

Editor’s Note: For the interested reader, an outline of the structure of the case study of “Bashiir” and of “Jaquann” is shown in Appendix 1.

Addressing Child Maltreatment by Infusing Multicultural, Feminist Tenets to Standard Clinical Approaches: The Cases of “Bashiir” and “Jaquann”

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ABSTRACT

Multicultural psychology emphasizes the role of social, cultural, and gender forces in creating an individual’s identity; the social and cultural world in which they live; and the psychological strengths that different cultures have to offer. In a complementary way, feminist psychology highlights the importance of collectivist alternatives to mainstream, individualistic thinking in the U.S.; and the identification and dismantling of patriarchal power structures that oppress women. Combining these two in a multicultural, feminist approach to psychotherapy highlights the importance of relating to clients with an understanding of, sensitivity to, respect for, and responsiveness to their cultural identities and life situations. This also involves the therapist building on strengths that come from some cultures bringing a collectivist rather than an individualist orientation to life’s challenges, such as combating child maltreatment.

To illustrate the potential of a multicultural, feminist approach to psychotherapy in cases of child maltreatment among minority individuals, the present article offers two highly successful case studies. The first involves “Bashiir,” a 16-year-old African, first-generation immigrant young man from Somalia; and the second involves “Jaquaan,” a 15-year-old African American young man. Both clients were referred to therapy because of poor school attendance and academic difficulties, and associated symptoms consistent with a Post-Traumatic Stress Disorder (PTSD) diagnosis. These symptoms derived from the clients having lived in poor, dangerous, high crime communities. A crucial component in both cases was the process by which the therapist employed the multicultural feminist approach to cross age, racial, gender, and

socioeconomic-class lines to establish a very strong, trusting relationship between the therapist and the client; and between the therapist and the clients’ families.

Key words: multicultural psychology; feminist psychology; child maltreatment; African clients; African-American clients; adolescents; Post-Traumatic Stress Disorder (PTSD); depression; case study; clinical case study

1. CASE CONTEXT AND METHOD

We three authors of these case studies of “Bashiir” and “Jaquann” first came together to write a book, *Preventing Child Maltreatment in the U.S.: Multicultural Considerations* (Fuentes, Singer, & DeBoard-Lucas, 2022). The book serves as an overview of a collection including three other books, addressing the prevention of child maltreatment in the U.S. from the Latinx perspective (Calzada, Faulkner, LaBrenz, & Fuentes, 2022); from the Black community perspective (Phillips, Moore-Lobban, & Fuentes, 2022); and from the American Indian and Alaska Native perspective (Ross, Green, & Fuentest, 2022).

The cases of Bashiir and Jaquaan, seen in therapy by author Singer and author DeBoard-Lucas, respectively, were briefly mentioned in our earlier book. To provide the reader a context for our approach and work, below are descriptions of our backgrounds, with an emphasis upon the development of our interests, knowledge, and skills in multicultural and feminist approaches to therapeutically working with children and their families where child maltreatment is an issue.

Rachel Singer

I trained as a Counseling Psychologist at Boston College in the Lynch School of Education, which is steeped in a rich tradition of training psychologists in research, scholarship, and clinical work. Our program interwove tenets of social justice, multicultural understanding and competence, and feminist ideology into (nearly) every class. While I didn’t come across the pivotal work by Kimberlé Crenshaw (1989) until years after my graduation from my doctoral program, the concept of intersecting identities became very familiar to me. When conceptualizing cases, our faculty members encouraged us to anchor discussion with a description of our clients’ identities using Pamela Hayes (2001) “ADDRESSING” model, which is an acronym for Age, developmental Disabilities, acquired Disabilities, Religion, Ethnicity, Sexual orientation, Socioeconomic status, Indigenous group membership, Nationality, and Gender. Many of my professors, mentors, and advisors oriented towards feminist relational methods of sharing power with clients and research participants to reduce hierarchical divisions, as well as recognizing the impact of systemic oppression to limit pathologization.

In order to fund my degree program, my classmates and I served on research teams. I followed the funding and moved to a different research team each year. While the topics varied

(e.g., explorations of masculinity and the impact on healthcare seeking; examining the effect of poverty on intimate partner violence survivors; and understanding the experiences of first-generation immigrants seeking mental healthcare), the underlying message was the same—identity impacts experience. That is, we are all steeped in a culture of individual identity, community connections, and larger systemic issues that either bolster or hinder our own well-being.

My background in qualitative research also highlighted the concepts of reflexivity (the importance of internal introspection; Morrow, 2005) and phenomenology (the subjective lived experience of an individual is central to understanding their perspective; Finlay, 2009). My dissertation focused on the subjective experiences of White clinicians working with racial minority immigrant clients. This research highlighted challenges and gaps in clinical experiences that contributed to rifts in the therapeutic alliance, and furthered my interest in clinical training with this population.

My clinical training included practicum placements in schools, therapeutic summer camps for individuals on the Autism spectrum, and in a community mental health setting working with many first generation and undocumented individuals. My year-long internship was in a community mental healthcare setting in Santa Monica working with children and their families, many of whom included undocumented immigrants from Mexico. This work in particular focused on treating a population with a high degree of trauma related to pre- during- and post-migration experiences. After graduating from Boston College, I trained for two years in a Postdoctoral Fellowship in Baltimore at Kennedy Krieger Institute. Many of my clients experienced high levels of poverty and exposure to neighborhood and community violence. In this Fellowship, my training included a specialization in Functional Family Therapy.

After completing this 2-year fellowship, I worked as a core faculty member in a Clinical Psy.D. department, practiced in an outpatient setting, and later launched a Postdoctoral Training Program. Currently I serve as a Clinical Director of an outpatient practice, offering individual, family, and group therapy (<https://www.resnikpsychology.com/>). Additionally, I am a part-time faculty member at the University of Maryland in their Psychology Department. My current role also includes conducting asylum evaluations with a specialization on evaluations for individuals who have been tortured as a result of their identity and whose safety would be threatened if returned to their country of origin. I have co-authored book chapters focusing on ethical interventions for immigrant clients, as well as a book on multicultural orientations to child maltreatment with my co-authors on this current article. I received the American Psychological Association’s Citizen Psychologist award for my professional work and outreach with immigrant and asylee populations.

My supervision experience has included a range of theoretical orientations, but generally has included a strong emphasis on using evidence-based interventions of cognitive behavioral therapy, family systems interventions, feminist relational methods (drawing heavily on Miller & Stiver’s [1997] approach to treatment). I have been encouraged to recognize aspects of cultural borderlands—noticing how my own identity, cultural expectations, biases, and concept of healthy functioning impacts my analysis of my client’s symptomatology. Many of my supervisors at my clinical placements shared one aspect of my identity—we were often White clinicians working with racial minority immigrant clients. This prompted curiosity, concern, and ultimately led me to focus my dissertation on that specific dyadic connection (Singer & Tummala-Narra, 2013).

Renee DeBoard-Lucas

I am a clinical psychologist, with expertise in assessing and treating trauma and anxiety. Although I work with clients across the age span, I especially love working with children and teens. There is so much room for therapy to have a positive impact at this age by addressing issues of self-blame, enhancing a feeling of confidence and bravery in talking about hard topics they never thought they could talk about, and contributing to a collection of coping skills that can help in the short term and over time. Jaquann, who you will read about in detail below, is a teen who benefited so much from trauma therapy and will always stick with me as an example of what can happen when all children, regardless of resources, have access to evidence-based trauma care.

My graduate training occurred at Marquette University. There, I received training in clinical psychology, with a concentration in working with children and adolescents. An interest in trauma and resilience stemmed from volunteer experiences I had prior to graduate school and a passion for this work grew from my clinical and research experiences at Marquette. My program included coursework and clinical training that focused on evidence-based treatments for a variety of mental health concerns. I saw children, college students, adults, and families at the university-based clinic and participated in training in the ADHD Clinic for approximately two years. I was fortunate to gain clinical training experiences in a variety of clinical settings. I completed a two-year externship at the Medical College of Wisconsin, where I trained in the behavioral health clinic and on multi-disciplinary teams in several medical clinics, including those focused on diabetes, urology and constipation, and feeding concerns. The training in these clinics occurred in both outpatient and inpatient settings and it was in the outpatient behavioral health clinic that I was first trained in Trauma-Focused Cognitive-Behavioral Therapy.

My master’s thesis and doctoral dissertation both focused on children’s experiences with, and responses to, intimate partner violence. I graduated from Marquette University in 2011 after completing a one-year clinical internship at the University of Rochester Medical Center

(URMC). At URMC, I continued my focus on children and adolescents and saw families impacted by trauma on an outpatient and inpatient basis. I was also trained in conducting behavioral health interventions in a Primary Care setting.

After completing my Ph.D. in Clinical Psychology, I participated in a two-year postdoctoral fellowship at Johns Hopkins Hospital. There I worked in inpatient, day hospital, and outpatient settings and saw children from a wide variety of circumstances. I completed rotations in the outpatient Obsessive-Compulsive Disorder Clinic and continue to enjoy treating youth and adults diagnosed with OCD. An experience that further fueled my interest in trauma was my time in the Trauma and Burn Clinic, which had both inpatient and outpatient components.

After completing my post-doctoral fellowship, I worked as a staff psychologist at Johns Hopkins Hospital before transitioning to private practice and later nonprofit work. During my time in private practice, I also sought training in immigration-related evaluations and completed pro bono evaluations with individuals to take to court to support their cases in seeking asylum, refugee, or another status.

In the past three years, I became a co-founder and now Executive Director of the Trauma, Resilience, Understanding, and Education (TRUE) Center, which has a mission to increase access to trauma-focused, evidence-based care and prevention services for Washington DC-area children and families (<https://www.truetraumacenter.org/about>).

Milton Fuentes

As a light-skin, Puerto Rican male, who experienced a fair amount a discrimination from my peers as I was growing up, I have always had a deep appreciation for how larger cultural and macro forces shape and inform one's identity and wellbeing. I recall as a clinician in a local mental health center thinking how despite my best efforts, my interventions with my clients were not going to address structural concerns, such as inept care, implicit bias, discrimination, and faulty social policies. To help address these larger structural concerns, I pursued training that would aptly equip me to address them. First, I received an MA in psychology with a Latinx clinical psychology focus from Montclair State University. I then earned a doctorate in clinical psychology with a community psychology concentration from the Graduate School of Applied and Professional Psychology at Rutgers University, which involved a pre-doctoral fellowship in clinical and community psychology at Yale University. Both of these graduate programs focused their training on underserved populations. I later secured post-doctoral training in epidemiology at Columbia University, where I oversaw a study that assessed the identification and management of clinical disorders in a primary care setting located in Washington Heights, New York.

In 1999, I pursued licensure in New Jersey and New York and joined the faculty in the psychology department at Montclair State University, where I am currently a professor and the associate chair. At Montclair, I established the Clinical and Community Studies laboratory, where I research topics related to diversity science, including equity, diversity, and inclusion. From 1999 through 2016, I worked with the Puerto Rican Family Institute as a consulting psychologist, focusing on families that were either at risk for or engaging in child maltreatment.

In 2001, I was selected to get trained in APA's *ACT Raising Safe Kids* program, an international parenting program that focuses on early violence prevention by focusing on parents and caregivers, teaching positive parenting skills and practices that help create stable, safe, healthy, nurturing environments and relationships (<https://www.apa.org/act/>).

In 2005, I co-developed the Latinx version of the ACT program with Dr. Elisa Velasquez, and in the height of the pandemic, when there were concerns about increasing child maltreatment, I led efforts to transition the program by co-creating a remote implementation manual with the ACT advisory Council members. Over the past decade, ACT has transcended its domestic boundaries and established an international presence. In addition to training professionals across the United States, I introduced the ACT Program to China, Guatemala, Mexico and Romania. I also served on the ACT Program's National Advisory Council and have offered several workshops at their Annual Leadership Conferences.

In 2010, guided by the principles of motivational interviewing, I partnered with the former Office of Violence Prevention at the American Psychological Association and developed *The Motivational Interviewing Companion Guide for the ACT Raising Safe Kids Program* (formerly known as the ACT/Parents Raising Safe Kids Program). This training manual, which has been translated into multiple languages, accompanies the facilitator kit, and is used by hundreds of facilitators across the world to assist with engagement and promote optimal parenting that is guided by the parent's values and goals. The ACT Program has undergone extensive evaluation and has received recognition from the Centers for Disease Control and Prevention, the World Health Organization, U.S. Department of Justice, and the U.S. Head Start Office (<https://www.apa.org/act/>).

Given my community psychology mindset, I thought it was important to serve at the national level to help shape policies and best practices for minoritized communities. In 2012, I served as the President of the National Latinx Psychological Association and under my leadership, we launched the APA-published *Journal of Latinx Psychology*. In 2014, I was appointed by APA's Board for the Advancement of Psychology in the Public Interest (BAPPI) to serve a 3-year term on the Committee of Ethnic Minority Affairs (CEMA); and in 2018, I was appointed by APA's Council of Representatives to serve on the Board for the Advancement of Psychology in the Public Interest (BAPPI). Through this appointment, I vetted and helped

promote APA’s *Resolution on Physical Discipline of Children By Parents* (APA, 2019). This resolution calls for attitudinal changes and positive parenting skills to curb the legal striking of children and has been accepted as official APA policy. Through this resolution APA joins other prominent associations, such as the American Academy of Child and Adolescent Psychiatry, the American Medical Association, the American Professional Society on the Abuse of Children, and the U.S. Centers for Disease Control, in ending the physical discipline of children.

While serving on APA’s BAPPI, I also was the delegate of the National Latinx Psychological Association to APA’s Council of Representatives. Within this role, I co-chaired the Council Diversity Work Group (CDWG), whose charge was to promote the greater inclusion of diversity issues and the promotion of psychological health for racial and ethnic minority communities within the business of the APA Council of Representatives. Within this role, I worked with the APA’s Equity, Diversity and Inclusion Collaborative, which were the lead architects of APA’s (2021e) EDI Framework (<https://www.apa.org/about/apa/equity-diversity-inclusion/framework>), in collaboration with APA’s Chief Diversity Officer. Lastly, I also function as a consultant to academic campuses, community-based agencies, and corporate clients, helping them center equity, diversity, and inclusion in their mission and strategic planning efforts.

2. THE CLIENTS

It is with great humility and respect that we introduce our clients, Bashiir and Jacquann. We are grateful for the opportunity to have worked with them and for the many lessons they taught us as we embarked on a multicultural, feminist journey with them. Out of respect to them and in accordance with our ethical code (Standard 4.07), we have modified, amended, or commingled with similar cases in order to protect their identity (APA, 2017).

Bashiir

Bashiir was a 16-year-old, African male, who was a first-generation immigrant from Somalia. He was enrolled in a public school near his home outside of a major metropolitan city on the East Coast of the United States. He lived in a 2-bedroom apartment with his mother, father, and siblings, aged 1, 3, 4, 7, 11, and 14 years old. His parents had been married for 18 years. Bashiir’s parents applied for asylum status in the United States and were awaiting more information regarding next steps.

At the time of his initial intake and treatment, Bashiir had been referred for therapy by his guidance counselor at school due to concerns regarding what was described as “truancy” (e.g., frequent unexcused absences from school) and subsequent academic struggles. Bashiir also reported a number of symptoms, like pains in his head and vivid nightmares about being back in

a refugee camp, which was consistent with an ICD-10 diagnosis of Post-Traumatic Stress Disorder (F43.10).

Jaquann

Jaquann was a 15-year-old African-American male who lived with his mother and two younger siblings in a major city on the East Coast of the United States. He was a high school student at a public school. He was a low performing student who had encountered school attendance difficulties related to symptoms stemming from early childhood traumatic experiences. He had received psychoeducational testing in school that indicated an IQ in the 70s. Jaquann and his family lived in government subsidized housing in the city. His mother had recently returned to work following a period of unemployment.

Jaquann was close with his father, who was currently detained for a charge of carrying an unregistered firearm.

Jaquann's treatment was mandated, as part of his involvement in the juvenile justice system. In addition, he reported a recent traumatic experience, in which he witnessed the shooting death of a close family friend that was the same age as he was.

At the time of intake, his symptoms met criteria for an ICD-10 diagnosis of Post-Traumatic Stress Disorder (F43.10).

3. GUIDING CONCEPTION WITH RESEARCH AND CLINICAL EXPERIENCE SUPPORT

The cases of the Black teenagers, Bashiir and Jaquann, presented below, both involve cases of purported child maltreatment. In our therapy with them and their families, we used a multicultural, feminist, public-health-oriented approach, considering the micro, meso, exo, and macro forces that shape this challenging and pressing social concern. Below, as conceptual context for the case studies, we first describe laws that define child maltreatment, and then present out multicultural, feminist approach to conducting therapy with such cases.

Defining Child Maltreatment

The Federal law defines child maltreatment as "any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation"; or "an act or failure to act which presents an imminent risk of serious harm" (Child Welfare Information Gateway, 2022). It includes both child abuse and neglect, involving acts of commission (e.g., abuse) and acts of omission (e.g., neglect; Child Welfare Information Gateway, 2022).

Examples of child maltreatment include, physical abuse, sexual abuse, emotional abuse, medical neglect, parental substance abuse and human trafficking (Child Welfare Information

Gateway, 2022). While an extensive discussion of the long-term consequences of child maltreatment are beyond the scope of this paper, scholars have extensively documented its pernicious effects on physical, social, cognitive and psychological health (National Scientific Council on the Developing Child, 2020).

Our Multicultural, Feminist Theoretical Approach to Therapy

While traditional trauma-based treatments (see below) were employed in the cases of Bashiir and Jaquann, our primary guiding approach was informed considerably by multicultural and feminist psychological lenses.

Multicultural Psychology

Multicultural psychology can be seen as having its roots in the social and political countercultural movements of the 1960s, with the associated development in philosophy of postmodernism (Fishman, 1999). However, it was not until 1986 that multicultural psychology was officially recognized by the American Psychological Association (APA) through the creation of the Society for the Psychological Study of Ethnic Minority Issues (Division 45). This approach has long held that psychological identity and functioning is informed by numerous cultural factors, such as race, ethnicity and class and their intersecting properties (i.e., intersectionality (APA, 2017b). Regretfully, the mainstream in the discipline of psychology has a long and problematic history of minimizing or dismissing racial and ethnic differences, centering White, Eurocentric norms, and ignoring intersectionality (APA, 2021a), leading to two major apologies to People of Color (APA, 2021) and Indigenous Communities (APA, 2023) for psychology’s role in promoting and maintaining oppression.

Many have argued for the distinctive importance of recognizing multicultural factors. For example, Pederson (1990) viewed the multicultural perspective had emerged as “fourth force” in mental health counselling arenas, following psychodynamic, behavioral, and humanistic frameworks. Over the past few years, Equity, Diversity and Inclusion (EDI) have garnered considerable attention. For example, three influential APA resolutions have offered a more coherent definition of racism (APA, 2021b); underscored the role of psychology in addressing oppression (APA, 2021d); and promoted health equity (APA, 2021e). All of these resolutions have informed an EDI framework that guides endeavors across the American Psychological Association, the field of psychology, and society (APA, 2021f).

Moreover, to help guide and center multicultural issues in psychology, APA released the first set of multicultural guidelines, promoting a culture-centered stance that advised psychologists to recognize the prominent role of culture in all their endeavors—training, research, and practice (APA, 2003). The second iteration of the guidelines adopted an ecological lens across five interrelated levels. The levels include the Bidirectional Model of Self-Definition

and Relationships (Level 1); Community, School, and Family Contexts (Level 2); Institutional Impact on Engagement (Level 3); Domestic and International Climates (Level 4); and Outcomes (Level 5). Notably, the guidelines draw more attention to identity, context, and intersectionality across all relevant parties in practice, research, and consultation (APA, 2018). Additionally, the guidelines highlight three dynamic processes—power and privilege, tensions, and fluidity—that permeate all five levels to assist practitioners in addressing trauma and increasing resilience.

On the clinical front, through these guidelines, psychologists are urged to consider several key cultural constructs such as racial-ethnic identity socialization; acculturation; critical consciousness; and intersectionality in their assessment and treatment of clients. To help guide these efforts, LaRoche and Maxie (2003) provided ten considerations for guiding cultural conversations in the clinical process between the client and the therapist—for example, recognizing the dynamic nature of identity; addressing client-therapist similarities and differences; assessing the relevance of culture as it relates to the presenting problem(s) and treatment approach; prioritizing client strengths; and considering larger socio-political developments in treatment.

Feminist Psychology

The same countercultural and postmodern forces in the 1960’s that led to the development of multicultural psychology also led to the development of feminist psychology. This approach raises significant and legitimate concerns around how traditional psychology conceptualized, characterized, ignored, or addressed the concerns of women (Enns et al., 2012), such as sexism and sexual violence. A major tenet of this framework involves identifying and dismantling patriarchal structures that oppress women (hooks, 2015). Several scholars observed that the prevailing frameworks were not attentive to the unique needs of women of color, ignoring, for example, the intersecting roles of race and class.

These important observations led to the creation of several feminist frameworks that acknowledged these important factors in the Black community (e.g., Womanism; Bryant-Davis & Comas-Díaz, 2016); the Latine community (e.g., Mujerismo; Bryant-Davis & Comas-Díaz, 2016); and the Indigenous community (Deer, 2019; Gearon, 2021). Rather than centering White, Eurocentric norms that emphasize the individual, these frameworks tend to embrace a more collectivistic stance that honors the multiplicative and dynamic nature of identity, while recognizing ancestry, strengths, liberation and transformation.

“Multicultural, Feminist Psychology”

While multicultural psychology and feminist psychology evolved independently, some scholars (Goodman et al., 2004; Enns et al., 2012; French et al, 2020) recognized points of

intersection, leading to “Multicultural, Feminist Psychology.” Specifically, Goodman et al. (2004) extracted six principles shared by these models that center social justice. They include (a) continuous self-examination; (b) sharing power with clients; (c) elevating voices; (d) raising consciousness; (e) fostering strengths; and (f) ensuring clients have optimal tools when they end treatment.

Enns et al. (2012) examined feminist multicultural perspectives in counseling psychology. Considering 40 years of “herstory”, these scholars captured the evolution of key concepts related to sex, gender, sexuality, and intersectionality; power, oppression and privilege; and modern forms of bias and discrimination. Borrowing from these insights, Courtois (2012) offered a treatment approach for counseling traumatized individuals, which includes a pre-treatment assessment process and three main treatment phases. This approach helps address developmental arrests that may have occurred because of the trauma, while prioritizing safety, emotion regulation, and trust. Honoring the cyclical nature of treatment, each phase ensures necessary grounding, cognitive reframing, optimal reintegration, and relevant skill development.

Social Justice

Social justice is a concept that connects with and underlies both multicultural and feminist perspectives. Recently, French et al. (2020) proposed a clinical model grounded in social justice that promotes radical healing with People of Color and Indigenous (POCI) individuals and facilitates transformative collective healing. Borrowing from several major frameworks, including liberation, Black and ethno-political psychologies as well as intersectionality theory, these scholars identified five anchors that foster these efforts, including (a) collectivism; (b) critical consciousness; (c) radical hope; (d) strength and resistance; and (e) cultural authenticity and self-knowledge. Notably, these authors suggested focusing on resistance and strengths over resiliency per se, as the latter focuses on “individual-level processes and thus does not promote transformative collective healing” (p. 27). In line with this, they proposed highlighting strength and resistance “as a part of radical healing to reflect POCI’s commitment to living joy-filled lives despite a critical awareness of racial trauma and oppression” (p. 27).

Application to Child Maltreatment

Borrowing from the multicultural and feminist psychology movements, Fuentes et al. (2022) and others (Calzada et al.; Philips et al., 2022; Ross et al., 2022) explored how these two approaches could be used to understand and address child maltreatment. Specifically, they urged practitioners to expand their critical consciousness as well as the consciousness of the communities they serve. They also advised clinicians to adopt culturally-congruent and strengths-based assessment and treatment processes. Additionally, recognizing that there are oppressive structural forces that inform child maltreatment, they recommended that professionals

as well as clients engage in advocacy efforts that extend beyond micro settings. For example, bearing in mind that children are still the only class of people, adults can legally strike, they encouraged the abolishment of physical punishment both in homes and in schools. Also, they challenged immigration policies that further traumatize children by separating them from their parents.

4-8. INTRODUCTION TO THE CASE STUDIES

In the next ten sections, we illustrate how the principles of the multicultural feminist psychological approach, described above in the Guiding Conception section, informed our treatments with two of our clients: “Bashiir,” for whom author Rachel Singer was his therapist and the author of his case study; and “Jaquann,” for whom author Renee DeBoard-Lucas was his therapist and the author of his case study.

Note that the next ten sections are numbered 4A-8A and 4B-8B, to indicate their parallel to sections 4-8 of a typical pragmatic case study (Fishman, 2013)—specifically: (4) Assessment of the Client's Problems, Goals, Strengths, and History; (5) Formulation and Treatment Plan; (6) Course of Therapy; (7) Therapy Monitoring and Use of Feedback; and (8) Concluding Evaluation of the Therapy Process and Outcome. Sections 4A-8A describe Bashiir’s therapy; and Chapters 4B-8B describe Jaquan’s therapy.

Section 9 presents a comparison of the two cases and a discussion.

4A. BASHIIR’S ASSESSMENT: PRESENTING PROBLEMS, GOALS, STRENGTHS, AND HISTORY

Presenting Problems

Bashiir was referred for therapy by his guidance counselor at school due to concerns regarding what was described as “truancy” (i.e., frequent unexcused absences from school) and subsequent academic struggles. His teachers described him as very quiet, but polite and respectful of authority. They indicated that when he did show up to class, he sat in the front row and was generally very quiet during class. He would respond to questions from his teachers but did not voluntarily participate without being called upon.

Bashiir’s guidance counselor indicated that he had been getting teased by some of his peers for his outfits (fitted white, button-up-collared shirts and slacks whereas most of his classmates were wearing low-rider jeans, bulky tee-shirts, and sweatshirts). Bashiir’s teachers noted that he generally appeared fatigued in class. In an initial phone call, which I made as Bashiir’s assigned therapist with the school’s guidance counselor prior to initiating treatment, the counselor reported that she was considering calling Child Protective Services due to concerns regarding potential neglect by Bashir’s family.

The counselor stated that when she had asked Bashiir about his frequent absences, he indicated that he was required to stay home to take care of his younger siblings when his parents were working. During the daytime, his older siblings (7, 11, and 14) attended school while his younger siblings (1, 3, and 4) remained at home. Bashiir's counselor also stated that he never seemed to have food to eat at school and would not opt to purchase lunch in the cafeteria. She indicated concerns that he was not being fed sufficiently at home. Frequent calls from the counselor to Bashiir's parents went unanswered. The counselor indicated that Bashiir's father appeared more fluent in English than his mother, who primarily spoke Somali, the primary language spoken at home by the family.

Family History

Bashiir's family emigrated to the United States approximately 8 months before he started therapy. His family initially left Somalia due to instability, armed conflict related to the Somali civil war, and limited employment. Prior to their arrival in the U.S., Bashiir's family had been living for two years in various refugee camps in Kenya.

During their time in Kenya, Bashiir's family faced significant hardships related to severe food shortages, unstable housing, exposure to violence, as well as sexual harassment of Bashiir's mother and sisters by others in the refugee camp. Bashiir witnessed multiple others in the refugee camps die of starvation or illness. His mother would often forego eating a meal during this time in order to ensure adequate nutrition for Bashiir and his siblings.

At the time of treatment, Bashiir's father, Mr. "Abdi," worked in a restaurant as a dishwasher and also took various jobs in construction. His mother, Mrs. "Abdi," worked in multiple jobs as a house cleaner. Both Mr. and Mrs. Abdi's jobs involved extensive and unpredictable hours.

Social Context

Bashiir's family resided in a neighborhood that had a small population of Somali immigrants, which was why his parents chose to move to this particular community. Bashiir attended a local public high school in which many of his classmates were first generation immigrants. Many peers came from families who were seeking asylum in the United States. Bashiir noted that there was a significant Somali community both in his neighborhood, but also in his school. However, he reported that there were often tensions between classmates who were born in Somalia and peers who were born in the United States. In several clashes with peers, Bashiir stated that he and his other first-generation immigrant peers from Somalia were told they were "too foreign," and that they should "go back home" to their country of origin. Classmates would make fun of his accent or tell him to speak English any time he tried to speak Somali to his Somalian classmates.

Bashiir indicated that on his walk to school, he had witnessed frequent incidents of neighborhood and community violence. He also noted several recent incidents at his school of classmates committing suicide through intentional overdose; and in one incident, by stepping in front of a moving train.

Diagnostic Presentation

Bashiir reported frequent somatic complaints related to pains in his head, which he described "like a drum beating hard." He indicated difficulty falling asleep at night, and often waking up with very vivid nightmares about being back in a refugee camp. These dreams often included a mixture of events that had already occurred combined with some fears that had not happened (e.g., a sibling dying in the refugee camp). As a result, Bashiir would often wake up multiple times per night, would try to avoid falling asleep, and would then feel extremely fatigued during the daytime.

At times during the day, Bashiir would start to feel dizzy or light-headed to the degree that he would need to put his head down in class or sit down during physical education. Bashiir would often forget to have meals and tell his family members that he was not hungry during meals. His parents indicated that he would always try to serve other family members first at meals and would say "I'm not hungry" or would wait to eat until everyone else had taken first or second helpings of food.

Bashiir reported that there would be times he would feel as though he were "there but not there" in that his body would be physically present but his mind would be somewhere else. During these moments of disconnection, he would sometimes experience what he called an "awake nightmare" in which he felt that he was back in Somalia or in a refugee camp.

While he disliked talking about his time in the refugee camp, when he did share details, he often reported feeling guilty that he had been able to leave the camp to migrate to the United States while some of his peers had not had that opportunity. Loud noises in his classroom (e.g., peers dropping books on the floor) and big group gatherings (e.g., assemblies) would often make Bashiir jump. He would either leave the classroom abruptly or stay in the bathroom for extended periods of time after these incidents. These symptoms resulted in marked interruption in his academic functioning, including Bashiir failing most of his classes despite reports from his teachers that he seems "very bright."

Bashiir's symptoms indicated a wide range of traumatic symptoms. In his experiences in Somalia and subsequently living in a refugee camp, Bashiir was exposed to *actual or threatened death*. Intrusive symptoms manifested through *recurrent distressing dreams* and *flashbacks* in which he felt that he was back in the moment. He also exhibited *persistent avoidance* of

discussing his past experiences in trying not to remember what happened to him. Bashiir’s symptoms also included feelings of guilt, and an *exaggerated startle response*.

Notably, symptoms of PTSD may also manifest more as somatic symptoms. The “HADStress” Scale, pioneered with Somali immigrants, is screening tool of four somatic complaints that have been inked to posttraumatic stress symptoms (Westermeyer et al., 2010). These symptoms include: Headaches, Appetite Change, Dizziness and Faintness, and Sleep Problems). Indeed, mental health diagnoses may manifest differently in different cultural groups with somatic symptoms sometimes arising as a primary indicator of distress (Ghumman et al., 2016; Nicolas et al., 2007).

Bashiir’s Strengths

As noted above, while he struggled across many academic courses, Bashiir’s teachers generally described him as motivated and a fast learner. Despite his frequent absences, he did turn in assignments when he was present. His teachers indicated that he was polite and respectful towards them in all interactions. Bashiir frequently discussed care and concern about his family members, indicating a strong sense of belonging and obligation. He appeared to make connections with peers, particularly those with whom he shared a cultural or linguistic background. Bashiir’s parents described him as very dependable and motivated to help them at home.

5A. BASHIIR’S FORMULATION AND TREATMENT PLAN

Formulation

Bashiir and his family were dealing with multiple overlapping crises. Bashiir was not able to fully access and engage in his education due to internal symptoms and external barriers. Due to the work schedules of his parents, he was expected to provide childcare to his younger siblings who were not old enough to be in school. Bashiir felt a sense of obligation to support his parents, and perhaps was parentified due to his age. Parentification is common among children of immigrants and can have a profound impact on family dynamics (Singer & Fuentes, 2018; Titzman, 2012). Bashiir’s own symptoms also impeded his ability to be fully present in the classroom. His profound symptoms related to the many traumas he had experienced and led to flashbacks, dissociative symptoms, changes in his appetite, and fatigue.

Using a traditional approach to treating trauma, the clinician might start with a goal of reducing internal symptoms of arousal, avoidance, and alterations in mood. Evidence-based interventions normed for diverse populations might include Trauma-Focused-CBT (National Child Traumatic Stress Network, 2012). However, attempting to address the individual symptoms may have been a miscalculation in this instance. Bashiir might have been unable to

address his own symptoms until the systemic supports were added that would have allowed him first, to attend and participate in school; and second, to fully engage in the therapeutic process.

Bashiir's sense of obligation to his family stemmed from a learned need to protect them. As one of the older males in his family, he had lived experiences of having to protect his mother and siblings in the refugee camp. Additionally, Bashiir had observed the model from his parents of forgoing food to feed young siblings. This behavior exemplified a selflessness of putting family needs ahead of individual ones. Indeed, after migrating to a new host country, Somali families are likely to bring cultural patterns from the old country of interdependence and to model expectations for children to contribute to the family system (Osman et al., 2021).

As Bashiir's school counselor's statements indicated, it might have been tempting to view Bashiir's parents from a lens of child maltreatment and label their expectations of Bashiir as neglect. It is within the scope of clinical practice to identify external needs not being met by clients. Indeed, Bashiir's child-caring responsibilities led to an inability to access school. His limited food intake at school might also have been seen as neglectful if his parents had access to food but were preventing him from consuming it. However, as the above-mentioned HADS Scale indicates, change in appetite may be one of the central signs of a traumatic response (Westermeyer et al., 2010). Rather than viewing Bashiir's symptomatic presentation through one lens, an outlook that dovetails systemic and multicultural approaches served as a more comprehensive and relevant foundation for treatment.

A Systemic Approach

Systemic theory posits that individuals exist within multiple overlapping systems: 1) *microsystems*, involving interactions between an individual and others; 2) *mesosystems*, involving interactions between microsystems; 3) *exosystems*, involving indirect sources of influence; 4) *macrosystems*, involving larger cultural forces as well as external ones; and 5) *chronosystems*, involving systemic changes over time (Bronfenbrenner, 1977). This lens is a critical one when considering issues of children's well-being, as environmental factors can either contribute to or buffer against harmful effects of child maltreatment (Belsky, 1980).

In Bashiir's case, there were factors to consider regarding the interaction (or lack thereof) between his parents and his school. His guidance counselor may have perceived his parents' lack of response as additional signs of neglect rather than simply not being accessible during their complicated work hours. Both parents worked multiple jobs, may not have had easy access to a phone during standard "business hours," and may have also experienced language barriers that prevented direct communication with the school. Using a systemic lens allows for both identification of contextual barriers and a focus on resources. This proved to be an essential component in Bashiir's treatment as described below.

A Multicultural, Feminist Approach

Using a multicultural approach that integrates aspects of individual, family, and systemic identity allows for a more comprehensive approach for conceptualization and treatment. As a first-generation immigrant Bashiir experienced some fluctuations in identity related to his acculturation status. Many immigrants often experience a feeling of being "strung between cultures, strung between identities" (Singer & Tummala-Narra, 2013, p. 294). Individuals often feel pressured to assimilate within one generation of immigrating to the United States, abandoning aspects of their original culture (American Psychological Association, 2012). Part of the pressure to assimilate may come from external influences, such as reactions from peers or larger macro forces (e.g., White supremacy or political ideology).

Bashiir's teachers and counselor noted some challenges with Bashiir being teased for his Somali identity. He may perceive these microaggressions as attacks on his identity. In order to protect himself and avoid harassment from peers, immigrants like Bashiir might feel pressured to take on more behaviors, dress, and mannerisms of peers who are native to their host country.

When considering Bashiir's identity, it was essential to acknowledge potential interplay between his identities. This intersectionality may have accounted for some of his actions, expectations, and experiences. For example, Bashiir's role as one of the older males in his family may have thrust him into the role of caregiver, protector, or secondary parent. These roles may have evolved out of necessity. In this light, his absence from school can be better understood as an adaptive response to a problematic system (Jensen & Hoagwood, 1997).

Additional stressful factors in Bashiir's situation were his family's low income level and challenging immigration status, which limited the family's options for living situations, childcare support, and ability to choose a neighborhood that included relative physical safety.

Treatment Plan

Based on the above assessment and formulation of Bashiir's presentation, my initial goals for treatment included the following:

1. Increase attendance and engagement at school,
2. Reduce emotional dysregulation,
3. Identify resources to support the family system, and
4. Increase positive coping strategies in response to trauma symptoms

6A. BASHIIR'S COURSE OF THERAPY

Initial Session: Diagnostic Evaluation

The initial intake session took place in an outpatient office of a community mental health agency. As the therapist, I (Rachel Singer) received a summary of Bashiir's presenting concerns as reported by his counselor prior to the initial session. Bashiir attended the diagnostic evaluation with his mother and father. During the session, Bashiir's father answered most of the therapist's questions directed to parents in English, with a thick Somali accent. His mother occasionally asked a follow-up question in Somali that she directed to her husband to ask the therapist.

The family indicated that they did not wish to have an interpreter present, as Mr. Abdi and Bashiir were conversant in English. Bashiir appeared appropriately dressed, wearing a white button-down shirt and dark pants. He answered the therapists' questions with a quiet voice, making direct eye contact with each response. His manner appeared respectful towards the therapist, and deferential towards his parents. Mr. Abdi indicated that he and his wife, Mrs. Abdi, would be unlikely to be able to attend most of the follow-up sessions due to their work schedules. He gave permission for Bashiir to attend the sessions on his own.

Bashiir appeared somewhat reserved and deferential in the intake session. He would not volunteer any information unless a question was specifically directed at him and would often wait until his parents had answered a question in full before sharing his response. He spoke in a soft voice, though his words were audible. When answering a question, he would often pause, look up as though deep in thought, and then answer the question. He kept his hands interlaced in his lap during the session and appeared to be limiting his physical movements. Bashiir's answers to the therapist's questions were clear, direct, and often short phrases. Bashiir did appear somewhat fatigued in the session, and occasionally would rub his eyes with his fingertips.

Phase One of Treatment: Individual Therapy, Sessions 1-8

After the initial diagnostic evaluation, I started with individual therapy at the recommendation of my supervisors. This phase of treatment lasted for approximately 2 months of weekly sessions. Initial therapy sessions consisted of rapport building activities, e.g. traditional card games such as Uno and Jenga and drawing activities. The goals for the first few weeks of treatment included increasing rapport and assessing Bashiir's current level of symptomatology.

Bashiir appeared more comfortable responding to questions while engaged in a game and exhibited enjoyment of the activities. During these individual sessions, I sought to elicit information regarding level of symptomatology through open-ended check-ins. Bashiir shared information about his very distressing experiences, particularly when living in the refugee camps. He discussed a sense of obligation to protect his family members, and he reported that he

felt it necessary to follow his parents' precise rules and directions in order to stay safe. At times, Bashiir discussed feelings of sadness at the sacrifices his parents had made in order for the family to migrate to the United States.

Despite sharing some degree of the depth of his emotional distress, Bashiir did appear somewhat quiet during individual sessions. As the therapist I tapped into the multicultural, feminist tenet of on-going self-examination to identify potential gaps in my knowledge of Somali culture as well as potential challenges related to divergent identities between the therapist and the client (Goodman et al., 2004). Building on these challenges and in consultations with my supervision group and during individual supervision (see section 7A below for more on my supervision), it became clear that additional peer support through a group therapy format for Bashiir might extend the benefits of individual therapy. A primary goal was to build on multicultural tenets to help Bashiir explore intersecting aspects of his identity, to create a support network with peers who had similar backgrounds, and to provide opportunities for Bashiir to generalize his coping strategies across multiple contexts.

***Phase Two of Treatment: Group Therapy,
Group Sessions 1-8 start after Individual Session 4 (see above)***

Bashiir joined a therapy group for Somali male high school-aged clients at the outpatient practice. This group occurred simultaneously to individual therapy and began approximately one month into treatment. As the individual the therapist, I contacted the family to see whether they would be interested, and Bashiir's response was very positive. This therapy group met for approximately 2 months of consecutive weekly sessions. Group members consisted of five male teenage clients, who were all born in Somalia and who currently resided within the U.S. The group members attended the same high school, though were not all in the same grade. All sessions took place at the therapists' office. The therapy group was co-led by myself and a male social worker who was also a first generation immigrant from Somalia.

Bashiir's affect appeared very different in his group therapy sessions compared to his individual sessions. Whereas in individual therapy, Bashiir smiled only occasionally (e.g., when playing a preferred game), he frequently smiled in response to his fellow group members' jokes. As most of the group members and one of the group leaders were fluent in Somali, they would often speak in Somali before switching back to English. Bashiir and his group members would often translate some of their conversation for me as the monolingual group leader. Creating these shared linguistic and cultural connections helped to normalize the experiences of Bashiir and his fellow group members, thus "giving voice" to their collective experiences of acculturation and identity (Goodman et al., 2004). 2020).

The format of the group consisted of an initial check-in (high point and low point in the week since the last group meeting) and follow up conversations about topics of each group

member’s choice. The group leaders facilitated conversation by asking group members to share ideas or advice for individuals who had reported specific stressors, such as strategies for managing interpersonal conflict, tools for managing symptomatology, and steps for navigating acculturative stress. Additional cross-conversation included questions from group leaders about shared experiences (e.g. “that reminds me of something that you had mentioned last week in group, Bashiir—does that sound familiar to you?”).

Following each group session, the group therapy leaders would meet briefly to discuss the content of the group, set goals for the following week, and identify any action steps that needed to be taken.

The group often discussed the members’ cultural experiences of acculturation in their school, and often commented on the clothing choices of other group members. Bashiir and one other group member who had both immigrated within the past year appeared to wear similar clothes (i.e., button-down shirts), while group members who had resided in the United States for more than one year often wore more loose fitting clothing including low-riding jeans, large tee-shirts, and oversized “hoodie” sweatshirts. Bashiir would occasionally get teased for his choice of clothing by peers who told him that he needed to dress differently to fit in (both in the group and with peers at school).

Group members appeared very playful with each other, often greeting each other with smiles, high fives, and pats on the back. When a group member was discussing his experience, other group members would orient physically towards that individual, leaning forward in their chairs, nodding encouragement, and asking questions. They often chose to focus on content related to their current experiences (e.g., bullying, witnessing neighborhood and community violence, and academic stressors) rather than discussing their experiences in Somalia or during migration. However, on the few instances that group members did bring up traumatic events that they had observed in refugee camps or in Somalia, other group members often endorsed having similar experiences.

Phase Three of Treatment: Family Therapy for One Session

While group therapy proved to be a very comfortable and therapeutically supportive environment for Bashiir, several months into the treatment process Bashiir’s school counselor contacted the therapist to note that his attendance continued to lag. The therapist thus sought to schedule a meeting with Bashiir’s parents to discuss issues related to Bashiir’s absences and commitments to his family for babysitting. However, scheduling proved difficult as Bashiir’s parents were frequently unavailable for parent-only consultations due to their busy work schedules.

After I had made several unsuccessful attempts to schedule a family session via phone, Bashiir's parents did agree to attend a family therapy session to discuss school scheduling. Part of Mr. and Mrs. Abdi's answer surprised me. Bashiir's parents indicated that they would make themselves available to attend a therapy session but requested that they bring additional members of their community to the therapy session. Specifically, they indicated that they would like to invite several elders from their community. They wanted to invite particular elders that they identified as resources to their family.

Uncertain how to proceed, I reached out to the Clinic's supervisors and Director to ask about how to facilitate this meeting. During one of the case consultation meetings, the clinical team discussed potential issues related to ethical concerns. Specifically, two of APA's Ethical Codes (2017) were particularly relevant:

4.02 Discussing the Limits of Confidentiality

(a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities.

10.02 Therapy Involving Couples or Families

(a) When psychologists agree to provide services to several persons who have a relationship (such as spouses, significant others, or parents and children), they take reasonable steps to clarify at the outset (1) which of the individuals are clients/patients and (2) the relationship the psychologist will have with each person. This clarification includes the psychologist's role and the probable uses of the services provided or the information obtained. (See also Standard 4.02, Discussing the Limits of Confidentiality.)

I sought to address these principles in establishing ground rules for meeting with Bashiir's parents and the community elders.

The therapy session included myself, Bashiir's parents Mr. and Mrs. Abdi, and four respected elders from the community. The family selected these specific individuals who were not related to the Abdi family. While I was not aware of the elders' job titles, the reasons for their selection became clear during the course of the session. The session took place in the largest therapy room available in the Clinic, but even still the room was full to the extent that additional chairs needed to be brought in, and multiple individuals sat on the floor. As the therapist, I encouraged the elders to sit in the chairs and opted to sit on the floor near Mr. and Mrs. Abdi. Mr. and Mrs. Abdi appeared more comfortable in the session than they had in previous parent-only or family sessions with the therapist.

After the therapist reviewed confidentiality recommendations, the initial portion of the session included introductions of each community elder. Mr. and Mrs. Abdi discussed their work schedules and needs for childcare. It became clear through the course of discussion that the community elders were individuals who were respected by the Abdi family and members of the extended community due to their (a) age and (b) extensive relationships with other members of the Somali immigrant community in this geographic area.

The community elders immediately began discussing members of the community who might be available to assist with watching Bashiir's siblings. It became clear that the elders were suggesting the names of individuals with whom the Abdi family was already familiar (e.g., neighbors, individuals who had children of similar ages).

As the elders shared their ideas and recommendations, I noted a visible decrease in the physical tension of the Abdi family. Their level of verbal engagement increased as they agreed with the suggestions and schedule made by the elders. It became clear that the elders were confident that those helpers they identified would say yes to their directions to provide instrumental support and childcare to the Abdi family.

A majority of the discussion took place without significant facilitation by the therapist. Integrating these critical elders into the therapy environment, creating a prominent place for them to discuss their concerns and ideas, and shifting the focus of the session towards tapping into collective wisdom of Bashiir's community meshes with the multicultural feminist goals of honoring collectivism, sharing power, and building on strengths (French et al., 2020; Goodman et al., 2004). In line with this, note that as the therapist I was actually sitting on the floor so that the community elders and Bashiir's parents could have seats, symbolically making a statement that deemphasized the usual in-charge power role in such a meeting by the professional co-leading it. Had I suggested directly to the Abdi family that they should draw on supports from their community, I do not think Bashiir's parents would have agreed. When the community elders made these suggestions, it seemed more like directives rather than offers for help. However, Bashiir's parents appeared satisfied with the plan in that they immediately agreed to the recommendations by the community elders.

Standard therapy sessions often include solely members of the family or just the client alone and take place over 45 minutes. This session lasted approximately 90 minutes and included multiple individuals unrelated to the client. However, by the end of the session, a tentative schedule had been drawn up that actively addressed the needs of the family. This plan involved multiple other families taking turns on different days to provide childcare support to the Abdi family. This new schedule allowed Bashiir to attend school during required hours and provided additional support after school when his parents were still working.

7A. THERAPY MONITORING AND USE OF FEEDBACK INFORMATION IN BASHIIR'S THERAPY

As the therapist, I engaged in weekly individual and group supervision throughout the course of treatment. Individual supervision consisted of meetings with licensed clinical psychologists who were also practitioners at the community mental health agency where Bashiir's treatment took place. These supervisors reviewed the therapist's written notes, provided recommendations regarding treatment interventions, and discussed next steps for therapy.

Group supervision consisted of meetings with a multi-disciplinary team including one or more psychiatrists, licensed social workers, licensed clinical psychologists, social work trainees, and clinical psychology trainees. In group supervision, each attendee was encouraged to take turns bringing up challenging cases. The format of this supervision also allowed for collaboration across disciplines, meaning that social workers would provide recommendations for systemic interventions, psychiatrists might discuss medication recommendations, and clinical psychologists would provide recommendations for therapeutic interventions.

Often multiple clinicians within a practice worked with each client or family. This consultation proved to be very valuable relevant to Bashiir's course of treatment, as the group therapy and family therapy interventions were recommended both in individual supervision and in the group consultation sessions.

8A. CONCLUDING EVALUATION OF BASHIIR'S THERAPY'S PROCESS AND OUTCOME

By the end of treatment, Bashiir had been able to return to full attendance at school. Members of the Somali immigrant community identified by the community elders were volunteering their time to provide daytime and some afternoon childcare support to the Abdi family. Bashiir still reported on-going challenges related to being teased at school and concerns about safety in his neighborhood. However, with the connections he made in his therapeutic group, he noted that he had more of a sense of connection with peers who "got him" and supported him unconditionally, leaving him with reduced levels of symptomatology, increased ability to attend and participate in school, and a newfound sense of community support (Goodman et al., 2004).

Due to the time limitation associated with my role as a therapist trainee, treatment ended after approximately 4 months, prior to all therapeutic goals being met. The therapist encouraged Bashiir and his family to continue therapy with a transfer therapist at the same clinical setting. It was my hope that with social and instrumental (e.g., childcare) supports in place, Bashiir would be able to continue his therapy to address his on-going PTSD symptoms. While I am not certain

of the outcome of Bashiir’s case due to the time-limited nature of my training at the mental health center, there were plans in place to continue the group and to identify a transfer therapist after my departure.

It is important to highlight the positive impact on the therapy of the family session, which included the four community elders. This positive impact revealed the limits of restricting therapy to one particular format, not allowing for opportunities to build on individual and community strengths. As French et al. (2020) noted, “relying on Western psychology’s theories of health and wellness is, at best, incomplete, and at worst, oppressive” (p. 27). Clinicians have an opportunity to “move beyond traditional spaces and modalities of treatment” (French et al., 2020, p. 28). Integrating pivotal individuals such as the elders is a way to engage in both cultural authenticity and acknowledging the benefits of collectivism (French et al., 2020). The family therapy session with community elders involved sharing power through encouraging partnerships and collaboration to actively problem-solve the family’s needs.

4B. JAQUANN’S ASSESSMENT: PRESENTING PROBLEMS, GOALS, STRENGTHS, AND HISTORY

Presenting Problems and Family Situation

Jaquann was a 15-year-old Black male who lived with his mother and two younger siblings in a major city on the East Coast of the United States. He was a high school student at a public school. He was a low performing student who had encountered school attendance difficulties related to symptoms stemming from early childhood traumatic experiences. Jaquann and his family lived in government subsidized housing in the city. His mother had recently returned to work following a period of unemployment.

Jaquann was not close with his father, who was currently detained for a charge of carrying an unregistered firearm, which was the same charge as Jaquann faced. His father had been detained for several years prior to Jaquann starting treatment and did not have regular contact with the family. Jaquann expressed the desire to participate without his father’s involvement. After this clinician consulted with colleagues and Jaquann’s mother, the decision was made to move forward with treatment with Jaquann and his mother.

Jaquann was mandated to participate in therapy, following his arrest and prosecution on a weapons related charge, specifically, carrying an unregistered firearm. Prior to receiving this charge, Jaquann had experienced several traumatic experiences related to community violence and was robbed at gunpoint on his way to the school bus stop. One of the requirements of his parole was that he participate in mental health treatment for emotional and behavioral dysregulation, while he awaited placement at a school/facility for youth involved in the juvenile justice system. The attorney working with Jaquann made a post on a city-specific mental health

listserv seeking a clinician who could provide pro bono treatment. I (Rene DeBoard-Lucas) responded, accepting the case and the intake process was initiated at my outpatient, private practice clinic.

At the beginning of my therapy with Jaquann, I was a licensed psychologist at the clinic. When receiving a referral through a source like above-mentioned mental health listserv, the administrative staff in my clinic have to be notified. In relaying background information about Jaquann's case, the staff became concerned that Jaquann may not be an appropriate case for the clinic due to the weapons-related charge. I sought and received permission to begin the assessment and treatment process on a tentative basis.

At the time Jaquann's mother called the clinic to schedule an intake, the intake coordinator asked to speak with Jaquann briefly, to assess some background information and receptiveness to treatment. After speaking with Jaquann, the intake coordinator suggested to me, as his assigned therapist, that he may not be able to participate effectively in treatment, as he gave one-word answers. After receiving psychoeducational testing from Jaquann's school that indicated an IQ in the 70s, his responses during the phone call were interpreted as indicators of a potential intellectual disability.

When Jaquann arrived at the clinic for the assessment, he was dressed casually in jeans and a hoodie sweatshirt. The hood covered a pair of headphones and was pulled up tight over his head. He came into the intake session with his mother and presented as quiet but receptive to the discussion. With his mother present, Jaquann initially responded to questions with few words, which was consistent with the intake coordinator's description.

When I met with Jaquann individually to gather additional diagnostic and background information, he elaborated slightly more on his responses. He acknowledged early childhood traumas and a recent traumatic experience, in which he witnessed the shooting death of a close family friend who was the same age as Jaquann. During the intake, I learned that Jaquann had no prior history of therapy or psychotropic medication.

I began by talking with Jaquann about the mandated nature of the current treatment and the associated limits of confidentiality. I then described what Jaquann could expect from therapy and encouraged him to participate fully, to help reduce his symptoms and improve his functioning. As part of this discussion, I told Jaquann that he "deserved to feel better." This phrase felt simple to me in the moment, but resurfaced shortly afterwards as something that resonated strongly with Jaquann. At the end of the first intake session, I shook Jaquann's hand, which appeared to surprise him.

Standardized Assessment and Diagnostic Presentation

During the intake, which spanned two sessions, I administered assessment measures

focused on anxiety, depression, and posttraumatic stress (see more below on the measures in section 8, Concluding Evaluation). This data, combined with other clinical information obtained during the intake, suggested ICD-10 diagnosis of Post-traumatic Stress Disorder (PTSD; F43.10) and Major Depressive Disorder, Recurrent, Moderate (F33.1). I described these diagnoses to Jacquann and his mother, and I provided psychoeducation about the associated symptoms and ways that treatment can reduce them, while increasing positive aspects of functioning.

Jaquann and his mother both expressed concern about the implications of the diagnoses but also conveyed interest in better understanding them. Jacquann’s mother identified treatment goals of reducing the PTSD and depression symptoms. Jacquann shared these goals and also expressed worry and fear related to his upcoming detention. I praised Jacquann for being vulnerable and acknowledged both the risk and maturity associated with sharing this information.

Strengths

At the end of the intake, familial and individual strengths were apparent in Jacquann’s case, including a supportive parent and extended family, motivation on Jacquann’s part to participate in treatment, and cognitive functioning that was clearly and significantly above that suggested by the previous psychoeducational testing.

5B. JAUANN’S FORMULATION AND TREATMENT PLAN

Case Formulation

I approached Jacquann’s treatment from a cognitive-behavioral perspective, with the inclusion of multicultural, feminist factors described above in section 3, Guiding Conception. Jacquann experienced several traumatic experiences at an early age, which elicited posttraumatic symptoms, including intrusive thoughts and images; avoidance of the school bus stop where he was robbed at gunpoint; and changes in cognitions and mood. Jacquann’s PTSD symptoms contributed to his absence from school for several weeks in a row, after which his mother was informed by the school that she was being reported to Child Protective Services for child neglect due to his prolonged absences.

When Jacquann contacted the school regarding missed assignments, he encountered microaggressions from the guidance counselor who remarked that she thought Jacquann had dropped out of school. These microaggressions exacerbated Jacquann’s low self-esteem and his thoughts that school “did not expect much from him.” With decreased engagement in school, Jacquann began spending more time with older friends who then asked him to hold a gun for them. His subsequent arrest and prosecution occurred in the context of a systemically racist system that overcharges and over-sentences Black youth and men relative to their White counterparts (U.S. Bureau of Justice Statistics, 2018).

In identifying symptoms consistent with diagnoses of PTSD and Major Depressive Disorder, Recurrent, Moderate, I observed Jaquann's thoughts, feelings, and behaviors that were all negatively impacted and exacerbated by experiences with trauma. As such, I identified Trauma-Focused Cognitive Behavioral Therapy (TF-CBT; Cohen et al. 2006) as an evidence-based treatment that could address Jaquann's symptoms, while including treatment modifications that incorporate experiences of racism and discrimination (Metzger et al., 2021) that Jaquann has experienced as a young Black male.

Treatment Plan

I then developed a treatment plan to implement Trauma-Focused CBT to (1) increase Jaquann's use of adaptive coping tools; (2) decrease symptoms of PTSD; and (3) decrease symptoms of depressed mood and increase euthymic mood. The treatment plan was shared with Jaquann and his mother and asked for their input and approval, in line with the principles of sharing power with and giving voice to clients as described in the multicultural, feminist approach (Goodman et al., 2004).

Also, as part of sharing power, Jaquann's mother indicated that due to her work schedule, she would not be able to participate in as many therapy sessions as she would have liked. A plan was then made for Jaquann to participate in most therapy sessions individually, with regular updates shared with his mother by phone.

6B. JAQUANN'S COURSE OF THERAPY WITH AUTHOR THERAPIST RENEE DEBOARD-LUCAS

Pre-Detention, Sessions 1-9

Given that Jaquann was scheduled to begin his detention approximately two to three months after starting the intake, there was insufficient time to begin and complete Trauma-Focused CBT prior to his detention. In efforts to maximize the benefits of treatment while reducing the potential harm of starting and not completing trauma therapy before entering the juvenile justice facility, I discussed the details of the treatment plan with Jaquann and his mother. A collaborative decision was made to introduce and practice skills such as cognitive coping (identifying and challenging cognitive distortions) and affect management (mindfulness and relaxation skills, including diaphragmatic breathing), as these would support Jaquann's coping with the stress of being detained. In addition, we would discuss and process the stress associated with this substantial upcoming change.

This plan was implemented as discussed with Jaquann and his mother. The approach included components of Trauma-Focused CBT while including modifications flexible enough to accommodate his circumstances. This means that although references were made to past traumas,

the focus was on skills to help Jaquann manage stress and fear associated with the upcoming detention.

In the first session following the intake, I assessed Jaquann's perception of the therapy plan and what it was like to discuss personal and stressful experiences with me, who was so new to him. Jaquann acknowledged that it was uncomfortable and that talking about his feelings is neither something he liked doing nor was used to.

However, he returned to my statement that "you deserve to feel better" as a positive element in the therapy experience. In this early session, Jaquann continued to present with his hood up and his face turned down towards the floor. However, his words were quiet but poignant as he said, "No one has ever told me that before." We processed this simple but meaningful concept and engaged in the multicultural feminist principle of "consciousness raising" (French et al., 2020; Goodman et al., 2004) as we discussed the systemic racism steeped in a society that attempted to convey that he was not as valuable as his white counterparts.

As these early sessions progressed, Jaquann seemed to "come out of his shell" more and he began to sit up in sessions and to show his face; however, the hood was still up.

Psychoeducation was discussed regarding common reactions to traumatic situations. In this way, the symptoms Jaquann was experiencing were "normalized" without having to fully explore the specific traumatic situations he experienced, as would be done in Trauma-Focused CBT. (As mentioned above, the full exposure part of the treatment was being postponed until after Jaquann finished detention.) In the process of sharing power (Goodman et al., 2004), we referred to the treatment plan to process these experiences once he was released from the facility and could devote more energy and resources to this very vulnerable part of treatment. Jaquann said that it was helpful to learn about posttraumatic stress symptoms, commenting that he experienced back pain that he began to speculate was related to his experiences with stress and trauma.

I became aware of the role of my implicit bias in initially assuming that Jaquann would not be interested in relaxation skills, such as diaphragmatic breathing (Falender & Shafranske, 2021). This awareness led me to try this skill with Jaquann. He was very receptive to the strategy and practiced it at home to manage anticipatory anxiety regarding his upcoming detention. When Jaquann and I practiced emotion-identification skills, including body scans to assess physical sensations in his body associated with various emotions, Jaquann identified comfortable and uncomfortable emotions and was receptive to adding to his emotional vocabulary. This is the youth that psychoeducational testing suggested may have an Intellectual Disability!

Over the course of these initial sessions, it became clear to me that Jaquann's cognitive functioning was consistent with his age and development and that this was another area in which systemic racism had impacted the services he was offered and, ultimately, misrepresented him.

As a final portion of treatment prior to his detention, Jaquann and I engaged in problem solving to develop a plan for managing stress concerning his upcoming detention in a way that benefited him, while also acknowledging potential risks to his physical and emotional safety that come from detention. In these conversations, Jaquann reported his worries and fears. He reported passive thoughts about suicide, as then "I wouldn't have to go to jail." In response, I completed a suicide assessment and engaged Jaquann in safety planning, which included relaying safety plans to his mother and, with Jaquann's permission, appropriate staff at the detention facility.

In one of the last sessions before Jaquann's detention began, he came in and sat down and took off the hood of his sweatshirt. I responded that this was the first time he had done so and mentioned how it seemed to reflect his increased comfort in treatment. Jaquann smiled and appeared somewhat shy in response. It seemed almost as if the comfort had "snuck up" on him, as it developed so gradually over time.

During Detention (Contact Maintained Via Email)

Jaquann was detained at the facility for approximately three months. With his mother's and the facility's permission, Jaquann and I stayed in email contact during this time. The emails were monitored, with everyone's awareness. Prior to his enrollment at the facility, I had clarified that we would not communicate about clinical topics but would touch base periodically to maintain the relationship, as Jaquann and his mother expressed the desire to resume treatment after he was released.

While at the facility, Jaquann participated in supportive therapy and medication management. I consulted with the clinical staff there to provide treatment updates and relay information about the suicidal thoughts and safety plan. According to facility staff, Jaquann engaged fully in treatment there and suicidal thoughts did not recur. After three months, Jaquann was released on time and re-engaged in treatment with me.

Post-Detention, Sessions 10-25

After Jaquann was released, I had a session with Jaquann and his mother to gather updates, engage in some processing about the detention experience Jaquann and his family had been through, and to plan next steps.

When Jaquann arrived at the clinic, he brought a blanket he had made during one of the therapeutic groups at the detention center. He gave the blanket to me and simply said "Thank you." During our email communication, Jaquann had mentioned some of the activities he was

doing and that he may make something for me. He said this in passing and I did not necessarily expect that plan to come to fruition. However, when he presented that blanket, I was deeply touched. I understood how significant our communications had been to maintaining a relationship and how meaningful the therapy environment was to him. I do not typically accept gifts from clients, but this was different and I also said “Thank you.”

Now that Jaquann had completed his sentence at the juvenile justice facility, we had time and emotional safety to begin TF-CBT, which again involves gradual exposure to the trauma and the opportunity to process the traumatic events more in depth. Weekly therapy sessions were scheduled. There were times that parent work schedules or family stressors meant that Jaquann needed to miss sessions. When this happened, his mother was communicative and attempted to plan alternate ways for him to get to the clinic or to participate in a virtual session. Most of the time this was effective and Jaquann attended, on average, three sessions per month. Although weekly would have been ideal, this is what was possible.

In the first few sessions post-release, I reviewed with Jaquann the coping skills he had learned previously in treatment, including affect regulation, involving mindfulness and diaphragmatic breathing. He showed good memory of the skills and reported that diaphragmatic breathing had been helpful for managing stress at the facility.

In reviewing affect regulation skills, Jaquann often described himself as angry and would say, “I just get so mad that I can’t control it.” We discussed how anger is often viewed as a “stronger” emotion than sadness and fear and that it can be “easier” to be angry than to experience the other, more vulnerable emotions. This idea really resonated with Jaquann, who said “I can’t let people see that I’m scared. It puts me in danger.” We talked about systemic racism—a lot. We talked about how these injustices and inequities had personally impacted Jaquann and contributed to reasons to be angry. We also talked about how his fears of police violence were not cognitive distortions but systemic issues. For example, he discussed examples in which he was treated in a racist manner by police and feared for his life during traffic stops.

TF-CBT includes gradual exposure, in which references to the traumatic experiences are woven into all therapy sessions (Cohen et al., 2006). I explained this approach to Jaquann to make the transition from treatment before to after detention less jarring. We began talking about his experience of being robbed at the bus stop, as well as earlier childhood traumas, such as exposure to community violence (Steele, 2023).

Initially, Jaquann appeared to “minimize” his description of how these experiences impacted him; and as trauma processing began, I noticed that he provided few details. Trauma processing was paused to discuss this in more depth. Jaquann ultimately acknowledged worry that information conveyed during trauma processing could be used against him in future, scheduled court proceedings. Knowing this and having it out in the open was a game changer.

Jaquann, his mother, and I had open discussions about the risks associated with talking openly about his past traumatic experiences and the ways that ethical treatment seeks to minimize these risks. By thus "sharing power," Jaquann was able to find a way to engage in trauma processing more fully. He was able to describe his experiences but left out names and other identifying information.

During this time, I noticed significant growth in Jaquann's ability to identify and express the emotions associated with these traumas, as he increased his understanding of the risks and felt more in control of what was shared. He was able to successfully complete a trauma narrative, which for Jaquann, took the form of a narrative in the format of a written book with chapters. During the narrative phase, he would identify thoughts and feelings associated with his traumatic experiences in order to process the events that occurred. A "re-processing" occurs, in which the clinician supports the client in identifying cognitive distortions or other unhelpful patterns that may contribute to trauma symptoms and the traumatic events begin to be viewed and processed in a more adaptive manner. For Jaquann, notably lower trauma and depression symptoms were reported at the end of treatment.

During the course of TF-CBT, a question arose for me as the therapist as to how best to implement in vivo exposures to situations that elicit trauma reminders. TF-CBT and other forms of exposure-based therapy involve exposure in which the client strategically enters situations that they have been avoiding due to trauma related reminders. This is done in a gradual way and is meant to return a client to activities they could engage in prior to the trauma. For clients experiencing depression, exposure also includes behavioral activation, which focuses on increasing activity level and engagement in preferred and necessary activities (Kanter et al., 2012).

In Jaquann's situation, he had been able to go out in his neighborhood prior to the trauma, but had concerns about community violence, both targeted at him and untargeted. I wanted to avoid making assumptions about the level of risk versus safety associated with his neighborhood. Increasing activity level would be beneficial for reducing depression symptoms, but would it put Jaquann at physical risk? Jaquann, his mother, and I engaged in conversation about this and how to strike a balance. With both of their inputs, we were able to identify a plan in which Jaquann slowly and gradually returned to going out in his neighborhood. Jaquann followed the plan and although anxiety initially increased (which is typical and expected), he persisted with the process and gradually became more comfortable increasing his time outside of the home.

In the termination session, Jaquann and I spent time reviewing and reflecting on his progress in treatment. He was able to identify concerns or reservations he had at the beginning of treatment, ways that treatment was challenging, and how he shifted the ways he views his traumatic experiences. I thanked Jaquann for trusting me, a stranger at the beginning of this

process, in the therapy journey. Jaquann returned the thanks for the support offered in treatment and we agreed that he was ready to terminate treatment. This information and process was reviewed with Jaquann's mother as well, who shared his sentiments.

7B. THERAPY MONITORING AND USE OF FEEDBACK INFORMATION IN JAQUANN'S THERAPY

To quantitatively monitor Jaquann's initial clinical status on PTSD and depressive symptoms, and to monitor his progress during therapy, two quantitative measures were administered during the intake session, midway through treatment, and as treatment ended. The results of these are described in section 8 below on Concluding Evaluation.

Therapy sessions were not recorded, since this was not required for supervision because the therapist was an independently licensed clinician, and because at the beginning of therapy, there was no need for this additional logistical demand.

Clinical notes of the sessions were entered into the clinic's Electronic Medical Record (EMR). As the therapist, I presented Jaquann's case in a peer clinical consultation group every few weeks; the feedback and input from colleagues was very helpful in thinking through various questions and decision points that arose.

8B. CONCLUDING EVALUATION OF JAQUANN'S THERAPY PROCESS AND OUTCOME

Quantitative Indicators of Success

The UCLA Post-Traumatic Stress Disorder Index for DSM-5

The UCLA PTSD Index-5 is a self-report measure that assesses symptoms of PTSD in children and adolescents and is based on DSM-5 criteria for PTSD (Pynoos & Sternberg, 2015)

A total score of 35 on the UCLA PTSD Index can be used as a clinical indicator of PTSD. Jaquann met criteria for PTSD at intake and at the treatment midpoint, but he no longer met this criteria at discharge. Thus based on this indicator the treatment was clinically successful for Jaquann's PTSD symptoms.

The Patient Health Questionnaire-9 (PHQ-9)

The PHQ-9 is a nine-item, self-report depression scale and diagnostic tool used to screen adult patients in primary care settings to assess the presence and severity of depressive symptoms and possible depressive disorder (Kroenke, Spitzer, & Williams, 2001).

To evaluate clinical severity on the PHQ-9, a respondent's scores are compared to the following levels: scores 0-4 = none/minimal; 5-9 = mild; 10-14 = moderate; 15-19 = moderately severe; 20-27 = severe. Jaquann's depression symptoms were in the moderately severe range at

intake; in the same range halfway through treatment; and mild as treatment ended. Thus, based on this indicator the treatment was clinically successful for Jaquann's depressive symptoms.

General Qualitative Indicators of Success

As treatment came to an end, I reviewed and reflected on his progress with Jaquann. We agreed that he made substantial progress, as he was able to engage in activities he wanted and needed to engage in, without trauma symptoms having an impact. For example, he was able to increase time he spent with friends and also applied for part-time jobs. The PTSD and depression symptoms both decreased to sub-clinical levels. Jaquann thought about the traumatic situations less and was able to cope effectively with reminders when needed. He reported feeling more in control of his emotions and indicated that he felt "a lot more like myself."

Jaquann's mother echoed this perception, and both she and Jaquann felt that treatment was successful and beneficial. In reflecting on the strategies Jaquann practiced, it seems that the trauma processing exposures and the affect management tools, like deep breathing and mindfulness, were the most effective. Although he reported identifying less with cognitive coping skills, like using coping thoughts, Jaquann appeared to use these skills to some degree and seemed to benefit from discussing systemic racism and its impact on his experiences. Jaquann's treatment goals were met and a planned end to treatment was held.

Four Specific Qualitative Indicators of Success

First, during Jaquann's detention, the staff reported to me that he actively participated in supportive therapy and medication management, and that he did not have any more suicidal thoughts. This suggests that his meaningful engagement with me in his pre-detention therapy helped to increase his receptiveness to the therapeutic aspects of his detention program.

Second, when Jaquann arrived at the clinic after his detention, he brought a blanket he had made during one of the therapeutic groups at the detention center. He gave the blanket to me and simply said "Thank you."

Third, approximately three months after treatment ended, Jaquann sent me a spontaneous message saying he was doing well and had gotten his first job.

A final indicator of the treatment's success was the intellectual blossoming of Jaquann's engagement in treatment. In the section 4B above on Jaquann's Assessment, I wrote:

After speaking with Jaquann, our clinic's intake coordinator suggested to me, as his assigned therapist, that he may not be able to participate effectively in treatment, as he gave one-word answers. After receiving psychoeducational testing from Jaquann's school that indicated an IQ in the 70s, his responses during the phone call were interpreted as indicators of a potential intellectual disability.

As described in section 8B above on Jaquann’s Course of Therapy, Jaquann showed a highly positive response to the therapist and the therapy process as the therapy proceeded—going from, at the beginning of therapy, providing single-word answers to questions and wearing a hoody with earphones, to, later in the therapy, taking off his sweatshirt and dialoguing in detail about topics like the traumatic situations he was exposed to and, more broadly, the presence of systemic racism in our society.

Working with Jaquann was a professionally gratifying experience. I am appreciative to Jaquann and his family for trusting me in this process and to Jaquann especially for engaging in it so fully and openly.

9. COMPARISON OF THE TWO CASES AND IMPLICATIONS

Important in the therapy cases of Bashiir and Jaquann is that they represent (a) two successful examples of adolescent Black boys and their families living in working-class households, each client with traumatic reactions in their presenting problems; and (b) that both cases were seen by adult White female therapist professionals, thus crossing age, racial, gender, and socioeconomic-class lines. In both cases, the clinical description illustrates that both therapists were able to establish a very strong, trusting relationship between the therapist and the client, and between the therapist and the clients’ families. The therapist-client relationship allowed each therapist to effectively motivate her client to learn and use specific psychological tools for handling their cognitive, emotional, and behavioral challenges. The therapist-family relationship allowed each therapist to effectively motivate her client’s family to provide positive support to their son.

Each therapist used multicultural and feminist theoretical principles to adapt generic therapeutic procedures to the particular circumstances of each client and family in order to build a strong, positive the therapeutic relationship. Some examples are provided below.

Bashiir

In Bashiir’s case, the therapist facilitated his involvement in conversation by playing card games with him as they talked, helping to cross some of the age, racial, gender, and socioeconomic-class differences between them.

These differences were next crossed by the therapist arranging for Bashiir to participate in a therapy group with his Somali teenaged male peers. This group further drew Bashiir into the therapeutic process of discussing his difficulties by providing models of other teens like himself grappling with similar, challenging—and at times traumatic—issues; so that Bashir did not feel

alone and could profit from the emotionally expressive and problem-solving nature of the conversation.

Finally, the therapist arranged for a family session and accepted the family's request to include Somali community elders. This broke the usual parameters of family sessions. The inclusion of the community elders honored multicultural, feminist principles by empowering the family to design the session, all the while recognizing the potential support offered by the family's community to impact positively on Bashiir's life—in this instance, helping to find childcare for Bashiir's younger siblings so that Bashiir could go to school.

Jaquann

In Jaquann's case the therapist began by not accepting the usual power differential between professionals and clients. Specifically, the therapist did not accept the conclusion of Jaquann's school counselor and the therapist's clinic coordinator that Jaquann had an intellectual disability. Rather, the therapist had the patience and respect to not pass judgment on Jaquann's intellectual ability, but rather provided him the opportunity to personally develop in the therapy an atmosphere of respect and trust, so that he felt able to express himself more fully. In line with this atmosphere, the therapist made a comment to Jaquann in the therapy that really hit home for him, that he "deserved to feel better." This might have been the first time in a long while an adult had not blamed Jaquann for his behavior and had communicated rather that he was a valuable person who should be treated better and have more positive opportunities.

There were a number of instances that showed the therapist's patience, respect for, acceptance of, and encouragement of Jaquann as he went from a hood over his head with earphones on and one-word answers to a fully participating client who communicated articulately and with psychological mindedness. Some of these instances included:

- Before he was detained, Jaquann expressed worry and fear related to his upcoming detention. The therapist "praised Jaquann for being vulnerable and acknowledged both the risk and maturity associated with sharing this information" (p. 142), thus communicating acceptance of Jaquann's personhood as including the experience and expression of vulnerability.
- The therapist had a systemic appreciation of the strengths of Jaquann's family and his community, which were a resource in the family session; and of the reality-based time limitations of Jaquann's family in having to miss many of the therapy sessions.
- Respecting Jaquann's unique situation of being seen in therapy for PTSD both before and after detention, the therapist modified the Trauma-Focused Cognitive Behavioral Therapy model employed to provide cognitive and emotional coping tools for Jaquann's PTSD-related anxiety before detention; and then waited until after his detention to undergo exposure therapy for his symptoms.

- The therapist recognized her awareness of implicit bias in initially assuming that Jaquann would not be interested in relaxation skills, such as diaphragmatic breathing, which in fact he responded enthusiastically to.
- While Jaquann was detained, the therapist periodically touched base with him and his mother, encouraging their desire to resume treatment after he was released.
- Initially, Jaquann appeared to “minimize” his description of how his traumatic experiences impacted him; and as trauma processing began, he provided few details. As described above, in response the therapist paused trauma processing to discuss this in more depth:

Jaquann ultimately acknowledged worry that information conveyed during trauma processing could be used against him in future, scheduled court proceedings. Knowing this and having it out in the open was a game changer. Jaquann, his mother, and I had open discussions about the risks associated with talking openly about his past traumatic experiences and the ways that ethical treatment seeks to minimize these risks. By thus “sharing power,” Jaquann was able to find a way to engage in trauma processing more fully. He was able to describe his experiences but left out names and other identifying information (pp. 146-147).

In sum, we have found that the principles of the multicultural, feminist therapy model can provide therapists with powerful concepts and tools in guiding them to effectively cross age, racial, gender, and socioeconomic-class lines to meet the therapeutic needs of a wide variety of clients in child maltreatment settings, as illustrated in the cases of Bashiir and Jaquann.

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APPENDIX 1. OUTLINE OF THE CASE STUDIES OF “BASHIIR” AND JAQUANN”

1. CASE CONTEXT AND METHOD

Rachel Singer
Renee DeBoard-Lucas
Milton Fuentes

2. THE CLIENTS

Bashiir
Jaquann

3. GUIDING CONCEPTION WITH RESEARCH AND CLINICAL EXPERIENCE SUPPORT

Defining Child Maltreatment
Our Multicultural, Feminist Theoretical Approach to Therapy
Multicultural Psychology
Feminist Psychology
“Multicultural, Feminist Psychology”
Social Justice
Application to Child Maltreatment

4-8. INTRODUCTION TO THE CASE STUDIES

4A. BASHIIR’S ASSESSMENT: PRESENTING PROBLEMS, GOALS, STRENGTHS, AND HISTORY

Presenting Problems
Family History
Social Context
Diagnostic Presentation
Bashiir’s Strengths

5A. BASHIIR’S FORMULATION AND TREATMENT PLAN

Formulation
A Systemic Approach
A Multicultural, Feminist Approach
Treatment Plan

6A. BASHIIR’S COURSE OF THERAPY

Initial Session: Diagnostic Evaluation
Phase One of Treatment: Individual Therapy, Sessions 1-8
Phase Two of Therapy: Group Treatment, Group Sessions 1-8
after Individual Session 4
Phase Three of Treatment: Family Therapy for One Session

7A. THERAPY MONITORING AND USE OF FEEDBACK INFORMATION IN BASHIIR’S THERAPY

8A. CONCLUDING EVALUATION OF BASHIIR'S
THERAPY'S PROCESS AND OUTCOME

4B. JAQUANN'S ASSESSMENT: PRESENTING PROBLEMS,
GOALS, STRENGTHS, AND HISTORY

Presenting Problems and Family Situation
Standardized Assessment and Diagnostic Presentation
Strengths

5B. JAQUANN'S FORMULATION AND TREATMENT PLAN

Case Formulation
Treatment Plan

6B. JAQUANN'S COURSE OF THERAPY WITH
AUTHOR THERAPIST RENEE DEBOARD-LUCAS

Pre-Detention, Sessions 1- 9
During Detention (Contact Maintained Via Email)
Post-Detention, Incarceration, Sessions 10-25

7B. THERAPY MONITORING AND USE
OF FEEDBACK INFORMATION IN JAQUANN'S THERAPY

8B. CONCLUDING EVALUATION OF JAQUANN'S
THERAPY PROCESS AND OUTCOME

Quantitative Indicators of Success
The UCLA Post-Traumatic Stress Disorder Index for DSM-5
The Patient Health Questionnaire-9 (PHQ-9)
General Qualitative Indicators of Success
Four Specific Qualitative Indicators of Success

9. COMPARISON OF THE TWO CASES AND IMPLICATIONS

Bashiir
Jaquann