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Cross-Cultural Factors in the Treatment of Trauma-Related Disorders: Overview

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> Trauma and its aftereffects have a texture. The experience conveys meanings that derive from personal histories; cultural heritages; and the social, political, and spiritual contexts in which the painful event happens. (Brown, 2008, p. 3)

Decades of research on trauma and its accompanying effects have refined our conceptions of trauma, posttraumatic stress disorder (PTSD), and related symptoms, and the current DSM-5 recognizes trauma as the direct exposure, experience, or witnessing of a traumatic event. The symptoms of PTSD may range from intrusive recollections of the event to flashbacks that cause a reexperiencing of the trauma. It is common for trauma survivors to experience disruptions in sleep and appetite, along with a general sense of being on guard and distressed when exposed to cues that resemble the initial trauma (APA, 2013). Epidemiological data indicates that 6.8% of adults meet criteria for a diagnosis of PTSD (APA, 2013), although it is likely that many more are suffering but not presenting for diagnosis or treatment.

While widespread prevalence studies indicate that women and members of minority groups experience disproportionately high levels of trauma (Pole, Gone, & Kulkarni, 2008), empirical research has only recently turned its attention to the role of cultural factors including gender, race, ethnicity, and sexual orientation. Members of marginalized groups are particularly impacted due to the weight of historical oppression, maltreatment, and structural disempowerment (Gone, 2013). This collective trauma may be passed on intergenerationally, as in the case of the Native American and African-American communities in the USA (Pole et al., 2008). Among minority groups with immigrant histories, individuals often carry premigration trauma and postmigration stressors, which exacerbate posttraumatic symptoms when exposed to additional traumatic events (Silove, 1999). These symptoms are further impacted by acculturation challenges, which may hinder the coping process (Abouguendia & Noels, 2001; Oppedal, Røysamb, & Heyerdahl, 2005). As such, cultural differences are not mere demographic variables, rather they contribute nuance and complexity to our understanding of trauma, the manifestations of posttraumatic symptoms, and the response to treatment.

Triandis (1972) described culture as a society's "characteristic way of perceiving the social environment" (Triandis, 1972, p. viii 3). Per Triandis, culture is a multifaceted construct that includes values, beliefs, norms, tasks, attitudes, and roles. Cross-cultural scholars have consistently affirmed that culture is the lens through

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which people view the world, and traumatologists have added that a social-ecological framework that considers an individual's relationship to multiple environmental systems is useful for understanding the impact of trauma (Orozco, Chin, Restrepo, & Tamayo, 2001; Torres & Maldonado, 2017).

Bronfenbrenner's (1979) ecological systems theory provides the ideal framework and allows us to incorporate the varying responses to trauma across cultures, particularly in cultures where concepts of psychology and mental health may differ significantly from mainstream Western ideals. Within this framework, trauma symptoms can also be better understood by examining somatic symptoms and idioms of distress. Trauma survivors from cultures where psychological symptoms are stigmatized may complain of gastrointestinal difficulties, headaches, back pain, or general fatigue, rather than depression or anxiety symptoms (Chester & Holtan, 1992; Smith & Keller, 2007). There is strong evidence that somatic symptoms are related to the emotional distress underlying anxiety and depression (Lipowski, 1988; Ritsner, Ponizovsky, Kurs, Lib, & Modai, 2000). Although these symptoms may genuinely reflect physical problems, others are patterned ways of discussing illnesses using words that denote physical rather than emotional concerns (Hinton & Lewis-Fernandez, 2010). Studies have also found that certain ethnic groups experience more reexperiencing, numbing, and dissociative symptoms (Rhoadesr & Sar, 2005). Working with trauma in diverse populations, therefore, requires an understanding of cross-cultural factors in assessment, diagnosis, and treatment, as well as specific knowledge about the client's cultural background.

> Amina is a 23-year-old mother of two who came to the United States after her family fled violence and war trauma in Syria. They have lived in Texas for two years and Amina has just started feeling comfortable in their new home. Recently, her son was invited to practice target shooting with a new friend and neighboring family. Amina did not feel comfortable, but her husband encouraged her to be open to their new culture. Hearing the gunshots, Amina began shaking and having stomach pain. For several weeks she reported extensive difficulty sleeping and loss of appetite, and presents to a local clinic for medical attention. The treating clinician tells her that she should tell her husband that she forbids future target practice outings, yet Amina insists that she cannot "disrespect her husband's authority". The clinician also attempts to reassure Amina that target practice is safe, and her son will learn a valuable skill. Amina nods meekly and accepts a prescription for sleeping pills.

The aforementioned case is rife with cultural missteps on the part of the clinician, beginning with a lack of awareness of the client's trauma history, an unfamiliarity with cultural roles, and unexamined biases regarding acculturation. A culturally competent system incorporates culture at all levels and adapts services to meet the needs of culturally diverse clients (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2016). For trauma clients in particular, understanding and rapport building are essential to recreating an environment of safety (Raghavan, 2018).

Rapport begins during the assessment process, when the clinician demonstrates openness and curiosity towards the client's subjective experience. Concretely, this involves basic communication, which may be impacted by language barriers. In translating a measure from one language to another, a literal word-for-word translation increases the risk of compromising construct validity. The generally accepted method of translating measures involves both translation and back translation conducted by two separate qualified translators. Discrepancies between the translations are discussed and attempts are made to resolve them (Geisinger, 1994; Weeks, Swerisson, & Belfrage, 2007). Both the original and translated measures should then be field tested with monolingual individuals and resulting scores be compared and reviewed by a translation committee (Flaherty et al., 1988; Geisinger, 1994; Weeks et al., 2007). However, many measures are not adapted according to these recommendations due to the cost, limited availability of skilled interpreters for uncommon languages, and the length of the translation process (Weeks et al., 2007). Weeks et al. (2007) argued that investing in sound translation at the outset is ultimately a cost-effective process, because it increases the likelihood that "equivalence of meaning is maxi-

mized, while data contamination is minimized" (p. 163).

Raghavan (2018) describes that when assessment does not involve written measures, skilled interpreters are an essential component of the process. Several studies have shown that clients who are unable to communicate adequately with their treatment providers report lower satisfaction with care (Baker, Hayes, & Puebla-Fortier, 1998) and are at greater risk for misdiagnosis (Ku & Flores, 2005). Language can impact symptom presentation; when clients are interviewed in a language other than their own, information about the presence and nature of psychiatric symptoms may be lost or misunderstood (Farooq & Fear, 2003).

Interpreters are invaluable because they often bridge cultural traditions in trying to translate the client's experience in a qualitatively meaningful way (Farooq & Fear, 2003). Although translation improves the treatment provider's opportunity to gather accurate clinical information, it may add another dimension of complexity to the assessment process. In working with trauma survivors from non-Western countries, interpreters are exposed to highly distressing content, which may further impact the accuracy of translation (Akinsulure-Smith, 2007).

Despite the challenges inherent in using interpreters, at present no viable alternatives exist for many of the individuals seeking treatment. Research suggests that using an interpreter is still superior to not using one, which may have far more serious consequences to patient assessment, diagnosis, and treatment (Baker et al., 1998; Ku & Flores, 2005).

Lastly, when assessing trauma survivors from other countries, it is essential to use normative data that is specific to the culture of interest. Establishing adequate criterion validity (Canino & Bravo, 1994) involves generating normative data for each culture and assessing whether a disorder, symptom, or psychiatric phenomenon exists according to those norms. Normative data not only needs to be collected at the outset, but also periodically updated, which often presents a significant hurdle for researchers given the scarcity of funding available for descriptive research (Mitrushina, Boone, Razani, & D'Elia, 2005). Mitrushina et al. (2005) cautioned that using outdated or inaccurate normative data may be as detrimental as using entirely inaccurate instruments and may lead to misdiagnosis or inaccurate treatment.

Despite these challenges, many common measures used with this population such as the Center for Epidemiological Studies Depression Scale (CES-D; Radloff, 1977), the Trauma Symptom Inventory (TSI-2; Briere, 2011), and the Harvard Trauma Questionnaire (HTQ; Mollica et al., 1992) do have extensive normative data on community, clinical, and culturally diverse samples. These data display considerable variation across cultural groups, confirming the importance of culture-specific norms. Manly (2005) cautioned that when using culture-specific normative data, one runs the risk of attributing observed differences solely to culture and misinterpreting the meaning of results. Thus, the assessing clinician needs to strike a balance between cultural sensitivity and diagnostic specificity.

This chapter offers an introduction to working with trauma in diverse populations. As Triandis described, culture is multifaceted and multilayered, and a thorough exploration of each aspect of culture is beyond the scope of this review. We instead focus on three large minority groups in the USA, African-Americans, Latinx persons, and Asian-Americans, but many of the theoretical principles and techniques can be adapted to other groups or applied to other aspects of culture. As Summerfield (2005) cautions, the problem … is not one of translation between languages but of translation between worlds (p. 76). Therefore, in this chapter, we approach different areas of traumatology in the context of culture, to attempt to translate the representation of trauma from one world to the other.

The following section examines the treatment of trauma in Asian populations. We describe the

Asian diaspora in the USA and discuss the impact of culture on symptoms and treatment.

The Asian Diaspora in the USA

> Tenzin is a refugee from Tibet who has been in the US for 2 years. Chinese police raided her home in Tibet and found books and photos from His Holiness The Dalai Lama. Tenzin and her family were beaten, imprisoned in solitary confinement, deprived of light and sanitation, and then released. The Chinese police returned and found paraphernalia on one other occasion and Tenzin was imprisoned and starved for three days before her release. She has applied for asylum, and one week prior to her interview, she visits a clinic reporting indigestion, diarrhea, and cramps. The nurse interviewing her is alarmed by her trauma history and assessed for PTSD and depression. Tenzin denies all mental health symptoms, saying she's generally doing well, does not think about her past or her feelings in general. "I am a grain of sand in a larger world," she states, and maintains that she wants to make sure her she is physically healthy for her asylum interview.

The US Asian population is diverse, with over 20 million Asian-Americans tracing their roots to more than 20 countries in East and Southeast Asia (Pew Research Center, 2017). The largest segments of the Asian population in the USA draw from China, India, and the Philippines. Data from the Pew Research Center (2017) indicates that they are projected to become the largest immigrant group in the USA, surpassing Hispanic immigrants by the year 2055.

Sociodemographic data from the Pew Research Center (2017) suggests that US Asians do well in comparison to the general US population, with higher levels of education and higher median incomes. However, these findings vary significantly by subgroup. For example, immigrants from India have the highest median incomes (approximately $100,000), while immigrants from Burma have the lowest, with median incomes of $36,000. Additionally, US Asians earn significantly less than White counterparts with comparable education levels (Park & Kim, 2008) and, despite overall economic success, are also less likely to own homes. This wide range reflects the complexity and diversity of Asia itself, informed by its colonial past and individual national struggles.

The perceived success of the US Asian population may mask its struggles to the population at large. Indeed, data indicates that US residents have less familiarity with Asian culture as compared to African-American and Latinx culture, are more likely to endorse stereotypes, and presume wider cultural distance between groups (Gee, Ro, Sherriff-Marco, & Chay, 2009). The damaging impact of the "model minority" myth is well documented (Gupta, Szymanski, & Leong, 2011; Qin, Way, & Mukherjee, 2008), and Asian-Americans who internalize positive stereotypes but fail to enact them are more likely to experience symptoms of depression, anxiety, low self-esteem, and suicidal ideation. This reflects what Chan and Mendoza-Denton (2008) termed "status-based rejection sensitivity" and has the particularly insidious effect of reducing the likelihood of help-seeking, thus prolonging distress symptoms (Inman & Yeh, 2007). Data on mental health service use in Asian-Americans reveals significant disparities: Among those with a diagnosable mental health condition, only 28% used services, as compared to 54% of the general population (Le Meyer, Zane, Cho, & Takeuchi, 2009). When Asian-Americans do engage in treatment, many withdraw within fewer than five sessions (Le Meyer et al., 2009). While research does reveal a mediating effect for acculturation status, rates are still significantly lower than those of White Americans.

Trauma Exposure in the Asian Population

Data on trauma exposure in the US Asian population is inconsistent, with some studies suggesting that Asians experience lower rates of trauma and PTSD (Alegría et al., 2013) and others indicating rates to be equivalent to that of other minority groups (Sue, Cheng, Saad, & Chu, 2012). The specific types of trauma experienced by US Asians vary and reflect the geography, culture, and sociopolitical climate of their countries of origin.

Researchers have described Southeast Asian refugees as a particularly high-risk group with regards to trauma and PTSD (Sue et al., 2012). As an example, Marshall, Schell, Elliot, Berthold, and Chun (2005) examined the mental health of Cambodian refugees and found that over 90% of respondents experienced near-death from starvation, forced labor, and having a family member or friend murdered as a result of political violence. Not surprisingly, 64% of these respondents met criteria for PTSD. In fact, Asians overall report higher rates of exposure to war trauma in comparison with other groups (Roberts, Gilman, Breslau, Breslau, & Koenen, 2011) along with migration trauma and postmigration stressors including linguistic difficulties, poverty, underemployment, and exposure to bigotry and prejudice (Roberts et. al., 2011).

Similar results were found in studies of Asian immigrants who were victims of natural disasters (see Bryant, 2006; Udomratn, 2009). The Asia-Pacific region has suffered the highest number of natural disasters in the past 20 years including cyclones, earthquakes, and floods causing death, injury, and property destruction. Victims of natural disasters may become permanently displaced as entire settlements are destroyed and may emigrate to countries such as the USA to begin anew.

Beyond mass trauma and immigration stressors, US Asians also suffer interpersonal trauma, although there is a lack of systematic research on the topic (Sue et al., 2012). Ho's (2008) examination of violence in Asian-American communities suggested that a staggering 77% of Asian and Pacific Islander adolescents had been exposed to physical or community violence in their lifetime, with over 40% reporting direct victimization. This finding is consistent with other research reporting high rates of physical abuse in Asian communities (Ima & Hohm, 1991; Kenny & McCeacham, 2000).

A particularly vulnerable subpopulation includes Asian women, who do report elevated rates of trauma exposure and mental health symptoms than Asian men (Sue et al., 2012). Cultural values surrounding the inferior status of women and the expectation of deference to male family members create barriers to disclosure or engagement in treatment. However, Gim, Atkinson, and Whitely (1990) found that Asian-American women expressed interest in participating in treatment, which suggests that early outreach may help.

To effectively provide care and treatment for minority populations, clinicians must recognize the cultural variables that may influence the manifestation of symptoms (Chester & Holtan, 1992). Culture can exert a powerful and often misunderstood influence on psychological assessment, and the challenge is to account for the social ecology and subjective experience of the client, as well as the objective symptoms or behaviors present (Ridley, Tracy, Pruitt-Stephens, Wimsatt, & Beard, 2008). The following section will detail the ways in which culture can impact the assessment and manifestation of symptoms in Asians.

Impact of Culture on Trauma Symptoms in the Asian Diaspora

As described in earlier sections of this review, culture can have a powerful impact on mental health and the manifestation of symptoms. Many trauma survivors may report somatic symptoms in lieu of psychological ones and may evidence entire culture-bound syndromes. One clear challenge reflected in the above data relates to underreporting and inconsistent reporting of trauma exposure and symptoms. This can be explained in two ways: first, stigma around mental health and cultural values around shame, saving face, and protecting family integrity can be impediments to reporting. The impact of stigma on use of clinical services in Asian communities is well documented, with Asians reporting the lowest levels of service use, even among those who meet criteria for a diagnosable psychiatric condition (Abe-Kim et al., 2007). These patterns persist even among US-born Asians and only equalizes in the third generation of immigration, wherein clinical service use patterns are more on par with those of White Americans. Alternatively, as previously alluded to, cultural conceptualizations of mental health in Asians may differ widely from those of mainstream Western culture, and as such, Asians

may not perceive themselves as experiencing psychological distress in similar ways.

Many somatic symptoms may also be considered idioms of distress. Specific to Asian trauma survivors, for example, is the "weak heart" syndrome present among Cambodian refugees who survived the Pol Pot dictatorship. Hinton et al. (2002) described the symptoms of weak heart as including intense fear, physical exhaustion, heart palpitations, and an exaggerated startle response, suggesting that it may fit within the nosology of anxiety disorders. Sufferers perceive the heart as failing in its role, therefore becoming "weak," and conveying both physical and psychological distress (Hinton, Hinton, Um, Chea, & Sak, 2002).

There are also a number of culture-bound syndromes present in Asian cultures that may be evident in Asian trauma survivors in the USA. Culture-bound syndromes are thought to be patterns of symptoms specific to an individual's culture, although research suggests that there is often overlap across cultures. Listing and describing every Asian culture-bound syndrome present is beyond the scope of this review, but Yeh, Ngyuen, and Lizzaraga (2014) indicate that they typically fall into categories that reflect Asian cultural values. Understanding these value systems is essential to working with this client population.

Many Asian cultures present some variation of the *dhat* syndrome, which reflects the value of the mind-body connection. The *dhat* syndrome originates in India and refers to intense anxiety and hypochondriacal beliefs around the discharge of semen in males (American Psychiatric Association, 2000). A similar variation is found in Chinese culture, where semen is considered to hold chi, or energy, for men, and its loss can be anxiety provoking (Yeh et al., 2014). Understanding of the mind-body connection and specifically concerns around this topic may be helpful in assessing Asian survivors of sexual trauma.

Culture-bound syndromes often include somatic symptoms, as described earlier, and reflect both the mind-body connection and the Asian value of emotional suppression. Neurasthenia is often considered the Chinese equivalent of major depression and involves physical symptoms including muscle weakness, shortness of breath, sweating, and fainting (Kleinman, 1997). Similarly, the Korean syndrome "Hwa-byung" was observed initially by Lin (1983) and described in the Diagnostic and Statistical Manual of Mental Disorders, fourth Edition (American Psychiatric Association [APA], 1994). This term literally translates to "fire illness" and, examined as such, may be difficult to understand. In context, it refers not only to the gastric distress of what Western societies may refer to as "heart burn," but additionally to a metaphorical "burning with anger." Thus, it refers to both physical and emotional distress associated with the experience of intense anger (Kirmayer, 2001; Lin, 1983). Understanding the value placed on emotional suppression may aid clinicians in "reading between the lines," so to speak, and understanding that Asian clients may be describing intense psychological distress in physical terms.

Asian culture also places value on spiritual and ancestral connections, and culture-bound syndromes may reflect this phenomenon. For example, in Taiwanese culture, *hsieh-ping* involves periods of disorientation where one is exposed to ancestral ghosts who are attempting to connect with them (Yeh et al., 2014). Trauma survivors experiencing bereavement or loss may communicate in these terms and should not be misdiagnosed as having psychotic symptoms.

A final theme Yeh et al. (2014) discuss is that of interdependence and a collectivist orientation, which may appear to stand in direct contrast to the independence and individualism emphasized by Western culture. This may be reflected in the phenomenon of *hikikomori* in Japan, whereby adolescents and young adults unexpectedly withdraw from society and isolate themselves for a minimum of 6 months. This is believed to be a result of fear of disappointing parents and an inability to meet social and academic pressures. The existence of a syndrome whereby young people are in deep despair due to disappointing their parents represents the power of the interdependent cultural value, and a culturally sensitive

clinician should be aware of these value differences and mindful of pathologizing them.

Treatment of Trauma and Guidelines for Culturally Informed Care

This final section will discuss the treatment of trauma in Asians and provide some guidelines for culturally informed care. Researchers have argued that collectivistic values that are traditionally held by Asian-Americans (Triandis, 1988) oppose the values associated with Western psychotherapy (Leong, Wagner, & Tata, 1995). Many traditional psychotherapy orientations place high value on open verbal communication, exploration of intrapsychic conflicts, discussion of family and childhood difficulties, and a focus on the individual. Sue (1977) maintains that these processes encourage the client to put their own individual goals before those of the collective, which is in direct conflict with traditional Asian views.

Furthermore, Western psychotherapy's emphasis on open communication regarding family experiences and overt displays of emotion also feel culturally inconsistent. Leong and Lau (2001) indicate that for many Asians, the sphere of intimacy extends to immediate family and perhaps extended family, but rarely further. Members of societies with these values often see disclosure of personal and family problems as bringing shame upon one's family, which is viewed as a serious offense. In fact, research by Tabora and Flaskerud (1997) found that the cultural value of avoiding family shame often outweighs the stigma of help-seeking.

For trauma victims, these values also create the additional barrier to disclosure and may in part explain the low reported prevalence rates of trauma in Asian populations. In particular fear of shame and desire to save face may impact individual's willingness to disclose interpersonal trauma such as physical or sexual abuse. These value systems persist even among highly acculturated Asians, who still report a low interest in engaging in mental health counseling (Leong & Lau, 2001).

For those who do enter treatment, there is limited empirical research regarding psychotherapy efficacy for Asian-American clients. Sue, Zane, and Young (1994) found that studies focused more on preferences of clients than actual psychotherapy processes and outcomes. Sue et al. did find that ethnicity matching increased retention in treatment for Asian-American clients but cautions that more research is needed on culturally appropriate services.

Recent research on Bangladeshi immigrants offers promising results using a community-based model. Karasz et al. (2015) worked with members of the immigrant community to develop a culturally consistent treatment for an indigenous syndrome "tension," similar to major depression. The researchers rejected the notion that Asian immigrants lack mental health literacy as embedded in Western notions of psychology and inherently placing blame on the clients themselves. In constant, they proposed that treatments developed within the value framework of that culture were more likely to be effective. Using a community-based participatory model, the researchers developed a group-based treatment focusing on concrete goals including building financial literacy and assertiveness skills and facilitating social connections. Preliminary trials of this treatment suggest it was effective in reducing psychological symptoms and participant attrition rates were significantly lower than what is typically reported in studies with minority clients. The authors describe the strength of the intervention as being culturally synchronous with client's value systems, thus allowing it to be more effective. This approach provides a model for developing culturally consistent interventions in the future.

The treatment of trauma in Asian populations then depends on a willingness to operate within their framework. In many ways this is consistent with modern Western views of psychotherapy, where therapists are encouraged to enter into the client's subjective experience and understand their worldview. Because trauma assaults an individual's sense of safety in the world, and inter-

personal trauma in particular violates the survivor's sense of personal integrity and comfort with others, culturally informed clinicians have the opportunity to provide a meaningful corrective emotional experience to clients and truly facilitate healing.

Leong and Lau (2001) summarize the importance of several treatment modifications for Asian-American clients, including the clinician establishing credibility with the client (Kinzie, 1985; Zane & Sue, 1991), enlisting family support in treatment (e.g., Sue & Morishima, 1982), proceeding slowly affective experience (e.g., Lorenzo & Adler, 1984; Nishio & Blimes, 1978), incorporating the client's interpretation and meaning of his or her symptoms into the assessment and treatment process (Tanaka-Matsumi, Sieden, & Lam, 1996), and using directive, concrete, problem-focused techniques (Kim, 1985). These recommendations share in common a respect for indigenous values that portray the clinician as a medical professional, the family as paramount sources of support, and the expression of emotion as uncomfortable and difficult. Leong and Lau (2001) further caution against using nondirective, abstract psychodynamic techniques that may alienate or confuse the client. Overall, clinicians should approach culture with curiosity and consider interventions that connect with those values. This approach is most likely to build rapport and facilitate healing in vulnerable populations.

The following section will explore the cultural dynamics unique to the Hispanic/Latinx diaspora, as well as trauma symptoms and exposure rates in this population.

Hispanic/Latinx Diaspora in the USA

> Maria, a 19-year-old from El Salvador, disclosed that she had witnessed an uncle's bullet ridden dead body on the floor following his murder. Maria remembers hearing gunshots at night on a weekly basis and eventually gang members threatening to kill her brother. As she raised her shirt displaying a keloid scar, she reported that at 12 years old a gang member threw boiling water at her abdomen severely burning her. She described that the scariest event was the day that she received a call from prison. They told her that she had to kill the person whom she most loved in order to become a part of the gang. She stated that the unspoken but clear implication was that she must join the gang by killing her mother and if she didn't, then her whole family would die. She fled to the United States because she wanted to ensure the safety of her family and to escape this threat. While crossing the border, she considered drowning herself in the river in the hopes that this sacrifice would save her other family members. She spent two months in an immigration detention center. She described being worried because chunks of her hair were falling out because of her "*nervios.*"

Hispanic Americans are estimated to comprise 17.8% of the total US population, making up the largest ethnic minority group in the USA (U.S. Census Bureau, 2016). Latino/as constitute a diverse population with distinct ethnic and racial compositions (Indigenous, Black, and White), as well as unique histories of migration to the USA. Hispanics originate from more than 20 countries in North, Central, and South America, as well as the Caribbean. Each country and its subregions have their own unique dialect and customs. Approximately 64% of those of Hispanic/Latino origin in the USA were of Mexican origin. Another 9.5% were Puerto Rican, 3.7% Cuban, 3.8% Salvadoran, and 3.2% Dominican (U.S. Census Bureau, 2016). Among the 3.4 million Central Americans residing in the USA, it is estimated that 85% percent hail from El Salvador, Guatemala, and Honduras (Lesser & Batalova, 2017).

The proper use of the terms Hispanic, Latino/a, and Latinx has been frequently contested. Hispanic is the "politically conservative term," while Latino is the "progressive/politically correct term" (Garcia-Preto, 2005). Technically, Hispanic refers to Spanish-speaking countries in the "New World" which were colonies of Spain, whereas Latino (masculine term) is more frequently used to refer generally to anyone of Latin-American origin or ancestry, including Brazilians. Latina is the feminine form of the word and the gender-neutral term Latinx has been used more recently. Clients should be allowed to self-identify and provide their own view of the verbiage.

According to the Pew Hispanic Center's National Survey of Latinos (Taylor et al., 2012), more than half (52%) of Latinos ages 16–25 identify themselves first by their family's country of origin. Approximately, 20% generally use the terms "Hispanic" or "Latino" first when describing themselves. Only about one in four (24%) generally use the term "American" first. This chapter will not debate the validity or technicality of these terms and will use them interchangeably. However, it should be noted that the population that is being referred to below, regardless of the term used, focuses solely on the people from the Latin-American and Caribbean Spanish-speaking countries that had been colonies of Spain in the past and do not include Spain, other European countries, or Brazil.

In addition to being the largest ethnic minority group, the Latinx population in the USA are also among the youngest ethnic minority groups. While levels of education are increasing, only about 15% of Hispanics earn a bachelor's degree or higher, which is much lower than the rates of Asians (63%), Whites (41%), and Blacks (22%) (Stepler, 2016). It is noteworthy that US-born Latinx youth go farther in school than their immigrant parents, who represent a declining subset of the Latinx population overall (NASEM, 2015). The disparity in educational outcomes has a significant impact on the Latinx community, who disproportionately occupy the lower rungs of the socioeconomic ladder.

Trauma Exposure in the Latinx Diaspora

While there are many differences between groups, there are some cultural values endorsed by most Latinx groups to varying degrees. For example, *familismo* refers to maintaining a close connection to the family, relying on the family to meet psychological, social, and security needs (Interian & Diaz-Martinez, 2007). It also refers to the willingness to make personal sacrifices for the welfare of the family and a shared sense of responsibility (DeArellano, 2006). *Simpatia* is the need for socialization that is pleasant and lacking confrontation or negative interactions; similarly, *personalismo* is having trust and warm interpersonal interactions with others. Finally, *fatalismo* is a belief that illness and misfortune are beyond a person's control and are attributed to fate and one could potentially feel a sense of resignation (Caplan et al., 2011). In the spirit of Triandis's definition of culture, these values are likely to impact Latinx persons' interpretations and reactions to trauma.

Latinx immigrant groups have a high probability of trauma exposure prior to their immigration to the USA (Jha, Orav, & Epstein, 2011; Perreira & Ornelas, 2013). Central America's Northern Triangle (El Salvador, Guatemala, and Honduras) is one of the world's most violent regions due to a combination of political instability and corruption, as well as significant gang violence (Prado-Perez, 2018). There has been instability and violence in Mexico and Venezuela; Venezuela has experienced drastic economic decline in the past 10 years (Ellis, 2017) Venezuela has been experiencing a political and economic crisis which has caused it to go from being among the richest to the being the poorest (Fisher & Taub, 2017). Mexico is one of the countries experiencing violence related to drug trafficking. Additionally, Latin-American countries have suffered numerous natural disasters. In 2017, hundreds of deaths resulted from Mexico's two earthquakes (magnitudes between 7 and 8), flooding in Peru, and landslides in Colombia (Umbert, 2018). Even in the USA, 1 year later, Puerto Rico is still recovering from the aftereffects of the Category 4 Hurricane Maria which is thought to have killed 2975 people (GWU, 2018).

Latinx immigrants often emigrate in stages, resulting in separation from family and primary caregivers (NCTSN, 2007; Santa-Maria-Cornille, 2007). In addition to premigration trauma, new arrivals often contend with a fear of deportation and worry for family left at home (Eisenman, Gelberg, Liu, & Shapiro, 2003; Silove, Momartin, Marnane, Steel, & Manicavasagar, 2010; Steel et al., 2009).

The APA Presidential Task Force on Immigration (2012) indicates that immigrant youth may experience potentially unique traumatic experiences. These experiences include racial profiling, ongoing discrimination, exposure to gangs, immigration raids, the arbitrary checking of family members' documentation status, forcible removal or separation from their families, placement in detention camps or in child welfare, and deportation. Latino/a immigrant adults could be at a higher risk of work-related discrimination and exposure to domestic violence (APA Task Force on Immigration, 2012).

While a sizeable portion of Latinx persons experience immigration-related trauma, research often fails to address the important differences between US-born Latinos/as and recent immigrants. In fact, the majority of Hispanics are US born and experience unique challenges as minorities in their nation of birth. Indeed, perceptions of discrimination are more widespread among US-born (62%) than foreign-born (41%) young Latinos (Pew Research Center, 2016). As previously mentioned, US-born Latino/as are more likely to have proficiency in English and complete high school, and as such the nature of their trauma exposure is likely different than that of the parent generation. However, clear data is unavailable as much of the ethnicity-based research on trauma in specific groups (e.g., police officers, veterans) likely included a predominately US-born sample or did not differentiate between the US-born or immigrant groups (Escobar et al., 1983; Galea et al., 2004; Kulka et al., 1990; Lewis-Fernandez et al., 2008; Norris, Perilla, & Murphy, 2001; Pole et al., 2001; Schell & Marshall, 2008).

Trauma Symptoms in the Latinx Diaspora

Epidemiological research of PTSD in the Latinx population reveals a wide range from 4% to 38% (Alegría et al., 2008; Cervantes et al., 1989; Eisenman et al., 2003; Santa-Maria & Cornille, 2007; Steel et. al., 2009; Yule, 2001). Despite variation in prevalence rates, research does suggest that Latina/os exhibit an increased risk of PTSD symptoms after exposure to a traumatic event (Eisenman et al., 2003). This holds true even when adjusting for differential exposure and sociodemographic factors. Latinx individuals are more likely than non-Latinx White counterparts to exhibit more chronic and severe PTSD symptom trajectories (Hinton & Good, 2015). An established body of research indicates that Hispanic adults are more likely than their non-Hispanic counterparts to experience severe symptoms of posttraumatic stress disorder (PTSD); however, explanations for this phenomenon vary (Escobar et al., 1983; Galea et al., 2004; Kulka et al., 1990; Lewis-Fernandez et al., 2008; Norris et al., 2001; Pole et al., 2001; Schell & Marshall, 2008). Some of these explanations for this phenomenon include a culturally based propensity to exaggerate or overreport mental health symptoms (Ortega & Rosenheck, 2000; Ruef, Litz, & Schlenger, 2000), a disposition toward acquiescent responding (Ortega & Rosenheck, 2000), and the tendency of Latinx to manifest suffering in physical rather than psychological form (Hough, Canino, Abueg, & Gusman, 1996). Other explanations include differences in the experience of traumatic life events (Frueh, Brady, & de Arellano, 1998), increased ethnic discrimination (Loo et al., 2001; Marsella, Friedman, & Spain, 1996), lack of coping resources following trauma exposure (Pole, Best, Metzler, & Marmar, 2005), as well as sociodemographic disadvantage (Pole et al., 2008).

In their study of traumatized veterans, Hall-Clark et al. found that both Hispanic and African-American service men reported more symptoms such as reexperiencing, fear, guilt, and numbing than their White counterparts. There is an indication that peritraumatic responses (reactions immediately following the event), such as peritraumatic dissociation or peritraumatic panic attacks, are associated with higher levels of PTSD. Hispanics have been found to endorse more peritraumatic dissociation such as depersonalization and derealization, as well as panic attacks, than other groups (Alcántara & Lewis-Fernandez, 2016). Peritraumatic dissociation was

also associated with PTSD severity in Latino/as exposed to community violence (Denson et al., 2007). Alcántara and Lewis-Fernandez (2016) suggest that peritraumatic responses account for a large percentage of variance in the risk of Latino/as and non-Hispanic Whites. However, depersonalization and derealization are not commonly assessed symptoms. These symptoms include feeling detached from their own feelings and/or experiences (depersonalization) and/or experiencing objects, people, and/or surroundings as unreal, distant, artificial, and lifeless (derealization) while maintaining intact reality testing abilities (Michal et al., 2016). These different manifestations of distress may require different treatments.

Working with trauma in Latinx populations requires a knowledge of idioms and distress and culture-bound syndromes, many of which incorporate supernatural explanations for their distress or unusual physical presentations (Caplan et al., 2011). This may include belief in concepts such as "mal de ojo" (evil eye) and witchcraft or hexes. One of the most empirically established culture-bound syndromes is *ataque de nervios* or "attack of nerves" and is a common idiom within Caribbean-Latino/a populations (Hinton & Lewis-Fernández, 2010). For some, *ataque de nervios* are considered as a normal reaction to a stressful or traumatic event which is associated with losing control. Commonly reported elements of *ataques* include screaming and shouting uncontrollably, attacks of crying, trembling, heat in the chest rising into the head, and becoming verbally and physically aggressive. Dissociative experiences, seizure-like or fainting episodes, and suicidal gestures are prominent in some *ataques* but absent in others. The attacks are often triggered by stressful events relating to the family, such as news of the death of a close relative, conflicts with a spouse or children, or witnessing an accident involving a family member. *Ataque de nervios* is most commonly found among Hispanic older females (Guarnaccia et al., 2010) even though the original research on *ataque de nervios* was conducted by US military psychiatrists in the 1950s and 1960s addressing symptoms in Puerto Rican military males. The prevalence of *ataques* has been found to be associated with a prevalence of various disorders and symptoms, including PTSD, dissociative symptoms, and panic disorder (Alcántara & Lewis-Fernandez, 2016; Guarnaccia et al., 1996; Lewis-Fernández et al., 2010; Schechter et al., 2000). It has been postulated that once exposed to a traumatic event, a peritraumatic reaction in the form of an *ataque de nervios* may increase the odds of PTSD onset or its prognosis (Alcántara & Lewis-Fernandez, 2016).

Similarly, to simply suffer from "nerves" can imply chronic anxiety, somatization, depression, and/or dissociation (Hinton & Lewis-Fernandez, 2010). The term *nervios* includes a wide range of symptoms of emotional distress, somatic disturbance, and inability to function. *Nervios* is described as episodes, usually chronic, of extreme sadness or anxiety associated with somatic symptoms such as headaches and/or muscle pain, nausea, loss of appetite, fatigue, insomnia, and decreased reactivity. It is more common in women and associated with stress, emotional imbalance, and low self-esteem (Nogueira et al., 2015). Ecuadorian Andes children also experience the "nervios" disorder with varied symptoms such as increased sadness and anger. This disorder is often said to be triggered by the children's separation from their parents, especially their fathers (Pribilsky, 2001). Mexican rural communities showed a prevalence of 15.5% in the general population for the diagnosis of *nervios* (Rhoades & Sar, 2005).

Susto, which literally translates to "fright," is more commonly found in Mexico, Central America, and South America. Symptoms include feelings of sadness, apathy, and low self-esteem along with somatic symptoms including sleep and appetite disturbances along with gastrointestinal distress. Those suffering from "susto" believe that the experience of a frightening event can cause the soul to leave the body. As such the "soul-less" person is left with sadness and sickness. Traditional healing will focus on calling the soul back to the body and cleansing the person. The "cleansing" is intended to restore the body and spiritual balance (American Psychiatric Association, 2013). Often the practice of *curand-*

erismo, a form of Hispanic traditional folk medicine, is used. This practice focuses on using natural plants to spiritually heal and obtain balance (Tafur, Crowe, & Torres, 2009).

Treatment Guidelines for Working with the Hispanic/Latinx Clients

Experts recommend that treatment with Latinx immigrant clients emphasize the importance of thoroughly exploring the client's context of exit from the country of origin and current neighborhood circumstance in the overall assessment of the client's well-being (Alegría & Woo, 2009). Clients may be reluctant to disclose their immigration status and/or their premigration traumatic experiences. For example, one research study had found that only 3% of the 267 Latinx patients who had experienced political violence reported ever telling a clinician about it after immigrating (Eisenman, Gelberg, & Shapiro, 2003). Traumatized patients may be silenced by shame, guilt, and mistrust and may not see their past trauma as related to their current complaints (Keller, Leviss, Levy, & Dyson, 2007). In addition to exploring premigration stressors, postmigration experiences should also be assessed, as they may impact acculturation and adjustment. For example, Cuban immigrants who are able to access strong social, economic, and political networks within ethnic enclaves fare differently than immigrants from El Salvador who may lack social capital in the USA. In sum, clients may present with different levels of acculturative stress which may exacerbate posttraumatic responses. Moreover, there may be significant differences even within families between immigrant and US-born clients.

Undocumented clients may not be aware that some of their premigration trauma and abuse-related experiences may make them eligible for documentation. This process while stressful in and of itself may lead to a reduction in stressors and increased opportunities in the future. Therefore, clinicians could play a role in referring clients to immigrant rights groups that could help with the legal process. Clinicians could also be involved in the required documentation needed for these varying claims (i.e., asylum, VAWA, U visa, T visa). Abused spouses of US citizens and legal permanent residents (LPR) or the non-abused spouse whose child was abused may be eligible for VAWA. Victims of certain crimes (including rape, incest, domestic violence, abusive sexual contact, abduction, felonious assault) who cooperate with police investigations may be eligible for a U visa. Victims of human trafficking who have reported this crime to officials and are cooperative with the investigation are eligible for a T visa. A person who is unable or unwilling to return to home country due to persecution on account of race, religion, nationality, political opinion, or membership in a particular social group could be eligible for asylum (Torres & Mercedes, 2018).

Beyond understanding immigration and acculturation experiences, clinicians should pay close attention to the nuances of symptom presentation. For example, clinicians should inquire about somatic symptoms, dissociation, and peritraumatic responses that standard clinical interviews may not address. Additionally, a culturally informed evaluation should also directly explore issues related to ethnic identity and experiences of discrimination. Formal measures such as the Hispanic Stress Inventory (HIS-2; Cervantes et al., 2015) may be effective in the assessment process.

Pole, Gone, and Kulkarni (2008) identified relevant cultural factors such as language, *familismo*, and *personalismo* in the treatment of Latinx persons. They emphasize that even when Latinx clients speak English fluently, those who spoke Spanish as their first language may recall more details and access deeper emotions (Altarriba, 2016) when they communicate in Spanish. Clinicians should also assess the extent to which *familismo* is important to their client, as treatment goals that incorporate the family may be more culturally salient. For Latinos who endorse *personalismo* there will be a preference for therapy relationships characterized by greater emotional warmth. Latino/a clients have frequently reported "coldness" among practitioners as a barrier to treatment

(Guarnaccia, Martinez & Acosta, 2005; Paniagua, 1994).

Clinicians working with this population should respect culturally consistent ideas around healing. If a client views their trauma experience as a part of fate and then using that language and belief, therapists can reframe their goals. For example, one can ask if the client believes that fate or God could have brought them to the therapy office to help them. If the client believes that there is a hex, one could explore how the individual came to that conclusion and how they believe they can be freed from this. In sum, the client's cultural myth about their illness requires attention in order to strengthen treatment adherence and therapeutic alliance (Benish, Quintana, & Wampold, 2011).

African/Black Diaspora

The next section will provide an overview of the African/Black diaspora, culturally specific differences in exposure and symptomatology, and treatment recommendations.

> Sasha, an older African-American mother, from a poor urban area was often dismissive of her young baby boy with whom she was being reunified. There was no history of abuse towards this child but she had been "in the system" because Sasha had given up custody of her oldest child due to past drug use. Sasha emphasized the need to be a strong black woman, to pray and keep her "family business" to herself. She expressed her mistrust of "the system" and therapy but never missed a session. She vacillated between appearing indifferent to highly anxious to somewhat combative. It was only after six months of treatment and discussions about the old neighborhood that she disclosed years of physical torture, as well as sexual abuse by her drug-dealing step-father. She described how she would hide the rope burns on her wrists with bracelets because she didn't want to give her mother more problems than she already had in this "racist place."

Approximately 13% of US residents self-identify as Black (U.S. Census Bureau, 2016). Since the year 2000, the number of Black immigrants living in the country has increased by 71%. Almost one in ten Blacks (9%) living in the USA are foreign born. Africans constitute 39% of the overall foreign-born Black population, whereas approximately half of all foreign-born Blacks living in the USA (49%) were from the Caribbean, especially Jamaica and Haiti (U.S. Census Bureau, 2016).

Africans in Africa are connected to African-Americans in the USA and other areas of the larger Black diaspora, including the Caribbean, "through a common racial ancestry as well as through myriad political and historical circumstances" such as the effects of colorism (Alex-Assensoh, 2009, p. 90). The Council of National Psychological Associations for the Advancement of Ethnic Minority Interests published by the Association of Black Psychologists (2003) indicated that "acknowledging people of African descent in this country, the focus of differences is often placed on race rather than culture."

The terms African or African immigrant refer to Black Africans, who have voluntarily migrated from Sub-Saharan or Black African countries over the last two decades (Alex-Assensoh, 2009). The African-American terminology refers to the racial group in America, which traces its ancestry to African slave population beginning in the 1600s (Franklin & Moss, 2010). The term Black refers to all individuals in America—including native-born African-Americans, African immigrants, and other Black immigrants—who are ascribed as "Black" based on the American system of racial categorization (Alex-Assensoh, 2009). However, there are many, very clear distinctions between these groups and their ethnic subgroups.

Among the most notable distinctions between groups is that African slaves were disconnected from their ethnic, geographical, linguistic, and cultural communities by slavery and discriminated against in America based on racial characteristics. As such, African-American identity has been shaped largely by racial identity rather than ethnic identity. On the other hand, voluntary African immigrants have strong connections to ethnic, geographical, cultural, and linguistic communities in Africa. Therefore, many have called into question the meaning and accuracy of the terms "Black" and "African-American" (Alex-Assensoh, 2009). As with all people the intersectionality of class, gender, and residential

patterns may also make a difference in a person's overall identity. Many ethnographic studies note the attempts by Black immigrants to distinguish themselves from—and avoid the stigma associated with—poor African-Americans (Alex-Assensoh, 2009).

Trauma Exposure in the Black Diaspora

Roberts et al. (2011) large national study found that Blacks had higher lifetime prevalence of PTSD and experienced higher levels of violent victimization than other racial/ethnic groups. They stipulate that perceived discrimination, race-related verbal assault, and racial stigmatization have been linked to PTSD symptoms and may partially account for the higher conditional risk of PTSD among Blacks. The Centers for Disease Control (CDC, 2017) indicates that homicide is the number one killer of Black males ages 10–35, whereas Black females are four times more likely to be murdered by a significant other than their White counterparts (Weiss et al., 2015). As such, they are disproportionally victims of these types of violence. Disproportionality refers to the representation of their group being larger or smaller than the same group's representation in the general population (Casey Foundation, 2018). One potential explanation for this disproportionality may be socioeconomic status. Both Latinx and Black immigrants are often at a much greater risk for poverty as compared to immigrants from Europe, Canada, or Asia (Mather, 2009). As a result of their lower socioeconomic status, African-Americans in the USA are often forced to live in areas that increase their risk of exposure to trauma, violence, and stress (Martinez, 1996; Roberts et al., 2011; Shihadeh & Flynn, 1996; Williams & Williams-Morris, 2000). Individuals from low-resource neighborhoods may present with daily living issues exacerbated by inaccessible or poor health care, reduced social or community support, as well as high crime and violence rates (Reardon, Fox, & Townsend, 2015).

Disparity examines the difference in relation to outcomes experienced based on race and ethnicity (Casey Foundation, 2018). The two most salient examples of disparity are related to child welfare and criminal justice involvement (Nellis, 2016). For example, research has indicated that racial disparities occur at several, decision points in the child welfare process (e.g., Detlaff et al., 2011; Font, 2013; Putnam-Hornstein, Needell, King, & Johnson-Motoyama, 2013). African-Americans account for 15% of all children in the USA, yet they account for 25% of substantiated maltreatment victims. Disparities are even more pronounced when it comes to out-of-home care as African-American children represent 45% of the total number of children in foster care (Casey Foundation, 2018). This factor alone may have the potential of increasing their risk of future traumatic experiences. Another example of the impact of disparity is that African-Americans are incarcerated in state prisons at rates that are over five times the imprisonment of Whites, and in some states the disparity is more than ten to one (Nellis, 2016).

As in many of the other diasporas previously covered in this chapter, Black immigrants may present with premigration trauma exposure. It should be noted that several African countries are considered among the most violent in the world due to political instability, including the Democratic Republic of Congo Libya, Somalia, Sudan, Nigeria, Ethiopia, Kenya, and Chad (Institute for Economics and Peace, 2017).

Trauma Symptoms in African/Blacks

Research exploring trauma-related differences within the Black diaspora is nonexistent (Pole et al., 2008). One study of African-Americans with PTSD symptoms found that perceived racial discrimination was associated with more severe PTSD symptoms (Pole et al., 2005). It is important to consider the role of racism in the perpetuation of the violent environment and how an exploration of this may help clients have a different perspective. For example, this may impact their views on the effects of gang vio-

lence, intimate partner violence/child maltreatment, and police use of excessive force, and this work attempts to highlight the repercussions of violence in the African-American community. A large-scale study using data from the National Survey of African Life (NSAL) found that 87% of African-American youth and 90% of Caribbean Black youth indicated that they had experienced at least one discriminatory incident in the past year (Seaton, Caldwell, Sellers, & Jackson, 2008). Carter (2016) theorizes that high rates of PTSD for Blacks may be related to or increased by racial discrimination. Trauma researchers have eluded to this association, but it has not been a focus of research (Carter et al., 2017; Loo, Fairbank, & Chemtob, 2005). Prior to the introduction of the race-based traumatic stress (RBTS) model, there was no specific link to an experience of racism and symptoms (Carter, 2016; Carter & Sant-Barket, 2015).

Carter (2016) has proposed that research demonstrates a connection between racial discrimination and a subsequent trauma response, including severe stress reactions (Carter, 2016; Carter, Forsyth, Mazzula, &Williams, 2005). In support of this RBTS model, Bryant-Davis and Ocampo (2005) found that while not all ethnic minorities who experience racist incidents will exhibit posttraumatic symptoms, many present with intense fear, anxiety, helplessness, reexperiencing the event, and avoidance in response to racial incidents. Carter et al. (2013) developed the Race-Based Traumatic Stress Symptom Scale to assess the prevalence and severity of psychological and emotional stress reactions to memorable encounters of racism and racial discrimination. Similarly, Ken Hardy (2013) described "race-related trauma wounds, such as internalized devaluation, assaulted sense of self, internalized voicelessness, and the wound of rage in African-American clients."

On a related vein, DeGruy (2005) conducted years of psychological research on the multigenerational trauma experienced by African-Americans. The term "Posttraumatic Slave Syndrome (PTSS)" was coined in her book that theorizes that centuries of slavery, systemic racism, and oppression, including mass incarceration, have led to multigenerational maladaptive behaviors in response to trauma. The key PTSS patterns that she describes are a marked propensity for anger and violence stemming from extreme feelings of suspicion of the perceived negative motivation of others. She also describes a racist socialization which leads to internalized racism. These symptoms are reminiscent of symptom presentations of mistrust and self-blame that are common in interpersonal trauma. However, this concept has not been without its criticism. For example, Kendi (2016) contends that PTSS is a more progressive racist theory that roots "dysfunctional" Black behaviors in the history of oppression instead of biological or cultural factors. Nonetheless, it is a very important concept to consider in terms of how our clients view themselves and whether anger/hostility should be considered in the context of trauma instead of as an externalizing disorder.

Of note there are a number of cultural-bound syndromes originating in West Africa, Haiti, and the African-American Southern United States. A number of these syndromes (e.g., *maladi moun*, rootwork, and *zār*) have a strong, external spiritual or magical component. There is a cultural notion that spirits or hexes can impact health. Caribbean and African groups may attribute symptomatology to the possession by a spirit or by a hex/curse placed by another individual. Rootwork is referred to the traditional medicine of Black Americans that has its origins in slave culture of the South. Its continued influence on the health behavior of Black Americans is reported for rural areas of the South and for poor urban areas throughout the USA. The rootwork system combines a belief in the magical causation of illness with cures by sorcery and an empiric tradition stressing the natural causation of illness with cures by herbs and medicines (Matthews, 1987).

"Falling out" or "blacking out" refers to a culturally bound syndrome that could potentially be associated with a traumatic experience. It is most commonly reported in the Southern United States and the Caribbean. The syndrome entails a constricted consciousness in which a person can see and hear but not act. The DSM had described it as

a sudden collapse, which sometimes occurs without warning, but sometimes preceded by feelings of dizziness or "swimming" in the head (DSM-IV-TR: American Psychiatric Association, 2000, p. 900). Similar to other idioms of distress, there is a feeling of loss of control of one's body.

Treatment Guidelines for Working with Blacks and African-Americans

Overall, the experience of racial oppression has a significant impact on the manifestation of trauma in Black and African-Americans. It is important for these racially discriminatory experiences to be acknowledged and validated so that they can resist oppressive environments and internalized oppression (Jernigan, 2009; Jernigan & Henderson-Daniel, 2011; Nicolas et al., 2008). Without the direct exploration of these concepts, we cannot fully engage all of the aspects of a traumatic experience. Therapists may believe that discrimination only occurs in other systems. However, the prevalence of racial/ethnic microaggressions in therapy is relatively high, with 53–81% of clients reporting experiencing at least one microaggression (Hook et al., 2016). Blacks and Latinx groups share a history of colonization and oppressed status that may also impact their willingness to share information. Yet discrimination is a factor that is often overlooked in clinical settings.

Discrimination experiences have a profound impact on the person's narrative regarding the traumatic experience and/or their sense of self. Many of our therapeutic approaches do not address aspects of discrimination and power or privilege within the therapeutic exchange. However, it has been found that minorities who strongly identify only with their ethnic group and not the dominant group may perceive greater stigma and discrimination are more likely to report greater PTSD symptom severity (Breslau, 2002; Galea et al., 2004; Khaylis, Waelde, & Bruce, 2007; Loo et al., 2001). If therapists explored racial and ethnic identity, as well as spiritualty beliefs, it could potentially help counteract the research that suggests the research that African-Americans have a less positive attitude toward mental health treatment after utilizing services (Diala et al., 2000).

Conclusion: General Treatment Implications

A wealth of research has shown that therapist integration of client's cultural narratives in intervention and the client's perceptions of how a therapist navigates cultural factors in treatment are correlated with outcome (Benish et al., 2011; Bernal & Adames, 2017; Griner & Smith, 2006; Smith, Domenech-Rodriguez, & Bernal, 2011; Tao, Owen, Pace, & Imel, 2015). In a similar vein, several books have been written addressing the impact of culture on trauma (Brown, 2008; Hinton & Good, 2018; Rhoades & Sar, 2005). This chapter attempted to succinctly explore the existing research regarding how cultural factors may play a role in trauma exposure risk, symptom presentation, and views about healing. The following list contains general recommendations for clinicians who are working with clients across cultural groups:

1. Start from a strengths-based, culturally respectful and curious perspective.
2. Promote cultural protective factors to reduce disparities in outcomes (e.g., ethnic identity, spirituality).
3. Welcome cultural adaptations and culturally appropriate models of explaining "illness."
4. Understand that treatment should be symptom-specific and culturally guided instead of technique- or diagnosis-specific, especially when working with clients with comorbidity and acculturative stress.
5. Obtain some basic immigration-related knowledge if providing services to undocumented individuals. Clinicians should be able to provide clients information about local immigrant rights groups and lawyers that could assist undocumented clients who have experienced trauma and abuse. Many undocu-

mented clients may have pathways towards citizenship through humanitarian options (i.e., VAWA, asylum, U visa, T visa, extreme hardship of documented spouse).

References

Abe-Kim, J., Takeuchi, D. T., Hong, S., Zane, N., Sue, S., Spencer, M. S., … Alegría, M. (2007). Use of mental health–related services among immigrant and US-born Asian Americans: results from the National Latino and Asian American study. *American Journal of Public Health, 97*(1), 91–98.

Abouguendia, M., & Noels, K. A. (2001). General and acculturation-related daily hassles and psychological adjustment in first-and second-generation South Asian immigrants to Canada. *International Journal of Psychology, 36*(3), 163–173.

Akinsulure-Smith, A. (2007). The use of interpreters with survivors of war, torture & refugee trauma. In Smith, Keller and Lhewa (Eds.) "… *Like a Refugee Camp on First Avenue": Insights and Experiences from the Bellevue/NYU Program for Survivors of Torture* (pp. 83-105). New York, NY: The Jacob and Valeria Langeloth Foundation.

Alcántara, C., & Lewis-Fernández, R. (2016). Latinas' and Latinos' risk for PTSD after trauma exposure: A review of sociocultural explanations. In D. E. Hinton & B. J. Good (Eds.), *The ethnography of political violence. Culture and PTSD: Trauma in global and historical perspective (p. 275–306)*. University of Pennsylvania Press. https://doi.org/10.9783/9780812291469-009

Alegría, M., Canino, G., Shrout, P. E., Woo, M., Duan, N., Vila, D., & Meng, X.-L. (2008). Prevalence of mental illness in immigrant and non-immigrant U. *S. Latino groups. American Journal of Psychiatry, 165*(3), 356–369. PMC2712949.

Alegría, M., Fortuna, L. R., Lin, J. Y., Norris, F. H., Gao, S., Takeuchi, D. T., … Valentine, A. (2013). Prevalence, risk, and correlates of posttraumatic stress disorder across ethnic and racial minority groups in the United States. *Medical care, 51*(12), 1114–1123. https://doi.org/10.1097/MLR.0000000000000007

Alegría, M., & Woo, M. (2009). Conceptual issues in Latino mental health. In F. A. Villarruel, G. Carlo, J. M. Grau, M. Azmitia, N. J. Cabrera, & T. J. Chahin (Eds.), *Handbook of US Latino psychology: Developmental and community-based perspectives* (pp. 15–30). Thousand Oaks, CA: Sage.

Alex-Assensoh, Y. M. (2009). African immigrants and African-Americans: An analysis of voluntary African immigration and the evolution of Black ethnic politics in America. *African & Asian Studies, 8*(1/2), 89–124. https://doi.org/10.1163/156921009X413171

Altarriba, J. (2016). Does cariño equal "liking"? *International Journal of Bilingualism, 7*(3), 305–322.

American Psychiatric Association. (1994). *Diagnostic And Statistical Manual of Mental Disorders (DSM-IV)*. Washington, DC: APA.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). Text Revision-DSM-IV-TR). Washington, DC: APA.

American Psychological Association, Presidential Task Force on Immigration. (2012). *Crossroads: The psychology of immigration in the new century*. Retrieved from http://www.apa.org/topics/immigration/report.aspx

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Baker, D., Hayes, R., & Puebla-Fortier, J. (1998). Interpreter use and satisfaction with interpersonal aspects of care for Spanish-speaking patients. *Medical Care, 10*, 1461–1470.

Benish, S., Quintana, S., & Wampold, B. (2011). Culturally adapted psychotherapy and the legitimacy of myth: A direct-comparison meta-analysis. *Journal of Counseling Psychology, 58*(3), 279–289. https://doi.org/10.1037/a0023626

Bernal, G., & Adames, C. (2017). Cultural Adaptations: Conceptual, Ethical, Contextual, and Methodological Issues for Working with Ethnocultural and Majority-World Populations. *Prevention Science, 18*(6), 681–688. https://doi.org/10.1007/s11121-017-0806-0

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Owusu Ananeh-Firempong, I. I. (2016). *Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care*. *Public health reports*.

Breslau, N. (2002). Epidemiologic Studies of Trauma, Posttraumatic Stress Disorder, and other Psychiatric Disorders. *The Canadian Journal of Psychiatry, 47*(10), 923–929. https://doi.org/10.1177/070674370204701003

Briere, J. (2011). *Trauma Symptom Inventory-2 (TSI-2) Professional Manual*. Odessa, FL: Psychological Assessment Resources.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Cambridge, MA: Harvard University Press. ISBN:0-674-22457-4.

Brown, L. S. (2008). *Cultural competence in trauma therapy: Beyond the flashback*. Washington, DC: American Psychological Association.

Bryant-Davis, T., & Ocampo, C. (2005). The Trauma of Racism: Implications for Counseling, Research, and Education. *The Counseling Psychologist, 33*(4), 574–578. https://doi.org/10.1177/0011000005276581

Bryant, R. A. (2006). Recovery after the tsunami: Timeline for rehabilitation. *Journal of Clinical Psychiatry, 67*(2), S50–S55.

Canino, G., & Bravo, M. (1994). The adaptation and testing of diagnostic and outcome measures for cross-cultural research. *International Review of Psychiatry, 6*(4), 281–287.

Caplan, S., Paris, M., Whittemore, R., Desai, M., Dixon, J., Alvidrez, J., … Scahill, L. (2011). Correlates of religious, supernatural and psychosocial causal beliefs about depression among Latino immigrants in primary care. *Mental Health, Religion & Culture, 14*(6), 589–611. https://doi.org/10.1080/13674676.2010.497810

Carter, R. T. (2016). Racism and Psychological and Emotional Injury. *The Counseling Psychologist, 35*(1), 13–105. https://doi.org/10.1177/0011000006292033

Carter, R. T., Forsyth, J. M., Mazzula, S. L., & Williams, B. (2005). Racial discrimination and race-based traumatic stress: An exploratory investigation. In R. T. Carter (Ed.), *Handbook of Racial-cultural Psychology and Counseling* (Vol. 2:. *Training and practice*, pp. 447–476). Hoboken, NJ: John Wiley.

Carter, R. T., Johnson, V. E., Roberson, K., Mazzula, S. L., Kirkinis, K., & Sant-Barket, S. (2017). Race-based traumatic stress, racial identity statuses, and psychological functioning: An exploratory investigation. *Professional Psychology: Research and Practice, 48*(1), 30–37. https://doi.org/10.1037/pro0000116

Carter, R. T., Mazzula, S., Victoria, R., Vazquez, R., Hall, S., Smith, S., … Williams, B. (2013). The development of the race-based traumatic stress symptom scale. *Psychological Trauma: Theory, Policy, Research, and. Practice, 5*(1), 1–9.

Carter, R. T., & Sant-Barket (2015). Assessment of the impact of racial discrimination and racism: How to use the Race-Based Traumatic Stress Symptom Scale in practice, *Traumatology, (On-Line 12.1.14), 21*(1), 32–39.

Casey Foundation. (2018, March). *Racial disproportionality in the child welfare system. Presentation at the Conference for Law Guardians*. Hamilton, NJ: Race and the Child Welfare System.

Center for Disease Control (CDC) (2017). *Youth Violence: Facts at a Glance*. Retrieved from https://www.cdc.gov/violenceprevention/pdf/yv-datasheet.pdf

Cervantes, R., Salgado de Snyder, V. N., & Padilla, A. (1989). Posttraumatic Stress in Immigrants From Central America and Mexico. *Hospital & Community Psychiatry, 40*(6), 615–619. https://doi.org/10.1176/ps.40.6.615

Cervantes, R. C., Fisher, D. G., Padilla, A. M., & Napper, L. E. (2015). The Hispanic Stress Inventory Version 2: Improving the assessment of acculturation stress. *Psychological Assessment, 28*, 509–522.

Chan, W., & Mendoza-Denton, R. (2008). Status-based rejection sensitivity among Asian Americans: Implications for psychological distress. *Journal of Personality, 76*(5), 1317–1346.

Chester, B., & Holten, N. (1992). Cross-Cultural Medicine a Decade Later: Working With Refugee Survivors of Torture. *Western Journal of Medicine, 157*(3), 301–302.

DeArellano, M. (2006, November). *Trauma Among Hispanic/Latino populations*. Paper presented for the National Child Traumatic Stress Network.

DeGruy Leary, J. (2005). *Post traumatic slave syndrome: America's legacy of enduring injury and healing*. Milwaukie, OR: Uptone Press.

Denson, T. F., Marshall, G. N., Schell, T. L., & Jaycox, L. H. (2007). Predictors of posttraumatic distress 1 year after exposure to community violence: The importance of acute symptom severity. *Journal of Consulting and Clinical Psychology, 75*(5), 683–692. https://doi.org/10.1037/0022-006x.75

Detlaff, A., Rivaux, S. L., Baumann, D., & James, J. (2011). Disentangling substantiation: The influence of race, income, and risk on the substantiation decision in child welfare. *Children and Youth Services Review, 33*(9), 1630–1637. https://doi.org/10.1016/j.childyouth.2011.04.005

Diala, C., Muntaner, C., Walrath, C., Nickerson, K. J., LaVeist, T. A., & Leaf, P. J. (2000). Racial differences in attitudes toward professional mental health care and in the use of services. *American Journal of Orthopsychiatry, 70*, 455–464. https://doi.org/10.1037/h0087736

Eisenman, D., Gelberg, L., Liu, H., & Shapiro, M. (2003). Mental health and health-related quality of life among adult Latino primary care patients living in the United States with previous exposure to political violence. *Journal of the American Medical Association, 290*(5), 627–634.

Ellis, E. (2017). *In the Media: The Collapse of Venezuela and Its Impact on that Region*. Retrieved from https://theglobalamericans.org/2017/07/collapse-venezuela-impact-region

Escobar, J., Randolph, E., Puente, G., Spiwak, F., Asamen, J., Hill, M., & Hough, R. (1983). Post-traumatic stress disorder in Hispanic Vietnam veterans. Clinical phenomenology and sociocultural characteristics. *American Journal of Psychiatry, 142*, 585–596.

Farooq, S., & Fear, C. (2003). Working through interpreters. *Advances in Psychiatric Treatment, 9*, 104–109.

Fisher, M., & Taub, A. (2017, May). How Venezuela went from the richest economy in South America to the brink of financial ruin. *Independent.* Retrieved from https://www.independent.co.uk/news/long_reads/how-venezuela-went-from-the-richest-economy-in-south-america-to-the-brink-of-financial-ruin-a7740616.html

Flaherty, J., Gavirigia, F. M., Pathak, D., Mitchell, T., Wintrob, R., Richman, J., & Birz, S. (1988). Developing instruments for cross-cultural psychiatric research. *Journal of Nervous and Mental Disease, 176*(5), 260–263.

Font, S. A. (2013). Service Referral Patterns among Black and White Families Involved with Child Protective Services. *Journal of Public Child Welfare, 7*(4), 370–391.

Franklin, J. H., & Moss, A. A. (2010). *From Slavery to Freedom: A History of African Americans,* 1st ed. New York: A.A. Knopf, 1947. Last update with Evelyn Brooks Higginbotham, 9th edn. McGraw-Hill Education, 2010.

Frueh, C., Brady, K., & de Arellano, M. (1998). Racial differences in combat-related PTSD: Empirical findings and conceptual issues. *Clinical Psychology Review, 18*(3), 287–305. https://doi.org/10.1016/S0272-7358(97)00087-1

Galea, S., Vlahov, D., Tracy, T., Hoover, D. R., Resnick, H., & Kilpatrick, D. (2004). Hispanic ethnicity and post-traumatic stress disorder after a disaster: Evidence from a general population survey after September 11, 2001. *Annals of Epidemiology, 14*, 520–531.

Garcia-Preto, N. (2005). Latino families: An overview. In G. J. McGoldrick & J. K. Pearce (Eds.), *Ethnicity & family therapy* (3rd ed.). New York, NY: Guilford Press.

Gee, G., Ro, A., Shariff-Marco, S., & Chae, D. (2009). Racial discrimination and health among Asian Americans: Evidence, assessment, and directions for future research. *Epidemiologic Reviews, 31*(1), 130–151.

Geisinger, K. F. (1994). Cross-cultural normative assessment: Translation and adaptation issues influencing the normative interpretation of assessment instruments. *Psychological Assessment, 6*(4), 304–312.

George Washington University (GWU). (2018). *Ascertainment of the Estimated Excess Mortality from Hurricane Maria in Puerto Rico*. In *Retrieved from*. https://prstudy.publichealth.gwu.edu/

Gim, R. H., Atkinson, D. R., & Whiteley, S. (1990). Asian-American acculturation, severity of concerns, and willingness to see a counselor. *Journal of Counseling Psychology, 37*(3), 281–285. https://doi.org/10.1037/0022-0167.37.3.281

Gone, J. P. (2013). Redressing First Nations historical trauma: Theorizing mechanisms for indigenous culture as mental health treatment. *Transcultural Psychiatry, 50*(5), 683–706.

Griner, D., & Smith, T. (2006). Culturally adapted mental health interventions: A meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training, 43*(4), 531–548. https://doi.org/10.1037/0033-3204.43.4.531

Guarnaccia, P. J., Rivera, M., Franco, F., & Neighbors, C. (1996). The experiences of ataques de nervios: Towards an anthropology of emotion in Puerto Rico. *Culture Medicine and Psychiatry, 20*, 343–367.

Guarnaccia, P. J., Martinez, I., & Acosta, H. (2005). Mental health in the Hispanic immigrant community: An overview. *Journal of Immigrant and Refugee Services, 3*(1-2), 21–46. https://doi.org/10.1300/J191v03n01_02

Guarnaccia, P., Lewis-Fernandez, R., Martinez, I., Shrout, P., Guo, J., Torres, M., … Alegria, M. (2010). Ataque de Nervios as a marker of social and psychiatric vulnerability: Results from NLAAS. *International Journal of Social Psychiatry, 56*(3), 298–309. https://doi.org/10.1177/0020764008101636

Gupta, A., Szymanski, D. M., & Leong, F. T. (2011). The "model minority myth": Internalized racialism of positive stereotypes as correlates of psychological distress, and attitudes toward help-seeking. *Asian American Journal of Psychology, 2*(2), 101.

Hardy, K. V. (2013). Healing the hidden wounds of racial trauma. *Reclaiming Children Journal, 22*(1). Retrieved from https://www.marypendergreene.com/bookshelf/docs/Ken_Hardy_Racial_Trauma.pdf

Hinton, D., & Lewis-Fernández, R. (2010). Idioms of distress among trauma survivors: Subtypes and clinical utility. *Cultural Medical Psychiatry, 34*(2), 209–218. https://doi.org/10.1007/s11013-010-9175-x

Hinton, D., Hinton, S., Um, K., Chea, A., & Sak, S. (2002). The Khmer 'weak heart'syndrome: Fear of death from palpitations. *Transcultural Psychiatry, 39*(3), 323–344.

Hinton, D. E., & Good, B. J. (2018). *Culture and PTSD: Trauma in Global and Historical Perspective (The Ethnography of Political Violence)*. Philadelphia: University of Pennsylvania Press.

Hinton, D. E., & Good, B. J. (Eds.). (2015). *Culture and PTSD: Trauma in global and historical perspective*. Philadelphia, PA: University of Pennsylvania Press.

Ho, J. (2008). Community Violence Exposure of Southeast Asian American Adolescents. *Journal of Interpersonal Violence, 23*(1), 136–146.

Hook, J. N., Farrell, J. E., Davis, D. E., DeBlaere, C., Van Tongeren, D. R., & Utsey, S. O. (2016). Cultural humility and racial microaggressions in counseling. *Journal of Counseling Psychology, 63*(3), 269–277. https://doi.org/10.1037/cou0000114

Hough, R., Canino, G., Abueg, F., & Gusman, F. (1996). PTSD and related stress disorders among Hispanics. In A. Marsella, M. Friedman, E. Gerrity, & R. Scurfield (Eds.), *Ethnocultural aspects of posttraumatic stress disorder: Issues, research and clinical applications* (pp. 301–340). Washington, DC: American Psychological Association.

Ima, K., & Hohm, C. (1991). Child maltreatment among Asian and Pacific Islander refugees and immigrants. *Journal of Interpersonal Violence, 6*, 267–285.

Inman, A. G., & Yeh, C. J. (2007). Asian American Stress and Coping. In F. T. L. Leong, A. Ebreo, L. Kinoshita, A. G. Inman, L. H. Yang, & M. Fu (Eds.), *Handbook of Asian American psychology* (pp. 323–339). Inc: Sage Publications.

Institute for Economics and Peace. (2017). *Global peace index*. Retrieved from http://visionofhumanity.org/app/uploads/2017/06/GPI-2017-Report-1.pdf

Interian, A., & Diaz-Martinez, A. M. (2007). Considerations for culturally competent cognitive-behavioral therapy for depression with Hispanic patients. *Cognitive and Behavioral Practice, 14*, 87–97.

Jernigan, M. M. (2009). Using a Sankofa intervention to influence Black girls' racial identity development and school-related experiences. *Dissertation Abstracts International Section A: Humanities and Social Sciences, 70*(2-A), 472.

Jernigan, M. M., & Henderson Daniel, J. (2011). Racial Trauma in the Lives of Black Children and Adolescents: Challenges and Clinical Implications. *Journal of Child & Adolescent Trauma, 4*(2), 123–141.

Jha, A. K., Orav, E. J., & Epstein, A. M. (2011). Low-quality, high-cost hospitals, mainly in south, care for sharply higher shares of elderly black, hispanic, and medicaid patients. *Health Affairs, 30*(10), 1904–1911. https://doi.org/10.1377/hlthaff.2011.0027.

Karasz, A., Raghavan, S., Patel, V., Zaman, M., Akhter, L., & Kabita, M. (2015). ASHA: Using participatory methods to develop an asset-building mental health intervention for Bangladeshi immigrant women. *Progress in Community Health Partnerships: Research, Education, and Action, 9*(4), 501–512.

Keller, A., Leviss, J., Levy, N., & Dyson, D. (2007). *Medical Evaluation and Care for Survivors of Torture/Refugee*. *Trauma.*. Retrieved from https://www.healtorture.org/sites/healtorture.org/files/Medical%20Evaluation%20and%20Care%20forSurvivors%20of%20Torture%20and%20Refugee%20Trauma.pdf

Kendi, I. X. (2016). *Post-Traumatic Slave Syndrome is a Racist Idea*. *Black Perspectives*. Published by AAIHS. Retrieved from https://www.aaihs.org/post-traumatic-slave-syndrome-is-a-racist-idea/

Kenny, M. C., & McEachem, A. G. (2000). Racial, ethnic, and cultural factors of childhood sexual abuse: A selected review of the literature. *Clinical Psychology Review, 20*(7), 905–922.

Khaylis, A., Waelde, L., & Bruce, E. (2007). The Role of Ethnic Identity in the Relationship of Race-Related Stress to PTSD Symptoms Among Young Adults. *Journal of Trauma & Dissociation, 8*(4), 91–105. https://doi.org/10.1300/J229v08n04_06

Kim, S. C. (1985). Family therapy for Asian Americans: A strategic-structural framework. *Psychotherapy: Theory, Research, Practice, Training, 22*(2S), 342–348.

Kinzie, J. D. (1985). Cultural aspects of psychiatric treatment with Indochinese refugees. *American Journal of Social Psychiatry, 5*(1), 47–53.

Kirmayer, L. J. (2001). Cultural variations in the clinical presentation of depression and anxiety: implications for diagnosis and treatment. *Journal of Clinical Psychiatry, 62*(13), 22–30.

Kleinman, A. (1997). Triumph or Pyrrhic Victory? The Inclusion of Culture in DSM-IV. *Harvard Review of Psychiatry, 4*(6), 343–344.

Ku, L., & Flores, G. (2005). Pay now or pay later: Providing interpreter services in health care. *Health Affairs, 24*(2), 435–444. https://doi.org/10.1377/hlthaff.24.2.435

Kulka, R., Schlenger, W., Fairbank, J., Hough, R. L., Jordan, B. K., Marmar, C. R., & Weiss, D. S. (1990). *Trauma and the Vietnam War Generation: Report of findings from the National Vietnam Veterans Readjustment Study*. New York, NY: Brunner/Mazel.

Le Meyer, O., Zane, N., Cho, Y. I., & Takeuchi, D. T. (2009). Use of specialty mental health services by Asian Americans with psychiatric disorders. *Journal of Consulting and Clinical Psychology, 77*(5), 1000.

Leong, F. T., & Lau, A. S. (2001). Barriers to providing effective mental health services to Asian Americans. *Mental Health Services Research, 3*(4), 201–214.

Leong, F. T. L., Wagner, N. S., & Tata, S. P. (1995). Racial and ethnic variations in help-seeking attitudes. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 428–432). Thousand Oaks, CA: Sage.

Lesser, G., & Batalova, J. (2017). Central American immigrants in the United States. *Migration Policy Institute-The Online Journal.* Retrieved from https://www.migrationpolicy.org/article/central-american-immigrants-united-states/

Lewis-Fernández, R., Gorritz, M., Raggio, G. A., Peláez, C., Chen, H., & Guarnaccia, P. J. (2010). Association of Trauma-Related Disorders and Dissociation with Four Idioms of Distress Among Latino Psychiatric Outpatients. *Culture, Medicine, and Psychiatry, 34*(2), 219–243. https://doi.org/10.1007/s11013-010-9177-8

Lewis-Fernandez, R., Turner, J. B., Marshall, R., Turse, N., Neria, Y., & Dohrenwend, B. P. (2008). Elevated rates of current PTSD among Hispanic veterans in the NVVRS: True prevalence or methodological artifact? *Journal of Traumatic Stress, 2*, 123–132.

Lin, K. M. (1983). Hwa-Byung: A Korean culture-bound syndrome? *American Journal of Psychiatry, 140*, 105–107.

Lipowski, Z. J. (1988). Somatization: the concept and its clinical application. *American Journal of Psychiatry, 145*, 1358–1368.

Loo, C., Fairbank, J., Scurfield, R., Ruch, L., King, D., Adams, L., & Chemtob, C. (2001). Measuring exposure to racism: Development and validation of a Race-Related Stressor Scale (RRSS) for Asian American Vietnam Veterans. *Psychological Assessment, 13*(4), 503–520. https://doi.org/10.1037/1040-3590.13.4.503

Loo, C. M., Fairbank, J. A., & Chemtob, C. M. (2005). Adverse race-related events as a risk factor for post-traumatic stress disorder in Asian American Vietnam veterans. *Journal of Nervous Mental Disease, 193*(7), 455–463. https://doi.org/10.1097/01.nmd.0000168239.51714.e6

Lorenzo, M. K., & Adler, D. A. (1984). Mental health services for Chinese in a community health center. *Social Casework, 65*(10), 600–609.

Manly, J. J. (2005). Advantages and Disadvantages of Separate Norms for African Americans. *The Clinical Neuropsychologist, 19*(2), 270–275.

Marsella, A., Friedman, M., & Spain, E. (1996). Ethnocultural aspects of PTSD: An overview of issues and research directions. In A. Marsella, M. Friedman, E. Gerrity, & R. Scurfield (Eds.), *Ethnocultural aspects of posttraumatic stress disorder: Issues, research and clinical applications* (pp. 105–129). Washington, DC: American Psychological Association.

Marshall, G. N., Schell, T. L., Elliott, M. N., Berthold, S. M., & Chun, C.-A. (2005). Mental health of

Cambodian refugees 2 decades after resettlement in the United States. *JAMA: Journal of the American Medical Association, 294*, 571–579. https://doi.org/10.1001/jama.294.5.571

Martinez, R. (1996). Latinos and lethal violence: The impact of poverty and inequality. *Social Problems, 43*(2), 131–146.

Mather, M. (2009). *Reports on America: Children in Immigrant Families Chart New Path*. Washington, DC: Population Reference Bureau.

Matthews, H. F. (1987). Rootwork: Description of an ethnomedical system in the American South. Soirtheru hfedical Joitrno/, SO, 885–889.

Michal, M., Adler, J., Wiltink, J., Reiner, I., Tschan, R., Wölfling, K., … Zwerenz, R. (2016). A case series of 223 patients with depersonalization-derealization syndrome. *BMC Psychiatry, 16*, 1–11. https://doi.org/10.1186/s12888-016-0908-4

Mitrushina, M., Boone, K. B., Razani, J., & D'Elia, L. F. (2005). *Handbook of Normative Data for Neuropsychological Assessment*. Oxford: Oxford University Press.

Mollica, R.F., Caspi-Yavin, Y., Bollini, P., Truong, T., Tor, S., & Lavelle, J. (1992). The Harvard Trauma Questionnaire: Validating a cross-cultural instrument for measuring torture, trauma, and post-traumatic stress disorder in refugees. *Journal of Nervous and Mental Disorders, 180*, 111–116.

National Academies of Sciences, Engineering, and Medicine (NASEM). (2015). *The integration of immigrants into American society*. In Mary C. Waters & Marisa Gerstein Pineau (Eds.), Washington, DC: National Academies Press.

National Child Traumatic Stress Network. (2007). Preliminary adaptations for working with traumatized Latino/Hispanic children and their families. *Culture and Trauma Brief, 2*(3), 1–8.

Nellis, A. (2016). *The color of justice: Racial and ethnic disparity in state prisons*. Washington, DC: The Sentencing Project.

Nicolas, G., Helms, J. E., Jernigan, M. M., Sass, T., Skrzypek, A., & DeSilva, A. M. (2008). A conceptual framework for understanding the strengths of black youths. *Journal of Black Psychology, 34*, 261–280.

Nishio, K., & Blimes, M. (1978). Psychotherapy with Southeast Asian American clients. *Professional Psychology: Research and Practice, 18*, 342–346.

Nogueira, B. L., De Jesus Mari, J., & Razzouk, D. (2015). Cultural -bound syndromes in Spanish speaking Latin America: The case of Nervios, Susto and Ataque de Nervios. *Archives of Clinical Psychiatry, 42*(6).

Norris, F., Perilla, J., & Murphy, A. (2001). Postdisaster stress in the United States and Mexico: A cross-cultural test of the multicriterion conceptual model of posttraumatic stress disorder. *Journal of Abnormal Psychology, 110*, 553–563.

Oppedal, B., Røysamb, E., & Heyerdahl, S. (2005). Ethnic group, acculturation, and psychiatric problems in young immigrants. *Journal of Child Psychology and Psychiatry, 46*(6), 646–660.

Orozco, E., Chin, E., Restrepo, A., & Tamayo, M. (2001). Transcending barriers: Implementing a culturally sensitive assessment with Latinos. *New Jersey Advisor, 6*, 3–8.

Ortega, A., & Rosenheck, R. (2000). Posttraumatic stress disorder among Hispanic Vietnam veterans. *The American Journal of Psychiatry, 157*(4), 615–619.

Paniagua, F. A. (1994). *Assessing and treating culturally diverse clients A practical guide*. Thousand Oaks, CA: Sage.

Park, Y. S., & Kim, B. S. (2008). Asian and European American cultural values and communication styles among Asian American and European American college students. *Cultural Diversity and Ethnic Minority Psychology, 14*(1), 47.

Perreira, K. M., & Ornelas, I. (2013). Painful Passages: Traumatic Experiences and Post-Traumatic Stress among Immigrant Latino Adolescents and their Primary Caregivers. *The International Migration Review, 47* (4), 10.1111/imre.12050. https://doi.org/10.1111/imre.12050

Pew Research Center. (2016). *Roughly half of Hispanics have experienced discrimination*. Retrieved from https://www.pewresearch.org/fact-tank/2016/06/29/roughly-half-of-hispanics-have-experienced-discrimination/

Pew Research Center. (2017). *Facts on US Immigrants, 2017* [Data file and code book]. Retrieved from http://www.pewresearch.org

Pole, N., Best, S. R., Metzler, T., & Marmar, C. R. (2005). Why Are Hispanics at Greater Risk for PTSD? *Cultural Diversity and Ethnic Minority Psychology, 11*(2), 144–161.

Pole, N., Best, S., Metzler, T., & Marmar, C. (2005). Why are Hispanics at greater risk for PTSD? *Culture, Ethnicity and Minority Psychology, 11*(2), 144–161.

Pole, N., Best, S., Weiss, D., Metzler, T., Ligerman, A., Fagan, J., & Marmar, C. (2001). Effects of gender and ethnicity on duty-related posttraumatic stress symptoms among urban police officers. *Journal of Nervous and Mental Disease, 189*, 442–448.

Pole, N., Gone, J., & Kulkarni, M. (2008). Posttraumatic Stress Disorder among Ethnoracial Minorities in the United States. *Clinical Psychology: Science and Practice, 15*, 35–61.

Prado-Perez, R. E. (2018). Web of Violence in Central America's Northern Triangle and the Maras. *Sociológica, 33*(93), 213–246.

Pribilsky, J. (2001). Nervios and `Modern Childhood': Migration and Shifting Contexts of Child Life in the Ecuadorian Andes. *Childhood, 8*(2), 251–273. https://doi.org/10.1177/0907568201008002007

Putnam-Hornstein, E., Needell, B., King, B., & Johnson-Motoyama (2013). Race, poverty, and maternal nativity: an examination of risk and protective factors for involvement with child protective services. *Child Abuse & Neglect, 37*(1–3), 33–46.

Qin, D. B., Way, N., & Mukherjee, P. (2008). The other side of the model minority story: The familial and peer challenges faced by Chinese American adolescents. *Youth & Society, 39*(4), 480–506.

Radloff, L. S. (1977). The CES-D scale: a self-report depression scale for research in the general population. *Applied Psychological Measurement, 1*, 385–401.

Raghavan, S. S. (2018). Cultural considerations in the assessment of survivors of torture. *Journal of Immigrant and Minority Health*, 1–10.

Reardon, S., Fox, L., & Townshend, J. (2015). Neighborhood Income Composition by Household Race and Income, 1990–2009. *Annals of the American Academy of Political and Social Science, 660*, 78–97. https://doi.org/10.1177/0002716215576104

Rhoades, G. F., Jr., & Sar, V. (Eds.). (2005). *Trauma and dissociation in a cross-cultural perspective: Not just a north American phenomenon*. Binghamton, NY: Haworth Press.

Ridley, C., Tracy, M., Pruitt-Stephens, L., Wimsatt, M., & Beard, J. (2008). Multicultural assessment validity: The preeminent ethical issue in psychological assessment. In L. Suzuki & J. Ponterotto (Eds.), *Handbook of multicultural assessment: Clinical, psychological and educational applications* (pp. 22–33). San Francisco, CA: John Wiley & Sons.

Ritsner, M., Ponizovsky, A., Kurs, R., & Modai, I. (2000). Somatization in an immigrant population in Israel: A community survey of prevalence, risk factors, and help-seeking behavior. *American Journal of Psychiatry, 157*, 385–392.

Roberts, A. L., Gilman, S. E., Breslau, J., Breslau, N., & Koenen, K. C. (2011). Race/ethnic differences in exposure to traumatic events, development of post-traumatic stress disorder, and treatment-seeking for post-traumatic stress disorder in the United States. *Psychological Medicine, 41*, 71–83.

Ruef, A., Litz, B., & Schlenger, W. (2000). Hispanic ethnicity and risk for combat-related posttraumatic stress disorder. *Cultural Diversity and Ethnic Minority Psychology, 6*(3), 235–251. https://doi.org/10.1037/1099-9809.6.3.235

Santa-Maria, M. L., & Cornille, T. (2007). Traumatic stress, family separations, and attachment among Latin American immigrants. *Traumatology, 13*(2), 26–31.

Schechter, D. S., Marshall, R., Salman, E., Goetz, D., Davies, S., & Liebowitz, M. R. (2000). Ataque de nervios and history of childhood trauma. *Journal of Traumatic Stress, 13*, 529–534.

Schell, T., & Marshall, G. (2008). Survey of individuals previously deployed for OEF/OIF. In T. Taniellian & L. Jaycox (Eds.), *Invisible wounds of war: Psychological and cognitive injuries, their consequences, and services to assist recovery* (pp. 87–115). Santa Monica, CA: The RAND Corporation.

Schhneider, B., Martinez, S., & Ownes, A. (2006). Barriers to educational opportunities for hispanics in the United States. In M, Tienda & F, Mitchell (Eds.), *National Research Council (US) Panel on Hispanics in the United States. Hispanics and the Future of America*. Washington, DC: National Academies Press (US). Available from: https://www.ncbi.nlm.nih.gov/books/NBK19909/

Seaton, E. K., Caldwell, C. H., Sellers, R. M., & Jackson, J. S. (2008). The prevalence of perceived discrimination among African American and Caribbean Black youth. *Developmental Psychology, 44*(5), 1288–1297. https://doi.org/10.1037/a0012747

Shihadeh, E. S., & Flynn, N. (1996). Segregation and Black urban homicide. *Social Forces, 74*, 1325–1352.

Silove, D. (1999). The psychosocial effects of torture, mass human rights violations and refugee trauma: towards an integrated conceptual framework. *Journal Nervous Mental Disease., 187*, 200–207. https://doi.org/10.1097/00005053-199904000-00002

Silove, D., Momartin, S., Marnane, C., Steel, Z., & Manicavasagar, V. (2010). *Adult separation anxiety disorder among war-affected Bosnian refugees: Comorbidity with PTSD and associations with dimensions of trauma. Journal of Traumatic Stress, 23*(1), 169–172. https://doi.org/10.1002/jts.20490

Smith, T. B., Domenech Rodríguez, M., & Bernal, G. (2011). Culture. *Journal of Clinical Psychology, 67*, 166–175. https://doi.org/10.1002/jclp.20757

Smith, H., & Keller, A. (2007). The context in which treatment takes place: The multi-faceted stressors facing survivors of torture and refugee trauma. In Smith, Keller and Lhewa (Eds.) "… *Like a Refugee Camp on First Avenue": Insights and Experiences from the Bellevue/NYU Program for Survivors of Torture* (pp. 1-37). New York, NY: The Jacob and Valeria Langeloth Foundation.

Steel, Z., Chey, T., Silove, D., Marnane, C., Bryant, R., & van Ommeren, M. (2009). Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: a systematic review and meta-analysis. *JAMA, 302*(5), 537–549. https://doi.org/10.1001/jama.2009.1132

Stepler, R. (2016). *Hispanic, black parents see college degree as key for children's success.*. Pew Research Center. https://www.pewresearch.org/fact-tank/2016/02/24/hispanic-black-parents-see-college-degree-as-key-for-childrens-success/

Sue, S. (1977). Community mental health services to minority groups: Some optimism, some pessimism. *American Psychologist, 32*(8), 616–624.

Sue, S., Cheng, J. K. Y., Saad, C. S., & Chu, J. P. (2012). Asian American mental health: A call to action. *American Psychologist, 67*(7), 532.

Sue, S., & Morishima, J. K. (1982). *The mental health of Asian-Americans*. San Francisco: Jossey-Bass.

Sue, S., Zane, N., & Young, K. (1994). Research on psychotherapy with culturally diverse populations. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (p. 783–817). John Wiley & Sons.

Summerfield, D. (2005). What exactly is emergency or disaster" mental health"? *Bulletin of the World Health Organization, 83*(1), 76–77.

Tabora, B. L., & Flaskerud, J. H. (1997). Mental health beliefs, practices, and knowledge of Chinese American

immigrant women. *Issues in Mental Health Nursing, 18*(3), 173–189.

Tafur, M. M., Crowe, T. K., & Torres, E. (2009). A review of curanderismo and healing practices among Mexicans and Mexican Americans. *Occupational Therapy International, 16*(1), 82–88. https://doi.org/10.1002/oti.265

Tanaka-Matsumi, J., Seiden, D. Y., & Lam, K. N. (1996). The Culturally Informed Functional Assessment (CIFA) Interview: A strategy for cross-cultural behavioral practice. *Cognitive and Behavioral Practice, 3*(2), 215–233.

Tao, K. W., Owen, J., Pace, B. T., & Imel, Z. E. (2015). A meta-analysis of multicultural competencies and psychotherapy process and outcome. *Journal of Counseling Psychology, 62*, 337–350. https://doi.org/10.1037/cou0000086

Taylor, P., Lopez, M. H., Martinez, J., & Velasco, G. (2012). *When Labels Don't Fit: Hispanics and Their Views of Identity*. Pew Research Center: Hispanic Trends. Retrieved from https://www.pewresearch.org/hispanic/2012/04/04/when-labels-dont-fit-hispanics-and-their-views-of-identity/

Torres, A., & Maldonado, M. (2017). Tools for Treating Trauma-Related Disorders Among Latinos. In L. Benuto (Ed), *Toolkit for Counseling Spanish-Speaking Clients.* Springer Publishing Company: NY. https://doi.org/10.1007/978-3-319-64880-4_3

Torres, A., & Mercedes, E. (2018, October). *Immigration-related psychological assessments: Improving practice by increasing knowledge.* Workshop presentation at the National Latinx Psychological Association, San Diego, CA.

Triandis, H. C. (1972). *The Analysis of Subjective Culture*. New York: Wiley.

Triandis, H. (1988). Collectivism v. individualism: A reconceptualisation of a basic concept in cross-cultural social psychology. In *Cross-cultural studies of personality, attitudes and cognition* (pp. 60–95). London: Palgrave Macmillan.

Udomratn, P. (2009). Mental health and the psychosocial consequences of natural disasters in Asia. *International Review of Psychiatry, 20*(5), 441–444.

Umbert, J. (2018). *Natural Disasters in Latin America: A Look Back at, 2017*. Retrieved from https://www.jdsupra.com/legalnews/natural-disasters-in-latin-america-a-90712/

U.S. Census Bureau. (2016). *American Community Survey*. Retrieved from https://www.census.gov/acs/www/data/data-tables-and-tools/data-profiles/2016/

Weeks, A., Swerissen, H., & Belfrage, J. (2007). Issues, challenges, and solutions in translating study instruments. *Evaluation Review, 31*(2), 153–165.

Weiss, N. H., Dixon-Gordon, K. L., Duke, A. A., & Sullivan, T. P. (2015). The underlying role of posttraumatic stress disorder symptoms in the association between intimate partner violence and deliberate self-harm among African American women. *Comprehensive Psychiatry, 59*, 8–16.

Williams, D. R., & Williams-Morris, R. (2000). Racism and Mental Health: The African American Experience. *Ethnicity and Health, 5*(3-4), 243–268.

Yeh, C. J., Nguyen, W., & Lizarraga, Y. N. (2014). Assessing Culture-Bound Syndromes Among Asian-Americans. In L. Benuto, N. Thaler, & B. Leany (Eds.), *Guide to Psychological Assessment with Asians*. New York, NY: Springer. https://doi.org/10.1007/978-J-4939-0796-0_18.

Yule, W. (2001). Posttraumatic stress disorder in the general population and in children. *Journal Clinical Psychiatry, 62*(17), 23–28.

Zane, N., & Sue, S. (1991). Culturally respective mental health services for Asian Americans: Treatment and training issues. In H. Myers, P. Wohlford, P. Guzman, & R. Echemendia (Eds.), *Ethnic minority perspectives on clinical training and services in psychology* (pp. 49–58). Washington, DC: American Psychological Association.