TRAUMA MATTERS

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THE ROLE OF PRIVILEGE IN TRAUMA TREATMENT

White Privilege is a term commonly used to describe unearned benefits or privileges afforded white American males of European descent - based solely on their gender and the color of their skin. In "*White Privilege: Unpacking the Invisible Knapsack*", written by Peggy McIntosh, she defines privilege as "an unearned advantage and conferred dominance" (Wellesley College Center for Research on Women, 1989). This statement begs the questions: What does it mean to be white; and, what does it mean to not be white? What does it mean to have "privilege"? Exactly what are these privileges of being male and white? Where does this privilege come from and how does it impact human interaction; and more specifically, counseling work?

I have known earned privilege in terms of having a comfortable life, in a middle class neighborhood, two cars, and a daughter who graduated Wellesley. However, many Americans will never know the experience of being white or male. I also know what it is like to grow up poor, to have uneducated parents, to look "different" and to feel ashamed of who I was, where I lived, and what I did not have. Inevitably when I teach a class on cultural competence and how culture and race affect access, acceptance, and admission to treatment, white males and females talk about how they too feel oppressed. Sometimes white males do not have the ability to understand what "white privilege" means. Perhaps that is because you never think about it if you have it. I will often hear, "It's not my fault, I didn't ask for it. Why should I feel guilty?" On the other hand, people not born into white privilege, tend to have an inherent understanding of the concept.

Consider various "movements" to gain civil rights; women's rights; gay, lesbian, and transgender rights. If we were in fact equal, why would anyone have to fight, march, or legislate equal rights? I don't recall any fights calling for white rights. Males of other ethnic and racial backgrounds, white women or non-white women of any class do not share the privilege enjoyed by white male, heterosexuals.

It is not possible to understand what cultural competence means without incorporating the attendant concept of white privilege. In 1973, the APA said that it is unethical to overlook the cultural backgrounds of clients and that it is unethical to deny services because the staff is inadequately prepared. Additionally, we know that persons who are a part of or in tune with the racial and ethnic culture of the clients they serve are better able to provide more culturally competent treatment.

When I ask students what it means to know the person sitting across the desk, they discuss cultural norms, ethnic belief systems, etc. I believe that as counselors we need to have a broader historical understanding of that person's experience. In fact, that person may be a descendent of any of 10-15 million persons brought to the United States against their will contending with daily experiences of what Derald Sue refers to as "racial microaggressions". According to Stella Ting-Toomey (1999) "We should learn to understand the historical conditions that frame the marginalization experiences of 'minority' group members"(p.172). Clients may suffer cultural paranoia, a belief that being honest with a "white" caregiver can be dangerous and that health and mental health systems are not trustworthy. They may recognize that a successful outcome is measured using the middle-class, non-minority yardstick. Their experiences may exemplify how "personal, institutional, and cultural racism are vehicles for continued exploitation and persistent inequalities" (Auletta & Jones, 1994, pps. 169-170).

THE ROLE OF PRIVILEGE IN TRAUMA TREATMENT (continued)

We must acknowledge, accept, and appreciate that a person of another race or gender is likely to carry a history of disrespect, disregard, and discrimination into any relationship. A counselor needs to have knowledge, empathy, and positive regard. He/she must be prepared to engage in the conversation about what it is like to be marginalized, oppressed, hated, and feared because of race or gender without being afraid of the anger and rage which the client may express. The empathy I refer to is not being able to understand what it is like to be in that person's shoes, it is trying to understand what it is like to be ***that*** person ***in their shoes***.

Here is an exercise I use to help students gain a visceral experience of these feelings. Each person is given a sign that is adhered to his or her forehead. They do not see the sign and are not allowed to read what it says. The signs have a variety of commands such as: look at me, frown, turn and walk away; point your finger at me and follow me around; smile and welcome me in; look at me with fear and back away slowly; laugh at me and whisper to others. Once the signs are in place, the group is told that their task is to mingle and to follow the instructions on each person's forehead. You can imagine what comes out when this is processed by the group. It is noteworthy how quickly students expect each person to respond to them in the same manner. They recognize that they have not done anything to deserve the treatment received. And so it is with privilege that is given, unearned and undeserved. And so, the question we need to address is this: Can you understand the person before you if you do not understand how white privilege affects them…and you?

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TRAUMA AND d/DEAF CONSUMERS

According to the CT Department of Mental Health and Addiction Services (DMHAS) Trauma-informed philosophy, it is believed that 99% of the clients served have experienced trauma of some kind. Research of non-mental health populations have shown that rate of trauma is doubled among the d/Deaf[1] as compared to their hearing counterparts. Life as a d/Deaf child has many adverse dimensions, such as being entrapped in a soundless world, confronting obstacles in communication and limited educational/socialization opportunities (Padden, 1998, & Glickman, 1996). Such narrowed dimensions may increase the child's vulnerability to becoming a victim of trauma and impede the disclosure process (Durity, 2005 & Kendall-Tackett, 2002).

Due to increased vulnerability and an unnatural communication modality with family members, there is limited opportunity to learn about emotional regulation. Incidental/experiential learning may be non-existent. Conversations that occur on the playground, in the classroom, at home, or on television are lost to most d/Deaf children and adults (Ogden, 1996 &Isenberg, 1996). There is a lack of cultural and linguistic resources related to basic safety and sexual education which further places d/Deaf consumers at risk of being exploited.

Many deaf consumers are automatically placed at a disadvantage due to the lack of mental health providers who understand their cultural and linguistic needs. Amongst d/Deaf survivors, there is a web of secrecy that a State Coordinator of Deaf Services described as being stronger than the Mafia. This may be due to the close knit community and the fact that perpetrators are often teachers and other persons who hold powerful positions in the deaf community. Therapists working with d/Deaf consumers should be aware of this hesitancy to disclose as well as the ramifications it may have on the consumer attempting to reengage in the deaf community.

Having a supportive therapeutic alliance empowers and enables consumers to be freed from the constraints of keeping silent about past trauma. Clear communication, empathy, knowledge of trauma work, and most importantly understanding of d/Deaf culture on the part of the therapist helps lead consumers to a place of safety and hope.

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[1] d/Deaf –lower case d signifies the medical model whereas upper case D signifies the cultural model, (Padden, 1998).

Trauma Treatment for Asian Americans

The U.S. Surgeon General's Report on Mental Health (U.S. Department of Health and Human Services, 2001) identified problems facing Asian Americans include low rate of admission for necessary behavioral health services, high drop out rate after initial contact, premature termination from service settings. Explanations for these problems include lack of cultural competency and cultural and systemic barriers. Cultural barriers to treatment include lack of confidence in Western behavioral health care services, attitude against help-seeking behaviors, fears of shame and stigma, level of acculturation, English proficiency, history of immigration or refugee experience, and cultural and religious beliefs.

Systemic barriers include the stereotype of Asian Americans as the *model minority* group; the term model minority refers to a minority ethnic, racial or religious group whose members achieve a higher degree of success than other minority groups. Historically, Asian Americans have been perceived as highly educated, well balanced in mental and physical health, highly professional, and financially secure. This stereotype of the group distorts the fact that mental health disorders among Asian Americans are similar to those of the general population and denies the need and eligibility for behavioral health care and social services. Similarly a major cultural barrier to mental health treatment is the lack of knowledge of *cultural bond syndromes*; a combination of psychiatric and physical symptoms recognized within a specific cultural group that is often overlooked by medical and behavioral health professionals as a physical complaint. A cultural bond syndrome is associated with cultural expression of underlying psychiatric symptoms. For instance, a person presenting Shenjing Shuairuo in Chinese (neurasthenia in Western), which is a combination of symptoms including fatigue, headache, anxiety, nerve pain and depression is often referred to a health care professional. Behavioral health professionals lack of knowledge of cultural bond syndromes and of cultural expression of psychiatric symptoms often fail to provide culturally sensitive treatment and exacerbate symptoms of untreated underlying psychiatric disorders.

Differences in worldviews between Asians and the dominant western cultures create barriers for building a trusting working alliance, e.g. interdependence vs. independence, collectivism vs. individualism, harmony vs. competition, holistic vs. scientific approach, and non-linear vs. linear thinking. Traditionally, an experience of trauma, extreme stress, mental health or substance abuse issue is considered to be an imbalance of ying-yang within one's body, mind, spirit, interpersonal relationship and physical environment and explained as karma from the past life, or an evil spirit from the universe. An attitude of fatalism helps an individual and the family reason, accept and handle those issues. Maintaining harmony in the family or social relationship outweighs solving an individual's problem. Yet, an individual's problem is perceived to be the collective responsibility of the family of origin and the extended family. Psychopharmocotherapy is perceived as a superficial temporary fix of the presenting problem yet for some Asian Americans, a holistic approach is deemed to be the means of recovery for one's wellbeing. Holistic approaches include practices of ying-yang, diet and of physical and mental exercise (taichi, yoga and meditation), herbal medicine, spiritual and religious practices, and traditional folk healing method (shaman).

In addition to being cognizant of cultural and systemic barriers, it is imperative for behavioral health care providers to acknowledge the diversity within Asian ethnic groups. Asian Americans include more than forty-three ethnic groups speaking more than one-hundred languages and dialects. The population of the Asian group is extremely heterogeneous in terms of ethnicity, socioeconomic status, education, language, religion, custom, life style., history of immigration, level of acculturation, English proficiency, and needs for mental health care. For instance, religions include Induism, Muslim, Buddhism, Taoism, Shintoism, Christian, Catholic etc. Among Southeast Asian refugees, 40% suffer from depression and 14% from posttraumatic stress disorder (NAAPIMHA).

A Person-Centered approach is often effective in delivering culturally-sensitive trauma service for Asian Americans. Person-Centered approach emphasizes respect and acceptance of an individual's value and belief systems and will prevent behavioral health professionals from overgeneralization of an individual's cultural experience and it will help to develop an empathic understanding and insight about an individual's worldview toward trauma, mental health and substance abuse. Moreover, with respect, acceptance and empathic understanding, a working alliance can be established between the individual and behavioral health professional to overcome the cultural and systemic barriers in service delivery for Asian Americans.

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CULTURAL TRAUMA RESOURCES

White Privilege

http://seamonkey.ed.asu.edu/~mcisaac/emc598ge/Unpacking.html
http://uts.cc.utexas.edu/~rjensen/freelance/whiteprivilege.htm

Asian/American Trauma

http://giftfromwithin.org/html/thriving.html
www.sph.umich.edu/apihealth/2006/wartrauma.htm
http://www.aapaonline.org/index.shtml
http://www.apiahf.org/apidvinstitute/ResearchAndPolicy/factsheet.htm

d/Deaf Trauma

http://www.nctsnet.org/nctsn_assets/pdfs/edu_materials/FactsonTraumaandDeafChildren.pdf
http://www.mhcd.org/Services/AddressingTraumaNeedsOfDeaf.pdf
http://kb.nctsn.org/SPT--BrowseResources.php?ParentId=241
http://new.vawnet.org/category/Main_Doc.php?docid=762

Getting into Trauma Matters

- You can access an electronic version of the "*Trauma Matters"* Newsletter at www.traumamatters.org; www.dmhas.state.ct.us; or www.womensconsortium.org
- Do you want to be placed on our mailing list or is there an event or topic you would like covered in this newsletter? Please call "*Trauma Matters"* editor Carol Huckaby at 203.498.4184, x25 or e-mail her at chuckaby@womensconsortium.org.

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