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Racism and Ethnoviolence as Trauma: Enhancing Professional Training

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Abstract

In trauma theory, research, and practice, post traumatic stress disorder (PTSD), a syndrome of psychobiological reactions to events perceived as cataclysmic or life threatening, often has been the focus of mental health interventions and research. Yet virtually missing from contemporary trauma literature is consideration of racism and ethnoviolence as catalysts for PTSD and related symptoms. The stress inducing effects of obviously life threatening racist or ethnoviolent events may be readily apparent to service providers and researchers although they have not been treated or investigated. However, observers seem not to view other types of racism and ethnoviolence as life-threatening (e.g., vicarious experiences, exposure to microaggressions) because the historical roots of the trauma are invisible. Such events may arouse immediate or delayed PTSD and related symptoms in the experiencing person if the experienced event(s) serves as a catalyst for recalling previous personal memories or identity-group histories of extreme threat. Current PTSD assessment schedules are critiqued for their inappropriateness for assessing stress reactions to racism and ethnoviolence specifically; quantitative scales are criticized because of developers' thoughtless application of traditional psychometric principles of scale development, such as maximizing the magnitude of internal consistency reliability coefficients. We recommend that researchers and practitioners conduct culturally responsive and racially informed assessment and interventions with African Americans, Latina/Latino Americans, Asian/Pacific Islander Americans, Native Americans, and related immigrant groups when they present with symptoms of trauma, particularly when their trauma responses are atypical or the precipitating stressor is ambiguous.

Keywords

racism, ethnoviolence, PTSD

Traumatic and extremely stressful life events contribute to disruptive emotional changes in individuals' mental states and their overall quality of life (Foa, 1997). Various epidemiological studies have estimated that 40% to 75% of individuals have been exposed to potentially stress inducing situations (Breslau, Davis, Andreski, & Peterson, 1991; Elliott, 1997) and about 1 in 12 adults develop Posttraumatic stress disorder (PTSD) at some time in their lives in response to major life stressors (Breslau, 2001). *PTSD* is defined as a psychobiological response to a traumatic event that is characterized by (a) physiological and psychological reexperiencing of the event, (b) avoiding stimuli perceived to be associated with the traumatic event, and (c) increased and persistent arousal (American Psychiatric Association [APA], 2000). Thus, PTSD is defined according to the reactions of persons to events rather than by the nature of the event(s) per se.

Moreover, for African/Black Americans, Latina/Latino Americans, Asian/Pacific Islander Americans, and Native Americans (ALANAS), prevalence rates for PTSD and related clusters of symptoms, such as stressor-induced depression and generalized anxiety, may be much higher than is evident in aggregated population statistics. For example, whereas the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision [*DSM-IV-TR*]; APA, 2000) estimates that the prevalence rate for PTSD for the general adult population is 8%, the National Center for PTSD (Kulka et al., 1990) reported prevalence rates for Vietnam veterans of 21% for Black Americans, 28% for Latina/Latino Americans, and 14% for White Americans. Furthermore, in community samples, ALANAS tend to report higher levels of PTSD after natural disasters (Breslau, Chilcoat, Kessler, & Davis, 1999; Breslau et al., 1998). For example, following Hurricane Hugo in 1992, 15% of Whites, 23% of Blacks, and 38% of Latinos reported symptoms that met the diagnosis for PTSD (Perilla, Norris, & Lavizzio, 2002). Thus, in comparison to Whites, ALANAS are more likely to develop PTSD after experiencing a traditionally defined traumatic event even though research suggests that people of Color

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experience fewer such traumatic events than White people (Perilla et al., 2002), but racial and ethnic cultural traumas are not ordinarily included in such analyses.

Most conceptual and research analyses of trauma focus on trauma catalysts or potentially traumatic stressors, which are defined as "an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others" (APA, 2000, p. 467). In the treatment and research literature, large-scale violence and transportation accidents, motor vehicle crashes, war, rape and sexual assault, intimate partner violence, stalking, torture, sex-trafficking and prostitution, child abuse, and life-threatening illness have all been identified as traumatic events (Allen, 1996; Briere, 2004; Bryant-Davis & Ocampo, 2005). As is the case for each of these traditional types of trauma, Briere, Bryant-Davis, and Ocampo point out that where racism and ethnoviolence are concerned, it is the victimized person's subjective interpretation of the events that they experienced rather than the objective reality or physical properties of the event that determine whether it is traumatic.

When defining potentially traumatic stressors, researchers and practitioners typically have not focused on racism and ethnoviolence as causal or aggravating factors in the development of PTSD or related symptoms of stress disorders (e.g., APA, 2000; Norris, 1990). For the most part, ALANA group(s) symptoms of PTSD have been compared to those of their White or dominant-culture counterparts and the etiology for between-group disparities has been inferred from systemic factors that disproportionately affect racial or ethnic groups of Color or nondominant cultural statuses rather than considering racism and other acts of discrimination as possible traumatic stressors. For example, lower socioeconomic status (SES) is often viewed as the explanation for the differential levels of stress disorders among racial and ethnic cultural groups (Chen, Keith, Airriess, Li, & Leong, 2007; Norris, 1990), but lower SES is not racism or ethnoviolence although lower SES may be one result of them for the disempowered group.

Nevertheless, threats to a person's cultural or racial self-integrity seem to make the person more susceptible to PTSD and associated symptom clusters. Kulkarni and Pole (2008) found that acculturative stress was associated with higher levels of posttraumatic stress following disastrous events; Bruce and Waelde (2008) found similar effects with respect to poor ethnic identity. A general premise of the present article is that reactions to either racism or ethnoviolence alone or combined with other traumatic events may pose threats to a person's psychological and physical well-being that may be as psychologically debilitating as reactions to natural disasters or other types of physical or psychological endangerment. In this article, we (a) define racism and ethnoviolence, (b) describe their roles as aspects of ALANA people's trauma experiences, (c) discuss their implications for trauma research, practice, and assessment, and (d) propose some training considerations for mental health researchers and service providers.

Racism and Ethnoviolence Defined

To facilitate discussion, we define *race* as a sociopolitical construction in which physical characteristics, such as skin color and hair texture of oneself or one's ancestors, are used to assign people to factitious, supposedly mutually exclusive, biologically distinct, demographic categories (Helms, Jernigan, & Mascher, 2005). Race or ascribed racial group membership does not directly cause the behavior of the racially classified person, but may indirectly influence the person's behavior because of others' racial attributions and manner of engaging with the person (e.g., racism). *Ethnic culture* refers to shared socialization practices and experiences, such as language spoken, customs, and values, that are intended to ensure the survival and well-being of in-group members (Helms, 1994). Thus, ethnic culture is both active and reactive. The same ethnic culture may be shared by people of different ascribed racial groups. So, for example, a person might be both Black and Latino, if he or she has Latina/Latino cultural origins and is perceived as Black. Alternatively, as Nicolas, Prater, and DeSilva (2009) note, one ascribed racial classification (e.g., Black) may encompass many ethnic cultures (e.g., African American, Haitian). Powerful out-group members may feel threatened by cultural practices, and, consequently, may stigmatize marginalized ethnic cultural groups because of presumed cultural practices or origins.

Bulhan (1985) defines *racism* as a system of oppression that is based on racial categories and domination that designate one group as superior and the other(s) as inferior, and which then uses these perceived differences to justify inequity, exclusion, or domination. According to Jones (1997), racism may occur at three levels: (a) individual (i.e., person against person), (b) cultural (i.e., devaluation of a racial group's cultural practices or products), or (c) institutional (i.e., discriminatory laws and social policies). *Ethnoviolence* may be defined as violence and intimidation directed at members of ethnic groups that have been marginalized and stigmatized by the dominant or host culture because their inability or unwillingness to assimilate threatens the dominant group's entitlement to society or community resources. Brubaker and Laitin (1998) contend that ethnoviolence is qualitatively different from conflict between ethnic groups. They describe conflict as involving nonviolent efforts to shame or coerce disaffected group members into assimilating to the dominant culture, but from their perspective, ethnoviolence involves direct use of force to cause bodily harm or symbolic force targeting the marginalized group's culture for the purpose of forcing them to behave in a desired manner.

By way of differentiating cultural racism from ethnoviolence, cultural racism generally is directed at observable

products of a group (e.g., language, music), whereas ethnoviolence is focused on the ethnic people who are treated as symbols of undesirable cultural practices. More generally, racism uses phenotypic characteristics of the person or the person's presumed ancestors (e.g., skin color) as justification for disparate treatment, but ethnoviolence is directed against people because of their ostensible cultural or regional origins. Both racism and ethnoviolence may be differentiated from within-group prejudice or preference in that they involve the use of power by a dominant group to impose its will on out-group members with the tacit or active support of large-scale social policies or structures rather than merely being in-group members' favoritism toward each other (Jones, 1997) or within-group efforts to punish or recall straying members (Brubaker & Laitin, 1998).

Racism and Ethnoviolence as Trauma

The perspective that traumatic responses and related symptoms may result from experiences of racism and ethnoviolence have been proposed by many scholars (e.g., Bryant-Davis & Ocampo, 2005; Butts, 2002; Carter, 2007; Comas-Diaz & Jacobsen, 2001; Loo et al., 2001; Scurfield & Mackey, 2001). Scurfield and Mackey (2001) argue that "exposure to race-related trauma, in and of itself, may be the primary etiological factor in the development of an adjustment or stress disorder" (p. 28). Bryant-Davis and Ocampo (2005) advise that racist incidents are traumatic and affect survivors in ways that are analogous to the impact that rape and domestic violence have on those who are victimized. As is the case for rape and domestic violence, racism may involve physical and psychological assaults that might be overlooked if racism is not considered to be an important cause of physical and emotional distress.

When rape occurs, although psychological abuse may accompany it, the rape is viewed as the primary source of the trauma, but Bryant-Davis and Ocampo (2005) suggest that psychological abuse may be the primary or sole catalyst for racial trauma. Therefore, if mental health professionals or researchers perceive the person of Color as arrogant, opportunistic, or hypersensitive, based on racial stereotypes, then they may minimize the impact of the assault; they might not view the traumatic event as racist or as a violation of the individual's personhood, and thus the victim of the incident is potentially revictimized.

Unlike other forms of trauma, Bryant-Davis and Ocampo's perspective suggests that the reactions and perspectives of powerful others (e.g., researchers, service providers, the perpetrators or colluders in the racism or ethnoviolence) rather than the person himself or herself, determine whether the person has experienced a traumatic event (Sue et al., 2007). When an earthquake occurs, its magnitude can be assessed and there is general agreement that it has occurred; but racial and ethnoviolent traumatic events have no such consensually agreed on criteria. Sue et al. (2007) observe that when an ALANA person reports that she or he has experienced a traumatic racial event or expresses relevant symptoms, the person's experiences often are challenged or denigrated. Nevertheless, racism, or what Bryant-Davis and Ocampo call "racist incidents," may be conceptualized as trauma, because it is a form of victimization imposed and perpetuated by powerful others, which can produce posttrauma-like symptoms (e.g., helplessness, fear). The symptoms specific to ethnoviolence may be difficult to differentiate from racism symptoms because ethnicity and racial designations are often conflated in U.S. society.

Furthermore, Bryant-Davis and Ocampo (2005) contend that race-based physical and verbal assaults and threats to one's personhood may affect one's sense of self and well-being. These various threats to one's emotional and psychological well-being can be sudden or systemic, intentional or not, vague and ambiguous, direct and specific, or vicarious. Regardless of the form racism takes, for Bryant-Davis and Ocampo, racist incidents are, at minimum, a form of emotional abuse and, therefore, can be traumatic. Moreover, ethnoviolence, regardless of form, is physical or emotional abuse whose cultural focus may not be immediately apparent to the opposing ethnic groups and thus may go unrecognized as an ethnoviolent event.

Symptoms of Racism/ Ethnoviolence Trauma

Most researchers' attempts to identify the mental health symptoms resulting from racism have focused on reactions to person-level racism, but theorists and researchers have not examined the types of symptoms (e.g., PTSD or related syndromes) that occur in response to racism experienced at institutional or cultural levels (Bryant-Davis & Ocampo, 2005; Carlson, 1997). Moreover, there has been a tendency to focus on self-reports of the frequencies of occurrence of everyday racist events or racial microaggressions (e.g., Sue et al., 2007), or to combine self-reported frequencies of direct and vicarious cataclysmic events and microaggressions (Waelde et al., 2010). Sue et al. define *racial microaggressions* as "brief, everyday exchanges that send denigrating messages to people of color because they belong to a racial minority group" (2007, p. 273; e.g., being called a racial slur or being followed around a department store by a sales clerk). Extrapolating from our previously quoted definition of PTSD (APA, 2000, p. 467), we define *direct racial or ethnic cultural cataclysmic events* as race-based or ethnic culture-based, potentially life threatening or murderous assaults against the person or the person's identity groups that involve death or threatened death or serious injury to the ALANA person or the person's selfhood, or endangerment of significant others in the person's life, or members of the racial or ethnic cultural groups with which the person identifies.

Vicarious events are the witnessing of direct cataclysmic racial or cultural events. One example of a vicarious cataclysmic event is Dassouri and Silva's (1998) report of their Latino American client's experiencing of PTSD symptoms after witnessing border patrols' televised beatings of Mexican, possibly illegal immigrants, even though their client was a citizen himself. As with traditional PTSD symptoms, it is the person's perception of the event, or we argue in some cases, others' (e.g., clinicians, researchers, aggressors) perceptions of the event that determine whether it is traumatic.

For the most part, theory and research addressing traumatic ethnoviolent events have tended to treat them primarily as international phenomena defined by intergroup conflicts and violence (e.g., Serbian–Croatian conflict; Brubaker & Laitin, 1998). Virtually no attention has been given to studying the impact of group-level ethnoviolence on individuals' mental health status, nor for that matter, have investigators studied the effects of racially-biased institutional policies and practices on symptom development. For example, when a dominant racial or ethnic cultural group engages in actions intended to provoke or justify intergroup violence (e.g., the KKK marching through an African American community or neo-Nazis parading through a Jewish community), it is likely that members of the targeted group(s) experience some types of trauma-related symptoms. Furthermore, it is often the case that social policies (e.g., freedom of speech) legitimize the rights of the perpetrators while disregarding the possible mental health consequences to the victims. Research is needed to help delimit the types of symptoms that are evoked by systemic and group-focused traumatic events.

Some symptoms that have been hypothesized to follow from person-level racism include cognitive impairments such as loss of memory and difficulty remembering and somatic symptoms such as headaches, body pains and aches, and trouble sleeping (Bryant & Ocampo, 2005). Victims may engage in self-blame, or exhibit feelings of confusion, shame, and guilt (Carlson, 1997). Although it seems plausible that people of Color and/or nondominant ethnic cultures might experience acts against their personhood as stressful or even traumatic, strategies for mental health professionals to use when assessing how someone is affected by racism are still in developmental phases.

Exploratory research, rather than clinical trials or interventions, has provided most of the available empirical information concerning ALANA reactions to racial or ethnic trauma events. Using Carter and Helms's (2002) definitions of racial harassment (active person-level discrimination) and racial discrimination (passive or avoidant discrimination), Carter, Forsyth, Mazzula, and Williams (2005) found that people's psychological and emotional reactions to racial harassment were more intense and lasted longer than their reactions to racial discrimination. It is important to note that most (98%) of the participants in Carter et al.'s study did not report being physically assaulted or threatened. Carlson (1997) posits that for an experience(s) to qualify as a traumatic reaction, it needs to be perceived as negative (cause emotional pain or threat of pain), be sudden, and uncontrollable. Carlson's conceptualization essentially requires that racism/ethnoviolence trauma must be analogous to other types of acknowledged traumatic events or actions (e.g., natural disasters, physical assault). Yet Carlson's conceptualization, which is consistent with *DSM-IV* criteria, may not be broad enough in that it does not include aspects of racism that might either be invisible to the person or unrecognized at the time (e.g., institutional racism)

With respect to ethnic culture specifically, although psychological reactions to traumatic events occur across cultural groups, the manifestations of these responses may differ considerably (Jenkins, 1996; Marsela, Friedman, Gerrity, & Scurfield, 1996). This observation is supported by research on emotions that highlights the major role that culture plays in the expression and manifestation of emotions and psychological disorders, such as depression and anxiety (Ekman, Friesen, & Ellsworth, 1972; Matsumoto, 1993, 1996). Culture serves as the filter through which traumatized individuals and communities consciously and unconsciously express their responses and, consequently, culture may play a significant role in the person's manifestation of symptoms and overall patterns of responses following a trauma. For example, Marsella, Friedman, Gerrity, and Scurfield (1996) found that not all of the PTSD criteria were applicable across different ethnic cultural groups. Symptoms, such as intrusive thoughts, avoidance, and arousal, were more likely to be differentially influenced by the person's cultural background.

In one of few attempts to empirically study the effects of racism on the PTSD symptoms of Asian Americans, Loo et al. (2001) found that race-related stress was a strong and significant predictor of PTSD for post-Vietnam veterans. The sources of racial trauma for their population were combinations of being at war, racial harassment by their non-Asian U.S. peers in combat zones, and the obligation to kill people who looked like them. The authors stated that "the stressful effects of exposure to combat and racism could be additive and that cumulative racism can be experienced as traumatic" (Loo et al., 2001, p. 504).

As is also the case for other mental health problems, it is imperative that PTSD symptoms be examined with attention to the interactions of racial and cultural socialization on the traumatized person's perceptions of the experience. Yet changing the person's cultural orientation or experienced racism should not be the service provider's primary goal. Instead, the service provider's focus, at a minimum, should be to assess the person's level of injury in a culturally responsive and racially informed manner. Furthermore, whereas it is easy to mistake the mere presence of cultural responses (e.g., avoidance of strangers) or putative racial characteristics (e.g., stereotypes associated with skin color) as the

source of atypical trauma symptoms, more often than not, it is the service providers' or others' misinterpretations of symptoms or endorsement of contemporary stereotypes that are trauma aggravating factors.

Racism, Ethnoviolence, Trauma, and Assessment

For many reasons, it is difficult to obtain an accurate assessment of the differential effects of racism and ethnoviolence on a person's mental health status. As previously discussed, racism and ethnoviolence may occur at many levels (i.e., person, institution, culture) and in many forms (e.g., direct vs. vicarious); they may also function as catalysts or as aggravating correlates of other traumatic events. Moreover, because their damaging effects may occur from a single powerful event or a sequence of threatening events, it is difficult to use traditional assessment and related research approaches to diagnose the severity of the person's reactions to the racial or cultural stressors. Often the only evidence that a traumatic racial event has occurred is the experiencing person's reports or presenting symptoms and the service provider's capacity to interpret such reports or symptoms in a manner that takes into account the racial and cultural histories of the survivor's contexts (Helms & Cook, 1999). Therefore, it might be useful to potential service providers and researchers to consider some of the limitations of contemporary approaches to assessing racial trauma, so that, victims of racial trauma or ethnoviolence are not misdiagnosed because we fear that such misdiagnosis might result in depriving trauma survivors of the services or reparations that their symptoms merit.

PTSD Assessment

Currently, the majority of trauma studies intended to investigate the relative prevalence of PTSD in ALANA and ethnic cultural groups have used PTSD measures created in the United States on predominantly White American samples. Such usage treats Whites' trauma experiences as normative and, thereby, ignores the diversity of racial and cultural experiences among groups. One might suppose that some of the standard PTSD interview protocols or quantitative measures might be modified to assess racism or ethnoviolence-related symptoms (Resnick, Best, Kilpatrick, Freedy, & Falsetti, 1993, cited in Kimerling, Ouimette, & Wolfe, 2002). Yet this approach is problematic, because the types of trauma assessed by such measures often are not equivalent to people's experiences of racism and ethnoviolence. As is standard for structured interviews, for example, Resnick et al.'s (1993, as cited in Kimerling et al., 2002) "Traumatic Assessment for Adults" (TAA) inquires about the person's lifetime history with respect to 13 potentially traumatic events, but none of the events refers specifically to racism or ethnoviolence. Most such measures incorporate the DSM criterion that the assessed person must perceive the event as life-threatening or severely injurious to merit a PTSD diagnosis, but ongoing ostensibly less extreme types of exposure to racism or ethnoviolence, such as microaggressions, might elicit unacknowledged PTSD symptoms that ought to be included in the assessment process. When faced with an ALANA or minority culture person seemingly exhibiting trauma symptoms, to avoid underestimating the person's condition, assessors should inquire about racial microaggressions or ethnoviolence that might have preceded, accompanied, or served as the traumatic event.

In postdisaster research, especially epidemiological studies, and crisis relief efforts, on-the-spot measures or a few items often are used to assess PTSD reactions to an objectively defined traumatic event, thereby, ignoring the possible effects of racism or ethnoviolence. Although the experience of PTSD occurs at the individual level, researchers typically report aggregated racial group data that describe between-groups' reactions to observer-defined traumatic events, which usually do not include racism or ethnoviolence (Chemtob, Tomas, Law, & Cremiter, 1997; Galea, Nandi, & Vlahov, 2005). Consequently, prevalence rates of PTSD symptoms involving racism or ethnoviolence as experienced by individuals are virtually nonexistent.

Racism Assessment

The most frequently used methodology for evaluating the effects of racism per se on individuals' mental health status is use of self-report racism exposure scales or inventories. It is worth considering how such measures might be used effectively. However, it merits mentioning that most of the procedures to be discussed have been used in research, but not clinical studies or practice where racism or ethnoviolence are concerned.

Exposure to racism measures. Six inventories have been developed specifically to assess the frequency of respondents' experiences of racist events. Examples of this genre are the Cultural Mistrust Scale (CMT; Terrell & Terrell, 1981), the General Experiences of Discrimination Scale (GED; Landrine, Klonoff, Corral, Fernandez, & Roesch, 2006), Major Racist Events (MRE; Williams, Yu, Jackson, & Anderson, 1997), the Racism and Life Experience Scales (Harrell, Merchant, & Young, 1997), and the Race-Related Events Scale (Waelde et al., 2010). By "experiences," most of the scale developers mean whether respondents report that the events happened to them rather than how they reacted to the events. Utsey (1998) provides a rather thorough review of most of these racism measures.

Each of the cited measures has been used in empirical investigations of linkages between racism experiences (i.e., traumatic events) and psychological symptoms. An extensive review of the relevant assessment literature is not possible. However, some examples are Hwang and Goto's

(2008) use of the GED to study perceptions of racism and psychological symptoms among Asian American and Latino American college students and Araújo's (2009) investigation of perceived racism (measured by the MRE), acculturation, and stress among Dominican immigrant women in the United States. Hwang and Goto found that higher levels of experienced racism were related to higher levels of general stress, suicidal ideation, state and trait anxiety, and clinical depression. Araújo found that self-reported exposure to major racist events was associated with higher stress levels, regardless of acculturation levels. Yet, it should be noted that Araújo's sample as a whole reported an average of less than one such experienced event, again suggesting that single racist events might precipitate serious trauma reactions.

General research problems with the quantitative measures of racist events are that they rely on traditional psychometric principles of test development. For example, all of the studies of these measures report Cronbach's alpha (CA) coefficients as their indicators of reliability (Cronbach, 1951). CA is a large-sample-level summary statistic, based on the assumption that reliability is maximized if each respondent endorses several events (i.e., items) and item responses are positively related. Yet, there is no reason why the person who endorses the item "treated rudely" from Waelde et al.'s (2010) 23-item scale would necessarily endorse "physical fight" (p. 11), but one needs some people in the sample to endorse both items or reliability will be reduced. There are several issues related to reliability and frequency scales that Helms, Henze, Sass, and Mifsud (2003) discuss. It would suffice to say here that it is common practice to discard items that only a few people report, but these might be the items that elicit strongest traumatic reactions from individuals.

Also, as previously noted with respect to Araújo's (2009) study, the results of many studies in which such measures have been used suggest that samples typically report one such event on average. Thus, although a sample's responses may be perceived as not reliable (i.e., low reliability coefficient), significant numbers of individual respondents in the sample still might have experienced a racist event that could have deleterious effects on their mental health. An assessor potentially commits a diagnostic assessment error if he or she requires that racial traumatic events must be replicated across persons to be legitimate. Also, diagnostic assessment errors potentially occur when the assessor presumes that members of different ethnic groups will have had the same historical experiences of racial or cultural trauma simply because they appear to be of the same racial classification.

Another problem with using quantitative measures as assessment devices is that currently there are no data that would guide evaluators in determining clinically relevant cut-off scores. That is, there are no guidelines for determining how many events or what types of events merit inquiry about PTSD or related symptoms. It might be argued that some of the preexisting measures of other types of trauma experiences, such as Norris's (1990) Traumatic Stress Schedule, might be modified to evaluate the severity of distress of the person experiencing racial or ethnic trauma. Yet, given the variety of ways in which racism and ethnoviolence may be manifested or experienced, it is not clear that current inventories could be adequately modified to reflect the fluidity and complexity of these constructs as catalysts for traumatic reactions.

Racism syndromes. Some theorists have proposed race-based trauma syndromes or collections of psychological symptoms that result from being traumatized. Most recently, Carter (2007) developed and defined "race-based traumatic stress injury," which he considers to be "non-pathological" constellations of emotional reactions to racism stress (p. 88). The emotional reactions potentially are analogous to those that characterize PTSD, but differ in that the catalysts for such reactions are the person's subjective experience of the events or incidents even if observers (e.g., clinicians, researchers) or perpetuators do not perceive the same events as traumatic. Carter contends that trauma symptoms may develop as a reaction to different types of racism including, (a) racial discrimination, avoiding or ostracizing the person because of her or his race or culture; (b) racial harassment, hostile race-based physical or verbal assaults; and (c) discriminatory harassment, aversive hostility characterized by "White flight" (p. 89). In both Carlson (1997) and Carter's (2007) systems, if the person's subjective experiencing of any of these types of racism is characterized by perceptions of the events as negative, memorable, sudden, and uncontrollable, then a variety of PTSD-like symptoms might be manifested. Obviously, a system with the nuances of Carter's racial syndrome approach does not readily lend itself to measurement by existing scales or inventories, but might be a focus for new measures.

Implications for Research, Assessment, and Practice

To evaluate the effects of a particular event on a person, it is necessary for the evaluating mental health professional or researcher to explore the meaning of the event, both to the person experiencing it and to the evaluator, because the same event may have different meanings for the two parties. Thus, the evaluator must attempt to provide an open and supportive environment for the recovering person, so that the person can articulate the particulars of her or his situation, no matter how subtle they are. Trauma practitioners and researchers typically are not trained to focus on their role in providing supportive assessment environments when race and racism or culture or ethnoviolence are the focus of the trauma. Table 1 uses Helms's (1995) social interaction model to describe four types of assessment environments that might either enhance or impede the assessment process. She advises

Table 1. Summary of Types of Assessment Environments Using Helms's (1995) Social Interaction Model

Type of interaction	Description	Evaluator behaviors	Assessee reactions
Parallel	Trauma evaluator and assessee understand the factors related to the racial or cultural trauma similarly.	Evaluator meets the assessee on common ground, but must be careful not to collude in avoiding the details of the trauma experience.	Assessee will experience the assessment environment as supportive, but may not be forthcoming with vital information if the evaluator colludes with her or him in denying the racial or cultural aspects of the situation.
Regressive	The evaluator, as the person in power, ignores the racial or cultural aspects of the situation and tries to convince the victim that such factors are irrelevant to the situation.	The evaluator attempts to impose his or her understanding of racial or cultural events on the trauma victim, possibly because the evaluator's life experiences have been different and the victim's understanding of her or his own experiences are threatening in some way.	The trauma victim experiences the assessment environment as unsupportive and withdraws. Typically, such assessment environments are retraumatizing and the victim may engage in some of the reactions that occurred with the original trauma.
Crossed	Participants are exact opposites in their reactions or understanding of the traumatic event and, consequently, react to one another from a combative or suspicious position.	Evaluators' assessment and/or treatment of the victim may be punitive, perhaps not purposefully. Because he or she is opinionated with respect to the racial or cultural aspects of situations and cannot set aside those opinions, the evaluator is unable to assess the situation from the victim's perspective.	Surviving trauma victims may withdraw from the interaction, which may be manifested as not talking, avoiding contact with service providers, or increased manifestation of psychological symptoms, such as depression.
Progressive	Supportive assessment environments characterized by efforts to understand the assessee's racial and cultural experiences of trauma even when they might not be evident to the person manifesting such symptoms or reactions.	Evaluator attends to person's racial/cultural issues and attempts to create an environment conducive to discussing race and culture. The evaluator is able to ask questions about racial or cultural conditions of the situations, even if the perceived antagonists in such situations are people who are racially or culturally similar to the evaluator.	The assessee experiences these environments as supportive, but may engage in tests to determine whether the assessor is authentic. Tests might include saying negative things about people from the evaluator's reference group to see how the evaluator will react.

that to create effective assessment environments, service providers and researchers ought to self-examine with respect to their own racial identity development and cultural orientations (Helms & Cook, 1999; Helms, Henze, Satiani, & Mascher, 2005).

Clinically, it is necessary to be aware of and be sensitive to the variety of ways that ALANA and immigrant individuals experience psychological distress subsequent to their exposure to a trauma. From their research, Perilla et al. (2002) strongly recommend that "symptomatology should be viewed in its totality, taking into consideration the historical, social, economic, and political factors in which individuals from these groups [ALANAS and immigrants] find themselves" (p. 41). From a research perspective, such findings call for greater attention to the assessment instruments used to assess psychological distress resulting from trauma among ethnically diverse individuals. Researchers should also attend to the racial and cultural dynamics of research procedures more generally, such as culturally adequate informed consent procedures and linguistically appropriate measures (Chemtob et al., 1997; Helms et al., 2006).

Assuming that people's and community's trauma experiences, symptoms, and responses are mediated by culture (Brewin, Andrews, & Valentine, 2000; Figley, Giel, Borgo, Briggs, & Haritos-Fatouros, 1995), interventions with ethnic cultural populations that use culturally authentic approaches will be most effective. Narrow psychiatric screening might miss the more prevalent problems that ALANA and ethnic cultural people face (Somasundaram & van de Put, 2006). Rather than concentrating on interventions that focus on the individual exclusively, it might be more prudent to use public mental health promotional activities as well as community-based interventions that allow healing and rehabilitation to occur within the restored family and community unit (Turner, 2000). However, in some circumstances, internalized shame that often accompanies victimization by racism or ethnoviolence might necessitate individualized interventions that shield the person from critical others.

More importantly, psychological intervention that is focused on individual trauma victims needs to be put into the context of the family, community, religion, and culture and must be sensitive to the sociopolitical history of racism and ethnoviolence in the community in which the traumatic event(s) occurred. Mental health professionals need to be willing to consider various cultural beliefs, concerns, and taboos surrounding illness and treatment in different settings, and the varying degree to which family and community members become involved. Clinical interventions such as cognitive behavioral therapy (CBT) might be used effectively by mental health professionals and trauma survivors in their individual cultural settings, but will need to be adapted to these settings on the basis of careful dialog between health care professionals, community and religious leaders, and survivors.

In sum, it is imperative that mental health professionals and trauma researchers work toward developing more comprehensive understandings of the experiences of traumas for ALANAS and ethnic cultural groups living in the United States. The focus of this quest for understanding, should start with improving the service providers or researchers' knowledge about the cultures of the groups in their surrounding communities, including their own. The quest should also include extensive examination of the racial dynamics that have characterized contexts in which the ostensible traumatic event occurred. Failure to recognize or acknowledge the mental health relevance of the sociopolitical, racial, and cultural factors that intersect with trauma experiences for the survivors of trauma as well as for the service providers will greatly inhibit one's ability to provide effective treatment programs or to conduct meaningful trauma research.

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