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1 COMMENTARIES

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**Trauma, Posttraumatic Stress Disorder, and
Ethnoracial Minorities: Toward Diversity
and Cultural Competence in Principles
and Practices**

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Medicine

Psychological trauma and posttraumatic stress disorder (PTSD) affect persons and communities of all ethno-cultural backgrounds. In light of the substantial evidence of intra- and intergroup diversity in the experience of psychological trauma and PTSD, it is essential first to reconsider the ways in which ethnocultural identity is defined and classified, in order to meaningfully study the relationship of race, ethnicity, and culture to the risk and adverse outcomes of psychological trauma. The role of racism as a risk factor for exposure to psychological trauma and PTSD, as well as a potential traumatic stressor with intergenerational effects, also requires careful study. Culturally competent psychological interventions to prevent or treat PTSD require informed practitioners who do not make stereotypic assumptions or inadvertently replicate racial biases.

Key words: clinical practice, culture, ethnicity, posttraumatic stress disorder, race, trauma, theory. [*Clin Psychol Sci Prac* 15: 62–67, 2008]

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Every individual, family, and community has a heritage that includes a distinctive blend of racial, ethnic, cultural, and national characteristics. Within this heritage, there often also is a legacy of personal or familial exposure to psychological trauma. As documented by the literature review article in this issue, psychological trauma and posttraumatic stress disorder (PTSD) occur across the full spectrum of racial, ethnic, and cultural groups in the United States. Trauma and PTSD are epidemic internationally as well, particularly for ethnoracial minority groups (which include a much broader range of ethnicities and cultures and manifestations of PTSD than typically recognized in studies of PTSD in the United States; De Jong, Komproe, Spinazzola, van der Kolk, & Van Ommeren, 2005). The scientific and clinical study of prevalence, impact, and treatment of PTSD among ethnoracial majority and minority groups is of great importance, especially given the disparities, adversities, and traumas to which ethnoracial minorities have been subjected historically and to which they continue to be exposed in health (www.cdc.gov/mmwr/preview/mmwrhtml/mm5401a4.htm) and health care (www.kff.org/minorityhealth/disparities.cfm), education and income (file:///C:/Documents%20and%20Settings/ford/Local%20Settings/Temporary%20Internet%20Files/Content.IE5/OGQUM23V/BrownPresDisparityData%5B1%5D.ppt#262,10,Poverty: Poverty Rates), and a adult criminal (www.civilrights.org/publications/reports/cj/) and juvenile justice (www.aecf.org/publications/pdfs/pathways8.pdf). In this commentary, three specific directions for further advancing the study of PTSD among ethnoracial minorities will be discussed: (a) reconsideration of the definitions of ethnocultural categorical groups, (b) clarification of the nature of the relationship between race/ethnicity and

1 racism and PTSD, and (c) steps toward an empirically
 2 based approach to adapting and enhancing PTSD
 3 treatment for ethnoracial minorities

5 **DEFINING AND CLASSIFYING ETHNOCULTURAL BACKGROUND**

6 Although Latinos (and possibly African Americans) persons
 7 are at greater risk than European Americans for PTSD
 8 (Pole, Gone, & Kulkarni, 2008), it is possible that the elevated
 9 prevalence may be due to differential exposure to psy-
 10 chological trauma (including prior traumas that often are
 11 not assessed in PTSD clinical or epidemiological studies;
 12 e.g., Eisenman, Gelberg, Liu, & Shapiro, 2003) or to
 13 differences in exposure to other risk or protective
 14 factors such as poverty or education (e.g., Turner & Lloyd,
 15 2003, 2004). In addition, the review notes that there is
 16 sufficient diversity (in norms, beliefs, values, roles,
 17 practices, language, and history) *within* categorical
 18 ethnocultural groups such as African Americans or Latinos
 19 to call into question any sweeping generalizations about
 20 their exposure and vulnerability or resilience to psy-
 21 chological trauma. Therefore, in order to meaningfully
 22 describe and study racial, ethnic, and cultural differences
 23 in exposure to psychological trauma and posttraumatic
 24 impairment (or resilience and recovery)—let alone to
 25 prescribe approaches to prevent or ameliorate trauma's
 26 adverse effects—it is essential that we first carefully re-
 27 examine the categories (and the criteria for assigning
 28 people or groups to distinct categories) with which we
 29 propose to classify people or groups based on race,
 30 ethnicity, and culture.

31 Race, ethnicity, and culture tend to be described with
 32 shorthand labels that seem to distinguish homogeneous
 33 subgroups but actually obscure actual heterogeneity
 34 behind a façade of uniformity (Marsella, Friedman,
 35 Gerrity, & Scurfield, 1996). Valuable qualitative data
 36 could be accrued by asking study participants or clinical
 37 patients to self-identify their own racial, ethnic, and
 38 cultural background (Brown, Hitlin, & Elder, 2006).
 39 Such data could be cumulated within and across studies
 40 to begin to define more sensitive categories for quantitative
 41 analyses. Factors likely to be associated with differential
 42 exposure to adverse experiences (e.g., racial-ethnic dis-
 43 crimination) or access to protective resources (e.g., income,
 44 healthcare, education) could be used as criteria for
 45 combining or partitioning ethnocultural subgroups, as
 46 well as to subsequently test the validity and utility of

different categories and groupings. For example,
 membership in indigenous ethnocultural groups has been
 shown to be associated with increased risk of discrimination
 and poor health in several studies internationally (e.g.,
 Harris et al., 2006; Liberato, Pomeroy, & Fennel, 2006).

Clarifying the Interrelationship of Racism, Trauma, and PTSD

The interactive effects of psychological trauma, PTSD,
 and racism and discrimination are complex. Specifically,
 racism may constitute: (a) a risk factor for exposure to
 psychological trauma, (b) a moderator that may exacerbate
 the impact of psychological traumas and increase the risk
 of PTSD or other posttraumatic impairments, and (c) a
 form of psychological trauma in and of itself.

Racism and Risk of Trauma Exposure. No studies have
 been reported that directly examine racism as a risk
 factor for exposure to psychological trauma. Studies
 based in the United States that are cited in the review
 article converge with findings from international samples
 (e.g., Australia; Macdonald, Chamberlain, & Long, 1997)
 to suggest that racial discrimination may have played a
 role in placing military personnel from ethnoracial minority
 groups at risk for more extensive and severe combat
 trauma exposure. Studies of survivors of the Holocaust
 and other episodes of ethnic annihilation provide particularly
 graphic and tragic evidence of the infliction of psychological
 trauma in a masse in the name of racism (Yule, 2000).
 Studies are needed that systematically compare persons
 and groups who are exposed to different types and degrees
 of racism in order to test whether (and under what
 conditions) racism specifically accounts for increased
 risk of trauma exposure.

Racism and Risk of PTSD. One study found that self-
 reported experiences of racial discrimination increased
 the risk of PTSD among Latino police officers particularly
 (and also African Americans) (Pole, Best, Metzler, &
 Marmar, 2005). However, the investigation's cross-sectional
 self-report data prevent any firm conclusions about the
 actual (as opposed to self-reported) causal or prospective
 (as opposed to correlational) association of racial dis-
 crimination and PTSD. As the review article makes
 clear, when racism leads to the targeting of ethnoracial
 minority groups for violence, dispossession, or dislocation,
 the risk of PTSD increases in proportion type and

1 degree of psychological trauma involved in these adverse
2 experiences. Another study, with Asian American
3 military veterans from the Vietnam War era showed that
4 exposure to multiple race-related stressors that met PTSD
5 criteria for psychological trauma was associated with
6 more severe PTSD than when only one or no such
7 race-related traumas were reported (Loo, Fairbank, &
8 Chemtob, 2005). This study more precisely operationalized
9 racism than any prior study, utilizing two psychometrically
10 validated measures of race-related stressors and PTSD.
11 However, as in the Pole et al. (2005) study, the stressors/
12 traumas and PTSD symptoms were assessed by self-
13 report contemporaneously, so it is unclear neither that
14 the relationship was not an artifact of the measurement
15 method nor what was the actual extent of racism
16 experienced in each distinct incidence. The study by
17 Loo et al. (2005) also did not control for the extent of
18 trauma exposure that occurred independently of traumas
19 that were race-related. In order to extend the valuable
20 work, these studies have begun, and it will be important
21 to utilize measures based on operationally specific
22 criteria for categorizing and quantifying exposure to
23 discrimination (e.g., Wiking, Johansson, & Sundquist,
24 2004) as a distinct class of adversities or stressors that can
25 be assessed separately from and concurrently with
26 exposure to psychological trauma.

27 As noted above, racism also may lead to pervasive
28 disparities in access to social resources such as education,
29 income, political influence, and health care. Research is
30 needed to determine to what extent the adverse outcomes
31 of racial disparities are the direct result of racism as a
32 stressor (e.g., racially motivated stigmatization, subjugation,
33 and deprivation), as opposed to the indirect effects of
34 racism as a diathesis reducing access to protective factors
35 (e.g., socioeconomic resources) that buffer against the
36 adverse effects of stressors (e.g., poverty, pollution) and
37 trauma (e.g., accidents, crime). It is important to deter-
38 mine whether PTSD is the product of either the direct
39 (stressor) or indirect (diathesis) effects of racism, par-
40 ticularly given its demonstrated association with
41 other psychiatric disorders (e.g., depression) and with
42 increased risk of physical illness (e.g., cardiovascular
43 disease) in ethn racial minorities (e.g., American Indians;
44 Sawchuk et al., 2005).

45 Education is a particularly relevant example of a
46 socioeconomic resource to which ethn racial minorities

often have restricted access and that is a protective factor
mitigating against the risk of PTSD (Dirkzwager,
Bramsen, & Van der Ploeg, 2005) and overall health
problems (Wiking et al., 2004). Racial disparities in
access to education are due to both direct influences (e.g.,
lower funding for inner-city schools that disproportionately
serve ethn racial minority students) and indirect associations
with other racial disparities (e.g., disproportionate juvenile
and criminal justice confinement of ethn racial minority
persons). Racial disparities in education have a potentially
cumulative adverse effect on vulnerability to PTSD,
because they are both the product of and a contributor
to reduced access by ethn racial minorities to other
socioeconomic and health resources (e.g., income,
health insurance; Harris et al., 2006). When investigating
risk and protective factors for PTSD, therefore, it is
essential to consider race and ethnicity in the context not
only of ethn cultural identity and group membership but
also of racial disparities in access to socioeconomic resources.

Although ethn racial subgroups are disproportionately
disadvantaged, disparities in access to vital resources and
over violence and loss due to displacement from home,
community, and national origins have occurred historically
across all racial and ethn cultural lines in the United
States and in other parts of the world (e.g., massively
displaced populations in the Balkans, Central Asia, and
Africa). When primary social ties are cut or diminished as
a result of violence and coercion the challenge expands
beyond survival of traumatic life-threatening danger to
preserving a viable developmental trajectory in the face
of life-altering loss (Garbarino & Kostelny, 1996;
Rabalais, Ruggiero, & Scotti, 2002). A recurring theme
in these studies is that trauma inflicted in service of racial
discrimination may lead not only to PTSD but also to a
range of insidious psychosocial impairments that result
from adverse effects on the psychobiological development
of the affected persons. When families and entire com-
munities are destroyed or displaced, the impact on the
psychobiological development of children (Ford, 2005)
and young adults (Ford, 1999) may lead to complex
variants of PTSD that involve not only persistent fear
and anxiety but also core problems with relatedness and
self-regulation of emotion, consciousness, and bodily
health that are described as “complex PTSD” (Cook
et al., 2005) or “Disorders of Extreme Stress” (De Jong
et al., 2005).

1 *Racism as Psychological Trauma.* A critical question
2 posed but not yet answered by studies of PTSD and
3 racial discrimination (Pole et al., 2005) and race-related
4 stress (Loo et al., 2005), as well as by the robust literature
5 demonstrating intergenerational transmission of risk for
6 PTSD (Kellermann, 2001), is whether racism constitutes
3 a “hidden” (Crenshaw & Hardy, 2006) or “invisible”
8 (Franklin, Boyd-Franklin, & Kelly, 2006) form of
9 traumatization that may be transmitted across generations.
10 Recent research findings demonstrate uniquely adverse
11 effects of emotional abuse in childhood (Teicher,
4 Samson, Polcari, & McGreenery, 2006) are consistent
13 with a view that chronic denigration, shaming, demoral-
14 ization, and coercion may constitute a risk factor for
15 severe PTSD. Research is needed to operationalize the
16 emotional and physical violence in racism, and to
17 empirically examine the unique and interactive effects,
18 this may have not only on directly victimized persons
19 and their families and communities but also on their
20 descendants across several generations.

22 **Designing and Adapting Psychological Interventions for PTSD to** 23 **Be Effective with Ethnoracial Minorities**

24 A fully articulated conceptual model for the scientific
25 study and social/clinical prevention and remediation of
26 the adverse impact of psychological trauma and PTSD
27 requires principles and practices informed by this
28 diversity of factors rather than a “black and white” view
29 of race, ethnicity, or culture, or of trauma and PTSD,
30 which can lead to misrepresentation of and false assumptions
31 about the individual’s and group’s heritage, nature, and
32 potentials for achievement and actualization. As the
33 review article shows, treatment preferences, in terms of
34 characteristics of the therapist and the therapy model,
35 may differ substantially not only across but also within
36 ethnoracial groups. As a result, it is not possible at this
37 juncture—and may never be possible—to formulate hard
38 and fast prescriptions for matching therapists or adapting
39 therapies to fit different ethnocultural groups. A
40 culturally competent approach to treating PTSD begins
41 with a collaborative discussion in which the therapist
42 adopts the stance of a respectful visitor to the client’s
43 outer and inner world—clarifying the client’s expectations
44 and preferences, and the meaning of sensitive interpersonal
45 communication modalities (e.g., spatial proximity, gaze,
46 choice of names, private versus public topics, synchronizing

of talk and listening, use of colloquialisms, providing
advice or education). To the extent that the therapist can
avoid stereotypic assumptions and become both a host
and guest in the client’s psychic world, the treatment will
be genuinely collaborative and gradually increasingly
sensitive to the client’s ethnoculturally based and individually
enacted goals and preferences (Parson, 1997; Stuart, 2004).

Cultural competence means many things to many
people, and unfortunately often is mistakenly conflated
with either being of the same racial, ethnic, cultural, or
national background as the persons involved in a study
or receiving services, or knowing *in advance exactly* what
those persons believe and expect, how they communicate,
and what their experience has been in relation to sensitive
matters such as psychological trauma or PTSD. Based on
the preceding discussion, this is likely to be a serious
mistake for several reasons. Sharing some general racial,
ethnic, cultural, or national features (or an apparently
identical language or religion) is not synonymous with
shared identity, knowledge, or history. Even persons
from as virtually identical backgrounds as monozygotic
twins raised in the same family have substantial differences
in physical and temperamental characteristics and often
quite distinct social learning histories, and thus rarely if
ever can reliably read one another’s minds or exactly
know each other’s vulnerabilities and strengths. Therefore,
cultural competence should not be defined in terms of
stereotypic assumptions about identity or prescience, but
instead based on a respectful interest in learning from
each person and community what they have experienced
and how they understand and are affected by psychological
trauma and PTSD.

5 The implication for psychometric assessment of
psychological trauma and PTSD with clients of ethnoc-
ultural minority groups (Cook et al., 2005) is that it is
essential to carefully select protocols that do not confront
individuals with questions that are inadvertently disrespectful
of their values or practices (e.g., including peyote as an
example of an illicit drugs in a Native American tribe
that uses it for religious rituals), irrelevant (e.g., distin-
guishing blood family from close friends in a group that
considers all community members as family), or in-
complete (e.g., limiting health care to Western medical or
therapeutic services, to the exclusion of traditional forms
of healing). This is not a rationale for avoiding systematic
assessment of trauma history and PTSD, but instead a

1 caution to know the person and their personal cultural
2 framework before assessing the trauma (Manson, 1996).
3 Interventions for prevention or treatment of post-
4 traumatic impairment typically have been developed
5 within the context of the Western medical model (Parson,
6 1997). However, evidence-based PTSD treatment models
7 are not necessarily incompatible with culturally specific
8 healing practices, and have in common the goal of
9 fostering not just symptom reduction but a bolstering of
10 resilience and mastery (Masten, 2001). The integration
11 of culturally specific methods and rituals in prevention
12 or treatment interventions for PTSD, however, will
13 require careful ethnographic study and collaboration
14 between PTSD clinicians and varied cultural communities.
15 Most importantly, in treating members of ethnoracial
16 minorities, cognizance of the complex interrelationships
17 of racism to psychological trauma and PTSD—along
18 with the knowledge that these remain to be fully
19 explicated—provides a basis for psychological treatment
20 that first does no harm.

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