) described resilience as a developmental capacity to adapt and survive through harsh surrounding circumstances by *resisting* threats to homeostasis. Clients of color demonstrate resilience when they resist potentially oppressive threats. In my practice, a resilience-focused therapeutic approach has helped to turn my irritation (about my AA clients' barriers to engagement) into empathy. Empathy and counter transference are two key factors in the psychotherapeutic experiences of AAs who are paired with European American therapists (Jones, 1982b).

The theory of resilience has been tested and validated. Markstrom, Sabino, Turner, and Berman (1997) found a correlation between the presence of resilience and *ego strength*, which Markstrom and Kalminar (2001) equate with *positive ethnic*

identity for African-Americans. The relationship between resilience and positive ethnic identity may suggest that a resilience-oriented therapeutic approach may help AAs develop more positive ethnic identities. This perspective is doubly important because it provides European American therapists with a less presumptuous way to work with AA clients *through an Afro-centric lens* (Parham et al., 1999).

Other strengths. In addition to their core strength of resisting oppression, AAs have other historically-rooted strengths and survival strategies which I have sometimes acknowledged directly and used intuitively in therapy sessions. These strengths include a strong church affiliation and sense of spirituality, flexible family roles, and strong family, extended family, and surrogate-family ties (Waites, 2004; Lum, 2003; Logan, 2001). Lum (2003) noted that these strengths developed out of the African tradition of clanship, helped African-Americans survive through slavery, and remain primary coping strategies in lower income, urban African-American communities. These strengths insulate African-Americans from the harmful effects of stress, poverty, depression, and traumatic oppression (Gaylord-Harden et al., 2006; Alleyne, 2004a; Alleyne, 2004b; Waites, 2004; Parham et al., 1999; Sharpe, 2010; Michalopoulos and Boyd, 2009; Grant, 2010; Lum, 2003; Robinson, 1995; Stewart and Simons, 2006).

AAs' use of group-oriented and community-oriented survival strategies to protect themselves from traumatic risk factors (e.g. poverty) parallels how social support helps chronic trauma survivors stabilize and recover from their traumas. This parallel is important because it demonstrates that the relationship between AAs' common plight and core principles of trauma theory extends into the recovery process.

Case Examples

Two case examples demonstrate how I have sometimes intuitively made use of AAs' core strengths and survival strategies in therapy. These cases illustrate how AAs' historically traumatic symptomatology may manifest in their psychotherapeutic experiences with European American therapists; how a more resilience-oriented, Afro-centric therapeutic approach can lead to positive therapeutic outcomes, and how the uniquely African-American process of traumatic suffering, recovery, and treatment coincides with core principles of trauma theories.

Case #1 summarizes my work with a 25 year old AA male who lived in an impoverished inner city community his whole life. He was in therapy with me for two years, had been a gang member since he was 15, was raised by an alcoholic mother, never knew his father, and exhibited a severe psychotic disorder. He presented as very intelligent, but with a strong tendency to intellectualize his feelings. He often spoke at length about his psychosis-laden philosophies of life, which often annoyed me.

I calmed my annoyance with him by thinking about how, unconsciously, he may have been trying to push people away for fear that they might hurt or abandon him. This behavior coincides with my previous discussions about how trauma may shatter the survivor's basic sense of trust and how African-Americans' may instinctively resist what they interpret as oppression.

While thinking about my 25 year old AA male client in this more empathic way, I sometimes interrupted his lengthy disclosures to ask him if he was feeling unsafe or threatened and was therefore speaking in broad, more general terms in order to protect himself. Usually, he readily agreed, calmed down, and explored what he was really afraid of. This case provides an example of how to *reframe resistance* in a way that meets a trauma-survivor's needs for trust, safety, and emotional exploration.

Case #2 summarizes my therapeutic work with a middle-aged AA male who I worked with when I was a counselor in a residential treatment center for men who had recently been released from prison. This client was in his late 40s and had been incarcerated for the last 30 years of his life. He told me he was

most recently in prison for kidnapping, but he did not volunteer details of what happened. I decided not to ask for elaboration, which might increase his resistance.

Early in our therapeutic work, I told him that I had never been to prison and asked him what it was like. I also let him know that I would understand if he didn't want to talk about it. Over the next two months of our work together, he told me about how the guards used to strip him naked and lock him in solitary confinement for days at a time without food. I suspected the guards were white. I didn't know exactly what that meant, but I knew it was an important detail.

When this AA client told me about his oppressive experiences in prison, he would watch me closely as if monitoring my reactions. I remember feeling shocked and horrified by what he had gone through and wondered if my feelings were a microcosm of what he felt. I felt a strong urge to take care of him. I think he knew I understood as much as I possibly could. Meanwhile, he was doing well in treatment. He had no significant conflicts with other clients, passed all of his randomly administered drug tests, and regularly attended therapy groups.

Then, almost suddenly, other clients started to get angry with him for stealing, and he began to fail randomly administered drug tests. I responded to his misbehavior by scolding him sternly. This was partially necessary given that his behavior could lead to serious conflicts with other clients. I have found that I sometimes need to display a harder clinical edge in order to be taken seriously by hardened, criminal justice-referred clients of color, particularly as a young, white male clinician. My frustrated reaction to this particular client may have led him to avoid contact with me. Two weeks later, he was back in prison.

My client's behavior in treatment suggested that he was profoundly affected by long-term institutionalization. It would be unrealistic to think I could reverse 30 years of such conditioning in just three months. Nonetheless, I think he tested me in the beginning of our work by telling me about how hard his life had been. Maybe I passed his test, which is why our relationship began to develop. Then, at an unconscious level, he again tested our relationship by acting out and recreating traumatic dynamics from his past.

Cultural Limitations

A major limitation of this article is that it is written by a European American male about AAs. Although I have personal experience growing up in a lower-income, urban AA community, my not being AA inherently makes it controversial for me to write about AAs. Furthermore, my home community is not necessarily representative of all lower income, urban AA communities. My personal experiences are relevant to the topic, but they may not be generalizable to larger AA populations. It is also important to note that this article may universalize AAs' experiences, or at least universalize lower income, urban AA experiences, risking ghetto-ization of AA culture (Parham et al., 1999). Unnecessarily universalizing AAs' experiences robs them of their individuality and re-creates the oppression that is at the core of their traumatic suffering (Jones, 1982b; 1984).

Practice Recommendations

My recommendations for practice coincide with Parham et al.'s (1999) advice that white therapists deeply and objectively look at how their issues with blackness manifest in treatment and then clinically practice in ways that coincide with the Afro-centric values. Although AAs need to be treated clinically as individuals, they generally differ from European Americans in significant ways that are helpful to consider during the course of therapy. Jones (1982b; 1984) agrees that European American therapists need to address their personal issues with blackness and be open to African-Americans' uniquely African-American experiences. However, Jones implies dubiousness about the possibility that European American therapists could generalize about AAs' experiences and apply those generalizations to clinical practice with AAs without

reinforcing racist stereotypes. Jones' (1982b) conclusions were based on results of large qualitative study of African-American's experiences in psychotherapy and how those experiences were affected by therapeutic matching.

Debate flourishes in the literature about what will help AAs heal as a population and as individuals in treatment. Parham et al. (1999) noted that *all Afro-centric theories* need to be more heavily researched in order to gain legitimacy in clinical circles. I have tried to address this gap between theory construction, research, and clinical practice by presenting many theories of AA development and treatment, noting where they agree with one another and other trauma theories. I demonstrated the relevance of these theories to clinical practice with AAs by presenting cases which showed that intuitively integrating core principles of trauma theories and the Afro-centric theories sometimes led to positive therapeutic outcomes and offered an instructive explanation for negative outcomes. Theoretical agreement is important because the trauma-focused theories have been heavily researched. Showing that core principles of *Afro-centric theories* coincide with core principles of trauma theories offers some support for their cogency in theory, while presenting cases in which they contributed to positive outcomes offers support for their efficacy in clinical practice.

Controversy. The way I applied trauma theories to AA development and treatment is controversial. I did not find any research that directly supported my way of framing AAs' plight as symptoms of trauma. I believe I have piloted a potentially helpful theory of practice, but more research is needed in order to establish its validity and reliability.

Conclusion

Writing this article involved deep reflection on my own personal and professional experiences as well as intellectually-focused, emotionally-detached research. This deep self-examination is absolutely vital to working competently and sensitively with AA clients as a European American therapist. My experience has been that European American therapists tend to be uncomfortable with personalized, cross-culturally focused exploration; they express their discomfort through denial, liberalization, or intellectualization. Deep and fearless exploration is a necessary step in the direction of competently serving AA clients; its absence contributes to their ongoing trauma and suffering (Parham et al, 1999).

REFERENCES

- Adkins, A. (2010). *Help-seeking patterns of African-Americans: Variables that affect professional help seeking* (Doctoral dissertation, Texas Tech University). Retrieved from: <https://dspace.lib.ttu.edu/etd/bitstream/handle/2346/ETD-TTU-2010-05-618/ADKINS-DISSERTATION.pdf?sequence=4>
- African American Therapists (2008, December 14). Re: African Americans and Therapy [Online posting] Retrieved from: <http://www.africanamerican-therapists.com/Therapy%20&%20Race.htm>
- Ainsworth, M., Blehar, M., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Lawrence Erlbaum.
- Alim, T., Graves, E., Mellman, T., Aigbogun, E., Gray, E., Lawson, W., & Charney, D. (2006). Trauma exposure, posttraumatic stress disorder, and depression in an African-American primary care setting. *Journal of Medical Association*, 8(10), 1630-1636.
- Alleyne, A. (2004). Black identity and workplace oppression. *Counseling and Psychotherapy Research*, 1(4), 4-8.
- Alleyne, A. (2004). The internal oppressor and black identity wounding. *Counseling and Psychotherapy Research*, 10(15), 31-88.
- American Psychological Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington D.C. First, M., Frances, A., Pincus, H., & Widiger, T.
- Applegate, J., & Shapiro, J. (2005). *Neurobiology for clinical social work: Theory and practice*. New York, NY: W.W. Norton.
- Bellow, G. (2009, December). *Attachment theory and child protective practice*. Paper presented at the Sanville Convocation, Los Angeles, CA.
- Benard, B. (2004). *Resiliency: What have we learned*. San Francisco, CA: WestEd.
- Blaustein, M., & Kinniburgh, K. (2005). Providing the family as a secure base for therapy with children and adolescents. *Attachment Theory into Practice*, 10(1), 48-53.
- Bowlby, J. (1960). Grief and mourning in early infancy and childhood. *The Psychoanalytic Study of the Child*, 15, 9-52.

- Bowlby, J. (1963). *Child care and the growth of love*. Baltimore, MA: Penguin Books.
- Bowlby, J. (1969). *Attachment and loss: Volume 1*. Lubbock, TX: The Hogarth Press & The Institute of Psychoanalysis.
- Briere, J., & Spinazzola, J. (2005). Phenomenology and psychological assessment of complex posttraumatic stress. *Journal of Traumatic Stress, 18*(5), 401-412.
- Butts, H. (2002). The black mask of humanity: Racial/ethnic discrimination and posttraumatic stress disorder. *The Journal of the American Academy of Psychiatry and Law, 30*, 336-339.
- California Department of Alcohol and Drug Programs. (2010). Grant, G. (2010). *Using trauma informed AOD treatment practices to improve outcomes for African-American survivors of domestic violence*. Ontrack Communications. Grant, G. Retrieved from: http://www.adp.cahwnet.gov/women/PDF/Trauma_Informed.pdf
- Cassidy, J., & Shaver, P. (2008). *Handbook of attachment: Theory, research, and clinical applications* (2nd ed.). New York, NY: The Guilford Press.
- Charles, C. (2003). Skin-bleaching, self-hate, and black identity in Jamaica. *Journal of Black Studies, 33*(6), 711-728.
- Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., DeRosa, R., Hubbard, R., Kagan, R., Linaud, J., Mallah, K., Olafson, E., & van der Kolk, B. (2008). Complex trauma in children and adolescents. *Psychiatric Annals, 35*(5), 390-398.
- Davis, R., Ressler, K., Schwartz, A., Stephens, K., & Bradley, R. (2008). Treatment barriers for urban African Americans underdiagnosed with posttraumatic stress disorder. *Journal of Traumatic Stress, 21*(2), 218-222.
- Drake, B., & Pandley, S. (1996). Understanding the relationship between neighborhood poverty and specific types. *Child Abuse & Neglect: The International Journal, 20*(11), 1003-1018.
- Duncan, L., & Johnson, D. (2007). Black undergraduate students attitude toward counseling and counselor preference. *College Student Journal, 41*(3), 696-719.
- First Five Alameda County. (2011, May 5). *Mandated child abuse reporting*. Training seminar facilitated by Hernandez, R., San Leandro, CA.
- Gaylord-Harden, N., Ragsdale, B., Mandara, J., Richards, M., & Peterson, A. (2006). Perceived support and internalizing symptoms in African American adolescents: Self-esteem and ethnic identity. *Journal of Youth and Adolescence, 36*(1), 77-88.
- Goffman, E. (1986). *Stigma: Notes on management of spoiled identity*. New York, NY: Simon and Schuster.
- Grogan, P., & Proscio, T. (2000). *Comeback cities: A blueprint for urban neighborhood revival*. Boulder, CO: The Westview Press.
- Gump, J. (2010). Reality matters: The shadow of trauma on African-American subjectivity. *Psychanalytic Psychology, 27*(1), 42-54.
- Herman, J. (1996). *Trauma and recovery: The aftermath of violence - from domestic abuse to political terror*. New York, NY: Basic.
- Hughes, D. (2006). *Building the bonds of attachment: Awakening love in deeply troubled children* (2nd ed.). Lanham, MD: Rowman and Littlefield.
- Jones, E. (1978). Black-White personality differences: Another look. *Journal of Personality Assessment, 42*(3), 244-252.
- Jones, E. (1982). Psychotherapists' impressions of treatment outcome as a function of race. *Journal of Clinical Psychology, 38*(4), 722-731.
- Jones, E. (1982). *Minority mental health*. Essex, UK: Abbey.
- Jones, E. (1984). Some reflections on the Black patient and psychotherapy. *Clinical Psychologist, 37*(2), 62-65.
- Kimmerling, R., Ouimette, P., & Wolfe, J. (2002). *Gender and PTSD*. New York, NY: The Guilford Press.
- Kozol, J. (2005). *The shame of the nation: The restoration of apartheid schooling in America*. New York, NY: Three Rivers Press.
- Lieberman, A., & Van Horn, P. (2008). *Psychotherapy with infants and young children: Repairing the effects of stress and trauma on early attachment*. New York, NY: The Guilford Press.
- Logan, S. (2001). *The black family: Strengths, self-help, and positive change* (2nd ed.). Oxford, UK: The Westview Press.
- Lum, D. (2003). *Social work practice and people of color* (5th ed.). Florence, KY: Wadsworth Publishing.
- Main, M., & Solomon, J. (1986). Discovery of an insecure disorganized / disoriented Attachment pattern: Procedures, findings and implications for classification of behaviour. In M.W. Yogman & T.B. Brazelton, *Affective Development in Infancy*, 95-124. Norwood, NJ: Ablex.
- Macy, R., Behar, L., Paulson, R., Delman, J., Schmid, L., & Smith, S. (2004). Community based, acute posttraumatic stress-management: A description and evaluation of a psychosocial-intervention continuum. *Harvard review of psychiatry, 12*(4), 217-228.
- Markstrom, C., & Kalmanir, H. (2001). Linkages between the psychosocial stages of identity and intimacy and the ego strengths of fidelity and love. *Journal of Theory and Research, 1*(2), 179-196.
- Markstrom, C., Sabino, V., Turner, B., & Berman, R. (1997). The psychosocial inventory of ego strengths: Development and validation of a new Eriksonian measure. *Journal of Youth and Adolescence, 26*(6), 705-733.
- McGoldrick, M., & Hardy, K. (2009). *Re-envisioning family therapy: Race, culture, and gender in clinical practice* (2nd ed.). New York, NY: The Guilford Press.
- McNally, R.J. (2007). Betrayal trauma theory: A critical appraisal. *Journal of Memory, 15*(3), 280-294.
- Michalopoulos, L., & Boyd, R.C. (2009, June). *Trauma, depression, and kinship support among Urban African-American women*. Paper presented at the annual meeting of the SCRA Biennial meeting at Montclair State University, Montclair, NJ.
- Nelson, J. (2008). *Seeing through tears*. New York, NY: Brunner-Routledge.
- Parham, T., White, J., & Ajamu, A. (1999). *The psychology of blacks: An African centered perspective* (3rd ed.). Upper Saddle River, NJ: Prentice Hall.
- Reese, C. (1998). *Trauma and the African American experience*. [Newsletter of the Center: posttraumatic disorders program, (3)2], n.p. n.w.e.
- Robinson, L. (1995). *Psychology for social workers: Black perspectives*. New York, NY: Routledge.
- Ryan, W. (1971). *Blaming the victim*. New York, NY: Random House.
- Saigh, P., Yarik, A., Oberfeld, R., & Halamandaris, P. (2008). The self-concept of traumatized children and adolescents with or without PTSD. *Behaviour Research & Therapy, 46*(10), 1181-1186.
- Saleebey, D. (2009). *The strengths perspective in social work practice*. Boston, MA: Pearson Education.
- Sharpe, T. (2010, n.m.). *Working with African-American families who have experienced trauma*. Paper presented at University of Maryland School of Social Work, College Park MD. Retrieved from: http://www.family.umaryland.edu/ryc_education_and_training/ast_cwa_files/PLACE%20MATTERS/Working%20with%20African%20American%20Families%20W%20Have%20Experienced%20Trauma%20B%20and%20E6.pdf
- Smith, G. (2003). Essay book review. *Journal of Family Therapy, 14*(4), 365-367. n.w.e.
- Spinazzola, J., Blaustein, M., & van der Kolk, B. (2005). Posttraumatic stress disorder treatment outcome research: the study of unrepresentative samples? *Journal of Traumatic Stress, 18*(5), 425-436.
- Stewart, E., & Simons, R. (2006). Structure and culture in African American adolescent violence: A partial test of "the code of the streets" thesis. *Justice Quarterly, 23*(1), 1-33.
- Street, A., Gibson, L., & Holohan, D. (2005). Impact of traumatic events, trauma-related guilt, and avoidant coping strategies on PTSD symptoms in female survivors of domestic violence. *Journal of Traumatic Stress, 18*(3), 245-252. R
- Sue, D.W. & Sue, D. (2008) *Counseling the culturally diverse: Theory and practice* (5th ed.) Hoboken, NJ: John Wiley & Sons.
- Scott-Tilley, D., Rugari, S.M., & Walker, C.A. (2008). Development of violence in men who batter intimate partners: A case study. *Journal of Theory Construction & Testing, 12*(1), 28-33.
- Tucker, J. (2007, August 26). Children who survive urban warfare suffer from PTSD. *The San Francisco Chronicle*. pp. A-1.
- Van der Kolk, B., Pelcovitz, D., Roth, S., Mandel, F., McFarlane, A., & Herman, J. (1996). Dissociation, affect dysregulation, and somatization: The complexity of adaptation to trauma. *American Journal of Psychiatry, 153*(7), 83-93. R. Van der Kolk, B., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress, 18*(5), 389-399.
- Waites, C. (2004). *Social work practice with African-American families: An intergenerational perspective*. New York, NY: Routledge.
- Walker, C. (2004). Modernity in black: Dubois and the (re) construction of black identity in the souls of black folk. *Philosophia Africana, 7*(1), 83-93.
- Wallin, D. (2007). *Attachment in psychotherapy*. New York, NY: The Guilford Press.
- Wilson, W. (2009). *More than just race: Being black and poor in the inner city*. New York: W.W. Norton.
- Young, A. (2004). *The minds of marginalized black men*. Princeton, NJ: Princeton University Press.
- Zinzow, H., Ruqquero, K., Hanson, R., Smith, D., Saunders, B., & Kilpatrick, D. (2009). Witnessed community and parental violence in relation to substance abuse and delinquency in a national sample of adolescents. *The Journal of Traumatic Stress, 22*(6), 525-533.
- Zucker, M., Spinazzola, J., Blaustein, M., & van der Kolk, B. (2006). Dissociative symptomatology in posttraumatic stress disorder and disorders of extreme stress. *Journal of Trauma and Dissociation, 7*(1), 19-31.

Graham Danzer, PsyD, Trainee, ASW, PPSC MRAS, is affiliated with The Sanville Institute in Berkeley, CA. He may be contacted at geminex3@hotmail.com.

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¹ Africanamericantherapists.com is a professional list serve that is made up of clinicians who are committed to increasing the effectiveness of professional helping efforts with African American clients. This source regularly publishes scholarly material online, including the statistics noted in the text.

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