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A Review of Trauma Literature and Approaches

The American Psychiatric Association (2013) defined *trauma* as an emotional response to a catastrophic or frightening event. For a person to be clinically diagnosed with posttraumatic stress disorder (PTSD), the trauma experienced must include death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence. Many types of hate victimization easily fit these criteria, resulting in a clear-cut clinical diagnosis of PTSD. As an example, imagine a transgender woman who is physically assaulted or severely beaten because of her gender identity (and who survives). Because she suffered an actual serious injury, and likely felt that her life was in serious danger, a clinician might easily label the incident as a trauma.

According to the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM–5*; American Psychiatric Association, 2013), survivors of trauma also tend to develop psychological stressors and engage in avoidant

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behaviors, including having intrusive flashbacks to the event, experiencing terrifying nightmares, waking in the middle of the night in a panic or a sweat, and eluding places or objects that remind them of the attack. For instance, the aforementioned transgender woman might have difficulty concentrating at work because she is always remembering or visualizing the details of the attack. She might be extra sensitive and jumpy when encountering smells, sounds, or sights that remind her about the assault. She might also have difficulty in sleeping because she is constantly dreaming about being attacked or killed.

When clinicians recognize that their clients are survivors of trauma and that they might be suffering from typical symptoms of PTSD, they may use an array of trauma-focused techniques in their treatment plans, including eye-movement desensitization and reprocessing (EMDR), dialectical behavioral therapy (DBT), and trauma-focused cognitive behavior therapy. These types of treatments have empirical support for their ability to reduce the types of traumatic symptoms felt by an array of trauma survivors—including veterans, survivors of physical and sexual assault, individuals who have had nearly fatal experiences, and many others (Brown, 2008; Ford & Courtois, 2013; Lopez Levers, 2012). Although treatment for clients who are diagnosed with PTSD symptoms might be difficult and extensive, labeling such trauma and creating an appropriate treatment plan can assist survivors in healing and moving on with their lives. But what can be done when nonviolent or noncatastrophic events result in trauma symptoms? If the traumatic event does not match the *DSM–5* or *International Classification of Diseases* (10th ed.; ICD–10; World Health Organization, 1992) criteria, would a clinician know to utilize trauma-focused techniques? Do all psychologists and other psychotherapists believe that a traumatic event must be life threatening to treat it as such?

When people are verbally harassed or terrorized because of their religion, race, sexual orientation, gender, gender identity, ability, or some other identity, they might not necessary fear for their lives; however, they might fear for their safety. They may avoid certain places or neighborhoods that their tormentors reside in or frequent, to reduce the possibility

of being harassed or physically hurt. They may even change their everyday functioning (e.g., dressing differently, taking a different route home from work or school) or give up interests or hobbies (e.g., quitting a sports team or afterschool club). They may also experience an array of psychological symptoms—including difficulty in concentrating, feeling edgy or consistently anxious, or even having nightmares and trouble sleeping. Thus, despite the presence of a life-threatening event, many people who are victimized might fit the criteria for trauma.

WHAT IS POSTTRAUMATIC STRESS DISORDER?

Before we examine the ways that discrimination can be traumatic and potentially result in symptoms related to PTSD, it is important to understand diagnostic criteria. When it was published in 2013, the *DSM–5* added a few criteria that differentiated trauma-related disorders from its earlier editions. For the first time, "Trauma- and Stressor-Related Disorders" were listed as separate from anxiety disorders (where they were previously categorized), given the wide range of traumatic stress and their major differentiations from traditional symptoms of anxiety. Additionally, the *DSM–5* added three new symptoms (for a total of 20 symptoms), included a new symptom cluster, and clarified that all symptoms must have begun or worsened after the trauma. Further, there are now two separate subtypes of PTSD: (a) PTSD preschool subtype (for children 6 years old or younger) and (b) PTSD dissociative subtype (which is accompanied by prominent dissociative symptoms).

The *DSM–5* definitions of *trauma* include exposure to (a) death, (b) threatened death, (c) actual or threatened serious injury, or (d) actual or threatened sexual violence. An individual can be diagnosed with PTSD if they had direct exposure to the trauma (e.g., a Muslim woman is the target of a violent hate crime), witnessed the trauma directly (e.g., a child witnesses her mother being sexually assaulted), experienced the trauma indirectly (e.g., a mother hears about her son's hate crime victimization), or had repeated or extreme indirect exposure to aversive details of a traumatic event (e.g., a first responder who tends to survivors of

violent hate crimes or assaults). According to the *DSM*, the indirect exposure trauma cannot be experienced through films, books, photographs, or any other forms of media.

A *DSM* diagnosis also requires the presence of intrusion symptoms or the inability to keep memories or thoughts of a traumatic event from occurring. To fulfill this criterion, the client must report at least one of the following five symptoms: (a) recurrent, involuntary, and intrusive recollections of the traumatic event; (b) traumatic nightmares; (c) dissociative reactions or flashbacks, which may range from brief episodes to complete loss of consciousness; (d) intense or prolonged distress after exposure to traumatic reminders; or (e) noticeable physiological reactivity after exposure to trauma-related stimuli. Sometimes trauma survivors have nightmares that do not seem trauma-related, or they may not remember the content of flashbacks when they regain conscious awareness, thus not identifying the role of the trauma.

The second criterion for a PTSD diagnosis is the presence of avoidance symptoms, or the effortful attempt to evade any stimuli and triggers that may bring back memories of the trauma. To fulfill this symptom, the client must either persistently avoid (a) any trauma-related thoughts or feelings, or (b) any trauma-related external reminders (including, but not limited to, people, places, activities, objects, discussions, or situations that might be related to the trauma). For instance, an individual may do her or his best to avoid ever thinking about the traumatic events (typically unsuccessfully) or to circumvent people or places that might remind them of the event.

The third criterion for a *DSM* diagnosis is the presence of adverse changes in cognitions and mood that began or worsened after the traumatic event. The individual must indicate at least two of the following criteria: (a) incapacity to recollect key features of the traumatic event (not due to head injury or substance use), (b) persistent negative beliefs and expectations about oneself or the world (e.g., "I am worthless," "No one can be trusted"), (c) incessant self-blame or blame of others for being the cause of the traumatic event, (d) continuing negative trauma-related emotions (e.g., anger, fright, guilt, shame), (e) noticeably diminished interest in significant activities that occurred before the trauma, (f) feeling alienated

from others, and (g) limited affect. Many symptoms under this cluster match similar symptoms of mood disorders, which is why it is important for clinicians to assess for the potential of traumatic events.

The fourth criterion for a PTSD diagnosis is the presence of changes in arousal and reactivity that are associated with the traumatic event. An individual must exhibit two out of six symptoms that must have started, or worsened, after the traumatic event: (a) irritable or aggressive behavior; (b) self-destructive or reckless behavior; (c) hypervigilance, or the enhanced state of sensory sensitivity to perceived threats; (d) exaggerated startle response; (e) problems in concentration; and (f) sleep disturbance. Although these symptoms must not be the result of substance use, medication, or any other physiological issue, substance use may enhance or interfere with some of these symptoms. For instance, if a survivor of trauma drinks alcohol, she or he may become intensely self-destructive or reckless.

To be diagnosed with PTSD, an individual must exhibit significant symptom-related distress or functional impairment. For more than 1 month, the person must also experience intrusion symptoms, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. If a person encountered a traumatic event and the symptoms do not persist for more than 1 month, she or he might be diagnosed with acute stress disorder (ASD). To meet the criteria for ASD, an individual must (a) have undergone a traumatic event, as described by the aforementioned definitions of trauma used for PTSD; (b) exhibit nine of the above PTSD symptoms; and (c) exhibit symptoms that have lasted for at least 2 days but under 1 month. Further, the traumatic event must have caused some clinically significant distress or must have impaired the individual's social, occupational, or other important areas of functioning. Finally, it must be ruled out that all of the symptoms presented are not substance-induced or due to some other physiological problem.

A diagnosis of PTSD must also be differentiated from adjustment disorder, which typically occurs as a response to some sort of life stress (whether traumatic or not). The four types of adjustment disorder are depressed mood, anxious symptoms, disturbances in conduct, and mixed symptoms. Adjustment disorder has traditionally been used to classify an

individual who does not quite meet the criteria for other diagnoses (e.g., depressive disorders, anxiety disorders, PTSD). Finally, when people are believed to have a stress-related disorder but do not quite fit the criteria for PTSD, ASD, or adjustment disorder, they may be diagnosed with "other specified trauma/stressor-related disorder" (American Psychiatric Association, 2013).

The ICD–10 has many similarities for diagnosis of PTSD as the *DSM–5* does but also has a few stark differences (Peters, Slade, & Andrews, 1999). First, regarding avoidance symptoms, only one symptom of actual or preferred avoidance is required (as opposed to two symptoms by the *DSM–5*). Further, for the ICD–10, a client must experience either (a) an inability to recall the event or (b) two or more of the following: sleep problems, irritability, concentration problems, hypervigilance, or exaggerated startled response. Finally, the ICD–10 requires that the symptoms occur within 6 months of the traumatic event, whereas a time onset is not required in the *DSM–5*. Given these, it appears that the ICD–10 generally has more flexible criteria for PTSD than does the *DSM–5*; however, the upcoming ICD–11 is expected to be more rigid than both the ICD–10 and the *DSM–5*—resulting in fewer PTSD diagnoses and, thus, fewer PTSD treatments (Sachser & Goldbeck, 2016).

A REVIEW OF INTERPERSONAL DISCRIMINATION AND TRAUMA

For more than two decades, several scholars have advocated for the expansion of clinical definitions of *trauma*, mainly in the *DSM* criteria for PTSD. Many psychologists have argued that trauma should not only refer to life-threatening or violent events but also include other catalysts of immense pain and suffering, such as oppression and discrimination. This section highlights previous literature that has examined four areas of research related to oppression and trauma: (a) insidious trauma, (b) race-based traumatic stress, (c) heterosexist traumatic stress, and (d) sexist and gender-based trauma.

Root first introduced her theory of insidious trauma in 1992, arguing that daily experiences of oppression (e.g., racial discrimination, poverty)

are so widespread in historically marginalized communities that they can potentially inflict mild to severe psychological harm. According to this theory, insidious trauma is dangerous because it is chronic (i.e., it can occur at any given moment) and is long lasting (i.e., can persist over extended periods of time). Root also argued that because insidious trauma can be just as damaging and severe as traditionally conceptualized forms of the trauma (and because insidious trauma can lead to severe psychological distress), mental health practitioners should add insidious trauma (or any other trauma related to oppression) to the definition of and diagnostic criteria for trauma.

Following Root's (1992) work, several scholars wrote about insidious trauma and its effect on mental health. Loo et al. (2001) revealed the types of race-related stressors that Asian American Vietnam veterans encountered when they served in the military, especially during combat or in warzones. This finding represents the multiple types of trauma people face due to intersectional identities, particularly when identities seem to be in opposition of each other (e.g., Asian American veterans may be terrorized or harassed by their non-Asian fellow officers, while fearing being killed on enemy lines by Vietnamese soldiers). The personal narrative of a Filipino American veteran who served during the Vietnam War exemplifies this conflict:

> When I was at the base . . . it wasn't uncommon for my "own" soldiers to turn on me. I was called a "gook" pretty often by the White and Black American soldiers. It wasn't every day, but sometimes it was several times a day. Once in a while, someone would say something like "Hey boy, where did you get that uniform?" I just tried to ignore it. I guess that I understood that they were taking their frustrations out on me—someone who looks like the "enemy." So, to avoid this altogether, I hung out with the Australian soldiers who were able to recognize that I was Filipino, that I was American, and that I wasn't the enemy. (Tabaco, 2010, p. 247)

Facing the atrocities of war is daunting in itself. However, to navigate racism in addition to combat-related traumas can be remarkably distressing and laborious.

In the mid-2000s, several scholars shifted the conversation and began to theorize and study the concepts of race-based trauma and race-based traumatic stress. Bryant-Davis (2007) defined race-based trauma as involving one of the following traits: (a) an emotional injury that is racially motivated and targets a person or group; (b) a race-related stressor that interferes with a person's ability to cope; (c) a racially motivated, interpersonal stressor that causes physical injury or a threat to integrity; or (d) a racially motivated interpersonal or systemic stressor that causes psychological distress. Carter (2007) described how race-based traumatic stress should not be classified along with other *DSM* examples of trauma but instead should form its own category, given its distinct focus on emotional reactions of trauma rather than life-threatening aspects. Carter et al. (2013) created the Race-Based Traumatic Stress Scale (RBTSS) to provide a baseline for understanding a client's experiences with and reactions to the trauma. Using the RBTSS, Carter and Sant-Barket (2015) indicated that people who experienced racial events as traumatic versus stressful are more likely to undergo a behavioral or personality-related change as a result of the event. Further, trauma symptoms and reactions within 1 month after the event correlate with individuals' recent trauma symptoms—indicating how trauma symptoms are pervasive and can last over time.

Although the literature regarding the effects of heterosexist or transphobic trauma on lesbian, gay, bisexual, transgender, and queer (LGBTQ) people is scant, studies have supported that LGBTQ people report more frequent exposure to traumatic life experiences (and subsequently a higher prevalence of PTSD or other traumatic stress symptoms) than their heterosexual or cisgender counterparts (Balsam, Rothblum, & Beauchaine, 2005; Roberts, Austin, Corliss, Vandermorris, & Koenen, 2010). Shipherd, Maguen, Skidmore, and Abramovitz (2011) shared that in a study with 97 transgender women, almost all (98%) reported experiencing at least one traumatic event in their lifetimes and most participants (91%) indicated multiple traumatic events in their lives. Almost half of their sample (42%) reported that at least one of the events was induced by transphobic bias, and almost one fifth (17.8%)

met the *DSM* criteria for PTSD. Second, in a study with 528 lesbian, gay, and bisexual youth, (a) nearly 80% of the sample reported instances of verbal abuse, (b) 11% and 9% revealed histories of physical and sexual abuse, (c) 9% fulfilled *DSM* criteria for a PTSD diagnosis, and (d) PTSD symptoms were directly related to sexual orientation victimization and gender nonconformity (D'Augelli, Grossman, & Starks, 2006). Some studies have revealed that LGBTQ people experience trauma that fits *DSM* criteria while exhibiting traumatic symptoms more aligned with insidious trauma (e.g., Bandermann & Szymanski, 2014; Szymanski & Balsam, 2011).

Finally, previous research indicates that women, in general, are 2 to 3 times more likely than men to be diagnosed with (or meet criteria for) PTSD (Kimerling, Weitlauf, Iverson, Karpenko, & Jain, 2013; Tolin & Foa, 2006). Despite this higher prevalence, women actually experience fewer traumatic events than men overall (Norris, Foster, & Weishaar, 2002). Further, when women and men undergo the same type of traumatic event (e.g., both survive a natural disaster), women still develop PTSD symptoms at much higher rates than men (Tolin & Foa, 2006). One explanation for the gender discrepancies in PTSD is gender socialization, which results in different coping styles for men and women. For instance, men who are exposed to trauma might turn to substance use or aggressive behavior, whereas women might be more likely to express their emotions and exhibit depression and anxiety (Tolin & Breslau, 2007). Another explanation for gender disparities in PTSD is that women report chronic hypervigilance, due to their valid concerns for safety or fears of being sexually objectified or assaulted by men (Fairchild & Rudman, 2008; Watson, Marszalek, Dispenza, & Davids, 2015). Because of this preexisting fear, also referred to as *physical safety anxiety* (Fredrickson & Roberts, 1997), women's PTSD symptoms may be exacerbated when they actually do face a trauma or psychological distress. Finally, one study indicated that women who experience sexual harassment in the workplace might exhibit traumatic stress symptoms (Palmieri & Fitzgerald, 2005), and another study revealed a correlation between everyday sexism and PTSD symptoms, specifically for women who reported more frequent experiences with sexist degradation (Berg, 2006).

A REVIEW OF SYSTEMIC AND COLLECTIVE TRAUMA

Now that we understand the various ways that interpersonal encounters with trauma can affect mental health, this section reviews the ways in which trauma can affect groups, communities, and even entire societies. First, *historical trauma* is defined as "a complex and collective psychological distress that is experienced over time and across generations of a group of people who share an identity, affiliation, or circumstance" (Mohatt, Thompson, Thai, & Tebes, 2014, p. 128). Literature on historical trauma has focused on experiences of Native Americans (Brave Heart & DeBruyn, 1998), Holocaust survivors (Kellermann, 2001), Native Hawaiians (Pokhrel & Herzog, 2014), and other groups who share a history of violence, victimization, colonization, or genocide. Due to slavery and systemic racism, Black Americans may feel a historical trauma that still has implications in present times. For instance, when Trayvon Martin was killed in 2012 (and George Zimmerman was found "not guilty" in 2013), many Black Americans reported a collective sense of psychological distress and emotional pain. Although they may not have known Trayvon Martin or his family personally, they empathized deeply, as though they did—perhaps because of their own fears that their innocent loved ones might be killed too or knowledge that another unarmed Black teenager was brutally murdered and whose assailant went free.

Historical trauma has also been found in LGBTQ communities. Herek and Berrill (1992) wrote that anytime a hate crime is committed, the event communicates "a warning to all gay and lesbian people to stay in 'their place,' the invisibility and self-hatred of the closet" (p. 3). To obtain empirical support for these concepts, Herek, Gillis, and Cogan (1999) surveyed LGBQ participants and found that individuals (who may or may not have ever been targeted for hate violence) reported multiple psychological stressors (e.g., being fearful of crimes, feeling vulnerable, viewing the world as a less benevolent place) at significantly higher rates than their heterosexual counterparts. Noelle (2002) referred to this phenomenon as a "ripple effect" that occurs when LGBTQ people learn about violence or hate crimes against people with shared similar sexual orientations and

gender identities. Even when LGBTQ people are not directly involved in traumatic events, they lose fundamental assumptions of benevolence and meaningfulness of the world, which negatively affects their mental health. For instance, in 2016, when 49 people (mostly Latinx) were killed at Pulse—an LGBTQ nightclub in Orlando, Florida—many LGBTQ people (especially LGBTQ people of color) experienced significant distress and grief. Some developed PTSD symptoms, and others began to be hypervigilant and cautious of the world.

Related to historical trauma is *collective trauma*, which is defined as a group's shared sense of psychological distress because of witnessing or observing a terrifying event or tragedy (Frantz, 2014). Collective trauma can affect specific communities or groups but is often used to describe psychological distress experienced by entire societies or countries. Some examples of collective trauma include the shared sense of loss, grief, or distress that most Americans felt after the September 11th World Trade Center attacks in 2001 or the Boston Marathon bombings in 2013. A systematic review on 27 collective trauma studies ($N = 8{,}011$) indicated that when people experience collective trauma, they develop PTSD symptoms and poorer health, most notably when they have low self-efficacy (Luszczynska, Benight, & Cieslak, 2009). A study examining collective trauma after 9/11 found that greater exposure to graphic media images predicted increased PTSD symptoms and poorer physical health (Silver et al., 2013). Yet, it must be noted that the *DSM* declares that trauma cannot be experienced solely from any type of media.

Although historical and collective trauma are similar in nature, historical trauma is described as being felt most by people of historically marginalized groups, whereas collective trauma is typically characterized as being felt by a more general population. As an example, in 2015, Dylann Roof, a White male, killed nine innocent people at the Mother Emanuel Methodist Church in Charleston, South Carolina. Although some media covered the event and its aftermath, news reporters did not label the incident as a terrorist attack, even though it fit all of the criteria (i.e., Roof admitted to wanting to start a race war and did not personally know the victims). Further, although more people were killed in the incident than

same regard or reverence, in that it was not viewed as a "national tragedy" but rather as a tragedy for the Black community. In this way, national tragedies seem to be defined as events in which White people are killed.

Vicarious trauma involves the ways that an individual can indirectly encounter trauma and develop symptoms usually felt by a direct survivor of trauma (McCann & Pearlman, 1990). Examples include people who learn of loved ones undergoing a traumatic event (e.g., parents who learn their child was murdered, tortured, or sexually abused) or people who are repeatedly exposed to trauma (e.g., first responders, mental health practitioners). Although their symptoms may not be as intense as those felt by direct trauma survivors, their symptoms can be painful and disruptive. If the individual identifies as part of the targeted group (e.g., a transgender clinician who works with transgender survivors of hate violence), the trauma may be even more intense, as the person fits criteria for both vicarious trauma and historical trauma.

Another related concept is *transgenerational trauma*, or the idea that trauma manifests across various generations in a family, above and beyond the generation of the original survivor of the trauma (Lev-Wiesel, 2007). For instance, although many children who lost parents on 9/11 were not born before the day of the tragedy and do not have direct memories from that day, they may still exhibit traumatic symptoms as a result of observing the pain and suffering felt by family members who were present. Specific to oppression, when people belong to groups that have been victimized (e.g., Black Americans, Native Americans, Japanese Americans in internment camps, Native Hawaiians) and also have a history of trauma in their families (e.g., a grandparent was killed because of hate violence, a parent was victimized by sexual abuse), they can report distress from both transgenerational and historical trauma.

ADVOCACY FOR A NEW DEFINITION OF TRAUMA

Over the past decade, many practitioners have advocated for new definitions of trauma. For instance, Helms, Nicolas, and Green (2010) argued that individuals (especially White people) fail to view racism and ethnoviolence

as life-threatening traumas because of a lack of awareness of historical context and the invisibility of violence in present-day forms of discrimination. In other words, because present-day White people are less likely to be violent toward people of color and because they do not remember (or choose not to remember) the racist history of the United States, many White people may believe that racism no longer exists. When people of color discuss encounters with racism, some White people label them as being paranoid or hypersensitive, instead of acknowledging how their reactions to racism can be natural or expected responses to trauma. Similarly, Bryant-Davis and Ocampo (2005) cited reasons that psychologists and other practitioners might be hesitant, unreceptive, or oppositional to labeling racism (or other forms of discrimination) as a form of trauma. First, some clinicians accept *DSM–5* or ICD–10 criteria as the field's standard and do not feel the need challenge it. Second, some people believe labeling racism as a form of trauma would diminish or delegitimize the severity of other traumas (e.g., if racism is labeled a trauma, it would diminish traumatic stress associated with combat veterans or survivors of violent sexual assault). Third, people from historically marginalized groups who speak up against oppression are viewed as "angry" or "sensitive"—as opposed to survivors of diagnostic trauma, whose reactions are "normal" responses to events that were "out of their control." Such sentiments are still common in that (a) many White psychologists do not feel compelled to challenge the status quo; (b) many still deny the existence or severity of racism; and (c) instead of validating their reactions, many blame people of color for reacting to racism.

Despite these arguments, when the new *DSM–5* was released in 2013, it did not include discrimination as an official part of its definition of trauma. However, one major change was that PTSD or ASD no longer included symptoms of fear, helplessness, or horror, which were prior requirements in previous *DSM* revisions. Thus, the *DSM* now leaves more room for interpretation, allowing for clinicians to decide whether encounters with discrimination are traumatic events that might possibly lead to symptoms of PTSD or ASD. Although this is a positive step, some advocates argue that not labeling racism, sexism, or heterosexism explicitly in the *DSM–5* enables practitioners with less cultural competence (i.e., therapists who might not be committed to social justice or who only have

surface-level understandings of systemic discrimination) to continue to exclude discrimination as a form of trauma.

Culturally Competent Treatment Approaches to Trauma

In recent years, psychologists have offered culturally competent approaches in working with trauma survivors, particularly those from historically marginalized communities. Examples include race-based trauma therapy (Bryant-Davis & Ocampo, 2006), racial trauma recovery (Comas-Díaz, 2016), feminist therapy (Brown, 2008), and queer-affirmative phase-oriented psychotherapy (Rosenberg, 2000). Although these theories may have been written initially for specific groups, components of each theory have implications for other marginalized groups.

Race-Based Trauma

Bryant-Davis and Ocampo (2006) recommended several approaches when working with survivors of race-based trauma, with an emphasis on understanding a client's trauma history and how the therapeutic relationship and therapeutic process can influence outcomes. In this model, practice can integrate the following steps (regardless of theoretical orientation). First, therapists must acknowledge the racist incident as a trauma—which validates to clients that they were not randomly targeted but that the incident was part of a greater systemic problem. Second, they encourage clients to share their trauma within environments where they are not judged or questioned. Third, therapists can assess clients' current level of safety (e.g., how threatening it would be for them to return to a traumatic environment) and self-care (e.g., how able clients are able to cope or avoid self-harm). Fourth, therapists allow clients to grieve or mourn any losses associated with the trauma (e.g., feelings of humiliation, shame, shock; physical injuries that occurred). Fifth, therapists guide clients in exploring shame, self-blame, and internalized oppression. Finally, therapists assist clients in connecting to and managing their anger; they also guide clients in developing both coping skills (e.g., strategies to employ when feeling triggered) and resistance skills (e.g., empowering oneself, advocating for justice). Bryant-Davis and Ocampo also suggested that therapists consider

methods such as art therapy, movement therapy, and storytelling. For clients who may have a strong sense of spirituality or religion, treatment can also include guiding clients in exploring healthy coping mechanisms through spiritual practices.

Racial Trauma Recovery

Comas-Díaz (2016) built on the work of race-based trauma and added a few more elements when working with survivors of racial trauma. Her racial trauma recovery model includes five steps: (a) assessment and stabilization, (b) desensitization, (c) reprocessing, (d) psychological decolonization, and (e) social action. In the assessment phase, by providing a safe environment and validation, clinicians encourage clients to provide testimony of their experiences with racial trauma. She also recommended evaluating the severity of a client's trauma with a measure such as Carter et al.'s (2013) RBTSS. Through desensitization, therapists can assist clients as they relive their traumas in therapy, by using traditional trauma techniques, such as EMDR or safe-place imagery. However, Comas-Diáz also encouraged integrating ethnic and indigenous healing or approaches that are aligned with a client's ethnic or cultural background. In the reprocessing phase, the therapist assists clients in searching for meaning and posttraumatic growth. For instance, therapists guide clients in reframing traumatic incidents as "wisdom-enhancing" sources of empowerment. Through decolonization, therapists address clients' colonial mentalities—or the ways that clients have internalized their own cultural groups to be inferior and dominant groups as superior. One goal could be for the client to develop a critical consciousness by unpacking how systemic oppression affects their self-esteem and their functioning. Finally, in the social action stage, the clients learn to advocate for social change (e.g., getting involved in their community organizations, voicing their experiences survivors of trauma, mentoring other survivors).

Feminist Approaches to Therapy

Although feminist therapy has evolved since its conception in the 1970s, its main tenets include therapist awareness of systemic sexism and its impact on gender roles and relationships, and advocacy for social action, egalitarianism, and the empowerment of women and other historically

disenfranchised groups (Brown, 2008). Specific to trauma, feminist therapists understand that survivors develop behavioral symptoms as a result of the trauma, and that systemic oppression may negate their healing and recovery (Brown, 2008). Further, although people may presume that feminist therapies are only effective for cisgender women, the treatment can be applied to a multitude of groups, including men (Mejía, 2005), transgender and gender nonconforming people (Richmond, Burnes, Singh, & Ferrara, 2017), and others.

Feminist theorists have provided several recommendations for working with survivors of trauma. First, therapists guide clients in learning how to advocate for themselves, specifically in working with people and systems that historically have been biased or discriminatory. One way to do this is to assist clients in developing a feminist critical consciousness, or an understanding of the ways that systemic sexism (and other forms of oppression) has shaped various aspects of the client's life. In understanding oppression, clients may understand that their trauma is based on a bigger societal problem, which may empower them to advocate for change. Feminist therapists may also help clients to develop a survivor's identity (Richmond et al., 2017), which may help them unpack emotions related to their trauma, while also encouraging clients to become role models to other survivors who still self-blame. Therapists may facilitate clients in self-reflection activities, such as journal-writing or art therapy; therapists may also use traditional methods of cognitive behavioral therapy, such as disputing irrational beliefs and encouraging positive self-talk (Brown, 2008).

Queer-Affirmative Phase-Oriented Psychotherapy

Although little research has examined trauma approaches for LGBTQ people, some authors have described integrating mainstream treatment approaches with LGBTQ-affirmative theories. For instance, Rosenberg (2000) discussed how one can use phase-oriented therapy with gay male survivors of trauma. The three main phases that are typically a part of this treatment include (a) stabilization and symptom reduction, (b) treatment of traumatic thoughts or memories, and (c) integration of new self and relational development. With each stage, the queer-affirming therapist may consider several factors that may influence treatment. For instance,

in examining meanings and cognitive distortions, therapists can guide clients in understanding how internalized homophobia or gender role norms have influenced their behaviors and their feelings about themselves. Further, queer-affirmative therapists must be flexible and knowledgeable in how behavior may manifest differently in each stage. For instance, nonmonogamous sexual behaviors are often shamed in general society but are more accepted in gay male communities; accordingly, therapists must not assume such behavior to be deviant without first asking clients the meanings of their behaviors, or considering the norms of queer communities.

CASE STUDY

Sara was a 34-year-old heterosexual White, Jewish American woman who sought therapy to discuss anxieties related to her romantic relationship. Her parents, Eileen and Ryan, have been married for 40 years, and she has an older sister named Debra. She grew up in a traditional Jewish household, within a larger predominantly Jewish community in the Mid-Atlantic region of the United States. When Sara's paternal grandfather died when she was 7 years old, her grandmother, Helen, moved in with her family. Having lived together in the same house for 10 years before Sara moved for college, Sara and her grandmother developed a close relationship.

In her first therapy session, Sara shared that her "Bubbie Helen" was a Holocaust survivor who was born in Germany in the 1930s. When Helen was 9 years old, her family was forced out of their home, and she and her mother were separated from her father and her two older brothers. She described that they were forced to board separate buses, that they were not allowed to say goodbye, and that she never saw them again. She later learned that her brothers were sent to one of the Auschwitz concentration camps and that both brothers were killed after attempting to organize a revolt. Helen was able to stay with her mother and her aunt for a short time, but she witnessed her mother being shot by a Nazi soldier when he accused her of being defiant. Her aunt became her guardian, and they escaped to Switzerland. They eventually moved to England, where Helen spent the majority of her adolescence. She immigrated to the United States in her late teens, where she later met her husband (who was also Jewish but not

a Holocaust survivor) and raised her children (who later married Jewish spouses too).

When Sara was 16 years old, she and her family went to the Holocaust Museum in Washington, DC, where she describes "crying the entire time." In college, she wanted to learn more about the Holocaust, so she enrolled in multiple classes and minored in Holocaust studies. She read every book and watched every film that she could find about the Holocaust—admitting that each made her cry but helped her feel more closely connected to her grandmother's experience. Every summer, she volunteered at a camp for Jewish youth; she loved teaching them about Judaism and encouraging them to develop proud Jewish identities. When Sara had just finished college, her grandmother was diagnosed with terminal cancer, which prompted Sara to move back home. Before she passed, her grandmother made Sara promise to never forget the Holocaust and to always honor her Jewish identity. Her grandmother hinted that it would make her so happy if Sara married "a nice Jewish boy" and raised her children in the Jewish faith.

Six years ago, Sara met Jason, a young multiracial, Catholic man of Italian American and Puerto Rican heritage. Although Sara was not interested in dating someone who was not Jewish, she thought he was very attractive, funny, and smart, so she agreed to go on a date with him. They dated for several months and fell in love. They moved in together after a year of dating, but because of his non-Jewish identity, Sara never thought their relationship would last. Sara mentioned in therapy that she also believed that Jason does not quite understand how important her religion and family history are to her, and that she often found herself trying to educate him about the Holocaust. Although Jason had never said anything anti-Semitic or invalidating, he also never expressed any real interest in learning more about Judaism or in feeling an emotional connection to the Holocaust. Sara tried to learn more about Jason's Catholic traditions and family history (as a way of demonstrating her love for him), but he assured her his religious identity lacks personal salience.

Sara sought therapy because she felt lost and did not know what to do. She loved Jason (who has been recently hinting at marriage), but she also remembered her promise to her grandmother. Further, because Sara was in her mid-30s, she worried that if she broke up with Jason, she would not

find anyone else and lessen her chance to have a baby. She also felt guilty because everyone in her family had Jewish spouses. So, if she did indeed marry Jason, she felt she would be letting everyone down.

CASE STUDY DISCUSSION AND CLINICAL RECOMMENDATIONS

Many issues must be considered in Sara's case, specifically involving historical trauma and transgenerational trauma. Sara was affected by historical trauma in that she is a Jewish American woman who has learned about the atrocities that Jewish people encountered during the Holocaust, including captivity, brutality, murder, and annihilation. However, Sara was also distressed by transgenerational trauma, in that her grandmother faced trauma firsthand and many relatives (e.g., her great grandparents and grand-uncles) were killed during this time. Both types of trauma can be daunting, but being able to relate to both might be exceptionally painful.

Sara's case also brings up the notion of transgenerational transmissions of trauma, in which psychological stressors, such as guilt or shame, can persist for several generations (de Mendelssohn, 2008). Although Sara is legitimately passionate about her Jewish faith, she also feels guilty about the promise that she made to her grandmother about marrying a Jewish man. She genuinely loves her boyfriend, but she feels guilty that she would not be marrying someone who comes from her same Jewish background. And because she does not have any role models of other family members who have married non-Jewish people, she may fear being ostracized or stigmatized if she married Jason and had children who were not raised Jewish.

Further, Sara's case demonstrates how trauma might not necessarily fit diagnostic criteria for PTSD. As far as the reader can tell, Sara has not encountered any life-threatening event in which she was personally exposed to danger or catastrophic circumstances. She has learned about the trauma her grandmother endured; however, such trauma occurred almost 75 years ago, and psychologists and other clinicians might not view learning about it as being as harrowing or intense as learning that a loved one suffered

from a traumatic event in the recent past. Similarly, although Sara claims that she has a strong emotional reaction to anything she sees or reads that is related to the Holocaust, the *DSM* clearly states that trauma must not be experienced through films, books, photographs, or any other forms of media. Accordingly, Sara's presenting issues might not be viewed through the lens of trauma, which may result in a clinician's overlooking the salience of trauma in Sara's life.

This case also illustrates the importance of understanding intersectional identities and extraneous factors, in that there are multiple other identities and experiences that influence the ways Sara was affected by trauma. For example, because Sara was a woman in her 30s, she worries that her age may influence whether she can be a mother. Perhaps if a Jewish man were put in the same situation, or if Sara were younger, the pressure would not seem as intense. Further, if Sara grew up in a home or community where religion was not heavily emphasized, it is possible that the historical or transgenerational trauma would not feel as intense for her.

One clinical approach that could be implemented in working with Sara is feminist therapy (Brown, 2008)—which would encourage Sara to develop a critical feminist consciousness while understanding how systems have influenced her behaviors. A feminist therapist might ask Sara to explore how anti-Semitism may have influenced her grandmother's expectations—particularly regarding her life choices and gender roles. A feminist therapist might encourage her to write journals to sort through her emotions or potentially might invite Sara to write a letter to her grandmother to connect to direct emotions that she might have. Additionally, a feminist therapist might encourage Sara to further develop her social justice and community involvement in her religious community, which seemed to be a source of healing for her.

Finally, using feminist therapy, the identities of Sara's therapist can also affect Sara's treatment. Although Sara did not indicate any preference for a type of therapist, potential clinicians must consider how their own identities might influence Sara's ability to share and be completely honest in the therapeutic context. Relatedly, psychodynamic or

relational psychotherapists might recognize how their different identity groups might affect both transference and countertransference. *Transference* is defined as a client's unconscious thoughts or feelings about people or experiences outside of a therapy session that are redirected toward a counselor or clinician. Conversely, *countertransference* is a counselor's or clinician's unconscious thoughts or feelings about people or experiences outside of a therapy session that are unconsciously redirected toward a client (D. Sue, Sue, Sue, & Sue, 2015). Analyzing transference and countertransference can be helpful in building a rapport with Sara and can help a therapist and client recognize potential unresolved issues, gender roles, or power dynamics that may manifest in Sara's life. For instance, if her therapist were an older Jewish woman, Sara may be reminded of her grandmother, which might deter her from fully exploring her guilt and other negative feelings; conversely, if Sara's therapist were a young, non-Jewish man, she might be hesitant to disclose her feelings, in fear that the therapist would side with Jason, judge her, or both.