FROM A CLINICIAN’S PERSPECTIVE: THE INTERNALIZED IDENTIFICATION AND
MENTALIZATION OF CULTURAL TRAUMA ON THE INTERNAL WORKING MODEL
OF AFRICAN AMERICAN CLIENTS

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Abstract

Introduction

To understand the relationship between Blacks and psychopathology, we must establish the historical contributors that impacted the psychological, emotional, and physiological un-wellness of people of color in America. Historically, the default perspective by which practitioners engaged clients has been from the clinical discourse of the dominant culture. The violence of cultural trauma has a much more collective effect, fracturing the beliefs of an entire population. Although growing research confirms the importance of including culture in assessments and treatment of Black/African American clients, research has not considered assessing and treating the impact the culture-based trauma has on the internal working model (IWM) of African American clients. This dissertation seeks to fill the gap in research by using a theoretical approach to explore clinicians’ ability to engage in culturally sensitive attachment work by exploring the perspectives of clinicians who treat African American clients. Hence exploring whether clinicians are integrating cultural trauma (CT) in their assessments, investigations of the clients’ internal working models and integrating CT in their interventions/treatment.

Methods

Recruitment for this study began with purposive sampling and progressed in recruiting additional participants through snowball sampling strategies of participants who meet the inclusion criteria. Clinicians were recruited through dissemination requests of targeted professional clinicians, including licensed social workers, professional counselors, marriage and family therapists, or any licensed/master’s level or higher degree mental health professional. Once the interviews were completed, the strategy moving forward consisted of the following: transcription, cleaning, organizing, and coding. To enhance rigor this researcher utilized peer debriefing and support through regularly engaging in debriefings with qualitatively experienced and tenured professors at the University of Pennsylvania School of Social Policy and Practice as well as fellow research students. Additional rigor strategies employed were auditing trails by documenting and maintaining memos throughout this process. The final rigor strategy utilized was member check-in, which was used on an as-needed basis when additional clarifications and/or follow-up to an interview were needed.

Findings

Collectively, 12 themes emerged from all three research questions. The following themes emerged from research question one: (1) connecting community cultural trauma and triggers; (2) analyzing individualist versus collectivist perspectives; (3) exploring feelings of hope or despair; and (4) identifying attachment connections. Research question two: (1) examining the internalization of trauma; (2) investigating messaging and influencers of internal models; and (3) integrating community and generational/intergenerational patterns. Research question three: (1) understanding attachment patterns; (2) exploring connections and baselines surrounding cultural traumas; (3) embracing community alignment and collective survivalism; (4) examining the
clinician’s self-awareness and use of self; and (5) integrating and utilizing practice models in therapy.

Discussion

Two essential factors emerged from the data relating to the inclusion of cultural trauma in assessments when treating African American clients: (1) assess how the client identifies their cultural community membership; and (2) establish how the client differentiates trauma. Regarding the exploration and investigation of CT’s impact on the internal working model, clinicians consider the client’s presentation of the conscious and unconscious internalization of historical and intergenerational traumas, as the data revealed there is an impact of external messaging on the internal working model of the client. Finally, this research uncovered that most participants identify the relevance of Attachment Theory in their assessing, interpreting, and intervention with their clients. A salient discovery and significant theme surrounds participants, identified as African American/Black, regarding their personal discovery and their clients’ individual discovery of making the connection with their self-awareness and shared community membership.
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Dedication

This dissertation is dedicated to my angels no longer with us, Samuel McFarlane, Lorna McFarlane, Florene Knibbs, and Camell Windley-Ginn.

And to the ancestors who paved the way for this honor. It is on the backs of so many that I stand. Without their sacrifice, this would not be possible.

I AM GRATEFUL!

DWENNIMMEN

(humility together with strength)
CHAPTER ONE: INTRODUCTION AND PURPOSE OF STUDY

Introduction and Purpose of Study

“Eight minutes and 46 seconds” became the rallying cry for justice and equality, a symbolic representation and a reminder of the racial and ethnic disparity that continues to exist in the United States of America. On May 25th, 2020, an African American man named George Floyd was murdered in broad daylight by a Minnesota police officer. The cause of his murder, many would say, was that Mr. Floyd was profiled, targeted, and then murdered for simply being “black.” Others may identify this as a modern-day lynching, replacing the rope with handcuffs and using their police badges as justification, legalizing the psychological oppression of people of color (Powell, 2018). In the days that followed Mr. Floyd’s murder, many individuals found themselves overwhelmed with emotions and possibly even found themselves confused, both adults and children hyper-focused on questions about equality, diversity, and a history of exclusion. Mr. Floyd was a regular person before May 25th, 2020; however, from that day forward, he became the name and face of a modern-day movement that motivated thousands of protesters and activists. Individuals around the globe stood in solidarity against institutions, systems, and practices that represented the residuals of the Jim Crow laws, white supremacy, oppression, marginalization, and violence against individuals motivated by skin color.

Woefully, the United States of America’s history is one of culture and color-based violence, a history that continues to haunt its present and future. A history longed to be forgotten but which lingers on like ghosts in the nursery of a traumatized child. America is like that child, “burdened by the oppressive past of [their] parents… [who are] condemned to repeat the tragedy of [their] childhood” (Fraiberg et al., 1975, p. 388). From Slavery to Jim Crow to police brutality, violence against people based on their culture or skin color has been a festering wound
in need of intense treatment but ignored because acknowledgment equates to validation (Powell, 2018; Talley, 2018; Wilkins et al., 2012; Eyerman, 2001). Therefore, a history written by the dominant culture controls the narrative and the record of what and how historical information is articulated, documented, and ultimately “remembered.”

Consequently, an inaccurately articulated history will impact the intergenerational transmission of information and misinformation (Blackburn, 2013), which eventually proffers inaccuracies in societal responses. Historically, identifying the supremacy of one culture over another led to the abuse, oppression, and marginalization of another, resulting in mass traumatic events such as Slavery (Graff, 2014). America’s efforts to articulate a history absent the acknowledgment and/or inclusion of the historical and residual effects of Slavery (Eyerman, 2001) would be to deny the very foundation that allowed for their extraordinary expansion toward becoming such an advanced nation (Graff, 2014). Contrarily, creating an illusion of Slavery as a movement of benevolence is injustice.

Intentionally forgetting history is to subsequently deny reality! The “refusal to remember, denial, disassociation, and disavowal are echoed in the absence of Slavery from the trauma literature and, until recently, from psychoanalytic literature” (Graff, 2014, p. 183). “Trauma literature gives attention to the Holocaust, floods, earthquakes, sexual abuse, rape, etc. but not to slavery” (Graff, 2014, p. 183), nor to the residuals of Slavery, as well as present-day culture/race-related cruelties. It is malpractice to ignore or fail to consider how our history affects our present-day experiences; trauma based on culture and race should be introduced and explored during assessing and treating clients of color, especially those of African American descent (Powell, 2018; Wilkins et al., 2013).
Historically, the default perspective by which practitioners engage with clients has been based on the discourse of the dominant culture. Dating back to the early pioneers of psychoanalysis, the theories, interventions, and treatment modalities were developed from the dominant culture’s perspective to treat the needs and further the agendas of the dominant culture (Powell, 2018; Salberg, 2019; Graff, 2014; Wilkins et al., 2012). In *Black Skin, White Masks*, Frantz Fanon concentrated on the extensive impact of colonialism on the Antillean people, more specifically, the French Martinique island (2008). Although his writing and research focused on the Martinican people, his theory and philosophy aligned with colonialism’s influences on the African American experience in the United States of America. Fanon argued that there remains an assigned historical relationship between psychopathology and the Negro person designed and perpetuated by the dominant culture. Confronting the absence of the Negro in early psychoanalytic investigation and literature, he highlights psychoanalytic pioneers such as Freud, Adler, and Jung’s intentionality in excluding “the Negro in all their investigations” (2008, p. 117).

Yet, in modern-day psychoanalysis, theories and treatment models designed by the aforementioned psychoanalyst are relevant and fundamental in practice, even when treating Negro’s/people of color, despite the Negro’s absence in the investigation, design, and literature. Fanon speaks to the correlation between colonialism and the psychopathology of the Negro (2008). He conceptualized that psychopathology, as it pertained to “negro”/person of color, was often riddled with fallacies, falsehoods, myths, and mischaracterizations, used by the dominant culture to establish dominance and superiority over another (Fanon, 2008).

Consequently, the reality is that psychoanalysis for African American individuals may have been perceived as unnecessary and/or irrelevant based on race, cultural assumptions, and
stereotypes (Powell, 2018). Contrarily, African Americans had no valid reason to trust the treatment offered by providers of the dominant race, having had a 400+ year history of being perceived and treated inferiorly, demeaned, and physically and psychologically dominated (Powell, 2018; Davey & Watson, 2008). Furthermore, the distrust of healthcare and treatment systems offered by the dominant culture reflects a 40-year legacy of deceit and abuse experienced by the African American airmen in the Tuskegee syphilis study from 1932 to 1972 (Davey & Watson, 2008). Therefore, clinicians should challenge the alleged cultural sensitivity and universality of theoretical frameworks and interventions influenced by the eco-socio-political ideology (Davey & Watson, 2008).

Although growing research confirms the importance of including culture in assessments and treatment of Black/African American clients, research has not considered assessing and treating the impact cultural trauma has on the internal working model (IWM) that impacts the attachment of said client. According to the pioneers of attachment theory, early attachment relationships are foundational and fundamental for relationships over the individual’s life span (Bowlby, 1969; Ainsworth, 1989; Magai et al., 2001). Furthermore, these early attachment connections with parents/caregivers are intricate as they “function as the mode of transmission [of trauma] in most if not all transgenerational transmission circumstances” (Salberg, 2019, p. 570).

Since attachment could be considered the oxygen of relationships and is necessary to feel safe, loved, and learn how to connect with others (Salberg, 2019), if said oxygen is then contaminated by cultural trauma, what is that client’s orientation of safety, feeling loved, and connection with others? For decades, research and literature have explored the impact of the Holocaust, mass violence, assassinations, pandemics, and genocides, along with the
psychological sequelae, all from a European context. However, the least explored atrocity has been Slavery and the psychic impact on the psychological well-being of the American population (Powell, 2018).

“The violence of trauma fractures [the individuals] experience of being in the world and pulls at the fabric of attachment, our intrinsic way of feeling safe” (Salberg, 2019); the violence of cultural trauma has a much more collective effect, fracturing the beliefs of an entire population. Safety no longer feels like an option when your color or culture triggers targeted violence, discrimination, or oppression. Therefore, it is the clinician’s responsibility to be attuned to cultural trauma’s collective tragedy in order to engage in effective treatment.

“Knowing the world” requires “identification,” which speaks to self-value, positions, and relationships. “Changing the world” requires “understanding,” which speaks to knowledge, power, and influence; however, both knowing and changing requires a connection between language, perspective, and messaging (Fanon, 1952). In his book, Black Skin, White Masks, Fanon posits that “What matters is not to know the world but to change it” (Fanon, 1952, p. 8). However, for clients of color, knowing and changing requires identifying positionality within their minds, community, and the world. Therefore, the clinician of an African American client must assist that client in “identifying and understanding” to help that client “change effectively.”

Empirical research has demonstrated that significant barriers contribute to African American clients’ decisions concerning the utilization of mental health services. The most common barrier identified in many studies is “stigma” (Alvidrez et al., 2010; Murry et al., 2011; Planey et al., 2019; Thurston & Phares, 2008; Alang, 2015). However, research has not examined the connections between these barriers and silent contributors, such as historical factors contributing to the influences of the client’s inner working model (IWM) of attachment
theory and its impact on their perception of self, others, and the world. This research aims to assess the clinician’s ability to engage in culturally sensitive attachment work by exploring the perspectives of clinicians who treat African American clients. Hence this dissertation will explore whether clinicians include cultural trauma as a contributing factor in assessing the client’s IWM.
CHAPTER TWO: LITERATURE REVIEW

African American Mental Health

The Psychology of Slavery and Historical Underpinnings

To understand the relationship between Blacks and psychopathology, we must establish the historical contributors that impacted the psychological, emotional, and physiological un-wellness of people of color in America. To accomplish such an understanding, one must examine the history of enslaved Africans dating back to the 1400s, when the first enslaved people were bought by Portuguese traders (Blackburn, 2011, 2013). During this period, Slavery within African countries was considered standard practice resulting from wars. Typically, the dominant African kingdom would often enslave its captives following the successful conquest of another African kingdom. In these instances, enslavement was seen as a “stain, but one that could sometimes be gradually washed away by lengthy service” (Blackburn, 2011, 2013, p. 83). Often, enslaved persons could engage in some redemptive role that allowed them the prospect of earning freedom and a place in their new society. For example, enslaved men could serve in the militia, and enslaved women could gain freedom by becoming the king’s concubine and/or bearing children for that royal (Blackburn, 2011, 2013).

With the French, English, and Spanish advancing sea travel during the 1400s, enslaved people became a respected commodity for trading, to the extent that “Portuguese captains who

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1 Enslaved – this word shall be used throughout this research when referencing individuals who were taken from their lands and placed into bondage, whose family, culture, and dignity were devalued and decimated. This research will honor the humanity and dignity of a person who experienced such great loss and pain. Outside of a direct quote, used for historical context, this research will honor the legacy of our ancestors, by referring to them as “enslaved” people, not as “slaves.”

2 Slavery – typical linguistic discourse calls for this word to be written in “lower case” letters which raises further questions surrounding the systemic and systematic impact of colonialism on how events concerning people of color are categorized and identified. In this research Slavery will consistently be identified and reflected upon as a period/event as clarified by owl.purdue.edu. Therefore the “S” will consistently be capitalized to honor the significance of this period/event in our history.
initiated the African coastal trade in the 1440s and 1450s treated the African kingdoms with respect. In addition, Portuguese officials encouraged the kings of the Kongo to convert to Catholicism and even arranged marital alliances between the royal families of Portugal and the Kongo” (Blackburn, 2011, 2013, p. 82). However, upon the entry of the 17th century came the introduction of a more violent and hostile trading period with other European countries who were no longer interested in mutual respect of African Kingdoms but sought to pillage and plunder, seeking to rule and dominate African people for eternity.

Over the years, slave trading became a significant part of the capitalistic society of the English, French, and Spaniards. According to Robin Blackburn (2011, 2013), by 1600, approximately half of the populations in three major cities in Mexico had enslaved Africans or free people of African descent. Blackburn also noted that enslaved Africans in the French and Spanish colonies were often allowed to buy their freedom and live within those societies as “free” individuals, free from turmoil and harassment, unlike the enslaved Africans in the “new world” of the United States of America.

Blackburn suggests further that the industrialization and the commercialization of the United States of America were heavily hinged on enslaved people and slave labor. By the turn of the 17th century, America saw a significant increase in commodity trades. The country’s exports had expanded to account for approximately a third to a half of the “leading Atlantic states,” solely produced from slave labor (Blackburn, 2011, 2013, p. 99). America found itself with an emerging economy rising to become an advanced formidable capitalistic society resulting from enslaved Africans’ free labor. These human beings were bred like animals to serve a country that saw the conceptualized value of their existence as its commodity. By the close of the 17th
century, Slavery became a perpetuation of turmoil, terror, and trauma and a standing historical factor for people of color in the United States.

Examining the period between the 1400s and 1700s provides essential information in understanding the purpose and rationale behind the psychology of Slavery and the pathologizing of enslaved and black people. However, establishing this understanding requires a shift in the conversation, bringing attention to the proposed psychology that rationalized the institution of Slavery. The much-debated letter of “Willie Lynch” introduces the ideology surrounding psychological control to ensure enslaved Africans remained afraid and distrusting, reinforcing their dependence on enslavers. Although the legitimacy of the “Willie Lynch Letter” and the existence of Willie Lynch himself as a figure in the 1700s is heavily debated among scholars, the argument presented within this work maintains validity when seeking an explanation for the years of psychological bondage endured by enslaved Africans and the residual effects seen hundreds of years later (Lynch, 2011).

In comparison to the Holocaust, it is said that Adolf Hitler’s intention was centered around destroying the Jewish nation; he focused his efforts on eliminating them by destroying their “physical bodies” but leaving the mind of his captives intact (Graff, 2014; Powell, 2018). The approach and efforts applied during the Holocaust to enslaved Africans were reversed; these oppressors intended to maintain the “physical bodies” but focused on destroying the collective minds of their captives to maintain Slavery in perpetuity. Therefore, when identifying the most atrocious remembrances of the worst of slave trading in America, it is essential to understand the intentionality of the slave traders and those who sought to maintain “power over” another culture of people.
In his seminal work, *Breaking the Chains of Psychological Slavery*, Na’im Akbar theorizes that despite the dominant cultural discourse toward erasing or denying the atrocities of Slavery, the pervasiveness of Slavery’s negative impact on the psychology of African American people cannot be constrained (1996, reprinted 2019). In his writing, Akbar introduces the concept of “slavery-based” behaviors and explores the prevalence of the impact of historical trauma on the collective minds of African American people (Akbar, 1996), which continues to prevail even in our modern-day 21st-century society. Identifying the worst form of Slavery, Akbar says that chattel Slavery resulted in “slavery that captures the mind and imprisons the motivation, perception, aspiration, and identity in a web of anti-self-images, generating a personal and collective self-destruction” (Akbar, 1996, p. v).

Enslaved Africans and their descendants were challenged by the intent of the dominant discourse to pathologize enslaved people to justify Slavery in early America. Often introduced were deceptive scientific characterizations of enslaved people. For example, a common diagnosis used to justify the harsh punishment of enslaved people seeking freedom was drapetomania, a form of mania that affected enslaved people only. Drapetomania was described as a disease manifested in enslaved people who experience the uncontrollable impulse/desire for freedom and/or attempts to wander or run away from their white enslavers (Coleman, 2015; Jackson, 2006). United States physician Samuel Adolphus Cartwright coined this distorted disorder in 1851 (Cartwright, 1851; Coleman, 2015; Jackson, 2006). This same American physician also coined the term dysaesthesia aethiopica concerning the general “condition” of the Negro, and often concerning the behaviors of the freed black person. Dysaesthesia aethiopica, also known as “rascality,” is a disorder used during the 19th century to characterize freed blacks and to justify the need for enslavement. The symptoms of dysaesthesia aethiopica portrayed an image of blacks
as mischievous and unintelligent (stupid/insensible) people, often engaging in destructive behaviors such as abuse of animals, stealing, and destroying their and others’ property (Cartwright, 1851; Jackson, 2006). Cartwright provided a fundamental understanding of the attempts to politicize the mental health field through social pathology. His efforts provided pseudoscientific justification for the furtherance of Slavery in the colonial south. Either freed or enslaved, African Americans were diseased, and the only treatment was enslavement, and preventative measures of violence were often referred to as “whipping the devil out of them” (Cartwright, 1851).

The Psychology of Oppression

According to Franz Fanon, oppressive psychology provides validation and agency to the pathologizing of people of color. Pathologizing “blackness,” which began during Slavery, proved to be an effective method of oppression, by which both the oppressed and the oppressor are persuaded to believe in the cathartic depictions of people of color, told in the childhood stories “written for white children, [where] characters symbolizing evil and fear representing” blackness (Butts, 1979, p. 1016); thus, the social construct of “blackness” established by the dominant discourse created a chasm between black/evil and white/good (Butts, 1979). Established by the dominant culture, this pathogenic process begins what Elaine Pinderhughes (1990) identifies as the Bowenian “societal projection process.” According to Pinderhughes (1990), this process elicits a societal group’s perception of their superiority over another group; this “superior” group is considered the “benefactors.” Once the identified benefactors establish their dominance, they then perceive and treat the other group as inferior and incompetent. “Through the use of projection upon the victims, the benefactors are [then] able to relieve tension and reduce anxiety [with]in themselves” (Pinderhughes, 1990, p. 292). Pinderhughes (1990) further espouses that
Bowen’s theory specifically identified victims of this “societal projection process” as being minority people, the poor, criminals, and those who are pathologized psychologically or medically.

As previously mentioned, the pathologizing of blackness had been used to oppress people of color long before Elaine Pinderhughes, Franz Fanon, and even Maurice Bowen. However, profound is the labeling, teaching, and practice of what Franz Fanon became uncomfortably acquainted with during medical school at Lyon, “medical racism,” referred to by professors as “culture-bound syndromes” (Fanon, 1952; Keller, 2007). “Culture-bound syndrome was referenced to be a “vague, generalized malaise;” a term used to categorize rare, exotic, unpredictable, and chaotic behaviors of uncivilized people (Keller, 2007; Ventriglio et al., 2015).

Therefore, categorizations such as this codify the perpetuations surrounding the sexuality of people of color, as discussed by Fanon (1952) in his writing *Black Skin, White Masks* which furthered the justification of seeing blacks as non-human. The furtherance of these and other similar theories resulted in the oversexualized perceptions of black males and females, which later became a justification for dominating, humiliating, and murdering people of color (Butts, 1979; Fanon, 1952), often exhibited in the intentional genital mutilation during the lynchings of the Jim Crow era (Powell, 2018).

Historically, culture-bound syndrome, whether identified as such or not, played a significant role in the systemic and systematic mistreatment, misdiagnosis, marginalization, and oppression of people of color within the medical and mental health professions (Butts, 1979; Fanon, 1952; Hannah-Jones, 2021; Keller, 2007; Powell, 2018; Robcis, 2020, 2021). Yet, the effects of culture-bound syndrome continue to find its place in present-day healthcare, as
evidenced in the many stories of racial disparities during the COVID-19 pandemic (Hannah-Jones, 2021).

Therefore, the significance of understanding the psychology of oppression is realized when society is confronted with the horror of colonialism and Slavery and its impact on the minds of not only the enslaved Africans, reaching through generations of descendants to modern-day African American communities, but also those of the oppressors, seeking to rationalize or justify generations of torture and atrocities, by the application of false characterizations and misdiagnosis (Eyerman, 2008).

**Barriers in Treatment**

Over the past decade, research has suggested that African Americans have demonstrated some of the most significant cases in need of treatment; however, they engage and/or complete services at a significantly lower rate than their white counterparts. Additionally, their follow-through when seeking health services is disproportionately lower than their Caucasian American counterparts (Burkett, 2017). Research further suggests that barriers and the lack of consistent facilitators contribute to the decreased engagement of blacks in mental health treatment. According to Planey et al. (2019), “barriers” are identified as “reasons or obstacles that prevent individuals from seeking, obtaining, or completing mental health treatment” (p. 191). On the other hand, Planey et al. (2019) further identify “facilitators” as “factors that make the process of seeking, obtaining, or completing mental health treatment easier or more likely” (p. 191). According to the Substance Abuse and Mental Health Services Administration (SAMHSA), commonly identified barriers to treatment within minority groups across sociodemographic are cost/affordability, stigma, minimization of symptoms or low perceived need, low perceived effectiveness of treatment, and structural barriers (Alang, 2015; SAMHSA, 2013). In a
systematic review of 44 studies, Reardon et al. (2017) suggest that common barriers/facilitators that are consistent despite culture, race, or region of the world are consistently identified as: “systematic/structural issues; views and attitudes towards services and treatment; knowledge and understanding of mental health problems and the help-seeking process; and family circumstances” (Reardon et al., 2017, p. 623). Further, Reardon et al.’s (2017) research evaluated studies conducted in the United States, Canada, China, New Zealand, and Australia but did not include barriers resulting from socioeconomic impacts. Despite the perceived universality of Reardon’s and colleagues’ (2017) review and suggestions of universal barriers/facilitators, the assumption that appears to be present is that the respective studies either did not find the prevalence or relevance of socioeconomic status (SES) or racial/cultural factors as barriers or facilitators of service.

However, according to Christopher Burkette (2017) in his article “Reconceptualizing the Mental Health (Help-seeking) Experiences of Black Americans,” a few common barriers identified in direct connection to culture, race, and SES were stigmatization, “lack of culturally relevant treatment models, and negative attitudes toward mental health services” (p. 813). Recent literature posits that these and other barriers are often rooted in systemic and systematic efforts to maintain the emotional, physiological, and psychological state of depleted existence, furthering the residual effects of historical tragedies such as Slavery and Jim Crow (Eyerman, 2008; Planey et al., 2018; Powell, 2018; Thurston & Phares, 2008). Often under-addressed are the influencers of said systemic and systematic efforts and the grave importance of their impact on African American clients’ mental health needs. Sigmund Freud, known as the “father” of psychoanalysis, believed that the “unconscious mind” is the most unknown and unpredictable area of the human psyche. The unconscious, at times, is defined as a large, below-the-surface area where
inaccessible thoughts, wishes, feelings, and memories are contained, which we are unaware of and unable to access readily (Cushman, 1995).

Freud’s discovery of the “unconscious” was groundbreaking. It provided an acceptable explanation and rationale for unplausible circumstances such as racial/ethnic traumas, urges, and drives to engage in favorable or unfavorable behaviors. Unfortunately, Freud’s theory of the unconscious also provided an opportunity for those who desired to dominate and exploit less dominant individuals/groups through manipulation, conditioning, and mandates to assimilate from cultural practices to the desired practices of a more dominant culture (Cushman, 1995).

In connection with Freud’s unconscious mind theory, as it relates to historical influences of systematic efforts to maintain atrocious institutions such as Slavery, another argument is introduced that proposes the significance of suggestions, messaging, and downright brainwashing of people of color. This notion is presented as we explore the idea and influence of the effects of pseudoscientists and so-called medical professionals such as Samuel Cartwright. Cartwright’s (1851) abuse of his power as a medical professional was used to politicize and justify the institution of Slavery by pathologizing the enslaved person. Cartwright (1851), who sought to substantiate further the necessity of white dominance and supremacy, created a diagnosis to pathologize freed blacks. As a result, the freedom of Blacks was equivocated to behaviors such as laziness, worthlessness, and hopelessness (Cartwright, 1851). Consider the generational impact of the internalized narratives concerning enslaved/freed blacks, not only by the psyche of the person of color but also by white America. Murry et al. (2011) found that a common barrier identified by African American mothers seeking services for their children was “cultural mistrust,” writing that, “Stigma and cultural mistrust were most frequently endorsed by these mothers as barriers to help-seeking” (Murry et al., 2011, p. 1123). Approximately one-third
of the mothers identified cultural mistrust as a factor as they believed “white professionals could not understand the problems of African American families” (Murry et al., 2011, p. 1123). Additionally, others endorsed that they were “suspicious that White professionals would not treat my child as well as s/he would treat a White child,” approximately 17% (Murry et al., 2011, p. 1123).

For many people of color, identifying barriers to treatment can be very complex in its categorization. A few common themes in the literature are value/belief, accessibility, and trust (Murry et al., 2011; Planey et al., 2019). The previously mentioned topics are not listed in order of importance or relevance and should not be considered an exhaustive list of potential barriers. Planey et al.’s (2019) research suggest these three topics as broader categories that represent a generalized view of barriers, acknowledging that the fundamental understanding of barriers is often influenced by the individualized conceptualization of each client’s historical reference and experience with barriers in treatment, and their impact on the client’s identification of need and openness to mental health services. Although these three categories may incorporate a myriad of sub-categories and topics, broadly stated, research suggests that (1) value/belief implies the client’s level of understanding and attitude toward the need for mental health treatment correlates with utilization; (2) a client’s “trust” in their provider, suggests that the client has vetted their provider and has identified that the provider has a “good-enough” understanding of the client’s needs and nuances; and (3) accessibility not only incorporates the client’s ability to achieve physical and financial access but also that the services being offered “meets the client where he/she/they are” emotionally and intellectually.

Rationalizations Regarding Treatment
When seeking services to treat a mental health condition, African Americans often seek support and guidance from de facto mental health providers such as family, friends, primary care practitioners, and clergy (Planey et al., 2019). Although supportive services from any or all of the previously mentioned parties can be beneficial, one should explore the rationale and perspective of African American clients concerning seeking mental health services from a mental health provider. Are the earlier mentioned barriers primary contributors that lend to a narrative of feeling unsafe in seeking support? Historically, the relationship between the African American client and treatment providers in the United States has been marginalization, oppression, exclusion, misdiagnosing, and maltreatment based on their race, skin color, or ethnic identification (Burkett, 2017).

Overall, the healthcare system, including mental health, has been plagued with the colonialized perspectives of the dominant culture concerning assessments, diagnosis, and treatment. Which typically excludes the nuances of culture and ethnicity in its development and application. Within this context, the extent to which colonialism, racism, and historical traumas have generationally impacted the perceptions of collective cultures must be considered. Therefore, clinicians must explore the generational transmission of misinformation regarding the trauma of Slavery and colonialism, as it has informed the collective understanding of how cultures have viewed themselves and the transmission of the conditioned thoughts of self, others, and the world (Eyerman, 2001, 2008). One factor contributing to the development of their inner working model (IWM) is how they consciously and/or unconsciously organize information relevant to how they see the world and exist within it (Delius et al., 2008).

According to Jang et al. (2015), an area that supports IWM’s impact on treatment-seeking can be evidenced in self-rated mental health assessments. Despite African Americans’ need for
mental health services, many under-identify and under-report mental health crises. Jang et al.’s (2015) research identified a strong correlation with service-seeking behaviors, implying that clients also engage in self-assessing and self-diagnosing. This study also indicated that external factors were significant influencers on the perceptions of self and specific needs of the African American client. Jang et al.’s (2015) study consisted of 460 male and female participants who self-identified as African American/black, between the ages of 40 and 85, who met the diagnostic criteria for major depression, generalized anxiety, and panic disorder. This study suggested that potential barriers to African Americans receiving mental health services are the decrease in the individual’s conceptualization of their overall mental health status. According to Jang and colleagues (2015), approximately 12% of participants were formally identified as having one or more of three common mental disorders assessed in this study (major depression, generalized anxiety disorder, and panic disorder). Of this group, despite disclosing a known diagnosis of mental illness, more than 48% reported having excellent/very good/good mental health. Of the 12%, only 55% pursued treatment (Jang et al., 2015). Findings suggested that barriers to African American client’s help-seeking may have origins in the lack of education and awareness of mental health; however, additional research also identifies stigma as a significant contributing factor (Alang, 2015; Jang et al., 2015; Murry et al., 2011; Wimberley, 2015) to the African American client’s recategorizing their mental health condition as excellent/very good/good.

Identifying barriers and facilitators of mental health services for African Americans can be a precursor to the impact of unresolved mental health needs manifested in later adulthood, or transmitted generationally, often referred to as predisposition (Stenson et al., 2020). Therefore, in evaluating barriers that influence an individual’s decision to access and complete treatment, one
must assess the individual’s narratives and schemata surrounding mental health. In considering
rationalizations behind the African American client’s decisions surrounding the utilization of
mental health services, evaluating the influence of historical scripts or schemata (Delius et al.,
2008), handed down generationally, may provide clarification regarding barriers to mental health
underutilization (Jang et al., 2015; Murry et al., 2011; Thurston & Phares, 2008). Therefore,
identifying the script or schemata may directly correlate historical and generational contributors
that place African Americans in a diminished position to trust and access tangible and intangible
resources that necessitate treatment.

Outcomes and Attrition of Treatment

A study by Adewale et al. (2016) explored the impact of imperialism and colonialism on
the internalization of perspectives on mental health among African American and Nigerian
American males and females. In this study, Adewale et al. (2016) believe that “historical
backgrounds from which each group arises can contribute to different attitudes and beliefs
around mental health diagnoses and treatments” (p. 79). The results of this study explored a
framework for the variation in perspectives of African Americans vs. Nigerian Americans and
the influence of colonialism and imperialism, respectively, on their close historical connections.
Adewale et al. (2016) specifically focused on the impact of racialization and the phenomena of
imperialism and Slavery on African American and Nigerian American mental health.
Specifically of interest were questions that focused on the attitudes toward
imperialism/colonialism and those surrounding the influence of said attitudes on the perception
of mental health, stigma, and biases. In this study, Adewale and colleagues (2016) found that
African Americans, more than Nigerian Americans, saw imperialism as an influencer on their
mental health perspectives, 90%, and 53 %, respectively. Furthermore, according to this study,
more African American participants disclosed evidence of white supremacy within structured systems such as penal, education, and health systems in the United States than Nigerian Americans. Such perception possibly contributes to the potential for mistrust in the established systems such as health and mental health care systems; therefore, “when a client mistrusts the system in which services, they are less likely to utilize” said system (Holden & Xanthos, 2009; Jang et al., 2014; Powell, 2008; Reardon et al., 2017; Thurston & Phares, 2008).

This study’s major themes were: “perceptions of self and one’s intimate environments; perceptions of illness; and perceptions of society and culture” (Adewale et al., 2016, p. 81). Adewale et al.’s (2016) study was limited to three geographical areas as they were all recruited from Virginia, Washington, D.C., and Rhode Island. Although a qualitative study, limiting the generalizability of the findings, the Adewale et al. (2016) study expounded upon the concept of the psychology of oppression and the continued impact of colonialism and Slavery on the perception of an individual’s mental health and internalized narratives: their Internal Working Model (perception of self, others, and the world around them). This study also introduced the concept of the “African Mind,” a concept established by British psychiatrists to provide validity and justification for Slavery and the oppression of Africans (Adewale et al., 2016). Internal working model (IWM) is described as the mental representation of conscious and/or unconscious organization of “attachment-related experiences, feelings, and ideations” (Main et al., 1985, p. 67) that impacts an individual’s perception of self, others, and the world (Miljkovitch et al., 2015).

Planey et al.’s (2019) systematic review also revealed a correlation with the perspectives of self, others, and the environment among African American youth, citing barriers identified as contributors to lack of commitment and completion of mental health services. Several themes
were identified as significant barriers to engagement and participation in services which was “largely consistent with the literature on [attitudes toward] mental health care…among African America adults and other racial minorit[ies]” (Planey et al., 2019, p. 197). Planey et al. (2019) identified themes contributing to African American clients’ dissuasion from participating in mental health treatment in this systematic review. This research identified barriers to the clinician and therapeutic factors, such as stigma, religion and spirituality, affordability, availability, and accessibility (Planey et al., 2019).

**Implications for Clinical Practice**

In her article, Dionne Powell (2018) speaks of the silence of American psychoanalysts concerning the clinical setting and engagement with clients surrounding the topic of “race, racism, and racialized trauma” (p. 1023). Powell (2018) introduces the idea of the “collective tragedy of racism” and its impact on our society, especially its influence within the clinical setting and, most specifically, the effect on the client/clinician relationship (2018). Powell suggests that race topics are more commonly addressed in sessions where clients and clinicians feel most comfortable with clinicians who belong to the same racial minority group. Additionally, Powell espouses that there are limitations in the idea of cultural comfort within culturally aligned clinical relationships, as there are limitations to the representation of minorities within the mental health field. At the time of Powell’s (2018) publication, African Americans represented 12% of the United States population (US Census, 2010) and only 3% of psychologists, according to the American Psychological Association (APA) (APA 2010).

The APA statistics remained consistent at 3% (APA, 2019). Although recent Census Bureau and BLS data support an analogous representation of African Americans within the mental health profession, it would be imperative to explore further specific qualifiers to ensure
those who identify as a “mental health professional” possess advanced degrees and are licensed to practice clinically, as a qualified mental health professional. According to the National Association of Social Workers (NASW), approximately 26% of all Social Workers indicated they were engaged in providing services to people with mental health needs; and of newly graduated Social Workers, between 2017 and 2019, 22% identified as African American (Salsbert et al., 2020).

However, more recent data suggest a tangential increase in African American representation in the mental health profession. According to the 2020 US Census Bureau, Black/African Americans represent 14.2% of the United States Population (US Census Bureau, 2020) and 19.7% of mental health professionals. Succinctly, the 2021 US Bureau of Labor Statistics (BLS) (BLS, 2021) reports that African Americans represent 17.6% of individuals within the mental health profession.

Despite the increase in the statistical data provided by the Census Bureau, anecdotally, African American clients continue to identify a common barrier in seeking mental health services as non-shared cultured clinicians. Therefore, if issues and topics surrounding race, racism, discrimination, microaggression, oppression, and cultural/racial traumas are limited to clinical settings where there is shared minority status, there may be a decreased likelihood of these discussions. Additionally, a client’s and/or clinician’s discomfort and/or bias on the previously mentioned themes may also decrease the probability of exploring how these topics impact the client’s IWM and presenting issues (Powell, 2018). Subsequently, if the statistical

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data of the APA is the most reliable, then non-African American clinicians treating clients of African American descent would possess a level of self-awareness of the weight on the client’s consciousness and the clinician as it relates to the atrocities of the “collective tragedy that is racism in America” (Powell, 2018, p. 1023).

Addressing this discomfort from a place of reflexivity allows the clinician the opportunity to evaluate their own biases or, as stated by Marianne Goldberger (1993), our “bright spots” in treatment, where the clinician has filled in the spaces of information based on assumptions of their own (Powell, 2018). It is equally, if not more imperative that clinicians who share ethnicity/culture with their clients pay close attention to “bright spots” as this creates a sense of familiarity that may lead to instances of transference-countertransference that causes the practitioner to miss subtleties and nuances presented in treatment; “skinship” is not a replacement for effective treatment and intervention. Important to client treatment is the clinician’s curiosity about race and culture and how it impacts the client’s sense of being, especially with people of color. Being “openly curious about trauma revealed in subtle manifestations and speaking to our patient’s trauma and resilience can lead to profound” (Powell, 2018, p. 1043) transformative understanding and treatment. A clinician’s openness to exploring topics and issues surrounding race, culture, and other differences implies that the practitioner sees the benefit to their humble engagement in truly treating a client from where “they” are, not from where the clinician is.

**Trauma**

*The Etiology of Trauma*

The original definition of “trauma” finds its origin within the Greek language; its earlier meaning was “wound”—originally referring to a physical injury to the body (Caruth, 1996). The
current use of the word “trauma” still maintains a biological connection to bodily injury; however, over the past few decades, “trauma” has spawned a more significant alignment with the mental and emotional health field. Cathy Caruth (1996), in the *Unclaimed Experience: Trauma, Narrative, and History* states that Sigmund Freud introduces the idea of “trauma” being a “wound inflicted not upon the body but upon the mind” in *Beyond the Pleasure Principle* (Caruth, 1996). According to Caruth, Freud theorized that trauma is a breach in the minds experiences that impacts the individual’s sense of “time, self, and the world,” as trauma does not simply exist in the current moment but often emerges in varied locations in time across the lifespan (1996). Trauma is not singular or binary in its conceptualization or how it impacts the victim. Instead, it finds its most complexity within “meaning-making.” Entangled in the language of trauma is the complex way in which knowing and not-knowing becomes a paradox.

Caruth (1996) describes trauma as “an overwhelming experience of sudden or catastrophic events in which the response to the event occurs in the often delayed, uncontrolled repetitive” intrusions of memories, thoughts, emotions, and behaviors (p. 11). As cited by Vincenzo Di Nicola (2018), modern-day philosophy on trauma states that there is not specifically a spectrum but a dichotomy that can be used to describe the variances seen in trauma literature and practice. Di Nicola (2018) cited Fassin and Rechtman’s characterizations of trauma as having two polarities—a “scientific strand and a moral strand” (Di Nicola, 2018, p. 19). The scientific strand is utilized in the domains of psychiatry, psychology, and psychoanalysis and addresses trauma from a theoretical and practical approach (Di Nicola, 2018). On the other hand, the moral strand is associated with “social conceptions, ‘traces changes in attitudes of misfortune and to those who suffer it’ and ‘towards the authenticity of such suffering’” (Di Nicola, 2018, p. 19). For this research, intertwining the scientific and moral strands of trauma is aligned with
Fassin and Rechtman, as well as Di Nicola (2018). This perspective of trauma is relevant in assessing and treating primary or vicarious trauma victims.

Robert Stolorow’s (2018) psychoanalytic framework and therapeutic approach to emotional trauma provide an alternative from a phenomenological perspective. Stolorow’s perspective illuminates two essential features of trauma—“its context-embeddedness and existential significance” (Stolorow, 2018, p. 53). Stolorow traces the cognitive impacts of trauma in his theory, “intersubjective-system theory,” by investigating and illuminating the client’s “worlds of emotional experience and the structures that organize them” (Stolorow, 2018, p. 53). Similar to attachment theory’s internal working model (IWM), Stolorow believes that, developmentally, recurring patterns of intersubjective transactions within the development system give rise to principles (thematic patterns, meaning-structures, cognitive-affective schemas) that unconsciously organize subsequent emotional and relational experiences. Such organizing principles are unconscious not in the sense of being repressed, but in being pre-reflective [before any conscious evaluation or awareness]. (2018, p. 54)

This can be fundamental in connections with historical or intergenerational trauma’s, not directly experienced by a client (Stenson et al., 2020). Stolorow (2018) further aligns his theory on trauma with attachment theory, implying that traumatic experiences create disorganized IWM, impacting the client’s sense of self, others, and the world around them.

Research supports that for many people of color, the relationship between historical events and present-day issues are many times overlooked. In revisiting Stolorow’s (2018) theory, the state of pre-reflective organizing of trauma material aligns with James Prochaska and Carlo DiClemente’s (1982) transtheoretical model of change in that the “unconscious mind” now
becomes the incubator of pre-reflective/pre-contemplative trauma material that plays an essential role in informing a client’s sense of self and others, and how they engage in the world—their internal working models (IWM). From a psychodynamic perspective, what proves to be relevant in treatment is the goal of identifying the etiology of the client’s presenting issue. Unfortunately, some clients may seek services during the precontemplation stage of the transtheoretical model and are unable to identify the cause of the issue but identify a need for intervention (Prochaska & DiClemente, 1982).

**Historical Trauma**

Historical trauma made its appearance in behavioral and health literature in 1995 as the representation of the postcolonial experiences of Indigenous peoples of North America (Brave Heart et al., 2011; Kirmayer et al., 2014). Historical trauma is “cumulative emotional and psychological wounding across generations, including the lifespan, which emanates from massive group trauma” (Brave Heart, 1998, 2003; Brave Heart et al., 2011). Historical trauma emerged from research conducted in 1992 that explored the atrocities exacted upon the Indigenous people of North America and has been instrumental in describing the intensive and extensive impacts of colonialism, cultural suppressions, and historical oppression of Indigenous people of the Americas (Kirmayer et al., 2014).

In their seminal work, Maria Yellow Horse Brave Heart and Lemyra DeBruyn (1998) suggest that historical trauma’s impact profoundly affected Indigenous peoples. Their research indicated that the social ills experienced by Indigenous people were direct products of colonialism and a legacy of “chronic trauma and unresolved grief” (Brave Heart & DeBruyn, 1998, p. 60) that has spanned across generations. Generally, trauma theory argues that there are broad commonalities between survivors of mass violence; however, each historical massive
violent act has been found to impact the micro and macro levels of communities (Kirmayer et al., 2014). However, the conceptual framework of historical trauma promulgates an event that has included the identification of a collective, communal, and generational experience that continues to impact the well-being of its victims generations later (Brave Heart & DeBruyn, 1998).

Historical trauma has found affiliation in trauma research associated primarily with the trauma experienced by Indigenous peoples in America, but more recent research has identified similarities with the experiences of other historical atrocities experienced by other cultural groups (Danzer et al., 2016; Wilkins et al., 2013; Williams-Washington & Mills, 2017). Essential to the growing body of research is the inclusion of other cultural tragedies that have occurred during history.

According to Wilkins et al., “failure to consider how Slavery and various other historical trauma affect aspects of clients’ experiences and presenting problems may lead therapist to conceptualize cases from the default perspective of the dominant discourse, which may lead to ineffective treatment or even harm” (2013, p. 14). Researchers and practitioners eager to identify appropriate contributors to the behavioral responses of clients also seek to determine the presence of any generational contributors and the generational transmission of methods and schemata. Current research explores the intersection of historical trauma, intergenerational trauma, and its alignment with posttraumatic stress disorder symptomology to establish a fundamental understanding that will inform treatment. Therefore, when assessing trauma responses, the approach should consider both micro and macro interventions; even when working with an individual client, the historical memories held by the collective are imperative to the individual’s development of their self-view, view of others, and world view.
Recent research by Goldsmith et al. suggests that evidence supports the theory that the residuals of historical trauma are often found within the systems of the United States of America and continue to perpetuate and further the traumatization of specific groups of people (Goldsmith et al., 2004; Wilkins et al., 2013). These residuals become the unseen influencers, the “ghost” referred to in Fraiberg and colleagues’ (1974) research, that silently and unknowingly impact and influence the development of schematas, “patterns of thought and behavior including internal representations of oneself, others and the environment” (Krause et al., 2016, p. 2), which is fundamental in the individual’s IWM (Bowlby, 1969/1982; Delius et al., 2008; Krause et al., 2016).

**Residuals of Slavery/Racialized Trauma**

The phenomenon of the unseen impact of historical atrocities and their generational effects has been researched and documented for decades concerning the Jewish Holocaust survivors, validating the presence and transmission of intergenerational trauma. In the early 1990s, Maria Yellow Horse Brave Heart was instrumental in the emergence of the recognition of the tragedies of colonialism on Indigenous peoples and its social, emotional, and psychological impact (Brave Heart & DeBruyn, 1998; Brave Heart et al., 2011). However, the presence and the effect of residuals of the “holocaust of enslaved people” is not a new phenomenon but is addressed with trepidation in historical literature and treatment (Wilkins et al., 2013).

According to Wilkins et al., “racial stratification is…a prominent feature of American culture” (2013, p. 15). “Race” is often defined as a social construct that finds its meaning entrenched in its utility, often used to differentiate between “blacks and whites.” Some linguists would argue that there is only one “race,” the human race; another may say that this is a socially acceptable construct with value and purpose used for hundreds of years.
Despite the intentions of the emancipation of enslaved people in America in 1863, according to Wilkins et al., emancipation, during that period, “translated into the freedom to die from starvation and illness” (2013, p. 17; Billingsley, 1968) as newly “freed” blacks were emancipated into a state of social, economic, and political disenfranchisement without structure or access to an established society in which to exist (Graff, 2014; Pinderhughes, 1990; Wilkins et al., 2013). Slavery was not the end of trauma for blacks, but was the beginning of what would evolve into intergenerational trauma of the residuals from slavery, “Jim Crow, lynching, [intentional] disenfranchisement, an economic system—sharecropping and tenancy—that left little room for admonition or hope, unequal education resources or ‘enforced ignorance’ (W.E.B. DuBois), terrorism, racial caricatures [and minstrels], and every form of humiliation and brutalization imaginable” (Graff, 2014, p. 185). Although enslaved Africans and freed blacks, in early America, are commonly revered as extremely resilient people for “surviving” trauma and overcoming oppression, it is not without consequences. For many survivors of the Holocaust of Slavery, “forgetting” became the most common treatment approach (Graff, 2014). However, research over the past two decades have brought to light that “the trauma of Slavery and its aftermath have been transmitted from generation to generation” utilizing various methods of transmission, but commonly seen in “poor parenting, connect to the [enslaver-enslaved] relationship as the template for all human relationships; the dominant one parent family structure created by Slavery; and transgenerational haunting/[ghost from unresolved individual trauma]” (Graff, 2014, p. 195).

Posttraumatic Stress Disorder and Intergenerational Trauma

In 1980, posttraumatic stress disorder (PTSD) became an official diagnosis in the Diagnostic Statistical Manual (DSM). In 1997, Rachel Yehuda and Alexander McFarlane
theorized that the prevalence of misidentification of PTSD symptoms resulted from the lack of biological evidence. Furthermore, they surmised that the years of clinical observations and biological research used to provide validity to this diagnosis also provided the foundation for future research to explore the “presence of familial and possibly genetic risk factors for PTSD” (Yehuda & McFarlane, 1997, p. xii).

Ronald Kessler and colleagues (2017) conducted a study of over 68,000 participants across 24 countries; this study explored the association of trauma types with posttraumatic stress disorder (PTSD). Their findings suggested that “prior trauma history predicted both future trauma exposure and future PTSD risk” (Kessler et al., 2017). In this study of over 68,000 subjects, 70.4% of respondents reported experiencing trauma within their lifetime (Kessler et al., 2017). The research questions assessed 29 trauma types, divided into seven categories: war, physical violence, intimate partner/sexual violence, accidents, unexpected/traumatic death, vicarious, and “other” (Kessler et al., 2017). The category of “other” included responses to two open-ended questions: “did you ever experience any other extremely traumatic or life-threatening event that I haven’t asked you about?” or “a question about a ‘private’ trauma” that the respondent preferred not to share (Kessler et al., 2017). Kessler et al.’s research acknowledged that often in trauma literature, there are questions concerning the validity of and the biasedness in assessing for trauma, more specifically posttraumatic stress disorder (PTSD), as the information is often self-reported and the “respondents are asked about lifetime exposure to each of a wide range of traumas but then assessed for PTSD only for the one trauma nominated by the respondent as their worst or most upsetting lifetime trauma” (Kessler et al., 2017, p. 2).

Kessler et al.’s research discovered the four highest trauma types reportedly experienced within the lifetime of a respondent: rape (13.1%), other sexual assault (15.1%), being stalked
(9.8%), and unexpected death of a loved one (11.6%). Explicitly missing from the research was trauma types/categories specifically correlated to traumas, such as racial, historical, or cultural traumas. However, an argument that could be made regarding Kessler et al.’s research is that the previous traumas were not excluded but were intuitively included in the specific trauma types of “physical violence (physically assaulted or any physical violence), accidents (other life-threatening accident, accidentally injured/killed someone, or any other accident), unexpected death of a loved one, other traumas of loved ones or witnessed (other trauma’s to loved ones, witnessed injury, death, dead body, or any other traumas of loved ones), and ‘other’ traumas (other or private traumas [not disclosed by the respondent])” (Kessler et al., p. 3).

Overall, trauma is a widely researched malady and has decades of research and publications documenting the pervasive and prolonged effects on well-being. Said findings are well established, and prominent evidence substantiates that the theory of intergenerational transmission of genetic traits; it is profoundly established in research (Bohacek & Mansuy, 2015; Legoff et al., 2019). Within the past few decades, on the subject of intergenerational transmission of epigenetic markers, there has been significant increase in research attempting to identify the connection between DNA and epigenetic markers that impact medical, behavioral, and psychological patterns in subsequent generations (Bohacek & Mansuy, 2015; Legoff et al., 2019). Current research further explores the impact of exposure to traumatic stressors in one generation and its impact on subsequent generations (Stenson et al., 2021).

There is a growing research interest in validating the scientific argument of intergenerational transmission of behavioral traits and the phenomenon of epigenetics (Bohacek & Mansuy, 2015; Legoff et al., 2019). According to Legoff et al. (2019), epigenetic coding is any information not encoded in one’s DNA sequence. Legoff et al. further posit that epigenetics
is characterized by its “molecular process that establishes a phenotype whereby the resulting changes persist in the absence of the original cause… any changes in gene expression and the transmission of phenotypic variations to subsequent generations that do not result from alterations in the DNA sequence are considered to be the consequence of a phenomenon called epigenetic inheritance” (Legoff et al., 2019, p. 1).

Bohacek and Mansuy’s research furthers this argument in that they believe “behavioral traits in mammals can be altered by environmental factors encountered acutely or chronically and can be transmitted by various modes. Acquired traits can be transferred to the offspring independently of germ cells…they [can] involve behavioral, social, physiological and/or hormonal parameters experienced pre-and/or postnatally and require exposure of each generation to the causative factor (or factors) for perpetuation” (2015, p. 641). However, the study further suggests that in certain mammal subjects, stabilized modifications to behavior can be transferred from the parent to the embryo during fertilization, becoming a functional consequence in the offspring’s development and/or adulthood. Therefore, specific behaviors can be transmitted to subsequent generations without exposure to the initial causative trigger (Bohacek & Mansuy, 2015). Although the findings of Bohacek and Mansuy (2015), as well as Legoff et al.’s (2019) research and many others, are groundbreaking in the scientific community, the argument continues to be challenged due to the limitations of such studies, since study subjects are animals and not humans and lack the complexity of a human’s conscious state, which cannot be predicted nor measured through animal subjects.

However, research concerning generational transmissions of emotional and behavioral patterns in mammals has been well established. Over the past few decades, growing research has provided converging evidence that suggests the connection between parental trauma and the
presence of trauma responses in their offspring (Stenson et al., 2020). The concept of intergenerational Trauma (IT) was initially introduced in psychiatric literature in the early 1970s. Seminal research conducted by Vivian Rakoff and John Sigal (1971) explored the behavioral concerns exhibited by children of parents who were survivors of Nazi concentration camps. During the early stages of research concerning this emerging concept of IT, Sigal and Rakoff’s research received a significant amount of negative responses (Yehuda & Lehrner, 2018) for their idiosyncratic observations of a small study sample, which they used to generalize findings concerning a much larger group of offspring of survivors of the Nazi concentration camps (Sigal & Rakoff, 1971; Sigal et al., 1973; Yehuda & Lehrner, 2018). During early studies of IT, rare were studies that presented an argument based on the premise that a “homogeneity of parental experience may lead to a particular homogeneity of behavior in their children” (Sigal et al., 1973, p. 320) outside of psychosis and addictions.

However, Sigal and Rakoff’s 1971 study provided early insight into the clinical implications of a clinician’s perspective of a client’s culturally related trauma experience as Sigal and Rakoff’s pilot study hypothesized that survivors of the concentration camps “who had been adversely affected would be defective as parents and that, as a consequent, their children might suffer from the experiences of the parents” (Sigal & Rakoff, 1971, p. 393). Their study provided further insight concerning the clinician’s perspective of their client’s ability to connect historical trauma and their current presenting issues requiring treatment.

According to Yehuda and Lehrner, a parent’s trauma exposure, which may have occurred before the birth and possibly before the conception of an offspring, can still impact that offspring (Yehuda & Lehrner, 2018). Since the early 1990s Rachel Yehuda and colleagues (1994) focused much of their research on the pervasiveness of mental health disorders among Holocaust
survivors. The study conducted in 1994 was designed to explore “depressive phenomenology, including current symptoms, dependency and self-criticism themes, and issues of self-efficacy, in Holocaust survivors with and without posttraumatic stress disorder (PTSD)” (Yehuda et al., 1994, p. 699). This study explored the impact of trauma considering severity, time lapsed, and experiences of chronic symptoms of PTSD and depression (Yehuda et al., 1994).

Yehuda et al.’s research revealed that Holocaust survivors with PTSD suffered from increased themes of self-criticism in comparison to non-PTSD survivors but not in dependency and self-efficacy (Yehuda et al., 1994). The survivor’s feelings of guilt were identified within the themes of self-criticism, which significantly impacted their internal schemata of self, others, and the world (Yehuda et al., 1994). Such mental representations are also imperative in perspectives and narratives surrounding worth and defectiveness.

Yehuda and Lehrner (2018) posit that “on the simplest level, the concept of intergenerational trauma acknowledges that exposure to extremely adverse events impacts individuals to such a great extent that their offspring find themselves grappling with their parent’s posttraumatic state” (Yehuda & Lehrner, 2018, p. 243) which is witnessed and examined via psychodynamic assessment or behavioral observations, such as the reenactment of fear and grief in offspring, their becoming “container[s] for the unwanted, troubling experiences of the parent” (Yehuda & Lehrner, 2018, p. 244). A more provocative explanation concerning intergenerational trauma is that “the effect of that [traumatic] experience is passed somehow from one generation to the next through non-genomic, possibly epigenetic mechanisms affecting DNA function or gene transcription” (Yehuda & Lehrner, 2018, p. 243).
Cultural Trauma

Within this past decade, a growing body of research and researchers are making distinct connections between the atrocities of the Jewish Holocaust and that of other holocausts experienced by different cultures. “Understanding how trauma impacts mental health requires a broader view of identity, community, adaptation, and resistance as forms of resilience” (Kirmayer et al., 2014, p. 313). This approach would require the clinician to assume a more global view of the interaction of past traumas (historical trauma), present race-based traumas (racialized trauma), and the intergenerational transmission (intergenerational trauma) of the traumatic experience. What emerges from the perspective just mentioned is the framework of cultural trauma. According to Neil Smelser (2004), several definitional accomplishments must be satisfied before an event can be qualified/classified as cultural trauma; the event must be “(1) remembered or made to be remembered…(2) culturally relevant; …and (3) associated with a strong negative effect, usually disgust, shame or guilt” (Smelser, 2004, p. 36).

Cultural Trauma

Defining Cultural Trauma

In 2004, sociologists Jeffrey Alexander, Ron Eyerman, Bernhard Giesen, Neil Smelser, and Piotr Sztompka collaboratively explored and developed the framework of cultural trauma as a behavioral science framework that would provide a foundational understanding of the impact of collective trauma (Eyerman, 2017). There are several definitions for cultural trauma that can be found in scholarship. This research will adopt and refer to various definitions; however, the principal definition will be that of Alexander (2004), defining cultural trauma as occurring when “members of a collectivity feel they have been subjected to a horrendous event that leaves
indelible marks upon their group consciousness, marking their memories forever and changing their future identity in fundamental and irrevocable ways” (Alexander, 2004).

Within the same scholarship publication, cultural trauma is further defined by Smelser (2004) as “an invasive and overwhelming event that is believed to undermine or overwhelm one or several essential ingredients of a culture or the culture as a whole” (Smelser 2004, p. 38). Smelser (2004) also provides tenets essential for an event to be classified as a “cultural trauma.” He states that the event must meet the following requirements: (1) the memory or event must be “remembered or made to be remembered;” (2) “the memory must be made culturally relevant, that is, represented as obliterating, damaging, or rendering problematic something sacred—usually a value or outlook felt to be essential for the integrity of the affected society;” (3) “the memory must be associated with a strong negative effect, usually disgust, shame, or guilt” (Smelser, 2004, p. 36). It is also imperative to note that not all cultural tragedies can be categorized as cultural trauma. According to Smelser (2004), common cultural events that may be considered a prime candidate for this classification of cultural trauma have not consistently met all three previously mentioned criteria (made to remember, culturally damaging, and associated with negative effects). With Smelser’s criteria in mind, evaluating historical events associated with the atrocities experienced during the holocaust of enslaved people and the fallout on their descendants, Slavery has provided evidence that aligns with the definitional accomplishments to qualify as a culturally traumatic event (Smelser, 2004).

**Slavery and Cultural Trauma – Historical Qualifications**

History often speaks loudly, regardless of the hearer’s desire to hear. Furthermore, according to Orlando Patterson (2019), culture matters as much as history, from the “mouth of history’s flow [that] which [will] interactively bear down on the oppressed, both externally and
internally” (Patterson, 2019, p. 911), consequently impact outcomes that come with generational implications (Lehrner & Yehuda, 2019). Over the past several decades, historians have increasingly acknowledged and identified the relevance and importance of enslavement in the foundational fabrics of western civilization and, more specifically, the United States of America (Patterson, 1977, 2016, 2019). As scholarship, literature, and research involving the topic and impact of mass trauma have become a significant area of study, one can ask what makes the effects of Slavery significant? As Orlando Patterson puts it…

There is nothing notably peculiar about the institution of Slavery. It has existed from before the dawn of human history right down to the twentieth century, in the most primitive of human societies and in the most civilized…why then is the commonplace that [Slavery] is ‘the peculiar institution?’ It is hard to say, but perhaps the reason lies in the tendency to eschew what seems too paradoxical. Slavery was not only ubiquitous but turns out to have thrived most in precisely those areas and periods of the world where our conventional wisdom would lead us to expect it least. (Patterson, 1982, p. vii)

The institution of enslavement was critical in the origins of the development of the Greek-Roman civilization (Patterson, 1977, 2016, 2019). According to Patterson (Patterson, 1977, 2019), it is said that the blueprint seen in the enslavement models of ancient Roman society was adopted by America and later evolved into what modern-day Americans would come to know as “chattel slavery.” Slave trading in ancient Rome was integral to the financial success of their society as it was a significant source of economic wealth for this society, and thus when adopted by the “New World,” also became integral to the financial success, advancement, and economic growth (Desmond, 2021; Patterson, 1977, 2019).
In 1865 “individual and legally based [Slavery]” (Patterson, 2019, p. 907) came to an end, followed by the “collective post-juridical system of slavery known as Jim Crow” (Patterson, 2019, p. 907), which ended in 1965. Patterson (2019) further posits that “the permeation of [Slavery] in American history, society, and culture [were] therefore deep, broad, foundational, and lasting” (2019, p. 907). Commonplace throughout Slavery and Jim Crow was the constant external and internal oppression. As with interpersonal abuse, psychological wounds linger long after the initial injury. This factor also holds with group abuse as well. Therefore, “if a people is brutally oppressed for several centuries, it is inevitable that their hurt, rage, and degradation are partly turned on themselves” (Patterson, 2019, p. 911), as the mental representations provided by individuals of power are that of constant degradation and oppression.

During the development of Sigmund Freud’s theoretical framework, his research and writings between 1888 and 1889 focused on what he termed psychical trauma and the implications of these events as they related to hysteria (Smelser, 2004). Over the years of developing his theory, Freud identified that trauma is a pivotal contributor to the psychological distress of his clients. Researchers such as Alexander (2004, 2016), Eyerman (2004, 2018), Smelser (2004), Stamm et al. (2003), and others expound upon Freud’s theory regarding the psychological distress of a client and identify the parallelism that exists between the individual experiences of trauma and that of the collective.

To better understand the impact of trauma on a specific culture, one should identify the potentiality of the presence of this parallelism between individual psychological trauma and cultural trauma. The context in which both are experienced provides the foundation for understanding the variation. Psychological trauma contextually is embedded in the individual’s experience, whereas cultural trauma is identified by its more universal impact, as it is
experienced by a collectivity and/or a “system” (Alexander, 2004; Eyerman, 2004; Smelser, 2004). Determining factors of a collectivity or system rests on the grouping of specific elements such as “values, norms, outlooks, beliefs, ideologies, knowledge, and empirical assertions, linked with one another to some degree as a meaning-system” (Smelser, 2004, p. 37). Both Alexander (2004) and Eyerman (2018) refer to the importance of meaning systems or “meaning-making forces” that possess the power to “influence the formation and direction of a process of cultural trauma” (Eyerman, 2018, p. 7). These meaning-makers are identified as mass media and “carrier groups” such as intellectuals, elites, religious leaders, scholars, and individuals who are deemed influential in the eyes of the larger collective (Alexander, 2004; Eyerman, 2018).

Eyerman (2018) identifies that meaning-making and a universal collective understanding of the event of cultural trauma require identification between the two polarities of cultural trauma—(1) “emotional experience” and (2) “interpretive reaction,” theorizing that the “usually asymmetrical polarity between perpetrator and victim is what distinguishes cultural trauma as a discourse” (Eyerman, 2018, p. 7). A significant struggle within the establishment of an event as a cultural trauma is the establishment of collective meaning, in which the aforementioned “meaning-making forces” such as carrier groups play a significant role in the collective remembering and re-membering of events; “remembering” equates to the collective memory of the specific traumatic event and “re-membering,” the identification with or membership within the said collective.

The aforementioned are deemed significant in that when reflecting upon the criteria of an event’s qualification as a cultural trauma, Smelser (2004) posited that the memory or event must be (1) remembered, (2) culturally relevant, and (3) associated with strong adverse effects. Smelser (2014) further identifies that within an essential element of the theoretical
acknowledgment of cultural trauma lies a need for a clear understanding of the experience of cultural trauma and its impact on the injured group. Therefore, when defining cultural trauma, the need for definition as well as management and control of the collective understanding of said events may be challenged when agreeing upon the collective memory and the value of meaning-making (Alexander, 2004; Eyerman, 2001, 2004). According to Main and other researchers, meaning-making finds its alignment with the formation of an individual’s mental representations of self, others, and the world around them (i.e., their internal working model (IWM) (Main et al., 1985). Delius et al. further expound that these mental representations are “defined as a set of conscious and/or unconscious rules for the organization of information” (2008, p. 396). Spangler and Zimmerman (1999) conceptualize the IWM to be a controlling mechanism that begins organizing and storing information from infancy. Subsequently, Spangler and Zimmerman’s study validates the “assumptions of attachment theory regarding the role of IWMs of attachment” (Spangler & Zimmerman, 1999, p. 284), specifically regarding emotional regulation. Spangler and Zimmerman’s work contributes to the much larger discussion regarding the potential significance of cultural trauma’s impact on the conscious and unconscious factors that affect the development of an individual’s view of self, others, and the world and its connection to the client’s presenting issue in treatment.

**Cultural Trauma and the Collectivity**

Cultural trauma enlists actions and reactions on the part of the collective to establish a ubiquitous memory of a historical event, for example, Slavery. According to Eyerman, “Slavery became a field or a site memory, an arena of potentiality, which allowed not only different interpretations but also ambiguity regarding meaning as well as [an] emotional response. The understanding of trauma depends upon a time sequence like the following: traumatic event—
suppression of understanding—reflection” (Eyerman, 2001, p. 33), which should be followed by confrontation concerning factual historical occurrences and events in the context of cultural trauma. The “suppression of understanding,” for this research, is interpreted to represent the rejection and deconstruction of the collective memories of Slavery, often facilitated in dominant discourse, which contributes to the misrepresentations of historical facts and truths, which are subsequently transmitted generationally (Graff, 2014; Gump, 2010; Salberg, 2015; Wilkins et al., 2013).

“While it may be necessary to establish some event as the significant cause, its traumatic meaning must be established and accepted, a process which requires time, as well as mediation and representation” (Eyerman, 2001, p. 2). According to Eyerman (2001), collective memory is formed through organized knowledge or memory of an event directly experienced or having had knowledge of the experience. Collective memory provides a cognitive map (Eyerman, 2001). It specifies the “temporal parameters of past and future, where we came from and where we are going, and also why we are here now” (Eyerman, 2001, p. 6). Within the narratives curated by collective memory, an individual has the opportunity to find connections and the formation of identities (Eyerman, 2001). However, the curation and transference of accurate memories have historically been confronted by intentional efforts to alter, augment, or eradicate. Therefore, the documentation of historical factors and the mediums by which the information is curated is essential to collective memory. According to Eyerman, common methods used to curate this history of Slavery have been through music, art, literature, and news publications (2001).

Collective memory is defined as “a force capable of linking together various generations” (Halbwachs, 1991, p. 82) through the recollections, reconstruction, completion, and renewal of events that have taken place in the past (Halbwachs, 1991). Discussions surrounding memory
and collective memory research have been debated among sociologists, historians, and art historians (Confino, 1997). Disputes typically question the validity, scientific processes, and consistency in the application of collective memory, as societies are often permeated by cultural amnesia (James, 1997). Therefore, what should be objective, historical facts, become subjective to serve the purpose of a specific group (Confino, 1997; James, 1997). Confino carries the questions of memory work and collective memory further, stating that the “notion of memory [is] more practiced than theorized,” but makes the distinction that regardless of practice versus theory, memory is the “ways in which people construct a sense of the past” (1997, p. 1386). In that, Confino identifies that there is value and usefulness of memory/collective memory but cautions that memory alone “does not offer any true additional explanatory power” and can only be illuminated when it is linked to “historical questions and problems, via methods and theories,” (Confino, 1997, p. 1388). Therefore, aligning historical factors, methods, and theories with collective memory can provide a framework for assessment and treatment.

The parallel between the individual’s trauma experience and that of a collective provides further understanding of the detriment of cultural trauma by exploring the impact of trauma on the individual IWM. According to Salberg (2019), the intensity of a traumatic event yields the ability to fracture an individual’s experience of being in the world; consequently, cultural trauma yields power to shift the future of culture by collectively impacting the self-view, others-view, and world-view of the collective both of the past and present.

Salberg puts it best: “If you are listening carefully, the history of generations will become audible” (2019, p. 570) as history has become a significant predictive factor, not (exclusively) biology, of future behaviors (Salberg, 2019). Her research suggests that transgenerational transmission can be the diffusion of content and experiences (Salberg, 2019). Salberg’s research
also implied that fragmented states of mind and dysregulated affective states could be transmitted generationally (2015). She theorizes that:

[…] children inherit altered biochemistry that can leave them more vulnerable to registering fearful and anxious situations and being more fearful and anxious themselves. Traumatized mothers are raising children with these more fearful propensities. This becomes the fuller legacy of trans-generational transmission of traumatic forms of attachment: an alteration in both the biology and the attachment systems. (Salberg, 2019)

When evaluating Salberg’s theory through a wider lens, it provides context for understanding the impact of cultural trauma and the perpetuation of that trauma on a culture that has been systematically traumatized to instantiate influence upon the collective view of African Americans culture, both internally and externally (Salberg, 2019).

As stated by Lehrner and Yehuda, “the shared experience of cultural trauma, targeting a cultural or ethnic group, becomes part of the story the community tells about the work, about itself, and about its survival” (2018, p. 1763). How the experiences are transmitted generationally relies on the interpretation and re-interpretation (Lehrner & Yehuda, 2018)—the remembering and re-membering (Eyerman, 2001) of the trauma experiences. In that, cultural trauma puts forth a framework that will allow clinicians, academics, and researchers the opportunity to explore the impact of events of trauma on culture and how trauma is transmitted from the collective to influence mental representations that form the schemata that shape the individual and the collectives view of self, others, and the world—the internal working model (IWM).

**Internal Working Model of Attachment Theory**

*The Ontogenesis of Attachment Theory*
In Sigmund Freud’s *Moses and Monotheism* and *The Outline*, he discusses the nature of trauma and provides a foundation that supports the importance of early developmental experiences. Freud (1940) theorized that the “ego” is “feeble, immature and incapable of resistance during early childhood, up to age five or six.” Freud (1940) posited that, although a fragile stage, this period of development is significant in ego development and that during this stage, if the ego “fails to deal with tasks which it could [possibly] cope with later” in life with much more ease, then psychopathology prevails (Bowlby, 1969; Freud, 1940). Both Freud and John Bowlby, a child psychologist from London, England, recognized the significance of early childhood experience and its impact on development. However, Bowlby’s (1969) theory diverged from Freud’s traditional psychoanalytic processes in that Bowlby’s theory explored early childhood experiences as significant in predicting relationship connections and future connections and behaviors.

In early psychoanalytic research, the importance of relational impact, specifically the caregiver/parental impact, on a child’s development was a topic to be debated. Pioneering psychoanalysts, such as Freud and others, theorized that understanding behaviors are most effective by working from an “end-product backward” process (Bowlby, 1969). However, in the 1950s, Bowlby began exploring the idea of a more predictive method of understanding behaviors. Specifically, Bowlby attempted to analyze behaviors in the opposite direction, from a predictive approach to understanding future or potential future behaviors (Bowlby, 1969). According to Bowlby, the aim of developing his theory was to “describe certain patterns of responses that occur regularly in early childhood and, thence, to trace out how similar patterns of responses are to be discerned in the functioning of later personality” (Bowlby, 1969, p. 4). Bowlby desired to shift the focus from the symptoms/behaviors of an individual to identify an
event or experience that may lead to the pathology of a personality. Bowlby’s Attachment theory explored the influencers and impacts the pathogen of losing a “mother[parent]-figure” in early development, ages six (6) months to six (6) years, has on the overall development of an individual. This new understanding began with the abandonment of Freud’s (1940) and Rene Spitz’s (1965) perspectives on psychosexual development and the bond between a child and its parent during the oral stages of development (Keller, 2013).

Prior to Bowlby’s attachment theory series, Freud’s theory was viewed as a significant contribution to psychoanalysis and understanding of behaviors and psychopathology. Freud’s theory was adopted and practiced by many as his conceptualization of trauma, in terms of “causal conditions and psychological consequences,” provided what was believed to be valid rationalizations of pathology during that era (Bowlby, 1969). In volume one of Bowlby’s attachment theory series, he provides an alternative to Freud’s theory regarding the conceptualization and treatment of trauma by engaging in a dialogue surrounding the presence of a phenomenon Freud termed “psychical energy” or nervous energy (1969). Freud believed that in mental life, as in life science, there is a presence of energy that produces cause and reactions; therefore, by the exhaustion and replenishing of that energy, the explanation of specific behaviors becomes predictable (Bowlby, 1969; Freud, 1940).

Freud’s psychical energy and the significance of ego fragility, compounded by early childhood experiences of trauma, provide foundational support for Bowlby’s connection between cognitive and behavioral psychology within attachment theory (Bowlby, 1969, 1982; Main et al., 1985; Slade, 1998). In his research, Bowlby discovered the significance of this connection between cognition and behavior when exploring infant/caregiver relational connections and predictions of future thoughts and actions. In this framework, Bowlby’s early identification of
the existence of an internal organization is discovered. This internal organization is represented in research as mental representations of attachment, establishing the conceptualization of the internal working model IWM. The IWM allows an individual to organize, categorize, and develop schemata for their thoughts, feelings, and memories; this is expounded upon in research conducted by Inge Bretherton (Bretherton, 1985), Mary Main, Nancy Kaplan, and Jude Cassidy (Main et al., 1985; Slade, 1998). These fundamentals become foundational in understanding the internal models and their impact on future cognition and behaviors.

**Significant Contributors to the Attachment Theory Model**

Bowlby’s research espoused that observing other species outside of the human species could offer supportive data to explore and explain human relational behavior. His early research was influenced by ethologists such as Konrad Lorenz’s theory on imprinting. During the 1950s, in another country, another scientist conducted research that would later provide the scientific data that would support Bowlby’s theory. Although thousands of miles apart, John Bowlby and Harry Harlow, an American psychologist, were simultaneously developing research that would transform the conversations surrounding the “nature of the bond between child and caregiver” (van der Horst et al., 2008b, p. 370). Unbeknownst to both, Harlow’s research with rhesus monkeys would provide the empirical data that would lead to the success of Bowlby’s work surrounding the attachment relationship between children and caregivers. Harlow’s research demonstrated that deprived infant rhesus monkeys preferred the warmth of a mother over basic needs (Keller, 2013).

Overall, Harlow’s research of monkeys suggested significance regarding the emerging theme of dependence, relational connection, and survival of infant monkeys on their maternal figures (Keller, 2013). Much like Harlow, Bowlby’s research of human infant children...
demonstrated the emergence of a similar theme surrounding proximity seeking and survival (Ainsworth, 1989; Bowlby, 1969, 1982; Slade, 1998; Main et al., 1985). As John Bowlby is identified as the pioneering theorist in the Attachment theory movement, the evolution of the theory was furthered by Mary Ainsworth, a Canadian clinical psychologist, who began what would later become a fruitful collaborative working relationship with Bowlby. Ainsworth began working with Bowlby in 1950, and their shared perspectives regarding the impact of relational connections between a child and parent over the next three years grew increasingly aligned (Ainsworth & Marvin, 1994).

Ainsworth’s perspective on attachment would change the trajectory of the theory in a direction that would focus on the significance of maternal sensitivity, incorporating the importance of Bowlby’s focus on proximity seeking and connection between mother and infant in the development of Ainsworth’s “Strange Situation” (Ainsworth et al., 1978; Main et al., 1985). Overall, Ainsworth’s contribution to the “psychological knowledge” and profession focused on the “infants’ attachment to their mothers” (Ainsworth, 1989, p. 709). Her research attempted to address (1) the normative development of attachment during the first year of life and (2) evaluate the universality of attachment via examination of individual differences (Ainsworth, 1989).

Ainsworth furthered the attachment theory research in her focus on the infant-mother dyad and the significance of this relationship in developing the infant’s attachment style. Ainsworth’s development of the “Strange Situation” procedure contributed to the exploration of the significance of an attachment figure, a discriminant person or persons said child has identified as a “secure base,” which provides security and sensitivity to address the child’s needs during episodes of child-caregiver separation and reunification (Ainsworth 1978; Bretherton,
Her research provided what some may consider indisputable support for Bowlby’s early attachment hypotheses and the emergence of the ideology of an infant’s capacity to engage in “satisfying, mutual and adaptive object relationships” (Slade, 1998, p. 1152). Emerging from Ainsworth’s research came categorizing children’s attachment styles: secure, avoidant, resistant-ambivalent, disorganized-disoriented (Ainsworth, 1978; Main, 1996).

According to Ainsworth, the fundamentals of attachment theory begin with conceptualizing the similarities between “attachment behaviors” and other behavioral systems (Ainsworth, 1989). Additionally, Ainsworth believed that attachment behavior is similar to that of other systems organized by behavioral responses that fundamentally rely on the systematic internal organization of external stimuli. She posits that behavioral methods include outward manifestations and an internal organization, presumably rooted in neurophysiological processes. Subsequently, this internal organization is subjected to developmental change under genetic guidance and “is sensitive to environmental influences. As the internal organization changes in development, so do the outwardly observable [behavioral] manifestations and the situation in which they are evoked” (Ainsworth, 1989, p. 710). Ainsworth’s belief regarding the internal organization reinforces the significance of the “inner organization” of both internal and external stimuli in establishing models, supporting the “inner/internal working model” (Ainsworth, 1989).

Following Ainsworth’s contribution, Mary Main further categorizes attachment styles in developing the Adult Attachment Interview (AAI) and the development of adult categorizations of attachment styles (Main et al., 1985; Main, 1996). Main’s research with colleagues Kaplan and Cassidy, as well as research from Bretherton (1985), provided the fundamentals in furthering the exploration of the development, function, and significance of the internal working models.
concerning attachment figures, in addition to the development of an individual’s perspective on self, others, and the environment. IWM will be discussed in further detail in this chapter.

**Internal/Inner Working Model Component of Attachment Theory**

Research overwhelmingly confirms the magnitude of the brain and its ability to perform compounded and complex tasks. Additionally, attachment research identifies the splendor in the brain’s ability to perform intricate tasks in both the conscious and the unconscious, specifically as it relates to mapping and storing information (Bowlby, 1969/1982; Delius et al., 2008; Krause et al., 2016). In Attachment, Bowlby espouses that the brain uses a model that “transmits, stores, and manipulates information that helps in making predictions” (Bowlby, 1969/1982, p. 80).

In volume one of John Bowlby’s works on Attachment, “Attachment and Loss,” the mention of the “internal working model” (IWM) as a significant necessity to the overall theory comes across as superficial. However, Bowlby’s description provides a strong argument for IWM to be significantly explored as it provides the foundation for connecting cognitive, behavioral, and intergenerational transmission of representational material and schemata (Bowlby 1969, 1982; Delius et al., 2008).

Inge Bretherton furthers this conceptualization in her 1985 publication by asserting that “through continual transactions with the world of persons and objects, [a] child constructs increasingly complex internal working models of that world and the significant persons in it, including the self” (1985, p. 11). Spangler and Zimmerman posit that from a theoretical perspective, the existence of IWM’s is vital for the explanation of “trans-situational and longitudinal effects” of early experiences and its impact on individual development (1999, p. 271). According to Bowlby, shaping an individual’s worldview is based on that individual’s knowledge of the world. Therefore, an effective plan of how they see themselves in the world is
shaped by understanding how they see themselves and possessing the “knowledge of their capabilities” (Bowlby, 1969/1982, p. 80).

Researchers now make the direct connection between internal/mental representations as an internal system, the nucleus of the attachment system that categorically organizes information and events, creating cognitive representations, scripts, and schemata that become foundational in the interpretation, assimilation, and accommodation of future events (Delius et al., 2008). They refer to this process as the development of internal or mental representations of experiences (Delius et al., 2008; Krause et al., 2016; Main et al., 1985).

In their 1985 research, Main et al. suggest a reconceptualization of the influences of an individual’s “mental representation of the self” concerning the individual’s attachment organization, occurring during infancy and older childhood through adulthood (1985). According to Main and her colleagues, a reconceptualization of what causes the difference in attachment models relies on an individual’s IWM (1985). The individual’s IWM not only directs their feelings and behaviors but is also an imperative contributor to attention, memory, and cognition (Delius et al., 2008; Main et al., 1985). Primary et al.’s approach in their 1985 study suggests a shift from the heavily behaviorally focused approach to that of mental representational.

Main and her colleagues define the internal working model (IWM) of attachment as “a set of conscious and unconscious rules for the organization of information relevant to attachment and for obtaining or limiting access to that information, that is, to information regarding attachment-related experiences, feelings, and ideations” (1985, pp. 66–67). Miljkovitch and colleagues opine that IWM’s play a “central role as mechanisms of continuity between early experience with caregivers and later socio-emotional development” (Miljkovitch et al., 2015, p. 492).
Attachment Theory, Culture, and Cultural Trauma

In her contribution to the John Bowlby Memorial Lecture in 2005, Kimberlyn Leary introduced her perspective on the impact of race relations in America on psychotherapy and how it’s “lived in the consulting room.” According to Leary (2006), race relations in America are often identified in politics and inter/intrapersonal experiences. In this, she identifies a significant gap in the discussions of race and race-based treatment in mental health services. Leary further opines, “psychoanalysis has had a curious relationship to issues of race and culture. On the one side, psychodynamic models are based almost entirely on the pathologies and protections of the Western nuclear family” and discourse (Fanon, 1952; Leary, 2006, p. 78; Powell, 2008). Another substantial gap identified in the research is the limitation of attachment studies that explore the variance in attachment patterns across cultural/ethnic groups (Magai et al., 2001). Most attachment studies either exclude ethnicity, race and/or culture as variables or use research samples consisting of “predominantly Caucasian” participants (Magai et al., 2001; Voges et al., 2019). However, “culture plays a significant role in the variations observed in the manifestation, expression, and meaning of attachment behaviors” (Voges et al., 2019, p. 802), as well as the development of mental representations and the development of schemata and scripts—the individuals state of mind, which is fundamental to the development of their internal working model (Delius et al., 2008; Main et al., 1985; Main, 1996).

Although brief, Volume One of Bowlby’s series on attachment and loss addresses the topic of the universality of attachment and addresses the issue of culture as he refutes the idea that behavior is infinitely varied from one culture to the next. Bowlby considered the behaviors of human beings to be diverse but “not infinitely so.” Bowlby believed that despite cultural variations, distinct commonalities could be specifically identified and discerned (Bowlby,
Bowlby identified commonalities that possess universal instinctual attributes despite cultural differences as mating, caring for babies and children, and a child and their parent attachment (Bowlby 1969/1982).

According to Fraiberg, Adelson, and Shapiro’s (1974) research, parent-child attachment has been an effective medium in transmitting generational information. Most relevant of Fraiberg et al.’s (1974) study is the concept of intergenerational transmission of trauma material, referred to as “ghost in the nursery.” Fraiberg et al.’s (1974) theory are pertinent to this research in that “ghost in the nursery” represents the transmission of messages, narratives, mental representations, and schemata via (the internal working model). According to Fraiberg et al., even among “families where the love bonds are strong, the intruders from the parental past may break through the magic circle in an unguarded moment, and a parent and their child may find themselves reenacting a moment or a scene from another time with another set of characters” (1975, p. 387).

**Rationale for Research**

As previously mentioned, pioneers in attachment theory identified that early attachment relationships and exposures are foundational and fundamental in the development of attachments over an individual’s life span (Bowlby, 1969; Ainsworth, 1989; Magai et al., 2001). Early attachment connections with parents/caregivers are intricate as they "function as the mode of transmission [of trauma] in most if not all transgenerational transmission circumstances" (Salberg, 2019, p. 570). In many cultures, relationships serve as a medium by which historical information is passed from one generation to another, conscious and unconsciously. Often the historical material communicated is derived from a collective understanding and acceptance of
said factors, which forms the “collective memories” that ultimately impact the identity of “the collective” as a whole, consequently affecting the identity of its individuals (Eyerman, 2001).

As previously mentioned, growing research has confirmed the importance of incorporating culture in assessments and treatment of clients of minority decent. Over the past decade, research regarding Jewish Holocaust survivors (Lehrner & Yehuda, 2018; Yehuda & Lehrner, 2018) has opened the door to conversations regarding the intergenerational transmission of trauma (ITT) and epigenetic factors experienced by offspring of other cultures with histories of mass atrocities. Research on the Jewish Holocaust has created space for researchers to explore the potential impact of ITT connected to other mass atrocities such as Slavery (Graff, 2014), the American Indian Holocaust (Brave Heart & DeBruyn, 1998), Japanese “comfort women” (Park, 2019), and survivors of the Armenian genocide (Graff, 2014). However, research concerning the connection between ITT and the impact culturally related traumas have on the development of the internal working model of the offspring of people of African descent in the United States of America ranges from limited to non-existent. The absence of research on this topic suggests a potential parallel process—limited focus in research may equate to limited focus in the therapy room, and this presents a potential barrier to the client accessing and maintaining mental health treatment. Research has confirmed that there are many barriers to African Americans accessing effective and appropriate mental health treatment. These range from “lack of culturally relevant treatment models, and negative attitudes toward mental health services” (Burkette, 2017, p. 813) to cost/affordability, stigma, minimization of symptoms or low perceived need, low perceived effectiveness of treatment, and structural barriers (Alang, 2015; SAMHSA, 2013). Further, buried in the previously mentioned barriers are residuals of cultural trauma (O’Connell, 2012), historical and present day, transmitted via ITT, impacting the client’s IWM, and then possibly
manifesting in what an African American client sees as relationship issues, depression and/or anxiety.

This dissertation research aims to explore clinician’s ability to engage in culturally sensitive attachment work as it pertains to the client’s self-view, others-view, and world-view—their IWM—by exploring the perspectives of clinicians who treat African American clients and their inclusion in discussions, assessments, and incorporation of cultural trauma in their treatment of African American adult clients.
CHAPTER THREE: METHODOLOGY

Qualitative research design has become a prominent design in many fields as it has in Social Work (Padgett, 2017). Debates regarding epistemology have allowed space for qualitative research to emerge as a valued research design, as it allowed an opportunity for personal contributions to research through participants’ experiences (Padgett, 2017). In short, it brings the humanistic research approach into the social sciences and introduces the reality of constructions developed, held, and practiced by the research participants.

Research Design

The format for this dissertation is a qualitative design to explore the perspectives of clinicians who offer mental health treatment to African American clients regarding the inclusion of cultural trauma as a tenant of attachment theory that affects the internal working model when assessing and developing potential treatment plans for these clients.

The methodological research approach used in this dissertation is grounded theory (GT). Introduced by Glaser and Strauss in 1967, grounded theory provides an opportunity for researchers to explore research topic and see the topic through the eyes of the participants (Charmaz, 2014; Makri & Neely, 2021). This dissertation will utilize GT to explore the internal working model of attachment theory and the relevance of integrating cultural trauma in the clinician’s understanding, application, and practice from an attachment theory perspective. As GT is used to build the foundation for the development of theory, this dissertation will explore the use of the integration of cultural trauma theory and attachment theory, specifically, the connection between cultural trauma and the tenets of IWM of attachment theory—assessing the impact of cultural trauma on the client’s self-view, others-view, and world-view. This dissertation will attempt to identify the clinician’s awareness and professional knowledge about
cultural trauma as a significant factor when treating African American clients. Subsequently, the study will explore the clinician’s perspectives, values, biases, etc., regarding the relevance and need to identify cultural trauma as contributing to the client’s current presenting issues. Overall, this dissertation intends to explore how clinicians who treat African American adult clients conceptualize, identify and assess clients whose presenting issues may connect with their direct or indirect experiences with cultural trauma, and how trauma impacts their internal working model (IWM) and whether the client is aware of this potential connection, either consciously or unconsciously.

To understand this phenomenon, this dissertation study will recruit licensed practicing clinicians who provide mental health services to adult African American clients within the continental United States of America.

**Recruitment and Sample**

Recruitment for this study began with purposive sampling and progressed in recruiting additional participants through snowball sampling strategies of participants who meet the inclusion criteria. Next, clinicians were recruited through dissemination requests of targeted professional clinicians, including licensed social workers, professional counselors, marriage and family therapists, or any licensed/master’s level or higher degree mental health professional. Disseminated materials included professional referrals, email blasts containing all study criteria and contact information, social media outlets, and word-of-mouth. Finally, interviews were conducted on a virtual platform, allowing clinicians from across the continental United States to participate without limitations or restrictions, allowing for the possibility of geographically diverse participation. Each participant participated in a pre-interview screening to answer any questions or concerns prior to consenting to participation. The goal for recruitment in this
research study was 12 participants over three months, or until methodological saturation was achieved. This participant goal was exceeded, as there were 13 clinical participants.

The targeted clinicians held at least a master’s degree in social work or a related field of study from an accredited university. In addition, all clinicians confirmed providing treatment to at least one client who identifies as African American.

Eligibility

Specifically, this research study’s eligibility inclusion and exclusion criteria are as follows.

Inclusion:

- Social workers, counselors, and family therapists who identify as practicing mental health therapists.
- Participants must have completed a minimum Master of Social Work or related program.
- Participants must have at least two years of mental health experience.
- Participants must be familiar with the tenets of attachment theory.
- Participants must provide mental health treatment to a minimum of one client who identifies as African American.
- Participants must provide mental health treatment for African American adult clients dealing with relationship issues and/or trauma.

Exclusion:

- Participants who are not familiar with the basic tenets of Attachment theory.
- Participants who do not see clients in a clinical setting.
• Participants who are not approved to provide mental health services in accordance with their state or local regulations.

• Participants who are not familiar with the tenets of Attachment theory.

• Participants who do not provide mental health treatment to a minimum of one client who identifies as African American.

• Participants who do not provide mental health treatment for African American adult clients dealing with relationship issues and/or trauma.

**Protection of Human Subjects**

According to the United States Food and Drug Administration (FDA), all formal studies require approval through Institutional Review Boards (IRB)\(^5\) to ensure the protection of human subjects. In alignment with this requirement, this dissertation research study’s application has been submitted to the University of Pennsylvania IRB for approval. The study’s informed consent document and interview questions have been submitted for review. This research study complies with all requirements of the University of Pennsylvania’s IRB committee, follow all feedback, and submit all requested adjustments. Following approval, each recruited participant who meets the inclusionary criteria has been supplied an informed consent form for review and agreement. The informed consent included the following items: (1) the intention and scope of the study; (2) potential areas of risk; (3) an explanation of processes and procedures around confidentiality protections; and (4) contact information for this researcher. Despite the limited possibility, risks were minimal if any at all. Due to the nature of the content and the risk of any post-interview emotional discomfort, additional information was provided detailing supportive

resources participants can access after the completion of their interview. As part of confidentiality practices, all data collected has been de-identified, and the participants have been asked to present pseudonyms to identify themselves. Interviews were facilitated via Zoom and stored in a password-protected manner. The data collected from these recordings was transcribed via a transcription company that is HIPPA compliant. Once the data was been transcribed, the recordings were destroyed from all platforms.

**Data Collection Method**

The data for this dissertation was collected via a semi-structured, in-depth interview guide. As “Strauss viewed human beings as active agents in their lives and their worlds rather than as passive recipients of large social forces…[and] assumed that process, not structure, was fundamental to human existence” (Charmaz, 2014). Therefore, in an effort to allow “human agency, emergent processes, social and subjective meanings, problem-solving practices, and the open-ended study of action” (Charmaz, 2014) to emerge from this dissertation study, open-ended, non-leading questions were utilized to collect data. The questions centered on understanding how participants defined cultural trauma, the internal working model, and the relevance of including tenets of cultural trauma (i.e., the collective and collective memory) in assessing the client’s presenting issues for treatment.

**Data Collection Sites**

Interviews were facilitated virtually to decrease limitations or barriers to participation. This dissertation research sought to include participants from diverse demographics, backgrounds, and geographical locations across the continental United States. Therefore, a virtual setting was identified as the most appropriate telecommunication vehicle to accomplish
this goal. The identified virtual platform used is Zoom, Inc., as it allows for recording interviews that can be reviewed for increased accuracy in transcriptions and observations.

Data Management

Data collected for this dissertation was facilitated through a single individual interview, with a follow up survey to collect demographic information. Interviews were semi/minimally structured but not entirely improvisational, allowing the researcher and the participant the opportunity to expound upon questions and responses during this process. Interviews were virtual and lasted approximately 90 minutes. The interviews were recorded for transcription and further observation, and were reviewed for accuracy.

Interviews were facilitated via Zoom, Inc. and stored in an encrypted, password-protected manner. The data collected from these recordings were transcribed via a transcription company that is HIPPA compliant. The data were delivered to the transcription company via a HIPPA-compliant medium to ensure that the data are encrypted from end-to-end. Once the data were transcribed, the recordings were destroyed from all platforms.

Data Analysis Process

In grounded theory, coding plays a pivotal role in making connections between the data and the emerging theory. Through coding, we define “what is happening in the data and begin to grapple with what it means” (Charmaz, 2014, p. 113). According to Charmaz, conducting grounded theory research requires a two-part coding process, a winnowing down of data received from participants (Charmaz, 2014; Padgett, 2017). The initial phase involves “naming each word, line, or segment of data” followed by a focused, selective phase that uses the most significant or frequent initial codes to sort, synthesize, integrate, and organize large amounts of data” (Charmaz, 2014, p. 113). Therefore, the initial coding practice utilized in this data analysis
was line-by-line coding which allowed this researcher to remain “open” and curious to the data that was collected (Charmaz, 2014). Line-by-line coding helped this researcher identify “implicit concerns as well as explicit statements” (Charmaz, 2014, p. 125). Charmaz shared the following strategies, which this researcher applied in the initial phase of the coding process:

1. Breaking the data up into their component parts or properties
2. Defining the actions on which they rest
3. Looking for tacit assumptions
4. Explicating implicit actions and meanings
5. Crystallizing the significance of the points
6. Comparing data with data
7. Identifying gaps in the data. (Charmaz, 2014, p. 125)

Phase two of the coding process, focused coding, built on the “strong analytic direction” established in the initial phase of “line-by-line” coding. Focused coding utilizes the fundamentals developed to “sift, sort, synthesize and analyze…the data” (Charmaz, 2014, p. 138) to bring about a strong conceptualization of the initial codes and ultimately the collected data.

Once the data was collected from the interviews, they were coded and analyzed for themes that emerged from the research participants’ experiences in providing therapeutic services to African American adults and their perspectives surrounding cultural traumas’ impact on the client’s self, others, and world-view as it related to the client’s current presenting mental health needs. The interview transcripts were analyzed using inductive coding. A detailed review and evaluation of the interview transcriptions allowed this researcher to explore multiple emerging perspectives. Through a thorough examination of the transcripts, this researcher was also able to identify observations and patterns significant for developing a framework for
analysis using coding for any broad ideas, concepts, behaviors, phrases, or feelings that emerge from the data.

The data collected during this process focused on the clinician as the expert and treating provider. Research interview questions explored the clinician’s knowledge and application of attachment theory and cultural trauma along with their assessment of their client’s characterization of “community” and trauma.

This analysis consists of data collection via an inclusion survey delivered via Google Forms and a virtual interview via Zoom. The inclusion survey engaged participants to determine their qualifications to meet eligibility. Subsequently, each participant was engaged via a pre-interview telephone meeting for approximately 10 minutes to build a connection before their interview to review the process and expectations and answer any questions. Afterward, each individual participated in a 60 to 90-minute virtual interview via Zoom. Each interview was initially expected to be 60 minutes; however, it was discovered during the first two interviews that more time was needed. The depth and reflectiveness of participant responses quickly exceeded the expected timeframe, and 60 minutes would not be sufficient; subsequently, interviews were extended to 90 minutes.

Once the interviews were completed, the strategy moving forward consisted of the following: transcription, cleaning, organizing, and coding. The audio recordings were transcribed by an online transcription company (Rev.com). The data was then cleaned by comparing the transcribed data to the visual recordings. The transcribed data was subsequently uploaded to the NVivo software for coding and organization. The organized data allowed the researcher to obtain a broader view of the participant’s perspectives. Subsequently, significant information was extracted and organized into codes, obtaining 13, 8, and 15 codes for research questions one,
two, and three, respectively. Characteristics of each code were examined and put into clusters based on their shared commonalities. Each cluster was labeled based on the codes grouped under it. The labels became themes that addressed the following research questions.

**Research Questions**

This dissertation study focuses on how clinicians engage African American clients in treatment, including the impact of culture and, more specifically, cultural trauma on their internal models. Therefore, this dissertation research was guided by the following three main research questions:

RQ1: How does the clinician include cultural trauma in assessing African American clients?

RQ2: What is the clinician’s perspective on the impact of the inclusion of cultural trauma when assessing the African American client’s internal models of Attachment?

RQ3: What is the clinician’s perspective on the inclusion of cultural trauma in treating the African American client?

**Trustworthiness and Rigor**

Trustworthiness and rigor are imperative to the acceptance of qualitative research data as this research method’s validity is sometimes scrutinized. According to Padgett, “threats to trustworthiness in qualitative research fall under three broad headings: reactivity, researcher biases, and respondent biases” (2017, p. 213). Studies are considered trustworthy when carried out ethically and with fairness/non-bias, ensuring that the findings are as close as possible to the participants’ experiences (Padgett, 2017). This researcher ensured that selected participants met the inclusion criteria and engaged without hindrance during their individual interviews without researcher-imposed limitations. Additionally, this researcher continuously maintained a
reflexivity journal to assess for potential bias. To ensure the integrity of this dissertation research, the participant inclusion criteria was strictly adhered to, and all participants were screened based on inclusionary characteristics before entering the study. To increase the value of the research, this study was open to participants across the continental United States, creating an opportunity for sampling diversity. The strategy for “rigor” that was utilized was peer debriefing, and support was utilized by engaging in regular debriefing with qualitatively experienced and tenured professors at the University of Pennsylvania School of Social Policy and Practice as well as fellow research students. Additional rigor strategies employed was auditing trails by documenting and maintaining memos throughout this process. The final rigor strategy utilized was member check-in, which was used on an as-needed basis when additional clarifications and/or follow-up to an interview was needed. These rigor strategies were instrumental considerations in the development of the interview guide, coding and analysis of the data, and the presentation of findings. Lastly, a reflectivity statement was included below which represents the ongoing bias reflections and adjustments that were monitored through a reflexivity journal.

The researcher’s relevant experiences and qualifications include a Master of Social Work from the University of Maryland, licensed as a Clinical Social Worker in the state of Maryland and the District of Columbia, and experienced as a mental health provider for 12 years. To ensure the most appropriate and ethical treatment of human subjects, this researcher completed the Collaborative Institutional Training Initiative (CITI) through the University of Pennsylvania.

**Reflexivity Statement**

“Reflexivity is commonly viewed as the process of a continual internal dialogue and critical self-evaluation of researcher’s positionality as well as active acknowledgment and explicit recognition that [their positionality] may affect the research process and outcome… [simply put]
reflexivity is the [researcher’s] self-appraisal in research” (Berger, 2015, p. 220). According to Padgett, a researcher who engages in reflexivity confirms to their audience their ability to acknowledge and examine potential biases, as well as their “unexamined preconceptions and assumptions (2017, p. 184).

Qualitative researchers are expected to engage in increased “focus on self-knowledge and sensitivity; better understand[ing of] the role of the self in the creation of knowledge; carefully self-monitor the impact of their biases, beliefs, and personal experiences on their research; and maintain the balance between the personal and the universal” (Berger, 2015, p. 220).

As a therapist, approximately 85% of my clients are African American adults. Through my work as a therapist, I have become aware of the potential impact cultural trauma imposed on the “collective and collective memory” of African Americans and the extent to which historical and present-day trauma impacts their self, others, and world-view. Through my personal experiences, I found similarities in the intersection of the profession, generational traumas, community/collective trauma, and personal/professional experiences.

Deep diving into literature has brought me closer to the research subject, and deep diving into coding and analysis has pulled me even deeper, activating memories and experiences that align with the research and its participants. Reflexivity once again played a critical role in helping me maintain a trustworthy research project in moments of alignment with participants, overidentification with the data, or “flooding” when they find themselves delving too deep into the minutiae or “going off-track” (Padgett, 2017, p. 176). Therefore, it would be imperative for me to explore the intersectionality of my various roles that align with their research subject and its participants.
CHAPTER FOUR: PRESENTATION OF FINDINGS

Introduction

As stated earlier in this dissertation study, empirical research has reported that significant barriers contribute to African American clients’ decisions concerning the utilization of mental health services. The most common barrier identified in many studies is “stigma” (Alvidrez et al., 2010; Murry et al., 2011; Planey et al., 2019; Thurston & Phares, 2008; Alang, 2015). However, research has not examined connections between perceived barriers and silent contributors, such as historical factors, that may influence a client’s inner/external working model (IWM). From this attachment construct, this dissertation seeks to identify whether clinicians actively engage their African American clients through a culturally sensitive lens, assessing from an attachment framework the impact cultural trauma has on the client’s perception of self, others, the world, and ultimately the presenting reason for treatment. Hence this dissertation has explored the perspectives of clinicians, regardless of racial/cultural identification, who provide mental health services to African American clients—focusing on their perspectives on the inclusion of cultural trauma in the assessment and treatment of said clients. The following are the focus questions of this dissertation research.

Research Questions

This dissertation study focuses on how clinicians engage African American clients in treatment, including the impact of culture and, more specifically, cultural trauma on their internal models. Therefore, this dissertation research has been guided by the following three main research questions:

RQ1: How does the clinician include cultural trauma in assessing African American clients?
RQ2: What is the clinician’s perspective on the impact of the inclusion of cultural trauma when assessing the African American client’s internal models of Attachment?

RQ3: What is the clinician’s perspective on the inclusion of cultural trauma in treating the African American client?

Demographics

Participants in this study are licensed clinicians with a minimum of a master’s degree in a mental health-related field earned at an accredited institution. All are currently practicing mental health therapists with at least two years of practice experience. Among participants, the number of African American clients served also ranged from a clinician who only worked with one African American client within the past two years to a participant who provided services to 150 African American clients within the same period. Data concerning racial community identification among participants was obtained by allowing them to self-identify their racial identity. Among the 13 participants, they identified the following: African American, Black, Black Latina, Ghanaian American/Black, Latino, White, and Mixed Race. Participants were male-identified, female-identified, and queer-identified.
**Table 1**

**Breakdown of Participant Demographics**

<table>
<thead>
<tr>
<th>Participant pseudonym</th>
<th>Identified race/ethnicity</th>
<th>Gender identification</th>
<th>Preferred pronouns</th>
<th>Highest degree</th>
<th>Types of licensures</th>
<th>Years of experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alexis</td>
<td>African American</td>
<td>Woman</td>
<td>She/her/hers</td>
<td>Masters in Social Work</td>
<td>LGSW/LMSW (Graduate)</td>
<td>11</td>
</tr>
<tr>
<td>Butterfly Wings</td>
<td>African American &amp; Black</td>
<td>Woman</td>
<td>She/her/hers</td>
<td>Masters in Social Work</td>
<td>LCSW-C (Clinical)</td>
<td>19</td>
</tr>
<tr>
<td>Carla</td>
<td>African American</td>
<td>Woman</td>
<td>She/her/hers</td>
<td>Masters in Social Work</td>
<td>LCSW-C (Clinical)</td>
<td>7</td>
</tr>
<tr>
<td>Dexter</td>
<td>Black</td>
<td>Man</td>
<td>Male</td>
<td>Master of Social Work</td>
<td>LCSW-C (Clinical)</td>
<td>11</td>
</tr>
<tr>
<td>E.G.</td>
<td>African American</td>
<td>Woman</td>
<td>Sher/her/hers</td>
<td>Master of Clinical Social Work</td>
<td>LCSW-R (Clinical)</td>
<td>12</td>
</tr>
<tr>
<td>Jennifer C.</td>
<td>Asian American &amp; Eurasian/French European/South Asian Indian</td>
<td>Woman</td>
<td>Sher/her/hers</td>
<td>Master of Social Work</td>
<td>LCSW-R (Clinical)</td>
<td>20</td>
</tr>
<tr>
<td>Jill Smith</td>
<td>African American &amp; Latino</td>
<td>Woman</td>
<td>Sher/her/hers</td>
<td>Master of Arts in Counseling</td>
<td>LMFT (Clinical)</td>
<td>25</td>
</tr>
<tr>
<td>Kristen</td>
<td>Caucasian American &amp; White</td>
<td>Woman</td>
<td>She/her/hers</td>
<td>Master of Social Work</td>
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<td>15</td>
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<tr>
<td>Lina Alex</td>
<td>Black</td>
<td>Woman</td>
<td>She/her/hers</td>
<td>Master of Social Work</td>
<td>LPC (Clinical)</td>
<td>11</td>
</tr>
<tr>
<td>Mike</td>
<td>Latino</td>
<td>Man</td>
<td>He/him/his</td>
<td>Doctor of Social Work</td>
<td>LCSW (Clinical)</td>
<td>21</td>
</tr>
<tr>
<td>Millie</td>
<td>Black</td>
<td>Woman</td>
<td>She/her/hers</td>
<td>Doctor of Social Work</td>
<td>LMSW (Graduate)</td>
<td>19</td>
</tr>
<tr>
<td>Shay Mitchell</td>
<td>Black</td>
<td>Woman</td>
<td>She/her/hers</td>
<td>Master of Social Work</td>
<td>LCSW (Clinical)</td>
<td>21</td>
</tr>
<tr>
<td>Skylar</td>
<td>Caucasian American</td>
<td>Woman</td>
<td>She/her/hers</td>
<td>Doctorate in Social Work/Public Health</td>
<td>LCSW (Clinical)</td>
<td>15</td>
</tr>
</tbody>
</table>

**Presentation of the Themes**

The first question explores the clinician’s perspective on their assessment. From the data collected, the following four (4) themes emerged: (1) Connecting community cultural trauma and
triggers; (2) Analyzing individualist versus collectivist perspectives; (3) Exploring feelings of hope or despair; and (4) Identifying attachment connections.

**Connecting Community Cultural Trauma and Triggers**

Assessing the client’s connection with their identified (self-selected) perceived (stereotyped by others), and known (socialized grouping) community is a crucial factor in identifying cultural trauma and triggers. Investigating how these connections impact safety, belongingness, and overall identification and membership within the said community is vital to the assessment process. Events and experiences such as the “George Floyd the incident...the atrocity that kind of opened up a new or a larger racial conversation,” says Carla shapes a client’s conceptualization of cultural trauma and how these show up as potential triggers.

According to participant Butterfly Wings (B.W.), “community is important, but community may not look the way we expect it,” as most of the families she works with “don’t feel as though they matter in the larger scheme of things.” Another participant confirms this further in her reports of her client, who “was never really able to see herself as a part of the ‘so-called’ larger community. She always [felt] very much like an outsider” (Millie). For some clients, at the center of their struggle with identification and belongingness is rejection and feelings of unsafety. Participants reported that historical challenges in community identification, belongingness, and safety are not only impacted by external influencers but also within the community itself. Several participants who treat African American clients who identify as LGBTQIA+ report their clients “struggle” with “historical experiences with queerness in the [African American] community” (Skylar). Sharing that clients report their connection to community, identification, and membership can be seen as paradoxical, holding membership in a space that feels familiar but underlined with feelings of unsafety. Consequently, this leaves some
clients feeling a sense of “insecurity because of...community,” says Millie. Study participants see this level of “rejection from their [clients] communities of origin, rejection from even some of...what would be their preferred community [as the catalyst for] the establishment or development of [sub-communities], their own community” of belonging and safety (Jill).

**Analyzing Individualist Versus Collectivist Perspectives**

Analyzing community membership provides essential data concerning client views of an individualist versus a collectivist perspective regarding how they connect with their culture and internalize their experiences. According to B.W., “It’s the community that’s experiencing this even though they’re experiencing it individually.” Many of her clients identify that their experiences are directly connected to their desired or undesired membership within the African American community. Carla adds that some clients’ perspectives are “influenced by their culture because...inside these traumas...I hear things that sound related to feeling like it happened to them because of their race. [That client is at times] collectively feeling marginalized.” Similarly, Jill found that her clients are reminded by their collective experiences; that it’s not just “this is what I’m experiencing, this is what’s happening to me, [but it’s actually] this is what’s happening to us.” Thus providing context concerning how their perspective impacts their identity and/or the capacity to connect or reject said community can be helpful during the assessment process.

**Exploring Feelings of Hope or Despair**

Exploring the client’s feelings of hope and despair surrounding their overall outlook on the state of the African American community is imperative in assessing how the client identifies the direct or indirect impact of membership within said community. Participants shared variations of their client’s expressions of hopelessness despite their hopefulness. More
specifically, B.W. shared that even in her clients, “hope [for] things [to] get better...deep down inside, just by the nature and the way they say it, there is little hope.” Similarly, Jennifer believes:

“It just sometimes has felt that maybe with reason, [the] African American community doesn’t necessarily want to share all of their strengths in terms of community and family resources because maybe there’s some fear of it being taken away or it’s not deserved or because I think there’s still so much systemic...and institutionalized racism.”

According to B.W., clients struggle with seeing beyond the despair to the achievement of hope as the institutionalization of cultural trauma makes it difficult to see the unity within their community,

“the construction of the neighborhood community, the models that are seen in these communities have shifted historically, progressive people [are no longer] living in the neighborhoods...If your neighborhood is drug infested, that means every house in that neighborhood is struggling with drug addiction,” and seeing a way out is more unlikely than not.

**Identifying Impacts in Attachment Connections**

Noteworthy among participants is the idea that attachment connections, both secure and insecure connections are significant not only within family and friendships but also between client and clinician, most interestingly between client and community. The client/clinician attachment was highlighted by the participant, E.G., and the client/community by Kristen. E.G., suggest that “the basis of [clients] initially being able to form a very basic form of Attachment with [her] would be on the basis that [she] happens to be ‘Black’ as well.” She further stated that the “idealization of them, [client/clinician], being attached in that way, [is] because you
understand...[and because of this] you can do really good and...rich work, because there’s some form of attachment/trust.” This idea suggests potential significance within shared community membership and attachment between clinicians/therapists and the client during the assessment phase of treatment.

Kristen’s discussions surrounding attachment connections introduced a paradoxical connection between client and community attachment. Her interview revealed a level of variability surrounding the “views” of the internal working model (self, other, and world view). Kristen shared about a client who was raised in a supportive, nurturing home and community environment and, for all intentions, demonstrated a “secure” attachment. This individual had positive exposures throughout his life until he experienced racially motivated verbal attacks while attending an Ivy League institution. According to Kristen, “this guy, with secure attachment...[who had] certain expectations about the world...[who] had one positive thing after another after another happen to him...[was now feeling] shock, anger, vulnerability”; overall, now felt insecure about his location within his school community, the representation of his world view. This example represents how engagements between a client and their surroundings/physical community (i.e., school), when racialized or cultural trauma is introduced, the individual’s sense of safety and security is negatively impacted, as it did in Kristen’s client’s case.

Throughout this data collection process, approximately 40% of the participants identified a connection among cultural trauma, community membership identification, and attachment relationships as an emerging formulation that impacts a client’s internal working models. “Knowing the type of attachment that the client has really helps to inform you of really the
different issues that a client may have and [provide] ...an idea of [how] to understand the kind of trauma that they may have experienced,” says Alexis.
Table 2

Summary Table Showing Features of the Themes for Research Question 1

<table>
<thead>
<tr>
<th>Theme</th>
<th>Case count</th>
<th>Code count</th>
<th>Meaning</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecting community cultural trauma and triggers</td>
<td>13</td>
<td>259</td>
<td>Identifying intersections in community membership, cultural trauma, and triggers</td>
<td>“Community is important, but community may not look the way we expect it.”</td>
</tr>
<tr>
<td>Analyzing individualist versus collectivist perspectives</td>
<td>10</td>
<td>25</td>
<td>The client’s alignment with either perspective impacts their connection or rejection of community membership.</td>
<td>“This is what I’m experiencing; this is what’s happening to me, [but it’s actually] this is what’s happening to us.”</td>
</tr>
<tr>
<td>Exploring feelings of hope or despair</td>
<td>3</td>
<td>8</td>
<td>The state of the community and how this outlook, directly or indirectly, impacts well-being.</td>
<td>“Hope [for] things [to] get better…deep down inside, just by the nature and the way they say it, there is little hope.”</td>
</tr>
<tr>
<td>Identifying attachment connections</td>
<td>5</td>
<td>13</td>
<td>The significance of attachment connections within significant relationships (self, family, clinician, and community.</td>
<td>“This guy, with secure attachment [who had] certain expectations about the world…[who] had one positive thing after another, after another happen to him…[was now feeling] shock, anger, vulnerability.”</td>
</tr>
</tbody>
</table>

Research question two explores the clinician’s perspective on the impact of the inclusion of cultural trauma when assessing the African American client’s internal models of Attachment.

From the data collected, the following four (4) themes emerged: (1) Examining internalization of trauma; (2) Investigating influencers of internal models; (3) Exploring messages and meaning-making; and (4) Integrating community and generational/intergenerational patterns.
Examining Internalization of Trauma

Attributing the cause of the trauma to oneself, not the offending party/ies, becomes the method by which a client makes efforts to recover or move forward following trauma exposures. For example, “this didn’t happen to me; I am the cause of it” may be a narrative applied by a client in this attempt. As confirmed by participant Mike, “when African American clients talk about their traumatic experiences, it’s embedded in their worldview and the way in which they’ve understood their own culture and, in a way, how they challenge other people’s perceptions about their culture,” are impacted by the cultural trauma’s they have internalized.

Additionally, “recognizing that…these larger, cultural traumas have filtered in whether or not they’ve known it, whether or not they accept it, it’s still coming through,” says Skylar. Personal and historical contributors are involved; there are “layers to it…coming from [their] own experiences from way back when,” says Millie. “One of the primary emotions…observed is shame…sometimes awareness becomes overshadowed by shame,” says, E.G., “general trauma becomes normalized…something that is [not] verbalized, but it’s something that they have internalized from experiences and their reality.” For clients exploring topics surrounding internalized trauma narratives, a common resolve can be a message such as “It’s just the way it is, and you just got to be strong” (E.G.).

Investigating Messaging and Influencers of Internal Models

Participants acknowledged that an integral component in assessing and treating African American clients is investigating how external influencers and facilitators influenced by historical factors impact the development of the client’s internal working models and the resulting emotional, behavioral, and psychological patterns. Establishing first that our internal working models are “the fabric of who [we] are and how [we]
present and how [we] interact with [our] world,” according to Lina. The meaning of “norms or idioms” should be investigated and its meaning challenged, as stated by Dexter, “how [clients] are viewing themselves... that’s what creates some of [their] issues... [for example, I encourage] single mothers [to]... ‘stop calling yourself single. You’re just parenting by yourself’ [the child] got a father.”

Some clients struggle with not having an “understanding of what was happening with [them] and why [they] operated in the way that [they] operated,” says, E.G. Another research participant, Carla, shared the following that, “internal working models and how their culture influences it,... I think that inside of these traumas... I hear things that sound related to [clients] feeling like it happened to them because of their race, feeling like it happened to them, because [of] assumptions” about race.

External influencer’s impact on internal working models of “the self” at times presents as deficiencies in one’s character, as noted by E.G., who speaks about her client’s struggle with “imposter syndrome,” that “there is no room for error because then you’re disqualified because you’re the only black person in the room.” Therefore, “historical, political, cultural, traumatic experiences have informed those choices and those behaviors and those belief systems,” says Skylar. She further stated:

The concepts of identity that clients are working on when they come in, that, so the stress that they bring in is often very specifically linked to, ‘I’m supposed to be able to do this, or what’s wrong with me that this is so hard,’ [are questions asked by clients]... The feeling of [their] identity cracking open, what comes out of that, at the core of that, tends to be linked to messaging and beliefs and assumptions that are part of the larger collective messaging... Open[ing] up a lot
of space so that [the] internal model becomes our scaffolding that we then can use as we go and find new doors and windows and opportunities [to create]...

awareness...[that] exists within you and has been unconsciously a part of your existence for your life.

Participants overwhelmingly confirmed the need to investigate external influencers and to challenge collective messages that are systemic and/or systematic to bring awareness to those that facilitates the perpetuation of cultural trauma.

**Integrating Community and Generational/Intergenerational Patterns**

The integration of the identification of self and the identification of community membership can be an arduous task for some African American clients. However, participants in this dissertation study shared opposing beliefs regarding the integration task being complex. All agree that many African American clients find themselves challenged with the lasting generational effect of messages/narratives that originated during historical periods such as Chattel Slavery, the Jim Crow Era, and the Civil Rights movement. Struggling with a way to integrate self and community, Skylar shared that her clients question if “integrating self and community membership] are mutually exclusive.” From Skylar’s perspective, “a lot of folks make the assumption that they’re mutually exclusive, and so then they operate in those multiple spheres,” presenting themselves in a manner acceptable as the current environment dictates or requires. On the other hand, B.W.’s clients “feel that all African Americans family lineage had to have come from slavery,” therefore, integrating self and community membership should not be exclusive, nor should it be optional.

In alignment with B.W., E.G., identified that although her clients did not “experience the exact trauma that their mother or their grandmother experienced, but somehow they feel it
[and] will talk to you as if they experienced it themselves...they internalized it [as] it’s been in some way unconsciously projected onto them.”

In reviewing responses surrounding this theme, the following, relating to specific generational patterns, emerged among several participants:

- “African American clients that as children, they’re taught you hush. You don’t speak unless you’re spoken to” (Shay)
- “Mother-daughter trauma relationships that were generational” (Shay)
- “Amongst most of my black clients, I see the pattern of a lot of single moms and a lot of those mother-daughter conflicts” (Alexis)
- “They also experience corporal punishment or things to help expand that conversation into that larger realm of cultural trauma, intergenerational components” (Skylar)
- “If it’s something like generational trauma of the sort, mother went through something; grandmother went through something, I would say something depending on what the patient is experiencing” (E.G.)

The pattern identified above highlights the transmission of trauma within the matriarchal downline within families. B.W. further espouses that if the integration of self and community is unaccomplished, the “children [then] grow up and have families of their own [that are potentially disconnected to their self-identity and community membership], unless they have... experienced the effects of it on their own; they have no way of imparting that knowledge to their children.”

The above statements further assert that these unaddressed, generational transmitted experiences increase the likelihood of developing adverse internalized models. As
shared by Skylar, whose client expressed her concerns about passing on “insecurities...that as an African-American woman coming out of particular circumstances trying to move forward in the world around me, that these pieces that [she] had internalized as a child, somehow they’re still getting through.” However, hope can be heard within the African American community, according to Shay’s attestation of her client’s desire to “break generational curse[s], so [they can]...stop ‘this’ from happening.” Reporting that clients have said, “I don’t want this cycle to continue. I want to be the first to do this, or I want [it to] end with me.”
Table 3

Summary Table Showing Features of the Themes for Research Question 2

<table>
<thead>
<tr>
<th>Theme</th>
<th>Case count (Number of participants)</th>
<th>Code count (number of relevant excerpts)</th>
<th>Meaning</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examining internalization of trauma</td>
<td>9</td>
<td>27</td>
<td>Attributing the cause of the trauma to oneself, not the offending party/ies, becomes the method by which a client makes efforts to recover or move forward following trauma exposures.</td>
<td>“recognizing that...these larger, cultural traumas have filtered in whether or not they've known it, whether or not they accept it, it's still coming through,”</td>
</tr>
<tr>
<td>Investigating messaging and influencers of internal models</td>
<td>9</td>
<td>63</td>
<td>Investigating how external influencers and facilitators influenced by historical factors impact the development of the client’s internal working models and the resulting emotional, behavioral, and psychological patterns.</td>
<td>“internal working models and how it is influenced by their culture...I think that inside of these traumas...I hear things that sound related to [clients] feeling like it happened to them because of their race, feeling like it happened to them, because [of] assumptions.”</td>
</tr>
<tr>
<td>Integrating community and generational/intergenerational patterns</td>
<td>8</td>
<td>29</td>
<td>Examining the effects of generationally transmitted messages and historical events and how they impact the client’s integration of identifying self and community membership.</td>
<td>“experience the exact trauma that their mother or their grandmother experienced, but somehow they feel it [and] will talk to you as if they experienced it themselves...they internalized it [as] it’s been in some way unconsciously projected onto them.”</td>
</tr>
</tbody>
</table>

Research question three explores the clinician’s perspective of including Cultural Trauma in treating African American clients. From the data collected, the following five (5) themes emerged: (1) Understanding attachment patterns; (2) Exploring Connections and Baselines surrounding cultural traumas; (3) Embracing Community alignment and collective survivalism;
(4) Examining the clinician’s self-awareness and use of self; and (5) Integrating and utilizing practice models in therapy.

**Understanding Attachment Patterns**

Attachment theory is considered to be a universal therapeutic model and is therefore considered to be culturally sensitive and applicable to all cultures. Familiarity with this theory was an inclusionary criterion for this dissertation study; all participants confirmed the familiarity and most actively utilized Attachment theory tenets within their assessment and/or treatment models. According to Carla, she uses this...

*framework...with every client...[her] perspective when applying it, is that [it shows us] how we’re learning about the world. That’s how we’re learning about ourselves, and then that becomes the filter and the frame through which we move through the world through adulthood unless that’s interrupted or reframed. Carla believes the “internal working model is probably the part of the concept...[she] utilizes the most frequently because the more [she] can understand how an individual sees the world and sees themselves inside of the world, the more [she] can help them do the same.*

Skylar reported a similar approach with a slightly different perspective in relationship to the application with African American clients. Skylar utilizes attachment as an assessment tool, but also as a psychoeducation tool within her intervention. She reported that “helping [clients] understand...the way [their] belief systems were framed and how ‘ism’s’...could be connected to intergenerational components of [their] attachment and attachment history.” She further stated that although “attachment theory actually works against African American clients [who are] seeking help across the board...attachment has been a really interesting way for [clients] to engage differently with their own assumptions and beliefs...[and]...when attachment theory is
brought into [the] conversation...[she has] seen [clients show] more gentleness toward
themselves, particularly African American women.”

Following are a few examples of how participants report utilizing or incorporating
Attachment theory in their practice:

➢ Carla
  o “Whatever is causing the symptom usually can be tracked much further back than
    whatever moment the client can identify.”
  o “It’s as much a guide for treatment as it is often a relief for my client to
    understand why they’re showing up in the world like they are and where that
    came from.”

➢ Lina
  o Lina challenges the client’s internal models.
  o “By the third session, we are bringing parallels to recognizing how that dynamic,
    childhood dynamic, and attachment is reflected in their current relational
    presenting problems.”
  o “Bring awareness and work on [what] I call it, detaching that the trigger from
    the trauma is what I call it, and creating new attachments and new associations to
    the relationship, the current adult relationship.”

➢ Mike
  o “I try to see if patterns are repeated or similar to relationships they have formed
    once they’ve been adults outside the family dynamic to see if there’s a
    relationship between those patterns and the patterns they’ve described growing
    up in their home.”
Millie

- “I like it as a therapeutic modality because it’s limitless in my perspective. And I think that regardless of your demographics, I think that you can find ways to make it fit. Whereas that’s a critique of some of the many modalities that we use because they are so white.”

Exploring Connections and Baselines Surrounding Cultural Traumas

Exploring connections between the client’s reflections on personal and historical experiences and the individual’s definitions and interpretation of cultural trauma based on personal and professional exposure can be complicated by how cultural trauma is identified and defined. According to Mike, establishing a baseline “could be problematic in the sense that what may [be] view[ed] as traumatic, may not necessarily be viewed as traumatic for [the] client. So part of this is getting a clear understanding of not only what their understanding about what [cultural] trauma is, but also what defines that in their world rather than making assumptions about whether or not what they’re [sharing] is traumatic or not.” Jennifer’s opinion adds to Mike’s previous statement as she believes clients can identify cultural trauma, “they do see it, but...it’s not verbalized...it [just] comes out in the treatment in different ways.” However, B.W.’s perspective is that most of her clients simply “don’t...understand that there is an impact...[and do not make the connection] that cultural trauma is impacting them.”

It is believed “that there’s a baseline of trauma [imposed upon African American clients] from marginalization [by the dominant culture], that whether [African Americans clients] were in a community that was diverse or they were in a community that was only African American, society still [found] a way to marginalize them;” therefore, “with [her] African American clients, [she encourages] digging a little deeper, [and] looking a little further” to uncover those
connections. A similar approach is also adopted by Lina and Kristen, who both reported engaging in explorative questioning to assist clients in unpacking this topic. Kristen “listens for it and then listens for an experience that the client might not even be identifying as trauma. And then ask the question of, ‘What is that like for you? How do you make sense of that? What does that feel like?’” to begin the dialogue surrounding connections and develop a baseline understanding of cultural trauma from that client’s perspective.

**Embracing Community Alignment and Collective Survivalism**

Clients’ values surrounding and openness to community alignment can be discovered in how they locate themselves within their community and investigate their perspectives surrounding collectivism and the intersection between their survival and that of the larger collective/community. Participants of this dissertation study reported that some clients “don’t feel that sense of cohesiveness in the larger community,” says B.W. This participant states further that “some of these families, when they think of culture, they think of the common African American narrative that we hear in media that this is just the way it is, that’s how these neighborhoods are, that’s how these people think,” perpetuating stereotypes. Therefore, clients report “not functioning as a community, as a unit...[instead] they just live in the same neighborhood, but it’s not really a community,” says B.W.

On the other hand, addressing the intersection of community membership may also impact how a client chooses membership. According to Mike, African American clients who identify as queer represent an added dynamic that may complicate matters further. Therefore, he believes “exploring the intersection between [and] discussing how [a client should] handled...situations in which [they] felt [marginalized when]...an inappropriate remark around
race” was made within the queer community is imperative to effective treatment, from his perspective.

Additionally, the following are approaches utilized by several participants during treatment with their African American clients:

- Carla
  - “Don’t create this universal experience of being African American.”
  - “Don’t assume what experiences they’ve had.”

- E.G.
  - “The assumption is you understand, which I do for the most part, what it’s like to be Black in America or just as Black in general, Black female.”

- Jill
  - Acknowledging when “trauma comes in and [labeling the action], ‘Okay, this is just really survival.’”

- Skylar
  - Explore and challenge “assumptions and beliefs about what is a failing and what is actually a component of intergenerational ways of survival.”

Examining the Clinician’s Self-Awareness and Use of Self

Self-assessment and self-awareness are essential tools of practice for any clinician engaged in trauma work and even more for those working with conscious and unconscious exposures to cultural trauma. Assessing one’s assumptions, biases, over-identification, and countertransference is imperative when seeking to engage in culturally sensitive work and establish an effective therapeutic relationship. According to Carla, being “passionate that as a [clinician], ... inside [your] own humanity, know that [your] experiences, [surrounding] cultural
trauma inside of communities, [has]...impacted the way [you] experience the world,” and is your “ethical responsibility,” says Kristen, to ensure that you “help [your client regardless of] of demographic differences.”

The diversity of participants in this research study allowed the opportunity to hear the perspectives of African-American and non-African American participants. Both groups expressed perspectives surrounding self-awareness and the use of self were very similar in that African American and non-African American participants expressed overwhelming pressure to perform.

A clinician’s ability to engage in reflective work requires that an individual be “vulnerable, [being okay, with] pay[ing] attention to [your] own discomforts,” says Kristen. Jennifer, a non-African American participant, and Carla, an African-American participant, spoke to the pressure in engaging work surrounding culture-based trauma. Jennifer shared that…

...internally, I think I was feeling... I mean, it felt so large; the whole thing felt large. The trauma [was] just my own internal. I started questioning my adequacy as a therapist, but also just as a person. I was like; I don’t know. I’m going to try and understand it. I know there’s a lot of historical contexts here, and there are other events and situations in which people have been falsely accused and killed. And so I know that it was a weight on the community, and I think I felt like ‘this’ small at times because I was like, hmm, I’m going to try and understand it. It really is hard.

Similarly, but significantly varied, Carla stated the following…”I know what that feeling of marginalization feels like. So, for me, in my mind, I don’t know that I always talk about it with my clients, but I do think that I hold for my clients of color” a safe space to express and feel heard. However, a particular challenge she experiences in safety concerns her cultural trauma
triggers. Carla further stated that she tries to be mindful of the over-identification and countertransference mentioned by participant E.G. Therefore, she tries to be cognizant that, …even inside of a cultural group that may look and feel like my own, it’s not always the same experience.” It’s just hard, [says Carla], to do all of that when I’m holding my own stuff, and I’m saying to myself, ‘Ooh, I know exactly how that feels. I remember the moment, and the moment comes up just like that for me. In a very transparent moment, Carla then shares the following…

    I want to be very clear. I don’t wish to be any other culture, but I wonder sometimes, what it would be just to do the work, did not have to hold the cultural trauma as a backdrop. It’s always the green screen behind us, right, that you don’t notice because it holds another image on it, but that green screen... It’s always there in the background. So, sometimes, I wish we just didn’t have a green screen. I just wish we did not have the weightiness of cultural trauma. For me, as aclinician, I wish that I didn’t have to think about how to decolonize my therapy practice to feel like I’m doing right by my clients. I wish my clients didn’t have to walk in the door with that on top of what has happened to them as an individual...It feels like extra work, and it feels like more of the narrative of cultural trauma. So, working on cultural trauma actually carries the burden [but] I feel frustrated that it is the burden that it is inside of the work that we all care so deeply about.

    Jennifer and Carla’s statements represent the shared expressions of other participants surrounding their work with clients with culturally traumatic experiences. Although “it’s tough...you have to be able to take care of yourself and attend to yourself while not letting that bleed into your session, and all the things we do and making space for the client,” we need to
make sure that we make space for ourselves…as “warriors on the battlefield fighting with all of our own wounds,” says Jill. Therefore, Dexter’s techniques of “self-evaluations…and…be[ing] mindful of [his] emotional state” is consistent with other participants of this study.

**Integrating and Utilizing Practice Models in Therapy**

Typically, within the therapeutic process, clinicians utilize integrative treatment methods. In addition to Attachment theory, participants of this study shared various methods used during therapy/treatment with African American clients, ranging from “Common Factors” of simply showing up as your authentic self as with B.W., who “just show up as I am”; others report incorporating cognitive behavioral theory and therapy (Jill and B.W.), a few utilizes Dialectical behavioral therapy (B.W. and Jennifer), psychodynamic (Carla and Lina), solution-focused (Carla and Jill); however, E.G., uses object relations, interpersonal therapy, and psychoanalysis in her integrated treatment model.

Integrating treatment models has been identified in this research study as a common practice, as when asked about additional models or frameworks that inform their practice, just about all participants identified at least one other theory/framework. Following are a few examples of how clinicians engage their African American clients in treatment when addressing topics related to culture and cultural-based trauma.

- **BW**

  1. Meet clients where they are.
  2. Let them tell the story…ask open-ended questions.
    
      a. Who supports you?
    
      b. How do you get along in this world?
    
      c. How do you relate to other people?
d. If there’s [an activating event in the] news [inquire about triggers or] any similarity.
   a. “Do you talk to your children about these things?
   b. How are they impacted by these things?

 ➢ Carla

1. Be curious “using language around cultural trauma [and] the collective; [about attachment relationships]. Attachment theory doesn’t always incorporate the idea that for communities of color, relationships look different, and their family system can be more expansive.”

2. Ask questions like…
   a. What do you have power over?
   b. Where’s your agency?
   c. Where’s your locus of control? Can we find that? (if we can find where you find that you have power, then we combat the global experience of disempowerment)
   d. what can I control?
   e. What is inside of my control?
   f. What can I reactivate control around?
   g. Where have I given up control that I could take back?
   h. Exploration is most often from the perspective that this is probably whatever they’re presenting as the first trauma.
3. Use Attachment Theory as a guide—“It’s as much a guide for treatment as it is often a relief for my client to also understand why they’re showing up in the world like they are and where that came from.”

4. Discover…trauma inside…early attachment relationship that led to a feeling of worthlessness…
   a. Take that perspective [and] test…to see if it is actually how they view themselves.
   b. Then…translate that into how they’re showing up in a relationship today.

5. Use [case] conceptualization to [create] a framing for whatever they’re seeing today, to expand the view beyond the symptom and to the underlying drivers.

6. When activating events occur, conduct frequent check-ins [Ask questions like]…
   a. How are you experiencing that?
   b. How’s your local community or your network experiencing that?
   c. What does that feel like for you as an individual and then as a collective?

7. Ensure “they don’t feel that sense of marginalization…[but] they feel…very supported, very held in this space.”

8. Finding the place where they feel like we’ve done restoration of power.
   a. It’s not always going to be in changing something global. Sometimes, it’s just changing your own home [or] just changing your own perspective.

➢ Dexter

1. [Identify]…what part of the internal working model will…help them work through their situation.
2. Allow them space to express freely, but be able to [help them identify] that connection [with the] community issue.

3. Support and validation…”I see it, I hear it, and I understand where you are.”

➢ E.G.


2. Write a new script for life.

3. Validate the fear, but also validate the part of [the client] that can’t live in the fear.

➢ Jennifer

1. [Establish the]…framework early by…asking about the family of origin [and] early experiences.

2. Define safety.

3. [Explore]…how culture influences [their] identity.

4. Listen, Validate, and Reflect.

5. [Be authentic, if you don’t] understand…say,…”I don’t understand. I’m trying to understand. Can you explain it to me?”

6. Move toward…concrete and manageable, [introduce psychoeducation if] it feels like the patient is overwhelmed.

7. Identifying connections and then…inject coping mechanisms and…skills that identify with that exact experience.

➢ Kristen

1. Meeting [the] client where they are

2. [Identify] protective factors for this ever-present risk factor

3. [Don’t] assume every person has had [the same] experience
4. [Assess the] internal working models

5. [Explore the] individuals [expectation of] their relationships

6. Is [it]…grounded in the sense of distrust

7. [Assess your biases and] assumptions…[regarding]…cultural trauma

Skylar


2. [Be aware of institutionalized barriers such as] social work history’s…erasure of African-American work and care and community engagement and…the assumed history of whiteness as the basis

3. [Identify] gaps in providing care to African-American clients.
Table 4

<table>
<thead>
<tr>
<th>Theme</th>
<th>Case count (Number of Participants)</th>
<th>Code count (Number of relevant excerpts)</th>
<th>Meaning</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding attachment patterns.</td>
<td>6</td>
<td>17</td>
<td>The layers of attachment patterns are identified in all significant relationships.</td>
<td>“helping [clients] understand...the way [their] belief systems were framed and how ‘ism’s’...could be connected to intergenerational components of [their] attachment and attachment history.”</td>
</tr>
<tr>
<td>Exploring Connections and Baselines surrounding cultural traumas</td>
<td>12</td>
<td>93</td>
<td>Exploring connections between the client’s reflections on personal and historical experiences and the individual’s definitions and interpretation of cultural trauma based on their personal and professional exposure.</td>
<td>“what may [be] viewed as traumatic, may not necessarily be viewed as traumatic for [the] client. So part of this is getting a clear understanding of not only what their understanding about what [cultural] traumas, but also what defines that in their world rather than making assumptions about whether or not they’re [sharing] is traumatic or not.”</td>
</tr>
<tr>
<td>Embracing Community alignment and collective survivalism</td>
<td>10</td>
<td>28</td>
<td>Exploring the client’s values surrounding and openness to community alignment. Locating themselves within their community, do they identify as a part of a collective and see their survival intersecting with that of the larger collective?</td>
<td>“assumptions and beliefs about what is a failing and what is actually a component of intergenerational ways of survival.”</td>
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<tr>
<td>Examining the clinician’s self-awareness and use of self</td>
<td>13</td>
<td>192</td>
<td>Self-awareness is used to monitor a clinician’s cultural sensitivities and effectiveness within a therapeutic relationship.</td>
<td>“passionate that as a [clinician]...inside [your] own humanity, know that [your] experiences, [surrounding] cultural trauma inside of communities, [has]...impacted the way [you] experience the world.”</td>
</tr>
</tbody>
</table>
Summary

In this chapter are participants’ perspectives concerning this dissertation study’s three research questions, which have focused on the impact of cultural trauma on the assessment, the client’s internal working models, and the clinician’s treatment process with African American clients. All participants were licensed mental health providers with a minimum of two years of practice experience. As previously mentioned, the data was collected via individual interviews of up to 90 minutes each, which were then transcribed and organized.

Collectively, 12 themes emerged from all three research questions. The following four themes emerged from the data collected concerning research question one: how does the clinician include cultural trauma in assessing African American clients? (1) Connecting community cultural trauma and triggers; (2) Analyzing individualist versus collectivist perspectives; (3) Exploring feelings of hope or despair; and (3) Identifying attachment connections. Research question two, what is the clinician’s perspective on the impact of the inclusion of cultural trauma when assessing the African American client’s internal models of Attachment themes focused more on the therapist’s exploration and understanding of cultural trauma’s impact on the client’s internal working model? These themes are: (1) Examining the internalization of trauma, (3) Investigating messaging and influencers of internal models, and (3) Integrating community and generational/intergenerational patterns. Finally, themes emerged from research question three, what is the clinician’s perspective on including cultural trauma in
treating the African American client? The data revealed informative information surrounding the participant’s treatment and intervention models: (1) Understanding attachment patterns; (2) Exploring connections and baselines surrounding cultural traumas; (3) Embracing community alignment and collective survivalism; (4) Examining the clinician’s self-awareness and use of self; and (5) Integrating and utilizing practice models in therapy.

The following section will discuss these findings and their relevance to the assessment of the presenting problem, internal working models, and treatment of African American clients.
Discussion of Findings

This study has aimed to explore the clinician’s perspectives regarding the inclusion of cultural trauma during assessment and treatment as well as the evaluation of cultural trauma’s impact on the internal models of their African American clients. Following are discussions of the findings that emerged from this research.

The Impact of Cultural Trauma on Assessment

Two essential factors emerged from the data relating to the inclusion of cultural trauma in assessments when treating African American clients. Initially, to assess how the client identifies their cultural community membership. Secondly, to establish how the client differentiates trauma. For a client to identify connections, according to the data collected, these two goals are essential in the process. According to participants, their clients struggled with identifying trauma. They reported that clients found it difficult to differentiate and identify trauma in their day-to-day occurrences. Therefore, not many were able to connect with cultural trauma’s impact on their existence and their daily experiences.

Identified community membership, the other essential component, plays a significant role as it provides insight into the client’s perspective on seeing themselves as individuals having individual experiences or as part of a larger entity having a joint experience. A few participants identified that their clients exhibited awareness of their connection to a larger collective and had a collective experience.

These two previously mentioned perspectives represent two competing frames emerging from the conflict created by Cultural Trauma. The collectivist community membership stems
from a historic perspective steeped within the African Diaspora that identifies the significance of community membership to their values, norms, and overall existence. On the other hand, the individualist perspective opposes the collective. The individualist perspective identifies the individual as its primary arbiter and influencer; it encourages the individuals to see themselves as not needing others or diminishing the value and necessity of aligning with others in shared likeness. The narrative held by clients holding this perspective would be “It’s happening to me, not it’s happening to us.”

Participants explicitly identified the client’s feelings of hope and despair as essential to the assessment process. Not all African American clients experience hope or despair independently of each other, but instead, they experience an interesting mixture of the two, which at times cancels out each other, leaving them in what may appear to be a neutral space that looks much like disconnection, unmotivated, lackadaisical, aloof, isolation, to name a few. They often adopt a narrative of “‘I hope things get better.’ But really deep down inside, just by the nature and the way they say it, there is little hope” (B.W.). Here again, we see the importance of other-identified versus self-identified community membership, as individuals sometimes find hope in their self-identified communities over that of the larger collective (i.e., the African American community). The data also revealed that most participants reported that clients who experience a strong sense of despair are often activated by historical events, personal and/or cultural, as well as by current societal tragedies that impact the African American community at large, as depicted in the events of targeting and violence against communities of color.

The data also revealed the significance of identifying attachment connections as an exploratory factor in assessing African American clients. Identifying the importance of the various attachment connections to family and community or the absence is a topic of discussion
between many participants and their clients. The importance of the client’s attachment relationship with their therapist emerged from the data. It was reported that clients expressed increased comfort in sessions with a therapist that creates safety within the therapeutic space. Contrarily shared community membership was not always a factor of safety and/or attachment with some clients. Participants who identified as Caucasian American/White expressed anecdotally about experiences with African American clients where the client gave permission to explore cultural trauma-related topics during the session; this represented that the client felt a sense of safety/security within their relationship with a non-African American therapist. However, it is essential to note that this was not the experience for all non-African American participants. Another non-African American participant shared an experience with one client who told her that culture-based traumas are not a “topic that you as a white person...have a right to explore with me” (Kristen).

**The Impact of Cultural Trauma and the Internal Working Model of Attachment**

With participants in this study, their observations of what clients say demonstrated the conscious and unconscious internalization of historical and intergenerational traumas. However, clients do not report identifying intergenerational and/or historical community traumas as contributing factors to their traumatized internal working model. As stated by a participant, “When African American clients talk about their traumatic experiences, it’s embedded in their worldview and the way in which they’ve understood their own culture and, in a way, how they challenge other people’s perceptions about their culture” (Mike).

This research reveals a consistent theme surrounding the impact of external messaging, specifically surrounding culture. One participant stated that their client expressed that “the feeling of [their] identity cracking open, what comes out of that, at the core of that, tends to be
linked to messaging and beliefs and assumptions that are part of the larger collective messaging” (Skylar). According to participants, clients acknowledged struggling with understanding the “why” behind unresolved and generational patterns in the manner in which they show up in life. However, most clients typically identify patterns for up to two generations, and very few make the connection of historical influencers’ impact on their models and how they see themselves, others, and the world. Approximately 50% of the participants were not familiar with the Attachment Theory concept, internal working model; most were familiar with the concept of internal models; and all were familiar with self-view, view of others, and world-view. The implication for most participants is that clients benefit from the incorporation of psychoeducation surrounding the internal working model of attachment.

Herein lies the paradox that may be experienced by many African Americans, both those in therapy and those not engaged in treatment: the integration of who you are today and the impact of your community membership, historically and generationally. Participant data revealed that their clients both understand and struggle to embrace the ideal of integrating patterns that are superimposed as a result of community membership, and which is subsequently handed down via generational/intergenerational transmission. Most clients do not make connections between the residues of historical events and present-day entanglements, until there is an activating event that occurs, either personal or within their “identified” community or the “socialized” community (African American Community). It is easier to make connections between the generational influences of the previous two familial generations, rather than looking beyond to historical factors dating back to Jim Crow, Chattel Slavery, etc. However, a small number of clients are able to make direct historical connections; as stated by a participant, some clients “feel that all African Americans family lineage had to have come from slavery,” (B.W.). Therefore, making
the connection and integrating community and generational/intergenerational patterns should be a task pursued by all clients.

Surrounding the theme of intergenerational trauma and patterns, an interesting trauma theme emerged. Of the traumas noted by clients, gender appeared to emerge as a significant contributing factor. It was reported that of the client scenarios involving a woman, 90% of the scenarios interplayed a narrative regarding generational mother/daughter trauma. Most clients express their desires to prevent generational transmission of trauma patterns experienced in their mother/daughter conflicts from being transmitted to their daughters.

According to Joy Degruy, these mother/daughter trauma patterns have a long historical connection. Degruy states that “the enslavement experience was one of continual violent attacks on body, mind, and spirit...In the face of these injuries, those traumatize adapted their attitudes and behaviors in order to simply survive, and these adaptations continue to manifest today...” (Degruy, 2005, p. 9). Dr. Degruy noted that as a result of fear of harm mothers adapted to protect their daughters. She espouses that the enslaved mother, “terrified that the slave maser may see qualities in her daughter that could merit her being raped or sold, says, ‘Naw, sir, she ain’t worth nothin.’ She cain’t work. She stupid. She shiftless.’...The mother denigrating statements about her daughter were spoken in an effort to dissuade the slave master from molesting or selling her, and of course, no one would fault her...For hundreds of years, enslaved mothers and fathers had been belittling their children in an effort to protect them. Yet what originally began as an appropriate adaptation to an oppressive and danger-filled environment has been transmitted down through subsequent generations” (Degruy, 2005, p. 9) where these protective factors are no longer needed, but has become an internal working model, impacted by the
residuals of Slavery. Despite this factor, participants reported that some clients are identifying the presence of trauma that is not directly their own but experiencing it as if it were.

**The Impact of Cultural Trauma in Treatment**

Historically, research regarding attachment provides foundational explanations for clinicians and clients alike. According to participants, Attachment Theory can be seen as a universal approach in its relational application as it pertains to explaining how relationships impact other relationships, and an individual creates models of organizing experiences and memories that informs how they see themselves, others, and the world. As stated by a participant, Attachment Theory is “how we’re learning about ourselves, and then that becomes the filter and the frame through which we move through the world through adulthood” (Carla).

An inclusion requirement for this research study was that all participants must be familiar with Attachment Theory. As the research evolved, not only were participants familiar, but demonstrated active use of Attachment Theory in their practice models. All participants reported using concepts and tenets of Attachment Theory either in assessment/diagnosis or treatment or both.

The findings in this research revealed that most participants found Attachment Theory relevant to their engagement with clients, despite the use of other preferred therapeutic frameworks and models. Participants spoke of the relevance of Attachment Theory in their assessing, interpreting, and intervention with their clients. A few clinicians implied in their disclosure their unconscious use of Attachment Theory in practice as they admitted engaging in a quick refresher of the theory prior to our interview, and realized during the interview how involved Attachment Theory was in their practice.
Overall, Attachment Theory was reported by participants as useful in identifying attachment patterns and providing fundamental understanding for the client as well as the treating provider. In its application, Attachment Theory helps clinicians assist clients in “understand[ing] ...the way [their] belief systems were framed and how ‘ism's’...could be connected to intergenerational components” (Skylar) of their internal models and how they show up in relationships. Attachment Theory allowed the clinician to gain understanding concerning levels of emotional injuries, if any, which provided clinical insight into the direction of treatment, especially concerning complex trauma topics such as culture-based traumas.

This research revealed that defining cultural trauma and establishing a shared/collective understanding is paramount to treatment. As the literature establishes the definition of cultural trauma from a sociological perspective, clinicians and clients vary in their conceptualization of the practical application of this term. One participant acknowledged that defining cultural trauma from a practice model perspective may be problematic for some as their understanding can be subjective to both the client’s and the clinician’s interpretation of what is cultural trauma. Therefore, most participants espoused that defining cultural trauma is the initial step to addressing this in treatment. Inclusive in the process of establishing a baseline is exploring self as the provider, and also exploring some of one’s personal and professional experiences that have impacted your perspective of cultural trauma and identify any biases. Identifying this in self is essential as one’s perspectives may influence their approach and treatment methods.

Community alignment and collective survivalism should be viewed from the viewpoint of historical disconnection or misconnection, which potentially leads to community misalignment. Consequently, misalignment brings to question the African American's perspective on collective survivalism. Are they seeing the survival of their collective to be
directly connected to them as the individual? Historical factors that impact a client in the present are not always identified by the client, as many may not be aware. Participants reported that their clients are more aligned with and believed that their internal model influencers are only of their previous two generations, and very few acknowledge the impact of historical factors dating back to Jim Crow, Chattel Slavery, etc. Ironically, present day African Americans experiencing historical disconnections and/or misconnections of the previously mentioned periods of history may be misaligning with an important factor, which is community membership.

Historically, community membership was an essential part of the African American community. However, as time progressed and society advanced, a system of meritocracy was misleadingly promoted to some minorities to believe in a system that, according to literature, did not include them in the design (Fanon, 1952/1963; Graff, 2014; Powell, 2018). This research provided evidence that there are some African American clients who embrace community alignment and believe in their individual survival being aligned with the survival of the collective, as well as those who do not. From this emerges an enlightenment continuum, providing a process of a client’s increased awareness and knowledge. Most clients’ scenarios shared by the participants, at some point in treatment, is that the client arrives at some form of enlightenment; however, conversely, there are those who do not.

As previously mentioned, relevant to a client’s treatment surrounding culture-based traumas is the clinician’s ability to engage in active, persistent self-reflection. Self-awareness and use of self are key common factors that can contribute to an effective therapeutic relationship. This data revealed that clinicians are engaged in self-reflection. They are aware of the impact their own community membership has on the therapeutic process. African American/Black-
identifying participants acknowledged their awareness of the impact of shared community membership, as does those who do not share community membership with their clients.

In this study, two of the four participants who identify as non-African American disclosed their struggle with “permission” surrounding the exploration of culture-based traumas in session with their African American clients. They expressed feeling that permission must be granted in order to proceed. One participant stated “it’s like what do I have permission to check in on...a younger client, 19 [years old], says, ‘This is a topic that you as a white person don’t have a right to explore with me’” (Kristen). Consequently, permission seeking is then paired as a trigger for the non-African American clinician, which we will refer to as “culture triggered permission-seeking.” With this type of permission seeking, non-African American clinicians found themselves engaged in introspections that led to questions of confidence, competence, and self-value. For these participants, culture triggered permission seeking, challenges their conceptualization of “privilege,” and levels of power that results from their role as clinician.

Additionally, a significant theme emerged surrounding participants who identified as African American/Black regarding self-awareness and shared community membership. Approximately 80% of the participants who identified as African American/Black expressed concern surrounding over-identification or countertransference. All of the participants who expressed this concern provided an example of a moment where they felt like, “I totally understand.” Here is where over-identification and countertransference confirms Marianne Goldberger’s (1993) idea of “bright spots” in treatment. Goldberg espouses that bright spots occur where the clinician fills in the spaces of information based on their own assumptions from their own experiences. With this the clinician runs the risk of oversimplifying a client’s experience or engaging in “missed-treatment” because they have overshadowed the client’s
experiences with our own. The other significant concern presented in this research, surrounding shared community membership, is the potential of the client’s experience of culture-based trauma becoming an activating event and triggering the clinician’s own unaddressed/unidentified “culturally traumatized internal working model.” Furthermore, navigating this experience both during and after session becomes a “cultural trauma trigger” for the African American/Black provider. Yet they hold the narrative that “it’s tough...you have to be able to take care of yourself and attend to yourself while not letting that bleed into your session” (Jill).

At the onset of each provider’s interview, when explored, most acknowledged not having a formal method or being intentional concerning the assessment, evaluation of the client’s internal working model, and treatment of clients from a Cultural Trauma Attachment Approach. However, the data showed that all participants described what can be considered a cultural trauma-influenced integrative attachment approach to assess and treat their client’s “culturally traumatized internal working model” (CT-IWM).

**Implications for Clinical Practice**

A noteworthy thread extrapolated from this data centers around levels of awareness versus unawareness of culture-based traumas and its impact on effective treatment. Although not directly identified as a theme, there are significant implications of awareness versus unawareness to clinical practice that prove to be essential to both providers and clients. According to Goldsmith et al., …

When people must endure chronically traumatic environments, it may be adaptive to isolate from awareness of information that would produce cognitive dissonance and threaten necessary relationships. Unawareness may also facilitate functioning in environments that invalidate the prevalence and impact of trauma…Though often initially adaptive, unawareness of [cultural] trauma is linked to the intergenerational transmission of trauma
and its effects and may preclude public and professional attention to trauma treatment and prevention. Understanding the processes through which individuals become unaware or aware of traumatic experiences is, therefore, essential to conducting effective psychotherapy with trauma survivors. (2004, p. 448)

Therefore, for some African American clients, it’s emotionally cathartic to forget, because remembering is too painful. In the Twi language, “the word kae means ‘to remember, recollect, remind, call to mind’” (Gilbert, 2010, p.428). The author of this essay, Michelle Gilbert, promotes the belief that “the memory of [a] tragic event [should] never [be] allowed to disappear from the collective memory” (2010, p. 429); remembering, despite the pain, facilitates a connection between the individuals and the collective.

The assessment phase in clinical practice is foundational in the establishment and trajectory of an effective intervention/treatment plan, helping the client to “remember” is essential to the process, as many have intentionally or unintentionally “forgotten.” The integration of an assessment model that incorporates the remembering of culturally traumatic events and investigating the internal working model of attachment theory could prove to be an effective tool when assessing African American clients, especially those who express thoughts and beliefs that align with intergenerational narratives associated with cultural trauma. As this research revealed, a client’s unawareness of cultural trauma’s impact on their internal models can be a barrier to providing appropriate treatment. An essential tool is for both clinician and client to co-create a safe environment within their therapeutic relationship to explore this issue. Also essential is establishing a culturally humble approach regardless of the clinician’s ethnic or racial differences in community membership.

Engaging in the exploration of familial relationships, generational patterns, and
identifying any connections with the client’s reason for treatment seeking is essential to early rapport building. Subsequently, providers should assist the client in their conceptualization of cultural trauma and its underlying impact. Therefore, conceptualization occurs when the clinician explores with the client their “definition of and attitude toward trauma [which] can affect [their] detection” (Hoshmand, 2007, p. 32) of cultural trauma’s impact.

Additionally, during the assessment, some clinicians raised awareness of the generational presence and intergenerational transmission of trauma and trauma narratives that impact clients’ internal models while normalizing that the common factor of forgetting trauma/history is easier and less painful than remembering. For some clients, unawareness is synonymous with intentionally forgetting, as the pain of remembering is too hard to bear. To further the development of safety within the therapeutic relationship, the clinician should: (1) proceed cautiously and assess the client’s readiness for this process; (2) investigate possible triggers and effective measures to achieve regulation when and if that occurs; and (3) explore and discuss the necessity of boundaries (P.I.E.).

Out of the data in the research emerged specific approaches clinicians utilize in treating cultural trauma. The first step aligns with the social work code of ethics in meeting the client where they are, which means starting where your client is in the therapeutic process. Commonly mentioned was the tool of psychoeducation. The following are suggested aspects of practice that may be applicable with clients who have experienced cultural trauma. In utilizing these suggested practice applications, the clinician should: (1) co-create a therapeutic environment that allows that the client’s progress to be determined by the individual; (2) acknowledge racial/ethnic difference; (3) be mindful of one’s own biases and “bright spots”; (4) explore the power and privilege within the therapeutic relationship; (5) engage in cultural
trauma-based clinical supervision; and (6) ensure the client is allowed the privilege of sharing their cultural trauma story as they see it (C.A.B.E.E.S.).

Overall, the findings showed that the clinicians did not use a specific model to establish facilitate the assessment of and intervention/treatment of African American clients from a culturally informed space that addresses the historical and present-day culture-based traumas. However, the clinicians in this research provided a co-created, integrative process to get to the underlying possible source of the manifestation of some of the cultural trauma rooted in the intergenerational transmission of trauma.

Therefore, clinicians who treat African American clients should be intentional in participating in cultural trauma-based clinical supervision. Such supervision could be beneficial to both African American/Black and non-African American clinicians. This format of supervision, for the African American/Black clinician, would address those “bright spots” (Goldberger, 1993); this supervision can address any countertransference and/or triggers that surface during sessions with a client. With the non-African American clinician, said supervision could address any “culture triggered permission-seeking,” biases, and cognitive dissonances surrounding the presence and residual of generational culture-based traumas. According to Goldsmith et al.:

A lack of awareness for trauma makes subsequent perpetration more likely and may contribute to the perpetuation of violence in our society. Another important dimension of awareness for trauma is professional awareness or the lack thereof…Personal and professional attitudes toward trauma are also likely to affect levels of awareness and subsequent behavior…[Therefore], acknowledgment of the prevalence and [the] impact of trauma challenges psychological theories that localize dysfunction within the
individual while ignoring the contribution of social forces on adjustment…Because the study of trauma involves strong emotions, it is especially important for researchers and therapists to evaluate personal reactions and biases that may influence their procedures. (2004, p. 450)

Goldsmith et al.’s research suggests that clinicians should be cognizant of how their own internal models influence their practice. Additionally, these clinicians should hold professional responsibility to challenge clinical discourse that attempts to minimize and relinquish the responsibility of mental health professionals to “do no harm” in assessment and interventions.

Therefore, awareness of race-based trauma in practice and the literature should reflect the intentionality necessary for effective treatment, and to limit engaging in ineffective models that are simply transactional and does not encourage a more psychodynamic exploration. However, from this data, collectively, participants demonstrate that a more integrative approach to treatment could be more effective. All the participants in this dissertation research reported not having a formal method of assessing or treating culture-based traumas; consequently, most weren’t aware of their informal methods and the need for more intentionality until this study.

Implication for Research

Goldsmith et al. espoused that one’s interpretation is ultimately their understanding of what one knows and believes (2004). The authors specifically address the issue of culture-based traumas and the need for effective psychotherapeutic treatment. This literature supports the implications in clinical practices identified in this dissertation research. The findings revealed that providers could benefit from a standardized way of understanding cultural trauma; with the development of a clear, practical definition, guidelines, and application, clinicians could be more consistently intentional in assessment and treatment, to include effective ways of communicating
with their clients regarding cultural traumas impact on the internal working model and the
generational transmission of internal models. Once a practical definition and clinical application
are developed, providers could benefit from a structured practice model and a clinical tool useful
in assessment and treatment.

Consequently, research can be furthered with the completion of a quantitative study that
will increase the generalizability and validity of the data collected. Qualitative and quantitative
research studies that focus on the client rather than the provider may also provide data useful in
the development of a reliable assessment tool to explore and assess for CT-IWM. In addition,
further exploration of the bifurcation (secure family attachment relationships, but insecure world-
view) of the impact of cultural trauma on the levels of the internal working models, more
specifically the “self-view, others-view, and world-view,” would be beneficial. As mentioned in
the findings, clients who have established secure attachments from early childhood through
young adulthood relationships, who later experience a personal or collective culture-based
trauma, may experience a conflict of internal models in relationship to their now developing
insecure perspectives; specifically, as this injury relates to an insecure view of others and world-
view.

Future research should also specifically explore cognitive dissonance among Caucasian
Americans who declined to participate in this study from the perceived perception of their
discomfort regarding topics surrounding culture-based traumas. Several Caucasian American
clinicians were invited to participate, and expressed interest, but declined after hearing the topic
of this study. This occurrence was observed but not formally documented. The literature reports
that cognitive dissonance may be a contributing factor in the professional attitudes of clinicians
toward the inclusion and relevance of cultural trauma in treatment (Goldsmith et al., 2004).
Limitations

The research presented here originated from one exploratory study of mental health providers who treat African American clients. As this study was a qualitative research study, inclusive of 13 participants, the data collected are limited and cannot be generalized across all providers of mental health services, especially as they pertain to the diverse group that was represented in the data. Additionally, the interpretation of findings was limited as qualitative studies consist of the perspectives and opinions of the individual participants.

This study was not representative of the current statistics reported by the APA, NASW, BLS, and the Census Bureau. According to the statistics reported by the previously mentioned agencies, between 83% to 97% of mental health providers in the United States of America identify as Caucasian American and/or White. However, in this research, only two participants identified as Caucasian American and/or White, totaling 15%, which is statistically significant. The remaining participants identified as follows: eight identified as African American and/or Black (62%); two identified as Latino (15%); and one participant identified as Asian American/Other (7%).

Goldsmith et al. speak to the cognitive dissonance or outright denial of culture-motivated atrocities as a challenge for the dominant culture’s community in providing unbiased therapeutic treatment to the African American community (2004). They acknowledge that a provider’s “personal and professional attitudes toward trauma are also likely to affect levels of awareness and subsequently behaviors” toward treatment (2004, p. 449). Goldsmith et al. further espoused that “acknowledgment of the prevalence and impact of trauma challenges…theories that localize dysfunction within the individual while ignoring the contribution of social forces on adjustment” (2044, p. 450). Therefore, literature and research provide these implications as feasible
explanations for potential malpractice, but they could also provide a rationale for the limited participation or perceived avoidance of Caucasian American/White clinician participation in this study.

**Conclusion**

This study aimed to explore the clinicians’ perspectives regarding the inclusion of cultural trauma during assessment and treatment, as well as investigation of cultural trauma’s impact on the internal models of their African American clients. As we discovered in our exploration, this topic is both sensitive for the provider as well as the client. We also discovered that these participants were more intentional in their efforts to support and explore topics surrounding cultural trauma. Although sometimes challenged with their own triggers and insecurities, they made an effort to engage and support their clients to the best of their professional ability. With that said, each participant acknowledged the relevance and need to include cultural trauma in their assessment, treatment, and investigation of the internal working models of their African American.

As discussed in the implications for clinical practice and research, there are several next steps that should be taken to ensure that social workers and other mental health providers not only offer services that reflect cultural humility but also incorporate a cultural trauma-influenced integrated attachment approach to assess and treat their clients’ “culturally traumatized internal working model” (CT-IWM).
Appendix A

UNIVERSITY OF PENNSYLVANIA
RESEARCH PARTICIPANT
INFORMED CONSENT FORM

Protocol Title: From a Clinicians Perspective: The internalized identification and mentalization of cultural trauma on the internal working model of African American Clients

Short Title: Clinician’s Perspective of cultural trauma on the internal working model of African American Clients

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RESEARCH STUDY SUMMARY FOR POTENTIAL PARTICIPANTS
You are being invited to participate in a research study. Your participation is voluntary, and you should only participate if you completely understand what the study requires and what the risks of participation are. You should ask the study team any questions you have related to participating before agreeing to join the study. If you have any questions about your rights as a human research participant at any time before,
during or after participation, please contact the Institutional Review Board (IRB) at (215) 898-2614 for assistance.

This research study is being conducted to learn about the experiences of clinicians who work with African American adults to explore the impact of cultural trauma on the internal working model (IWM) of said client. This study will explore a clinician’s ability to engage in culturally sensitive attachment work as it pertains to the client’s self-view, others-view, and world-view – their IWM, by exploring the perspectives of clinicians who treat African American clients and the inclusion in discussions, assessments, and incorporation of cultural trauma in their treatment of African American adult clients. We are seeking to understand clinicians’ views and experiences so that it will help to further the exploration of, and interventions to effectively engage in a culturally sensitive manner to address the influences of historical, intergenerational, and present-day trauma.

If you agree to join the study, you will be asked to participate in one Zoom interview lasting 60 to 90 minutes.

Your participation in this study would be of potential benefit to practicing and future clinicians who provide therapeutic services to African American clients. The most common risk of participation is potential emotional discomfort during the interviews; however, you may end the interview at any point, upon request.

If you are interested in participating, I will review the full information with you. You are free to decline or stop participation at any time during or after the initial consenting process.

**WHY AM I BEING ASKED TO VOLUNTEER?**

You are being asked to take part in a research study because you are a mental health clinician who provides therapy services to African American adults. Your participation is voluntary which means you can choose whether or not to participate.

**WHAT IS THE PURPOSE OF THE STUDY?**

The purpose of the study is to learn more about whether clinicians consider assessing for the potential impact cultural trauma may have on the internal working model (IWM) of their African American clients. Additionally, exploring if clinicians’ perspectives on the inclusion of cultural trauma in assessment can be important when assessing their clients’ presenting problems and identifying any connections to intergenerational and/or historical experiences of their identified communities.

**HOW LONG WILL I BE IN THE STUDY?**

The study will take place over a period of eight (8) months, September 2022 to May 2023. Your participation in this study includes time spent in an individual interview and any follow-up contact from the researcher, each of which you are consenting to by signing this form. The researcher may contact you after you complete your individual interview to ask a question or clarify something you said, but if that is not necessary, your study participation ends when you complete your interview. By signing this form, you are consenting to participate in a single interview using Zoom, Inc. platform, or by phone, and to the possibility of a follow-up conducted by this researcher to clarify responses or ask additional questions.

**Where will the study take place?**
For interviews, participants are asked to download Zoom, Inc. application and select a physical location of their choosing that would provide privacy and a quiet environment for the interview. You may ask the researcher to work together with you to identify what could be deemed a suitable location.

**How many other people will be in this study?**

We aim to recruit 12 to 15 actively practicing mental health therapists/clinicians who are currently working with African American adult clients.

**What will I be asked to do?**

In the interview, you will be asked a series of questions about your experience as a mental health therapist/clinician providing therapeutic services to African American adult clients.

**What are the risks?**

The risks associated with participation in this study are minimal. One potential risk is that you may experience emotional discomfort when you discuss your views or reflect on challenging work with clients. If these feelings become unmanageable for you or you experience distress, the researcher will offer to stop the interview. You may also request the interviewer pause or terminate the interview at any time. The interviewer is a licensed clinical social worker with experience in assessment and crisis intervention. Assessment, support, and referral information will be offered and available to you at no cost.

**How will I benefit from the study?**

This study will not be of direct benefit to you, however, participation in this study could help researchers, educators, practicing therapist/clinicians and future clinicians better understand if exploring cultural trauma in therapy with African American clients is important and useful. In the future, findings from this study may help other practitioners examine ways in which they can actively and intentionally navigate and foster a more culturally sensitive practice to address overlooked contributors to mental health problems experienced by African American clients.

**What other choices do I have?**

Your alternative to being in the study is to not be in the study.

**What happens if I do not choose to join the research study?**

You may choose to join the study, or you may choose not to join the study. Your participation is voluntary. There is no penalty if you choose not to join the research study. There are no negative consequences to choosing not to participate.

**When is the study over? Can I leave the study before it ends?**

The study is expected to end in May of 2023 after all participants have completed their single interview and any follow up contacts are completed. The study may be stopped without your consent for the following reasons:

- The researcher feels it is best for your safety and/or health, you will be informed of the reasons why.
- You have not followed the study instructions or are ineligible.
- The primary researcher, the sponsor, or the Institutional Review Board (IRB) at the University of Pennsylvania can stop the study anytime.

You have the right to drop out of the research study at any time during your participation. There is no penalty or loss of benefits to which you are otherwise entitled if you decide to do so. Withdrawal will not interfere with your future work as a social worker.

If you no longer wish to be in the research study, please contact the co-researcher, Dianna McFarlane, at (240) 257-6654 or mcdianna@upenn.edu and take the following steps:

Speak with Dianna McFarlane or leave a voicemail at the phone number listed above explaining that you would like to withdraw from the study. You do not need to provide a reason; however, if you are willing to share the reason, the researchers would welcome it. There will be no negative consequences for choosing to withdraw from the study.

How will my personal information be protected during the study?

We will do our best to make sure that the personal information obtained during this research study will be kept private. If information from this study is published or presented at scientific meetings, your name, the agency name or identifying information about your clients, and other personal information will not be used. You will be asked to select a pseudonym prior to the start of the interviews. However, we cannot guarantee total privacy. Your personal information may be given out if required by law. The Institutional Review Board (IRB) at the University of Pennsylvania will have access to the study records. An exception to confidentiality is if you report child or elder neglect or abuse, or if you report suicidal or homicidal ideation or intent to the research team. Any information about child or elder abuse or intent to harm yourself or others will be reported to the authorities, as required by law. Additional steps include:

- Every attempt will be made to avoid having identifying information in the digital recordings of the interview. You will be asked to select a pseudonym at the beginning of the interview. Demographic information will be scanned and uploaded separately to a password-protected computer by co-researcher, Dianna McFarlane.

- All digital recordings and other study related electronic documents such as transcribed interviews will be password protected with only the researcher, Dianna McFarlane, and her dissertation chair, Joretha Bourjolly, PhD having access. Both researchers will maintain and adhere to the highest standards of confidentiality related to your participation in this study.

- A pseudonym selected by the participant will be used to identify the participant’s interview recording and transcription which will further protect your confidentiality.

- All hard copy study related materials will be scanned and uploaded to a password protected computer, and then securely destroyed at the end of the study.

- All study recordings will be destroyed at the conclusion of this study.

What may happen to my information collected on this study?

If information from this study is published or presented at conferences, your name, the agency name, identifying information about clients, or any personal information which could identify you, will not be used. Your information will be de-identified. De-identified means that all information that could reveal the identity of a participant, their clients, or the agencies in which they worked have been removed. The
information could be stored and shared for future research in this de-identified fashion. It would not be possible for future researchers to identify you as we would not share any identifiable information about you with future researchers. De-identified data can be shared without seeking additional consent in the future, as permitted by law. The future use of your information only applies to the information collected for this study.

**Electronic Medical Records and Research Results**

Medical records are not part of this study.

**What is an Electronic Medical Record and/or a Clinical Trial Management System?**

An Electronic Medical Record (EMR) is an electronic version of the record of your care within a health system. An EMR is simply a computerized version of a paper medical record.

**What happens if I am injured from being in the study?**

Sustaining an injury as a result of participation in this study is highly unlikely; however, if you are injured as a result of participation, please notify the researcher, Dianna McFarlane, as soon as possible. Ms. McFarlane will make every effort to assist you in accessing medical care to treat your injuries directly resulting from participating in this study such as calling 911 emergency service, notifying a family member or friend, or making other appropriate efforts. The health care provider accessed may bill your insurance company or other third parties, if appropriate, for the costs of the care you receive, but you may also be responsible for some of the costs.

There are no plans for the University of Pennsylvania to pay you or give you other compensation for the injury. You do not give up any legal rights by signing this form.

**Will I have to pay for anything?**

There are no costs to you for participation in this study.

**Will I be paid for being in this study?**

As a study participant you will receive a single $25 gift card to Amazon.com for your participation. Gift cards will be offered up to fourteen (14) days of the completion of your interview.

**Who can I call with questions, complaints or if I’m concerned about my rights as a research subject?**

If you have questions, concerns, or complaints regarding your participation in this research study or if you have any questions about your rights as a research subject, you should speak with the Principal Investigator listed on the first page of this form. If a member of the research team cannot be reached or you want to talk to someone other than those working on the study, you may contact the IRB at (215) 898 2614.
When you sign this form, you are agreeing to take part in this research study. This means that you have read the consent form, your questions have been answered, and you have decided to volunteer. Your signature also means that you are permitting the University of Pennsylvania to use your personal information collected about you for research purposes within our institution. You are also allowing the University of Pennsylvania to disclose that personal information to outside organizations or people involved with the operations of this study.

A copy of this consent form will be given to you.

________________________        ____________________________  ________
Name of Participant [print]               Signature of Participant               Date
Appendix B

RECRUITMENT FLYER

"A Clinicians Perspective: The internalized identification and mentalization of cultural trauma on the internal working model of African American Clients"

Research Participants Needed!

Do you offer mental health services to African American Clients?
Ever found yourself curious about how cultural trauma impacts your client in everyday situations and relationships?
If so...
Then this study is for YOU!!!

We Need You if You...
• Hold a min of a Masters degree in a mental health-related field
• Are a practicing mental health provider
• Have a min of two (2) years of mental health therapy experience
• Provide therapeutic services to African American adults dealing with relationship issues and/or trauma.
• Able to participate in one 60-minute interview via Zoom.

Why You Should Participate
Findings from this study has the potential to aid therapists to participate in a deeper exploration of their perspectives on culture and trauma. How they engage and navigate discussions with African American clients from an approach that explores the potential impact of ancestral and cultural contributors to the client’s current mental health problems and how it impacts the client’s internal perspectives of self, others, and the world.

More information:
**Participants who complete their 60-minute interview, will receive a $25 Amazon gift card**

Register with the code below

To Participate simply scan the QR-code or contact Dianna McFarlane @ mcdiana@upenn.edu or by text @ 240-257-6634
Appendix C

INTERVIEW GUIDE

A. General questions regarding therapeutic practices

1. Can you tell me a little about the demographics of clients you see in your practice?
   i. i.e. race, ethnicity, gender identification, sexual orientation?

2. What would you say is the percentage of your clients identifying as African American?

3. Tell me about the most common presenting problems identified by your clients as their reason for seeking treatment with you.

4. Tell me about the most common presenting problems specifically identified by your African American clients as their reason for seeking treatment with you.

5. Can you tell me about any experiences you have had where the treatment goals differed from the presenting problems in treating African American clients?
   i. Can you share how frequently this occurs?

B. Questions related to the use of attachment theory in practice

1. Tell me about the concepts of Attachment Theory you are most familiar with.
   Abandonment, security,

2. In what ways does attachment theory inform your clinician practice? (looking for IWM)
   i. How does AT influence your thinking about your work with AA and non-AA clients?
   ii. How does AT impact your conceptualization of your AA client’s reason for seeking treatment?
3. Tell me what concepts of Attachment Theory you utilize most in your practice.
   General understanding of clients perception of how they relate to others
   Secure attachment, impaired attachment

4. How do you use IWM (an attachment theory concept) to inform your
   conceptualization of your client’s presenting problems?
   How do you explore their internal models in connection with their presenting problems?
   Can you provide an explanation and/or example?

C. Question-related to concepts of cultural trauma

1. Tell me about how your clients, AA and Non AA, talk about their connections to their communities.
   i. In what ways do AA clients talk about their identification of their membership in their larger communities? (identification of community may be better)
      Common interest, similar world views, shared experiences.
   ii. What are some of the shared community cultural experiences and/or narratives expressed by your AA clients?

2. Tell me about any instances where you have observed your client’s identification of an intersection between a collective community experience and their presenting issue (excluding any client identifiers (i.e. names, email, addresses, etc.). (connection with the community cultural experience and their presenting issue)?
3. Can you tell me the ways in which you engage and explore topics surrounding collective community experiences?

4. In what ways do you think shared collective community memories/experiences play a role in a client’s presentation of the clinical challenges?

D. Internal Working Model & Cultural Trauma in practice

1. Tell me about how clients talk about their general trauma experiences within their day-to-day life.
   
   i. How do they position themselves in their trauma?
   
   ii. How often do you find yourself assisting AA clients identification of trauma? What’s your rational?

2. What are some of your observations of how AA clients navigate discussions surrounding trauma?

3. How often and in what ways have you seen culture play a part in the trauma narrative of your AA clients?

4. How often and in what ways have you seen your AA clients see CT as part of trauma narrative?

(Now, shifting to your awareness of yourself as the provider)

5. Tell me about any experiences, personal and/or professional, that have informed or shaped your perspectives on Cultural Trauma.

6. In what ways do (would) you assess for cultural trauma when working with African American clients?
   
   i. Can you tell me about the formal or informal methods you use?
ii. In what ways do you see or have seen a connection between your client’s presenting problem and cultural-related trauma? At what point in the assessment?

7. This next question is similar to an earlier question, but slightly different…Can you share an example of when a client made the connection between their presenting problem and cultural trauma (direct or indirect w/collective community trauma), excluding any client identifiers (i.e. names, email, addresses, etc.)?
   i. How did you engage in that discussion after that connection was made?
   ii. What was your observation of yourself in that moment? [what were your somatic responses] did it feel like, and what were your reactions?

8. Tell me about how you helped the client navigate making the connection between cultural trauma, their presenting problem, and how they show up in the world.

E. General closing questions

1. I know this research focuses on AT and CT, but would you mind sharing some of the biggest influences (i.e. other theories, frameworks, or models) on how you engage AA clients in your practice?

2. Is there anything about IWM, CT, AT in your work with AA clients and these topics that you would like to share?
Appendix D

Clinicians Perspective: The internalized identification and mentalization of cultural trauma on the internal working model of African American Clients

This research is seeking to understand the perspectives of clinicians/mental health therapists who treat African American adults and their perspectives on the inclusion of cultural trauma in the engagement, assessment, and treatment of said clients from a culturally sensitive attachment approach.

Exploring how cultural trauma impacts the client’s views on self, others, and the world around them and the ability to identify connections between cultural trauma and the client’s presenting issue. This research is seeking to understand your perspective and how this influences your assessment and treatment of African American clients from a culturally sensitive attachment approach.

* Indicates required question

1. Email *

2. Today's date *

   Example: January 7, 2019

3. First and Last Name *

4. Phone number *

5. Do you have a Master’s degree or greater in a mental health related field? *
   MARK ONLY ONE OVAL.

   Y
6. Are you a practicing mental health provider? *  
   MARK ONLY ONE OVAL.
   [ ] Y  
   [ ] N

7. Do you have a minimum of two (2) years of mental health therapy experience? *  
   MARK ONLY ONE OVAL.
   [ ] Y  
   [ ] N

8. Do you provide therapeutic services to African American adults dealing with relationship issues and/or trauma?  
   MARK ONLY ONE OVAL.
   [ ] Y  
   [ ] N
9. Approximately how many African American adult clients have you treated over
the
* past two (2) years?

10. How would you describe your racial identity?

11. If you are interested in participating in this research study, please go to section 2 *
to answer additional screening questions.

**MARK ONLY ONE OVAL.**

☐ Y  ☐ e  ☐ s  ☐ N  ☐ o

If you agree to participate...
I will ask you questions about your perspectives as a clinician/mental health
therapist of your assessment and treatment of African American adults surrounding
the impact of cultural trauma on the clients present day presenting concerns and
how, if at all you address any potential underlying influences of cultural trauma.

12. Are you interested in participating?

**MARK ONLY ONE OVAL.**

☐ Yes  ☐
13. Would you be willing to schedule your interview with me right now?

MARK ONLY ONE OVAL.

☐ Yes
☐ No

14. You will be contacted within 72 hours to discuss your participation and scheduling.
Appendix E

Demographics Questionnaire

In finalizing my dissertation, participant demographics have shown to be significant to the findings. As this information was not collected at the time of your interview, we humbly request your participation in this short survey. The information collected will be used for the sole purpose of reporting and interpreting the data provided and will be associated with the pseudonym you previously provided. Your responses will be kept private and secure and will comply with the confidentiality agreement signed at the onset of your participation. With that said I am graciously requesting the completion of this very short survey by July 12th, 2023.

* Indicates required question

1. First and Last Name *

2. Identified Race/Ethnicity (please select all that apply) *

   * Check all that apply.
   
   - African
   - American
   - Asian
   - American
   - Caucasian
   - American
   - Hispanic
   - American
   - Native
   - American
   - Black
   - Biracial or Multiracial
   - Hispanic
   - Indigenous to America Latino
Pacific Islander
White
Other:
3. **Gender identity (optional; choose all that apply)**

*Check all that apply.*

- [ ] prefer not to disclose
- [ ] agender
- [ ] demigender
- [ ] genderqueer or gender fluid
- [ ] man
- [ ] questioning or unsure
- [ ] trans man
- [ ] trans woman
- [ ] woman
- [ ] Other: ____________________________

4. **PREFERRED PRONOUNS**

*Check all that apply.*

- [ ] prefer not to disclose
- [ ] She/her/hers
- [ ] He/him/his
- [ ] They/theirs/them
- [ ] Other: ____________________________

5. **HIGHEST DEGREE ACHIEVED**

*Mark only one oval.*

- [ ] Bachelors degree
- [ ] Masters degree
- [ ] Doctorate or post graduate
- [ ] Other: ____________________________
6. Degree area of study *

7. HIGHEST LEVEL OF LICENSURE *

Check all that apply.

☐ LGSW/LMSW (Licensed graduate Social Worker) LGPC (Licensed graduate Professional Counselor)
☐ LGMFT (license graduate Marriage and Family Therapist) LCSW (highest clinical license in Social Work)
☐ LPC/LCPC (highest clinical license in Professional Counseling) LMFT (highest clinical license in Marriage and Family Therapy)
☐ Other:

8. YEARS OF MENTAL HEALTH THERAPY EXPERIENCE *
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CLINICIAN’S PERSPECTIVE: CULTURAL TRAUMA AND INTERNAL WORKING MODELS

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