Assessing Racial Trauma Within a DSM–5 Framework: The UConn Racial/Ethnic Stress & Trauma Survey
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CITATION
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Many ethnic minority groups experience higher rates of posttraumatic stress disorder (PTSD) compared to their European American counterparts. One explanation for this is the differential experience of racism, which can itself be traumatic. This article aims to provide a theoretical basis for the traumatizing nature of various forms of racism within the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders’ framework for PTSD. PTSD caused by racism, or racial trauma, is likely to be underrecognized due to a lack of awareness among clinicians, discomfort surrounding conversations about race in therapeutic settings, and a lack of validated measures for its assessment. We review the literature and existing measures for the assessment of racial trauma and introduce the UConn Racial/Ethnic Stress & Trauma Survey (UnRESTS), a clinician-administered interview. The UnRESTS is useful to clinicians as an aid to uncovering racial trauma, developing a culturally informed case conceptualization, and including experiences of racism in the diagnosis of PTSD when warranted. Three case examples that describe the impact of racial stress and trauma and the role of the UnRESTS in understanding the experiences of those impacted by racism are included.

Clinical Impact Statement

Conversations about race are often uncomfortable and as a result are avoided by clinicians to the detriment of their clients of color, who may be suffering from the traumatizing impact of racism. This article provides a context for understanding how racism can lead to a diagnosis of PTSD according to the Diagnostic and Statistical Manual of Mental Disorders (5th ed.) and how the UConn Racial/Ethnic Stress & Trauma Survey can assist in assessment.

Keywords: posttraumatic stress disorder, trauma, racism, ethnicity, assessment

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Psychological trauma occurs when an event, series of events, or circumstances are experienced as physically or emotionally harmful or threatening and have lasting adverse effects on the person’s functioning and well-being (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). Racial differences have been observed in rates of trauma exposure; for example, Hispanic Americans and African Americans are more likely to report experiencing traumatic events, and they are more likely to report polyvictimization than are their White American counterparts (Andrews et al., 2015; Hatch & Dohrenwend, 2007). Posttraumatic stress disorder (PTSD) is a reaction to a traumatic experience that impacts various facets of human functioning, including cognitive, behavioral, and affective components. PTSD is a highly disabling condition that tends to elicit pervasive and maladaptive avoidance behaviors associated with the traumatic experience. Avoidance within PTSD is a strategy aimed at regulating anxiety and safeguarding an individual from real or imagined further danger. This avoidance, however, perpetuates both anticipatory anxiety and the anxiety response associated with traumatic triggers.

The National Survey of American Life found that African Americans have a prevalence rate of 9.1% for PTSD compared to 6.8% in non-Hispanic Whites, indicating a notable mental health disparity (Himle, Baser, Taylor, Campbell, & Jackson, 2009). Increased rates of PTSD are found in other groups as well, including Hispanic Americans, Native Americans, Pacific Islander Americans, and Southeast Asian refugees (Pole, Gone, & Kulkarni, 2008). PTSD is associated with severe distress and disability (Rodriguez, Holowka, & Marx, 2012), and the vast majority of individuals meeting criteria for PTSD also meet criteria for at least one other psychiatric disorder (Brady, Killeen, Brewerton, & Lucerini, 2000). PTSD may be more disabling for people of color; for example, African Americans with PTSD experience significantly more impairment at work and in carrying out everyday activities (Himle et al., 2009). Further, having another stigmatized identity in addition to being a person of color may have compounding effects (e.g., lesbian Chinese American; Ching, Lee, Chen, So, & Williams, in press).

Experiences with racial discrimination are posited as one reason that people of color experience higher rates of PTSD, also termed racial trauma (Butts, 2002; Comas-Díaz, 2016). Racism, defined as prejudice, discrimination, and aggression against a subordinate racial group based on attitudes of superiority by the dominant group, continues to be a daily part of American culture. Common examples include harassment by law enforcement, exclusion from important opportunities, and mistreatment in the workplace (e.g., Smith, Allen, & Danley, 2007). Racial discrimination is a stressor that induces distress, frustration, and anxiety; adversely affects mental and physical health; and leads to increases in substance use and risky sexual activity (Berger & Sarnyai, 2015; Brody et al., 2006; Clark, Salas-Wright, Vaughn, & Whitfield, 2015; Williams, Neighbors, & Jackson, 2003). In addition to these detrimental effects, correlations between perceived discrimination and symptoms of PTSD have been documented across several studies (e.g., Chou, Asnaani, & Hofmann, 2012; Pieterse, Carter, Evans, & Walter, 2010; Woo, 2017).

Etiology of Posttraumatic Stress Disorder

PTSD is typically conceptualized as a response to a specific trauma, but not all traumas result in PTSD. Traumatic experiences involving interpersonal violence (e.g., rape, physical assault), versus impersonal traumatic experiences (e.g., accidents, natural disasters), tend to be correlated with increased likelihood of developing PTSD. Resnick, Kilpatrick, Dansky, Saunders, and Best (1993) found that only 9% of PTSD cases in America were the result of interpersonal trauma. Additionally, a 1998 community study from Detroit, Michigan, showed that assaultive violence (e.g., military combat, sexual assault, threats) carried a 20.9% risk of PTSD versus other injury or shock (e.g., car accident, life threatening illness), which is associated with a 6.1% risk (Breslau et al., 1998). Because racial trauma, whether direct or indirect, is often an interpersonal experience, it is plausible that the rates of PTSD from racial stressors would be statistically more similar to rates pertaining to the assaultive violence category.

Further, a longitudinal study conducted by Bryant and Guthrie (2005) indicated that nega-
tive appraisal of self, others, and the world were associated with the etiology of a diagnosable trauma reaction from a traumatic experience. As referenced earlier, these data may help to explain the divergence in the prevalence of PTSD between racial groups. For example, covert everyday racism in the form of microaggressions (subtle actions or verbal interactions that are dismissive, derogatory, or discriminatory; Pierce, 1970) is linked to several negative psychological symptoms (Chae, Lincoln, & Jackson, 2011). The experience of ongoing microaggressions may begin to reshape individuals’ perceptions of themselves, their ethnic group, and the benevolence of the world, leading to low self-esteem, psychological distress, and even suicidal ideation (O’Keefe, Wingate, Cole, Hollingsworth, & Tucker, 2015; Williams et al., 2003). These negative cognitions may then potentiate the traumatization process.

In exploring factors that prevent the natural abatement of symptoms following an upsetting encounter of racism, Bryant-Davis and Ocampo (2005) noted similarities between sexual assault victims and victims of racism. As noted, both events are an assault on the personhood and integrity of the victim. Similar to the case with sexual assault victims, victims of race-based trauma may respond with disbelief, shock, or dissociation, which can prevent them from responding to the incident in an adaptive manner. Victims of racism may then feel shame and self-blame about their inability to respond or defend themselves, which may lead to low self-concept and self-destructive, maladaptive, coping behaviors. In the same study, a parallel was drawn between racial trauma victims and victims of domestic and interpersonal violence. In both situations, survivors are made to feel shame over allowing themselves to be victimized. Perhaps due to associated stigma, the experience is embarrassing, and victims often avoid having conversations about the traumatic event, thus preventing adaptive social processing of the experience. Furthermore, the literature has indicated that there are social costs for sharing personal experiences of racism or discrimination—costs that include being perceived as less likable, viewed as a complainer, and accused of attempting to avoid personal responsibility (Garcia, Reser, Amo, Redersdorff, & Branscombe, 2005; Stangor, Swim, Van Allen, & Sechrist, 2002). Therefore, people of color must attempt to resolve dissonance between their personal reality of encountering racial stressors and conflicting social messages that indicate racism is not a valid explanation for their experiences (DeLapp & Williams, 2015).

Although most people with acute PTSD-like symptoms following a traumatic experience will experience a natural abatement of symptoms over time (McFarlane, 2000), for some, intrusive thoughts (e.g., memories, situations, and feelings associated with traumatic experiences) are so intense that there is a desire to avoid thinking about things related to the trauma. This avoidance causes the thoughts to become more frequent, because attempting to avoid thinking about something keeps the noxious topic in the forefront of the mind, perpetuating trauma symptoms (Foa, Hembree, & Rothbaum, 2007; Wegner, Schneider, Carter, & White, 1987). Those who experience distressing symptoms coupled with this avoidant tendency are likely to experience depressive symptoms and anxiety and to require clinical intervention for the treatment of PTSD (Marx & Sloan, 2002; Polusny, Rosenthal, Aban, & Follette, 2004; Roemer, Litz, Orsillo, & Wagner, 2001). People are more likely to avoid thoughts, situations, and feelings associated with experiences that involved interpersonal violence; triggered intense negative emotion; and/or confirm their negative appraisals of self, others, and the world. Thus, if racial trauma is viewed as having sequelae similar to those for individuals who have experienced assaultive violence, it follows that racial trauma could be severely debilitating in the same way (Pascoe & Smart Richman, 2009) and could even lead to the differential rates of PTSD between European Americans and people of color.

Cumulative and Cultural Trauma

It is increasingly understood that conceptualizing PTSD as the result of a single traumatic event provides an incomplete understanding of the disorder. Breslau, Chilcoat, Kessler, and Davis (1999) found that the development of a diagnosable traumatic reaction resulting from exposure to any traumatic event increased the risk that future trauma would result in PTSD. This finding has been repeatedly explicated in the professional literature and advanced as a stress sensitization hypothesis (McLaughlin,
Conron, Koenen, & Gilman, 2010), demonstrating that the cumulative effects of multiple traumas increase the likelihood of a pathological response to future traumatic exposure. Additionally, the collective effects of environmental stress (e.g., prejudicial attitudes, racial discrimination) over time can produce cumulative trauma (M. J. Scott & Stradling, 1994), as well as disturbances in self-regulatory processes, such as difficulties with aggressive or angry behaviors, social avoidance, dissociative symptoms, and anxiety (Cloitre et al., 2009). It is important to understand that many types of racism are common stressors faced by people of color and have cumulative effects that can contribute to traumatization (Kanter et al., 2017; Torres & Taknint, 2015; M. T. Williams, Kanter, & Ching, 2017).

Traumatized individuals appear to be able to pass their traumatization on to their offspring. A mechanism of intergenerational trauma was explicated by Kira (2010), who defined identity trauma as the process whereby both individual and collective identities are shaped by intergenerational trauma suffered by specific ethnic groups. Kira showed that individuals’ experience of environmental stress as it relates to their ethnic identity has the potential to produce a trauma reaction, which is then passed on to subsequent generations. Extant literature provides clear examples of this type of trauma associated with many well-known world events and in various populations. For example, the descendants of Holocaust survivors have been shown to seek out services in higher numbers and to represent a larger proportion of individuals receiving psychiatric services than have nonsurvivor descendants (Baranowsky, Young, Johnson-Douglas, Williams-Keeler, & McCarrey, 1998). Additionally, intergenerational trauma research has shown that many Japanese Internment Camp victims refuse to talk about their time in the camps (Nagata, Kim, & Nguyen, 2015); this collective avoidance, intended to shield future generations from the pain of their experiences, can cause second and third generations to believe the worst about their parents’ or grandparents’ experiences, contributing to anxiety. Talking about the experiences was associated with higher levels of emotional distress in descendants, indicating that having a trauma-exposed relative is associated with deleterious effects (Nagata et al., 2015).

The research literature also indicates that individuals can inherit a biological predisposition to the development of the disorder due to experiences of previous generations. Bierer and colleagues (2014) found that traumatic experiences are evident in enzymatic alterations in PTSD sufferers and that those alterations are heritable, being expressed in the DNA of PTSD sufferers’ children, specifically in the genes of the offspring of Holocaust survivors. These intergenerational alterations then increase the etiological likelihood of both depression and anxiety disorders. Such alterations, known as epigenetic changes, are activated in the face of environmental stress (e.g., Dias, Maddox, Klengel, & Ressler, 2015). These predispositions toward maladaptive stress responses can be observed at a purely physical level, showing the impact and consequence of trauma exposure. Glucocorticoids, hormones involved in effective and adaptive stress response, are dysregulated for individuals who have been significantly affected by traumatic events. The Bierer and colleagues study further revealed that the younger an individual is at the time of traumatization, the more developmentally pervasive or stable the glucocorticoid dysregulation was likely to be. Finally, the study found that the same glucocorticoid down-regulation present in PTSD sufferers was also found in their offspring. Such findings relate to the present study of American racism and the cumulative etiology of PTSD in ethnic minority individuals across generations. Traumatic experiences tend to increase the occurrence of traumatization, particularly those experiences that involve assault on the personhood or integrity of the victim (e.g., racism and discrimination). For trauma sufferers, these traumas cause enzymatic changes in the brain (e.g., glucocorticoid down-regulation), which are then passed to their children, increasing the likelihood of hereditary anxiety (e.g., PTSD) and depression.

Stigmatized minorities may be further traumatized by familial, historical, or sociopolitical accounts of discrimination or ethnoviolence in their communities, often referred to as cultural trauma (Helms, Nicolas, & Green, 2012; SAMHSA, 2014). Emerging literature has suggested that even watching news accounts of violence on TV can contribute to traumatization (Bernstein et al., 2007; Naeem, Taj, Khan, & Ayub, 2012), especially in the case of national events.
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like September 11 (Ahern, Galea, Resnick, & Vlahov, 2004; Otto et al., 2007). This is particularly relevant to the African American experience, which currently includes mass media coverage of unarmed African Americans’ being abused or killed by police. People of color have reported feeling hopeless, angry, anxious, and depressed by the footage (e.g., I. M. Scott, 2016). These violent and dehumanizing images, which have been the catalyst for the Black Lives Matter movement, are replayed on social media outlets and may compound both cultural and intergenerational trauma in the African American community when viewed in the context of a violent history of slavery, the Jim Crowe era, and oppression into current times (e.g., Bor, Venkataramani, Wiliams, & Tsai, 2018). Another example is the historical trauma experienced by Native people of North America, who experienced genocide, loss of land, and forced assimilation into White culture, which has left many feeling traumatized into present times and struggling with distortions of indigenous identity. One study of cultural trauma examined Lakota adults and found that most were forced into boarding schools at the age of 9, where over half were subjected to physical and/or sexual abuse from staff; they also routinely experienced racism from school staff and were punished for speaking their Native language, continuing the cycle of cultural trauma (Weaver & Brave Heartz, 1999).

Despite the cultural trauma that many ethnic minorities have suffered in the United States, which often impacts multiple generations, there continues to be little research on evidence-based practices for working with these populations (Comas-Díaz, 2016). The children and grandchildren of individuals who directly experienced cultural traumas may require the same levels of treatment as do older generations, but minority value systems are often incongruous with mainstream American therapeutic practices (Gone, 2013). Understanding racial trauma is especially important for clinicians working with these populations, due to the disproportionate and compounding impact of not only intergenerational trauma but ongoing systemic racism, microaggressions, and cumulative trauma as well (Harrell, 2000; Leary, 2005). Therefore, the next necessary step is the development of comprehensive and effective tools for understanding racial trauma. This is needed to fill existing gaps in the literature and to facilitate to a deeper understanding of the role of racial stressors as traumatic experiences and the resulting trauma-related sequelae.

Diagnosing Racial Trauma Within the DSM–5 Framework

The diagnostic criteria for PTSD are various and wide-ranging (American Psychiatric Association [APA], 2013), but the cognitive, behavioral, and affective presentations of the disorder consistently fall into categories of reexperiencing of the trauma, avoidance of trauma reminders, negative mood–cognitions, and hyperarousal. The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM–5; APA, 2013) places the following clinical parameters on the identification of PTSD. The diagnosis first requires that a person have a history of traumatic event exposure. The range of experiences that can cause trauma reactions leading to PTSD has been the focus of recent debate, and the DSM–5 is more liberal than was the DSM–IV in its inclusion of experiences that qualify as traumatic. However, the DSM–5 still limits traumatic experiences to direct exposure to physical and sexual violence up to and including actual death (e.g., serious and fatal accidents, combat exposure and torture, childhood physical abuse and other physical attacks, and sexual assault), repeated exposure to traumatic information in a work setting, and indirect exposure by way of receiving news of a traumatic event involving a close friend or loved one (APA, 2013). There are concerns that broadening these criteria may adversely impact the integrity of the diagnosis (Levin, Kleinman, & Adler, 2014); however, the 10th edition of the International Classification of Diseases (World Health Organization, 1992) does not explicitly restrict the types of traumas that may result in a diagnosis of PTSD.

Some researchers, however, have contended that experiences outside the scope of DSM–5 Criterion A can cause trauma reactions for individuals (e.g., Butts, 2002). Carter (2007), for example, argued that experiencing racism (e.g., race-based trauma) can be stressful and traumatic to sufferers. As noted, the notion of racial trauma tends to include covert racism that is hidden or unacknowledged by either individuals or society (e.g., aversive racism, modern—
symbolic racism, microaggressions) Although covert racism may fall outside the DSM–5’s criteria for possible traumatic experiences, there is strong evidence that it causes significant stress and over time inflicts psychological and physiological damage on members of minority groups (Chae et al., 2011, 2015). Carter posited that although the DSM–5 does not acknowledge the experience of covert racism as a Criterion A traumatic event, with appropriate and empirically supported instrumentation, race-based traumatic stress may yet be acknowledged as contributable to an authentic (and thus diagnosable and treatable) form of PTSD. Other scholars have called for the DSM to expand its criteria to include traumas resulting from racism and oppression (Butts, 2002; Holmes, Facemire, & DaFonseca, 2016).

Potential causes for racial trauma include covert racism such as pervasive microaggressions—everyday racism (e.g., vague remarks and insults, disrespectful behaviors), as well as overt or traditional racism (e.g., threats, physical assault related to race, victimization by law enforcement). This, in addition to the present lack of empirical measurements needed to definitively identify racial trauma, often leaves authentic racial trauma reactions misdiagnosed as depression or substance use, or clinically disregarded altogether (e.g., Malcoun, Williams, & Bahojb-Nouri, 2015).

Criterion B involves reexperiencing and suggests that an individual’s reaction to a traumatic experience tends to be marked by intrusive, involuntary recollections of the event(s; APA, 2013). These recollections include intrusive memories, recurrent dreams, dissociative reactions, and strong affective and physiological responses in the face of internal or external cues that symbolize aspects of the traumatic event(s). It is not difficult to imagine that individuals who have experienced overt forms of racism, where there was immediate threat of bodily harm, may reexperience the event in a manner that satisfies Criterion B, whereas an individual’s reexperiencing of more subtle forms of racism may vary in the level of intrusion experienced.

From a therapeutic perspective, such intrusive and involuntary recollections might be said to result from memories that have been left improperly emotionally processed. Using Lang’s (1977) idea of information-processing theory, Foa and colleagues (2007) theorized that anxiety is the result of memories that are organized into fear structures. If left unprocessed or improperly processed, these fear structures can lead to an individual’s involuntarily reexperiencing a traumatic experience in an attempt to make sense of the events. As previously noted, people victimized by racism may not have the opportunity to emotionally process these experiences through traditional therapy or other interpersonal means due to social punishment for disclosing them. Thus, individuals suffering from racial trauma are likely to meet Criterion B due to unwanted attempts at processing (e.g., reexperiencing) their negative race-related encounters.

Criterion C stipulates that individuals must demonstrate an avoidance of memories, thoughts, feelings, and situations (e.g., “triggers”) associated with the traumatic experience. People suffering from racial trauma are perhaps differentially impacted by such sequelae due to the aforementioned compounding effect of frequent racial encounters faced by people of color. Contrary to a single traumatic event that produces its own set of traumatic experiences to avoid, cumulative effects of racism could result in an individual’s avoiding the workplace, law enforcement, TV news shows, social media, or even White individuals altogether (e.g., M. T. Williams et al., 2014).

According to Criterion D, cognitive and affective alterations often characterize those who have been affected by clinically significant traumatic experiences. These negative alterations in cognitions and mood include forgetting important aspects of the traumatic experience; negative appraisals of self, others, and the world; a tendency to consider oneself the cause of traumatic events; negative affective experience; anhedonia; and estrangement from others (APA, 2013). A common example of such cognitive alterations is that those with PTSD due to racial trauma may come to believe they are inherently defective simply because something bad happened to them. For example, they may endorse an idea such as “I was beaten by police because I was a bad person; therefore I am a failure and to blame for what happened to me” rather than recognizing that they were singled out due to racial profiling and did not deserve to be treated in that way. Some research, in fact, has suggested that negative, pretrauma appraisals of one’s own competence, the trustworthiness of
others, and the overall safety of the world correlate to higher susceptibility to development, not just the perpetuation, of PTSD (Beck & Emery, 1985; Bryant & Guthrie, 2005). That is, the higher rate of PTSD among many ethnорacial groups may be facilitated by core beliefs about the lack of benevolence in the world due to historic, witnessed, or perceived experiences with racism and discrimination (Poulin & Cohen Silver, 2008; M. T. Williams, Jayawickreme, Sposato, & Foa, 2012).

Criterion E stipulates that a diagnosable reaction to a traumatic event is characterized by an increase in arousal and reactivity (APA, 2013). Such an increase can take on varying presentations among individuals with PTSD, including irritable or even aggressive behavior, self-destructive tendency, hypervigilance, exaggerated reflex, diminished concentration, and disrupted sleep (Olatunji, Ciesielski, & Tolin, 2010). Criterion E is particularly relevant when assessing for racial PTSD, because the literature has consistently documented that experiences with racism and discrimination are often perceived as exceeding one’s ability to cope, which results in feelings of anger, frustration, and irritability, as well as stress-related diseases including hypertension, cancer, and coronary heart disease (Chae et al., 2015; Neblett & Carter, 2012; Utsey & Payne, 2000).

According to the DSM–5′s Criterion F, the duration of the just-mentioned symptom presentations must exceed 1 month. Previous longitudinal studies have documented both internalizing and externalizing problems as a result of racial stressors that are sustained for 2–5 years (Brody et al., 2006; Pavalko, Mossakowski, & Hamilton, 2003; Schulz et al., 2006; Simons, Chen, Stewart, & Brody, 2003). These problems (e.g., depression, anxiety, anger) are accounted for in the DSM–5′s conceptualization of PTSD and would be captured through an assessment of racial trauma that follows these criteria. Thus, it is likely that individuals who are indeed experiencing racial trauma according to the DSM–5 would meet Criterion F regarding symptom duration.

If the experience of the previously cited symptom presentations causes clinically significant distress or impairment within various life spheres (e.g., social, vocational), Criterion G would be met. This is defined in terms of functionality. As previously mentioned, research has supported a clear connection between racism and both distress and impairment in multiple domains (Stevens-Watkins, Perry, Pullen, Jewell, & Oser, 2014).

Criterion H requires the ruling out of other alternative causes, namely that the presentation of the previously mentioned symptoms is not better explained by substance use or another medical condition. Therefore, clinicians should ensure through their assessment that perceived posttrauma reactions are indeed race-based and not better diagnosed as substance abuse, depression, social anxiety, and so forth. However, as noted, experiences of racism and discrimination can result in a range of problems, including substance use, anger and irritability, restlessness, social isolation, withdrawal, and confusion (e.g., Gibbons et al., 2007). So, racial trauma should not be ruled out simply based on the presence of these additional symptoms, even if the individual meets criteria for an additional disorder.

A Model for Racial Trauma

Given the extent to which research has validated experiences of racism as traumatic, Figure 1 shows how racism can lead to PTSD. Although not all racial traumas will lead to PTSD, for a subset of people with certain vulnerabilities (e.g., genetic risk factors due to historical

![Figure 1. Model of the cumulative effects of racial stress and trauma. See the online article for the color version of this figure.](image-url)
trauma, cultural trauma, racial oppression), it is posited that these events have the ability to lead to PTSD. These vulnerabilities result in a base of stress that is exacerbated by ongoing experiences of racial maltreatment (i.e., overt and/or covert racism). Following a triggering experience of racism, which likely includes a perceived threat to safety, life, or personhood, individuals experience emotions associated with the traumatic event (e.g., fear, disbelief, anger). Subsequently, and possibly after having their experience invalidated and having no perceived safe space to process said experience, they begin to experience the typical symptoms of PTSD (reexperiencing the event, avoiding trauma reminders, worsening cognitions and mood, altering arousal and hypervigilance for an extended period), thus causing significant distress or impairment that is not otherwise explained or treated. Further, due to the marginalized status of the victims, avenues for professional help may be limited, thus maintaining and/or worsening traumatization. Figure 2 shows how racial trauma can lead to PTSD as well. This is based on the race-based traumatic stress injury model by Carter (2007) and reconceptualized to align with the framework of the DSM–5’s PTSD criteria. Collectively, these symptoms stem from a traumatic experience of interpersonal racism and could result in an individual’s meeting full criteria for PTSD due to racial trauma.

Identifying and Measuring Racial Trauma

Limitations of Existing PTSD and Racial Trauma Measures

With respect to assessment, Wade (2005) asserted that all intake evaluations should encompass experiences of racism; however, few traditional measures that are used for the detection and formal diagnosis of PTSD examine racism specifically. Among the more extensively used PTSD measures is the Clinician-Administered PTSD Scale (CAPS; Blake et al., 1990; CAPS-5; Weathers et al., 2013), which includes both a self-report section and a formal interview section and has been used widely for people of all races. However, this measure has not been validated with an exclusively ethnic minority sample, nor does it specifically include prompts about racial trauma; therefore, no assumptions can be made concerning its validity for detecting race-based PTSD (e.g., Malcoun et al., 2015).

Additional measures include the Structured Clinical Interview for DSM–5 (SCID-5; First, Williams, Karg, & Spitzer, 2015) and the Diagnostic Interview Scale (Regier et al., 1984), which has continuous severity scores, and the fifth edition of the PTSD Symptoms Scale—Interview (PSSI-5; Foa et al., 2016), which is brief and easily completed. The main problem with such scales is the requirement that the traumatization be the result of a discrete event, which fails to consider the effect of cumulative racial trauma. Two additional measures sometimes used to diagnose PTSD are the Keane PTSD Scale of the Minnesota Multiphasic Personality Inventory (MMPI; Keane, Malloy, & Fairbank, 1984) and the MMPI-2 (Lyons & Keane, 1992). Both measures have been studied in combat veterans as well as in a nonclinical population. However, the authors of these scales have called for further validation in other clinical samples of trauma survivors (Blake et al., 1995). In addition, several self-report questionnaires, such as the Distressing Event Questionnaire (DEQ; Kubany, Leisen, Kaplan, & Kelly, 2000), the Los Angeles Symptom Checklist (King, King, Leskin, & Foy, 1995), and the Screen for Posttraumatic Stress Symptoms (Carlson, 2001), can also be used to assess for PTSD; however, many of them have not been validated in various ethnoracial minority groups (Malcoun et al., 2015).

Given this gap in diagnostic methods, Carter and colleagues (2013) developed a measure called the Race-Based Traumatic Stress Symptom Scale (RBTSSS), designed to assess racist experiences and the associated psychological and emotional reactions and validated in multiple ethnoracial groups. RBTSSS contains 52 items that compose seven scales, descriptive of symptoms of depression, intrusive thoughts, anger, hypervigilance, physical reactions, low self-esteem, and avoidance. The measure requires the client to identify three upsetting experiences of racism and then identify the one most memorable experience, which serves as an anchor for subsequent questions. Limitations to the measure include that it is primarily a self-report measure, it requires a complicated scoring procedure, it rates only a single racial event,
and it does not follow the DSM–5 framework for understanding the trauma related symptoms.

**Overview of the UConn Racial/Ethnic Stress & Trauma Survey**

To further address this diagnostic gap, we developed a new clinician-administered interview for racial trauma: the UConn Racial/Ethnic Stress & Trauma Survey (UnRESTS). The interview is intended uncover various forms of racism experienced by clients, which can be critical for case conceptualization, and to help to determine whether those experiences were collectively traumatizing. This understanding is essential for providing proper support, validation and culturally informed care. The interview includes questions to assess ethnic identity development, a semistructured interview to probe for a variety of racism-
related experiences, and a checklist to help determine whether the individual’s racial trauma symptomatology meets DSM–5 criteria for PTSD. The format of the UnRESTS is modeled after the DSM–5 Cultural Formulation Interview (CFI; APA, 2013). Unfortunately, neither the CFI nor its supplementary modules examine racism or discrimination, despite the CFI’s having been developed as a cultural assessment. Therefore, it is important for clinicians to also have access to an interview such as the UnRESTS, which is specifically designed for the assessment of discrimination and its impact.

Like the CFI, the UnRESTS is formatted into two columns, with one column describing instructions for the evaluator and the other column describing questions for the examiner to ask the examinee (see the online supplemental materials). The interview guides the examiner in obtaining information about the client’s experiences of racism, and it is intended to be used in a flexible manner to build rapport with the client. As such it may be necessary to ask follow-up questions to get more details.

The interview portion of the UnRESTS is divided into various sections to obtain pertinent details from the examinee’s life. These sections include Introduction to the Interview, Racial and Ethnic Identity Development, Experiences of Direct Overt Racism, Experiences of Racism by Loved Ones, Experiences of Vicarious Racism, and Experiences of Covert Racism (i.e., microaggressions). It should be emphasized, however, that the UnRESTS should not be used as the only determination of a PTSD diagnosis, but rather as an aid for collecting information about racial and ethnic identity and how they feel about their group to better inform the clinician about the context of their distress. When administered in self-report format, the six racial and ethnic identity questions included are highly correlated to the 12-item Roberts et al. (1999) version of the MEIM ($r_{H11005} = .95$, $p_{H11021} < .001$), with good reliability in young adults ($r_{H9251/H11005} = .81$; M. T. Williams, Duque, & Wetterneck, 2015). The total score for the UnRESTS racial/ethnic identity items ranges from 0 to 12, with scores of 0–3 considered low, 4–8 average, and 9–12 high, for people of color.

The introduction section provides information regarding the scope of the interview and asks clients what racial and ethnic group they identify with. To understand the context in which people of color experience racism, it is important to understand something about their racial and ethnic identity. Developed throughout life, racial and ethnic identity is the framework through which these stigmatized groups experience and understand discrimination. Based on the Multigroup Ethnic Identity Measure (MEIM; Roberts et al., 1999; M. T. Williams, Duque, Wetterneck, Chapman, & DeLapp, 2018), the Racial and Ethnic Identity Development section focuses on clients’ socialization to race and ethnicity and how they feel about their group to better inform the clinician about the context of their distress. When administered in self-report format, the six racial and ethnic identity questions included are highly correlated to the 12-item Roberts et al. (1999) version of the MEIM ($r = .95$, $p < .001$), with good reliability in young adults ($\alpha = .81$; M. T. Williams, Duque, & Wetterneck, 2015). The total score for the UnRESTS racial/ethnic identity items ranges from 0 to 12, with scores of 0–3 considered low, 4–8 average, and 9–12 high, for people of color.

Following the introduction section, the structured interview portion of the measure moves to questions about discriminatory events. To that end, the interview guides the clinician in asking about individuals’ experiences surrounding explicit and obvious racism toward them, racism experienced by loved ones, being vicariously impacted by racist experiences that were learned about, and experiences with subtle forms of racism or microaggressions.

**Format of the UnRESTS**

The UnRESTS was developed based on the first author’s extensive experience as a clinician, researcher, and diversity educator, in response to consistent trainee anxieties about how to ask sensitive questions about race and racism (e.g., Wade, 2005). All questions were reviewed and tested by numerous diverse clinicians with various levels of experience and then refined to arrive at the final interview. This process included soliciting input from PTSD and diversity experts during the early stages of development, followed by piloting the interview and eliciting feedback from clinical psychology doctoral students and clinicians at clinical diversity workshops. The refined UnRESTS was then tested at several additional sites, including varied clinician workshops, a student counseling clinic, outpatient clinics, a multisite PTSD treatment program, a multinational PTSD research study, and forensic settings, all with positive feedback from users.

The introduction section provides information regarding the scope of the interview and asks clients what racial and ethnic group they identify with. To understand the context in which people of color experience racism, it is important to understand something about their racial and ethnic identity. Developed throughout life, racial and ethnic identity is the framework through which these stigmatized groups experience and understand discrimination.
The UnRESTS also includes a section in which symptoms and associated distress from racism are evaluated using yes–no response items to help users determine whether respondent symptoms match DSM–5 criteria for PTSD. The racial trauma checklist is based on the DSM–5 items, with some items adapted from the PSSI-5, and it has been well validated in African Americans (Malcoun et al., 2015). A Likert scale of items that can be summed for a total score is currently being validated for quantitative use, and the UnRESTS has also been translated into Spanish, with input from bilingual clinicians speaking several different Spanish dialects (M. T. Williams, Peña, & Mier-Chairez, 2017).

Case Examples

The following three examples are from individuals who were assessed for racial stress and trauma using the UnRESTS, which served as a guide for asking sensitive questions about race and racism for the purpose of culturally informed assessment and/or treatment. (The names and some details have been changed to protect their identities.)

African American Woman Facing Workplace Trauma

Ms. Bates was a middle-aged African American woman living in the Midwest who sought treatment for racism-related stress after experiencing discriminatory experiences in her workplace. At the time of assessment, she presented with symptoms of anxiety, panic attacks, restless sleep, constant rumination, anger, feelings of powerlessness, and depression. Ms. Bates was given the UnRESTS by a masters-level African American male therapist to help understand the factors that were contributing to her distress. The clinician was able to collect detailed information about her ethnic identity and lifetime history of experiencing racism and discrimination (e.g., being called a monkey in front of a classroom full of White students), as well as ongoing racial stressors. Ms. Bates described the onset of her symptoms as occurring after politely confronting her European American boss about a racially offensive comment, which was met with her boss becoming defensive and then victimizing toward Ms. Bates and other ethnic minority staff at her workplace. She felt distressed about the experience and also blamed herself over the mistreatment of her coworkers. Using the checklist at the end of the UnRESTS, the clinician was able to identify DSM–5 PTSD symptoms due to her experiences of racial trauma.

Primary treatment goals for Ms. Bates included processing the discriminatory experiences that took place at her workplace and throughout her childhood, while also sorting through and labeling her emotional reactions. Further, processing her racial and ethnic identity was used to facilitate a better understanding of how she related racist messages to her sense of self. Treatment involved building realistic expectations for future race-related interactions by acknowledging the oppressive systems at play and providing psychoeducation around microaggressions and other sources of racial stress. Goals for Ms. Bates also included exploring her affect, encouraging the expression of emotions other than anger (e.g., helplessness, confusion), and engaging with her emotional needs through mindful meditation.

Through processing her racial traumas, Ms. Bates was exposed to much of the uncomfortable affect that she was taught to avoid. Additionally, she was able to cope with her anger and pain, to speak about her experiences with a more balanced perspective, to acknowledge the systemic processes keeping her boss from being penalized for her actions, and to view experiences of racism with more realistic expectations. Although Ms. Bates was still experiencing some symptoms of anxiety at the conclusion of treatment, she no longer met DSM–5 criteria for PTSD.

Custody Evaluation for African American Father

Mr. Carrington was a 36-year-old African American father who presented for a court-ordered evaluation for parenting fitness to inform a custody issue. His daughter was living with her biological mother in a different state, and they had been involved in a custody dispute for over 10 years. He had not seen his daughter in 2 years at the time of assessment. Mr. Carrington reported undergoing at least two previous court-ordered mental health evaluations in an attempt to regain custody, and he was denied
partial custody because prior evaluations indicated that he had “anger issues.” Mr. Carrington’s mother was non-Hispanic White, and he expressed concern that his daughter was missing critical years of socialization pertaining to her African American heritage. He wanted to regain equal custody and be allowed to spend unsupervised time with her, and he indicated that he had not been allowed to discuss certain religious topics or her ethnic background with his daughter in the past.

Mr. Carrington’s clinician was an early-career, European American psychologist. When presenting for assessment, Mr. Carrington was likable and cooperative, albeit frustrated with perceived injustices in attempting to regain custody of his daughter. In addition to Mr. Carrington’s being assessed concerning his cognitive ability, family and social history, parenting, anger measures, and completing a personality inventory, he received a series of race-based assessments that indicated he was having frequent experiences of microaggressions and experiencing higher levels of distress than do other African American individuals. To gain a fuller understanding of his experiences, the clinician administered the UnRESTS. In addition to numerous experiences with microaggressions, racism, and discrimination, Mr. Carrington reported that the “Rodney King beating” in Los Angeles was a major turning point in his awareness of difficulties that could be encountered because of one’s race. He also shared receiving negative messages about his ethnicity since childhood from others outside his family, stating that he was “called the n-word so much I thought it was my first name.” He noted that he is repeatedly reminded of these experiences when he sees events occurring in the media involving shootings of African American individuals and that these events cause him significant distress when they were occurring. He also reported experiencing reoccurring distressing memories of pictures of unarmed African Americans who were recent victims of police shootings. Mr. Carrington described avoidance of places, particularly small towns, in which he worried he would be confronted with racism, and he indicated experiencing negative attitudes toward himself and his racial group because of these experiences. Mr. Carrington indicated experiencing negative attitudes toward White authority figures, feeling that the world is dangerous, blaming himself for discriminatory events that have happened to him, experiencing fear while driving, and feeling alienated from others. He also described feeling frustrated, alert, and easily startled and that his relationships have been impacted by his experiences with racism.

Although Mr. Carrington appeared frustrated at times, his frustration did not present as anger but rather discouragement with his current situation. There was no evidence to suggest that Mr. Carrington was violent or aggressive with other individuals; thus, his anger and frustration were considered representative of his feelings in this situation rather than a pervasive personality characteristic. Mr. Carrington also endured a significant history of racially motivated discriminatory experiences that contributed to his desire to be present for his daughter in helping her cope with such experiences, given that she was likely to experience similar events in her lifetime. Mr. Carrington expressed a great deal of worry that his daughter was not experiencing proper racial socialization with African American individuals. Research has indicated that racial socialization is associated with stronger ethnic identity, feelings of closeness to other individuals of the same ethnicity, stronger social support, and better mental health outcomes overall (Demo & Hughes, 1990), indicating that Mr. Carrington’s fears were not unfounded.

Although Mr. Carrington was clearly suffering from racial stress, it did not meet the level of PTSD. Thus, at the conclusion of this assessment, Mr. Carrington was rendered no diagnosis, although it was recommended that he consider support to cope with the distress associated with attempting to regain custody of his daughter and to process experiences of discrimination. Given Mr. Carrington’s history of being denied equal custody due to perceived
anger management issues, and the subsequent determination that he was successful in treatment, it was recommended that Mr. Carrington be permitted more frequent visits with his daughter and extended time during the summer.

Hispanic American Student With Racial Stress at School

Marjoree was a 28-year-old Hispanic American woman completing her master of fine arts in dance at a private college on the East Coast. She presented for therapy due to stress at school and missing her family in California. The UnRESTS was used to better understand the client’s experience of being a racialized minority and her history of racism. The therapist, a European American male graduate student, reported experiencing some initial discomfort when administering the UnRESTS because he was not accustomed to discussing racial issues with clients. However, as he moved past his own initial anxiety, the client also became more at ease and open, which allowed them to explore this important material together.

Marjoree was born in Peru and immigrated to California at the age of 9 due to armed conflict in her country of origin. She identified her race as “Latina.” Even though the UnRESTS indicated Marjoree had a strong level of attachment and pride related to her racial group, she felt a great deal of personal shame for “looking different” and “not fitting in.” Marjoree had experienced colorism from a young age in Peru due to her darker skin and more indigenous features, which led to a negative self-image. This internalized racism resulted in anxiety about learning English as a recent immigrant in grade school. Marjoree recounted multiple experiences of both direct and vicarious racism in the United States related to being Latina, largely taking the form of microaggressions. The psychological fallout of her experiences had many similarities to the symptoms of racial battle fatigue that results from the cumulative effects of microaggressions in predominately White environments (Smith et al., 2007).

In high school, Marjoree’s academic ability was often explicitly questioned due to race. This was determined to be the key event where for the first time she became fully aware that she was experiencing racism. Marjoree described feeling “punched in the stomach” as a result of having her intelligence questioned, and at first she had difficulty accepting that it was an act of racism and not a legitimate assessment of her intellectual ability. She described ruminating on the memory later in college, especially when other microaggressions occurred. The accumulation of these experiences created cognitive distortions and anxious distress, because they undermined her experiential reality and pushed her toward self-blame for feeling overly sensitive. In her first semester of graduate school, Marjoree continued to experience racial microaggressions as one of few students of color in her program. She described feeling intense emotional distress that resulted from the isolation and pressure placed upon her by the graduate program to prove she belonged. Her distress was likely compounded by the environmental microaggressions, now happening more frequently in an almost entirely White, homogeneous graduate program setting, with fewer social resources and support and being far from her home in California. She started having nightmares, avoiding her White classmates, and experiencing uncontrolled crying spells in her room for an hour at a time.

Despite Marjoree’s feeling some distress during the interview, both she and the therapist had a positive and meaningful experience with the UnRESTS. The therapist felt it allowed him to do a more thorough assessment for stress and potential trauma due to experiences of racism and reflected that it would be clinically important to assess the degree to which these experiences impacted the client even if DSM diagnoses were not a concern. The client reported feeling respected, safe, and heard during a potentially uncomfortable interview. Using the information gathered from the UnRESTS and a clinical interview, the therapist concluded that she was experiencing racial trauma. However, the client did not meet DSM–5 criteria for PTSD, because there was no qualifying Criterion A event, so she was instead given a diagnosis of adjustment disorder, with mixed anxiety and depressed mood.

The information gathered using the UnRESTS was critical in informing the therapist and developing a treatment plan. As Marjoree attended therapy, she experienced increased relief as she learned more about multicultural issues through culturally informed discussions with her therapist. Gaining the language to de-
scribe stereotyping and microaggressions empowered her to take ownership of her narrative. Being able to label and contextualize her experiences allowed her to make sense out of her external experiences and internal beliefs and to better understand how racism had impacted her emotional health and self-image. Through this process, she was able to employ positive coping strategies when direct or vicarious experiences of racism occurred, including seeking social support from other minority students and spending more time at the university cultural center. Cultivating a deeper understanding of her own and other students’ experiences with racism helped further Marjoree’s racial identity development. The reclamation of her racial identity likely also served as a protective factor as she continued to cope with microaggressions. By the end of treatment, Marjoree had developed increased pride related to her Peruvian heritage, indigenous appearance, and Latina American culture.

Conclusion

Experiencing racism is stressful and can lead to traumatization. PTSD can follow the experience of a discrete traumatic event or be a cumulative reaction to a series of stressful, interpersonal events. Here, we have illustrated that the catalyst of a trauma reaction such as PTSD extends beyond those presently emphasized by the DSM. The experience of racism in the lives of people of color, including the cumulative effects of microaggressions, potentiates the development of clinically significant distress and an identifiable trauma reaction. The need for clinicians to conceptualize cases in accordance with the ethnicity and cultural heritage of clients is ongoing and of paramount clinical importance, due in part to the tremendous impact that racism and discrimination can have upon the mental health of people of color.

The UnRESTS is an interview designed to assist psychologists and other mental health professionals in identifying racial trauma in individuals and in developing a qualitative understanding of their experiences for case conceptualization and culturally informed care. The administration of the UnRESTS can create space for individuals to process these experiences within a therapeutic environment and provide the clinical clarity for practitioners to better conceptualize whether a trauma is race-based. The development of this interview and the contribution it offers to the literature is important to modern society and the future of peace and diversity. Of equal value, the UnRESTS may offer an increased sense of hope to the individuals who constitute the populace, who see that the field of psychology is attending to their unique experiences as people of color.

Racism continues today as a destructive force within society and an affront to the ideals of modern Americanism. Individual experiences, identities, and lives are marked by discrimination, prejudice, and even violence. Mental health practitioners, among others, bear the important burden of both identifying the perpetuation of racism within modern society and also treating the psychological distress and wounds that result from it. It is posited here that, through understanding an individual’s reactions to racially traumatic events within the DSM–5 framework, future evidence-based psychotherapeutic interventions designed to reduce symptoms of PTSD could be utilized to reduce these potentially harmful sequelae. Further directions in research should center on quantitative assessment of racial trauma and the effective treatment of individuals suffering from it (Comas-Díaz, 2016; Gone, 2013; M. T. Williams & Leins, 2016; M. T. Williams et al., 2014). Furthermore, work needs to be done to reduce racism in all forms to make our society a healthier space for people of color.

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