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Assessing PTSD in Ethnic and Racial Minorities: Trauma and Racial Trauma

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LEARNING OBJECTIVES: On completing this lesson, the clinician will be able to (1) recognize various factors that contribute to an increased risk for *posttraumatic stress disorder* (PTSD) in people of color; (2) identify underrecognized race-based traumatic experiences; and (3) indicate appropriate applications of assessment tools and treatments for race-based trauma and PTSD in people of color.

LESSON ABSTRACT: Ethnic and racially motivated traumatic events can cause PTSD in people of color. Unfortunately, this type of trauma is often not identified during clinical assessments. PTSD can persist without appropriate treatment, and failure to detect it may only prolong the distress further and increase the risk of developing and maintaining PTSD. This lesson presents up-to-date methods of detecting racial trauma, validated self-report and clinician-administered PTSD assessment tools that are appropriate to use with persons of color, and guidelines for selecting the most appropriate treatment for patients with race trauma-related PTSD. Additionally, common causes of racial trauma are identified and case examples are provided to help clinicians conceptualize racial trauma and support their ability to detect racial trauma-related PTSD in patients of color.

COMPETENCY AREAS: This lesson supports *patient care* and clinician *performance in practice* by providing current information and appropriate tools to identify and assess racial trauma-induced PTSD accurately in patients of color. It also summarizes treatments considered appropriate based on current research and *evidence-based practices* and identifies feasible methods of evaluation and support.

Introduction

***Posttraumatic stress disorder* (PTSD) is a debilitating condition that is characterized in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*) by five main criteria:[1] (1) exposure to a perceived life-threatening event or sexual violence; (2) re-experiencing the trauma (typically as intrusive memories and/or nightmares); (3) avoidance of trauma reminders (attempts to escape from or avoid external stimuli that appear to match components of the trauma, including thoughts or feelings associated with the trauma); (4) changes in mood and cognition (e.g., a more depressed outlook, a sense of a shortened future or of the world being inherently dangerous, losing trust in oneself/others, and self-blame for the trauma); and (5) trauma-related arousal and reactivity (e.g., hypervigilance [feeling "on edge"], increased irritability, an exaggerated startle response, and difficulty sleeping).**

PTSD has been linked to employment problems[2, 3] impaired relationships,[4, 5, 6] and a worsened quality of life.[7, 8] Comorbidity is the norm (~90%).[9, 10] Adults and adolescents with PTSD are at increased risk for suicidal ideation and attempts,[11, 12, 13] with the risk being greater for those who experienced maltreatment during childhood or violence and for those with a comorbid major depressive disorder.[10, 14, 15] PTSD is also associated with physical health problems,[10] including metabolic disease, joint disease, cardiovascular issues, chronic pain, lung disorders, and asthma.[16, 17]

Generally, PTSD does not go away on its own.[18, 19, 20] As a result, the duration of the somatic conditions accompanying it may be prolonged. Even when the comorbid physical ailments are accounted for, patients with PTSD tend to use greater amounts of medical services, including inpatient treatment.[21, 22] Thus, an accurate assessment and prompt institution of appropriate care is essential to reduce patient suffering and healthcare costs.

The accuracy of an assessment depends on the ability of the clinician to understand what constitutes a traumatic event in each population. Given that PTSD is seen worldwide (~4%; possibly higher in areas involved in war, facing natural disasters, etc.),[23, 24] with increased rates seen in the United States and Canada (6%-9% and ~9.2% respectively)[10, 25, 26]—in part possibly because of the diversity of the population in each country—the task of identifying risk factors for PTSD in each patient can seem quite daunting.[27, 28] In North and Central America, indigenous groups may be at increased risk for PTSD, but not for generalized anxiety or panic disorder; this also suggests a role for race, ethnicity, or sociocultural issues in the risk for PTSD.[29] Black and *Latinx* (gender-neutral term for Latino) populations in the United States appear to be at greater risk for PTSD than whites, whereas Asian individuals appear to be less likely to develop this disorder.[30, 31, 32] Estimates of trauma exposure among racial and ethnic groups are mixed, although people of color appear to be at greater risk for trauma related to maltreatment during childhood,[17, 33] immigration issues, war, or by witnessing domestic violence.[32] The expression of symptoms may also vary by race or ethnicity. For example, African-Americans with PTSD may demonstrate a more negative world view less heightened arousal than others, whereas Latinx patients may demonstrate physical symptoms and avoidance more often than members of other ethnic groups.[31, 34]

Complicating the process of making an accurate assessment is the disparity in access to services and quality of treatment across diverse populations. Studies have shown, for example, that black patients are less likely to receive treatment referrals or to be diagnosed with PTSD by a licensed psychiatrist or psychologist disability claims examiner; this, in turn, reduces their access to care.[35, 36] Furthermore, a black American with PTSD living in the inner city may never receive any mental health treatment.[37] In this lesson, we will shed light on important areas to consider in the assessment of PTSD in various populations.

Defining PTSD and Racial Trauma

The current diagnostic criteria for PTSD that appear in the *DSM-5* cross cognitive, behavioral, and affective presentations of the disorder.[1] Additionally, the *DSM-5* contains an important prerequisite for the identification and diagnosis of PTSD (referred to herein as "Criterion A"): a history of *trauma exposure*.

The *DSM-5* defines a traumatic event as one resulting from *direct exposure* to physical or sexual violence (e.g., a serious and fatal accident, combat experience, torture,

child abuse, or physical/sexual assault), *indirect exposure,* (i.e., learning about a traumatic event affecting a close family member or friend), or *repeated exposure* to traumatic events in an occupational setting.[1] **Certain experiences that are not covered under the "Criterion A" umbrella can still cause a traumatic reaction.** This has led to arguments for the legitimization of exposure to racist acts and other forms of oppression as traumatic events worthy of consideration in the diagnosis of PTSD.[38, 39] Carter explains that exposure to racial acts can trigger a traumatic reaction.[40] ***Racial trauma* can be defined as a traumatic response to race-related experiences that are collectively characterized as *racism,* including acts of prejudice, discrimination, or violence against a subordinate racial group based on attitudes of superiority held by the dominant group. Racial trauma can be caused by overt or covert actions carried out by individuals or society (e.g., aversive racism, modern/symbolic racism, racial microaggressions, etc.).** There is already strong evidence that over time, racial trauma can result in significant psychological and physiological damage in people of color, thereby contributing to various forms of psychopathology, including PTSD.[41, 42, 43]

Common Causes of Racial Trauma

Table 1 summarizes several forms of racial trauma that are commonly experienced by various ethnoracial groups.

Table 1:
Examples of Race-based Traumas That May Meet DSM-5 Criteria for PTSD

Common Racial Trauma	Examples of Criterion A Required for a Diagnosis of PTSD
Overt racial slurs and threats made in any environment by anyone	Perpetrator uses a negative racial/ethnic epithet to refer to the victim and/or threatens the victim with assault or death.
Police harassment, body searches, and assaults	Law enforcement officers assault the victim physically, issue threats, or search the victim's body for evidence of a crime (e.g., weapons, drugs).
Workplace discrimination	Coworkers express racially motivated threats or carry out physical assaults against the targeted individual in the workplace.
Community violence	Victim witnessed violence or was afraid for his/her life/personal safety or that of family members.
Distressing medical experiences	Victim has persistent fear for life of self/loved ones due to medical mistreatment.
Incarceration	Victim was physically or sexually assaulted while in prison.
Immigration difficulties	Victim experienced physical/sexual assault or robbery or feared for life of self/loved ones during the immigration process.
Deportation	Children witness violent confrontation and abduction of parents by law enforcement.

Overt Racial Slurs and Threats:

Implying that someone does not belong in a certain place and needs to leave "or else," referring to that individual using an ethnic or racial slur, or a combination of these two actions can be interpreted as a threat to commit bodily harm when the target is a person of color. Some of the examples described in Table 1 fit the criteria for trauma quite well, whereas others are associated with cultural learning that associates degrading language with violence. It is important to note that some clinicians may recognize such actions as evidence of overt racism and carry out their due diligence to denounce them, yet fail to provide investigative follow-up, even when the action in question qualifies as a Criterion A.

Police Harassment, Search, and Assault:

The ongoing epidemic of police brutality across the United States and the commission of extrajudicial killings of people of color that are considered "justified" on the basis of persistent racial stereotypes have had a negative effect on the social, emotional, and psychological development and well-being of all African-Americans, but particularly young African-American men.[44] Gallup poll data on attitudes and perceptions of the police from 2011 to 2014 show that 59% of white people have "quite a lot of confidence" in the police compared with only 37% of black people.[45] Men of color often report physical, psychological, and sexual violence carried out by the police, as well as neglect by police of physical or medical needs.[46] The traumatic effect of these experiences are due primarily to the imbalance of power between police and civilians, as well as the public's perception of police officers as having a prejudicial mindset. For example, when a police officer puts a gun to someone's head when that person has not threatened the officer, that person will be in fear for his/her life. When someone is stripped naked and subjected to a cavity search, s/he will interpret that act as a sexual assault. Experiencing racially motivated police harassment and violence can lead to chronic difficulty in achieving or maintaining good mental health and being prosocial.[47] Recognizing the role of the police in the perpetuation of racial trauma could be the first step toward healing for its victims. Case studies have revealed that individuals who experienced a posttraumatic reaction to police violence that was initially inadequately conceptualized (i.e., it was mistaken for anxiety, depression, oppositionality, etc.) had better outcomes when each situation was viewed more accurately as the outcome of racial trauma within a PTSD framework.[48]

Workplace Discrimination:

Workplace discrimination based on race, ethnicity, and gender can have multiple traumatic effects, some of which are described in the following case examples.

Carter and Forsyth presented the case of an African-American salesman who was treated in a demeaning manner by the store manager (i.e., he was denied time off, assigned to menial tasks, instructed to keep close tabs on black customers to make sure they did not steal anything).[49] After he filed several complaints against the store manager for racially discriminatory acts, the manager retaliated by firing him. As a result of these experiences, he exhibited symptoms of depression, anxiety, irritability, and hyperarousal while experiencing flashbacks and difficulties in his interpersonal relationships. These experiences were eventually conceptualized as reactions to race-based, trauma-related stress.

Williams and colleagues presented the case of a black woman employed as an IT professional who was invited to dinner by a white coworker during an overseas training.[43] During dinner, the coworker—a former soldier—bragged about torturing and killing people, making racist remarks along the way. He eventually made sexual advances toward her and threatened to kill her if she told anyone. Fearing for her life, she promised not to tell his story to anyone. She spent the rest of the night in her hotel room awake and holding a small knife while sitting in the bathroom where she had locked herself in and stayed until she was sure her "dinner companion" was on a plane back to the United States. She continued to fear for her life among her other white coworkers. A diagnosis of PTSD was made based on symptoms that included severe panic attacks and agoraphobia.

Muslim women who wear hijabs in the workplace are also targeted, experiencing verbal or sometimes physical assaults by colleagues who accuse them of being "terrorists."[50] The stress of such continual workplace harassment, punctuated by significant negative events (e.g., being passed over for a promotion), can contribute to traumatic reactions to future workplace stressors.

Community Violence:

Impoverished urban neighborhoods often present an environment in which residents experience an

increased threat of interpersonal trauma (e.g., from gang violence and armed robbery). Having fewer resources to buffer themselves against such assaults than individuals living in more economically stable communities, the residents of low-income communities may feel the need for greater vigilance, yet still react with increased anxiety to traumatic experiences.[51, 52] Given the recent dramatic rise in homicide rates in both white and black communities (due to a spike in the number of males aged 16 to 24 years, among other factors),[53, 54] coupled with a persistently dramatically higher unemployment rate for black males aged 16 to 24 years (e.g., 14.3% – 27.7% in second quarter of 2018) compared with whites in the same age groups (6.5% – 13.4% in second quarter of 2018),[55] the crime rate is higher in poor black communities. Being a victim of crime can result in traumatic stress reactions (e.g., flashbacks, hyperarousal, avoidance behavior) characteristic of PTSD; frequent exposure to crime simply increases the severity of the reaction. Individuals in such communities usually do not have the economic resources to move and may feel trapped in a perpetually stressful and traumatic environment. This sense of entrapment can exacerbate the severity of PTSD symptoms further. These factors collectively may contribute to the increased exhibition of symptoms of PTSD that is being seen in African-American children today.[56]

Distressing Medical and/or Childbirth Experiences:

Underrecognized causes of trauma include medical conditions and treatments. For example, childbirth—considered a "natural" and "normal" condition—actually poses a serious risk to the mother and infant. **Fear of injury or death to the mother or the infant can be traumatizing enough to result in a diagnosis of PTSD.[57]** When a traumatic response to pregnancy is potentiated by the actions—or inactions—of the medical providers—i.e., if their actions are interpreted by the pregnant woman as dehumanizing, disrespectful, or showing a lack of care—the sense of trauma is increased. Although the United States spends more money on prenatal care and childbirth than any other nation,[58] maternal and infant mortality rates lag far behind those of other developed countries. The main reason for this is poor labor and delivery outcomes in African-American communities, where maternal mortality is four times higher than for white women and infant mortality is twice that seen in other ethnic and racial groups.[59] Among other factors, racial differences in socioeconomic status, both real and presumed, contribute but only partially explain these differences.[60] For example, it is often assumed that a black woman seeking prenatal care is unmarried, multiparous, on welfare, and has poor health habits.[61] In turn, the black patient often believes the healthcare provider with this attitude is indifferent and disrespectful; as a result, she is less likely to be confident that the healthcare provider has her best interests at heart and wants to provide the best care.[61, 62] Patients who do not trust their providers are less likely to keep follow-up appointments for diagnostic screenings or adhere to treatment recommendations, which puts them at increased risk for adverse outcomes. Research has shown that providers are indeed more likely to have a negative bias against African-Americans that can result in poor pregnancy outcomes, particularly in low-income black communities.[63, 64]

Incarceration:

The trauma of incarceration has been likened to "being locked in cage [that] has a psychological effect upon everyone made to endure it" from which "no one leaves unscarred."[65] Incarceration can be so psychologically painful that it can result in posttraumatic stress reactions by the time the prisoner is released. Individuals who become incarcerated are more likely to have experienced both physical and sexual trauma during childhood (9.6%) than during adulthood (e.g., 3.7%).[65] The harsh, punitive environment of a prison, with its rigid rules and requirements for discipline, coupled with close proximity to violence, sexual victimization, and physical assaults, only serves to retraumatize these individuals.[66] Furthermore, exposure to trauma in prison is strongly associated with various behavioral problems (e.g., aggressiveness) and clinical symptoms (e.g., emotional dysregulation and hopelessness), which does not bode well for release.

Immigration Difficulties:

Immigration is a stressful and potentially traumatic experience involving complex emotional and physical challenges. In a study of Cuban refugees, for example, investigators found that the typical entrant had to traverse an average of 4.6 countries (*SD* = 2.70) before arriving in the United States;[67] they were often robbed, raped, or otherwise assaulted on the way and many of those traveling on boats witnessed or risked drowning. In a study

of foreign-born adolescents and their parents, Perreira and Ornelas found that 29% of adolescents and 34% of parents experienced physical assault, accidental injury, muggings, rape, etc. before reaching the United States;[68] others experienced severe illness, natural disasters, war, or persecution. Additional factors contributing to the risk for trauma consisted of premigration poverty; the clandestine nature of their entry into the United States; the loss of familial networks that can provide social, financial, and cultural support; and postmigration discrimination and violence. The challenges continue while they try to assimilate into a new cultural environment, learn a new language and societal norms, and accept jobs that they soon learn are associated with racial or ethnic stereotypes (e.g., a Latina working as a cleaner) and cause them to deal with a significant decrease in income, social status, and employability. These changes have been correlated with domestic violence and negative physical and mental health outcomes.[69, 70]

Deportation:

The effects of deportation are similarly to those of immigration, particularly if it is ordered after the family has established ties with new support networks in the "new" country. Witnessing the deportation of their parents can be extremely distressing and traumatizing for the children left behind. Allen, Cisneros, and Tellez investigated the effects of parental deportation on the psychological well-being (as reported by current caregivers) of the children who were left behind and found a significantly greater number of externalizing and internalizing problems in these children than in children whose parents were not deported or who were currently fighting deportation.[71] These problems were expected, given the traumatic nature of involuntary and often very sudden separation from one's parents and placement in the care of relatives or even strangers (i.e., foster families), particularly with no knowledge of what will become of the parents. These changes represent disruptive and destabilizing events that can reduce the sense of security in the family unit.

Trauma is Cumulative

Conceptualizing PTSD as the outcome of a single major traumatic event is inadequate. According to the "stress sensitization" hypothesis, exposure to prior traumatic events can increase the risk of PTSD on exposure to additional trauma in the future.[72, 73, 74] For individuals with multiple minority identities that are commonly stigmatized, the stressors and traumas related to each identity and the intersections among them can increase the risk for pathological responses exponentially.[75] Trauma may also accumulate in an intergenerational manner. Chronic exposure to environmental stressors associated with one's ethnoracial identity can trigger biological reactions that are passed along to subsequent generations,[76] causing them to develop an inheritable biological predisposition to respond to those stressors in a similar manner. Specifically, chronic exposure over several generations to stressors that induce racist trauma may be able to induce an epigenetic change in the levels of enzymes governing pathogenic processes involved in various depressive and anxiety disorders—including PTSD—and these changes may be inherited by later generations. The genes governing these enzymes may, in turn be activated by environmental factors.[77] Traumatic stress reactions in the offspring of Holocaust survivors may be an example of this process.[78] Based on this research, we believe that future studies will find that stress and trauma, based on racist experiences, can be cumulative and heritable.

The trauma induced by ongoing racism may be similar to the trauma triggered by bullying or sexual harassment and could result in PTSD. A study of Chinese-American immigrant youth found that chronic verbal and physical bullying, harassment, and/or other acts of discrimination (e.g., being ignored or socially ostracized) by school peers were perceived as stressful and overwhelming[79] and resulted in reduced self-esteem and academic achievement, along with doubt and confusion about the value of their ethnoracial identity. Similarly, chronic sexual harassment of women in the workplace can lead to pervasive feelings of powerlessness, vulnerability, and fear, as well as job dissatisfaction, reduced productivity, social withdrawal, and detachment from the organization.[80] These reactions have been linked with somatic complaints and an overall sense of being psychologically unwell. Importantly, these effects parallel outcomes commonly observed in victims of racial trauma.

In a similar vein, subtle forms of racism (i.e., racial microaggressions), particularly when experienced on a daily or almost daily basis, can have a traumatic effect on one's sense of psychological well-being and impair the individual's ability to cope with adversity.[52, 81] Racial microaggressions can be verbal or nonverbal, as well as intentional or unintentional, and are consistently

experienced by the targeted individual as subjugating, disturbing, demeaning, belittling, and, ultimately, dehumanizing.[82, 83] Exposure to microaggressions may disrupt self-regulatory processes involved in the control of aggressive or angry behaviors and result in social avoidance, dissociative symptoms, and anxiety—all of which are common in people with PTSD.[84]

Cultural and Historical Traumas

Because the effects of trauma may be inherited, it may be important to consider the impact of historical and cultural trauma on its survivors and on the generations that follow.

Research has shown that many of the Japanese Americans who were held in internment camps during World War II refuse to talk about their experiences in those camps.[85] This may reflect the horrifying and traumatic experiences they endured and may have been intended to serve as a means of avoiding reminders of the trauma; this is a characteristic of individuals with PTSD. It may also have been intended as a means of shielding their children from the pain they experienced. Ironically, the desire to shield future generations from their pain may have caused those generations to believe the worst about the experiences of their elders, and this can contribute to anxiety. Similarly, the descendants of Holocaust survivors have been shown to represent a larger proportion of individuals seeking and receiving psychiatric services than descendants of similar individuals who were not Holocaust victims,[86] perhaps as a result of the inheritable nature of trauma. Talking about the experiences has been associated with an increase in emotional distress in their descendants, however, indicating that having a relative who had been exposed to trauma is associated with deleterious effects.[85] These findings show that regardless of how survivors cope with war-based traumas, there tend to be negative intergenerational effects.

African-Americans report experiencing more discrimination during their lifetime than any other racial group in the United States.[31] The role of racism in the captivity, enslavement, and murder of their ancestors heightens the traumatic effect of racism they experience today, such that traumatic racism is experienced as a life-threatening event.[86] Such heightened trauma can accumulate over generations, thereby increasing the risk for PTSD in each subsequent generation.

Cultural losses remain relevant for many Native Americans in the United States. A majority of Native Americans think about these losses occasionally or frequently, and this may put them at increased risk for anxiety, mood disorders, and substance use disorders.[35] These cultural losses affect the people of the First Nations in Canada as well, where indigenous people are at an increased risk for trauma and twice as likely to complete suicide attempts as non-indigenous Canadians.[87] *Indian Residential Schools* (IRS; government mandated until 1996) disciplined children for expressing their indigenous culture (e.g., for speaking in their primary language), thereby fostering a sense of ethnic shame. Descendants of individuals who attended an IRS are at increased risk of suicidal ideation and suicide attempts. This risk is increased in individuals with two generations of IRS exposure.[87]

Case Examples

Racial Profiling of an African-American Male:

Kevin, a 25-year-old black man, was traveling with three friends to North Carolina to visit his family. The road took them through a rural area; soon, Kevin found himself lost in Virginia, driving through cotton and tobacco fields. A car ahead pulled out of the shadows and traveled in the opposite direction then made a quick U-turn, and was right behind Kevin's car. Suspecting that he was being followed, Kevin tried to evade the unknown vehicle. Emergency lights were turned on in the other vehicle and it soon became apparent that it was a police car. This made Kevin even more fearful, not only for his own life but also for his friends. He sped off and was successful at evading the police for miles—until he crashed into a hardware store.

Kevin was from Baltimore, Maryland, where the constitutional rights of black people are violated on a routine basis.[88] Keven had experienced a number of traumatic encounters with law enforcement personnel in the past. One of the most traumatizing experiences occurred when he was walking home from school alone. Two police officers approached him and began harassing him. One of the officers threatened to "put a hole" in him. Kevin was assaulted and pushed to the ground. He attempted to break his fall

by extending his hand, but he sustained an injury to his wrist that required surgery. After searching him, the officers stated they had the wrong person and let him go.

Kevin had also witnessed several troubling events in his community. For example, he saw his neighbor, who is black, shot by the police 17 times while unarmed. He was also troubled by the death of Freddie Gray, a 25-year-old black man who died after falling into a coma while riding in the back of a Baltimore police van in which he was being transported after being arrested for allegedly being in illegal possession of a knife. Kevin was also disturbed by the sudden death of several close relatives. His experiences caused him to be afraid that he would someday be shot by the police simply because he was black. Kevin now tries to stay out of plain sight and in public places to avoid police harassment. In fact, his primary motivation that night in Virginia was to drive until he found a place where other people were around, because he believed he would be less likely to be killed by the police in front of witnesses. After the high-speed chase and crashing his car, he was assessed by the first author (MTW) and found to be suffering from racial trauma.

Racial Harassment of an Asian-American Woman:

Amy is a 21-year-old, first-generation Japanese-American college student who sought mental health treatment with the second author (THWC) at a large, predominantly white public university in New England. Amy described an emotionally charged racist conflict with her white boyfriend's brother that had recently occurred in his parents' home during a Super Bowl party. She described the incident as "the straw that broke the camel's back." According to Amy, the racial tension in the room escalated quickly. While drinking, her boyfriend's brother made increasingly overtly racist comments about black football players, e.g., "These black players are only in here because they needed them to make up numbers." He used the "N-word" and hurled other derogatory racial epithets at players as they appeared on the television screen. Amy told him several times that she was hurt and angered by his behavior, only to face vicious verbal responses (e.g., "Shut up, you stupid b*! What the f*** do you know about football, you slant-eyed b****? Your people don't even f***ing play football!"). Amy felt threatened and powerless, because neither her boyfriend nor his parents stood up for her against the barrage of racist insults. She finally left the house in tears. A week later, her boyfriend broke up with her, and this exacerbated her sense of betrayal and abandonment.**

After these events, Amy reported feeling depressed and anxious and having difficulty sleeping. Despite being an achievement-oriented student until then, she lost her motivation to excel academically and her self-esteem declined even further. She also reported having nightmares about the incident (the primary cause of her sleep disturbances) and actively avoided her ex-boyfriend and his brother on campus. Reminders of the incident (e.g., seeing her younger sister wearing her ex-boyfriend's sweatshirt, which he had left at their home) triggered strong emotional reactions, including a "panic attack." After a careful assessment, she was diagnosed as experiencing racial trauma.

Assessment of PTSD in People of Color

Common validated measures of PTSD do not provide the opportunity to review incidents of racial trauma; therefore, no assumptions can be made concerning their validity for detecting race-based PTSD. **Only two validated self-report measures assess the patient for trauma due to discrimination and racist events: the *Race-Based Traumatic Stress Symptoms Scale* (RBTSSS) and the *Trauma Symptoms of Discrimination Scale* (TSDS).[89, 90]**

The RBTSSS is a comprehensive, 52-item assessment of racial trauma and stress. Each item is rated twice on a scale from 0 ("does not describe my reaction") to 4 ("this reaction would not go away") to indicate the patient's endorsement of symptoms immediately after the event versus recent symptoms and to determine if the patient knows if any of the symptoms were noticed by others. The RBTSSS includes a checklist of racism-related traumas and open-ended questions about the patient's traumatic experiences that can serve as an anchor for

questions about symptoms. This measure has seven scales: Depression, Anger, Physical Reactions, Avoidance, Intrusion, Hypervigilance/Arousal, and Low Self-Esteem. Scores are interpreted by converting the summed scale scores into T-scores. Research on the RBTSSS has been carried out in Asian, Latinx, and black populations, and it has been shown to be a reliable and valid measure of racial trauma.[89]

The TSDS was designed to evaluate anxiety-related symptoms of race-based trauma. This measure contains 21 items to assess the extent of distress resulting from discriminatory experiences. Rated on a scale from 1 ("never") to 4 ("often"), the total score consists of the sum of the patient's ratings. At the end of each measure, the patient can report the type of discriminatory activity that was experienced (i.e., racial/ethnic, sexual orientation, age, gender, religious, and other). Preliminary results have shown good convergence of validity and reliability when used with monoracial and biracial black college students. The TSDS is a fairly new assessment; more research is needed to determine its reliability and validity in various ethnoracial groups. However, it does show promise as a short and easily scored assessment tool.[90]

Williams and colleagues designed a survey—the *UConn Racial/Ethnic Stress and Trauma Survey*[91] UnRESTS)—to assess racial stress and trauma and help clinicians ask patients difficult questions about their experiences. The UnRESTS survey includes questions that can be used to assess the development of ethnoracial identity, a semi-structured interview to probe for a variety of racism-related experiences, and a checklist to determine whether the patient's racial trauma meets *DSM-5* criteria. The UnRESTS format is modeled after the *DSM-5* Cultural Formulation Interview,[1] which is available in both English and Spanish.

Minority Representations in Empirically Supported Treatments for PTSD

People of color may be more likely to underutilize mental health services or end treatment prematurely.[82, 92] Common reasons for disparities in treatment engagement include cultural taboos against mental health care, discriminatory actions experienced while attempting to access services, as well as language barriers and socioeconomic status.[93, 94, 95] People of color are consistently underrepresented in treatment studies, which further limits our understanding of treatment efficacy in these groups and differences across groups. US-based treatment efficacy studies were reviewed to determine whether minority groups were represented[96] in studies of *prolonged exposure* (PE), *cognitive processing therapy* (CPT), and *eye movement desensitization and reprocessing* (EMDR) in PTSD. The majority of participants across all studies were white (51.2%); however, black participants were oversampled compared with the black population in the United States (26.3% vs 12.7%, respectively) and Latinx and Asian participants were under-sampled (3% vs 17.8% and 0.8% vs 6.0%, respectively). Ethnoracial identity was unknown for 17% of participants because of the omission of demographic data or the combination of participants from different races into a "non-white" category.[96]

Research on the efficacy of PE therapy in people of color has been limited primarily to black (28.9%) and Latinx (3.5%) participants.[96] PTSD symptoms decrease with PE in ethnoracial minority groups at a rate similar to that seen in white participants,[97, 98] and there seems to be no significant difference in the continuation of treatment among these groups.[99] *Cognitive behavioral therapy* (CBT) may also be promising for people of color with PTSD. In studies in primarily African-American and non-Hispanic white-American populations, researchers found similar rates of treatment retention and symptom reduction in children who received trauma-focused CBT, imagery rehearsal, and nightmare management.[100, 101]

Some of these treatments had mixed results in people of color; in some studies, the differences in outcomes were not assessed. The EMDR studies were least likely to include Asian (0.0%), black (0.0%), and Latinx (0.8%) participants. CPT studies included the most Asian participants (2.5%) compared with the other PTSD treatment studies,[96] although several of the articles made a direct comparison between Black and White participants.[19, 102] In a sample of veterans accessing care through the Department of Veterans Affairs, white participants were more likely to have lower pretreatment PTSD symptom scores and greater degree of symptom reduction after treatment. Non-white participants also saw a significant reduction in symptom severity.[103] After controlling for socioeconomic status, researchers found that they were significantly more likely to remain in treatment than African-Americans (73% vs 45%, respectively), yet both groups experienced a reduction in PTSD symptoms.[19] In other studies,

treatment retention rates and decrease in symptomology was similar for white and non-white participants.[102, 104] These findings suggest that further research is needed to understand the efficacy of CPT in people of color.

The efficacy of *narrative exposure therapy* (NET) has been evaluated in numerous efficacy trials in participants from diverse ethnoracial groups with PTSD in refugee populations. Refugees, most of whom had insecure asylum status, had a high treatment retention rate with NET and demonstrated a significant reduction in PTSD symptoms that was sustained for 12 months after treatment.[18, 105, 106] The efficacy of this method has been evaluated in refugee children and adolescents; 75% of these patients no longer met the criteria for PTSD after 6 months of treatment. Similar improvements were observed in adult refugees.[20, 107]

Conclusion

In this lesson, we reviewed the symptomatology of PTSD and showed how racial trauma to people of color can elicit posttraumatic stress reactions. To do so, we provided a variety of examples of how race-related traumatic experiences can occur and the importance of being able to recognize and fastidiously assess patients for the occurrence of such experiences and their effects on the patient's mental health. **People of color with PTSD may present to medical appointments with primarily somatic complaints, which may not be recognized as PTSD, leading to a missed diagnosis and failure to provide appropriate treatment. Therefore, it is critical to evaluate patients thoroughly using a culturally competent PTSD assessment tool.**

Many clinicians feel uncomfortable discussing traumatic events associated with racism. It is imperative, however, for the clinician to set aside his or her emotions and assess the person of color objectively, rejecting stereotypes and providing a safe space to discuss race-based trauma. It is also important to let the patient know that you believe that the traumatic event being reported is, indeed, related to racism. Any attempt to provide an alternative explanation for the event could be seen as an attempt to invalidate the trauma or insinuate that the patient is at fault for the trauma. This, in turn, may traumatize the patient further. White clinicians can help establish a therapeutic alliance with each patient by setting aside their own feelings of guilt or defensiveness and not worry about their cultural competence. Clinicians of color should remain aware of their own internalized biases and avoid any countertransference.[108] Additional resources are available to identify treatments that are appropriate for race-related stress and trauma.[91, 108, 109] By acknowledging the nature and severity of each incident, carrying out an accurate assessment, and selecting an appropriate treatment for each patient with race-related PTSD, the clinician takes a critical step toward removing mental health disparities for all patients.

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