TRAUMA MATTERS

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TREATING TRAUMA IN LATINO COMMUNITIES

High birth rates and immigration rates have continued to make Latinos in the U.S. the fastest growing ethnic minority subgroup. It is predicted by the U.S. Census Bureau that by 2050, Latinos will make up 29% of the U.S. population. The Latino population in the U.S. consists of people from diverse racial and cultural backgrounds and countries of origin. Nationally, Mexicans make up the largest Latino group (64%) followed by Central and South Americans (14%), Puerto Ricans (11%), and Cubans (3.4%). In the U.S., Latinos also represent the largest foreign-born population group (44.2%); however, over half (55.8%) of all Latinos living in the U.S. are born here. Although Latinos do share a common language and cultural values orientation as a group they vary in terms of social, political, racial, economic, historical and migratory realities. Recognizing the diversity of Latinos and the unique needs each client brings is crucial in providing effective, specific, appropriate, culturally sensitive mental health services needed in order to address their unique trauma needs.

As in other ethnic minority groups in this country, Latinos confront an array of social problems including poverty, unemployment, poor educational attainment, oppression, sexism, racism and discrimination. Yet despite these problems, they have demonstrated marked resiliency in not showing higher rates of mental health problems than the general population as a whole based on the most recent epidemiological studies. The exception is for some very specific psychiatric disorders such as depression, anxiety, somatization, substance abuse and Post Traumatic Stress Disorder (PTSD) and among these specific psychiatric disorders, a tremendous amount of variability exists between and within Latino subgroups. Thus, caution in making generalizations should be taken.

The incidence of PTSD in Latinos has been reported to be higher and of greater severity than the general population in epidemiologic studies, community and clinical studies involving adolescent, women, elderly and male veterans. Some of the general findings cited in the literature have been that Latinos have a higher incidence of life time trauma, often have more delayed reaction, but tend to show no difference in service utilization which indicates a clear self identification of a traumatic event. Other findings cited in the literature related to PTSD in Latinos suggest that increased use of alcohol and drugs and family conflicts often mask PTSD. Another finding is that PTSD seems to be associated with high levels of acculturation and generational status. In other words, Latinos who are born and raised in this society tend to exhibit higher rates of PTSD than recent immigrants.

Dissociation and somatization appear to be higher for certain Latino groups who present with PTSD, such as Puerto Ricans. Even culture bound syndromes, such as "ataque de nervios" have been found by one of the authors (Rivera-Arzola, 1992) as being an idiom of distress that was highly associated with a life time history of traumatic events (PTSD) in the women in her study. Ataque de nervios has also been associated with psychosomatic symptoms, which suggest that the psychosomatic aspect of PTSD may be confounding with symptoms of ataque de nervios. Other researchers have noted that Latinas often present in clinical settings identifying primary feelings of sadness, anxiety, nervousness, and fear as presenting problems. The most common feeling was "sad" (*triste)*, "angry" (*enojada*), "nervous" (*nerviosa*), and "scared" (*miedo*) and that these feelings are often associated with trauma.

Some of the ethno cultural variables that should be taken into account when assessing and treating Latinos who present with PTSD are as follows:

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Treating Trauma in Latino Communities (continued)

- Language: It is important to assess the language proficiency of the client and therapist since it has a direct impact on the therapeutic outcome. First, if there is no language congruency between the client and the therapist it can lead to over or under pathologizing and it could make the client feel misunderstood, thereby leading to early treatment termination. Finally, even in bilingual clients, language code switching has been noted during emotionally charged situations and is often directly related to traumatic life event.
- Acculturation: Assessing client's level of acculturation based on a multidimensional measurement is important. Doing this will allow you to gear your intervention to their value orientation, current cultural customs and practices, and language usage involving their native and host culture. It is also important to assess and reduce the unique stress related to the acculturation process (often referred to as Acculturative Stress).
- Immigration Status: Understanding the reasons for a person's decision to immigrate to this country is important in order to create a trusting relationship in therapy. For instance, a client who is here for political reasons may have different needs from someone who came to this country in search of better economic opportunities or medical attention. Also, their legal status will often determine the level of institutional contact and support.
- Level of Social Support: Given that many Latino clients migrate as a consequence they loose social support from extended or nuclear family. It is important for the therapist to assess and help the client develop more informal social support networks as a means of alleviating and buffering the client from further trauma.
- Resiliency Level: It is imperative for clinicians to search, and validate aspects of the client's resilience and coping mechanism. Focus on a strength based approach will lead to quicker treatment gains, coping strategies and resolution of the client's PTSD symptoms.

Although the literature on PTSD contains many recommendations for culturally sensitive interventions, little empirical evidence supporting or refuting such treatments are available. What seems to be constantly promoted and practiced is a combination of Cognitive Behavioral Therapy and psychopharmacological intervention, devoid of any cultural considerations. In one of the author's experiences, a treatment modality which has been successful with many of the clients at The Center involves something on the order of Paulo Freire's model of critical consciousness in helping Latino clients critically understand the historical, political and social problems that interact with their own interpersonal issues and relationships. The intervention also incorporates feminist psychology by encouraging a self-critical, self-reflective and self-determined approach. Finally, although this article offered brief guidelines on working with Latino clients who present with PTSD it is important to learn more about the specific Latino subgroups you may be working with in order to avoid stereotypical assumptions.

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Gay, Lesbian and Bisexual Survivors of Trauma

In June, we celebrated the Gay Rights movement to commemorate the 40-year struggle for civil rights for GLBT people. Although many gains have been made during these years, the coming out process and homophobia and transphobia has lead to many GLBT people being victims of verbal and physical abuse. In addition, gay, lesbian, bisexual and transgender people may also experience trauma unrelated to their sexualities and gender variance. This article highlights some of the clinical issues and how clinicians can be GLBT-affirming in providing trauma-informed care.

Many GLBT clients have had negative experiences when we seek therapy. Some have heard hurtful messages from some professionals who have tried to change our sexualities or refute how we feel in our genders. So, imagine you have been the victim of verbal, physical or sexual abuse, which was traumatizing. Once you were willing and able to communicate about it, you get an appointment with a mental health professional. As you start to share about yourself and what has happened, you get the feeling that either you are not liked or misunderstood. This "helping process" can start to feel re-traumatizing and instead of facilitating recovery, it can make the process more protracted.

Several studies have shown that GLBT people are at increased risk for depression, anxiety and substance use

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GAY, LESBIAN AND BISEXUAL SURVIVORS OF TRAUMA (CONTINUED)

disorders (Cochran and Mays, 2000; Gilman, et al., 2001). GLBT people living with a mental illness are more vulnerable, underserved and sometimes invisible. GLBT victims fear the consequences of reporting incidents. They want to "move on" from the incident. And often they may start to believe that the incident stemmed from poor personal judgment.

GLBT youth of color face additional challenges. Unlike racial stereotypes that family and one's ethnic community can positively reframe, many ethnic minority communities reinforce negative cultural perceptions of homosexuality, bisexuality and gender variance. Up to 46% of GLBT youth of color report experiencing physical violence related to their sexual orientation. (GLSEN, 2004) They lack positive role models, may take sexual risks and/or attempt suicide as a means to cope and escape.

How can we be GLBT-affirming in our work with trauma survivors?

Know your own GLBT-competency and level of comfort. Seek supervision and consider referral if too much is in the way. Be frank about your own sexual orientation. GLBT people often feel more comfortable with "out" GLBT therapists, but genuine, affirming messages can facilitate trusting therapeutic alliance with therapists who are allies can be equally effective. Be sensitive to language. For example – use the phrase sexual orientation not preference. A preference is something you prefer vs. orientation is constant and unchanging. GLBT folks are born as they are and do not feel it is a matter of choice. Give yourself permission not to know all about GLBT issues and make a personal commitment to expand that knowledge out of session.

Submitted by
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TRAUMA TREATMENT FOR HUMAN TRAFFICKING VICTIMS

Human trafficking is described as a modern day form of slavery and victims are subjected to force, fraud or coercion for the purpose of sexual exploitation or forced labor. Victims of trafficking are young children, teenagers and men and women and are foreign born or United States citizens. Many victims of trafficking are exploited for purposes of commercial sex, including prostitution, stripping, pornography and live-sex shows. However, trafficking also takes place as labor exploitation, such a domestic servitude, sweatshop factories or migrant agricultural work. Traffickers can be individuals, companies, or legitimate businesses. According to the U.S. Department of State, between 14,500 and 17,500 victims are trafficked into the United States each year and the number of U.S. citizens trafficked within the country each year is even higher, with an estimated 200,000 American children at risk for trafficking into the sex industry.

Most of the literature on trauma and trafficking found that in addition to experiencing terrorizing physical and sexual violence and brainwashing, victims often experience multiple layers of trauma including psychological damage from captivity and fear of reprisals if escape is contemplated. These victims may suffer from anxiety, panic disorder, major depression, substance abuse and eating disorders or a combination of any of these diagnoses and in some cases, the trauma induced by someone they once trusted results in pervasive mistrust of others and their motives.

Traditional therapeutic services are often ill-designed to respond to the needs of trafficking victims. The key to helping trafficking victims is providing trauma informed and responsive mental health treatment services that are flexible which may not be supported by existing systems of care. A trauma sensitive therapist will be able to: (1) understand that certain survivor behaviors are a response to trauma; (2) be knowledgeable regarding the mental health [and substance abuse] effects of violence and in particular, sexual violence; (3) is skilled and knowledgeable regarding trauma and trauma treatment; (4) Is able to provide culturally competent services and seeks supervision regarding cultural issues; and (5) is responsive to emergency mental health issues of clients. The Connecticut Women's Consortium is providing several trainings on identifying victims of Human Trafficking this fall. For more information on these trainings, please go to www.womensconsortium.org.

Submitted by
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CULTURAL TRAUMA RESOURCES

Resources for Working with GLBT Survivors:

- LGBT Survivors of Sexual Violence Carissa or Anja @ (203) 624-4576
- Women's Center for Psychotherapy (860) 724-5542
- Inpatient Substance Abuse Treatment for LGBT people
  - PRIDE Institute www.pride-institute.com (800) 54-PRIDE
  - Brattleboro Retreat (800) 738-7328
- GLBT Affirming Therapists – CT state-wide list
  - GLBT Task Force of the CT Psychological Association (860) 666-7645
  - "True Colors" (860) 649-7386

Resources for Human Trafficking

- www.humantrafficking.org

Resources for Latino Trauma Tretament

- www.nctsnet.org/nccts/nav.do?pid=ctr_rsch_prod_ar
- http://www.chadwickcenter.org/WALS.htm
- http://www.nctsnet.org/nctsn_assets/pdfs/culture_and_trauma_brief_v2n3_LatinoHispanicChildren.pdf
- http://www.svcmc.org/body.cfm?id=788

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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