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Building Resilience through Culturally Grounded Practices in Clinical Psychology and Higher Education

Catarina Campbell & Phyu Pannu Khin, B.Sc.

There is no “one size fits all” approach when it comes to the process of healing, particularly for individuals who are continuously affected by the many barriers and impacts of systemic oppression. This reality demands the sustained development of a praxis rooted in trauma-informed and culturally grounded care so that we may better serve our most-impacted communities (such as Black, Indigenous and People of Color [BIPOC], disability, queer, and survivor communities). As practitioners in the fields of Clinical Psychology and Higher Education, we engage in cross-disciplinary analysis so that we may amplify and share our tools for collective healing. We highlight the importance of supporting client and student development through multisystemic and resilience-oriented frameworks. Specifically, we discuss the implications of the Minority Stress Model (Meyer, 2003) and Bronfenbrenner’s Ecological Systems Theory (1979) in serving our communities more effectively to enhance positive clinical and academic outcomes.

Keywords: clinical psychology, culturally grounded, higher education, resilience, trauma

Connection across disciplines and sharing of knowledge is necessary if we are to collectively move toward more culturally grounded approaches to liberation and healing. The fields of higher education and clinical psychology each expand our paradigms of how knowledge around trauma and transformation can become more relevant and accessible. It is imperative that these disciplines prioritize access for communities disproportionately impacted by the forces of white supremacy,

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ableism, and homophobia that corrode the efficacy of our educational and psychological systems.

Research in psychology confirms the realities we witness in our communities within higher education: many of the frameworks that dictate how we offer support reinforce fragmentation and lack relevance for those we serve. Scholars of Liberation Psychology, an emerging field from Salvadoran social psychologist Martín Baró, concur. In their seminal text on Liberation Psychology, Mary Watkins and Helene Shulman posit that it is negligent to analyze symptoms in isolation without recognition of how those presentations enmesh with one's socio-political, cultural, and personal circumstance (Watkins & Shulman, 2008). Correspondingly, many practitioners in the field propose that for treatment of complex trauma to be effective, it must also be culturally attuned. For example, the scholarly work of Dr. Peterson and Dr. DeLoach on traumatic response demonstrates that:

Much of what is known about trauma intervention is based upon a biomedical model with treatments devised for individuals diagnosed with PTSD, which is largely based on a culturally narrow understanding of trauma as a discrete event that results in a particular set of categorical responses. Thus, research tends to be inconclusive about treatment effectiveness with clients who demonstrate non-traditional symptom constellations, such as altered life schemas or those with complex or cultural trauma. (DeLoach & Petersen, 2010, p. 47)

This developing consciousness within the realm of clinical research implores us to attune more intentionally to how most-impacted communities (Black, Indigenous and People of Color [BIPOC], disability, queer, and survivor communities, etc.) address and recognize the need for contextually and culturally informed healing. Through this recognition comes the potentiality of a truly healing dynamic, where those we serve no longer have to silo their identities from their traumas (e.g. see a specialist on bipolar here, work on your childhood trauma there, find a place to feel racially and culturally safe somewhere else, etc.) Disjointed care and lack of clarity among clinicians and student affairs professionals alike severs the individual from their communities and precludes the possibility of an encompassing treatment/support plan.

In the field of clinical psychology, practitioners continue to strive for more comprehensive treatment that raises awareness of cultural sensitivity. For example, the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the handbook utilized by clinicians for the diagnosis of mental disorders, has updated the diagnostic criteria to consider cross-cultural differences in the concepts of cultural distress and presentations (American Psychiatric Association, 2013).

Many clinicians are attempting to conduct more comprehensive and client-centered assessments through structured interviews to conceptualize treatments that are culturally grounded and respectful to the clients that we serve. Although these tools bring practices closer to culturally appropriate care in the field of psychology, more progress is needed in both clinical modalities and research practices to better serve communities whose traumas are continuously exacerbated by systemic barriers and oppression.

Models from psychology reflect the psychosocial realities we witness in our student communities within higher education. In order to facilitate culturally grounded practices for healing within and beyond the academy, we should consider integrating knowledge from the Minority Stress Model (Meyer, 2003). The Minority Stress Model (Meyer, 2003) stems from social and psychological theories describing how stigma, prejudice, and discrimination on minority groups potentially lead to heightened risk of psychological distress and mental health struggles. In this model, Meyer (2003) proposed that minority stress is: unique (not experienced by non-stigmatized individuals, additive to general stressors experienced by all), chronic (related to stable underlying social and cultural structures and accrue over time), and socially-based (stems from social processes, institutions, and structures beyond the individual characteristics). The model has received much empirical support; studies have shown that the LGBTQ community at large faces significantly higher rates of harassment as well as verbal, physical, emotional, and mental abuse that is unique, chronic, and socially based on sexual and gender identity (Kosciw et al., 2014; Robinson & Espelage, 2011). Correspondingly, a literature review on empirical studies also demonstrated that experiences of racial prejudice and discrimination escalated risk for various mental health conditions including depression, psychological distress, anxiety, and general threats to one's well-being (Paradies, 2006; Williams et al., 2003).

Despite research and theoretical contributions on minority stress, there is limited literature on how to address minority stress in clinical practice. Practitioners of evidence-based clinical treatments in the field often struggle with fully integrating issues of minority stress in therapy unless they use clinical judgement to make modifications to the manualized protocols in order to provide more culturally sensitive care. When implementing evidence-based tools like Cognitive Behavioral Therapy (CBT) in our communities, it is possible to apply strategies and support from the literature to enhance the resilience of the individual, which is especially important for working with vulnerable communities. To foster resilience, it is critical for clinicians and practitioners to continuously recognize and address issues of power, privilege and oppression.

An example of how to apply resilience-based practices arises in the way clinicians address certain automatic thoughts such as “the world is not a safe place.” Culturally

attuned practitioners will recognize that considering the world an unsafe place is not a dysfunctional thought if the client has a lived history of systemic oppression, violence, and/or identity-based trauma. When in a supporting role for individuals from these communities, one must honor that the world was indeed not safe for them in the past, and therefore, such thinking patterns are often adaptive rather than pathological. With the individual's greater context in mind, clinicians and higher education practitioners alike can shift our consciousness to bolster the resilience of those we serve to move forward in life meaningfully. The example of how clinicians respond to automatic thoughts demonstrates how practitioners in higher education must hold a similar understanding of function/dysfunction to support our students. Clinicians are coming to realize that one must hold presence for both realities to create a genuine possibility of healing. This often takes form in supporting the client to recognize "sometimes, the world indeed feels unsafe for me," and yet, "at the same time, I feel at ease and protected by my own resilience/love from my community."

What clinical psychologists are discovering is that contemporary treatments provide a framework that those in higher education can utilize to further transform practices within the academy. Concerned clinicians working with CBT are asking a series of questions to generate a more nuanced and effective utilization of the framework. To begin, clinicians strive to identify the unique and specific systematic stressors that shape the lives of communities they serve (e.g., racism, transphobia, homophobia, ableism, xenophobia, discrimination). Intuitively, the question arises as to which of those psychosocial factors are amenable to change at the interpersonal level or at the community level.

From this perspective, rooted in the foundation of one's environment rather than in the signs of distress as isolated incidents, clinicians can explore how these factors are associated with the onset, maintenance of distress, and treatment outcomes in diverse populations. In higher education, symptoms and suffering are often the primary catalysts of pedagogical and procedural change; attunement to the wellness of underrepresented communities heightens in the presence of achievement gaps or dire and collective mental health distress. Following the process of clinical psychologists allows student affairs practitioners to more effectively evaluate the extent to which the ethos of our campuses and classrooms are responsible for the pains and plights of underrepresented student populations. As a final focus, clinicians and scholars can shift our awareness from the causes of distress to the identification and cultivation of unique resiliency factors within each of our communities. In this practice, we can collectively conceptualize healing from a strengths-based framework (without purely focusing on "symptomatology").

Clinical research affirms the need for wrap-around support strategies on behalf of most-impacted communities within therapeutic and educational practice. Studies

confirm that diverse communities respond to prejudice with resilience and coping strategies both at the individual level and at the community level. Community resilience in the form of group solidarity and cohesiveness is commonly observed as a protective buffer for under-represented communities from adverse mental health outcomes (Clark et al., 1999; Miller & Major, 2000; Postmes & Branscombe, 2002; Shade, 1990). These findings exemplify why campus climate and access to relational support matter for student wellness, success, and retention in collegiate communities. When clinicians and educators cultivate resilience for those we serve, we ameliorate the impacts of trauma and stress to empower clients and students to thrive with positive clinical and academic outcomes.

Therefore, in order to better serve individuals from vulnerable communities, it is vital for practitioners to employ a complex and multi-systemic lens. One of the best-known frameworks for conceptualizing such a comprehensive approach is Bronfenbrenner's Ecological System Model (1979), popular both within clinical practice and student affairs. Bronfenbrenner's model considers the influences of the large number of environmental factors, also known as ecological systems, on the individual's development and experiences. Specifically, Bronfenbrenner (1979)'s Ecological System proposes that there are four ecological systems in which an individual interacts with that can affect their development. These systems (Bronfenbrenner, 1979) include:

1. the Microsystem (which includes the interaction with the individual's immediate surroundings such as peers, family members, teachers);
2. the Mesosystem (which describes how different parts of a microsystem interact; e.g., the quality of relationship between family members; the collaboration between parents and teachers, etc.);
3. the Exosystem (which contains societal or environmental factors that may indirectly impact the individual, such as parent's job security, neighborhood, community safety/violence, etc.);
4. the Macrosystem (which encompasses geographic location, government systems, racial and community-based ideology, and all other cultural, historical, and societal factors or beliefs that influence the individual, etc.).

In serving our communities, both higher education practitioners and clinical psychologists would benefit from discerning individual differences based on the guidelines from the Ecological System Framework. Utilizing the Ecological System Framework becomes particularly important when working with those who have a history of trauma. An initial action for providing culturally grounded services is cementing our understanding that there is no "one size fits all" approach capable of treating or longitudinally soothing trauma responses in those we serve. Consequently, we in clinical and educational practice must consider how each of these

various ecological systems shape the lived reality of those in our care. With any given student or client, we are implored to consider that a particular trauma response might be related to family dynamics and peer victimization (the microsystem) and/or be influenced by political and systemic oppression (the macrosystem). As we consider these respective systems, educators and clinicians must also incorporate the source system, which goes unaddressed in the Bronfenbrenner model (1979): the body and one's most basic needs. With this consciousness, practitioners recognize the importance of assuring that those we serve have their basic and personal safety needs met. Bronfenbrenner's offering, like any developmental paradigm, should not be applied in isolation; clinical and higher education practitioners must also incorporate influences of basic needs factors with environmental forces in shaping our therapeutic, social, and pedagogical responses to trauma in our communities.

With guidance from these connected frameworks, service providers in both clinical and educational practice have the necessary tools to infuse our fields with trauma-informed service and care. Trauma-informed care can manifest across all system levels to generate a myriad of potential solutions. For example, at the macrosystem level, policy makers and administrators can implement trauma-sensitive programs and policies. Symbiotically, those at the microsystem/mesosystem level providing direct services (clinicians, student support staff, and faculty) can engage in their work through a strengths-based lens. Such changes allow us to actively avoid but continuously redirect current practices that isolate and re-traumatize.

As we explore the effects of various systems on those we serve, practitioners in clinical and educational realms alike must consider the impact that myriad systems of trauma and oppression have on our ability to do our work. If one considers the visceral resonance of trauma in those we serve, we must also acknowledge how that trauma reverberates within us as members of the same communities and as ones who experience vicarious trauma and secondary traumatic stress (Van Der-noot Lipsky & Burk, 2009). Support of and access to self and communal care is imperative for the success and retention of clinicians and higher education practitioners who work with those impacted by trauma. By creating an organizational culture of providing trauma-compassionate services, practitioners at all levels of mental health and higher education systems can perpetuate an emergent culture of manifold healing and vibrancy for all.

Both therapeutic and educational spaces support the individual toward self-actualization, meaningful relationship with one's community, and agency to positively learn from and contribute to the world around them. None of these objectives can be met through clinical or pedagogical practices that neglect to put the individual in context; this is especially true for those from communities who are chronically underrepresented in the research that informs contemporary practice. The benefits of culturally attuned and trauma-informed practice in clinical settings translate to

successes in higher education: amplified wellness of the individual and the collective as well as a deepened propensity for belonging (retention), engagement, and ability to learn/thrive. This article expounds on the connection between clinical paradigms and higher education; in the future we would collectively benefit from a more robust exchange and application of higher education theories and modalities to the realm of clinical psychology, as well. By applying an interdisciplinary lens to build resilience through culturally grounded practices, we can share strategies to make possible a more broad and tangible healing from the clinic to the classroom and beyond.

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