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Multicultural and the Treatment of Child Trauma: Research Trends from the Last Ten Years

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Multiculturalism and the Treatment of Child Trauma:

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Abstract

The purpose of the present study was to determine the extent to which the peer-reviewed research literature on the treatment of childhood trauma has incorporated multiculturalism, and themes in this body of literature current and recent literature on the topic. A PsycINFO search of the peer-reviewed literature with keywords related to: multiculturalism, broadly; names of specific cultural groups; and the treatment of childhood trauma yielded 41 articles. Latent semantic analysis was used to examine the abstracts from these articles, resulting in a similarity matrix that was then analyzed using cluster analysis to identify two main clusters and four sub-clusters. These clusters were then named based on a subjective review of the abstracts in each theme. The two main clusters were: (1) Individual Focus and (2) Group and Systems Focus. The sub-clusters were: (1) Treatment for Specific Populations, (2) PTSD Diagnosis and Comorbid Diagnoses, (3) Family and Community Systems, and (4) Group Interventions. Results suggest that additional research is needed related to childhood trauma among racial and ethnic minority populations and people from lower socioeconomic groups in the U.S. Research is also needed on childhood trauma globally, particularly from impoverished countries..

Keywords: Adverse childhood events, childhood trauma, diversity, multiculturalism

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Childhood trauma can include a variety of experiences including physical, emotional or sexual abuse or neglect. It also includes witnessing or being a victim of domestic, community, or school violence, severe accidents, natural or man-made disasters, death of a parent, sibling or other important attachment figure, exposure to war, terrorism, refugee conditions or multiple and complex traumas (American Psychiatric Association, 2013; Cohen, Mannarino & Deblinger, 2016). Certain factors can affect a child's possibility of developing enduring trauma symptoms. Age, developmental level, inherent or learned resiliency, and external sources of support, specifically the amount and quality of trauma-related emotional support, and the presence of parental support can all significantly affect how a child responds to a traumatic event (Cohen et al., 2016).

It is currently generally accepted that exposure to trauma can cause severe and long-term impairment in children (Alisic, Jongmans, van Wesel & Kleber, 2011). Childhood trauma exposure is much more common than was once thought (Fairbank & Fairbank, 2009). Children exposed to multiple traumatic are at a much higher risk for a range of adverse mental and physical health problems than those who were not (Fairbank & Fairbank, 2009).

Epidemiologic studies of Child Traumatic Stress (CTS) have four main categories of research focus: estimating prevalence and impact of trauma in general populations of youth, estimating prevalence of child maltreatment, estimating the severity of exposure to and impact of specific disasters on children and youth and studies of distribution and determinants of CTS among children at high risk for exposure to traumatic events (Fairbank & Fairbank, 2009). The

most studied psychological consequences of childhood trauma are posttraumatic stress and its pathological extremity post-traumatic stress disorder (PTSD) (Alisic et al., 2011).

The Developmental Victimization Study, a national survey of exposure to violence in a representative sample of 2,030 youth 2-17 years old in the United States found that more than half of the sample experienced physical assault in the past year, that more than one in eight experienced at least one form of child maltreatment and that more than one in three children and youth witnessed violence (Fairbank & Fairbank, 2009). The National Survey of Adolescence, a representative household probability sample of more than 400 adolescents 12-17 estimated that nearly 5 million American youth experienced serious physical assault, nearly 2 million experienced sexual assault, nearly 9 million witnessed interpersonal violence, and the prevalence of PTSD was 3.7% for males and 6.3% for females (Fairbank & Fairbank, 2009). About 1 in 3 children exposed to trauma develop PTSD (Alisic et al., 2011).

Outcomes of childhood trauma can affect many factors including physical health, mental health, interpersonal trauma symptoms and education. Physical health factors in response to a traumatic event include physiological responses such as increased heart rate, respiration and blood pressure. Childhood trauma and PTSD are associated with chronic changes in neurotransmitter and hormonal activity in the brain and other parts of the body (Cohen et al., 2017). Traumatized children have been known to experience higher resting pulse rates and blood pressure, as well as greater physical tension. After experiencing a traumatic event, children can experience inaccurate or irrational cognitions in which they feel shame or blame themselves for the event that occurred (Cohen et al., 2017). They can experience complex PTSD or develop traumatic grief. Traumatic grief can occur following the death of a significant attachment figure which can lead to trauma responses, as well as complicated or maladaptive

grief responses (Cohen et al., 2017). Child trauma exposure can manifest in interpersonal trauma symptoms in which children are shown to withdraw from peers or have difficulty enjoying usual activities. This withdrawal may interfere with social interactions to varying degrees. Children may generalize untrustworthiness of one person to all people or they may seek out inappropriately close relationships with peers or adults who may or may not be safe (Cohen et al., 2017). Children with a history of sexual abuse, physical abuse, or exposure to domestic violence were found to have smaller brain size, lower IQ, poorer grades, a smaller corpus collosum and higher dissociation scores (Cohen et al., 2017).

Multicultural Psychology

As our society continues to become more diverse, there has been in increased focus on diversity and multiculturalism, both globally and within the United States. Multiculturalism has been called the fourth major force in psychology. The shift in focus towards multiculturalism was due to an increase in research demonstrating mental health disparities among racial and ethnic minority populations in the United States (Davis et al., 2018). Emphasis on multicultural competencies have been included in accreditation requirements and guidelines for all areas of psychological science and in many other disciplines, including education, social work, counseling, law and medicine (Davis et al., 2018). The body of literature has demonstrated the need for training related to multicultural competencies, specifically in terms of practice and therapy.

The research has shown a series of issues in regards to psychological treatment of racial and ethnic minorities. A series of studies concluded that many therapists have more positive outcomes when working with white clients than with minority clients (Davis et al., 2018). Microaggressions towards racial and ethnic minorities are often prevalent in therapy, 53% to

81% of clients have reported experiencing at least one microaggression (Davis et al., 2018). From these issues, we can infer that racial and ethnic minorities are not receiving as high quality treatment as their white counterparts are. Minority groups may also face certain mental health problems due to excess stress from belonging to stigmatized social categories, known as minority stress, that other groups do not (Meyer, 2003). Psychological treatment should be able to account for and treat these disparities. It is important that varying backgrounds and experiences, particularly those experienced by minority groups, be acknowledged and influence research and practice to be most effective.

In psychology, extensive research has been done on multiculturalism and on childhood trauma. However, less explicit attention has been paid in the literature to the intersection of these domains. For example, when doing preliminary PsycINFO searches on December 11, 2018, I found 16,350 general search results for the word "multicultural." A search for "child* trauma" yielded 30,921 results, but "multicultural child* trauma" yielded only 129 total results, highlighting a gap in the research merging these two important areas. These were not keyword searches, but general term searches. Therefore, the aim of the current study was to review the existing peer-reviewed research at the intersection of childhood trauma and multicultural psychology to see better understand the current state of research in this domain, and to offer recommendations for future research. Specifically, the present study aims to analyze the content themes of the existing literature on multiculturally-focused child trauma treatment. This analysis was done using latent semantic analysis (LSA). The output from the latent semantic analysis was then subject to a cluster analysis in order to establish the content themes.

Latent Semantic Analysis

Latent semantic analysis (LSA) is a method used to statistically extract the contextual meaning of words within a body of text (Landauer & Dumais, 1997). The basic idea of LSA is that the aggregate of the word contexts provides a set of mutual constraints that determines the similarity of meaning of words and sets of words to each other (Landauer, Foltz & Laham, 1998). This technique analyzes the relationship between the set of documents entered and the terms the documents contain and then produces a set of concepts showing the relation between the documents and terms. LSA presumes that similar pieces of text will contain the words that are related or close in meaning. The resulting relationship matrix contains word counts per paragraph, with rows representing unique words and columns representing each paragraph. The values shown in this matrix close to 1 represent very similar paragraphs, while values close to 0 represent dissimilar paragraphs. The paragraphs run in our study were each of the articles abstracts.

Method

Sample

The sample consisted of 41 abstracts of peer-reviewed journal articles found by doing PsycINFO searches for three groups of keywords: multicultural term focused, specifically group focused and childhood trauma focused (see Table 1 for the full list of search terms). The multicultural term list included terms such as multicultural, culture, or socioeconomic status. This groups of search terms was meant to focus the articles to multicultural research and related issues. The second groups of terms was specific minority groups, with terms such white, black, LGBT and disabled. While the first group narrowed down the searches for a multicultural focus, this second group of terms helped bring in searches that may have a multicultural focus without

necessarily using the first list of terms. The third groups of terms was purely childhood trauma term focused to make sure the results also included the child trauma aspect we were looking at. Using the combined lists of search terms, I found a total of 1,409 results at the time the search was conducted, completed March 8, 2019. I chose to limit the search to articles published within the last ten years in order to gain a better understanding of the most current state of the literature. Of the 1,409 results, 970 of them were published in the last ten years. I then manually reviewed the abstracts of these 970 articles to ensure they met three specific criteria: the article was multicultural focused, child trauma focused, and treatment focused. When evaluating articles to make sure they matched the required criteria, I would first look at the title and judge if it mentioned anything that would relate to childhood trauma. If the title of the article seemed relevant, I would read through the abstract to see what group the research was done on or if this research was looking at differences between groups or minorities. If the article had both a childhood trauma focus and a multicultural focus, I would make sure it was evaluating a specific treatment or implementing a treatment. Articles that did not meet all three of these criteria were not included in the sample. The final sample is comprised of 41 articles.

Procedure

The abstracts from the 41 articles in the sample were placed into a single Word document. The articles were screened for prepositions (e.g., *in, on, of*), conjunctions (e.g., *and, but*), articles (e.g., *a, the*), transition words (e.g., *first, then, finally*), proper nouns (e.g., authors' names), numbers (including years), and all punctuation. These words and characters were removed from the abstracts to leave only content words that would better characterize the studies. All acronyms were also replaced with the actual words they stood for.

The 41 abstracts were entered into a matrix comparison latent semantic analysis program, using "term to term" comparison in a semantic topic space based on text from three college level psychology textbooks. This psychological semantic space has 400 factors (Laham, 1998). The analysis results in a similarity matrix that represents how similar each abstract was to every other abstract in latent semantic content. The resulting 41 x 41 similarity matrix was then transferred to SPSS to run a cluster analysis.

Cluster Analysis

A cluster analysis was run as a way to represent the data from the similarity matrix. In a cluster analysis, the data are represented as discrete, rather than as dimensional. This type of analysis examines differences in the type of data, rather than the amount. We used Ward's method of hierarchical clustering with a Euclidean distance measure, which allows us to examine how the content themes found through LSA are qualitatively different from one another. Specifically, we looked at the dendrogram as a visual model of how the articles were clustered.

Results

LSA Analysis

The cosines indicating the similarity between each of the 41 pairs of abstracts could range from 0.00 indicating no similarity to 1.00 indicating perfect similarity. In our sample of 41 abstracts the cosines ranged from .69 to .87. The mean of the cosines was .80 with a standard deviation of .05. To my knowledge, this is the first study of its kind in this body of literature, so there is not information available to compare these cosine means.

Cluster Analysis

We examined the dendrogram to determine the best cluster solution. Figure 1 shows the dendrogram for the cluster analysis. We also examined the fusion coefficients for an "elbow" to

help determine the appropriate number of clusters. Both of these methods suggested two main clusters, each with two sub-clusters (see Figure 2). The first main cluster contained 17 articles. Based on a subjective review of the abstracts of the articles included in this cluster, we decided this cluster was the *Individual Focus* cluster. Sub-cluster one, named *Treatment for Specific Populations*, had 9 articles. Sub-cluster two, labeled *PTSD Diagnosis and Comorbid Diagnoses* had 8 articles. Main cluster two was named *Group and Systems Focus*. This cluster contained 14 articles. Sub-cluster three, *Family and Community Systems* had 9 articles, and sub-cluster four, *Group Interventions*, had 5 articles.

The Individual Focus cluster was the larger of the two main clusters, containing 27 of the 41 articles in the sample. It was is named Individual Focus because its two sub-clusters, *Treatment for Specific Populations*, and *PTSD Diagnosis and Comorbid Diagnoses* focused more on interventions for individuals, especially compared to the second *Group Intervention* cluster. In the first sub-cluster, *Treatment for Specific Populations*, which contained 18 articles, we noticed a focus on interventions specifically focused around specific groups, communities, or populations. Some examples of these studies included: *Intensive Child-Centered Play Therapy in a remote Australian Aboriginal Community* (Wicks, Cubillo, Moss, Skinner, & Schumann, 2018), and *Feasibility of Trauma-Focused Cognitive Behavioral Therapy for Traumatized Children in Japan: A Pilot Study* (Kameoka et al., 2015). The second sub-cluster, *PTSD Diagnosis and Comorbid Diagnoses*, contained 9 article and showed a very strong focus on PTSD and post-traumatic stress. There was also a significant mention of anxiety and depression, but post-traumatic stress was the main focus of each of these articles. Examples of articles from this cluster were: *Preschool PTSD Treatment (PPT) for a young child exposed to trauma in the Middle East* (Puff & Renk, 2015), and *An Art Therapy Intervention for Symptoms of Post-*

Traumatic Stress, Depression and Anxiety Among Syrian Refugee Children (Ugurlu, Akca, & Acarturk, 2016).

The second main cluster found in this study included 14 studies with a *Group and Systems Focus*, which stems directly from the third sub-cluster *Family and Community Systems* and the fourth sub-cluster, *Group Interventions*. The 9 articles in the third sub-cluster, *Family and Community Systems*, specifically examined the systems and conditions surrounding the children experiencing trauma affect the trauma and their outcomes. For example, an article from this cluster was *School-Community Partnerships in Rural Settings: Facilitating Positive Outcomes for Young Children Who Experience Maltreatment* (Hartman, Stotts, Ottley, & Miller, 2017). This study, similar to the others in this cluster, focused on how the rural setting and school-community relationship can affect childhood trauma outcomes and help facilitate positive outcomes for the affected children. The fourth sub-cluster, *Group Interventions* was the smallest of all the clusters formed in this study, containined five articles focused on group interventions, such as a group-based trauma recovery program (Allen et al., 2016), or a specific group of affected children, such as American Indian and Alaska Native children (BigFoot & Schmidt, 2010). This sub-cluster seems to be the most narrowly focused of the four, which could explain why it is the smallest.

Discussion

The cluster analysis of the similarity matrix resulting from the LSA of the 41 abstracts in the sample allowed us to look at the content themes present in the current body of work surrounding multicultural treatment of childhood trauma found through this study's searches from 2009 to the start of 2019. We examined the dendrogram to figure out exactly where the clusters of articles fell and found two main clusters and four sub-clusters. The main clusters

contained articles with either an *Individual Focus* or a *Group and Systems Focus*. Having these two as main clusters matches with how the current body of research is laid out. Studies are typically focusing treatment of specific patients (Harley, Williams, Zamora & Lakatos, 2014), populations (Hoskins, Duncan, Moskowitz, & Ordonez, 2018) or mental disorders (Klag, et al., 2016). In the *Individual Focus* main cluster, even when the studies were studying populations, the studies tend to eventually focus more on individually-focused treatments, after looking at how being part of a population can affect a patient's current state of mental health or treatment. The sub-clusters for the *Individual Focus* cluster were *Treatment for Specific Populations* and *PTSD Diagnosis and Comorbid Diagnoses*.

The articles that comprised the first sub-cluster in the *Individual Focus* main cluster, *Treatment for Specific Populations*, had aspects of the themes found in the other three sub-clusters. In this sub-cluster, there were articles focusing on posttraumatic stress symptoms (Kangaslampi, Garoff & Peltonen, 2015), group play therapy (Kwon & Lee, 2018), and family and community contexts (Fraynt, 2014). What draws these articles together when they could likely all fit into another sub-cluster is their focus on specific trauma treatment or treatment of very specific populations. The cluster of articles may seem to cover a broad area, but they are actually more specific. For example, the Ooi et al. (2016) study looked at war-affected young migrants living in Australia, focusing on three specific groups, war-affected children, migrants, and those living in Australia. The other articles in this cluster shared this specificity, making them similar and therefore clustered together. The second *Individual Focus* sub-cluster, *PTSD Diagnosis and Comorbid Diagnoses* contained articles purely focused on PTSD and varying comorbid disorders, as seen in the fourth main category of the epidemiology of CTS (Fairbank & Fairbank, 2009). As previously mentioned, PTSD is the most commonly studied symptom of

childhood trauma (Alisic et al., 2011), so it makes sense that this would be a subcluster in the body of literature on multicultural childhood trauma treatment. The articles in this study were more specifically treatment related and were not just child traumatic stress focused, but still mostly followed the four main categories shown in the epidemiological review of child traumatic stress.

Group interventions are common when working with children, especially school-based interventions because it makes it easier to provide treatment to a larger group at the same time. Children are also extremely involved in systems, both family and community-wise, so evaluating the systems they are a part of and how the systems may be affecting them is critical for effective treatment. The sub-clusters for main cluster two were *Family and Community Systems*, and *Group Interventions*. *Family and Community Systems* articles shared a common focus on how family and community contexts can affect child experiences and clinical symptoms. Children's clinical symptoms can only be fully understood by considering their individual and family contexts (Obasaju & LiVecchi, 2018). African American children living in poverty, for example, often experience an overexposure to violence, which can cause an increase in future mental health problems (Patterson, Stutey & Dorsey, 2018). It is crucial that mental health providers understand how these systems and experiences can lead to mental health problems and clinical symptoms in order to provide effective services and interventions.

The articles in the *Group Interventions* sub-cluster account for these systems while evaluating how to treat them in group-based interventions. Bigfoot and Schmidt (2010) exemplified this in their study of a child trauma-focused cognitive-behavioral therapy intervention adapted for the vulnerable populations of American Indians and Alaska Natives, who face significant levels of trauma exposure. This type of intervention is important because it

focuses on the specific vulnerable aspects of these populations and works with these issues to treat trauma symptoms in its children.

In the Fairbank and Fairbank (2009) epidemiological review of Child Traumatic Stress (CTS), they presented the four main categories of research. The first category was made of studies that aimed to estimate the prevalence and impact of trauma in general populations of youth, the second category included studies that estimated prevalence of child maltreatment, the third category included studies that estimated the severity of exposure to and impact of specific disasters on children and youth, and the fourth category included studies of distribution and determinants of CTS among children at high risk for exposure to traumatic events. Since our research was treatment focused, all four of the clusters have a treatment focus to them, they are not just generally looking at childhood trauma. However, the articles found in this study did seem to follow the same general trends of the four main categories of child traumatic stress research. There were articles focusing specifically on natural disasters and war exposure (Aduriz, Bluthgen & Knopfler, 2009; Lee, Lin, Chiang & Wu, 2013) which fits with the third main category of research.

While this is a decent start to a body of work on multiculturally-focused treatment of childhood trauma, a sample of only 41 articles over a timespan of ten years is quite limited. Research has demonstrated the importance of both multicultural research and childhood trauma research. I think it is important to do more to combine these two fields and have a greater amount of research on multiculturally informed childhood trauma in general. All areas of psychological science and many other disciplines have implemented multicultural competencies in their accreditation requirements and guidelines (Davis et al., 2018). This emphasis does not seem to have truly transitioned to the field of childhood trauma yet. If there is research

demonstrating mental health disparities among racial and ethnic minority adult populations, it is reasonable to assume that these disparities are also seen in children (Davis et al., 2018). In fact, growing up as a member of a minority group could cause child mental health issues to manifest earlier or differently than those in the majority group. I assert that there should be a greater focus on multiculturally informed treatment of children, but particularly children who have experienced childhood trauma, such as those in extreme poverty. The current general consensus is that exposure to trauma can cause severe and long-term impairment in children. In order to better combat this in all children, but particularly children of a minority group, treatment of childhood trauma should implement a significant multicultural focus. This implementation will have to start with a greater focus on multiculturally informed research to childhood trauma treatment, like the articles found in this study.

Limitations

The gathering of articles was done entirely by myself, so it is possible that there was an error, either in how the searches were conducted, or by missing a topically relevant article through oversight.

Conclusions

Childhood trauma research needs a greater multicultural focus. This emphasis should include more research on specific, especially vulnerable populations, the unique issues they face, and how to best treat these issues. Practitioners should consider the population or background a patient comes from when deciding on a course of treatment and base the treatment plan to work effectively with these contexts. There is a decent amount of research looking at responses to specific traumatic events, but I think there needs to be more research done looking at responses to and treatment for more common types of trauma that greater amounts of children experience.

While treating the trauma of victims of natural disasters and war-torn areas is obviously important, adverse childhood experiences are increasingly common and can also lead to trauma symptoms. I think there needs to be more research on interventions for populations that may be exposed to adverse experiences in childhood but are often overlooked or otherwise ignored. For example, additional research on interventions that use an ecological framework, culturally mediated models, resilience and coping mechanisms, trauma-focused therapy is needed.

Based on this study, there seems to be an interest in research in Australian cities, American cities, or other areas of the world that have experienced wars or extreme disasters. There are some studies in South Africa, but other areas of Africa are not really mentioned. There also does not seem to be much research on South American or European countries. I am not sure the reasons for this lack of research in these areas, but to be as culturally competent as possible I think it is necessary for the populations in these countries to be explored as well.

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Table 1. *List of Exact Search Terms Used in PsycINFO search*

if(multicultural OR culture OR multiculturalism OR diversity OR cultural OR social justice OR cross-cultural OR oppression OR privilege OR privileged OR discrimination OR prejudice OR diverse OR ability OR disability OR age OR ethnicity OR gender OR gender identity OR nationality OR race OR religion OR spirituality OR sex OR sexual orientation OR social class OR socioeconomic status)	if(white OR black OR African American OR American Indian OR Alaskan native OR Asian OR Asian American OR native Hawaiian OR pacific islander OR Arab OR Arab American OR Hispanic OR Latino OR Latina OR lesbian OR gay OR bisexual OR transgender OR queer OR homosexual OR heterosexual OR LGB OR LGBT OR working poor OR working class OR middle class OR disability OR able-bodied OR deaf OR blind OR disabled OR women OR men OR Jewish OR Muslim OR Moslem OR Christian OR Buddhist OR native American OR catholic OR holy OR international OR adolescents OR children)	if(childhood trauma OR child trauma OR child traumatic events OR childhood traumatic events OR child trauma exposure OR childhood trauma exposure OR trauma in children OR trauma exposed children OR children and trauma OR trauma history OR trauma during childhood OR early trauma exposure OR adverse childhood experiences OR ACE)

Figure 1. *Dendrogram from Cluster Analysis*

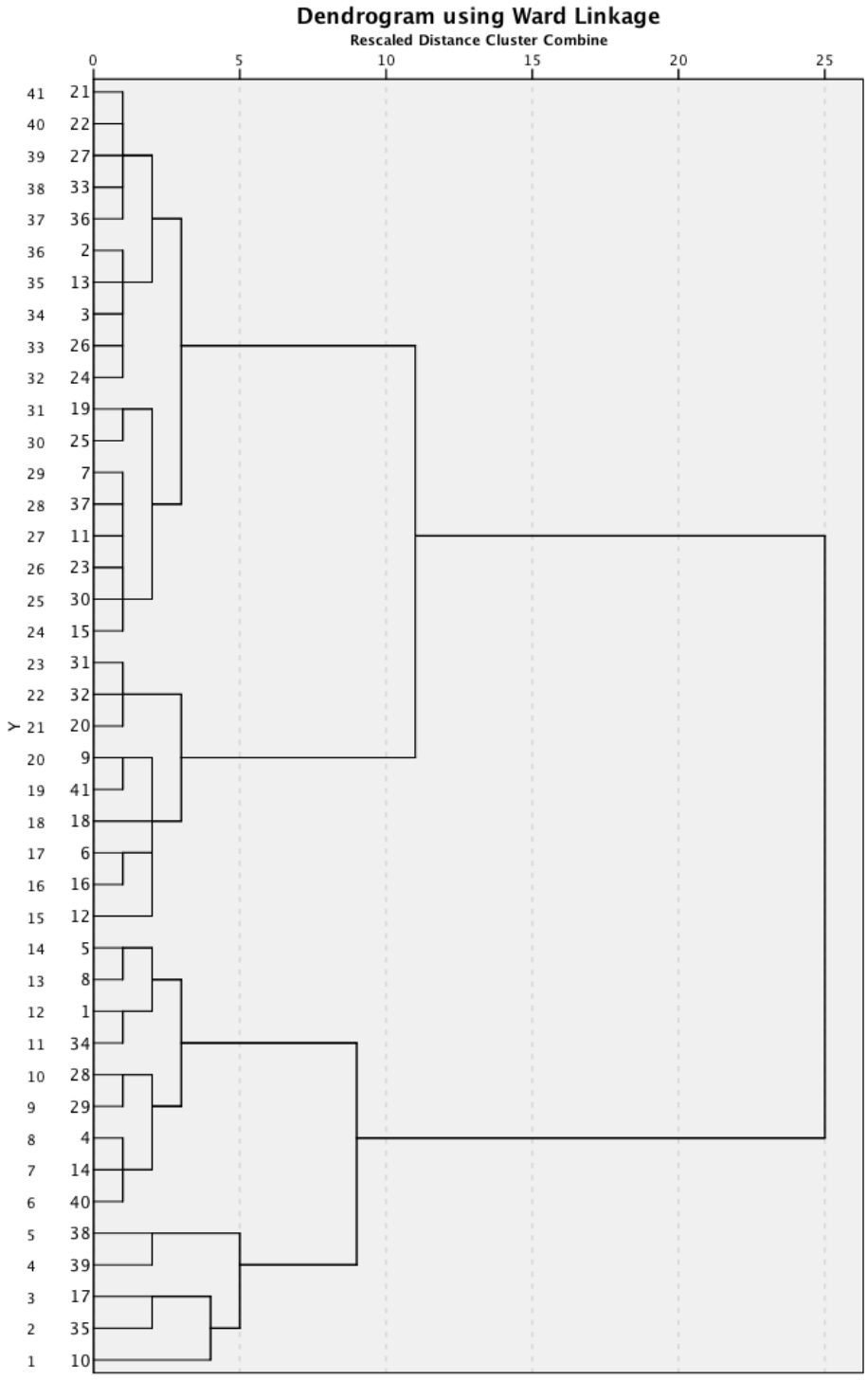

Figure 2. *Visual Representation of Main Clusters and Sub-Clusters*