Understanding Race-Based Trauma
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PTSD in Minorsities

Allen was a young African American man working at a retail store. Although he enjoyed and valued his job, he struggled with the way he was treated by his employer. He was frequently demeaned, given menial tasks, and even required to track African American customers in the store to make sure they weren’t stealing. He began to suffer from symptoms of depression, generalized anxiety, low self-esteem, and feelings of humiliation. After filing a complaint, he was threatened by his boss and then fired. Allen’s symptoms worsened. He had intrusive thoughts, flashbacks, difficulty concentrating, irritability, and jumpiness – all hallmarks of posttraumatic stress disorder (PTSD). Allen later sued his employer for job-related discrimination, and five employees supported his allegations. Allen was found to be suffering from race-based trauma (from Carter & Forsyth, 2009).

PTSD is a severe and chronic condition that may occur in response to any traumatic event. The National Survey of American Life (NSAL) found that African Americans show a prevalence rate of 9.1% for PTSD versus 6.8% in non-Hispanic Whites, indicating a notable mental health disparity (Himle et al., 2009). Increased rates of PTSD have been found in other groups as well, including Hispanic Americans, Native Americans, Pacific Islander Americans, and Southeast Asian refugees (Pole et al., 2008). Furthermore, PTSD may be more disabling for minorities; for example, African Americans with PTSD experience significantly more impairment at work and carrying out everyday activities (Himle, et al. 2009).

Changes in the DSM-5

Changes to PTSD criteria in the DSM-5 have been made to improve diagnostic accuracy in light of current research (American Psychiatric Association, 2013; Friedman et al., 2011). Previously, a person was required to have directly experienced a discrete traumatic event for a diagnosis. But under the new criteria, if a person has learned about a traumatic event involving a close friend or family member, or if a person is repeatedly exposed to details about trauma, they may now be eligible for a PTSD diagnosis. These changes were made to include those exposed in their occupational fields, such as police officers or emergency medical technicians. However, this could be applicable to those suffering from the cumulative effects of racism as well.

The requirement of responding to the event with intense fear, helplessness, or horror has been removed. It was found that in many cases, such as soldiers trained in combat, emotional responses are only felt afterward, once removed from the traumatic setting. The most notable change to the criterion is from a three to a four-factor model. The proposed factors are intrusion symptoms, persistent avoidance, alterations in cognition and mood, and hyperarousal/reactivity symptoms. Three new symptoms have been added – persistent distorted blame of self or others, persistent negative emotional state, and reckless or self-destructive behavior. These symptoms may be also seen in those victimized by race-based trauma.

Racism and PTSD

One key factor in understanding PTSD in ethnoracial minorities is the impact of racism on psychological well-being. Racism continues to be a daily part of American culture, and racial barriers have an overwhelming impact on the oppressed. Research has documented that implicit and explicit racism create barriers to health care
hyper vigilance, and other symptoms associated with PTSD may develop or worsen (Bryant-Davis & Ocampo, 2005).

Many clinicians only recognize racism as trauma when an individual experiences a discrete racist event, such as a violent hate crime. This is limiting given that many minorities experience cumulative experiences of racism as traumatic, with perhaps a minor event acting as “the last straw” in triggering trauma reactions (Carter, 2007). Thus, the conceptualization of trauma as a discrete event may be inadequate for diverse populations. Moreover, existing PTSD measures aimed at identifying an index trauma typically fail to include racism among listed choice response options, leaving such events to be reported as “other” or squeezed into an existing category that may not fully capture the nature of the trauma (Malcoun, Williams, & Bahojb-Nouri, 2015).

This can be especially problematic as minorities may be reluctant to volunteer experiences of racism to White clinicians, who comprise the majority of mental health care providers (US Department of Labor, 2013). Patients may worry that the clinician will not understand, become defensive, or express disbelief. Additionally, minority patients may not link current PTSD symptoms to cumulative experiences of discrimination if queried about a single event.

To address this need, Carter and colleagues (2013) developed a new measure called the Race-Based Traumatic Stress Symptom Scale (RBTSSS), designed to assess racist experiences and the associated psychological and emotional reactions. RBTSSS contains 52 items that comprise seven scales, descriptive of symptoms of depression, intrusive thoughts, anger, hyper vigilance, physical reactions, low self-esteem, and avoidance. Although more study is needed, this measure may be one good way to evaluate the impact of racism in ethnic and racial minority patients. **Implications for Treatment**

Racism is not typically considered traumatic by mental health care providers. Psychological difficulties attributed to racist incidents are often questioned or minimized, a response that only perpetuates the victim’s anxieties (Carter, 2007). Thus, patients who seek out mental healthcare to address race-based trauma may be further traumatized by microaggressions — subtle racist slights — from their own clinicians when they encounter disbelief or avoidance of racially charged material (Sue et al., 2007).

Mental health professionals must be willing and able to assess race-based trauma in their minority patients. Clinicians assessing ethnoracial minorities are encouraged to directly inquire about the patient’s experiences of racism when determining trauma history. Some forms of race-based trauma may include racial harassment, discrimination, witnessing ethnoviolence or discrimination of another person, historical or personal memory of racism, institutional racism, microaggressions, and the constant threat of racial discrimi-
nation (Helms et al., 2012). The more subtle forms of racism may be commonplace, leading to constant vigilance, or “cultural paranoia,” which may be a protective mechanism against racist incidents. However subtle, the culmination of different forms of racism may nonetheless result in victimization of an individual parallel to that induced by physical or life-threatening traumatic experience.

Unfortunately, many clinicians are unprepared to address cultural issues due to social taboos surrounding racism, discrimination, and White privilege. This will in turn prevent open dialogue with patients about potentially relevant experiences. Thus it is important that all clinicians are well-trained in the delivery of culturally competent care to enable them to properly serve diverse patients (see Miller et al., 2015 for a discussion).

**Summary**

Although changes to the DSM increase the potential for better recognition of race-based trauma, more awareness is needed among clinicians to properly identify it. Additionally, current instruments for screening and assessing trauma are generally inadequate for race-based trauma. More research is needed to develop validated tools and a culturally competent model of PTSD to address how culture may differentially influence race-based trauma. In the meantime, clinicians must be educated about the impact of racism in lives of their ethnic minority patients, specifically the connection between racist experiences and trauma (Williams et al., 2014). To that end, interventions to increase awareness and improve clinical dialogue should have the same value as other aspects of medical training (Penner, Blair, Albrecht, & Dovido, 2014). *Article references are accessible here.*

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**School of Medicine**  
**Dean’s Perspective on Race**  
*by Toni Ganzel, MD, MBA, FACS*  
*Dean, School of Medicine*

The theme topic for this month’s Diversity Newsletter is race, and I was asked to contribute my perspective. I view race as one of the factors at the heart of diversity, but certainly not the only factor. Diversity represents a rich constellation of elements such as age, gender identity, religion, national origin, sexual orientation, etc. and adds dimensional depth to our culture and climate.

As Dean, my goal for promoting diversity and a climate of inclusion at the School of Medicine is twofold. First, being an academic community that reflects different perspectives and experiences makes us a more highly performing institution; it enhances the educational experiences of our learners, broadens our leadership pipelines and advances our mission of improving the health of our patients and our communities. In 2014, the American Psychiatry published an article entitled *The Critical Need to Diversify the Clinical and Academic Workforce* in which it was noted that diversifying the academic community enables institutions to “enable the next generation of leaders to incorporate new ways of thinking in discovery application, integration and teaching, as well as to better serve the needs of an increasingly diverse society.” Our organizational pillars of education, research, patient care, and community engagement are directly impacted by the degree to which we are successful in weaving diversity and inclusion into the core values of our school. Second, a diverse current and future workforce of physicians and scientists can better meet the medical needs of the underserved and contribute to addressing health disparities. According to the Association of American Medical Colleges (AAMC), “diversity in the physician workforce impacts the quality of care received by patients. For example, race concordance between patient and physician results in longer visits and increased patient satisfaction, and language concordance has been positively associated with adherence to treatment among certain racial or ethnic groups.” The AAMC goes on to suggest that, based on tracking data, physicians from underrepresented racial and ethnic backgrounds are more likely to practice in low socioeconomic and federally designated medically underserved areas.

A particularly troubling statistic related to racial diversity in medicine is the tragic paucity of black