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Amy Beth Basford
Applying and Adapting
Testimonial Psychotherapy to
Address the Effects of Race-
Based Traumatic Stress on
People of Color in the United
States

ABSTRACT

Testimonial psychotherapy, a socially and politically rooted theory, has been proven to be effective in alleviating symptoms of posttraumatic stress disorder with populations of varying races and ethnicities from all parts of the world. All of the people who have participated in testimonial psychotherapy have also been victims of torture and persecution by oppressive governments in their countries of origin. However, testimonial psychotherapy has never been used with populations whose country of origin is the United States.

Racism is a sociohistorical and political construct that affects the lives of people of color in the United States in adverse ways. Overt, but possibly more harmful covert, acts of racism at all levels (i.e., institutional, cultural, intergenerational) of society weave a tightly wound web. Daily acts of racism can have a cumulative effect sometimes resulting in race-based traumatic stress (RBTS).

Applicability of testimonial psychotherapy to working with people of color in the United States to address RBTS will be explored. Adaptations of the theory will be provided. Finally, implications for social work will be addressed.

APPLYING AND ADAPTING TESTIMONIAL PSYCHOTHERAPY TO ADDRESS
THE EFFECTS OF RACE-BASED TRAUMATIC STRESS ON PEOPLE OF COLOR
IN THE UNITED STATES

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2008

ACKNOWLEDGEMENTS

I dedicate this thesis to my father, Adrian Earl Basford who in life and death has instilled in me a great sense of justice and community. Wherever I am, you will always be a part of my garage community--rooted deep in my soul. I did it Dad! But you had no doubt.

Many thanks to my mother and sister who have supported me along the way from twirly dresses to cap and gown. Much love to you both.

To my dear half Jules. Through many evolutions we have been my dear, dear friend. You are an inspiration to me. A true maker of change. And most of all, a true BFF.

To my ladies on the porch. Karen, Erin, Griffin and Emily. Without those hours of procrastination I do not know if this journey at Smith would have been so rich, amazing, and gosh darn fun! I have learned so much from each and every one of you. Thank you.

Karen, thanks for the ride home. I don't know how I would have done it without you.

To Edith Fraser, Josh Miller, Holly Simons, and Adin Thayer who supported me in ways unimaginable through grief unimaginable. To Susan, Mansour, Dennis and Katherine—where it all began. Thank you all for bringing awareness and unending commitments to social justice into my life.

To Arden for the innumerable gifts.

Many thanks to the Bay Area TSG. You all are amazing. The support unending and always within reach--just a glass of wine away.

To Maisie: rockstar of organization and support a la velo rouge and fake fish.

Unending, deep, and unspeakable thanks to the grief group of '07. What a ride, no?

To adventures in the woods with Ollie.

To Beth Kita. What more do I have to say? I feel blessed to have you in my life.

To my therapist, Liz, for the holding, wit, wisdom, and encouragement through this most expansive year.

Lastly, to my partner in life, Jaycelle. You are one of the most beautiful people I have ever met. With you, I am finally able to be me. Mahal kita.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	ii
TABLE OF CONTENTS.....	iii
CHAPTER	
I INTRODUCTION	1
II THEORY	11
III PHENOMENON	37
IV APPLICATION AND ADAPTATION.....	64
V CONCLUSION	97
REFERENCES	104

CHAPTER I

INTRODUCTION

People of color have experienced trauma as the result of racial differences in the United States from the time Europeans landed on United States soil. Throughout United States history overt and often brutal attacks have occurred on the basis of socially constructed racial differences. Currently overt attacks are not quite as common (or at least not reported on as often), but an arguably more damaging form of racial trauma occurs daily in more insidious ways. This becomes apparent after such tragedies as Hurricane Katrina where racial inequities became transparent during this natural disaster. Therefore, I am interested in exploring ways to address race-based traumatic stress (RBTS) that people of color experience on multiple levels throughout a lifetime and ways in which testimonial psychotherapy could be applied as part of a process of healing from the effects of RBTS in the United States. The purpose of this study is to explore the following question: “Can testimonial psychotherapy be adapted to address effects of RBTS on people of color in the United States?” Answering this question necessitates an exploration of testimonial psychotherapy and RBTS.

Chapter II will provide a complete understanding of testimonial psychotherapy. There is not an expanse of literature available specifically addressing the use of testimonial psychotherapy. The works of practitioners, such as Inger Agger (1992), Stuart Lustig et al. (2004), Steven Weine et al. (1998), and Dori Laub (2006) will be explored. Testimonial has been used in other contexts, but its use and resulting literature

is not prevalent. The literature available reveals that testimonial psychotherapy was first used in Chile the 1970s (Cienfuegos & Monelli, 1983, Lustig et al., 2004)). Testimonials were taken from people who survived torture inflicted by the repressive military. Since then it has been used in many parts of the world with many different populations. The particular framework that will be looked at throughout this research is the same that grew out of the work of Cienfuegos and Monelli (1983).

Chapter II will begin with an overview of the origins of testimony and testimonial psychotherapy, including a summary of testimonial psychotherapy's key components. Next, Chapter II will present a section on the power and importance of creating an integrated trauma story. It will then move to an exploration of both the varying populations and the physical locations testimonial psychotherapy has been used, highlighting its adaptability and effectiveness as a treatment modality. The chapter will proceed with a description of the technique involved in taking a testimonial including the number of session, process, and the role of the therapist/interviewer. Lastly, outcomes measured and reported on the alleviation of posttraumatic stress disorder (PTSD) will be given.

The effects of racism are harmful, painful, and pervasive within the United States. One-time racist incidents and cumulative racist experiences often lead to some level of trauma for the individual who has experienced the racism. RBTS, which some argue should be added to the *Diagnostic Statistical Manual IV* as a form of PTSD, often impedes a productive, fulfilling life and breaks down feelings of worthiness and hopefulness. It can have long-lasting psychological and physiological effects and sap

individuals and communities of energy that could otherwise be focused on other aspects of one's life. People of color bear the burden of society's racist structure.

Race and racism are politically and socially rooted constructs. RBTS happens as a result of a multitude of layers and interactions of socially, historically and politically constructed sources of racism (i.e. institutionally, culturally, interpersonally, intergenerationally, as well as through the mechanisms of internalized racism). Therefore, while examining RBTS, the sociohistorical and political context in which the individual of color has been socialized will be a present perspective. It is beyond the scope of this research to go into the many layers and intricacies of how racism is perpetuated, but it is essential that it be mentioned and explored.

Chapter III will explore RBTS as it pertains to the United States. This chapter will begin with an operational definition of *racism* for the purposes of this research. That will be followed by a definition of *race-based traumatic stress*. Following these definitions, sources of RBTS will be examined. This section will be focused on the following sources of RBTS: institutional, cultural, interpersonal, intergenerational, and through mechanisms of internalization. The next section of Chapter III will survey psychological and emotional effects of RBTS, especially as they relate to already accepted forms of trauma such as rape and domestic violence. Following this, a brief survey of physiological symptoms of RBTS will be provided. Finally, Chapter III will end with a critique and expansion of the language and literature of trauma and the DSM-IV-TR.

Testimonial psychotherapy is a politically and socially rooted theory that has, built into the theory, a way to connect the personal psychological healing journey to the

larger social, historical, and political system. Paying special attention to this aspect of the theory, it appears that this modality of conducting psychotherapy carries with it many possibilities for expansion. It is the researcher's belief that testimonial psychotherapy can be adapted in such a way that it can, once adapted, be utilized with oppressed populations to begin a process of healing from the effects of RBTS in the United States. A version of this theory will be introduced that, among other adaptations, expands upon the "altruistic" component of the theory, allowing for stronger connection between the personal healing process and a local community (and ideally national) level healing process. The impetus behind this is the thought that one cannot happen without the other as the initial traumas are the result of not only a social construction of race by the dominant culture, but also the multidimensionality of the traumatizing and healing process. As it stands now, when testimonial psychotherapy is used, the majority of the process and energy is focused on taking testimony. It appears possible to enhance the connection between the personal and communal without diminishing the importance of the testimony taking process. It is supposed that the balance of both will be imperative if the theory is to be used in the United States with issues of RBTS.

In addition, testimonial psychotherapy has never been used in cases where there is ongoing trauma, but rather after major or ongoing traumas are over. This however, assumes that the person the therapy is being used with is not experiencing new traumas after coming to the United States. This is another area of the theory that will be briefly explored as possibly being adapted for use in the United States with ongoing daily, often more subtle forms of trauma resulting from racism.

As a result of exploring both the power and uses of testimony and testimonial psychotherapy in Chapter II and the devastating effects of racism in the United States on people of color in Chapter III, an adapted version of testimonial psychotherapy will be presented in Chapter IV to answer the research question posed. Chapter IV will apply the theory of testimonial psychotherapy to the phenomenon of RBTS in the United States. First, ways in which utilizing testimonial psychotherapy to address RBTS is applicable to the United States will be outlined. The main points outlined will be as follows: variation in and within populations, working from a non-Eurocentric framework, the implications of shifting power in the therapist/testifier relationship, injury and healing at many different levels (i.e. institutional and personal), the role of oppressive governments, contextualization, and alleviating symptoms. The next section of the chapter covers this author's recommendations for ways to adapt testimonial psychotherapy to be used in the United States to address RBTS. Here some points of adaptation such as: focus groups, number of sessions, more reframing, and stronger connections to the community level will be offered. Chapter IV ends with a discussion about the implications of this research on social work practice and research.

It is crucial to engage various aspects of society that perpetuate racism in the healing process. As renowned author and intellectual bell hooks writes in her book *killing rage: ending racism*, "the wounded African-American psyche must be attended to within the framework of programs for mental health care that link psychological recovery with progressive political awareness of the way in which institutionalized systems of domination assault, damage, and maim" (1995,p. 138). Healing from RBTS will not

happen without awareness and action from the political and social contexts that created the damaging environment in the first place.

It is important for clinicians to understand the effects and symptoms of RBTS on the United States collectively—as a whole and with the individual within the context of their immediate environment. With this understanding, clinicians will be able to bear witness to individual and collective, community level healing. In addition, considering social work’s longstanding commitment to social justice, an adapted version of testimonial psychotherapy provides a modality of therapy in the same vein as other socially, politically and historically rooted empowerment therapies. Some examples of these are “Just” practice, empowerment practice, and feminist practice. The original framework of testimonial psychotherapy has an empowering component worked into the theory that acts as a connector between the personal, political and social. Although empowerment, or a sense of agency, needs to be experienced and held as being that of the clients, it will give clinicians an avenue to play a role in facilitating a process of collective healing within a larger setting (e.g. neighborhood, town, community, etc.). This research will be particularly important for clinicians interested in intersecting micro, mezzo, and/or macro level work within the United States. It will also be important for clinicians interested in working within a space where clinical work actively becomes politically and socially rooted. Finally, social work is a profession that upholds the view that a person must be taken within the context of their environment for healing to occur. Racism often encompasses other socially constructed “isms,” such as classism, heterosexism, and homophobia, that have the capacity to be debilitating and painful and cannot be separated from a client’s life experience and lived environment. As it stands,

many social workers are committed to facing the intersecting “isms,” but racism is one of the hardest and still most socially taboo to talk about. Given the history of the profession of social work and the ways in which social workers often confront the adverse affects of various social constructions, it seems crucial for social workers to take notice and commit to playing a role in facilitating a healing process from the devastating effects of racism to our society as a whole.

METHODOLOGY

Before proceeding to chapter 2 examining testimonial psychotherapy, conceptualization and reasoning for the methodology chosen will be presented. Reasons for choosing testimonial psychotherapy as the theory and RBTS as the phenomenon to study will be given. As a part of this discussion, the researcher’s potential methodological biases will become transparent. Finally, strengths and limitations of the study will be discussed.

I chose the theory of testimonial psychotherapy for this research as the result of a timely convergence of personal history, exposure to the theory, a commitment to anti-oppression work, and entering an anti-racism institution. After experiencing a country (El Salvador) almost ten years out of war and a country actively engaged in war (the Former Yugoslavia) within a year’s time, the traumatic effects of war coupled with the power of the war story to heal became regular topics of reflection for me. Being in places where political unrest and possible revolutions are happening provided fertile ground for beginning awareness and understanding of what is needed to repair injustices and begin a process of healing. The story, or testimony if I may, became a central focus of this internal conversation.

I was exposed to testimonial psychotherapy through attending a talk given by Stuart Lustig in San Mateo, California. What first appealed to me about this theory was the way in which it was presented as a means to reconnect people to their community through the use of story. After reading the works of Lustig et al. (2004) and Weine et al. (1998), the adaptability of testimonial psychotherapy became apparent. It has been proven to be effective with populations of varying races and ethnicities from all parts of the world. All of these populations have suffered the effects of oppressive governments in their countries of origin.

The following summer, sitting in a class on collective trauma, I was once again reminded of the power of the testimony and started to think about it in terms of applicability to the United States and racial trauma. That is where the two, testimonial psychotherapy and RBTS, merged. In this class I made quick connections between the psychological and physical effects of war and torture on communities (almost all of which were outside of the United States) we were learning about and the psychological and physical effects of racism in our country. Interest in the testimonial psychotherapy, coupled with past experiences and a commitment to addressing the effects of racism as oppression in the United States, resulted in this research.

I have many biases in this work. I am a queer white woman from a working class background. The beginnings of a deep understanding of how some of my own target identities have challenged my life affect my sociohistorical and political views of oppression. My own contextual experiences have led to passion, compassion and commitment to working toward liberation. As Lilla Watson once said, "If you have come here to help me, you are wasting your time. But if you have come because your

liberation is bound up with mine, come let us work together” (as stated in a speech to UN Decade for Women Conference in Nairobi, 1985). An additional bias I have is a deep instinct and commitment around the effectiveness of testimonial psychotherapy. It speaks to many values that are important to me. This deep, not yet fully explicable, commitment may lead me to overlook important components or views concerning the theory. I will be trained in testimonial psychotherapy in a few short months.

The fact that I am white and writing about a therapeutic intervention for people of color both limits my work and adds bias. Another limitation of this work is that many of the examples used pertain to the African American community, sometimes creating a black/white dichotomy. Although works from other communities of color were researched, read, and cited, the voice most present throughout is that of the African American experience, and often as it relates to the legacy of slavery. This is a reflection of the imbalance of literature found. This limitation makes visible the voices that are not always being heard. Future work, of my own and other social workers, needs to create a strong presence by actively seeking out the unheard voices. Finally, another limitation is that this research is only addressing the traumatic effects of racism on people of color. White people are also traumatized by racism but, considering that people of color are denied many rights at the hands of a white dominant culture, the necessity and urgency falls with creating visibility around the traumatic effects of racism to people of color. Awareness and acknowledgement that racism is a real force alive in the United States is necessary for healing to begin.

The first strength of this study is that it is an acknowledgement and discussion of ways in which racism has the potential to be traumatizing to people of color in the United

States. Another strength is that it is research that is setting the foundation for future action both by the author and hopefully other social workers. A third strength is that it is offering a therapy that embraces both the individual and community, offering a way to heal within the sociohistorical and political context of the lived reality of both. Finally, another strength is that it is creating exposure for testimonial psychotherapy, a form of therapy that is not widely used, but has great potential for assisting in a healing process.

The next chapter, Chapter II, will provide the reader with a full discussion of testimonial psychotherapy. Chapter II will address the history of testimonial psychotherapy. It will then move into a discussion of its adaptability. Finally, the actual process will be outlined, followed by literature on its proven effectiveness.

CHAPTER II

TESTIMONIAL PSYCHOTHERAPY

Origins and brief description of testimonial psychotherapy

The taking of and use of testimony has been around for hundreds of years. The first written definition has been dated to 1382. Testimony has been present in rituals and structures of cultures around the world as a means to convey information, seek truth, and establish character. It has, for many centuries, carried with it multiple meanings. How testimony is used and which of these multiple meanings is attached is dictated by the setting in which it is used. Testimony is commonly used within the context of law and unlawful acts of one person or persons on another or group of people. It is a means to convey information; often including the emotional implications of whatever crime may have been perpetrated on an individual, or group of people. Within this legal realm, testimony is a way to gather information in pursuit of truth or in the pursuit of proving guilt or innocence in the case of a legal trial. It is used as supporting evidence to a fact or a statement. It can be used as proof.

When placed in another context, such as a religious practice, testimony carries a different meaning. Within religious constructs, testimony is a means by which to make an “open declaration or profession, as of faith” (Akinyela, 2005, p.6.). Involved in this declaration is often a very emotional story of what the person declaring has overcome or seen that has confirmed or led them to have faith. This declaration can be done privately or publicly within a spiritual space of worship, often with witnesses present. For

example, within Christianity, testimonies have been utilized as a means to declare one's faith (including the story of the journey of how one got to that declaration), but they are also seen as the teachings of God, as in the Ten Commandments.

Testimony within a legal setting tends to be more objective, judicial, public, or political (Agger & Jensen, 1990, p.116). Within religious or spiritual realms, it tends to be more subjective, spiritual, cathartic, and private and more akin to the definition of giving a testimonial (Agger & Jensen, 1990, p. 116). Testimony, in present day, is regularly used in legal trials, religious rituals, and to attest to one's qualities or character. But since the 1970s it has also been introduced and utilized within the context of psychotherapeutic work. Specifically, a kind of therapy that uses the taking of testimony as its primary modality, called testimonial psychotherapy, has been used mostly with people who have been victims of political repression/oppression. Often as a part of political oppression, people taking part in the testimonial psychotherapy process have either experienced torture and/or some form of abuse, or witnessed such atrocities perpetrated by political regimes onto friends, family, and/or comrades.

When brought into the realm of psychotherapy, the use of testimony has the potential to carry all aforementioned meanings (objective and subjective, as proof, or a tool leading to catharsis, etc.) simultaneously in a balance that may have the capacity to promote healing, discovery, and either a sense of closure and justice, or actualized closure and justice. As Agger and Jensen (1990) so aptly wrote "Thus the use of the word 'testimony' in itself in a psychotherapeutic setting with victims of political repression implies that the subjective, private pain is to be seen in an objective, political

context” (p. 116). It is within these ties of objective and subjective, political and private, that healing occurs.

The objective, subjective, public and private aspects of testimonial psychotherapy are reflected in the fact that it is a socially and politically rooted theoretical framework for providing psychiatric care for people who have experienced trauma.

Testimonial psychotherapy recognizes that it is not the only way to gather a written narrative, but that it is unique in the way that it focuses on, and creates a document of, recent world events (Lustig et al., 2004). Traditionally, it has been used with refugees. It works to record the testimony of the client and utilize that testimony for “altruistic” (i.e., the testifier may use the testimonial in some capacity that may lead to others’ healing via education, community connection, mirroring, etc.) means. It allows for a process of transforming private pain into political or spiritual dignity (Agger & Jensen, 1990) and shifts the focus of therapy to be political, not clinical.

Testimonial psychotherapy does this through a therapeutic process that entails a loosely guided narrative, or testimony. The clinician may ask follow-up questions for clarification or to facilitate the process, but starts the sessions by allowing the client to start wherever they would like. After each session, or a set of sessions, the clinician and/or interpreter transcribe the testimony. Throughout the process, with the exception of Dori Laub’s work with video testimony, the client has the opportunity to change, add, and/or delete anything that he/she wants. After the process of witnessing, through all present signing, and transcribing the testimony, the person taking the testimony binds it into a book. Often, in the final session, the testifier is presented with a “Certificate of Appreciation” along with the bound and signed copy of the testimony. In addition, in

Lustig's work, in the next to last session, the clinician asks reframing questions of, "What advice would you give to others to survive difficult things?" and "Are there ways in which your experiences have made you more strong, or more wise?" (Lustig, 2004, p. 37). This provides a time and space for reframing and reflecting the testifier's experience. This is also a time that has the potential for the testifier to feel a sense of connection to the larger community as an educator or as a way to provide hope to others. It is also a part of the process that has great potential for the testifier to feel empowered by their story and a sense of ownership over the past, present and future.

Another aspect of the theory that allows space for creating hope and empowerment for the testifier is through the "altruistic" component referenced earlier. This may be better renamed as a chance for connection or reconnection with the larger community. The hope is that, with the testifier's permission and involvement, their testimony would be connected to the larger, macro level, and be used within the community to start healing from the effects of trauma. The clinician works in conjunction with the client to set up, or create, an arena for the testimony to be distributed with the goal of educating, informing, or aiding in the healing process of others who may have gone through similar situations, or to prevent them from occurring again in the future. This may come in the form of a performance, website, media coverage, community talks, etc.

This connection to the community is important on many levels. For one, the testifier needs to feel as though giving their testimony will be effective, meaningful, and most importantly, helpful to the greater good. Also, the testifier needs to feel the power of recreating, constructing, sometimes reconstructing, and assigning meaning to the story

of their personal trauma. These components of connecting to the community are referred to as a need because when this happens, it counteracts feelings of isolation, helplessness, powerlessness and hopelessness. The hope is that the combination of testimonial therapy's focus on an individual's strengths and resources in conjunction with creating a document to be used for community level social and political purposes will produce a sense of agency, purpose, and empowerment to counteract feelings of powerlessness and inferiority as a result of the trauma (Lustig et al., 2004). Testimonial psychotherapy needs to be an experience of facilitating a process of rehumanization. Connecting, or reconnecting, one to other humans, who may or may not have been through similar experiences, and the hope that one's story may help others to not ever suffer what they may have suffered, is one step toward rehumanization.

In order to facilitate the rehumanization process, Lustig et al. (2004), argue that testimonial psychotherapy works best: when there is a sense of safety on the part of the testifier, when that person has come from a collectivistic style family system/community, and when the meaning and power of story are upheld in the community. It also works best within cultures that believe in the possibility of change to occur in the future (Lustig et al., 2004). This does not mean, however, that it cannot be used if these aspects of a person's life are not present. It is simply what has been observed thus far as components that facilitate the process and possibly aid in making meaning of one's experience.

The impact of giving/taking a testimonial on healing from trauma induced by political oppression was first documented in the early 1980s. The "birth" of testimonial psychotherapy has been placed with an article first published in 1983 by two Chilean psychologists, Ana Cienfuegos and Cristina Monelli. It was with their work that

testimony taking and testimonials took on a form not yet seen. It had entered both the realm of psychological healing and social justice. In the early 1970's Cienfuegos and Monelli (1983) started taking testimony from survivors of political torture resulting from the Pinochet regime. Their original aim was political in nature--to collect information to be used against the regime. However, the psychologists noticed relief from posttraumatic stress symptoms as a result of the testimony taking process. They published their findings under the pseudonyms of Cienfuegos and Monelli out of fear for their lives.

Soon after they published their findings, others started using this method around the world. Testimonial psychotherapy has been used, among others, by Inger Agger (1992) with women who have survived politically based torture focusing on survivors of sexual abuse and torture, by Steven Weine (1995, 1998) with Bosnian refugees living in Chicago, by Stuart Lustig et al.(2004) with a group of the "Lost Boys of Sudan," and by Dori Laub (1992, 1995, 2006) taking testimony from Holocaust survivors. Each one of these practitioners has a slightly different way of implementing testimonial psychotherapy with the respective groups that they were/are working with. Although variation exists, a basic format is followed that includes important key components such as reconnection to the community, a ritual space, a bound document, the power of a witness, and opportunities for the person giving the testimony to have control over what is documented through a process of editing.

In the first part of the chapter the power and importance of creating an integrated, reframed trauma story will be examined in the section entitled *Creating a Trauma Story*. Next, respective groups of people that each practitioner worked with will be discussed in the section entitled *Populations and Places*. This will be done through briefly

mentioning where each group is from and where the testimonials are being conducted. Noting each population that testimonial psychotherapy has been used with is useful in beginning a dialogue and understanding of the possibility of great adaptability in this modality to many populations regardless of race, gender, ethnicity, primary language, differing traumatic experiences, historical contextual position, and age. In this section the work of Cienfuegos and Monelli, Dori Laub, Agger, Agger and Jensen, Weine, et al., Lustig et al., and Van Dijk et al., will be discussed.

Next, in the section entitled, *Techniques*, variations in the actual process of testimonial psychotherapy used by each practitioner will become apparent through an examination of how each one is using this modality. Describing the variations in the process and the diversity of experiences and people giving testimony will provide a sense of its adaptability and applicability to many different groups of people, contextual experiences, and settings. Exhibiting the variations in process and people is also a testament to the inherent healing properties of a person having the power to use their voice to tell their own story in a ritualized setting. This is evident as, even though such things as the number of sessions, editing process, and amount of interaction by the therapist vary in each person's work, the fact remains that the practitioners have all seen trauma symptoms reduced after the survivors have given their testimony. This seems to exhibit the power of healing inherent in having a person construct their trauma story in the presence of a witness and creating a tangible document as a result of the processed.

Following the discussion on *Techniques*, the section, *Role of therapist/interviewer* will address how different practitioners using this modality view the role and responsibilities of the therapist. Throughout this chapter therapist, clinician, interviewer,

and practitioner will be used interchangeably. Survivor, testifier, and person giving the testimony will be used interchangeably referring to the person giving the testimony.

Lastly, in the section entitled, *Outcomes*, a look at the empirical findings and additional observations of testimonial psychotherapy's effectiveness in alleviating posttraumatic stress symptoms will be explored.

Creating a trauma story

Some stories are so disturbing that they must be told in order for them to lose their destructive power (Agger, 1992, p.5).

All of the practitioners mentioned, along with Judith Herman (a respected trauma expert and author of the classic text *Trauma and Recovery*), speak directly to the power and importance of creating a trauma story to alleviate symptoms from the traumatic experience. In this section the works of Cienfuegos and Monelli, Weine et al., Agger, Agger and Jensen, and Herman will be used to discuss the power of storying a traumatic event. In "The Blue Room," Agger (1992) states, "one of the most important elements in a healing process is to come to possess your own story and thereby create your own narrative" (p. 5). She states that narrating a trauma story can have "transforming power" (p. 5). This transforming power comes, as a person is able to integrate, and hopefully give new meaning to, the trauma story.

Cienfuegos and Monelli (1983) and Weine et al. (1998) speak to the power and importance of creating a trauma story in similar ways as Agger does in "The Blue Room." They speak of how giving testimony helps the victim integrate the traumatic experience into their lives. This happens as the person is able to identify the significance of their experience not only within the social and political context in which it happened,

but also within the context of the person's own personal history (Cienfuegos & Monelli, 1983). Cienfuegos and Monelli speak of the process of the survivor verbalizing their experience as one that sets "object-conscious processes in motion" (p. 45). The importance of becoming aware of the ways in which the torturers have become internalized objects and the subsequent ability to have an "emotional-cognitive experience of knowing, understanding, and being object-conscious" is, in their experience "encouraged by verbalization" (Cienfuegos & Monelli, 1983, p. 45) and an important step toward integration and symptom relief. Just as Agger speaks of creating a document that reveals the methods of the dictatorship, Cienfuegos and Monelli write that an important aspect of creating a trauma story is to denounce, on paper, through a written essay, the "violence and injustice that they [the survivors] have been subjected to" (p. 48).

Agger and Jensen (1990) reiterate the importance of telling the trauma story through testimony by stating that, once the story is told, it can be not only given a meaning, but also be reframed. They believe that it is within this reframing that "private pain is transformed into political dignity" (p.115). In the "Blue Room" and then again writing with Jensen, Agger writes about how a large part of this transformation is a result of the survivor having the opportunity to confess any shame or guilt that may be associated with, or connected to, the trauma. When the survivor is able to talk about the shame and guilt then there is a chance that it can be reframed.

Just as Cienfuegos and Monelli write about creating a document to denounce the dictatorship, Agger writes that when the survivor is able to speak of the methods utilized by the dictatorship in harming the individual, then the trauma story has the potential to

not only elucidate the methods of torture the dictatorship used, but also heal wounds inflicted by these same methods (Agger, 1992). In addition to integration and transformation, Agger and Jensen speak of the creation of the trauma story as necessary because of the way in which it allows the survivor to step back and see “the universal in pain” which the person may have been experiencing solely as a “personal encroachment” up until reconstructing the trauma story (Agger & Jensen, 1990).

In her influential work, “Trauma and Recovery: The Aftermath of violence—from domestic abuse to political terror” Judith Herman speaks extensively about the process of reconstructing the traumatic memory. She, like the others already mentioned, refers to integration as a primary reason it is important for survivors to reconstruct the trauma story. She states, “this work of reconstruction actually transforms the traumatic memory, so that it can be integrated into the survivor’s life story” (Herman, 1992, p. 175). In fact, she states, “the goal of recounting the trauma story is integration, not exorcism” (p. 181). After this recounting of the story, it transforms in a way by becoming more present and real for the person. She references Richard Millica talking about his work with refugees. He refers to the transformed trauma story as a “new story.” When this “new story” has been created it is no longer about “shame and humiliation” but now “about dignity and virtue” (p. 181). When the story is told in a safe and protected relationship, the actual “action of telling a story” produces a change in how the traumatic memory is processed. She contends that along with this transformation of memory comes relief from many major PTSD symptoms (p. 183).

Populations and Places

The work of Cienfuegos and Monelli grew out of a group of psychiatrists, psychologists, social workers, and occupational therapists that wanted to set up a mental health program for people, most of whom were political prisoners, who had suffered from various forms of political repression in Chile (1983, pp. 46-47). This was in the early 1970s. At first they were recording the testimonies of people who had experienced “extremely brutal torture” (p. 44). When they started to see the therapeutic effects of taking these testimonies, they expanded to taking testimony from people who had directly and indirectly “suffered the effects of different forms of political repression” and whose “experiences ranged from the death and disappearance of loved ones to torture, exile, loss of employment, and general harassment” (Cienfuegos & Monelli, 1983, pp. 43 & 47).

Around the same time that Cienfuegos and Monelli’s work arose, Dori Laub (2002) began taking video testimony. His work focuses on people who have suffered from experiences with genocide and has primarily been with survivors of the Holocaust. He started taking video testimony from survivors in Connecticut. This expanded to survivors all over the east coast of the United States and eventually all over the world. His work led him to Israel where he worked within two psychiatric institutions for survivors of the Holocaust, all of whom had severe, chronic mental illness. Prior to his work in Israel most of his video testimony work was conducted in clinics and community centers. In 1982 he founded the Fortunoff Video Archive for Holocaust Testimonies at Yale University.

In her well-known book, *The Blue Room*, Inger Agger (1992) used the testimonial method in Denmark with women refugees from Latin America and the Middle East. The

women had experienced torture, imprisonment, and often rape in their countries of origin. Her book focuses primarily on the sexual abuse the women endured and their ways of making meaning of the abuse within constructs of gender and political power structures. She gathered the testimonials of these women in a blue room in her apartment. In addition to her work that specifically addresses women and sexual and political violence, Inger Agger has worked extensively with Soren Buus Jensen, using testimonial psychotherapy with political refugees from all over the world. Again, they were working in Denmark.

Stevan Weine (1995, 1998) has used, and is currently using, testimonial psychotherapy with refugees from Bosnia. He began with Bosnian and Bosnian Muslim refugees resettling in Chicago, but his work has expanded to include work in Bosnia and the Bosnian Diaspora. Weine's work with Bosnian refugees will be the focus of this research as dictated by the literature he has published, but it is important to note that his work now includes taking testimonials from refugees from Kosovo as well. Similar to Laub's work, in 1994 Weine, along with Ivan Pavkovic, founded The Project on Genocide, Psychiatry, and Witnessing at the University of Illinois at Chicago's Department of Psychiatry. A major component of this project has been a Survivors' Testimonies Oral History Project. This serves as an archive of testimonials from Bosnian and Kosovar refugees.

Stuart Lustig et al. (2004) discovered that testimonial psychotherapy might be appealing and helpful for the "Lost Boys" of Sudan through conducting a focus group with members of the Sudanese community in Boston and with staff members of the Lutheran Social Services, as they were the organization that brought the boys to Boston.

The “Lost Boys” are, a group of adolescent refugees who fled Sudan’s religious civil war. They spent five years walking 1000-miles from Sudan, to Ethiopia, back to Sudan, and finally to a refugee camp in Kenya. They got to the refugee camp in 1992. Many of the “Lost Boys” now live in the United States (Lustig et al., 2004). Lustig’s use of testimonial psychotherapy with this population is different from the aforementioned practitioners as it was focused on working with adolescents. Lustig continues to use this method, but now in the San Francisco Bay Area with refugees and people seeking political asylum from all parts of the world. His focus is still on adolescents.

Van Dijk et al. (2003) brought the use of testimonial psychotherapy to their national institute, Centrum ‘45/De Vonk in Noordwijkerhout, the Netherlands. They used this method with people from around the world who are “asylum seekers or legal refugees in the Netherlands and victims of war” (p. 362). All of the patients are diagnosed with trauma related disorders (p. 363).

As shown through these short descriptions of the work of people who are using testimonial psychotherapy, there is a wide range of differences amongst the groups of testifiers. They come from all parts of the world, but specifically from Chile, the Sudan, the Middle East, Latin America, Bosnia, Kosovo, Israel, and Eastern Europe. They range in age from adolescents to elders. The spaces in which the testimonials are taken also vary greatly from clinics at university settings, community centers, people’s homes, and medical and psychiatric settings. All of the testifiers, with the exception of Cienfuegos and Monelli’s work in Chile, are not in their country of origin, but rather are all considered refugees or asylum seekers. Another exception to this is Laub’s work with survivors of the Holocaust. Most of them are not in their country of origin, but while

giving testimony they are also not considered refugees or people seeking political asylum—although at one time in history they may have been. All of that to say that there is great variation in the populations that testimonial psychotherapy has been used with.

Techniques

Number of sessions

One slight variation important to note in the different methods of testimonial psychotherapy is in the number of sessions each practitioner took to complete the process. There is not a standardized number, yet each person or persons conducting the therapy have found positive results in terms of trauma symptom alleviation.

In the work of Cienfuegos and Monelli (1983), the first one or two sessions with a therapist were devoted to taking basic information on the patient's life history, political repression, and to establish a therapeutic relationship (p. 48). Following these first few sessions anywhere from three to six more are conducted to record the details of their suffering at the hands of the dictatorship. This means that in Cienfuegos and Monelli's work anywhere from four to eight sessions were conducted to complete the process. Weine et al. (1998), Lustig et al. (2004), Van Dijk et al. (2003), and the collaborative work of Agger and Jensen (1990) all loosely follow the tradition of Cienfuegos and Monelli (1983) by utilizing multiple sessions to complete the testimonial taking process. Weine et al. (1998), met for an average of six sessions either weekly or bi-weekly. Each session was about 90 minutes long and the process, on average, took about six weeks to complete. Lustig et al. (2004), conducted anywhere from three to nine sessions, plus an introductory and concluding session. Van Dijk et al. (2003) set their number of sessions at twelve and added an element where the patient draws a line that reflects the major

events of their life (p. 363). Finally, in their working model, Agger and Jensen (1990) spend anywhere from twelve to twenty weeks taking one person's testimony.

In contrast to the multiple-session work of the practitioners mentioned above, Laub (2006) most often completes taking of video testimony in one session that, on average, lasts 60 to 90 minutes. Similarly, in her work with Middle Eastern and Latin American refugee women, Agger (1992) generally met with the women one time, and for an average of three hours. In addition to her one-time testimony taking session, she also contacted the women ahead of time, via a letter, explaining her work, her past work, and what her aim of the study is.

Process

Components of the process of taking survivors' testimony are similar throughout all of the works read. There is always some sort of introduction to the procedure and some psycho-education around the fact that strong emotional reactions may arise as a result of the process. Cienfuegos and Monelli (1983) do this within the first one or two sessions. In their work the therapist explains the ways in which talking about the details of their experience may be painful and help them to understand emotions associated with trauma. Agger (1992) does this through a letter sent prior to the testimony session. Agger and Jensen (1990) do this in the first and second sessions in which they explain the method verbally and with hand-outs and introduce the interpreter. Weine et al. (1998) and Lustig et al.(2004) also explain the process, ending in a ritual of signing an informed consent. Van Dijk et al. (2003) have a very psycho-educationally heavy first and second session, which includes psycho-education about trauma therapy, specifically testimony

therapy, information about PTSD, and discussion of the final purpose of the document (p. 364). In addition, a general overview of the patient's life is conducted.

Testimonial psychotherapy is a politically and socially rooted therapy working to create a story based in a person's direct experience of political oppression. Cienfuegos and Monelli (1983) talk to the survivors about this being an opportunity to "denounce, through written essay, the violence and injustice to which they have been subjected" (p. 48). Agger (1992) also directly addresses political oppression through her process by concentrating on two themes throughout the testimony. The first is how the individual woman has become a refugee and the second addresses her life in the homeland and in exile. She does this for a few reasons. One is that her overall idea and goal approaching this work with the refugee women is to extrapolate an overarching "one testimony" to illuminate the solidarity of experiences between the women. The other is to try and bring together the woman's personal, private experience with her public, political, and social experience. In contrast to the other practitioners, Agger asked very specific questions to guide the survivors toward these themes. The questions were taken from a mimeograph created by New York Radical Feminists in the late 1960's called "Suggested topics for consciousness-raising" (Agger, 1992, p.16). These questions address such topics as: sexual development, sexual trauma, marriage, housework, pregnancies, births, motherhood, divorce, work, and age (Agger, 1992, p. 16).

This is in contrast to the work of Laub Lustig et al. (2004) who take the testimony either through very open-ended questions to get started or through letting the survivor start wherever they want. Weine et al. (1998), Agger and Jensen, and Van Dijk et al. (2003) all work similarly in that their testimony taking sessions are "semi-structured" in

order to cover, with varying specificities, life before the traumatic experience(s), account of the traumatic experience, and life after the traumatic experience. An example of the varying specificity encompassed by semi-structuring the testimony process is Weine et al.'s work. They ask the survivor to speak to:

1) the life history from the era of multiethnic living, 2) the life and family history from World War II, 3) the trauma story of surviving ethnic cleansing and war, 4) the life experiences of being a refugee, 5) the survivors' experience of their current lives and their sense of the future (Weine et. al., 1998, p. 1722).

With the exception of Laub and Agger's (1992) work, all of the others tape record the testimonies as they are given. When needed, the practitioners also provide interpreters. Once the transcript is translated, it is either read silently or out loud, as a collective, often with therapist, interpreter, and testifier. This is more evidence of testimonial psychotherapy's adaptability to many situations and circumstances as the person giving the testimony does not need to be able to read to go through this process. It can be a completely verbal process. This process provides opportunities for the survivor giving the testimony to add, delete, elaborate, or change any information, new recollections, and details in the testimonial. This is an important component of the work because it gives the opportunity to the survivor to have complete control over their situation and which words will be documented and which will not. There is the potential for much empowerment and meaning making of one's story to occur during this ritual.

Another important ritualized aspect of the testimonial process is the completion of the testimonial. Once it is in a form satisfactory to the survivor, the survivor signs it with the practitioner and, if applicable, the interpreter as witnesses. The practitioner makes a bound copy and presents it to the survivor along with a certificate of completion. This is

the process that was used by Cienfuegos and Monelli (1983), Agger and Jensen (1990), Weine et al. (1998), Lustig et al.(2004), and Van Dijk et al. (2003) In the work of the clinicians mentioned, written testimonials ranged anywhere from eleven to 120 pages. In Laub's video testimony work there is a process at the end in which therapist, interpreter, and survivor all review and discuss the video as a whole.

Lustig et al. (2004) speak of how testimonial psychotherapy works best if a person has come from a collectivistic style family system/community, and when the meaning and power of story are upheld in the community. This has been found to be true, yet making meaning of one's story and reconnecting with others are integral parts of healing from trauma in general. Weine and Laub (1995) beautifully capture the power of the testimonial as a personal, collective, historical, and healing process when they write:

The act of making a testimonial record may serve as one appropriate means for connecting the survivor's personal story with a larger collective's history. The act of giving and receiving testimony can be thought of as a clinical intervention that addresses both the fragmentation created by the trauma and the profound sense of loss and aloneness that is the empty core of the refugee's experience....Giving testimony can be a crucial step in establishing the reality and the veracity of the trauma that was previously unassimilable and unknown even to the participant. Belatedly it may establish the event as an experience that took place and as a real personal historical occurrence that can be shared (Weine & Laub, 1995, p. 256.)

As Weine and Laub address above, connecting to a larger collective and history holds with it many healing properties. Almost all of the practitioners address reconnection as an essential component of the process of testimonial psychotherapy. Cienfuegos and Monelli (1983) speak of reconnecting to the political movement, ideological commitment, and comrades. Inger Agger (1992) speaks of the women in *The Blue Room* connecting with each other through a sense of solidarity because of similar experiences. Weine et al. (1998) speak of the concept of *merhamet* in Bosnian culture, which is

described as a vital self and group concept associated with multi-ethnic co-existence that was lost with the process of ethnic cleansing. A collective process of giving testimonials has helped to redeem a sense of *merhamet* amongst many Bosnian refugees.

Along with reconnection, it is important that the person who has given the testimony decide what they want to do with their copy and, if they are interested, ways in which they may want to use it to educate, help, or reconnect with others via the testimony. In the work of Laub (2006) and Weine et al. (1998), the video testimony and written testimony, respectively, are deposited into archives mentioned previously. In addition to this the testifier can use their testimonial to give to family, friends, partners, future therapists, or to be used in cases of political asylum. The people giving testimony may see it as tool with which to help others so that the same thing will not happen to them. It may be a way to get a story out about a group of people and the testifier may see their testimony as a possibility to prevent future wars, conflicts, or violence.

Creative ways of using the testimonial have been done as well. One of the Lost Boys of Sudan created a play out of his. All three “Lost Boys” who gave testimonials with Lustig et al.(2004) agreed to post portions on the Physicians for Human Rights website. Theater groups have worked in conjunction with testifiers and books written based on testimonials. Survivors may decide to never open the document again and simply have it as a proof of their own objective and subjective sociohistorical reality.

Role of the therapist/interviewer

According to Cienfuegos and Monelli (1983) the therapist is there throughout the whole process encouraging the patients to tell their story in their own words and in any way that they need to. The therapist may ask questions for clarification or to gather more

detailed information in relation to significant events. The therapist is also there to review, revise, and edit the final written testimonial as a cooperative effort.

Laub's work focuses on the importance of history. He also focuses on the great importance of having a witness to the often-untold historical account of the survivor. Weine and Laub (1995) co-authored a paper called, "Narrative Constructions of Historical Realities in Testimony with Bosnian Survivors of 'Ethnic Cleansing'." In this paper they speak of the clinician's role to be an "empathic, safe, and historically informed listener" (Weine & Laub, 1995, p. 256). The power of the testimony rests in the process of the clinician and a survivor witnessing and creating a subjective and objective history together. Weine and Laub also reference Lifton who speaks of the clinician as a "witnessing professional" and one who sets his or her clinical knowledge within a historical and ethical framework to address not only the survivors of traumatic experiences but also "the historical dislocations within which the trauma took place" (Weine & Laub, 1995, p. 259). Another important role of the clinician is to watch the final video of the testimonial with the testifier.

Agger and Jensen (1990) speak to the central role of the therapist as that of witness. They go on to discuss the importance of the interviewer in clarifying details in order to create a document that is as precise as possible. They state that this must be done through "employing therapeutic sensitivity" (Agger & Jensen, 1990, p.129). They also make a point to mention that it is up to the therapist as to whether or not they want to make their own pain in reaction to the testimony public or keep it private throughout the process.

Once the survivor starts telling their story, Weine et al. (1998) write, the overall role of the interviewer is to ask questions that are “succinct, open-ended, and clarifying” and in reference to the “person’s experiencing of significant historical or traumatic events” (p.1722). The interviewer recording the testimony is to constantly emphasize the life history, the social context of life, and the sense of self in history and the history in one’s life (Weine et al., 1998, p.1722). It is also the role of the interviewer to provide support and structure while the survivor is recounting particularly traumatic event.

In Lustig et al.’s (2004) work, the role of the lead clinician was to monitor the adolescents for “signs of hyperarousal or any discomfort” (Lustig et al., 2004, p. 37). In addition, it was also seen as the interviewer’s responsibility to ask the boys reframing questions in the next to last session. During the time the adolescents gave testimony Lustig writes that it is vital to “remain attentive to participants’ physical and emotional comfort levels, create a physical and emotional space that feels receptive to testifiers, and clarify points at a comfortable pace for them” (Lustig, 2002, p. 15).

Van Dijk et al. (2003) state that the therapist’s role throughout is “to support the patient and structure the story” (p. 365). They also state that if it seems that the patient is avoiding essential details, it is the responsibility of the therapist to slow the process down so that the patient will not become overwhelmed by the memories (Van Dijk et al., 2003, p. 365). They address the importance of the subjective nature of history and the creation of a historical memory and trauma story when stating:

The therapist helps to define the political and historical context of the traumatic events. He/she never calls the testimony into question, but may ask for clarifications when there are contradictions or historically incorrect facts in the story (p. 365).

Outcomes

Studies done by Cienfuegos and Monelli (1983) and Weine et al. (1998) are the only ones that have gathered empirical evidence about the effectiveness of testimonial psychotherapy in alleviating symptoms of posttraumatic stress. The rest of the information on the effectiveness of using this method has come from clinical observation, case studies, and feedback from participants. The methods used to take the testimonials by Cienfuegos and Monelli and also Weine et al., were outlined in a previous section so they will not be summarized again here. What will be summarized is a recap of the populations studied and the results found/observed by each study.

Cienfuegos and Monelli's landmark study was an assessment of 39 individuals seeking treatment at the center they, along with many other clinicians, created in Chile. The group of 39 people consisted of "relatives of prisoners who had disappeared (N=2), prisoners who had themselves been tortured (N=15), relatives of prisoners who were executed, prisoners who survived execution attempts (N=2), and political exiles returning to Chile (N=5)" (Cienfuegos & Monelli, 1983, p. 47). Within this group, the major symptoms included, but were not limited to "helplessness, anxiety, sleeplessness, feelings of disintegration, inability to concentrate, impaired memory, specific or generalized fear, social withdrawal, irritability, loss of appetite, and a variety of psychosomatic symptoms" (Cienfuegos & Monelli, 1983, p. 47). It is important to note that because of the "urgency" of the patients needing psychological care, a more detailed psychological analysis was not done (p. 47).

To provide a context in which to understand their findings, it is useful to know the categories used during evaluation. Cienfuegos and Monelli used the following categories to evaluate the effectiveness of using testimony as a psychotherapeutic instrument:

- 1) *Success*: Testimony leads to mitigation of the most acute symptoms, such as anxiety or acute depression, sleeplessness, bouts of weeping, etc.
- 2) *Partial Success*: Testimony diminishes the severity of the most acute symptoms, although they do not disappear completely
- 3) *Failure*: Testimony does not alleviate patients' acute symptoms; subjects continue to have the same complaints (1983, pp. 48-49).

They found the highest rate of success with patients whose traumas were the result of being tortured (p. 49). In those cases twelve out of the fifteen patients reported that the testimony "led to alleviation of anxiety and other acute symptoms" (p. 49). In two cases of patients who had been tortured, they reported partial success and one failure. They attributed this failure to "serious pathology in the premorbid personality of the individual prior to the experience of torture" (p. 49).

Next, they report that for the cases in which the patient survived execution attempts, taking their testimony proved to be therapeutic. They had one success and one partial success. The researchers also noted, however, that two cases is not enough to make a generalization about testimony as an effective therapeutic experience for people who have survived execution attempts (Cienfuegos & Monelli, 1983, p. 49).

In relation to the families that gave testimony, Cienfuegos and Monelli found that, although there were a few successes and a few failures, there was only partial success in the majority (eleven out of fifteen) of the cases. They attributed these outcomes to a great presence of unresolved grief during the time following the testimony process (p. 49).

Mixed results of success and partial success were found after taking the testimony of the five patients who had returned from exile. It was found that the mixed results were linked to conditions in the place in which they resided during exile. Finally, giving testimony was found to be a failure for the two relatives of missing persons.

Cienfuegos and Monelli (1983) argue that, overall, the results from this study suggest that “testimony can be an effective therapeutic instrument with psychiatric patients who have suffered political persecution, cruel and degrading torture, imprisonment, or prolonged detention in concentrations camps” (p. 49). They state that it may not be as effective with relatives of victims.

Stevan Weine et al., published results of a study conducted with 20 Bosnian refugees in Chicago in 1998 in an article entitled “Testimony Psychotherapy in Bosnian Refugees: A Pilot Study.” All of the participants were ethnic Bosnian adult survivors of “ethnic cleansing.” Out of the participants there were eight women and twelve men. Their ages ranged from 23 to 62 years old (p. 1721). It was found, through the Communal Trauma Experiences Inventory, that each person had experienced an average of 16.0 traumatic experiences and all met DSM-IV criteria for PTSD (p. 1721).

Unlike Cienfuegos and Monelli (1983), Weine et al. (1998) did psychiatric assessments with their subjects before beginning the testimony taking process. They were evaluated for “traumatic stress, depression, psychosocial functioning and screening for prior psychiatric history” (p. 1721). The instruments used for these evaluations were “the PTSD Symptoms Scale, the Beck Depression Inventory, and the Global Assessment of Functioning Scale” (p. 1721). They also did follow-ups at six, fourteen, and 30 weeks and compared those findings to the baseline at time of treatment.

They discovered that “the rate of PTSD diagnosis decreased from 100% pre-testimony to 75% post-testimony, 70% at 2-month follow-up, and 53% at 6-month follow-up” (p. 1722). During follow-up times they found that the following decreased: PTSD symptom severity, re-experiencing symptoms, avoidance symptoms, and hyperarousal symptoms (p. 1722). The scores for the Beck inventory decreased while the Global Assessment of Functioning Scale increased. Finally, they found that giving testimony also reduced depressive symptoms that are often present with PTSD in this population (p. 1722).

Weine et al. (1998), believe that their findings illustrating the effectiveness of testimony psychotherapy at reducing both the diagnosis and severity of PTSD, are consistent with the findings of Cienfuegos and Monelli. They discuss how their findings add verification that testimonial psychotherapy is an effective therapeutic instrument because of their use of standardized instruments, follow-up assessments, and statistical analysis as none of these were present in Cienfuegos and Monelli’s study.

In addition to the empirical work of Cienfuegos and Monelli (1983) and Wine et al. (1998), others have observed reduction in symptoms of trauma as a result of testimonial psychotherapy. Agger and Jensen (1990) write about their work with a 25 year-old man from Africa seeking asylum in Denmark. After his twelfth session they report observing a reduction in symptoms, less interest in therapy, and a reengagement in cultural and political activities of his exile group and countrymen (Agger & Jensen, 1990, p. 123). They also tell of the case of a 30 year-old engineer from the Middle East. After 30 sessions his reenactment of the traumatic event through an obsession with torture and horror videos went away. He was still, however, left with somatic memories of the

trauma. In other clinical observations, in a follow-up with the “Lost Boys of Sudan,” Lustig et al., found that they considered their experience to be a positive one.

Conclusion

This chapter started with the historical development of testimonial psychotherapy as a socially and politically rooted theory. This led the researcher to a discussion about the power and importance of creating an integrated trauma story. Next, the adaptability of testimonial psychotherapy was explored through an examination of the various populations and places in which it has been used. The technique involved in taking a testimony was given, including the effectiveness of reconnecting the individual to the community, and the role of the interviewer. Lastly, outcomes based in empirical research and observations were presented.

Through the empirical research and observations it was shown that testimonial psychotherapy is adaptable to populations of varying races and ethnicities and has been proven to be effective in alleviating many symptoms of PTSD with these populations. The next chapter will focus on individuals and communities of color in the United States. Specifically, it will discuss the phenomenon of RBTS and the effects it has on people of color. In Chapter III a definition of RBTS will be given followed by sources of RBTS. Many of the symptoms of RBTS are akin to PTSD. To illustrate the similarities between the two, the psychological and emotional, as well as the physiological symptoms of RBTS on people of color will be given. Finally, suggestions for expanding definitions of trauma and the DSM-IV-TR will be provided.

CHAPTER III

RACE-BASED TRAUMATIC STRESS

Prior to the exploration of whether or not testimonial psychotherapy can be adapted to be utilized in the US the concept of *race-based traumatic stress* needs to be defined and expounded. In this chapter the following components of race-based traumatic stress (RBTS) will be addressed: theoretical construction, sources (institutional, cultural, interpersonal, intergenerational, as well as internalized), symptoms, and current diagnostic formulation. This will be followed by a discussion of ways in which definitions of PTSD and trauma need to be expanded to encompass the unique kind of trauma that results from living as a person of color within a racist society. Because the discussion of RBTS is predicated on how we define racism, this chapter will begin with an operationalization of racism.

Although for the purposes of this discussion racism is being defined, the reader is cautioned not to limit racism to only what is presented here. It should be held by the reader that ultimately racism is a subjectively defined event. Keeping in mind the idea that we all live in our own subjective reality, throughout this chapter and research, the author would like to make clear that: 1) Not all people of color are traumatized by racism; 2) People of color are traumatized in different ways by racism; 3) It cannot be assumed that all people of color have the same symptoms if they are traumatized by the effects of racism. Additionally, throughout this research, and especially within the context of this chapter, when terms such as racism, discrimination, and dominant culture are used, they

are referring to, if not otherwise stated, white racism, white discrimination, and white dominant culture. This is a distinction that is not always made and often works to perpetuate subtle forms of racism in the United States.

Definition of racism

Racism is a process, a condition, a relationship that violates its victims physically, socially, spiritually, materially, and psychologically (Susan Speight, 2007 p. 127).

Many definitions of racism created by academics, intellectuals, clinicians, historians, and theoreticians from many disciplines exist (Carter, 2007). Some rely heavily on the political aspects of racism; some tend to focus on the historical roots of racism, others the institutional and structural components of racism. For the purposes of this paper, racism will be operationalized using Jones and Carter's (1996) and Omi and Winant's (1994) theoretical standpoints. Carter's (2007) working definition of racism used in his recent article, "Racism and Psychological and Emotional Injury: Recognizing and Assessing Race-Based Traumatic Stress" (2007) will be used along with Omi and Winant's theory on what racism is in their influential book *Racial Formation in the United States: From the 1960s to the 1990s* (2nd edition, 1994). Both will be used, as neither was sufficient on its own. Structural aspects of racism interplay with the individual and the individual's psyche, as it is set in a time and place in space and history. One definition was not found that encompassed all of the layers.

Carter's (2007) working definition is as follows:

Racism can be defined...as the transformation of racial prejudice into individual racism through the use of power directed against racial group(s) and their members, who are defined as inferior by individuals, institutional members, and leaders, which is reflected in policy and procedures with the intentional and unintentional support and participation of the entire race and dominant culture (Jones & Carter, 1996).

His working definition is very useful in framing a discussion about racism. This is namely because it encompasses many aspects of racism such as: the intentional and unintentional nature, the use of power, and the individual and institutional aspects of racism. Carter makes the beginnings of links of racism to psychosocial functioning (Carter, 2007).

What is absent from this definition is mention of the ways in which racism has been a means by which to organize society in the U.S. For Omi and Winant, race is used as an organizing principle for social relations at the micro (individual) and macro (collective) levels (Omi & Winant, 1994). If the ways in which racism has been used as a means by which to organize society since, and before, the formation of the United States were to be included in a definition, it would automatically ground racism within a social, political and historical time and place. Viewing racism as being situated in a social, political, and historical context would link the definition to the fact that race and racism are social constructs and that they are fluid. They are always evolving and changing with time and according to the political and social climate (Omi & Winant, 1994). Omi and Winant argue that race is a sociohistorical concept (1994). By not explicitly addressing the sociohistorical and political aspects of racism, it does not leave room to address the link between racism of today and historical atrocities such as slavery, internment, and expulsion.

This yearning to add more to Carter's working definition, because of the feeling that it is not quite enough to encompass either all aspects of racism, or the scope of this research, parallels discussion around definitions of race and racism in the larger academic world. Omi and Winant (1986) write:

Recent academic and political controversies about the nature of racism have centered on whether it is primarily an ideological or structural phenomenon....We believe it is crucial to disrupt the fixity of these positions by simultaneously arguing that the ideological beliefs have structural consequences and that social structures give rise to beliefs. Racial ideology and social structure, therefore, mutually shape the nature of racism in a complex, dialectical, and overdetermined manner (pp. 74-75).

For the sake of this research, in the spirit of Omi and Winant, the idea that racism does not have a fixed definition that is either ideological or structural, but rather is an interplay of both will be embraced. This is especially important for work that is interested in examining and integrating both the micro and macro level effects of white racism in the United States on individuals of color.

Race-Based Traumatic Stress: Definition

Throughout this research, the term *race-based traumatic stress* refers to the kind of traumatic stress and comorbid symptoms resulting from racism. Variations of this terminology are present in the literature. Conversation and debate has ensued as to the appropriate terminology to use when discussing trauma a person of color may experience as an outcome of living in a racist society. RBTS has been called by various names including, but not limited to, societal trauma, intergenerational trauma, racist incident-based trauma, insidious trauma, psychological trauma, emotional abusiveness, and racism.

For the purpose of a working definition and common understanding within the context of this research, a definition of RBTS taken from Bryant-Davis (2007), with its roots in the work of Carter (2005), will be used. She defined it as:

- (a) an emotional injury that is motivated by hate or fear of a person or group of people as a result of their race;
- (b) a racially motivated stressor that overwhelms a person's capacity to cope;
- (c) a racially motivated, interpersonal severe stressor

that causes bodily harm or threatens one's life integrity; or (d) a severe interpersonal or institutional stressor motivated by racism that causes fear, helplessness, or horror (p. 135).

This definition gives primacy to the central role of racism in this particular form of traumatic stress. The term *race-based traumatic stress* signifies a specific kind of traumatic stress, one that is the result of a racially based incident(s) situating it within a social context. The term *traumatic stress* calls upon knowledge of traumatic stress as a state of mental health that is the result of conditions acted upon a person that results in stress and trauma. Hence, *race-based traumatic stress* encompasses both the source of the traumatic stress and, inherent in the already known definition of traumatic stress, the symptoms that arise as a result of traumatic stress. Most importantly, explicitly saying *race-based* connects the traumatic stress to a very specific source—race. The trauma is now situated within the sociohistorically dependent construct of race and encompassing all levels, institutional to interpersonal, of racism.

RBTS: Sources

The amount of energy utilized to deal with the psychological and physical stress of racism often leads to trauma which manifests in symptoms similar, but not confined to, the symptoms people have after experiencing various traumatic events—both one-time and ongoing. The symptoms that manifest from the traumatization also vary from one racial and/or ethnic group to another racial and/or ethnic group and from individual of color to individual of color. Numerous studies (Carter et al., 2005; Collins et al., 2004; Din-Dzietham et al., 2004; Forman, 2003; Harrell, Hall, and Taliaferro, 2003; Klonoff et al., 1999; Loo et al., 2001; Mossakowski, 2003; Murry et al., 2001; Romero & Roberts, 2003) have examined various ways in which people of color are traumatized emotionally,

psychologically, and physiologically by white racism. The literature indicates that RBTS both arises from and is perpetuated institutionally, culturally, intergenerationally, as well as through the mechanism of internalized racism. Although sources of racism are being delineated into these categories, racism itself works in insidious ways. As Speight (2007) writes, “particularly because racism is part of our social reality, it can be difficult to discern, like the water we swim in or the air we breathe” (p. 127).

The specific categories of racism chosen for this research are, in a way, forced distinctions as the whole system of racism in our society is intertwined, interconnected, and interdependent (William & Williams-Morris, 2000). There is a ripple effect from one form of racism to another. For example, housing segregation along racial lines is often a result of poverty. The economic base of a community directly influences how much funding a school system has to invest in the education of its students, which in turn impacts workforce readiness and higher education opportunities. Under or unemployment is associated with community violence and high involvement in the criminal justice system, which undermines the community further (Waquant, 2001; Williams & Williams-Morris, 2000). Although mutually influencing, each of these components can be examined individually.

Institutionalized Racism

In a broad sense, institutionalized racism limits opportunity and prevents people of color from getting services and channels them into certain institutions (i.e., prisons, wage labor) (Miller & Garran, 2008; Wacquant, 2001). For example, a poor community of color may have only one option for a mental health clinic (Miller & Garran, 2008). Another example is loans. It used to be that people of color were frequently flat out

denied mortgage loans. Now, a practice of “predatory lending” is more common in which people of color are offered loans, but with much higher interest rates, shorter payment periods, larger penalties for falling behind, or a larger down payment required than usual (Massey, 2005, pp. 149-150). This results in limitations on where a person of color is able to afford a house and sometimes even what kind of house.

The discussion of institutional racism most often focuses on housing, employment, healthcare (including mental health care), the legal/criminal justice system and law enforcement, and education. (Carter, 2007; Chien et al., 2007; Massey, 2005; Le Cook, 2007; Miller & Garran, 2008; Renner & Moore, 2004; Wacquant, 2001; Wade, 1993; Williams & Williams-Morris, 2000). Additional examples of institutional racism, which adversely affect communities of color are: laws and policies which are differentially favoring people based on race, divestment, differential sentencing terms, racial profiling, and various forms of environmental racism (Boer et al., 1997; Lipsitz, 1998; Massey, 2005; Miller & Garran, 2008; Powell, 1999, Wacquant, 2001).

Miller and Garran (2008) refer to the interconnected systems (i.e., housing, education, media) that uphold institutionalized racism as creating a “web of institutional racism” (p.63). They argue that all aspects of the web work off each other, increasing each one’s ability to exclude and deny people of color (Miller & Garran, 2008). The authors outline five important intricacies of the web that maintain its existence. They are:

- 1) It is systematic and comprehensive; 2) It exists on many levels; 3) It combines formal and informal practices (covert and overt); 4) It is cumulative; and 5) It contains power to make, enforce, fund, define, and present laws and policies (Miller & Garran, 2008, pp. 65-66).

Basically, this means that institutionalized racism creates a skeleton for the operation of the United States. It affects all corners of the lives of people in the United States. In this way, it is a major source of RBTS.

Cultural racism

Young (1990) speaks of *cultural imperialism* as a conduit through which racism becomes internalized. Cultural imperialism is the thought that one culture dictates how the rest of the cultures present in a society should act, think, believe, eat, speak, etc. According to this description of cultural imperialism, white dominant culture is the imperialist culture in the United States. The imperialism takes many forms and is a part of every aspect of a person's life in the United States, but frequently excludes the needs and ways of being of many people of color. The cumulative experience of not having one's identity present in many aspects of society is a source of RBTS.

White dominant culture is able to use the power it holds to perpetuate cultural heritage. It is not only in the perpetuation of Eurocentric cultural heritage that RBTS is found, but also in the way that it is, and has historically been, imposed on communities of color. A prime example is the way in which European colonizers forced Native American children to assimilate to white culture through: sending them to boarding schools and not allowing them to be with their families of origin, practice their own spiritual practices, eat the food they were used to subsisting off of, or speak their native languages (Brave Heart & DeBruyn, 1998).

Carter (2007), among many others, speaks of the ways in which cultural racism manifests in the United States. He states:

Some examples of cultural racism are when people of color are treated as if they are not American because of their race or language. People often assume that Asians or Hispanics are foreigners and treat them with surprise when they speak English or disgust when they use their native language (p. 88).

To this day there is still the expectation that everyone in the United States “needs” to speak, read, and understand English. The assimilation imposed on Native Americans continues today and is extended to other groups. It comes through messages such as an absence of: food a person of a race or ethnicity other than white might eat in grocery stores, literature available in different languages in waiting rooms, respect and days off for religions other than Christianity, or images in the media that may mirror the experience and/or context of a person of color’s life.

As all forms of racism and sources of RBTS, cultural racism is intertwined with, and dependent on, institutional, interpersonal, and internalized racism. As mentioned at the beginning of this section, however, cultural racism is considered a conduit for internalized racism as it is here that images, stereotypes, and messages of who has decision-making power and who does not, whose voice counts and whose does not, who is “supposed” to be rich and who is not, what kinds of jobs one is “supposed” to have and what kind not are continuously reinforced and repeated. It is under the “cultural racism” category that messages of who is desirable and who is not, who is supposed to have sex and who is not, who is diseased and who is not, are perpetuated. These messages are perpetuated through larger systems such as the media, but also smaller systems such as the relational, or interpersonal, encounter between two people.

Interpersonal racism

In times past, racism was exhibited through more direct means, or what is often referred to as overt racism. Examples of this are actions such as segregated bathrooms and schools, lynching, being told that a job rejection is based on the color of one's skin, direct racial slurs, and refusal of services. In present times, racism has taken on a different form. In what is often referred to as "modern" forms of racism, it has become covert and coded. A word often used in reference to it is subtle, or insidious.

This form of racism is often exhibited through less direct means called microaggressions (Pierce, 1974). Microaggressions are most often subtle, unconscious, and automatic (Miller & Garran, 2008). Pierce's (1974) original definition of microaggressions referred to them as sources of stress for people of color that occur in interactions between people of color and white people. Some examples of these are: the way in which a person of the white dominant culture may hold their shoulders or glances at a person of color as they are speaking to them, ignoring a person of color in a group of people, being mistrusting of a person of color, asking a person of color to speak for the experience and point of view of their entire race, and denying that race is a relevant factor in a situation (Miller & Garran, 2008). It is in such acts as: a white person crossing the street in order to avoid a person of color walking down the same side of the street, the tone of voice used and the choice to touch a person of color's hand or not in a money transaction, and through a white person assuming that a person of color is having the same experience as they are in any given situation.

Miller and Garran encapsulate the cumulative effect of microaggressions when they state, "they occur repetitively, and their impact can be cumulative, like a thousand

paper cuts as opposed to one deep wound” (Miller & Garran, 2008, p. 97). The emotional and psychological effects are exhausting, often leading to people of color feeling hurt, mistrustful, beleaguered, and exhausted (Solorzano et al., 2000, as cited in Miller & Garran, 2008, p. 97). This is congruent with Carter’s (2007) discussion of microaggressions where he makes a connection between the cumulative effects of stress and levels of depression, anxiety, and declining physical health (p. 27). He does this through noting that in stress literature and research, the equivalent term to microaggressions is *daily hassles* or *minor events* (Taylor, 1999, as cited in Carter, 2007, p. 26). It has been found that the compounding effects of daily hassles are integral to the make up of psychological well-being (Carter, 2007).

Microaggressions are particularly powerful to understand while examining sources of RBTS as they materialize as the result of institutional, cultural, and individual racism. It is also important to note that how an individual responds to the daily stress resulting from microaggressions may have a lot to do with their general state of well-being. How a person responds has much to do with individual variation including gender, racial-identity status, and aspects of resiliency.

Intergenerational Transmission

Because racism is pervasive, operating at the interpersonal and institutional levels simultaneously, its effects are cumulative, spanning generations, individuals, time and place—encompassing much more than discrete acts. Consequently psychological injury that is due to racism is not limited to that caused directly by one perpetrator, at one time, in one place (Speight, 2005, pp. 126-7).

According to the DSM-IV-TR, evidence has been found that there is a “heritable component to the transmission of PTSD” (4th ed., text revision; *DSM-IV-TR*; American Psychiatric Association, 2000, p.466). Much has been written on intergenerational

transmission of trauma, especially the transmission of trauma and PTSD from people who survived the Holocaust to their children. This subject has been well documented and studied (Rowland-Klein & Dunlop, 1997; Laub, 2002; Lev-Wiesel, 2007). Just as children of Holocaust survivors live with the trauma caused by this horrendous event, children of color, and therefore adolescents and adults of color, also live with trauma passed down through generations as the result of racism in the United States (Brave Heart & DeBruyn, 1998; Thompson-Miller, 2007; Pinderhughes, ch 8 in *Living Beyond Loss* 2nd ed. 2004 by Walsh and McGoldrick; Cheng, 2001; Bryant-Davis & Ocampo, 2005). The double whammy, however, is that while people of color live with the effects of hundreds of years of racial oppression being passed through generations, they are simultaneously being traumatized by continued racial oppression.

DeGruy-Leary, Wade, and Wyatt (2005) speak to this intergenerational transmission within the African-American community, tracing it back to the time of chattel slavery. They then connect this transmission to, among other adapted beliefs, behaviors, and emotional effects, Black-on-Black violence, punitive parenting styles, views on sexuality, feelings of powerlessness, vacant self-esteem, and loss of identity (Essence, 2005). DeGruy-Leary (2003) states that trauma has been transmitted through generations in three ways: family, community, and, society.

Although (as cited above) there is literature examining the intergenerational transmission of trauma among various people of color, the majority of the literature explores that of African American people and slavery. An example of passing the trauma of slavery through family was discussed during an interview with DeGruy-Leary, Wade, and Wyatt (2005). They speak of the intergenerational transmission of trauma as it is

played out in parenting. They address the necessity of, during times of slavery, parents being aggressive or overly punitive to “keep them in line” to prevent a master or overseer from punishing the child if the child was acting out. They also speak of the mother’s need to speak poorly of a child, referring to her child as “stupid, shiftless, unruly, can’t work,” if a slave master pointed out that a child was “coming along” in order for the child to not be sold to a different owner, more often than not resulting in a separation between mother and child (Essence, 2005, p. 152). DeGruy Leary states that these ways of parenting, along with a fear of getting too close to a child because of the constant threat of the family unit being split apart during times of slavery, are based in a great fear of abandonment. As a result, in current times, DeGruy Leary speaks of working with African American parents as they struggle with the lasting trauma of slavery and teaching parents to hug and praise their children. In the interview, they connect these forms of parenting to current methods of parenting within the African American community and directly link them to the generations of trauma at the hands of slavery with no options to heal during and after slavery ended.

At the community level, Crawford (2003), Nobles (2003), and DeGruy Leary (2003) speak of the interaction between parenting style and community reinforcement, both positive and negative, in an example of intergenerational transmission of trauma. They reference how, during times of slavery, children were severely punished by their parents in order to not be punished by the slave owners. This time she speaks of how the males, in particular, were punished more to destroy signs of aggression. In more recent generations, this has continued in order to make sure that African American boys do not stand up to any sort of white authority (Crawford, Nobles, & DeGruy Leary, 2003, p.3).

They state, “while this practice was clearly the result of the hostile and oppressive environment in which African American families lived, it resulted in an assault on the collective psyche of the group as a whole” (Crawford, Nobles, & DeGruy Leary, 2003, p. 3).

Because culture, belief systems, worldviews, etc. are transmitted from parent to child, all groups of color are likely to transmit the particular traumas of their particular racial and/or ethnic group intergenerationally. Crawford, Nobles, and DeGruy Leary state that all methods of transmission interact with the larger society, “adding consistent and enduring trauma” (Crawford, Nobles, & DeGruy Leary, 2003, p. 3). This means that not only is trauma transmitted intergenerationally, but also compounded and perpetuated by systems in the larger society. This happens through “policies of continuing inequality, discrimination, and scarcity of resources, coupled with crass materialism and a mass communication system which allows everyone to see the stark disparity between the ‘haves’ and the ‘have nots’” (Crawford, Nobles, & DeGruy-Leary, 2003, p. 3). The ways in which trauma is passed through generations (family, community, society) hold true for many communities of color regardless of race and/or ethnicity, making it a crucial source of RBTS to examine.

Internalized Racism

Internalized racism is all about the cultural imperialism, the domination, the structure, the normalcy of the “way things are” in our racialized society (Speight, 2007, p. 129).

There are aspects of racism and the trauma that results that are not comparable to *DSM-IV-TR* definitions of trauma or the symptoms that are the result of other traumatic experiences (like rape and domestic violence, for example). The ways in which

internalized racism can affect a person of color's mental health is one of those aspects. Internalized racism is both a source of RBTS and a symptom of it. Internalized racism has been described as simultaneous oppression from within and oppression from without (Bulhan, 1985, p. 123).

Internalized racism is most often described in terms of its relationship to cultural imperialism. As noted in a previous section, Speight (2007) states that it is cultural imperialism that is most relevant to a conversation about internalized racism as it is "the conduit through which subordinate groups come to internalize their oppression" (p. 129). Young (1990) describes cultural imperialism as involving "the universalization of a dominant group's experience and culture, and its establishment as the norm" (p. 59). She states that the dominant group is able to do this because it is able to construct the appearance that its experience is "representative of humanity." This results in making the oppressed group invisible while also stereotyping it and calling it "other." She states, "the culturally dominated undergo a paradoxical oppression, in that they are both marked out by stereotypes and at the same time rendered invisible" (Young, 1990, p.59).

Cultural imperialism is seen as the conduit through which internalized racism happens because while the oppressed are searching for an identity, the oppressors' definition of the oppressed, based on stereotyped images, becomes internalized (Speight, 2007). Williams and Williams-Morris (2000) state that, "internalized racism refers to the acceptance, by marginalized racial populations, of the negative society beliefs and stereotypes about themselves" (p. 255). These negative beliefs and stereotypes are backed by the culture and institutional structure of the white dominant culture. A few examples of how the negative beliefs and stereotypes presented by the dominant culture

are supported are through such means as: media images, language of white dominant culture, and daily interactions with dominant culture (i.e., a white woman crossing the street because a black man is walking toward her on the same side of the street, a Latina being followed around in a store, etc.).

White dominant culture holds the power in the United States. This means that whites construct the “reality” and “norms” of a certain way to be, act, and believe. Because white dominant culture is so present and holds the power, there is more opportunity for white dominant culture to become introjected. As a part of the white dominant culture there is an “institutionalization and normalization of oppression” (Speight, 2007, p.130). People of color, as well as people of the white dominant culture, introject this. “Looking to the larger society to construct a sense of self, members of the target group find negative images that serve to colonize and recolonize them” (Speight, 2007, p.130).

Speight (2007), among others, argues that the shame that a person of color feels as a result of internalized racism is the most psychologically damaging symptom of racism. She quotes Akbar (1984) as he describes internalized racism as “psychological slavery” and compares it to slavery of the 1800’s:

As cruel and painful as chattel slavery was, it could be exceeded only by a worse form of slavery...The slavery that captures the mind and incarcerates the motivation, perception, aspiration, and identity in a web of anti-self images, generating a personal and collective self-destruction, is more cruel than the shackles on the wrists and ankles. The slavery that feeds on the psychology invading the soul of man, destroying his loyalties to himself and establishing allegiance to forces which destroy him, is an even worse form of capture (p. 2).

Internalized stereotyped images, or “anti-self images” as Akbar writes, are damaging.

They can lead to poor performances in the workplace and academic settings. Feelings of

powerlessness and not deserving can also stem from living with these internalized images.

Thomas, Witherspoon, and Speight (2005) examined how stereotyped images become internalized and the subsequent effects. Specifically, they studied the internalization of certain stereotypes for black women. Thomas et al., found that when “attitudes related to Mammy and Sapphire images” are found in black women, they predicted levels of self-esteem. It was found that the images played a greater role in self-esteem than did racial identity attitudes. This is important to note as studies that have been done in the past looking at racial identity development and racism found that racial identity and strength of group identity protected, to varying degrees, a person of color from being as severely affected by the stress of racism. In this study they found that this is not completely true for black women and that the internalized negative stereotypical image may reduce the protective effects of racial identity attitudes in regard to level of self-esteem. In a later study conducted in 2006, Witherspoon, Thomas, and Speight found a connection between internalized stereotypes and psychopathology, leading the authors to conclude that, “internalized racism is the most damaging psychological injury due to racism” (Speight, 2007, p.130).

RBTS: Psychological and emotional symptoms

When determining if a person has been traumatized by an event either acted upon them, someone they know, or something they witnessed, the standard used has been the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision; *DSM-IV-TR*; American Psychiatric Association, 2000). It is often impossible to obtain insurance coverage for mental health care without a diagnosis and resultant diagnostic code taken

from the DSM-IV-TR. Typically, in order to present a defense or evidence in support of a legal case involving mental health, a diagnosis from the DSM-IV-TR must be given. When referring to the DSM-IV-TR to diagnose a person, there are certain criteria that need to be fulfilled in order for a person to be considered to have whatever diagnosis the clinician feels fits with the client. In this section, the longstanding invisibility of racism as a source of trauma will be made visible through a discussion of how similar the symptoms of RBTS are to already established symptoms of PTSD. To illuminate the connection, rape and domestic violence will be discussed in parallel to RBTS. For reference, the full symptom picture and criteria currently listed for (PTSD) in the most recent version of the DSM are presented.

Loo et al., (2001) found that racism is a risk factor in the development of PTSD. Others have proven that people of color who are survivors of racist incidents may have cognitive effects such as difficulty in remembering and concentrating, and self-blame (Bryant-Davis & Ocampo, 2005; Bryant-Davis, 2007, Carter, 2007). Carter (2007) lists the critical signs/symptoms of race based traumatic stress injury as avoidance, intrusion, and arousal (p. 89). Mistrust of those people who look similar to those who have perpetrated the racist acts is also a result of being traumatized by racism. This mistrust can lead to a sense of hypervigilance and “the feeling of never being able to let down one’s guard when in the company of Whites” (Daniel, 2000, p. 136). The symptoms of a person who has been a survivor of race-based traumatic stress are often analogous to the symptoms that are seen as the result of other forms of traumatic acts that a person has experienced. Bryant-Davis and Ocampo (2005) state that, like other traumas, race-based

traumatic stressors affect victims cognitively, affectively, somatically, relationally, behaviorally, and spiritually (p. 487).

Specifically, the list of cognitive effects resulting from the stress of racism may include difficulty concentrating, remembering and focusing. The affective effects may include numbness, depression, anxiety, grief, and anger. Bryant-Davis and Ocampo (2007) state that somatically, people complain of migraines, nausea, and body aches. In terms of relational effects the authors speak of victims distrusting members of the dominant group or people of their own group (as the result of internalized racism). Self-medication with substances or self-harm are listed as behavioral effects of racism and race-based trauma. Finally, for spiritual effects, they speak of how victims may question their faith in God or humanity or both as the result of RBTS in their lives (Bryant-Davis & Ocampo, 2007, pp. 139-140). In addition, anger, intrusive thoughts, intergenerational transmission of traumatic memories, internalized racism, avoidance, hypervigilance, fear, helplessness, powerlessness, hyperarousal, anxiety, hostility, paranoia, survivor guilt, and depression have also been identified as symptoms of RBTS (Bryant-Davis, 2007; Bryant-Davis & Ocampo, 2005; Carter, 2007; Cheng, 2001; Daniel, 2000; Speight, 2007; Williams & Williams-Morris, 2001; Witherspoon et al., 2006).

Bryant-Davis and Ocampo (2005) illuminate how both one-time racist incidents and ongoing racist incidents create traumatic reactions and physiological and psychological symptoms. The authors first compare and contrast race-based trauma to rape. They state, “Both racist incidents and rape produce cognitive, emotional, and physiological sequelae and affect victims’ ability to maintain healthy relationships” (Bryant-Davis & Ocampo, 2005, p. 487). Secondly, they compare and contrast trauma as

the result of domestic violence to trauma a person of color experiences as the result of racism. Like domestic violence, racist incidents are typically not single-event traumas. They state that, “People living in conditions of domestic violence or in societies where racist incidents occur may not always be able to establish safety first and then seek treatment. They must live with the threat of future violations” (Bryant-Davis & Ocampo, 2005, p. 492). The chronic nature of both domestic violence and racist incidents leads to symptoms slightly different than those from one-time traumatic experiences and is a very important component to examine while looking at the nature of trauma as a result of racism.

One of the ways Bryant-Davis and Ocampo (2005) make parallels between rape and one-time racist incidents, is by elucidating similarities in emotional and psychological effects of each act. Emotional and psychological effects may include: denial, numbness, shock, dissociation, shame, and self-blame. Shame is a particularly urgent emotional/psychological effect to examine as intense feelings of shame can lead to suicidal ideation. Bryant-Davis and Ocampo cite the Federal Bureau of Investigation and Ialongo et al. (2002) when they state, “Suicide is increasing among African Americans and is now the third leading cause of death for African Americans aged 15-24” (Bryant-Davis & Ocampo, 2005, p.488). Shame also has the potential to lead to a lower self-concept for a person who has survived a race-based traumatic incident.

The authors address symptoms of trauma present when a person has experienced ongoing trauma. More often than not, domestic violence and racist incidents fall under this category. Living with uncertainty of when an act of violence is going to happen, but certainty that it will at some point, leads to feelings of hyperarousal, fear, and anxiety

(Bryant-Davis & Ocampo, 2005, p. 492). Like a one-time incident, an ongoing trauma leads to the survivor feeling shame and self-blame, and as though the violent act was their fault. Feelings of powerlessness, fear, and confusion result from these kinds of traumas (Bryant-Davis & Ocampo, 2005, p. 492).

Survivor guilt is an emotional symptom resulting from the effects of RBTS. Survivor guilt is most often explained within the context of guilt one may feel for being alive when someone close has died. In addition, it is often recognized with survivors of the Holocaust (Garwood, 1996; Leys, 2007). Bryant-Davis and Ocampo (2005) expand discussion of survivor guilt by stating that it is present for people of color who have survived racist incidents. This is especially true when a person of color has survived and is thriving and managing to acquire education, wealth, status, or fame. For some who have survived racist incidents, it is the knowledge that others “who may share their ethnic or racial identification continue to be limited by oppression” (Bryant-Davis & Ocampo, 2005, pp. 494-495). Survivor guilt can lead to feelings of shame, distress, identity confusion, and alienation (Bryant-Davis & Ocampo, 2005, p. 495).

RBTS: Physiological symptoms

In fact, race is one of the most powerful determinants of a person’s life course, opportunity, and health issues (Bryant-Davis & Ocampo, 2005, p. 577).

RBTS results in physiological changes in a person’s body (Morris-Prather et al. 1996; Clark et al., 1999; Harrell et al., 2003). Those changes can lead to somatic symptoms, especially if exposure to the stressor has been prolonged and at the hands of another human being. The *DSM-IV-TR* states, “The disorder may be especially severe or long lasting when the stressor is of human design (e.g., torture, rape)” (*DSM-IV-TR*,

2000, p. 466). Dohrenwend (2000) did a study looking at the relationship between a person's perception of racism on physical and mental health. As a result of this study it was found that, "Perceived racism and reports of maltreatment from doctors affected mental and physical health" (Carter, 2007, p. 45).

Many studies have shown the resultant physiological effects of RBTS (Troxel et al., 2003; Guyll et al., 2001, as cited in Carter 2007). Carter (2007) conducted a meta-analysis of studies done on the psychological and physiological effects of racism. All have the same general outcome: Racism creates stressors that affect a person of color's physiological functioning, starting in utero. Higher rates of heart disease, low birth weights, hypertension, diabetes, migraines, and general somatic aches and complaints have been found amongst communities of color (Collins et al., & Mustillo et al., 2004 as cited in Carter, 2007; 2004; Din-Dzietham et al., 2004). These studies reviewed show how racial discrimination directly affects the physical health of people of color.

There are studies that have been done directly linking such conditions as increased risk to heart disease to racism and race-based stress (Harrell et al., 2003, as cited in Carter, 2007). Regular, daily stress caused by microaggressions and daily hassles, along with one-time racist incidents stress the body and can cause physiological changes in the way the body functions (Guthrie et al., 2002, as cited in Carter, 2007). Over time these physiological stressors and changes can lead to a variety of health problems and illnesses. Couple this with mistreatment and discrimination within the healthcare system on people of color and the result is deleterious (Daniel, 2000; Williams and Williams-Morris, 2000).

RBTS: New definitions of trauma and the DSM-IV-TR

Although much literature has come about within the most recent decade recognizing racism and racist incidents as creating stress and trauma, it has still not been legitimately recognized as a form of trauma that is worth specific treatment (Carter, 2007; Cheng, 2001; Bryant-Davis & Ocampo 2005; Franklin et al., 2006; Sanchez-Hucles, 1998; Speight, 2007; Sue et al., 2007; Tummala-Nara, 2001; Williams & Williams-Morris, 2001). As was shown in previous sections, the symptoms that arise as a result of RBTS are akin to symptoms that arise from other sources of trauma already alive in discourse and treatment. Bryant-Davis and Ocampo (2005) discussed parallels between trauma resulting from racism and trauma resulting from rape and domestic violence. Others, such as Wyatt (1990), Carter and Helms (2002), and Villena-Mata (2002) have made parallels between trauma as the result of racist incidents and childhood sexual abuse, sexual harassment, and child abuse, respectively.

It has been shown how the symptom picture caused by trauma as the result of racism is similar to the symptom sequelae that manifests as the result of the DSM-IV-TR's definition of what qualifies as traumatic and PTSD. However, as of now, there are no criteria present in the DSM-IV-TR specifically addressing RBTS. Many of the clinicians of color who are writing about the traumatic effects of racism have called for an expanded definition of trauma and PTSD to not only be added to the DSM-IV-TR, but to be added to the lexicon of literature, discussion, diagnosis, and treatment of trauma. They argue that trauma, as it is defined now, is narrow in scope and does not encompass many forms of trauma, especially trauma as the result of racism and oppression. Sanchez-Hucles (1998) writes, "What appears to be necessary, therefore, is to develop a

conceptualization of PTSD that is based on the experiences of ethnic minorities as they cope with the trauma of racism rather than trying to make this trauma fit existing models” (p.73). Racism is unique from other experiences of trauma and needs to be handled in such a way.

Some symptoms, such as internalized racism that arise from RBTS are unique. Also, the way in which racism currently and most commonly operates in this society is different than other sources of trauma, which means that the sources of PTSD offered in the DSM-IV-TR do not begin to cover sources of RBTS. As it stands now the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision; *DSM-IV-TR*; American Psychiatric Association, 2000) states:

The essential feature of Posttraumatic Stress Disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one’s physical integrity; or witnessing an event that involves death, injury or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member other close associate (Criterion A1) (DSM-IV-TR, 2000, p. 463).

Looking at the specific kinds of “extreme traumatic stressors” shows that they are all associated with actions/events that center around a person’s physicality. For example, the DSM-IV-TR lists military combat, violent personal assault (sexual assault, physical attack, robbery, mugging), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disasters, severe automobile accidents, or being diagnosed with a life-threatening illness as events that are traumatizing if experienced directly (DSM-IV-TR, 2000, p. 463-4).

The DSM-IV-TR does mention that this list of events is not an exhaustive list.

Furthermore, it states that events that can be traumatizing if witnessed include: observing the serious injury or unnatural death of another person due to violent assault, accident, war, or disaster or unexpectedly witnessing a dead body or body parts. Finally, it lists violent personal assault, serious accident, or serious injury experienced by a family member or a close friend; learning about the sudden, unexpected death of a family member or close friend; or learning that one's child has a life-threatening disease as being traumatizing because they are "events experienced by others that are learned about" (DSM-IV-TR, 2000, p. 464).

According to the DSM-IV-TR an event is traumatic if it is physical in nature, or revolves around physical, tangible loss or threat of some sort of tangible loss, witness of a physical loss, or learning of a loss or threat of loss to a close friend or relative. There is no mention of emotional abuse, chronic discrimination, name-calling, being ignored, internalized racism, being the target racial profiling, incarceration, and the list could go on, as events that have the potential to be traumatizing. Actual physical threats to a person of color's life, family, friends, and/or belongings still do happen, but more often than not, events that lead to RBTS are, "chronic, systemic, invisible assaults on the personhoods of ethnic minorities" (Sanchez-Hucles, 1998, p. 72). Daily microaggressions committed by the white dominant culture toward a person of color are unique to racism and, through accumulation, often lead to symptoms that mirror PTSD symptoms. This is not accounted for in the DSM-IV-TR.

Many clinicians have proposed constructs, theories and new categories that do not try to fit the trauma experienced as a result of white racism in the United States into preexisting constructs, models, categories, and theories of trauma, but rather seek to more

accurately encompass the full spectrum of causes and symptoms related to RBTS. Spanierman and Poteat (2005) suggested adding a category called *oppression-based trauma* to the DSM-IV. Sanchez-Hucles and Jones (2005) offer ways to expand upon some clinical definitions that are already present in the world of trauma like, “type II traumas, complex posttraumatic stress disorders, safe world violations, cumulative trauma, and postcolonial syndrome” (p.551). Bryant-Davis (2005) points out that all of these concepts are, “related to constructs of postslavery syndrome, intergenerational trauma, and historical trauma” (p. 578).

As discussed earlier, DeGruy Leary (2005) has researched the ways in which trauma has been passed through generations from the time of slavery and how that is connected to the experience of African Americans in the United States now. She refers to the symptomology of trauma that is from hundreds of years of slavery combined with continued institutionalized racism and no chance to heal from either, as Post Traumatic Slave Syndrome. She is specifically talking about the African-American community, but similar categories of Post Traumatic Stress could be conceived of such as Post Traumatic Japanese Internment Syndrome, or Post Traumatic Trail of Tears Syndrome, that would address and acknowledge how specific communities of color in the United States have also been affected by racism for hundreds of years. This is especially true after reading literature regarding the intergenerational transmission, and current effects of, RBTS as the result of the colonization of American Indians (Braveheart & DeBruyn, 1998; Braveheart, 1999), the legacy of trauma as the result of Japanese Internment camps (Isomura et al., 1987; Schreuder et al., 2000; Nagata, 1989), the experience of Latinos and Latino immigrants in the United States (Diaz et al., 2001; Villenas & Deyhle, 1999;

Villenas, 2001), and the experience of Asian-Americans in the United States (Cheng, 2001; Noh, 2007; Tummala-Nara, 2001, Loo et al, 1994; Sue, 2007).

Conclusion

This chapter began with defining racism and RBTS. This was followed by a discussion of sources of RBTS, including institutional, cultural, intergenerational, and mechanisms of internalized racism. Following the overview of sources, emotional and psychological symptoms of RBTS were discussed. A summary of physiological symptoms resulting from RBTS followed. Finally, ways in which current definitions of trauma and the DSM-IV-TR need to be expanded to encompass trauma resulting from racism were suggested.

In the next chapter, testimonial psychotherapy will be adapted to address the phenomenon of RBTS. Prior to offering adaptations, reasons why testimonial psychotherapy is appropriate to be used in the United States with people of color to address RBTS will be put forth. Areas of applicability to be discussed including: variation in and within populations, oppressive governments, symptom alleviation, and injuries that occur on many levels. After applicability is explored, the focus will switch to specific ways in which testimonial psychotherapy can be used in the United States with people of color to address RBTS. Included in this discussion are changes to the number of sessions and additional ways to connect the individual to the community. Finally, implications for social work practice and research will be suggested.

CHAPTER IV
APPLYING AND ADAPTING TESTIMONIAL PSYCHOTHERAPY FOR
WORK WITH RACE-BASED TRAUMATIC STRESS

Thus far the details of testimonial psychotherapy have been presented as well as the phenomenon of RBTS. This chapter will apply the theory of testimonial psychotherapy to the sociohistorical and political phenomenon of RBTS. The purpose of this chapter is to examine reasons testimonial psychotherapy is appropriate to be used in the United States with people of color to address RBTS. An adapted version of testimonial psychotherapy will be provided. This author asserts that testimonial psychotherapy can, indeed, be adapted to be utilized in the United States. The basis for this argument has been established throughout this research. The populations testimonial psychotherapy has been utilized with, the actual process of using the framework of testimonial psychotherapy, and empirical research in support of the effectiveness of testimonial psychotherapy were presented in Chapter II. Definitions, sources, and psychological and physiological effects of racism and RBTS were explored in Chapter III, as were expanded definitions of trauma and criterion for the DSM-IV-TR.

In this chapter, the first section entitled *Applicability to the United States*, will address the ways in which testimonial psychotherapy has the potential to be effective in addressing RBTS as is specific to communities of color in the United States. This section is broken down into subsections concentrating on different aspects of the theory as the author sees they may apply to communities of color in the United States. In *Variation in*

and within populations, testimonial psychotherapy's adaptability and effectiveness in its use with many different races and ethnicities, including its effectiveness with collectivistic systems of living, will be explored. Next, a discussion of the ways in which testimonial psychotherapy is not a Eurocentric form of therapy and the implications of this will be looked at in the subsection, *A non-Eurocentric framework*. Following that, shifts in power as a result of the framework of testimonial psychotherapy are discussed as they relate to empowerment and self-determination in the person giving the testimony in, *Shifting the power makes more room for empowerment*. Following that, a subsection entitled, *Injuries at many levels*, will bring together testimonial psychotherapy's ability to simultaneously support healing at the individual and community level and ways in which racism injures a person of color at multiple levels. Next, in *Oppressive governments*, a link will be made between the effectiveness of testimonial psychotherapy with people who have been persecuted at the hands of their oppressive governments and how this translates to working with people of color who have been oppressed and persecuted by the United States government. A subsection entitled, *Contextualization*, will address the importance of testimonial psychotherapy as a politically and socially rooted therapy in relation to RBTS as a sociohistorical and political construct. Finally, the last subsection, *Alleviating symptoms*, will speak to the ways in which testimonial psychotherapy alleviates symptoms, including shame and isolation, anger, guilt, powerlessness and hopefulness.

The final section, *Recommendations for Adaptation*, will focus on specific recommendations of ways in which testimonial psychotherapy can be adapted to be utilized in the United States to begin addressing the effects of RBTS. Focus groups,

number of sessions, increased chances for positive reframing, addressing ongoing trauma, settings in which the testimony is taken, and stronger links to the community (including, but not limited to archival projects) will be the key points of the adaptation presented. Finally, the ways in which testimonial psychotherapy is applicable to the field of social work research and practice will be provided.

Applicability to the United States

Variation in and within population

The first reason that testimonial psychotherapy is appropriate to be used in the United States is found while reflecting on the theory's adaptability and applicability to many different groups and populations. In Chapter II, the wide range of populations (from adolescent refugees from Africa residing in Boston to Bosnian-Muslim refugees in Chicago to Holocaust survivors all over the world) that testimonial psychotherapy has been used with was discussed. It must be assumed that within the populations discussed in Chapter II, in-group variation was present as well. That testimonial psychotherapy has been found to be beneficial in alleviating symptoms of PTSD and depression with all of the groups speaks to its adaptability.

There is much variation within racial and ethnic groups in the United States. Some of these variations include religion, socioeconomic status, regional influences, sexual orientation, color-caste, gender identity, ability, etc. This author contends that because of testimonial psychotherapy's success with all of the groups it has been used with, testimonial psychotherapy's adaptability will translate to working within communities of color in the United States. Its effectiveness also speaks to the inherent power of healing through having the space to construct and reconstruct, or both, one's

trauma story. In Chapter II the power and necessity of integrating a fragmented traumatic experience through recreating and reframing the trauma story were discussed.

Testimonial psychotherapy has been predominantly used and effective with communities who live within a collectivistic framework. Many communities of color live within a more collectivistic or communitarian framework (Braveheart & DeBruyn, 1995; Miller & Garran, 2008; Villenas & Deyhle, 1999; Wang, 1995). A collectivistic system differs from an individualistic (read: white dominant American or Western framework) system of living. A true exploration of a collectivistic model of living and an individualistic one are beyond the scope of this research, but in very general terms, some of the differences between the two are present in ways of communicating and relating to one another. A collectivistic model often places much more value on familial ties and extended family. A collectivistic framework employs ways/forms of healing that may not necessarily find a Eurocentric individualized therapy valuable or useful. Much of this has to do with the fact that a lot of Eurocentric therapy for the individual does not encompass a sense of “us-ness.” As Carter (2007) states:

a person of Color who is identified with his or her racial-cultural group must determine “who owns the event.” In mainstream White American culture, the individual typically “owns” the event. But in some racial-cultural traditions, the event (e.g., school- or work-related decisions) may belong or be owned by the family or the head of the family and not just by the individual....Thus the lack of ownership may influence the stress process in ways not accounted for (p. 26).

A Eurocentric framework is often limited to the individual and their internal psychological world and does not truly bring in the community context in which one is living.

A non-Eurocentric framework

A second reason testimonial psychotherapy is appropriate to be used in the United States to address the effects of RBTS on people of color is that it is a modality that was not developed out of a Eurocentric individualistic framework. It was first utilized in a particular context, Chile in the 1970s, where collective healing and collective political effort against a dictatorship was crucial. Because of its roots, testimonial psychotherapy does not resemble the traditional framework of a Eurocentric clinical setting. It actively supports reconnecting one to their lived context, political comrades, family, and/or larger community. Although sometimes conducted in very clinical settings physically, testimonial psychotherapy is often conducted outside of a clinical setting in community centers and people's homes. This works to embody, by choice of physical space, a sense of being in and of a community. Even when it is conducted within a clinical setting, testimonial psychotherapy does not inherently follow the same spoken and unspoken "rules" of more traditional forms of psychotherapy.

The importance of one's sociohistorical and political context are emphasized as a large presence in the therapy from the beginning. There is an honoring of us-ness from the start. It is a modality of therapy that acknowledges and respects the uniqueness of the testifier's story while simultaneously acknowledging the necessity of the relationship between witness and testifier and between testifier and a collective experience. This results in a modality of therapy that is more congruent with people who have been socialized within a collectivistic framework.

Shifting the power makes more room for empowerment

As a part of acknowledging the individual testifier's experience within the context of a collective community experience, an important shift occurs that sets testimonial psychotherapy apart from Eurocentric frameworks. It shifts the power dynamic away from clinician and client to a relationship of testifier and witness. The "expert" is not the clinician, but rather the person giving testimony. The relationship becomes that of two people co-creating a story. Weine et al. (1998) speak to this when they write:

Testimonial psychotherapy is relational. Two individuals, a survivor and a listener, enter into a relationship that centers on the task of documenting and communicating the survivor's story. As in other psychotherapies, the relationship must be safe, trusting, and caring. In testimony, the listener must have adequate knowledge of the historical events through which the survivor lived. The story belongs, first and foremost, to the survivor; in some ways, however, the story belongs to the relationship. In most cases, were it not for the relationship, the story would not be told and documented at all...The testimony is relational in another sense: the listener plays a major role in facilitating the unfolding of the narrative and reframing the story. In our experience, the story that comes out of testimony is different from the stories that come out of survivors' solitary attempts to render their experiences into stories, regardless of the narrative abilities (p. 1724).

Testimonial psychotherapy reframes the life history of the person as one that is that of a survivor. In other words, inherent in the process of testimonial psychotherapy is potential for empowerment. Instead of the clinician empowering (which is actually impossible as it already assumes that the client has no power) the client, the clinician is

now in a dynamic to acknowledge the power of the testifier and assist in the empowerment process. It is a picture of two sitting beside instead of one sitting over, or above, another.

Aside from prompts and reframing questions, the testimony comes from the testifier. The testifier is the most verbal participant in this process as it is their lived narrative, but the power of having another witness a story can be a profound experience for both. In a society where much of the RBTS stems from the fact that white culture is dominant, holding the power, and making decisions, shifting the focus of power in the therapeutic relationship from an imbalanced therapist-client relationship to a testifier-witness relationship can be a healing process by itself.

This power shift and framework of empowerment provides a setting for healing from the effects of RBTS through the words of the person who has been the victim of sociohistorical political settings that cause traumatic symptomatology. This switch can allow space for a huge moment of reclamation of personal experience and words for the testifier. By using the story and words of the person, it provides a setting in which to frame and validate the person's experience in all of its subjective and objective parts. All too often the experiences and words of people of color are not heard. And if they are heard, they are too often dismissed as not valid or real. This lack of acknowledgement of a person of color's experience and dismissal was referred to, in Chapter III, as a source of stress and possibly trauma. The process of taking a person of color's testimony is one that takes the person's testimony as truth without questioning what was/is painful and what is not.

Additionally, the whole process of testimonial psychotherapy is done verbally. One does not have to know how to read or write to create the bound testimonial as it is recorded and then transcribed. It is accessible to people from all levels of education, experience, and socioeconomic backgrounds. It also means that it may be more appealing to people of color who come from religious or faith based traditions that uphold oral tradition, and even the testimony as an already practiced aspect of the religion. As was mentioned in Chapter II, giving an oral testimony of one's trials, tribulations, and victories has traditionally been a part of many religious practices.

As was discussed in Chapter II, part of the process of creating a bound testimonial includes the person giving the testimony and the practitioner sitting down to edit the testimony. This part of the process can be done orally as well. In addition to respect for the oral tradition, through the editing process testimonial psychotherapy recognizes the testifiers as "self-determining subjects with their own resources for healing" (Akinyela, 2005, p. 7). The person giving their testimony has power over what is edited out of their testimony, what is added, what stays in, and how that information is ultimately used. This allows for agency and self-determination, both of which many people of color are often denied in the United States. Many communities of color communicate, pass on information from generation to generation, and heal through oral traditions. This way of telling and revising one's story is more congruent with the way in which many cultures and communities of color communicate and heal through traditional oral practices than is a Eurocentric form of therapy.

Injury at many levels

As was discussed in Chapter III, race and racism are social and political constructs. That is, racism has the potential to be traumatizing in every aspect of a person of color's life from the institutional level to the interpersonal to the internalized. And as was discussed in Chapter II, testimonial psychotherapy is a socially and politically rooted theory. That is to say, it is not grounded in the internal psychological state, but rather in the social, political, and historic moment in which one is living.

For Omi and Winant, race is used as an organizing principle for social relations at the micro (individual) and macro (collective) levels (Carter, 2007, p. 22). Testimonial psychotherapy addresses all of these levels. As was explored in Chapter III, stress and trauma as the result of racism does not come from just one source. It is the result of many forms of racism (institutional, cultural, interpersonal, etc.) converging, overlapping, and intertwining. Testimonial psychotherapy addresses all of the levels involved in race-based stressors and trauma. The testimonial is being taken with an individual, but within the context of the sociohistorical and political environment, including the person's experience with family, friends, community, institutions (such as housing), in which the person has been traumatized (Bryant-Davis & Ocampo, 2005; DeGruy Leary, 2005; Thompson-Miller & Feagin, 2007).

Cienfuegos and Monelli (1983) write about the way in which testimonial psychotherapy addresses all areas in which the trauma has occurred. They state:

Finally, besides its therapeutic value, the testimony is a way of registering private suffering caused by social conditions. With consent of the victim, it may be used to denounce such crimes. The testimony is a way of sharing the story just as it happened, just as it was suffered, with all its contradictions and all its horror. When personal damage has been massive, reparations must have a social

dimension as well. In this context testimony works as a means of prevention of future mental illness, because it does not simply express the emotional trauma, but facilitates its personal and social elaboration (Cienfuegos & Monelli, 1983, p. 51).

The injury happened on many levels so the healing needs to happen on many levels.

They recognize that within the process of taking a testimony, a process of both “personal and social elaboration” occurs. Clinicians of color writing about RBTS call for the necessity to address all levels of injury in the healing process. This is harmonious with what the pioneers of testimonial psychotherapy also view as major component in the healing process.

Oppressive governments

As discussed in Chapter II, testimonial psychotherapy has been used with populations who have been traumatized by institutional terror, specifically by oppressive regimes that wanted to keep people oppressed to uphold some sort of dominant place in society. The persecution has occurred for all of the groups because of their membership in a specific group. The ways in which people who have given their testimonies have been tortured physically and psychologically as targets of their governments, as political prisoners, in war, or just by being a specific race or ethnicity (Bosnians, survivors of the Holocaust, the “Lost Boys of Sudan, etc.), is similar to the ways in which the United States treats, and historically has treated, people of color.

Sources of RBTS were discussed in Chapter III. The interconnectedness of all forms of racism was addressed, as was the shift from overt racism of the past to covert racism of the present. Laws, policies, governmental institutions, and cultural systems based in racism torture people of color physically and psychologically. Some examples of this are denying jobs and funds for housing to people of color, Japanese internment,

expulsion, and attempts at assimilating Native Americans. The United States government instituted all of these examples.

Now, as was discussed in Chapter III, covert acts of racism are backed by the government and reinforced through the white dominant culture of the United States. The problem is that the ways in which people of color are kept down have gone so far underground, even to the level of the unconscious that many white people do not think that racism exists anymore. This lack of acknowledgement often leads those who are being harmed to question the reality of their pain. It is difficult to ignore the research discussed in Chapter III on the physiological and psychological effects that people of color experience as a result of racism and subsequently, RBTS.

Linking testimonial psychotherapy's proven effectiveness with survivors of torture outside of the United States with the ways in which the United States oppresses people of color, leads to the belief that testimonial psychotherapy can be utilized in the United States. Carter (2007) backs both the claim that racism is harmful to people of color in the same ways that torture are and the claim that there is the need for theories not influenced by "American cultural patterns." He states:

Racism can and does create damage to one's psyche and personality in the same way that being subjected to community violence, being held captive, or being psychologically tortured can create emotional damage" (Herman, 1992; Johnson, 1993; Wallace & Carter, 2003). Even in the case of these types of traumas, mental health professionals who are influenced by dominant American cultural patterns tend to focus on how the individual must adjust to her or his circumstances, thereby viewing the individual's difficulties as dispositional or characterological as opposed to being a result of situational stress (Herman, 1992). It is difficult to overcome the dominant American cultural lens that tends to locate people's problems in their personal failures (p. 83).

Therapy created by white dominant culture is not going to help people of color heal from the traumatic effects of white dominant culture. His words also support the view that the symptoms of trauma a person of color experiences at the hands of racism are not to be credited to the character of the person, or any inherent fault. Rather, the contextual (sociohistorical and political) influences of racism need to be included as sources of difficulties a person may be having in their life.

Contextualization

Testimonial psychotherapy shifts away from giving the testimony as an endeavor to “heal” the individual to giving the testimony as an endeavor to create a sociohistorical politically grounded document about what was happening in the person’s life—in its entirety before, during and after the trauma. Testimonial psychotherapy has a purpose—to externalize traumatic stories in order to create a social, historical, and political document. Carter (2007) talking about the work of Omi and Winant states:

“race” is a sociohistorical concept. They [Omi and Winant] asserted that the meaning assigned to racial categories, and the particular form of expression surrounding race and racism as reflected in social relationships, is determined by the historical context and political climate at a particular time in history (p. 21).

Testimonial psychotherapy is a way to place RBTS within its entire social, political, and historical setting. It can acknowledge the effects of the intergenerational transmission of trauma and simultaneously how RBTS has affected the individual in their immediate past, present and future. It creates documentation that can be used to educate future generations about the struggles and survivals of a whole community. This bound testimony can be employed in many ways. It can be: used to argue a case seeking political asylum, made into a play, given to a therapist to enhance treatment, shared with

friends and family members, etc. Felman and Laub (1992) and Weine and Laub (1995) emphasize the importance of creating a historical account with the testimony. The documents can be archived to create a historical witness (i.e. reporting the daily happenings of the community all the way to the political environment) of sorts that may otherwise be absent. Testimonial psychotherapy serves to make the private public, reconnect with community, and to have a tangible, accounted for, validated, and acknowledged historical account of one's life experiences.

Greenwald et al., (2006) and Laub (as cited in Felman & Laub, 1992, p. 79) speak about how, for some, providing testimony is the first time some people's story has been told. It is the first time the history has been created because now there is a witness to share the history with and the person giving the testimony no longer has to wonder if their history was a reality or just a story that they made up that has lived in their head alone their whole life. The authors often reference the need for the testifier's subjective history to be held with as much validity and importance as the objective history that is already on the books, as they say, for the historical timeframe in which the person is recounting their life experience. This is exactly what was also argued in Chapter III regarding the necessity for a person of color's traumatic experienced, as a result of racism, to be seen as their own personal truth in all its objective and subjective parts.

Laub (as cited in Felman & Laub, 1992, pp.59-63) recounts a very illustrative example of valuing a person's lived history. He tells the story of a woman who was a survivor of Auschwitz where one of the only uprisings by the prisoners in history took place and was almost successful. He presents her testimony to a group of psychologists and psychiatrists at a conference of sorts. After his presentation the practitioners at the

conference start arguing that she must have not actually been there and her story cannot be true because the established historical account already “on the books” about this particular concentration camp had two chimney stacks and she kept talking about four stacks blowing up. It cannot be true that she was actually there, they argued. Laub (as cited in Felman & Laub, 1992, pp. 62-63) pointed out that for the person who has been traumatized it does not matter. There is a reason why she remembers four stacks and not two. That was her subjective reality. There may be many very real and symbolic reasons she saw four stacks and not two. There may have actually physically been four stacks and not two. The point was that she was pulling together a fragmented history and story and putting meaning to an experience that made absolutely no sense to her before, but lived as fragmented parts in her psyche until that first telling.

What matters is the process. What matters is her healing. What matters is her reality. This is akin to how many of the clinicians read talk about needing to hold both objective and subjective experiences of racism as true and traumatizing for people of color. Taking testimony has the capacity to do that. Laub (as cited in Felman & Laub, 1992, p. 62), Lustig et al. (2004), and Weine et al. (1998) write about honoring whatever comes out in the testimony as that person’s truth of their experience and their life. The person giving their testimony knows best what they have experienced.

Alleviating symptoms

The primary purpose of testimonial psychotherapy is the creation or re-creation of a traumatic event(s) to produce a bound document. However, an amazing secondary gain to this process is that it has been proven and observed to alleviate some PTSD symptoms. As was explored in Chapter II, the basis for much of this alleviation comes from the

process of integrating fragmented parts of a trauma story. Testimonial psychotherapy sets up the conditions to be able to do this. The loosely guided questioning frames the testimonial within the context of the person's life before the trauma occurred, a telling of the traumatic event(s) and then life after the trauma. The outcomes of empirical studies and clinical observations of the effectiveness of testimonial psychotherapy were presented in Chapter II. This section will relate the ways in which testimonial psychotherapy may help to alleviate some of the symptoms that arise as the result of RBTS.

As a brief recap, in the works of Cienfuegos and Monelli (1983), testimonial psychotherapy was found to lessen and/or alleviate the following: "helplessness, anxiety, sleeplessness, feelings of disintegration, inability to concentrate, impaired memory, specific or generalized fear, social withdrawal, irritability, loss of appetite, and a variety of psychosomatic symptoms" (p. 47). It is interesting to note that the highest success rate was with people who were tortured. The work of Weine et al. (1998) showed a decrease in "PTSD symptom severity, reexperiencing symptoms, avoidance symptoms, and hyperarousal symptoms" (p. 1722).

As was discussed in Chapter III, some of the symptoms that arise as a result of RBTS are: shame, self-blame, hyperarousal, fear, anxiety, powerlessness, confusion, anger, intrusive thoughts, internalized racism, avoidance, hypervigilance, helplessness, powerlessness, survivor guilt, depression, and various somatic symptoms. The PTSD symptoms that testimonial psychotherapy has been found to alleviate overlap, at many points, with the RBTS symptoms that people of color deal with as a result of racism in the United States. The ways in which testimonial psychotherapy may be able to aid in

alleviating some of the symptoms of RBTS, such as shame and isolation, anger, guilt, and powerlessness and hopelessness, will be discussed.

Shame and isolation. Testimonial psychotherapy may alleviate feelings of shame by linking people together who have similar traumatic experiences. There is a lot of power in hearing people tell their story of the ways in which they have been affected by racism. It is often very powerful, as it was in the case of the Bosnian refugees, to just have the knowledge that others are giving their testimony. This is where archival projects may be invaluable. If an archive of RBTS testimonies were available for whole communities to read, others could gain strength from a feeling of solidarity and also learn about how others are coping with the daily affects of racism. For various reasons, people cope with stress, trauma, and race-based stress and trauma in different ways. Some of what determines how a person is able to cope depends on family, family strength, family stories, family support, racial identity development (including how positive or negative group image the person has about their own group), faith, and what a person is born with—their temperament. In the cases where people are not born into spaces with a lot of support, whether it is family-centered or community, they may not have had the chance to learn some of the coping mechanisms. Testimonial psychotherapy could be helpful in those cases, and in all cases, to connect people to others who may have been given more coping mechanisms to give some level of protection from the affects of RBTS.

In addition to connecting people through their testimonials to gain strength, solidarity, and awareness of coping skills, making testimonies visible and public through something like an archive may also give some sense of normalizing the symptoms. What

is meant by this is not a normalizing of racism or RBTS, but rather an acknowledgement that it makes sense and is completely valid that a person of color is having x, y, or z symptoms because the effects of racism are damaging. This act of normalizing can work to reduce shame. Thompson-Miller and Feagin (2007) state:

Clearly addressing the cumulative impact of racism ...will require the ability to explain carefully to many patients just how normal their experiences are, that they are not, in fact, alone in this regard. One source of mental distress comes for those people of color whose families have not provided them with such understandings (p.112).

It seems that having a person of color convey, through a testimonial or the disbursement of the testimonial to other people of color, how normal their experiences of racism are, could be even more powerful than having a clinician take on this role. This kind of explanation could, however, also be a part of the testimony taking process. Connecting testimonials could be a way to convey that it is not a fault of the person that they are angry, depressed, anxious, etc. Those reactions are normal reactions to trauma and racism is traumatizing.

Normalizing the symptoms could also serve to reduce feelings of isolation that are often present with trauma. Not only the act of giving the testimony, but also the knowledge that others are doing the same could begin to help a person reconnect with their own sense of belonging to a community. Testimonial psychotherapy has a component that is used to connect one's testimonial to the community. An archive is just one idea, but there are many other ways. These are all actions that could be used to reduce feelings of isolation.

Anger. People of color often experience a lot of anger as a result of RBTS.

Bryant-Davis and Ocampo (2005) state, “survivors of racist incidents and rape are judged harshly for expressing anger....The problem of racism thus transforms into the survivors’ alleged anger problem” (p. 491). Testimonial psychotherapy can be used as a space for a person of color to express the anger and rage they experience because of RBTS. This is not implying that a person of color’s anger needs to be “dealt with” or necessarily always needs a place to go that it is “socially accepted” (read: acceptable by white dominant culture). It is just an acknowledgement that it is important for people to have a space to express anger and rage because of the possible negative side effects of not expressing it. When anger and rage are kept internal, or turned against one’s self, they can develop into depression and anxiety. Testimonial psychotherapy is not only a space in which anger can be expressed, but it also has a purpose for which to express the anger—to create a document of indictment. Cienfuegos and Monelli (1983) state:

Communication of traumatic events through testimony may also have been useful in the present study because it channeled the patients’ anger into a socially constructive action—production of a document that could be used as an indictment against the offenders. The possibility of putting their experiences to use resulted in the alleviation of guilt (p. 50).

Guilt. Laub (2002), Weine et al. (1998), and Cienfuegos and Monelli (1983) all speak to the ways in which testimonial psychotherapy can alleviate PTSD symptoms by alleviating a level of guilt. This guilt may be felt by survivors because of the fact that they have survived and others have not. As was discussed in Chapter III, Bryant-Davis and Ocampo (2005) also address these feelings of survivor guilt that people of color may

experience as a result of surviving racist incidences or thriving in the face of racism.

They state that this perception can:

create shame, distress, identity confusion, and a feeling of alienation. Survivors of racist incidents who utilize their resources to aid those still struggling with the institutional impact of racist incidents can replace guilt with responsible activism (p. 495).

Testimonial psychotherapy can give a person of color an opportunity to share their testimony for purposes of “responsible activism,” possibly leading to an alleviation of guilt.

Powerlessness and hopelessness. Feelings of powerlessness and hopelessness are common when a person has experienced a traumatic event. This was found to be true by the practitioners already using testimonial psychotherapy with the populations they worked with. It seems that it would hold true while working with communities of color as well. Testimonial psychotherapy has the potential to capitalize on the power and hope a survivor has through providing a space to talk about personal, familial, and/or community victories and strengths. As Lustig et al., state, “The testimonial process also allows the victim to gain some distance from the event, and to focus on different aspects of the story, such as the courage or intelligence that led to survival” (Lustig et al., 2004, p. 33). Highlighting power and hope to a person who is feeling powerless and hopeless can lead to a sense of reclaiming or embracing that power and hope. It is important to stress that the person giving the testimony is an agent of change. It is also essential to emphasize ways in which creating their testimony has the ability to: help others, work toward liberation, be used as a tool in community organizing, or as exposure of racist

systems, document an untold story, etc. This can develop the power and hope that already exists within a survivor of RBTS. With testimonial psychotherapy this is done through the socially and politically foundations of the theory. In addition, reframing questions throughout or at the end of the process can be a part of the empowering process.

Recommendations for Adaptation

In this section, arguments for why it is this author's belief that testimonial psychotherapy could be used in the United States to address the effects of RBTS are given. In this section, ways in which this author feels testimonial psychotherapy would need to be adapted in order to be most effective in the United States will be given. Focus groups, number of sessions, more chances for positive reframing, addressing ongoing trauma, settings in which the testimony is taken, and stronger links to the community (including, but not limited to archival projects) will be the key points of adaptation presented.

Lustig et al. (2004) started their work with the "Lost Boys of Sudan" by doing a focus group within the community. They originally did this to get a sense of what kinds of therapy would work best with the adolescent refugees. As mentioned in Chapter II, they included people from the Sudanese community in the Boston area and members of the Lutheran Social Services in one focus group and then did a second with adolescent Sudanese refugees. Considering that there are often many racial and ethnic groups present within one community in the United States, and that there is much heterogeneity within racial and ethnic groups, it is only appropriate to start this process with a series of focus groups to get a sense if people of the community would find testimonial psychotherapy beneficial.

Furthermore, there are often underlying community narratives alive within any given community context. Focus groups may be a way to get a sense of the overall story of the community, including ways in which the community has felt victorious moments, resiliency, and oppression. In relation to having a sense of the community narrative, focus groups may provide an idea of who has been included and who has not been included in the community. This is important on many levels; one being that those voices not heard may be the most marginalized in the community. Another is that those voices not traditionally heard may be isolated from support systems available in the larger community or outside of the community. This may include people in the community who are living with differing abilities, elders, LGBTQQ folks, or people of a race or ethnicity other than the dominant race of the community.

A second point of adaptation is in the number of sessions that the testimonial is to be taken in. It is the author's belief that there should not be a fixed number of sessions. Containing a person's story in a pre-set number may send the message that only a certain amount of one's story is valid or necessary. It is essential to create a holding environment for the person giving their testimony, but that can be built out of the relationship between the testifier and the witness (clinician) --not in a restricted number of sessions.

Having the opportunity to let a testimony unfold in an organic way over a course of time may allow more freedom, space, and chances for reframing and restorying to occur. If a person gives bits of their testimony once a week or once a month for a year or two or five, how is this different than a person being in therapy for that amount of time? This is not to say that the process should be completely open-ended with no goals in

mind. The goal of creating a sociohistorical and political document should stay in tact. Having an open-ended number of sessions supports a belief and practice of recognizing that everyone works at different paces. Allowing for unlimited sessions recognizes that this process can be empowering and painful at the same time and that people have different thresholds for how long they are able to sit with the power and pain involved in their trauma story. It is not this author's belief that testimonial psychotherapy has to be as brief an intervention as it has been thus far. It has the potential to be utilized as a longer, or even long-term therapy.

Another point of adaptation is to add more chances for positive reframing throughout the process. It is unclear as to how much of this occurs with the practitioners currently using testimonial psychotherapy. Lustig et al. (2004) write about asking questions such as, "What advice would you give to others to survive difficult things?" and "Are there ways in which your experiences have made you more strong, or more wise?" in the next to last session (Lustig et al., 2004, p. 37). Asking a testifier to consider some of these questions may open space for them to, among many other things, claim their resiliency, offer others who may be in a similar place as they are support, and feel proud of overcoming adversity. The question of reframing used by Lustig et al. (2004) would be included in the adapted version of testimonial psychotherapy, but additional questions throughout, such as the ones presented below by Akinyela (2005), and a focus on *victorious moments* would be added as well. This would encourage people giving the testimony to focus on strengths that have led them through traumatic experiences in addition to recounting the trauma.

Dr. Makungu Akinyela writes of his work with an African-centered therapy called Testimony therapy. This form of therapy encompasses many of the same principles that testimonial psychotherapy is based on. It was not explored in the testimonial psychotherapy chapter, as its process is not the same as the testimonial psychotherapy with its roots in Chile that the author chose for this research. It is invaluable, however, to bring Testimony therapy into a discussion on ways to adapt testimonial psychotherapy. In his use of Testimony therapy, Dr. Akinyela uses four healing questions, three of which were derived from Pemina Yellowbird's (author of *Wild Indians: the Untold Story of the Canton Asylum for Insane Indians*) work. Yellowbird asks, "What happened to you? How does what happened to you affect you now? and What do you need to heal?" (Akinyela, 2005, p.16). Akinyela adds another question that he feels helps to uncover what he refers to as the *victorious moments* and that is, "In spite of what happened to you, what gives you the strength to go on?" (He places this added question as the third question, making "What do you need to heal?" the fourth question asked in the series.) (Akinyela, 2005, p.16). The victorious moments are moments that "contradict stories of doom and gloom" (Akinyela, 2005, p. 11).

These questions are not so dissimilar from the open-ended questions that practitioners such as Weine et al. use. Their aim is to loosely guide the testimonial process, eliciting from the testifier what life was like before, during, and after the traumatic event. This author contends that both should be used as a way to simultaneously hold and highlight the traumatic event(s) and the victorious moments leading toward healing. This may be particularly important with people of color who may be confronting ongoing trauma in their life.

Lustig et al. (2004) write that testimonial psychotherapy may not be a good idea “In settings of ongoing trauma in which exploring the depths of trauma could weaken one’s psychological defenses in the struggle to survive” (Lustig et al., 2004, p. 34). This is another place where the author feels testimonial psychotherapy needs to be adapted in order to be used in the United States to address the effects of RBTS. A parallel between domestic violence and racist incidents was presented in Chapter III. Domestic violence is a situation, like race-based stressors and trauma that is often ongoing. In conditions of ongoing trauma, one cannot wait for the trauma to be “over” in order to provide treatment. Bryant-Davis and Ocampo (2005) state:

People living in conditions of domestic violence or in societies where racist incidents occur may not always be able to establish safety first and then seek treatment. They must live with the threat of future violations (p. 492).

Studies have not been completed that focus on testimonial psychotherapy and one-time versus ongoing trauma, but it is hard to believe that it could not be beneficial for a person to have a safe space in which to story the trauma they have (or are currently) experienced (ing). There are times when a clinician would not treat a person in an intimate partner violence situation until the person got out of the relationship. Considering the insidious nature of racism, this is not an option for people of color. They often do not have the ability to “get out of racism.” If practitioners were to wait to treat RBTS until racism ended, it is unlikely that healing would ever occur. Consequently, this author asserts the notion that creating a story of one’s life and traumas placed within a sociohistorical and political framework could be beneficial for anyone, regardless of the situation -- be it a one-time or ongoing race-based trauma.

An adaptation that is not quite a full adaptation would be to find spaces to take a person of color's testimony that do not feel clinical. Many of the practitioners mentioned in the second chapter already do this, but many also practice within very clinical settings. Finding spaces that feel safe to the testifiers in which to take their testimony is a way to create holding and containment. Testimonial psychotherapy claims to be a socially and politically rooted theory. Taking the testimonial taking process out of a clinic and placing it in the community embodies these claims. Places like community centers, homes, and local organizations already deeply involved with and trusted in the community are possible spaces in which to take testimonials.

Finally, another adaptation being presented that is not a full adaptation, but a plumping up of sorts, would be to provide more, and stronger, links and avenues for people to bring their testimony to their communities. One idea for this includes building coalitions with other organizations in the community to provide opportunities for the testimonies to be part of a larger community or communities' wide project(s). The coalition building could be something already set in place by those taking testimonies or a joint project between those giving testimonies and the witnesses. Examples of such projects are: documenting an oral history of a community and gathering "proof" of the ways in which a whole community has been targeted with a specific kind of racism (for example—environmental racism, segregated housing/housing racism, etc.). A situation could be imagined where testimonies could be gathered documenting the ways in which the operation of incinerators in a community has affected the health of the community. These testimonies could be presented to local (or larger) government in conjunction with organizations already working on closing down the incinerators.

Creating an archive project, like Laub and Weine have done with the testimonials they have gathered, is another possibility. Having an archiving project in place prior to taking testimonials could provide a physical space in which to create an invaluable bank of historical, social and political information about a certain moment in time in a specific community(s). An archive also has the potential to create something like *merhamet*. Weine talks about *merhamet* in his work with the Bosnian refugees. It is a sense of shared experience, multi-ethnic co-existence, and community. The Bosnians did not even have to read each other's testimonies, but the mere fact of knowing that others were sharing their stories, and that there was a collective archive of the stories, helped them to feel less isolated and reconnected to their community.

Having an archive as an option for all communities that testimonial work is being done with is a public acknowledgement that the stories of the individuals and the community count. Grieving loss is an important part of living and healing from the effects of trauma. People of color often do not have the chance to grieve losses (such as loss of identity, chances, futures, opportunities not provided, dignity, etc.) at the hands of racism in the United States because there has to be a recognition that something was lost in order to have the space to grieve. It is hard to grieve something that everyone tells you has not really been lost.

Finally, this author has a dream that there could be some equivalent of the Australian National Sorry Day in the United States that could start a process of collective, countrywide healing around racism and the resulting traumas. It seems that similar events could happen here for Native Americans, others (Mexicans) indigenous to this land, and also for the slaves that white people brought to the United States.

National Sorry Day was started in Australia in 1998 after an investigation was done looking at the removal of Aboriginal children from their families. These children have been referred to as the Lost Generation. Sorry Day was started to acknowledge the wrongdoings to the families and as a remembrance of the mistreatment of the Aboriginal people. As a part of the original Sorry Day events, Australians passed books around the country that held stories of the Aboriginal people and experiences in their lives. Many of the white people in Australia had no idea of the struggle the Aboriginals had, and still confront. As a part of passing this book of stories around the country there was also the opportunity for white Australians to write comments back—mostly apologies. There were, and now are, many other Sorry Day events. The idea of passing a book around of stories (read: testimonials) is striking and most powerful. It is almost unfathomable to envision what it would do for the people of this country to openly acknowledge the multitude of ways that people of color have been wronged. With open acknowledgement comes open space for a healing process.

In this section, ways in which testimonial psychotherapy could be adapted to be utilized in the United States to address the effects of RBTS were explored. Many of the suggested adaptations take resources greater than what is usually available. This is where connecting to organizations within a community are crucial. This serves many purposes. One is to pool resources; another is to create a sense of a collective community experience and movement. It is this author's hope that with these adaptations, testimonial psychotherapy will become available as a powerful tool to employ as one small component of a larger movement toward liberation.

Implications for Social Work Practice

The adapted version of testimonial psychotherapy has the potential to be added to the discourse, literature, theories, modalities, and practice of anti-oppression and liberation theories already in use such as “Just” Practice, Feminist theory, Empowerment practice, Ethnic sensitive practice, narrative approaches, and Mutual aid groups.

Testimonial psychotherapy is a modality of therapy that is being used in limited ways. It has not yet been used with populations whose country of origin is the United States. This adapted version of testimonial psychotherapy will add to modalities of therapy available to be utilized with oppressed populations whose oppression has come as a result of living within white American culture. Social workers practicing this adapted version of testimonial psychotherapy will be contributing to a movement to recognize the psychological and physiological effects of racism. Both hooks (1995, 2004) and Comas-Diaz (2000) state that until there is societal recognition of the effects of racism, healing cannot begin. Even before engaging in testimonial psychotherapy, the practitioners’ recognition that racism has had dire effects on individuals of color opens space for healing. Bryant-Davis and Ocampo (2005) state:

Counselors should address the traumas of societal oppression with the concern and compassion that are afforded survivors of other traumatic experiences. Only by addressing these wounds can counselors assist in the healing and recovery of those who have experience emotional, verbal, and/or physical racist assaults (p. 495).

Bryant-Davis and Ocampo (2005) devote an entire article to addressing the implications of practitioners addressing RBTS. They argue that, considering that race determines much of a person’s life course, the future of mental health as a society depends on the ways in which we address *pathologies of oppression* that affect our clients

(p. 577). They also offer that exploring racism will bring to light the experiences of all in this society, “victims, perpetrators, and those who passively benefit from racism” (p. 577). It is in understanding the experience of the racially and ethnically oppressed that social workers will be able to provide preventions and interventions. The responsibility of this lies with everyone, not just clinicians and people of color (p. 576).

Thompson-Miller and Feagin (2007) speak to this responsibility of all. They point out that RBTS is the result of white dominant culture. Whites are also the majority of people in the mental health profession. They call for the necessity of white professionals to unpack their own, “racist socialization and framing” before being able to meet the psychological needs of people of color (p. 114). They sum this up beautifully by drawing on the Biblical phrase, “Physician, first heal thyself” (p. 114).

The call for taking personal responsibility for combating racism and addressing *pathologies of oppression*, as mentioned above, are congruent with the guiding ethics and principles for social workers and can be accomplished through using the adapted version of testimonial psychotherapy. The adapted version of testimonial psychotherapy suggested is synonymous with the National Association of Social Workers (NASW) code of ethics that guides social work. In particular, testimonial psychotherapy promotes the values of social justice, dignity and worth of the person, and importance of the human relationship. By using this adapted version of testimonial psychotherapy, a non-Eurocentric therapeutic framework, a social worker would be challenging the social injustice of racism and RBTS. People of color have been oppressed since the inception of the United States. Any effort working toward liberation and ending oppression should be taken by social workers. Under the umbrella term of social justice, the code of ethics

specifically refers to focusing primarily on “poverty, unemployment, discrimination, and other forms of social injustice” (NASW Code of Ethics, 2006, p. 5). A person of color often faces disproportionate levels of each of these. By utilizing testimonial psychotherapy, which focuses on the full sociohistorical and political context of a person and not solely on the individual’s inner psychology, such injustices are not only addressed, but a key part of the process.

Dignity, respect for the inherent worth of the person, is another value embraced by the NASW’s code of ethics. Testimonial psychotherapy, especially in its adapted form, does this. The code of ethics states, “Social workers promote clients’ socially responsible self-determination” (NASW Code of Ethics, 2006, pp. 5-6). As was discussed earlier in this chapter, testimonial psychotherapy promotes a person’s sense of self-determination through such processes as the person having complete control over the content and use of their testimony. Self-determination within the context of testimonial psychotherapy also comes through the action of linking to the community and the possibility of using one’s testimony to create personal, familial, local, or larger levels of change.

Finally, the NASW code of ethics includes the value of the importance of human relationships, recognizing human relationships as central to the work. The code of ethics states:

Social workers understand that relationships between and among people are an important vehicle for change. Social workers engage people as partners in the helping process. Social workers seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the well-being of individuals, families, social groups, organizations, and communities (NASW Code of Ethics, 2006, p. 6)

The description of this value sums up much of the aim of the adapted version of testimonial psychotherapy described in this chapter. Testimonial psychotherapy's aim is first and foremost to create a bound document that has the potential to be used as an agent of change, but there is a person behind that document who is the real source of change. A benefit of testimonial psychotherapy is the way in which it can alleviate many symptoms of RBTS. When a person is relieved of some of these symptoms, they are better able to interact with themselves, their families, and all aspects of community. Testimonial psychotherapy also works to reconnect and revive relationships.

To aid in reviving and reconnecting personal and community level relationships, it is important to emphasize the strength, power, and hope of the individual and the community. Williams and Williams-Morris (2001) stress the importance of clinicians needing to address the psychosocial resources and cultural strengths of communities of color. Working from this strengths-based perspective is often missing while discussing RBTS. The adapted version of testimonial psychotherapy utilizes the strength, power, and hope of the individual to assist in the healing process. Testimonial psychotherapy provides opportunities to focus on a person of color's personal, familial, and communal victorious moments.

Implications for Social Work Research

Research questions pertaining to the applicability of testimonial psychotherapy to the ongoing-ness of race-based trauma need to be addressed in more depth. It was established in this chapter that the psychological and physical torture perpetrated on people who have used testimonial psychotherapy is similar to the oppression that people

of color experience in the United States. Having established this, it would still be worthwhile to research what is absent or present within the context of the United States that may or may not allow for testimonial psychotherapy to be as effective. One could foresee that the lack of recognition of white privilege in society and the overall perpetuation of racism and white dominant culture could be potential roadblocks.

Bryant-Davis and Ocampo (2005) suggest areas in which further research needs to be done concerning the effects of racism. They are as follows:

(a) epidemiological studies to determine the extent of racist incidents among clinical populations and general community populations, (b) qualitative research to determine the complexity of racist incidents by documenting and analyzing the stories of individuals who have experienced racist incidents, (c) quantitative research to determine the correlates of racist incident-based trauma to determine the range of posttrauma symptoms, (d) quantitative research to determine the risk and protective factors that mediate the relationship between racist incidents and the development of posttrauma symptoms, and (e) research on prevention and intervention approaches with perpetrators of racist incidents (pp. 495-496).

It is particularly interesting to note their suggestion for qualitative research through documenting and analyzing stories of individuals who have experienced racist incidents (p. 495). This is a natural place where testimonial psychotherapy and research around racist incidents could overlap. Suggestions for research on racist incidents would inform the practice and further research with the adapted version of testimonial psychotherapy.

Research pertaining to finding the most effective ways to create community level healing and healing between communities could extend the scope of the effectiveness of testimonial psychotherapy. Research around whiteness and taking testimonials in white communities is suggested. Considering ways in which a white person may trigger re-experiencing traumatic memories and/or incidents for a person of color, the effectiveness, challenges, and implications of white clinicians taking testimony from people of color

needs to be explored. Research investigating the best ways to highlight hope and power in the testimonial taking process would be beneficial. It is important to conduct research regarding testimonial psychotherapy's effectiveness in addressing intersecting oppressions and target identities such when race intersects with queerness, ability, gender, and socioeconomic status. Testimonial psychotherapy in conjunction with other forms of anti-oppression, liberation, and empowerment practice could be researched to provide an even larger network of clinicians and practitioners to address the effects of racism.

CHAPTER IV

CONCLUSION

The aim of this research was to answer the question, “Can testimonial psychotherapy be adapted to address the effects of race-based traumatic stress on people of color in the United States?” The author asserts that the answer to the stated question is yes. Through synthesizing explorations of testimonial psychotherapy and the phenomenon of RBTS, the author presented reasons for the theory’s applicability to the United States. In addition, this author suggested adaptations necessary to utilize testimonial psychotherapy with people of color to address RBTS. Adapting and applying testimonial psychotherapy to be used in the United States, and specifically with people of color affected by RBTS, would not have been possible without an understanding of testimonial psychotherapy and RBTS.

Chapter II led the reader through a brief history of how testimonial psychotherapy came to be. Its grounding as a socially and politically rooted theory rising out of the testimonies of Chilean dissidents in the 1970’s was presented as well as testimonial psychotherapy’s essential components. This was followed by discussion of the power and importance of creating an integrated trauma story. The act of creating a trauma story is central to the healing properties of testimonial psychotherapy. Works such as Judith Herman’s (1992) *Trauma and Recovery* and Inger Aggar’s (1992) *The Blue Room* have been key writings illuminating the necessity of creating a meaningful trauma story. For example, Herman speaks of creating and recreating a trauma story with people who have

survived ongoing trauma, mostly as the result of domestic violence, as being a central component in the process of integrating the nonsensical trauma into one's life story. Aggar sits with women who have experienced torture primarily in the form of sexual abuse and listens to their testimony with the goal of bringing the private to public for purposes of furthering human rights.

The various populations and places in which testimonial psychotherapy has been used were outlined next. People from Bosnia, various countries in Africa, various parts of the Middle East and Latin America, and Holocaust survivors from all parts of the world have given testimonies within the testimonial psychotherapy framework. The importance of noting this is to speak to the adaptability of the theory. The populations testimonial psychotherapy has been used with thus far have all experienced trauma in the form of torture and persecution at the hands of oppressive governments.

Following discussion about populations and places, actual technique including number of sessions, process, reconnecting to the community, and the role of the therapist/interviewer were presented. Reconnecting the individual to the community plays a hand in alleviating some symptoms of PTSD. The use of testimonial psychotherapy, by practitioners such as Agger (1992), Lustig et al. (2004), Weine et al. (1998), and Laub (2006), with people from a wide range of races and ethnicities has shown to be effective in alleviating symptoms of PTSD. This was discussed in the last section of Chapter II. Because testimonial psychotherapy is a socially and politically rooted modality, avenues to reconnect are inherent in the process. The most obvious tool for reconnecting one to the community is one in the same with the overarching purpose of the therapy—to create a bound document of the testimony. The document can be used

in many ways, one being the creation of an archive to record the history of the community.

Chapter III was focused on a RBTS. *Racism* was operationalized using a definition of Jones and Carter (1996) and the works of Omi and Winant (1986; 1994). Both were used, as neither was sufficient on its own. Structural aspects of racism interplay with the individual and the individual's psyche, as it is set in a time and place in space and history. By using both definitions the author was able to capture the importance of structural aspects of racism as well as the necessity to recognize racism as a fluid construct that changes over time depending on the sociohistorical and political time and space. Next, *race-based traumatic stress* was operationalized using the ideas of Carter (2005) and Bryant-Davis (2007). *Race-based traumatic stress* was chosen over other terms in the literature as it encompasses both the source of the traumatic stress and, inherent in the already known definition of traumatic stress, the symptoms that arise as a result of traumatic stress.

Next, sources of RBTS were discussed. This section began with a discussion of institutionalized racism. Institutionalized racism limits opportunity and prevents people of color from getting services and channels them into certain institutions. Housing, employment, healthcare (including mental health care), the legal/criminal justice system and law enforcement, and education were all examples of interconnected systems that create and sustain the "web of institutional racism." Next, cultural racism has been referred to as a conduit for internalized racism, as it is here that images, stereotypes, and messages of who has decision-making power and who does not and whose voice counts and whose does not are continuously reinforced and repeated. Following cultural racism,

interpersonal racism was addressed centering on the negative effects of daily, subtle, often unconscious acts of racism, called microaggressions, perpetrated against people of color. Next, the intergenerational transmission of trauma was discussed focusing on ways in which RBTS is transmitted through the family, community and society. Lastly, mechanisms of internalized racism were discussed. Internalized racism is a complex source of RBTS as it is simultaneously considered a source and a symptom. It has often been referred to as the oppressor within and the oppressor without.

The next section included providing a sense of psychological and emotional effects of RBTS. This section was built around Bryant-Davis and Ocampo's (2005) work where they made parallels between rape and one-time racist incidents and then between domestic violence and ongoing trauma from racism. The section following provided a survey of the physiological effects of RBTS. They include migraines, somatic complaints, and heart disease. Chapter III concluded with a discussion of expanding current definitions of trauma in order to add them, not only to the DSM-IV-TR, but also to current literature, practice and lexicon around trauma. This is important as a place to begin acknowledging the damaging effects of RBTS on people of color.

Chapter IV provided a synthesis of the material discussed in chapters two and three. First, the applicability of testimonial psychotherapy to be utilized in the United States with people of color to address RBTS was provided. This author believes that testimonial psychotherapy can be applied to work with populations of color in the United States. The proven effectiveness of testimonial psychotherapy with a wide range of populations was discussed as well as its effectiveness with people who have been socialized with a collectivistic context. Next, testimonial psychotherapy's

appropriateness for use in the United States was discussed. It was first utilized in a particular context, Chile in the 1970s, where collective healing and collective political effort against a dictatorship was crucial. The following subsection spoke to the shift in power dynamic away from clinician and client to a relationship of testifier and witness that is inherent in testimonial psychotherapy. The relationship becomes that of two people co-creating a story, as the “expert” is not the clinician, but rather the person giving testimony. This creates more space for empowerment. Reframing and self-determination were also discussed in this chapter. The next section connected the way in which testimonial psychotherapy addresses many levels of healing (from individual to community) and the importance of this in relation to how RBTS often adversely affects a person of color in almost all aspects of their life (from interactions with systems, to the interpersonal).

Discussion of injuries and healing at many levels leads the reader to a subsection of Chapter IV that compares testimonial psychotherapy’s connection to working with people who have been the target of oppressive governments in their country of origin and people of color in the United States as being tortured and persecuted by the United States government. Following this there is a subsection that speaks of the importance of testimonial psychotherapy’s purpose of externalizing traumatic stories in order to create a social, historical, and political document. Testimonial psychotherapy is a way to place RBTS within its entire social, political, and historical setting through acknowledging the effects of intergenerational transmission of trauma and simultaneously how RBTS has affected the individual in their immediate past, present and future. Lastly, the ways in which testimonial psychotherapy may be able to aid in alleviating some of the symptoms

of RBTS, such as shame and isolation, anger, guilt, and powerlessness and hopelessness, were discussed.

The next section of Chapter IV gave points of adaptation. In brief, the author suggests the following changes: holding a number of focus sessions, having an open-ended number of sessions, a larger presence of positive reframing to point out *victorious moments*, working with ongoing trauma, expanding places in which testimonials are taken to “less clinical spaces,” and finally, more options to connect to the community, including archiving projects. Finally, the last section of Chapter IV provides implications for social work practice and research.

It is this author’s belief that more research around the use of testimonial psychotherapy and RBTS need to be done. This is especially true when examining the literature found in search of answering the research question presented. There was limited literature on the specific use of testimonial psychotherapy. In addition, many of the examples cited throughout the literature are specific to the African American community. This is indicative of the imbalance in literature found on the effects of racism on all communities of color in the United States. There is literature that supports the research question as it pertains to American Indians, Asian Americans, and Latinos, but these populations do not have as much of a presence in the literature found. Researchers, such as Williams and Williams-Morris (2000), argue that this is the result of the institution of slavery lasting for 250 years in the United States. This author calls for social workers and others interested in racial justice and liberation work to seek out the voices that are not being heard. Furthermore, there was not a large presence of a conversation focusing on the resiliency of communities of color as the result of enduring

years of RBTS. Again, William and Williams-Morris (2000) suggest further research on the benefits of resiliency and psychosocial supports in protecting a person of color from some of the effects of RBTS.

Testimonial psychotherapy is just one theory presented here that has the potential to join the literature, dialogue, and practice of other theories working toward racial justice and liberation. Considering the entrenched state of racism in the United States and the dire effects it has on many people and communities of color, it is crucial to have a large repertoire of theories addressing these issues. The necessity for such theories of racial justice and liberation was created throughout the history of the United States.

The United States is a country that was colonized and settled in a racialized way. Race determined who immigrated, who stayed, and the conditions under which one's immigration was either included or excluded from dominant culture. "American" culture was created through explicit laws that defined who was fully American and who was not. For many years, only white Americans were granted citizenship. It took centuries for many of these laws to be overturned.

These laws, along with the systematic enslavement of black Americans, the expulsion and forced assimilation of Native Americans, the segregation of Japanese via internment camps, the exploitation of Latinos, especially migrant workers, as well as the extension of discrimination to all people of color has concretized racism as a foundation for all aspects of the lives of people who live in the United States. This has been true throughout the history of the United States and, although the ways in which racism is enacted and perpetuated has changed over time, it has not been eradicated.

It is neither possible nor preferable to pull apart the myriad ways in which institutionalized, cultural, interpersonal, and internalized racism interact with each other creating a “web of racism” in which people in the United States are socialized and live on a daily basis. Instead, our focus should shift to how the experience of this web has traumatized people of color. The burden of shifting a conversation to make visible the often-invisible traumatizing effects of racism should not lie solely with people of color. I would argue that it is more the responsibility of white people to hold most of the weight of this shift. The sociohistorical and political context in which this country was founded and still exists within today has created such a necessity. It is the responsibility of social workers to work within and against these systems until there is no work left for us to do.

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