• **Major Contribution**

Racism and Psychological and Emotional Injury:
Recognizing and Assessing Race-Based Traumatic Stress

Robert T. Carter
Teachers College Columbia University

The purpose of this article is to discuss the psychological and emotional effects of racism on people of Color. Psychological models and research on racism, discrimination, stress, and trauma will be integrated to promote a model to be used to understand, recognize, and assess race-based traumatic stress to aid counseling and psychological assessment, research, and training.

Racial stratification and systemic racism have been and continue to be endemic and ingrained in all aspects of American life: in customs, laws, and traditions. As such, these barriers to equality have had a profound impact on both those who have been racially oppressed and subjugated to racism in all forms and those who are the oppressors (Adams, Bell, & Griffin, 1997; Akbar, 1984; Freire, 1993; Prilleltensky, 1994). During the 20th century there have been efforts to address the history of racial injustice and oppression in many areas of American life (Jaynes & Williams, 1989; Omi & Winant, 1986, 1994), including in the domain of mental health practice and service (Carter, 1995; Prilleltensky & Gonick, 1994; Sue & Sue, 2003).

Racial equity has been an elusive but central factor in mental health professionals' efforts to provide services and treatment to people from various

---

I would like to thank Hardin Coleman who served as the guest editor for this issue. This article is based in part on my Helms Award Invited presentation given at the Winter Roundtable Conference on Cultural Psychology and Education, February 21, 2004. Development was supported by The Ira Glasser Racial Justice Fellowship awarded to the author by the National office of the American Civil Liberties Union. Thanks also to Madonna Constantine for encouraging me to develop and submit this major contribution. I also thank members of my research group (Jessica Forsyth, Bryant Williams, Alex Pieterse, Silvia Mazzula Roman, Sidney Smith, Kern Second, Roshnee Vazquez, Sinéad Sant, Nancy Cha, Shekeva Hall, and Kisha Bazelais) for helping in the preparation of the manuscript as well as colleagues Dorie Clay, Helen Neville, and Nancy Hansen for their assistance in providing feedback on drafts. Correspondence concerning this article should be addressed to Robert T. Carter, Counseling & Clinical Psychology, Teachers College, Columbia University, TC Box 032, New York, NY 10027; e-mail: rtc10@ columbia.edu.

THE COUNSELING PSYCHOLOGIST, Vol. 35 No. 1, January 2007 13-105
DOI: 10.1177/0011000006292033

races (Carter, 1995, 2005). Inequity in mental health services and practices has been documented by extensive government research cited in the Surgeon General's report, *Mental Health: Culture, Race, and Ethnicity* (U.S. Department of Health and Human Services [USDHHS], 2001).

According to the report, people of Color have less access to and are less likely to receive needed care, and the care they ultimately receive is often of poor quality. The report identified a number of barriers that racial–ethnic people encounter in the mental health system including, "Clinicians' lack of awareness of cultural issues, bias, or inability to speak the clients' language and the client's fear and mistrust of treatment" (USDHHS, 2001, p. 4). The report also stated that "disparities also stem from minorities' historical and present struggles with racism and discrimination, which affect their mental health and contribute to their lower economic, social, and political status" (USDHHS, 2001, p. 4).

Perhaps a major contributing factor to the problem of racism and its impact on the mental health of its targets is a failure to clearly understand the emotional, psychological, and, to some extent, physical effects of racism on its targets. Much has been written about the social, economic, and political effects of racism (Feagin, 2000; Jones, 1997; Marger, 2003), but less is understood about specific aspects of racism that are directly linked to the particular psychological effects or reactions of its targets (Bowser & Hunt, 1996; Bryant-Davis & Ocampo, 2005; Thompson & Neville, 1999; Williams & Williams-Morris, 2000). Scholars have presented models and discussions of how oppression and racism can create psychological damage and can be harmful to victims (e.g., Abdullah, 1998; Comas-Diaz & Jacobsen, 2001). Yet these discussions tend to be general and global with respect to the overall characteristics of racism as a form of oppression and violence. What is less clear is what specific aspects of racism are related to emotional and psychological harm given a person's unique way of responding and coping with such experiences.

It might be possible to gain a better understanding of the specific aspects of racism that lead to particular psychological and emotional effects as well as reactions if the acts and experiences associated with racism were deconstructed into specific types of encounters such as racial discrimination and racial harassment. By using more specific types of encounters with racism, it may be possible to show that targets of racism are harmed psychologically from the stress and perhaps trauma (i.e., Bryant-Davis & Ocampo, 2005; Comas-Diaz, 1994) such encounters produce (Williams, Neighbors, & Jackson, 2003).

Researchers (Landrine & Klonoff, 1996; Utsey, 1999; Utsey & Ellison, 2000) have shown that people of Color are stressed by individual, institutional, and cultural encounters with racism. The race-based stressors are thought to have an impact on their psychological and physical health (Clark,

Anderson, Clark, & Williams, 1999; Carter, Forsyth, Mazzula, & Williams, 2005; Harrell, 2000). Last, the notion that racism is a stressor that can harm or injure its targets is not recognized in psychological or psychiatric diagnostic systems (Prilleltensky, 1995). Therefore, there is a need to develop a way to recognize, assess, and treat people of Color who have race-based stress reactions (Johnson, 1993).

Mental health professionals have acknowledged and researched the mental health effects of life event stress, trauma, and racial discrimination (Clark et al., 1999; Norris, 1990; Sanders-Thompson, 1996; Taylor, 1999; Utsey & Ponterotto, 1996). However, these bodies of research and scholarship do not overlap, and many studies have not investigated the direct effects of racism. In addition, when race-related stress has been studied, trauma was not considered as a possible reaction. Stressful life event researchers (e.g., Taylor, 1999) have studied racially diverse samples, but generally do not focus on the particular effects of racism, although some of the manifestations of racism such as low socioeconomic status are considered. Trauma researchers (e.g., Norris, 1990) typically do not focus on racism as a factor in the development of posttraumatic stress disorder (PTSD) after exposure to a potentially severe stressful event (e.g., disasters, combat, and violence). However, they have found that people of Color have elevated levels of PTSD not fully explained by the event or other factors.

In many studies of discrimination (e.g., Sanders-Thompson, 1996) and race-related stress (e.g., Clark et al., 1999; Utsey & Ponterotto, 1996), exposure to such experiences are related to psychological (e.g., anxiety) and physical distress (e.g., increased blood pressure), but they have not considered whether racism may produce trauma. Although mental health scholars (e.g., Comas-Diaz & Jacobsen, 2001) have discussed sensitivity to racial encounters, few have established ways to relate specific experiences of racism to particular mental health effects for individuals. It is difficult to know what specific aspects of racism or race-based experiences impact people and whether the stress of such experiences produces a traumatic reaction.

When scholars and researchers (e.g., Bryant-Davis & Ocampo, 2005; Loo et al., 2001) have connected racism to trauma, they usually have done so by adhering to the definition of trauma as PTSD, thereby relating racism to physical danger and pathology (e.g., Williams & Williams-Morris, 2000). It is less clear which specific aspects of racism are implicated in the stressful effects, particularly in light of the fact that people vary in how they react to stress and in how they understand and perceive race to matter in their lives. Currently, in scholarship and research, the terms *racism* and *discrimination* are used in a way that makes it difficult to connect particular types of acts or experiences with racism to specific mental health effects.

Most mental health studies of racial discrimination and investigations of the effects of stress show that some people suffer psychological distress such

as clinical depression, anxiety disorders, PTSD, or personality disorders as a result of major stressors. It is not clear, however, whether particular aspects or types of encounters with racism contribute to the psychological distress. More important, the mental health impact of racism is not considered or captured by traditional counseling psychology or psychiatric theory or assessment models (American Psychological Association, 2003). Existing and traditional theories or assessment approaches provide mental health professionals and counseling psychologists with no guidance in recognizing the often subtle and indirect incidents of racism and discrimination, and provide little guidance in assessing the specific effects of race-based encounters that produce psychological distress and perhaps traumatic injury. Therefore, there is a need to help counseling psychologists and mental health professionals assess and recognize the effects of specific acts of race-based encounters and experiences on people of Color (Clark et al., 1999).

To illustrate how racism may result in trauma, Butts (2002) presented the following example of a trauma reaction that resulted from discrimination:

> A light-skinned Hispanic male was treated courteously when he made application for an apartment in New York City. However, when he returned with his African-American wife, the renting agent became aloof and informed them that the apartment was rented. In response to the denial of the apartment, the wife immediately became depressed, insomniac, and hypervigilant. She had repeated nightmares. At the time of the alleged discrimination, she noticed that her hair had begun to fall out, that her skin was dry, and she was constipated. There were no hallucinations, delusions or ideas of reference, and there was a mild paranoid trend. All of her symptoms were causally related to the discrimination. (p. 338)

One could argue that the woman in the Butts (2002) study experienced a race-based traumatic stress reaction to racism that was caused by an injury to her emotional and psychological state. Clearly, the event triggered a crisis. It is not known what personal factors were at play in her life prior to the event, and it is not possible to know how these contributed to her vulnerability. Regardless, she suffered from an act of racism, and it seems more reasonable to assess her reaction as the result of the situational event that produced emotional pain rather than to treat her reactions as a mental disorder (e.g., PTSD).

Reliance on the dispositional approach (i.e., mental disorders or diagnoses) seems to hold the target responsible for situational factors outside her or his control. It may be more accurate to employ the notion of "injury," which does a better job of capturing the external violations and assaults inherent in racism or in race-based encounters and experiences. Moreover, the idea of psychological injury is associated with the idea that the person who is injured has had his or her rights violated, and therefore has the legal right to pursue damages for these violations (*Merriam-Webster's Collegiate Dictionary*, 2003). Thus, injury characterizes the reactions that are linked to

specific aspects of racism as nonpathological external and situational factors that affect one's mental health rather than as a mental disorder. Yet as noted previously, to be effective in determining how race-based encounters and experiences produce psychological injury, it is necessary to specify the particular aspects of racism that bring about reactions of stress or perhaps trauma.

Racism has been defined in many ways. However, for the most part, as will be discussed in more depth later, the definitions do not offer a way to connect specific acts and experiences of racism to particular emotional and psychological reactions (Carter & Pieterse, 2005; Jones, 1997; Thompson & Neville, 1999). An approach to understanding racism in more specific terms that connect particular experiences with psychological and emotional reactions was introduced by Carter and Helms (2002) and Carter, Forsyth, Mazzula, et al. (2005). They contend that identifying specific types of experiences with racism, such as avoidance or racial discrimination, hostility or racial harassment, aversive–hostility, or discriminatory harassment (which will be introduced in this article), might help targets, mental health professionals, and researchers connect specific experience(s) directly with particular types of emotional and psychological reactions. Their definitions of these common terms depart somewhat from the everyday, professional, and legal uses of similar terminology.

The goals for introducing new ways to recognize and assess race-based stress and trauma, as well as different types of racism, are to (a) facilitate recognition by targets and others of systematic, covert, subtle, and unconscious forms of racism; (b) guide counseling, psychiatric and psychological analysis, and assessment; (c) investigate and gain a more accurate understanding of the perceptions/experiences of targets of racism who lodge claims or complaints, as well as those who work on their behalf (psychologists and lawyers); and (d) provide a framework for future research in this area that would support the previously stated objectives.

To place the current discussion in a theoretical and empirical framework, several sections follow. In each section, I will review and discuss a particular area of research and scholarship. The first section begins with definitions and a discussion of some key terms and concepts. The second section presents a selective review of the stress literature and its relation to mental health. The brief review of the stress research is followed by a discussion and selective review of the research on trauma and PTSD. The next section presents a selective review of literature on discrimination, race-related stress, and racial identity. The last section offers a review of mental health standards and trauma scholarship. I present definitions of types of racism that can be connected to mental health effects, and discuss how to recognize and assess race-based traumatic stress injury by offering a review of mental health standards and trauma scholarship.

DISCUSSION AND DEFINITION OF TERMS

Terms Defined

Key terms used in the article will be defined here and discussed in the following subsection. *Race* is defined as a social construction in which people in the United States are identified by their skin color, language, and physical features, and are grouped and ranked into distinct racial groups. The groups include Whites and people of Color, including refugees and immigrants, as well as biracial people who have "at least one parent who has been classified as a racial minority" (Thompson & Neville, 1999, p. 162). *People of Color* refers to historically disenfranchised Americans, Black/African, Hispanic/Latino, Asian/Pacific Islanders, Native–Indigenous Indians, and biracial people.

Racial group rankings are used in multiracial societies to distribute social rewards, economic resources, and access and opportunity (Carter & Pieterse, 2005; Marger, 2003). American racial groups were socially and legally separated for centuries and therefore were able to retain and sustain distinct cultural patterns and preferences. Therefore, race is associated with a group's culture (Marger, 2003). *Culture* is defined as a system of meaning with values, norms, behaviors, language, and history that is passed on from one generation to the next through socialization and participation in the group's organizations and institutions. Racial group membership refers to one's social demographic and presumed cultural group. When a person indicates that his or her race has meaning to him or her, this is thought to be a reflection of one's "race identity," which is sometimes called "racial identity." As it is typically used, race has social implications and people infer psychological meaning from sociodemographic group membership. When used in this way, race has no psychological meaning. Rather, the psychological meaning of race is reflected in how one thinks about her or his racial group membership. The psychological meaning one attributes to his or her racial group has been defined as his or her *racial identity ego status*, which is one's psychological orientation to race. Racial group members' psychological orientation to their race may vary among people within and between particular racial groups (Carter & Pieterse, 2005; Helms & Cook, 1999; Thompson & Carter, 1997). Research on racial identity has shown over the past 35 years that how one understands or experiences racism is associated with a person's psychologically based racial identity ego status (see Carter, 2005). Also, one's racial identity is experienced in relation to his or her gender, ethnicity, social status, religion, age, and other factors (Essed, 1991).

Stress is defined as a person–environment, biopsychosocial interaction, wherein environmental events (stressors) are appraised first as either positive

or unwanted and negative. Then, if the appraisal is that the stressor is unwanted and negative, some action to cope and adapt is needed. When coping and adaptation fail, one experiences stress reactions. Although trauma is a form of stress, it is distinct in that it is a more severe form of stress understood in terms of both the nature of the stressor(s) and the type of reaction to the stressor(s). Thus, *trauma* has been defined in two ways: as PTSD and as traumatic stress. According to the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–IV–TR*; American Psychiatric Association, 2000), PTSD and related severe stress reactions such as adjustment and acute stress disorders result from

> exposure to an extreme . . . stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or threat to one's physical integrity . . . the person's response must involve intense fear, helplessness, or horror. (p. 463)

In addition, for the event or reaction to be characterized as PTSD, the response must specifically lead to symptoms of avoidance, reexperiencing, and arousal. Carlson's (1997) model of traumatic stress defines the core stressor(s) for trauma as emotionally painful events that are sudden, negative, and out of one's control and that result in primary symptom clusters that include avoidance, arousal, and intrusion, as well as other reactions (e.g., depression; see Carlson, 1997).

Discussion of Racism and Stress

Racism and stress are complex constructs, and a more in-depth discussion of these terms is necessary to place the established definitions into a larger sociocultural context. It is important to note that although the construct of racism has been lived, practiced, and experienced for centuries, and is well understood by those who are subjugated by it, the term *racism* was not formally used or accepted until the late 1960s. The word was first used and widely circulated when it appeared in the Kerner Commission report on civil unrest (Kerner, 1968). Thus, the term and the concepts associated with racism are less than 40 years old. The Kerner Commission stated the following:

> White racism is essentially responsible for the explosive mixture which has been accumulating in our cities since the end of World War II, among the ingredients . . . are pervasive discrimination and segregation in employment, education and housing . . . Black in-migration and White exodus . . . creating a crisis in deteriorating facilities and services and unmet needs in . . . the [B]lack ghettos were segregation and poverty . . . converge to destroy opportunity and enforce failure. (p. 10)

Nevertheless, since its introduction into the lexicon, racism has been used and defined in many ways.

Jones (1997) analyzed some 18 definitions of racism from scholars representing several disciplines such as sociology, anthropology, history, and social psychology. Drawing from his analyses, the various definitions that have been proffered over time reflect several different perspectives on racism. Some definitions or conceptualizations of racism have emphasized that racism is a complex set of rational and logical beliefs and attitudes that serve to justify the superiority of the dominant racial group while deemphasizing its systemic characteristics and sociohistorical context. Some definitions characterize racism as attitudes and beliefs that rob minorities of their dignity and access to resources (Feagin & Vera, 1995), whereas other definitions emphasize the role of racial group membership categories and invoke group-based self-interest and political processes (Ani, 1994; Goldberg, 1990). Still others recognize the systemic and structural nature of racism, and emphasize the sociohistorical context and the changing nature of racism over time. Few existing definitions offer a link between specific types of racism and the psychological and emotional impacts these acts have on targets.

The ahistorical conceptualization of racism as a set of rational and logical beliefs or attitudes is captured by terms like *nationalism*, *xenophobia*, *White nationalism*, *modern racism*, *symbolic racism*, and *aversive racism*. An example of this particular understanding of the term *racism* and its reliance on rational process is illustrated by the definition of modern racism as a

> belief that discrimination is a thing of the past because blacks and other minority groups have freedom to compete in the market place. . . . Blacks are pushing too hard and too fast into places where they are not wanted. . . . These tactics and demands are unfair therefore recent gains are underserved and institutions are giving them more attention and status than they deserve. (cited in Jones, 1997, pp. 368-370)

Aversive racism has been defined as "ambivalence based on the conflict between dealings and beliefs associated with a sincere egalitarian value system and unacknowledged negative feelings and beliefs about blacks" (cited in Jones, 1997, pp. 368-370). Jones observed that these definitions reflect feelings of antagonism and ambivalence about race and allegiance to traditional American values. Thus, they rest on a form of justification that is grounded in American values and beliefs in equality. The definitions point to the failure of minority groups to meet standards of conduct and social participation, and these perceptions and feelings seem to be justified through rational and logical analyses. According to Jones, a key notion associated with these definitions of racism is the emphasis on personal character rather than on systemic processes. Yet, as Jones noted,

these definitions overlook the fact that the group in power defines what is acceptable and what is not.

The group in power determines what values, behaviors, and beliefs are considered to be proper. In this way, they determine when and if a group or its members fail to meet the standards of good character or appropriate behavior. Thus, the rational approach to racism "makes it easy to maintain one's superior status without opening one's self to accusations of racism" (Jones, 1997, p. 372). Nevertheless, these definitions focus on Whites' beliefs about their social status and their perspective that Blacks and other minorities must earn their social status, and should do so without preference. There is little in the rational and logical definitions of racism that adds to the understanding of the relation between racism and mental health.

A number of definitions of racism strive to explicate the systemic dynamics of domination and oppression that are embedded within a sociohistorical context. For example, Bulhan (1985) defined racism as a form of oppression that is based on racial categories and systems of domination that designate one group superior and the other(s) inferior. The superior group then uses these imagined differences to justify inequity, exclusion, or domination. Bulhan suggested, in a general way, though not in specific terms, that Blacks and people of Color are harmed by such treatment because oppression is a form of violence. He also argued that the violence of racism may be internalized and turned against the self and others of one's oppressed group. This definition of racism begins to establish a possible conceptual link between racism and more specific potential mental health effects, but the reference to the violence of oppression is so broad and undefined that it fails to provide a foundation for linking specific types of racism to particular mental health outcomes. Although the definitions discussed thus far capture important elements of racism, in general they do not convey a way to connect particular experiences to mental health effects.

Omi and Winant (1986, 1994) argued that more than anything, "race" is a sociohistorical concept. They asserted that the meaning assigned to racial categories, and the particular form of expression surrounding race and racism as reflected in social relationships, is determined by the historical context and the political climate at a particular time in history. In this way, the variations in meaning attributed to race over time and circumstances can be understood. For these scholars, race and racism are shaped by politics and social relationships. Omi and Winant (1986) contended that scholars have sought to understand race as a concept related primarily to ethnicity, class, or nation. Therefore, such models

> missed the manner in which race has been a fundamental axis of social organization in the United States . . . we attempt to develop an alternative concept

> which does not treat race epiphenomenally or subsume it within a supposedly more fundamental category. (p. 13)

For Omi and Winant, race is used as an organizing principle for social relations at the micro (individual) and macro (collective) levels. They coined the term "racial formation" to capture the process of how racial meaning is shaped and altered to determine social relationships. Omi and Winant highlighted the reality and constant changing nature of race, its meaning, and manifestations in society. Their construction is useful for understanding the central and changing nature of racial meaning and racism, but it does not provide a connection between racism or racial formations and mental-health-related effects. Moreover, their analysis is primarily political and historical, and is therefore somewhat removed from the direct reactions of targets to encounters with racism.

Essed (1991) provided a definition of racism that focuses on the actual experience of targets, thus capturing its complex and systematic nature. In her qualitative study of 55 Dutch and American Black women, she documented, described, and defined *everyday racism* as

> a process in which socialized racist notions are integrated into meanings that make practices immediately definable and manageable, . . . familiar and repetitive, and . . . race relations are actualized and reinforced through these routine practices in everyday situations. (p. 52)

Everyday racism is enacted through direct and indirect means in which indirect enactments occur in the development and application of policy and procedures as well as in media portrayals of Blacks and people of Color. Essed wrote that everyday racism

> is a coherent complex of oppression continuously present and systematically activated personally through encounters, vicariously through the experiences of other Blacks (or people of Color), through the media and through the daily awareness of racial injustice in society. (p. 53)

Essed did an excellent job of describing individual variation in recognition of everyday racism and in documenting the types of events and experiences that characterize women's lives. However, she did not discuss or describe how the women were impacted psychologically and emotionally by the different manifestations of everyday racism.

Williams and Williams-Morris (2000) defined racism as an organized system that leads to the subjugation of some human groups. The ranking of a group's worth relative to other groups leads to the development of negative beliefs and attitudes toward the *out-group*, which is deemed inferior. These

negative beliefs generate and justify differential treatment of out-group members by other individuals and social institutions. Their discussion emphasizes the systemic or institutional aspects of actions and beliefs rather than individual behaviors and attitudes. Clark et al. (1999) put it this way, "Racism is operationally defined as beliefs, attitudes, institutional arrangements, and acts that tend to denigrate individuals or groups because of phenotypic characteristics" (p. 805).

Thompson and Neville (1999) agreed with the structural emphasis presented by Williams and Williams-Morris (2000) in that for them racism affects the mental health status of both people of Color and Whites (Bowser & Hunt, 1996). For these scholars, racism is structural and ideological and operates on individual, institutional, and cultural levels. In addition, racism has changed its form and application over time and place, and has shifted from legal, overt, and direct acts of violence, discrimination, harassment, and denigration to illegal, subtle, and indirect acts of aversion and hostility. Structural racism is perpetuated through a social system of stratification that limits people of Color's access to and opportunity from social, educational, economic, and political participation. Marger (2003) described this process from a sociological perspective as denial of primary structural assimilation (no close personal relationships with people from groups in positions of power and authority) that operates as a system of impediments that limit access to power. It is possible that this denial to access and opportunity produces psychological effects, but it is not clear what types and at what point in ones' experience the mental health affect might occur.

Racism as ideology is contained in "ideas about race and race relations, which serve to protect the status quo . . . the system of racial domination in which racial minorities experience institutional discrimination" (Thompson & Neville, 1999, p. 165). The racial ideology of out-group inferior status or stereotypes is communicated through the media, science, social policy, and popular beliefs. Many of the manifestations of these beliefs contribute to direct and indirect policies, practices, and acts of hostility that people of Color endure. Research on stereotype threat (Steele, 1997) suggested that Blacks' cognitive ability in some situations is hampered by the threat of the stereotype of them as less able. Thus, this aspect of racism may lead to particular mental health reactions, but there has been little research to support this contention.

A number of scholars have emphasized the distinction between racism and individual prejudice. Jones (1972) observed that individual racism was distinct from prejudice in that it included the use of *power* by the dominant group to oppress out-group members (people of Color). This theme is captured in many of the definitions discussed previously. Institutions are collections of individuals, and the culture they represent is the cumulative experience of individuals

over time. Yet institutions and the social culture operate independently of individuals, and these systems have "lives" of their own. Racism goes beyond the individual and includes institutions and the culture. Jones (1998) puts it this way:

> It is clear that prejudice functions to create immediate and direct discrimination based on race. [It is also clear] that discrimination is all the more meaningful when it co-occurs with a societal structure that aligns choice and chances with racial group membership. When this alignment privileges one race over another, and does so over centuries with the accompaniment of theories, rationales, and beliefs, this recurring dynamic transcends simple race prejudice. Thus, the cumulative effects of race prejudice over time combine with the cultural rationales and beliefs about racial essences to enable the institutions' implementation of racism. (p. 283)

The implementation of racism sets barriers and endorses acts that compromise the dignity of people of Color at individual and cultural levels. Thus, individual racism is defined as the belief in one's superiority and members of the out-groups' inferiority. Institutional racism is defined and reflected in the gross and unequal outcomes in social systems and organizations such as in education, health, occupation, and politics. Institutional racism is evidenced in the following facts:

> White males make up one third (33%) of the U.S. population, yet they occupy 80-90% of the tenured positions in higher education, 80% of the U.S. House of Representatives, 99% of the U.S. Senate, 92% of the Forbes 400 executive CEO-level positions, 90% of public school superintendents, 99.9% of athletic team owners, and 100% of U.S. presidents (Sue, 2003, p. 9).

Cultural racism is defined as the belief that the characteristics and values of one's racial group are superior to that of other racial groups (Jones & Carter, 1996). Regarding cultural racism, Sue (2003) stated,

> White Euro-Americans use power to perpetuate their cultural heritage and impose it on people of Color while diminishing the importance of or destroying another group's way of life (cultural genocide), it represents racism of the extreme kind. History is replete with governmental actions used in the United States to stamp out the language and religious practices of Native Americans. In cultural racism's contemporary form, some teachers forbid the use of a second language in their classrooms. (p. 34)

Thus, racism can be defined, and for the purposes of this article will mean, the transformation of racial prejudice into individual racism through the use of power directed against racial group(s) and their members, who are defined as inferior by individuals, institutional members, and leaders, which is reflected in policy and procedures with the intentional and unintentional

support and participation of the entire race and dominant culture (Jones & Carter, 1996). Although the various definitions presented here describe the elements of racism well and locate many of the avenues by which it is expressed, what is missing are definitions that allow for an analysis of the relation between a particular type of racist act or experience to a person's emotional and psychological reactions and its subsequent mental health effect. It is the case that, as broadly defined in its various forms, racism has been found in research to be a form of stress and, as such, has affected the mental and physical health of its targets.

Stress

Many definitions of stress exist. Nevertheless, for most scholars stress is an emotional, physical, and behavioral response to an event(s) that is appraised as positive or unwanted. The initial appraisal is followed by a secondary assessment that is focused on action to cope and adapt to the event. If coping or adaptation fails, stress reactions intensify. However, the extent to which a person is affected by stress depends on his or her personal characteristics and predispositions. Although a stress response can help one adapt, it can be harmful. Harm occurs when the response to stress is prolonged or the stress produces trauma. Studies show several harmful health outcomes associated with the consequences of exposure to stress.

Pearlin (1989) argued that to understand stress and stress reactions, one must consider the role of social structures. Many stressful experiences occur within the context of social structures or systems of social stratification such as socioeconomic status, race, and gender and are often related to a person's place within that structure.

Stress is a central construct in the race-based traumatic stress injury model (i.e., an emotional trauma brought on by the stress of racism). It is important that a brief review of stress research be presented so that there is an understanding of how stress affects people. This research is particularly relevant because studies of discrimination and race-related stress were built on the foundation of basic stress and life event research, and similar methods and measurement strategies are used to examine both (e.g., list the number and types of events that occur, then sum for a total stress score). The researchers who have studied stress and its psychological and health effects have typically not focused on the health-related impact of race or racism.

In a detailed review of the health and psychological research, Taylor (1999) outlined dimensions of stressors that increase the likelihood for the production of stress. Stress increases if an event is ambiguous, negative, unpredictable, and uncontrollable. Stress is greater if there are problems and conflicts with central roles in one's life (i.e., personal relationships, work, and

parenting). Researchers report that negative life events in personal relationships tend to be stronger predictors of depression. Stress reactions occur whether the stressor(s) are objective (e.g., sudden death or accident) or subjective (e.g., perception of discrimination); in research, both have been shown to independently predict psychological and health effects. It is important to highlight that some people exposed to stressful situations or events can adapt and cope effectively with them while others may not. Also, under conditions of long-term and chronic stress people suffer negative psychological and physical consequences (Taylor, 1999).

Regarding long-term stress, Taylor (1999) noted that people can adapt to or experience strain as a result of ongoing stressful events. However, it is difficult for some people to adapt to these highly stressful events. Even after psychological adaptation to long-term strain from prolonged stress, physiological changes resulting from the long-term stressful circumstance may continue and can impact psychological well-being. Said another way, even when people seem to adapt to it, stress can still make one sick.

It seems reasonable to argue that racism causes tension and deprivation for many of its targets as well as a range of mental health consequences. Thus, "Stress is problematic not just because it is unpleasant to go through, but because its effects may persist for a long time and do cumulative damage" (Taylor, 1999, p. 183). Documented physical and mental health disparities have been shown to be race based in that people of Color fare poorly regardless of economic resources. The Institute of Medicine's *Unequal Treatment* report (Smedley, Stith, & Nelson, 2003) and the Surgeon Generals's *Mental Health: Culture, Race, and Ethnicity* report (USDHHS, 2001) are examples of such documented evidence. Both documents point to racism and discrimination as major contributing factors in the findings of health and mental health disparities.

The basic method used in early research on life events has evolved, and many instruments have been developed. The methods for measuring life event stress, PTSD, discrimination-related distress, and race-related stress—all to be presented in more detail later—employ the listing of events technique. In addition, many measures ask respondents to indicate if they had ever experienced such an event and if so, how they were affected or how upset they were by the experience.

One area of inquiry that has received attention in the research literature is minor events or daily hassles (Taylor, 1999). Scholars believe that day-to-day hassles can compromise psychological well-being. According to Taylor's review, day-to-day stress can affect mental health when a large number of minor events add up and wear down a person, thus making her or him vulnerable to poor health. In the context of racism, daily hassles are described as "microaggressions." Pierce (1974) first described microaggressions as

sources of stress (being treated as if one is a threat to others or as if one does not exist) in the form of daily slights and insults directed at someone because of her or his race. Researchers (e.g., DeLongis, Coyne, Dakof, Folkman, & Lazurus, 1982; Kanner, Coyne, Schaefer, & Lazarus, 1981; Levy, Cain, Jarrett, & Heit-Kemper, 1997) have generally found that daily hassles were related to depression, anxiety, and decline in physical health. With respect to racism, daily encounters would emerge from individual and institutional racism as well as from applications of racial stereotypes that prompt people from all racial groups to treat members of non-White groups as dangerous, criminal, or uneducated (Braithwaite & Taylor, 2001). However, it has been argued that individual differences in how people respond to daily events might lead some to report greater hassles and psychological distress because of predispositions to react to events (Lazarus, 1999). Thus, research points to the importance of considering individual variation in how people respond to events in their lives (e.g., gender, racial identity statuses, etc.). In addition to major life events and day-to-day hassles, researchers have focused on chronic and ongoing sources of stress. Scholars (e.g., Jackson et al., 2003; Jaynes & Williams, 1989) have argued that restricted housing, segregation, and limited economic opportunity and access to social participation produce chronic stress for many people of Color. Epstein (2003), writing about how poor communities may be making people sick, stated that

> the grinding everyday stress of being poor and marginalized in America [experienced by people of Color] is weathering, a condition not unlike the effect of exposure to wind and rain to houses. . . . Stress hormones threaten the health of poor people, . . . Blacks, and Hispanics . . . when people feel frustrated, frightened, or angry stress hormones, affect the body. (p. 80)

Epstein interviewed people and asked them what they thought was responsible for their health and mental health problems. One of her female interviewees "answered without a beat, 'Racism'" (p. 81). It should be noted that being poor alone could produce stress and illness, yet the double impact of racism with its associated disparities seems to compound the experience of poverty. Even with this understanding, there is still less direct evidence regarding the connection between the emotional and psychological impact of particular aspects of racism.

Stress has been the subject of many mental health investigations. Scholars and researchers have proposed, discussed, and studied various models of stress (Cohen, 2000; Schwarzer & Schulz, 2003). Definitions and measurement strategies for stress have varied (R. A. Martin, 1989), yet irrespective of the research method and conceptual model, there is agreement among mental health professionals that stress affects both mental and physical health (Braithwaite & Taylor, 2001; Cohen, 2000). Lazarus and Folkman's (1984)

model is one of the more widely used frameworks to study the effects of stress. The model emphasizes the role of cognitive appraisal, or how one assesses a situation to determine if it is a stressor, in the development of health and mental health outcomes. For most scholars who study stress, cognitive appraisal moderates the environmental stimulus (potential stressor) and therefore either increases or mitigates a person's response (psychophysiological) to the stimulus (Cohen, 2000).

What researchers have come to understand, through prevalence, incidence, and correlational studies, is that stress plays a central role in many areas of life (Braithwaite & Taylor, 2001; Dohrenwend, 2000; Lazarus, 1999; Monroe & Peterman, 1988; Schwarzer & Schulz, 2003; Taylor, 1999). Depression and anxiety are the most common reactions to stressful life events. Life events found to be stressful include—but are not limited to—unemployment, discrimination, poverty, sudden death, marriage, war zone combat, assault, accidents, as well as natural and technological disasters (Kessler, Mickelson, & Zhao, 1997). Some investigators have included race and racial group–related stressors in their studies. A few will now be discussed.

Prelow and Guarnaccia (1997) reported that White adolescents had higher levels of life stress than their Black and Hispanic counterparts, and stressful life events were significantly related to psychological distress for all racial groups. The results of this study seem to counter the suggestion that non-White racial group members experience more life stress. Yet other studies show different results. Brown and Gary (1988) found that, in the absence of social support, Black adults were more likely to experience depression in relation to stressful life events. Also, Spangenberg and Pieterse (1995) investigated stressful life events and mental health among Black South African women, and they found that significant chronic daily hassles were related to psychological distress. They also found that the relation held only for interactions with social institutions, suggesting a possible link between institutional and cultural aspects of racism and life event stress.

Ruggiero and Taylor's (1997) findings support the role of perception in race-based experiences. They found, with Asian and African American female students, that high levels of self-esteem and an attribution style that equated negative feedback to racism, rather than personal failure, moderated participants' reactions to negative feedback. It appears that how one perceives the experience influences whether one interprets the racial event as stressful. However, Chapleski, Kaczynski, Lichtenberg, and Gerbi (2004) found in their longitudinal study with elderly American Indians that physical and mental health might be linked. They found that a history of depression was the stronger predictor of current depression, but that life stress was associated with short-term effects on mental health, and that poor health tended to have a longer term impact on mental health. Perhaps these findings were associated with aging, but it could also be that poor health adversely impacts

psychological health. Thus, life events research shows that people are affected by such events and that they may experience poor health and negative mental health outcomes as a result. How one is affected depends on a variety of individual and racial–cultural factors (Dohrenwend, 2000).

According to Slavin, Rainer, McCreary, and Gowda (1991), the standard stress model as reflected in the Lazarus and Folkman's (1984) work, does not consider culturally relevant aspects of the stress process. Therefore, a model was needed that considered more than individual, White American culturally based responses to stress. Slavin et al.'s multicultural stress model includes consideration of the racial–cultural and social embeddedness of the minority or person of Color. The occurrence of a life event that has the potential to be stressful is expanded to include events that may also be stressful for a person of Color, but not for Whites or for people who identify with White American culture. Some examples of these types of events are minority status, being the only person of one's racial group in an institution or organization, experiences of discrimination (e.g., being subjected to a racial incident, not having social or political power), and living by a group's racial customs (e.g., having to marry according to cultural ways).

Slavin et al. (1991) also added racial–cultural elements to the primary and secondary appraisal process of these events. Primary appraisal involves a judgment about the meaning or significance of the event. For instance, one appraises whether as a result of the event one thinks he or she is in trouble. These scholars contend that events are appraised within the context of one's racial–cultural experience and family background. Thus, the question of being in trouble is, for many people of Color, related to whether the event occurred because of one's race. This issue usually needs to be considered early on in the stress appraisal process. Slavin et al. observed that "concern about the possibility of racial harassment may increase the stressfulness of otherwise relatively benign events" (p. 159). In addition, a person of Color who is identified with his or her racial-cultural group must determine "who owns the event." In mainstream White American culture, the individual typically "owns" the event. But in some racial–cultural traditions, the event (e.g., school- or work-related decisions) may belong or be owned by the family or the head of the family and not just by the individual. In this sense, there needs to be a "fit" between the event and the racial–cultural traditions of the person and family. Thus, lack of cultural fit or ownership may influence the stress process in ways not accounted for in the standard model.

During the secondary appraisal phase, one tries to determine what can be done about the event. Again, additional culturally relevant issues arise. Slavin et al. (1991) noted that racial–cultural groups vary in how members determine what can be done about a situation or an event and who should determine appropriate actions. They observed that "members of minority groups may hold strong beliefs about racism and oppression in the majority

society and about the responsiveness of various social systems . . . to the needs of the group" (p. 160). Because of these beliefs and prior experiences, how or whether people seek help and/or engage in problem-oriented behavior is strongly influenced.

Another area for consideration has to do with whether individuals hold negative views of their ability or have internalized social stereotypes. If they have a poor self-concept or have internalized racial stereotypes, these individuals may not be able to cope or adapt to the experience, which may generate greater levels of stress: "An adolescent who is proud of his/her racial group may find a racist remark less upsetting than would an adolescent who feels badly about his or her group membership" (Slavin et al., 1991, p. 160). Determination of available resources may also vary by racial–cultural group. Some groups may define family relationships more broadly and thus may have more support than do people who see family in a more narrow or restricted way. One's racial–cultural group membership, according to Slavin et al., may influence the choices of ways to cope. For instance, religious beliefs held by racial–cultural group members might influence choices in coping responses. Also, options for coping presented by mainstream institutions may not be consistent with the racial–cultural patterns of the group (e.g., seeking help through a counselor). Moreover, some ways of coping used by people of Color may be met with social sanctions by majority institutions. "For example a poor African American man who is assertive with staff members to get information about his hospitalized child may be treated much more punitively than a man of European descent in the same circumstances" (Slavin et al., 1991, p. 160).

When coping fails, does one's racial group membership matter? Slavin et al. (1991) would say it does. In the last phase of the stress process, how the stress is expressed will vary according to one's racial–cultural group. Racial groups might vary in the forms of psychological–physical expression used to handle the stress they experience. For instance, Asians have been found to express stress through somatic or physical complaints. Other groups might invoke spirits, which is not common among White Americans, and therefore would not be understood. Thus, the model presented by Slavin et al. has considerable utility in understanding the stress response in people of Color, particularly because it recognizes racism as a core and central source of stress and identifies how one's racial–cultural status may influence the stress process. Stress also occurs with distinct levels of severity, and it is important to note that although both life stress and trauma are forms of stress, they differ considerably.

The study of life event stress and psychological health is different from the area of research that focuses on the development of more severe stress reactions such as posttraumatic stress because of exposure to a life-threatening event. In part, the former has been concerned with major and everyday events

such as marriage, moving, or work-related activities; the latter has focused on events that are more extraordinary and more severe, and as a result are less common. Although both events are forms of stress, the key and critical difference between the two is the level of severity of the event and the reaction to it that produces the stress or trauma. Nevertheless, the research on trauma is a distinct body of research and scholarship.

To place the scholarship and research on trauma in context, a brief overview of the history of trauma and how it has been defined is offered. The recognition of psychological trauma is more constrained in the mental health profession, and its use and meaning have evolved over time. It is important to note that race has neither been explicitly studied in life event research nor has it been a focus in studies of trauma, yet a number of scholars (e.g., Bryant-Davis & Ocampo, 2005; Carter, Forsyth, Mazzula, et al., 2005; Scurfield & Mackey, 2001) have argued that race-based experiences fall within the domain of traumatic experiences.

PTSD AND TRAUMATIC STRESS MODELS

Issues of severe stress are usually assessed according to *DSM–IV–TR* (American Psychiatric Association, 2000). Currently, race-based experiences are not considered within the domain of the *DSM–IV–TR* or in regard to severe stress reactions. The *DSM–IV–TR* criteria for assessing trauma are limited to life threats and physically dangerous events, which dramatically limit the types of events that can cause stress-related disorders.

Trauma was first recognized in psychiatric and mental health diagnostic systems in the late nineteenth century and in the early twentieth century. Initially, incidents of stress-related trauma were recognized as the result of combat (shell shock) or railway accidents in civilian life (Turnbull & Turnbull, 1998). As more social and physical science researchers worked to understand traumatic reactions, it became clear that the stress, which resulted in trauma, had distinct psychological, social, and physiological components. Biological researchers found that exposure to certain events caused a response that produced distinct physiological and psychological changes. For instance, extreme stress reactions increase adrenaline and decrease endorphin production, resulting in increased muscle tension and greater sensitivity to pain. These changes correspond to psychological manifestations of the reaction as well. For instance Boone, Neumeister, and Charney (2003) indicated that

> because traumatic events indeed stimulate release of cortisol and catecholamine, the result could be a deeply engraved traumatic memory that is clinically expressed in the form of intrusive recollections, flashbacks, and repetitive nightmares, perhaps facilitating conditioned emotional responses.

> A positive feedback loop would be formed, because every time the traumatic memory is vividly re-experienced, cortisol, epinephrine, and norepinephrine are released further strengthening the memory. (p. 7)

PTSD criteria changed overtime (*DSM–III–R [1987], DSM–IV [1994],* and *DSM–IV–TR [2000]*) and has included consideration of a number of additional symptoms and responses that are now incorporated into the current criteria for PTSD. For instance, avoidance responses are now included in the criteria of PTSD. In addition, the requirement that the event be life threatening was then added. Later, witnessing life events was added as part of Criterion A (the initial category for the diagnosis). *DSM–IV–TR* requires six criteria for a diagnosis of PTSD (American Psychiatric Association, 2000). PTSD is usually the cornerstone used for understanding trauma in mental health practice and research. Therefore, its criteria are important but not sufficient for understanding or recognizing race-based experiences that might be traumatic.

The first and most critical criterion, without which a diagnosis cannot be made, is Criterion A, which requires that an event be physically dangerous and life threatening. A reaction of intense fear, helplessness, or horror that leads to impairment of functioning must also be present. A diagnosis of PTSD also mandates the presence of Criteria B, C, D, E, and F. Criteria B requires that the person either reexperiences the traumatic event or has intrusive memories, which can occur in one of five forms: (a) recollections, (b) dreams, (c) flashbacks, (d) reliving the event through psychological reactions, or (e) reliving the event through physiological reactions. For Criterion C to be met, the person has to either engage in avoidance behavior and thought or has to push away the experience. Three of the following seven markers need to apply before Criterion C can be met: (a) psychological avoidance, (b) physical avoidance, (c) poor recall, (d) diminished interest in significant activities, (e) feeling detached or dissociated from people, (f) limited or restricted feeling, or (g) a limited view of the future. For Criterion D to be satisfied, the person must have reactions characterized by hyperarousal or sleeplessness. Two of the following five elements must exist: (a) problems with sleep, (b) irritability, (c) difficulty concentrating, (d) hypervigliance, or (e) startle response. The requirement for Criterion E involves determining the duration of symptoms and that all of the symptoms (Criteria B, C, and D) last for more than 1 month. Last, Criterion F is used to determine if the symptoms cause clinically significant impairment in life and work (Kubany, Leisen, Kaplan, & Kelly, 2000). If the duration of the symptom is more than 3 months, the condition is considered chronic; if the duration is less than 3 months it is considered acute.

In summary, diagnosis of PTSD requires that an individual be exposed to a form of external danger that is life threatening, reexperience the trauma, avoid people and places associated with the trauma, experience increased

arousal, and have significant impairment in his or her daily functioning that lasts for at least 4 weeks. It is not appropriate to use PTSD criteria for recognizing or assessing race-based stress or trauma because the criteria are too limited. The diagnosis is limited by the fact that the person's subjective perceptions are not part of the criteria, and the event that triggers the reactions must be physical and life threatening. Furthermore, using PTSD would mean the target of racism is mentally disordered. It is probable that the target of racism is distressed and made ill by racial encounters and incidents. Nevertheless, focusing on the person leaves out consideration of the acts or experiences of racism responsible for the stress or trauma that one has had to endure, and that has left an engraved memory or has produced significant amounts of stress.

Taken together, the criteria for PTSD leave out many life experiences that have the potential to produce trauma (Herman, 1992). Thus, in the case of racism, only acts of physical violence would meet the criteria for PTSD. Although some scholars (Bryant-Davis & Ocampo, 2005) have argued that there are parallels between the experiences of physical violence and racist incidents; however, incidents associated with racism are more indirect, subtle, and systemic. A model of traumatic stress that can be used to recognize and assess race-based experiences that does not rely on physical danger and pathology is needed—and has been offered by Carlson (1997).

TRAUMATIC STRESS

With the increased recognition of severe or traumatic stress in various areas of life, counselors, mental health professionals, and researchers have begun to investigate the incidence and prevalence of lifetime and recent exposure (within 1 year) to severe stress or PTSD. Of interest was the frequency of potentially traumatic life events that might produce *DSM–IV–TR*–relevant, stress-related disorders. One objective of epidemiology studies of people in the general population who experienced traumatic life events was to determine whether the definition or classification of a traumatic event could go beyond that provided by *DSM–IV–TR* criteria. Norris (1992) argued that a traumatic event could be defined as any event that is perceived or experienced by the individual as shocking enough to produce symptoms of intrusion, numbing, and arousal. Thus, Norris offered a broader definition of a traumatic event as "a violent event marked by sudden or extreme force from an external agent" (p. 409). The violence could then be psychological or emotional rather than physical. Extreme force could refer to the intensity of the emotional impact of the event. The external agent could be an act of racism or a race-based encounter.

Carlson (1997) and others (e.g., Herman, 1992) offered alternative models for assessing and defining traumatic reactions because the *DSM–IV–TR*

definitions of PTSD, acute stress reactions, and other diagnoses were not applicable to all possible experiences that could produce trauma. It seems reasonable to include racism as an experience in which PTSD is not applicable and as an experience that could produce trauma.

The goals of Carlson's (1997) model are to (a) expand the definition to include a wider range of traumatic events, thus including events and experiences that are psychologically and emotionally, but not physically, threatening; (b) allow for a life span developmental perspective of traumatic events, which takes it beyond single events and short-term effects; (c) include a wider range of reactions; and (d) allow for research because it presents hypotheses that can be examined. The use of traumatic stress to recognize race-based stress and trauma fits the goals of the model in that race-based events are often not physical, they occur across the life span, and they usually reoccur in different situations and contexts. It is also likely that there are a wide range of reactions, coping responses, and efforts to adapt to race-based encounters. A more specific model for recognizing and assessing race-based trauma would allow for more research to be conducted and would aid mental health professionals to better understand and more effectively treat people who are subjected to such experiences.

Carlson (1997) argued that trauma is not well understood, despite its prevalence and the level of distress it causes. Most research has focused on single events, such as those experienced in combat and natural disasters (life-threatening physical danger), and their related short-term effects (after 1 to 3 months). Models that use PTSD tend to separate short- and long-term effects. Knowledge about trauma has only begun to accumulate since the late 1980s; information is therefore limited.

Carlson's (1997) model of traumatic stress involves three essential elements. The first is the subjective appraisal or perception that the event is negative. As Carlson stated,

> Some experience(s) are traumatic because they are emotionally painful . . . or because they involve the threat of emotional pain. In this case the negative valence is related to the psychological meaning of the event to the individual, not the physical consequences of the event. (p. 29)

Slavin et al.'s (1991) multicultural stress model is useful here because what is most important is the psychological meaning of the event to the individual. As noted earlier, people of Color are likely to find experiences that involve race as stressful. The person of Color may be the only one in a situation or organization and may therefore be expected to represent the group, or he or she may be subjugated to various racial incidents. The psychological pain of such experiences produces or causes damage or threat of damage to one's sense of self. Thus, the key aspect of this element is the perception

of the event. If one does not perceive an event as negative, it will not produce harm. This aspect of trauma is consistent with general and multicultural models of stress as conceptualized by Slavin et al.'s and Lazarus and Folkman's (1984) models.

The second element of Carlson's (1997) model is that the event is experienced as sudden in its occurrence. It is more difficult to adapt to an event that occurs without warning than to one that is gradual and takes place over time. "Escaping a traumatic response is more likely if one has months or years to adjust to a negative event" (Carlson, 1997, p. 32). This is not to say that events that are long term and grinding do not produce trauma.

The third element is that the event is experienced as uncontrollable. The belief that one has some degree of control over events serves as a form of protection. Trauma is more likely in situations in which one believes that he or she is not able to control the highly noxious event(s). Carlson (1997) noted,

> The ability to control an event renders it more predictable, and the ability to predict an event may make control over it more possible . . . predictability is not an essential element in the trauma process. Regardless of whether an event is predictable, it will be traumatizing if it is experienced as uncontrollable and sufficiently negative. . . . It seems that predictability could even cause experiences to be more traumatic since the stress and tension of waiting for uncontrollable negative experiences could lengthen the period of distress. (p. 33)

There are many aspects of racism at its various levels (individual, institutional, and cultural) that render encounters and resulting manifestations as negative, uncontrollable, and sudden. Yet, it is also true that, given the centuries of racist practices, some elements of racism can be considered predictable and constant but not in a way that permits a sense of control. Most forms of racism constitute assaults on one's sense of self and do so in ways that heighten tension within and between its targets (Bulhan, 1985). While it may be known that racism exists in many areas of life in the United States, it is not possible to know when or how one may encounter specific racial incidents or what emotional or psychological impact the encounter will have. In this way, being vigilant, or relying on "cultural paranoia," may help potential targets to prepare for a racial affront. Nonetheless, vigilance may not help one to know when an event with considerable emotional or psychological power will occur. The inability to predict when or where such events may occur or to prevent them from occurring renders such events sudden and uncontrollable.

Researchers (cf. Carlson, 1997) have found that people with severe stress share three core reactions that may be expressed through one or several

physiological, emotional, cognitive, or behavioral modalities. The core reactions are (a) *intrusion* or reexperiencing, (b) *arousal* or hyperactivity, and (c) *avoidance* or psychic numbing. For example, one might have thoughts or images that "intrude" on daily life. Or one might experience images of the encounter (reexperiencing) and have loss of memory or recall for the specific elements of the event(s) (avoidance). In addition, one may be anxious or express anger through aggression or hyperactivity, and may also stay away from the people or the location of the event. Finally, one may experience sleeplessness or startle easily (arousal) or have difficulty with concentration (intrusion).

The core reactions of intrusion, arousal, and avoidance may be manifested in other responses such as depression and anxiety that reflect or contain the core reactions. Similarly, one may experience a loss of self-worth and may have difficulty with intimate and interpersonal relationships. Guilt and shame may arise because of self-blame and a sense of responsibility for the experience. Some scholars have referred to self-blame and feeling responsible in the context of racism as "internalized racism" (Neighbors & Williams, 2001). Neighbors and Williams (2001) stated the following:

> The normative cultural characterization of the superiority of whiteness and the devaluation of blackness (or people of Color), combined with economic marginality . . . can lead to self-perceptions of worthlessness and powerlessness. Several lines of evidence suggest that the internalization of cultural stereotypes by stigmatized groups can create expectations, anxieties, and reactions that can adversely affect social and psychological functioning. (p. 112)

Slavin et al. (1991) noted also that such reactions can heighten or lessen the stress process for people of Color.

It is important to note that other factors influence responses to trauma that include the person's physical condition, level of development, severity of the trauma, social context before and after the event, and quality of life events before and after the trauma. An important factor is severity, which includes the number, intensity, and duration of events. For instance, Carlson (1997) pointed out that

> to the extent the person is biologically vulnerable . . . is younger, the trauma is more severe (e.g., multiple, highly intense events of long duration), the social context is unsupportive, and previous or subsequent life events are very stressful, there would be a more pronounced and long-lasting traumatic response. (p. 37)

Therefore, because people of Color are subjected to various forms and levels of racism, many are rendered vulnerable to lifelong exposure and as a result have higher rates of poor physical and mental health, experience

numerous life event stressors, and receive little societal support or recognition for their social plight. It seems reasonable to conclude that racism can be a traumatic stressor. Consider further that for trauma to be severe, events might be frequent and intense. When racism is involved in traumatic events, intensity is often reflected in the number of areas of life that are simultaneously affected (work, living, education). The stress of the varied forms of racism across a range of settings can set the stage for a particularly painful event that makes the stress severe and traumatic. Furthermore, because racism has endured for hundreds of years, it seems reasonable to argue that the chronic and pervasive nature of racism in society can cause people to become physically and emotionally vulnerable. This notion is reflected in Slavin et al.'s (1991) multicultural stress model in that people of Color must determine on a regular basis if an event is related to one's race or not. It is also reflected in the ways that one can cope or adapt to stressful situation(s) in that many reactions may be met with social sanctions, and may thus create a greater degree of stress that could also push the stress to the levels of severity that produce trauma.

It would be of value to use the definition of traumatic stress in counseling psychology and mental health practice to capture some of the effects of racism given the fact that its effects may be expected but nonetheless sudden. Racist incidents may be repeated and reoccurring, subtle, and covert as reflected in language or symbols. They occur within the context of a society that for centuries sanctioned and made legal various forms of racial harassment and discrimination. So, the concept of traumatic stress is valuable in assessing and recognizing race-based experiences both as stress and as trauma.

Although racism is not directly a focus of the research on PTSD, the research provides indirect evidence regarding the possible role of racism as trauma in the lives of study participants. One of the strengths of this body of research is that it includes people of Color. In addition, several important trends can be observed. One is that although not all people develop PTSD or traumatic reactions to potentially stressful events, people of Color, both as civilians and as combat veterans, show higher levels of PTSD than Whites. Even given the limitations of using the PTSD diagnosis, the higher rates of PTSD among people of Color in relation to Whites can demonstrate that racism may be a contributing factor in these traumatic reactions. Also, studies that identify risk factors for the development of PTSD show that many risk factors are experiences that people of Color are exposed to in greater proportions than are Whites (e.g., violence). Furthermore, scholars have speculated in the face of the findings that people of Color have elevated levels and rates of PTSD that are not explained by the exposure to the event or risk factors alone, that racism may play a role in the racial differences they

have found. The following brief review of research on traumatic stress and PTSD among diverse populations provides evidence, albeit indirect, of the emotional and psychological impact of racism.

RESEARCH ON TRAUMATIC STRESS AND PTSD

A selected group of studies on PTSD are reviewed in the section to follow. The literature reviewed here focuses on issues of life event stress and posttraumatic stress disorder. The goals of most researchers cited in this section were to determine what life events were associated with severe stress reactions, such as PTSD, and to gauge the prevalence of such life events during the past year as well as during the course of people's lives. As indicated, the research offers indirect evidence of the differential race-based experiences of people of Color. The research and scholarship that address the responses to potentially traumatic life event stress fall into two broad categories. The first category includes studies that investigated combat veterans' reactions to combat, and the second category involved studies of the general population in which respondents were interviewed and self-report instruments were used to assess their reactions to life events such as natural disasters, accidents, and sudden death.

Studies of veterans have found that 15% of the total group had PTSD symptoms and 31% had lifetime PTSD. The National Vietnam Veterans Readjustment Survey (NVVRS; Kulka et al., 1990) found racial differences in that 21% of Black, 28% of Hispanic, and 14% of White veterans suffered from PTSD according to the criteria of the *DSM* as well as other psychological symptoms (Frueh et al., 2002). Other studies of the lifetime rates of PTSD found that for American Indian veterans, the rates were 45%, with 57% for Northern Plains Indians and 38% for Native Hawaiians. Ruef, Litz, and Schlenger (2000) found that Hispanic veterans from Central America had a 52% rate of PTSD, and Mexican Americans were found to have a 25% rate of PTSD. Significantly, even when researchers (Frueh, Brady, & de Arellano, 1998) accounted for premilitary factors such as poverty, prior affective disorders, and substance abuse, they still found that prevalence rates for veterans of Color remained high. Some researchers suggested that race differences would be minimal when social class and other personality factors where considered. With the exception of one study (Loo et al., 2001), however, few explored the role of racism.

Loo et al. (2001) measured war zone race-related stress in Asian American veterans. They found that 37% of these veterans met the *DSM* criteria for PTSD and that the symptoms correlated with low rank and high levels of combat exposure. When race-related stress was added to the prediction of PTSD, it was found to be an even stronger predictor than exposure to combat

or rank. The studies of veterans of Color show that they experienced greater levels of PTSD not fully explained by personal history, combat exposure, or rank. Loo et al.'s study strongly suggests that racism was a significant factor for Asian Americans, and it seems that similar patterns are evident in studies of the general population.

In general, studies of disasters and other life events have found that lifetime rates of PTSD in the general population range between 5% and 39% (Breslau, 2001). However, although the range is wide for the development of PTSD, most researchers report that, on average, after exposure to a severe stress-producing event, about 5%-10% of people develop PTSD (Norris, Friedman, & Watson, 2002; Norris, Friedman, Watson, et al., 2002). Norris's (1992) study of 1,000 racially diverse adult civilians examined lifetime and past year incidence of perceived stress and PTSD (i.e., assault, car accidents). She found that Whites were more likely to be exposed to violent events, but the impact of stressful life events was strongest for Blacks who were more vulnerable to the stress of life events. Perceived stress was highest for Blacks—Black men in particular. Other studies (e.g., Gleser, Green, & Winget, 1981) have found Blacks to experience lower levels of exposure to and reactions to possible traumas. However, Norris argued that conflicting findings point to the need for specifying the cultural context in which trauma occurs. Norris's findings were supported by Breslau almost a decade later when she reported that Black men "appeared to be the most vulnerable to the effects of traumatic events" (p. 117).

Perilla, Norris, and Lavizzo (2002) studied a racially diverse sample of adults 6 months after Hurricane Andrew struck southern Florida in 1992. They found the prevalence of PTSD differed by racial groups. For example, whereas Whites had the lowest rate of PTSD at 15% after exposure to the storm, Latinos who spoke Spanish had the highest rate (38%), and Blacks had a rate of 23%. People of Color experienced more severe trauma, and the severity was related to the development of PTSD. Perilla et al. noted that differences because of race and culture accounted for the variations in PTSD symptom development. They stated, "Culture-specific responses to Hurricane Andrew suggest the need to view psychological symptoms in light of possible adaptive nature of the behaviors because of political, social, economic, and historical perspective" (p. 20).

Studies (e.g., Robin, Chester, Rasmussen, Jaranson, & Goldman, 1997) of the effects of life events in other groups of Color have found that for American Indians the prevalence of lifetime PTSD was 22%. These rates are higher than in the general population. Similar findings were reported by McNeil, Porter, Zvolensky, Chaney, and Marvin (2000) for adolescent Plains Indians. Piotrkowski and Brannen (2002) investigated whether indirect exposure to the 9/11 attacks was related to symptoms of PTSD in Black and

Hispanic adults. Investigators found that 15% of the sample met criteria for PTSD, still a bit higher than average rates.

In summary, the review of the empirical research on PTSD demonstrates that a small proportion of those who are exposed to potentially traumatic life events develop psychological symptoms. The rates in the general population for developing PTSD after exposure to a potentially stressful event are between 5% and 10%. People of Color experienced rates beyond the 5%-10% average rate typically reported for developing PTSD after exposure to stressful events. Veterans of Color had rates twice to three times the average (20%-60%) for Whites, which was not explained by exposure to combat. Studies of the general population showed similar patterns in that people of Color often had higher rates (20%-40%) of PTSD than the average individual.

In a recent review of research that involved some 60,000 disaster victims and more than 160 studies, Norris, Friedman, Watson, et al. (2002) noted, regarding studies that reported racial differences, that people of Color had an elevated risk for PTSD and that explanations offered by scholars were not complete. Regarding people of Color and their high rates of PTSD compared with Whites, Norris, Friedman, Watson, et al. stated the following: "Their historical marginalization may have affected their psychological functioning in ways that were not captured well by measures collected at the individual level" (p. 236).

Thus, scholars and researchers observed that important aspects of people of Color's experiences are not assessed in the majority of studies. They implicated racism as a possible and plausible factor in the higher rates of PTSD for people of Color in the general and veteran population studies.

Although there does appear to be evidence establishing a relation between stressful life events and psychological distress, critics have argued that stressful life events and PTSD research suffers from methodological flaws, which influence the validity of some of the findings. Criticism has included a concern for a lack of clear definitions of a stressful life event as well as lack of clarity regarding the impact of chronic versus singular stressful events. Critics identify the role of memory recall and the self-report nature of most of the life event inventories as particularly problematic areas of PTSD research (McLean & Link, 1994). The stated concerns notwithstanding, there is, however, indirect evidence that connects life events and trauma exposure to various forms of psychological distress for Whites and people of Color (Dohrenwend, 2000; Kessler, 1997; Perkins, 1982; Tennant, 2000). Although the use of strict PTSD criteria to recognize and assess race-based traumatic stress is not adequate, the studies do suggest that it is reasonable to argue that race-related experience(s) can and do contribute to the development of stress and traumatic stress reactions.

One area that has received increased attention in the psychological literature is the impact of discrimination and race-related stress on mental health.

An examination of the role of racial group membership as direct evidence of racism's mental health and health effects is warranted before a more complete understanding of the psychological impact of racism can be achieved.

DIRECT EVIDENCE—RACIAL DISCRIMINATION RESEARCH

The preceding section documented indirect evidence of PTSD and life event exposure and suggested that the high rates of PTSD for people of Color might be associated with racism and race-related experiences. But PTSD and life event researchers did not consider racism directly as a factor in traumatic reactions. Scholars and researchers have studied the health and mental health effects of discrimination and race-related stress on racial groups, and this body of research offers direct evidence of the effects of discrimination and racism (see Table 1). In many cases, this research suggests that the effects experienced by targets approach the symptoms described by traumatic stress researchers such as Carlson (1997).

Scholars have called for an examination of stress and its impacts on racial groups (Allison, 1998; Slavin et al., 1991) and have argued that being a member of certain oppressed and stigmatized groups could be a type of stress that has been ignored in social science theory and research (Clark et al., 1999; Harrell, 2000). Slavin et al. (1991) and Smith (1985) have observed that "racial and minority statuses are sources of stress" (p. 565). Clark et al. (1999) presented a psychophysiological model of racism as a stressor. They argued that environmental stimuli, rooted in either personal or structural aspects of racism, exert a deleterious effect on opportunities and access for Blacks or people of Color. These stimuli act as stressors, and any social barrier can produce reactions that create a physiological memory trace that could establish a recurring recall of race-related experiences. Moreover, these scholars (Clark et al., 1999; Slavin et al., 1991) argued that while the stress process associated with racism is influenced by contextual factors such as socioeconomic status and individual psychological makeup, it ultimately influences physical and mental health negatively.

Direct evidence of the health and mental health effects of racism and discrimination is available in the science and social science literature. Researchers have investigated the frequency of discrimination and have studied the psychological, physical, and emotional effects in experiments, naturalistic settings, and survey research. Various studies conducted with racially diverse samples have found that the incidence and frequency of racial discrimination tend to be high for people of Color and that exposure

(*text continues on p. 58*)

TABLE 1: Summary of Studies of Discrimination

Author	*Purpose*	*Participants*	*Method*	*Findings*
Bennett, Merritt, Edwards, & Sollers (2004)	Examined affective response to overtly racist content	74 Black males	Laboratory scenarios were used with a mood scale; and exposure to racism was measured by the Perceived Racism Scale.	Ambiguous compared with overt racist stimuli can be viewed as chronic stressors that may promote extended periods of cognitive processing and affective arousal.
Biasco, Goodwin, & Vitale (2001)	Attitudes toward racial discrimination	520 students	Attitudes of racial discrimination assessed by a 21-item instrument.	Blacks, Hispanics, and Asians perceive racial discrimination in higher percentages than do Whites.
Branscombe, Schmitt, & Harvey (1999)	Attributing outcomes in life to prejudice (negative and positive) effects to well-being	139 African Americans	Prejudice was measured by 10 items and, racial discrimination by 2 items.	Prejudice experiences have a direct negative effect on well-being, and minority group identification increases psychological well-being. Therefore, attributions to prejudice have both negative and positive outcomes.

Broman, Mavaddat, & Hsu (2000)	Explored the link between discrimination and personal outcomes	312 African American adults	Four variables assessed discrimination (e.g., getting a job, at work) and one dichotomous variable measured experienced discrimination (in any/all of the above scenarios).	60% were discriminated against in the past three years, most while shopping. Males 6 times more likely to perceive being discriminated against by the police. Those who perceived discrimination suffer for it and have lower levels of mastery and higher levels of psychological distress.
Brown (2001)	Comparison of alternative survey measures of discrimination	586 Blacks	Discrimination was measured by a single item: "Unfair treatment" was assessed by 6 items and what was attributed as the cause (e.g., gender, race). Lifetime depression was measured by an interview.	The framing of discrimination influenced its relation with mental health status. An unfair event attributed to race was predictive of depression but not with life satisfaction, stress, and psychological resources.
Carter, Forsyth, Mazzula, & Williams, (2005)	Critical incidents of racial discrimination and lasting effects	323 people of Color	Open-ended questions about racial discrimination and the lasting psychological	89% reported encounters with racism. And 74% had lasting psychological and emotional effects,

(continued)

TABLE 1: (continued)

Author	*Purpose*	*Participants*	*Method*	*Findings*
			effects. Ten categories for discrimination and 9 for emotional effects.	many of which reflected traumatic reactions.
Collins, David, Handler, Wall, & Andes (2004)	Examined effects of racial discrimination on pregnancy/birth outcomes	312 Black mothers	Administered questionnaire within 72 hours of an infant's admission. Racial discrimination exposure during their lifetime and pregnancy in five domains.	Black mothers who experienced racial discrimination during their lifetime delivered very low birth weight children.
Danoff-Burg, Prelow, & Swenson (2004)	Examined the effects of hope, life satisfaction, and race-related stress	104 Black students	Hope Scale (12 items), Satisfaction With Life Scale (5 items), and COPE Inventory.	Experiences with race-related stress make active coping useful for students with low hope. Low-hope students' use of seeking social support, emotional expression, and processing reflects belief in collective action in dealing with racism.

Deitch et al. (2003)	Study of everyday discrimination in the workplace	314 Black and White American workers, 5,483 U.S. Navy men and women, and 8,311 U.S. Army men and women	Mistreatment (10-item scale), everyday mistreatment (5-item scale), emotional well-being (5-item scale).	Blacks reported more mistreatment than did Whites. Blacks' job stress impaired their well-being. Blacks are experiencing everyday racism in the form of minor pervasive mistreatments and unfairness.
Din-Dzietham, Nembhard, Collins, & Davis (2004)	Investigated connection between blood pressure and stressful racism	356 Black adults	General stress and racial discrimination were measured using a scale that was adapted for the study. Racism was assessed using two questions	There was an increase in hypertension with increased levels of perceived racism at work, primarily with non-African Americans. Greater increase in blood pressure when there was racial discrimination.
Dohrenwend (2000)	Examined the relations between the perceptions of racism physical and mental health	623 Black respondents	Racism was measured with two questions, and subjective well-being was measured by two items. Physical health was the total number of doctor-reported conditions	Perceived racism and reports of maltreatment affect mental and physical health.

(continued)

TABLE 1: (continued)

Author	*Purpose*	*Participants*	*Method*	*Findings*
Fisher, Wallace, & Fenton (2000)	Examined the impact of discrimination on youths	177 Black, Hispanic, Asian, and White adolescents	The 15-item Adolescent Discrimination Distress Index.	Racial discrimination is a pervasive stressor in the daily lives of adolescent minorities. Negative racial stereotypes dramatically depress academic performance.
Forman (2003)	Examined workplace racial segmentation and psychological well-being	1,199 Blacks Americans from the National Survey of Black Americans and 347 Detroit Area Study	Two questions were used to measure perceived racial segmentation. In the Detroit Area Study, one question assessed racial segmentation.	A negative relation between perceived racial segmentation and psychological well-being. A link was found between perceived discrimination and psychological well-being.
Gary (1995)	Investigated if demographic factors, stressors, and sociocultural patterns predicted racial discrimination	537 African American men	The short form of the Bem Sex Role Inventory was used; racial consciousness and racial discrimination were assessed by responses to 22 vignettes; and the Social Readjustment Scale and the Daily Hassles Scale were used.	Young men were found to perceive racial discrimination more often than older men.

Goto, Gee, & Takeuchi (2002)	Investigated perceptions of discrimination	1,503 Chinese Americans	Discrimination was measured by 2 items; and level of acculturation was measured by years living in the United States and language fluency.	21% of participants reported being unfairly treated in their lifetime because of race, ethnicity, language, or accent. 43% reported an incident within the past year. Higher social status and acculturation were related to more racial discrimination.
Guthrie, Young, Williams, Boyd, & Kintner (2002)	Examined smoking habits and racial discrimination	105 African American adolescent females	Discrimination was assessed using the 9-item Everyday Discrimination Scale; cigarette use was measured using two questions; and daily hassles were measured by a 26-item Daily Hassles for Adolescents Inventory.	52% of the current sample reported having experiences of racial discrimination. Perceptions of racial discrimination were related to smoking habits. Discrimination and smoking were explained by the daily hassles.
Guyll, Matthews, & Bromberger (2001)	Examined cardiovascular reactivity to both mistreatment and discrimination	363 women (101 Blacks, 262 Whites)	Mistreatment was measured by 10 items, and cause of discrimination was assessed by 1 item.	Racial discrimination is a chronic stressor that negatively impacted the cardiovascular health of Black women. The

(continued)

TABLE 1: (continued)

Author	*Purpose*	*Participants*	*Method*	*Findings*
			Cardiovascular reactivity was measured as blood pressure and heart rate.	findings showed a positive relation between subtle mistreatment and cardiovascular reactivity.
Harrell, Hall, and Taliaferro (2003)	A review of studies on racism and physiological activity	16 studies were reviewed	Event perceived as racist and physiological arousal or negative health sequels were mental health measures.	Certain forms of racism increase arousal states such as anxiety and hypervigilance. External stressors permanently alter physiological functioning. Racism increases stress and may contribute directly to the physiological arousal that is a marker for stress-related diseases.
Hite (2004)	Explored views of female managers regarding career opportunities	276 Black and White female managers	Discrimination was measured with survey items that assessed the availability of workplace opportunities.	White participants viewed women of Color as having equal access to career opportunities, whereas the Black women did not.

Kessler, Mickelson, & Williams (1999)	Assessed whether discrimination affects mental health	3,032 participants	For perceived discrimination, a series of 11 yes-no questions and 9 questions for chronic daily encounters were used. Mental health was nonspecific psychological distress the month before and emotional disorders the year before.	34% reported exposure to major lifetime discrimination, and 61% reported exposure to daily discrimination.
Klonoff & Landrine (2000)	Tested how skin color is related to discrimination	300 Blacks	Racist events and stress appraisals were measured by the 18-item Schedule of Racist Events. Self-Reported Skin Color Scale (5-point scale) was used.	Cluster groups revealed that 67% who experienced frequent discrimination were dark skinned, and 9% were light skinned.
Klonoff, Landrine, & Ullman (1999)	Examined racial discrimination and psychiatric symptoms	520 Blacks	The Schedule of Racist Events, the Psychiatric Interview Life Events Scale, and the Symptom Checklist were used.	Racial discrimination was predictive of anxiety, somatization, interpersonal sensitivity, and obsessive-compulsive symptoms.
Loo et al. (2001)	Race-related stressors with veterans	300 Asian veterans	The Race-Related Experiences Questionnaire, the	Race-related stress was a strong predictor, over and above war zone

(continued)

TABLE 1: (continued)

Author	*Purpose*	*Participants*	*Method*	*Findings*
			Mississippi Scale, and the Brief Symptom Inventory were used.	exposure and rank, for the development of PTSD and general psychiatric symptoms.
Martin, Tuch, & Roman (2003)	Explored how discrimination might be related to drinking	2,638 African Americans from National Survey of Black Americans	Problematic drinking was measured using the 4-item CAGE alcoholism screening. Current and lifetime discrimination was assessed with 11 items.	71% reported personal experiences with discrimination. 75% perceived prejudice against Blacks to be widespread. Perceptions of prejudice were not significantly related to problematic or escapist drinking.
Mossakowski (2003)	Examined ethnic identity depressive symptoms and discrimination	2,109 Filipino Americans from the Filipino American Community Epidemiological Study	Symptom Checklist-Revised; Ethnic Identity Scale; perceived lifetime racial/ethnic discrimination was measured by 1 item. Everyday discrimination was measured by 8 items.	Racial-ethnic discrimination over the life span and everyday discrimination in the past month were associated with increased symptoms of depression. Ethnic identity buffered the stress of discrimination and had a strong

				association with fewer depressive symptoms.
Murry, Brown, Brody, Cutrona, & Simons (2001)	Focused on social contexts and normative family patterns	383 African American families with 10- or 11-year-old children	Used the 13-item Experiences of Discrimination Scale, which was developed for the study; and psychological functioning was assessed using two subscales, depression and anxiety, from the Mini-Mood and Anxiety Symptom Questionnaire. Relationship quality was assessed by stability and satisfaction.	High levels of distress were related to dissatisfaction and instability in their relationships with partners and children. When racial discrimination is greater, families had more stressful life events and psychological distress. Intimate relationship quality and caregiver relationships were greatly diminished for those exposed to racial discrimination.
Mustillo et al. (2004)	Examined effects on preterm and low birth weight deliveries	352 births among Black and White women	Experiences of racial discrimination were assessed by 7 items; unfair treatment was assessed by 1 item; depression was measured by the Center for Epidemiological	Racial discrimination was associated with preterm and low birth weight deliveries. Such experiences may contribute to Black-White disparities in prenatal outcomes.

(continued)

TABLE 1: (continued)

Author	*Purpose*	*Participants*	*Method*	*Findings*
			Studies Depression Scale; and participants self-reported data on birth of their infants.	
Noh & Kaspar (2003)	Examined how racial discrimination is related to depression	180 Korean immigrants	Definitions of discrimination were given before, and participants were then asked about seven accounts of racial discrimination (e.g., insulted or called names), acculturation, and social support; and the Korean version of the Center for Epidemiologic Studies Depression Scale was used.	For Korean adults, 83% reported some type of encounter with discrimination. A positive association was found between discrimination and depression. Problem-focused coping had stress-moderating effects, whereas the uses of emotion-based coping were associated with higher levels of depression.
Pak, Dion, & Dion (1991)	Explored the correlates of discrimination	90 Chinese students	Self-esteem and sense of control were measured from the Internal-External Control Scale; 6 items from the Social Readjustment Rating Scale were used; and	Discrimination was related to heightened stress and more positive attitudes toward own group. Self-esteem was a function of both gender and experience with

			discrimination was assessed with 6 items.	discrimination (e.g., women had lowered self-esteem from discrimination).
Plummer & Slane (1996)	Examined coping patterns during racially stressful situations	376 White and 156 Black adults	A directed version of The Ways of Coping Questionnaire, a 66-item instrument, was used.	Blacks engaged in more problem-focused coping and emotional-focused coping compared with Whites. Overall, both Black and Whites tended to use more confrontive coping for racially stressful situations, but less problem-focused and emotion-focused coping.
Romero & Roberts (2003)	Examined Latino adolescents and depressive symptoms	994 rural sixth and eighth graders	Language preference was assessed; the Rosenberg Self-Esteem Scale, and depressive symptoms with the 31 items from the Diagnostic Interview for Children were used.	The perception of stressors was associated with depressive symptoms beyond demographic variables and self-esteem. Derogatory ethnic jokes were found in the type of stressors that youths reported.

(continued)

TABLE 1: (continued)

Author	*Purpose*	*Participants*	*Method*	*Findings*
Rosenbloom & Way (2004)	Described how minority students experienced discrimination	20 Asian, 20 Latino, and 20 African American ninth-grade high school students	Semistructured and in-depth interviews assessed subjective experiences of discrimination by peers, discrimination by adults, and within-group discrimination.	Variations in experiences differed depending on race. Peer discrimination may have serious effects on peer relations and on psychological adjustment.
Ruggiero & Taylor (1997)	Examined self-esteem and perceived control and discrimination	50 Asians and 50 Black females undergraduates	Participants were given measures that assessed attributions for negative feedback. They had to rate the extent to which the quality of their answers and discrimination affected their grades.	Blacks and Asians tended to minimize discrimination in achievement-oriented situations, instead they attributed blame to themselves for failing. But, females with high self esteem blamed discrimination.
Sanders-Thompson (1996)	Perceived racism and symptoms of distress	200 African Americans	Racism questionnaire asked whether participants had experienced racism. If they had experienced racism within the past 6 months, participants were asked to describe	33% of participants reported experiences with racism within 6 months. Intrusive scores increased as the severity of the racial incident reported increased. Avoidance symptoms

			it. Raters coded racism as minor, moderate, or major. Intrusive and avoidance symptoms were assessed.	did not differ based on severity.
Sanders-Thompson (2002)	Explored whether racism was a unique source of stress	156 adults: 70 Black, 58 White, 18 Asian, and 6 Hispanic Americans	General stress was measured by the Daily Stress Inventory; and discrimination was assessed using the Experience of Discrimination Questionnaire.	Blacks, compared with other racial groups, reported greater impacts from discrimination.
Schneider, Hitlan, & Radhakrishnan (2000)	Examined the nature and correlates of ethnic harassment	462 Hispanic and White students, 200 Black and 110 Hispanic and White employees	Ethnic harassment was measured using the 7-item Ethnic Harassment Experiences Scale; mental health was measured using anxiety and depression from the Mental Health Index, and affective disposition was measured using a version of the Neutral Object Scale.	Ethnic harassment was experienced by 40%-67% of the participants. Harassment experiences were negatively related to well-being.

(continued)

TABLE 1: (continued)

Author	*Purpose*	*Participants*	*Method*	*Findings*
Taylor & Turner (2002)	The association between racial discrimination and depression	434 African American and 463 White public school students	Discrimination was measured by 8 items; the Epidemiology Depression Scale was used; general stress was determined with several scales; and 41 items measured lifetime exposure to major traumatic events.	Discrimination was related to depression for Blacks compared with Whites. It was found that 45% of Blacks were exposed to discrimination compared with 29% of Whites. Blacks had greater exposure to general stress.
Troxel, Matthews, Bromberger, & Sutton-Tyrrell (2003)	Investigated chronic stress	109 African American and 225 White adult women	A composite score was developed that had four indicators of stress, and a scanner was used to assess carotid measurements.	African Americans reported more chronic stress and had higher carotid intima media thickness (IMT) than Whites. In addition, among the African American participants, Composite Stress Index scores and unfair treatment were linked to higher IMT.
Utsey, Payne, Jackson, & Jones (2002)	Examined race-related stress, quality of life, and life satisfaction	113 older African Americans	The Index of Race-Related Stress, the 5-item Satisfaction With Life	Older African American men had higher levels of race-related stress than

			Scale, and the short form of the National Health Survey were used.	women in regard to institutional and collective racism. Institutional racism-related stress was a significant but negative predictor of psychological health. Those with poorer mental health functioning experienced more stress related to institutional racism.
Utsey, Ponterotto, Reynolds, & Cancelli (2000)	Assessed the coping strategies and effects of racism	213 African American college students	Coping was assessed by using the Coping Strategy Indicator. The 46-item Index of Race-Related Stress, the 5-item Satisfaction With Life Scale, and the 10-item Rosenberg Self-Esteem Scale were used.	Overall, women preferred avoidance coping. The best predictors of racism-related stress were seeking social support coping and cultural racism. Avoidance coping was found to be a significant predictor of self-esteem and life satisfaction.

to such incidents of racism is associated with lower levels of physical health and psychological well-being (Klonoff & Landrine, 1999; Landrine & Klonoff, 1996; Pak, Dion, & Dion, 1991; Sanders-Thompson, 1996; Schneider, Hitlan, & Radhakrishnan, 2000; Utsey, Chae, Brown, & Kelly, 2002). These studies have indicated that lower levels of physical health can be a contributing factor in psychological distress and stress reactions.

Physiological and Health Effects of Racism

Racial stressors have been found, in a variety of studies, to produce physical outcomes such as high blood pressure, risk for heart disease, and increased vulnerability to a variety of negative health outcomes that can contribute to greater psychological and emotional distress (e.g., Bennett, Merritt, Edwards, & Sollers, 2004; Brondolo, Rieppi, Kelly, & Gerin, 2003; Clark et al., 1999; Collins, David, Handler, Wall, & Andes, 2004; Din-Dzietham, Nembhard, Collins, & Davis, 2004; Guthrie, Young, Williams, Boyd, & Kintner, 2002; Guyll, Matthews, & Bromberger, 2001; Harrell, Hall, & Taliaferro, 2003; Klonoff & Landrine, 2000; J. K. Martin, Tuch, & Roman, 2003; Mustillo et al., 2004; Troxel, Matthews, Bromberger, & Sutton-Tyrrell, 2003; Williams et al., 2003; Utsey, 1997). With regards to physiological reactions to racism, a review of the experimental literature revealed "that direct encounters with discriminatory events contribute to negative health outcomes" (Harrell et al., 2003, p. 243). Harrell et al. found that external stressors associated with individual acts of racism change physiological functioning. Moreover, physiological investigators have found that anxiety and worry are often immediate reactions to racism that prompt people to rehearse defensive and aggressive responses as ways to cope and adapt (Harrell et al., 2003).

An example of the type of alteration to biological and physiological mechanisms was explored by Collins et al. (2004) and Mustillo et al. (2004). These researchers examined whether racial discrimination affected women who delivered preterm or low birth weight (LBW) infants. They found "women reporting higher levels of racial discrimination were almost five times more likely than women reporting no racial discrimination to deliver low birth weight (LBW) infants" (Mustillo et al., 2004, p. 2128) and that Black women exposed to discrimination were more likely to deliver very LBW infants when compared with White and Black women who did not deliver LBW children. Collins et al. (2004) concluded that "lifetime exposure to interpersonal discrimination is explicitly included as a chronic stressor" (p. 2136).

Another outcome of biology, physical appearance, and skin color, or one's phenotype, is that it also serves as a marker for racial group membership. People who are darker in skin color are seen as members of denigrated

racial groups and as such may be exposed to greater levels of racism than people who may have White or light skin. Klonoff and Landrine (2000) found that 67% of dark-skinned Black adults were more likely to experience racial discrimination than light-skinned Blacks, 8% of whom reported a high frequency of racial encounters. Thus, one's biological makeup does seem to function as a marker for negative race-related treatment and experiences. The study highlighted important within-group variation as a result of individual characteristics and historical aspects of oppression as well as within-group conflict (Bulhan, 1985; Carter, 1995; Freire, 1993).

Brondolo et al. (2003) reviewed studies of heart disease risk, hypertension, and racism. With regards to heart disease risk, they noted that "these studies suggest that acute exposure to racism is associated with increases in cardiovascular activation (CVR). In addition, past exposure to racism may influence current CVR to race-related and other stressors" (p. 61). For instance, Guyll et al. (2001) found that for Black women "the experience of subtle mistreatment [discrimination] was positively related to cardiovascular reactivity, but the experience of blatant mistreatment was not" (p. 322). Bennett et al. (2004) found, in a somewhat different study, a similar result with Black men. Their findings demonstrated that for some Black people, there are stronger effects that come from subtle or ambiguous racial encounters, a result that is consistent with the general stress research and the finding that ambiguous events can increase the stress response.

Brondolo et al. (2003) found mixed and inconsistent results in their review of the literature on hypertension. But Din-Dzietham et al. (2004) found a relation between racial discrimination and hypertension. Participants in their study who experienced racism at work from non–African Americans had significantly higher levels of hypertension. However, the increase in hypertension was greater when the person responsible for the discrimination was another African American. This is an important finding because few researchers consider the effects of within-group encounters with racism. Thus, their study documents a historic reality and another element of the within-group dynamics discussed and described by scholars that focus on oppression, suggesting that people from the same racial group can be perpetrators of oppression and racism (e.g., Akbar, 1984).

Some researchers have investigated the incidence and role of discrimination and stress in the development of maladaptive or coping behaviors such as drinking and smoking. J. K. Martin et al. (2003) reported data from 2,638 respondents to the National Survey of Black Adults. Drinking and reasons for consuming alcohol were assessed along with lifetime and current discrimination in nine areas of life (work, school, housing, etc.). They found that 71% were discriminated against in one or more domains or areas of life, with an average of two incidents during one's lifetime. The most frequent

encounters with discrimination were in school and work (hiring, promotion). They found no support for the notion that general perceptions of prejudice or discrimination affected participants' reasons for drinking or their consumption patterns. However, Guthrie et al. (2002), in a study of adolescents, found that everyday discrimination seemed to be strongly associated with smoking. Thus, some studies suggest a connection between racism and physical health that appears to continue throughout a person's life span. In addition, these studies elucidate a range of possible effects, which can result from the stress of racism and in turn compromise mental health.

Discrimination Effects on Families and Adolescences

Studies of racial discrimination have also focused on its effects on families (e.g., Murry, Brown, Brody, Cutrona, & Simons, 2001) and adolescent development (e.g., Caldwell, Kohn-Wood, Schmeelk-Cone, Chavous, & Zimmerman, 2004; Fisher, Wallace, & Fenton, 2000; Prelow & Guarnaccia, 1997; Romero & Roberts, 2003; Rosenbloom & Way, 2004; Taylor & Turner, 2002). For instance, Murry et al. (2001) explored how chronic stress and racism influenced relationship quality in hundreds of African American families. They found that mothers who were subjected to high levels of discrimination and general life stress had more symptoms of depression and anxiety, which was related to conflicted and less effective parental relationships. Murry et al. noted that "chronic racial discrimination amplifies the effects of other ongoing stressors in African American families" (p. 923). Racism and experiences with discrimination also affect adolescents' academic performance, interpersonal interactions, and their daily lives.

Fisher et al. (2000) investigated whether racism affected self-esteem in a racially diverse sample of youths. African American and Hispanic youths reported higher incidents of institutional (in and out of school) racism in comparison to Asians and Whites. Asian students reported higher levels of peer discrimination. It was found that 50% of students of Color were distressed by race-based hassles in school. Also, Black and Hispanic youths thought racial bias was behind perceptions of them as less intelligent and as dangerous. An important finding of the Fisher et al. study was that adolescents of Color's experiences of discrimination in school affected their self-esteem and that Black and Hispanic youths reported that their race was responsible for them being discouraged from taking advanced courses, being wrongfully disciplined, and receiving lower grades.

Regarding peer relationships, Asian and White youths felt excluded from activities in their schools and verbally assaulted because of their race, a notion found in related studies. For instance, Rosenbloom and Way (2004) found that when racial discrimination among Black, Latino, and Asian

youths were compared, intergroup tension seemed to be related to teacher bias in favor of Asians. Latinos and African Americans harassed Asians as a result of teacher preference. Yet teachers were unaware of their behavior and the intergroup tensions that it created. These findings may reveal how structural and institutional racism operates and how it may be reflected in interracial group tension. The Rosenblom and Way study suggested that the stress associated with discrimination can lead to acts of aggression and violence perhaps between and within racial groups. This finding is supported by research conducted by Caldwell et al. (2004), who found that racial discrimination was a strong predictor of aggressive behavior in young Black adults. Thus, stress from discrimination may be coped with in ways that bring social sanctions from mainstream authorities, as noted by Slavin et al. (1991), or may be expressed in ways that are accepted by members of the racial group in question. For young Black and Hispanic men, aggression is more accepted and expected than other forms of coping with their feelings of frustration and anger.

Taylor and Turner (2002) explored the relations between discrimination, social stressors, and depression among White and Black youths and found that discrimination was related to depression more in African Americans than in Whites. Romero and Roberts (2003) found discrimination to be related to distress and depression among Mexican youths as well. Thus, adolescents' family relationships, school performance, interactions, and psychological well-being seem to be adversely impacted by their experiences with racism. Do the patterns continue through the college years?

Discrimination and College Students

Researchers (e.g., Biasco, Goodwin, & Vitale, 2001; Contrada et al., 2001; Landrine & Klonoff, 1996; Pak et al., 1991; Schneider et al., 2000; Sellers & Shelton, 2003) have investigated the frequency of the relations between racial discrimination and psychological symptoms for college students.

Biasco et al. (2001) sampled participants from a southeast university, 80% of whom were White and 20% of whom were Black, Hispanic, and Asian. Participants were asked if students encountered discrimination in their lives, and 53% thought they did not whereas 44% thought they did sometimes. For most students (the White majority), discrimination in society was infrequent. When asked about campus encounters with racism, 33% said it never happens and 36% said encounters might happen weekly or daily. Participants were asked if minority students experienced discrimination: 41% of the White students and 66% of the students of Color from each group said yes. Participants were asked if they thought racial hostility existed between racial groups, and 75% of the students thought that racial

hostility was present, just not expressed openly. This is evidence that even while denying the experiences of racism, both White and students of Color acknowledge the subtle and hidden forms of racism. Blacks were thought to be the most frequent target of racial hostility. This study highlighted the differences in both the experience of racial discrimination and the variation of perceptions between Whites and non-White racial groups. It also showed that considerable hostility exists between racial groups, with Blacks taking the brunt of the hostility that is often frequent and subtle or hidden. It could be that the hostility is expressed in the form of microaggressions or other unstated and indirect actions designed to demean and denigrate while maintaining the appearance of being nondiscriminatory.

In their study, Landrine and Klonoff (1996) used a mixed sample of Black students, faculty, and staff and a race-related events and stress measure along with the Hopkins Symptoms Checklist. Ninety-eight percent of the participants in their study experienced racial discrimination that was stressful in many places (work, schools, public) during the past year. Sellers and Shelton's (2003) study of African Americans found that more than 50% of their college sample reported more than a dozen (13) daily racial hassles with strangers. Schneider et al. (2000) investigated racial discrimination in a sample of students and adult employees who were mostly Hispanic. In general, they found that about 67% of the students and 40% of the employees experienced one racially harassing event that was associated with lower levels of psychological well-being.

Pak et al. (1991) found that Chinese college students who experienced discrimination felt stressed by the experience. Contrada et al. (2001) studied Asian, Latino, African American, and White college students' experiences of perceived racial discrimination, negative mood, and satisfaction with life. They reported that Whites had the lowest level of perceived discrimination and Blacks the highest and that perceived discrimination was related to symptoms of depression. However, Liang, Li, and Kim (2004) did not find a relation between psychological distress and racism-related stress for Asian American students.

Like Schneider and colleagues, Landrine and Klonoff (1996) also reported positive relations between racist events and low self-esteem as well as a variety of stress-related and somatic symptoms. Thus, studies of racial discrimination during the college years have shown a range of frequency rates from 40% to 98%, depending on the investigation. The studies have also shown that discrimination is associated with high levels of stress, depression, less life satisfaction, and negative moods. Yet it is also the case that the researchers often used different methods in these studies and assessed discrimination across the life span and over the course of a year, typically treating the cumulative events as the primary measure of discrimination. The

stressfulness reported by participants of the events was often retrospective and subject to bias in recall. Nevertheless, there does seem to be some direct evidence that discrimination is stressful and is associated with anxiety, depression, and other emotional as well as psychological reactions and symptom clusters.

Discrimination in the Community

Investigators (e.g., Broman, Mavaddat, & Hsu, 2000; Carter, 2004; Carter, Forsyth, Mazzula, et al., 2005; Carter, Forsyth, Williams, & Mazzula, 2005; Cohen & Williamson, 1988; Deitch et al., 2003; Essed, 1991; Forman, 2003; Gary, 1995; Goto, Gee, & Takeuchi, 2002; Jackson et al., 1996; Klonoff & Landrine, 1999; Klonoff, Landrine, & Ullman, 1999; Sanders-Thompson, 1996, 2002; Ulbrich, Warheit, & Zimmerman, 1989; Utsey & Payne, 2000; Utsey, Payne, Jackson, & Jones, 2002) have also studied nonstudent, community-based samples' prevalence and frequency of racism and its mental health impact.

Gary's (1995) and Sanders-Thompson's (1996) investigations of African Americans' perceptions of discrimination found that, in both samples, about 40% of respondents reported at least one experience of discrimination over the previous year or 6 months and that men who had a college education and who were employed, younger, and unmarried were more likely to perceive racial discrimination. Klonoff and Landrine's (1999) examined experiences with racist events for Blacks and the level of stress associated with the experiences. They found that 96% of the participants reported an experience of racial discrimination in the past year that left them feeling stressed. Broman et al. (2000) found that 60% of their Black participants had been discriminated against in the past 3 years, but that the incidence of discriminatory experiences varied by age. Older people reported fewer incidents, but men were six times more likely to be hassled by the police than were women.

Goto et al. (2002) investigated Chinese Americans' encounters with racism and found that 21% reported experiencing racial discrimination in their lifetime and 43% had racial encounters in the past year. The incidents of discrimination increased outside of their communities. Furthermore, acculturation was associated with increased occurrences of discrimination, a finding that suggests that the more Americanized the Asian person was, the greater the frequency of encounters with racism. Perhaps this finding can be explained by the fact that these Asians were more aware of racism in American society.

Carter, Forsyth, Mazzula, & Williams (2005) and Carter, Forsyth, Williams, & Mazzula (2005) investigated people of Color's experiences with racism by using a Web-based method of data collection. In the studies,

89% reported critical incidents of racism. The most frequent occurrences were as follows: multiple experiences (18%), hostile work environment (17%), verbal assaults (14%), denied access or service (12%), and racially profiled (12%). These incidents were followed by the following: treated on the basis of a stereotype (9%), violated racial rules (8%), other events (4%), physical assaults (2%), and own group discrimination (1%). In another analysis of the web study, Carter, Forsyth, Williams, et al. used statistical analyses to compare racial discrimination (avoidance) and harassment (hostile). Their findings revealed that racial harassment occurred significantly more frequently than did racial discrimination.

Deitch et al. (2003) explored work-related experiences with discrimination as acts of mistreatment and compared Whites and Blacks in several types of organizations (i.e., corporation, federal, military). The researchers found that Black employees (20% of the sample), in comparison to Whites, reported higher levels of mistreatment and lower job satisfaction. Overall, the studies of the frequency of racial discrimination showed that it occurs in community settings and at work with frequencies ranging from 40% to 96% and that many of the participants felt stressed as a result of these encounters. But there is within-group variation that might account for the wide differences in reporting encounters or in the perception of racism. What about the mental health effects of encounters with racism?

Ulbrich et al.'s (1989) study of adults focused on psychophysiological distress, stressful life experiences, and socioeconomic status. They found that race alone did not predict psychological distress and that lower class Blacks reported more life stress than lower class Whites. Gary's (1995) and Sanders-Thompson's (1996) investigations of African Americans' perceptions of discrimination and psychological symptoms found that, in both samples, the participants experienced subjective distress. These studies indicate that social factors (marriage, employment, etc.) might interact with the experience of racism as a perceived stressor.

In another community study, Jackson et al. (1996) found a weak or inverse relation between racism and mental health. Respondents who reported a perception of racism had higher scores for physical health, and there was no relation to psychological distress. Sanders-Thompson (2002) examined whether perceptions of racism were stressful for African, White, Asian, and Hispanic Americans. Her results indicated that race accounted for varying levels of daily life stress, with Asian Americans reporting the highest amount of daily life stress and African Americans reporting the highest rate of experiences of discrimination.

Utsey and Payne (2000) explored the relation between race-related stress, anxiety, and depression in Black men. They found that race-related stress predicted anxiety and depression scores. Klonoff et al. (1999) used

a race-related stress measure to predict psychological symptoms with a sample of Black adults. They found that racist events were predictive of three symptom scores: total symptoms, somatization, and anxiety. Klonoff et al. tested whether racial discrimination added to general life stress and contributed to psychological symptoms. They also investigated whether race-based stress contributed to all psychological symptoms above and beyond social class and general life stressors. In a study of various types of race-related stress (individual, institutional, and cultural), Utsey et al. (2002) found that for people of Color, cultural racism was related to lower levels of quality of life. They also found that Blacks indicated more experiences of individual and cultural race-related stress and were equal to Asians in reporting institutional race-related stress.

Broman et al. (2000) found that, of the adults studied, targets of discrimination exhibited lower levels of mastery (control and problem solving) and higher levels of psychological distress (feeling depressed, restless, etc). In a study examining the relation between experiences with racism-related stress, quality of life, and satisfaction with life among older African Americans, Utsey et al. (2002) found gender differences. Men reported higher levels of institutional and cultural racism-related stress than women. They also assessed physical and psychological health status, and found that institutional racism was the lone predictor of overall health status.

The studies by Carter, Forsyth, Mazzula, et al. (2005) and Carter, Forsyth, Williams, et al. (2005) found that 74% (173) of the respondents who had encounters with racial discrimination reported lasting psychological effects. The researchers examined the frequencies for psychological and emotional effects. For all racial groups, extreme emotional distress (36%) was the most frequently reported emotional effect, followed by mild emotional distress (16%) and hypervigilance or arousal (15%). Lower self-worth, avoidance, and distrust were reported with almost equal frequency at 9%, 8%, and 8%, respectively. Positive outcome (3%), intrusion (2%), and other (3%) were reported much less often.

They examined the frequencies for psychological and emotional effects by racial group. Blacks and Latinos tended to report similar types of effects, whereas biracial people and Asians were more similar to one another. Blacks and Latinos reported extreme emotional distress, followed by hypervigilance. Blacks and Latinos differed in their third most frequently reported effects, with Blacks reporting moderate emotional distress, and Latinos reporting lower self-worth. Among Asians, moderate emotional distress was the second most commonly reported emotional effect. Biracial people reported moderate emotional distress at the same rate that they reported extreme emotional distress.

In a follow-up investigation, Carter, Forsyth, Williams, et al. (2005) sought to determine whether individuals who experienced racial harassment

were more likely than individuals who encountered discrimination to experience psychological injury. The emotional effects categories were labeled as either *psychological injury* or *no injury*. The results indicated that the participants who experienced racial harassment were significantly more likely to report injurious, lasting mental health effects.

It is important to note that Carter (2004) also found, in a smaller sample of participants, statistically significant differences between the categories of harassment and discrimination. Moreover, he found that those who had experienced a combination of harassment and discrimination (discriminatory harassment) were more likely to experience injurious psychological effects than participants who had encountered harassment or discrimination separately.

Another important area of inquiry has been the role of discrimination in the workplace. One study by Deitch et al. (2003) found that Black employees, in comparison to Whites, reported higher levels of mistreatment and lower job satisfaction. They also found that the everyday and subtle mistreatment adversely affected indicators of well-being. These researchers pointed out that irrespective of race, mistreatment affects one's well-being:

> We found compelling evidence in the different samples, that everyday discrimination against Blacks is occurring on the job, with negative outcomes for its targets. Furthermore, by using subtle measures that assess more general mistreatment, we were able to assess the existence of everyday discrimination apart from the respondents' propensity to make attributions to discrimination. (p. 1316)

In a study of racial segmentation and institutional racism, Forman (2003) found that perceived racial segmentation was negatively associated with well-being and that the effect was stronger for Blacks of higher status. Thus, these findings indicate that the psychological costs of structural racism and related social factors affect people's encounters with racism. But the findings are not conclusive, and they are varied.

It is important to note that in the various studies reviewed, discrimination was measured differently, with most studies relying on participant self-report. In addition, the indicators of emotional effects were often not directly related to a particular event. In most cases, the number of encounters across the lifetime or the number of encounters in various areas of life was counted, and that total was related to the measured stress or psychological effect. Even in the face of these limitations, across the studies cited there does seem to be a strong trend and pattern that when people of Color experience various types of racism over the course of their lives, they find these events to be sources of stress and psychological distress. Furthermore, although it would be difficult to determine whether the events reported in the various studies would

qualify as traumatic stressors using Carlson's (1997) conceptualization, there seems to be quite a bit of evidence that many of the reactions experienced by people of Color are similar to either the core symptom clusters or the secondary symptoms she identified as associated with traumatic stress reactions.

Another clear pattern in the studies was the within-group variation in that a number of factors seem to be related to people's experience of racism. Age, gender, marital status, social class, physical health, coping style, acculturation, and perhaps racial identity ego status seemed to be associated with how an individual from various racial groups experienced racism. As Slavin et al. (1991) noted, aspects of within-group variation could reflect racial–cultural aspects of the stress process, thus noting that researchers have tended to use sociodemographic group markers for race and have not fully considered the racial characteristics of people's experiences (Helms, Jernigan, & Mascher, 2005).

Essed (1991) argued that certain cognitive processes were necessary to recognize everyday racism. According to Essed, general knowledge of racism involves some of the following components:

> the ability to explain individual experiences in terms of group experience, acknowledgement of the historical experiences of the group, explanation of the group experiences in terms of race domination, acknowledgement of the relation between the personal . . . and the groups experiences. (p. 76)

Knowledge about racism is processed in ways that are consistent with Slavin et al.'s (1991) stress process and is acquired in several ways that also might account for within-group variation. One learns about racism through the process of racial socialization that takes place in the family and community, as well as through political exposure during the life span (beginning with childhood) and by education in schools or on one's own. One also learns through social movements and learning about such movements. In addition, there is personal and practical experience with racism, the experiences that others convey, and the process involved in struggling against cultural oppression or the denial of one's groups value and culture. Essed (1991) general knowledge that describes processing racial information is similar to the models of racial identity statuses (e.g., Carter, 2005; Helms, 2001). In their study of middle-class Blacks, Feagin and Sikes (1994) described several coping strategies that people used in their effort to live with racism. In general, these strategies were avoidance and denial that the action was based on race, and were used to avoid the conflict. In other words, "If one can name racial discrimination something else, it may not hurt so much" (Feagin & Sikes, 1994, p. 277). Considerable assessment is involved in determining that the event was because of race. Both Essed (1991) and Feagin and Sikes stressed these

processes of evaluation and assessment. Another strategy was resigned acceptance as a way to handle frustration, which might come at a psychological cost. Then there was confronting racism. As Slavin et al. noted, this can also come with a cost, "By regularly confronting whites . . . [B]lack Americans run the risk of being ostracized or labeled" (Feagin & Sikes, 1994, p. 282). Some individuals use formal communications and lawsuits to address their experiences. Other defenses and strategies that people use will be discussed in more detail in another section. The research that reflects some of these varying ways for understanding racism will be briefly discussed. Space limitation prohibits a fuller review of all aspects of within-group variation. Therefore, coping and racial identity research will be presented as a way to capture within-group variation.

Within-Group Variation

It is important not to treat members of racial groups as monolithic or psychologically similar in regards to their experiences and understanding of racism (Carter & Gesmer, 1997; Helms et al., 2005; Thompson & Carter, 1997). Researchers and scholars who use sociodemographic racial categories infer social and psychological attributes from racial categories. In so doing, they make the false assumption that people who are presumed to be part of a particular racial group are also psychologically invested in that groups' culture; in essence, group members are treated as if there is no difference between or among them. Sources of within-group variation are seldom accounted for beyond socioeconomic status and gender, as noted previously.

Studies of coping and racial identity as moderators of racism and its stress will be discussed next. Racial groups have distinct sociopolitical histories that influence both social perceptions of the individual and of the group. These histories, coupled with one's personality, interact with one's family and community systems and contribute to an individual's idiosyncratic response to environmental stress, which influences the types of experiences he or she will have. For instance, Asians and Native Americans are perceived and treated differently than are African Americans. African Americans' history of slavery has set them apart from other groups of Color, as has the nation status of Native Americans.

Plummer and Slane (1996) investigated coping among White and Black adults. They found that both groups experienced race-based situations as more stressful and used different strategies to deal with race-related situations compared with general situations. In racially stressful situations, Blacks used a greater number of coping strategies than did Whites, and they used more confrontation than other options. The authors suggested that

because Blacks experience more stress, they use more ways to cope. These findings were supported in other investigations as well (e.g., Danoff-Burg, Prelow, & Swenson, 2004; Utsey, Ponterotto, Reynolds, & Cancelli, 2000).

Danoff-Burg et al.'s (2004) study found gender differences for Blacks in that women used social support more to cope with racism-related stress than men did. There were also differences in responses to different levels of racism-related stress. For instance, Black women used avoidance with individual racism. Last, self-esteem and life satisfaction were lower when avoidance coping was used. Thus, these studies suggest that coping varies for people of Color as a function of the type of racism and the source of the stress and that the coping strategies one uses may have an impact on psychological and emotional outcomes. But how might racial identity influence responses to racism?

Racial identity theorists conceptualize race as a psychological construct that allows for a more complex understanding of the processes involved in responding to race-based experiences (Carter & Pieterse, 2005; Essed, 1991; Feagin & Sikes, 1994). Racial scholars have suggested that racial identity acts as a buffer for Americans of Color against the negative or harmful effects of exposure to racism and discrimination (Franklin, 1999; Utsey, 1997). A brief review of theory and research that identify racial identity as a potential buffer or within-group variable is presented.

There is now a substantial amount of literature that focuses on racial identity as a core aspect of personality and racial socialization (Carter, 1995, 2005; Sellers & Shelton, 2003), which should have particular relevance for understanding how individuals respond to race-based stress. Racial identity theorists (e.g., Carter, 1995; Helms, 2001; Sellers & Shelton, 2003; Thompson & Carter, 1997) explain the varied manner in which schemas, affective states, and behaviors can be classified according to the various racial identity ego statuses that individuals psychologically embrace or reject. Also, individuals may be ambivalent about their race, racial group, and the dominant racial group. Racial identity statuses, as outlined by Carter (1995) and Helms (2001), have all received empirical support in the research literature (Carter, 1995, 2005).

Racial identity ego statuses vary from less mature or external dominant racial group identification to more mature or internal own racial group identification. Models of racial identity exist for Whites, Blacks, and people of Color. Black and people of Color racial identity ego statuses are (a) *Preencounter or Conformity*, in which race is not salient; (b) *Dissonance or Encounter*, which is considered to be a transition status; (c) *Immersion–Emersion*, in which one idealizes one's own reference group; and (d) *Internalization or Integrative Awareness*, in which one internalizes investment in one's own racial group (see Table 2).

TABLE 2: People of Color and Black Racial Identity Development Model

Status	*Description*	*Possible Reactions to Race-Based Stress*
Conformity or Preencounter	External self-definition and attitudes that reflect preferences for the dominant race and culture and negative attitudes toward one's own race and culture.	Believes race is not a factor in life and therefore if racism exists, it does not influence him or her. Thinks life struggles are because of family or lack of effort.
Dissonance or Encounter	Feelings and attitudes that reflect confusion and conflict relative to one's own group and the dominant racial group.	Typically attributes personal or interpersonal reasons for obstacles and life stress. Therefore, internalizes events that may be due to racism.
Immersion–Emersion	The dominant culture and race are rejected, and a person immerses him- or herself into his or her race and culture of origin. Begins to develop internal definitions of self (emersion).	Immersion: Recognizes race-based stress and racism and is clear that White racism is responsible for many ills in her or his life, attributions are mostly social. Emersion: More likely to shift attributions from mostly social to include personal beliefs in social and group efforts to address racism, but still affected by the stress it produces. Able to cope better, given the understanding of the power of systemic racism. Therefore, less likely to internalize events that may be because of racism.
Internalization or Integrative Awareness	Use of internal criteria for self-definitions. Commitment to sense of self-fulfillment, capable of accepting and functioning within the dominant society while valuing and taking pride in his or her own racial-cultural heritage.	Race is an important aspects of self, understands racism and its manifestations. Good coping skills because of awareness, but still can be affected by the trauma and stress of racism.

NOTE: People of Color includes African, Latino, Asian, and Native Americans and immigrants.

There are a few studies that provide evidence for the effect of racial identity status attitudes on various race-related variables such as coping, perceptions of discrimination, psychological well-being, psychological distress, preferences for social change activities, and perceptions of institutional racism (e.g., Carter, Helms, & Juby, 2004; Coard, Breland, & Raskin, 2001; Franklin & Carter, 2007; Jefferson & Caldwell, 2002; Neville, Heppner, & Wang, 1997; Nghe & Mahalik, 2001; Sellers & Shelton, 2003; Watts & Carter, 1991).

Neville et al. (1997) examined whether racial identity ego status attitudes were predictive of perceived stressors and coping styles in Black college students. They found that Immersion–Emersion attitudes were associated with lower levels of psychological health, increased perception of general stressors, and greater use of suppressive coping styles. Internalization attitudes were associated with less awareness of race-specific stressors, while Encounter attitudes were related to greater perception of race-specific stressors. Thus, the Neville et al. study showed psychological variation in how racial stressors are perceived and how coping is used. These findings are somewhat contrary to theory in that Internalization status attitudes would be expected to be related to greater awareness of racism. It is also not clear why Encounter status attitudes would be associated with more awareness of race-specific stressors. It is possible that the measures and sample characteristics might explain some of the findings.

Sellers and Shelton (2003) examined whether Black racial identity (measured by the Multidimensional Inventory of Blacks Identity) was related to perceived discrimination and psychological distress. The dimension of racial identity that was associated with perceptions of discrimination was racial centrality. Those who felt being Black was important (racial centrality) experienced more discrimination. Nationalistic racial ideology and public regard (understanding how Blacks are seen in society) were found to buffer the effects of perceived racial discrimination. For instance, if one thought Blacks were held in low public regard, this lessened the negative impact of discrimination. Furthermore, their results confirmed prior research indicating that the more frequent the experience of discrimination, the more negative the psychological outcomes. Perceived racial discrimination was significantly related to psychological distress as assessed by measures of depression and anxiety. Sellers and Shelton's investigation revealed considerable variation in how racial identity dimensions influence perceptions of racism.

Watts and Carter (1991) studied whether Black racial identity status attitudes were predictive of perceptions of racism in the workplace. They found that Preencounter attitudes were not associated with the perception

of racism at work, whereas Immersion–Emersion and Internalization attitudes did predict perceptions of institutional racism defined as the absence of Blacks in positions of power and authority.

Franklin and Carter (2007) studied the relation between racism-related stress, racial identity, and psychological health among Black adults. They found that racism-related stress and racial identity were predictors of psychological outcomes (i.e., well-being and distress) and that personal encounters with racism (individual) predicted greater levels of psychological distress while institutional and cultural racism did not. Furthermore, they reported that racial identity and racism-related stress predicted psychological distress, with racial identity accounting for more of the variance in psychological distress. Racial identity also predicted psychological well-being, over and above racism-related stress. More specifically, Preencounter was positively related to psychological distress, and Internalization was positively related to psychological well-being and negatively related to psychological distress. The findings associated with these analyses suggest that racial identity statuses serve as complex filters for racial stimuli and psychological outcomes.

However, Helms's (1990) White racial identity theory suggests that Whites (and people of Color) who are charged with assessing race-based stress may not have developed enough awareness of their own racial history and intergroup dynamics to make informed assessments of either the incidents in question or the psychological and emotional reactions that result. In a study using individual racial identity status profiles, Carter et al. (2004) found that racists' beliefs were associated with specific profiles. Therefore, the racial identity ego status of Whites involved in psychological assessment, education, and training warrants attention. However, the specifics of such a discussion are beyond the scope of this article (Carter, 1995; Carter et al., 2004).

Like other bodies of research, the racial identity and coping research findings are mixed and inconsistent. The racial identity status attitudes that were related to perceptions of racism varied from study to study. Nevertheless, the research does suggest that racial identity and coping styles are aspects of within-group variation. Yet, again, most studies involved Blacks. Less is known about how racial identity affects other people of Color's perceptions of racism and discrimination. The information that does exist seems to lend support to the argument that racism is a stressor that might produce trauma for people of Color. Furthermore, it suggests that there might be value in unpacking racism so that more specific aspects of the experience can be related to mental health effects and that employing the definition of traumatic stress could be a way to capture more accurately the mental health impact of racism.

Summary of the Direct Evidence

Despite the existence of some direct evidence supporting the contention that racism is experienced as a stressor, there has nonetheless been resistance on the part of mental health professionals to accept the idea, reality, and conceptualization of racism as a form of stress. Perhaps the idea that racism is a stressor is difficult to accept because the evidence is not conclusive or consistent, or because the idea of racism is relatively new in the psychological and health literature. Alternately, it is possible that the denial is another manifestation of racism (Essed, 1991; Feagin & McKinney, 2003). Clark et al. (1999) made the observation that there is

> a tendency to discount perceptions of racism as stressful (yet this denial) is inconsistent with the stress literature which, highlights the importance of the appraisal process . . . the perception of (environmental) demands as stressful is more important in initiating stress responses. . . . With this in mind, the initiation of psychological stress responses as a result of perceiving environmental stimuli involving racism would qualify [race-based] stimuli as stressors. (p. 810)

Butts (2002) described the process of denying the effects of racism when he stated that

> knowledge of the impact of racism on the psyches of African-Americans (and people of Color) is limited by . . . the tendency to deny, minimize, and rationalize the existence of racism; the tendency to ascribe inferior status to African-Americans (and people of Color); the application of many stereotypes and myths to African-Americans (or people of Color) that serve to have them viewed as non-responsive to human influences. (p. 336)

The research on stress, life events, PTSD, discrimination, and race-related stress supports Clark et al.'s (1999) and Slavin et al.'s (1991) assertion that the perception of racial stimuli as stressors initiates stress reactions for the majority of participants in the reviewed studies. However, the findings are not conclusive, and although they seem to suggest the possibility that racist encounters can be experienced as traumatic, what is not yet clear is whether the reactions do rise to the level of being traumatic (Carter, Forsyth, Williams, et al., 2005).

The studies reviewed previously do show that the incidence and frequency of discrimination tends to be high for many people of Color. Yet the frequency of occurrence varies, perhaps because of how the discrimination was perceived, measured, or assessed. In general, researchers have found that overt and subtle behaviors of racism and discrimination conceptualized as stressors have adverse impact on the heath and mental health of targets (Williams et al., 2003).

Studies of racism and perceptions of discrimination have several limitations: (a) The majority of the studies focused on African Americans, therefore there is less information about other groups of Color; (b) some of the studies (e.g., physiological effects) were conducted in laboratory settings and did not include systemic racism variables, which limits their external validity; (c) in some cases, the evidence from the research was indirect (e.g., high rates of PTSD); (d) few studies (e.g., Carter, Forsyth, Mazzula, et al., 2005; Essed, 1991; Feagin & Sikes, 1994) drew directly from participants' own descriptions and reports of critical incident encounters with racism and the accompanying lasting emotional effects; (e) some studies used single-item measures of discrimination, and overall the instruments from study to study varied; and (f) the effect of race-related stress has been studied in terms of its mental health effects, but mostly in terms of numerous encounters in one's lifetime and in the past year (see Table 1).

It is difficult to know if specific types of racism (e.g., discrimination, harassment, physical violence) impact people differentially. Carter, Forsyth, Mazzula, et al.'s (2005) and Carter, Forsyth, Williams, et al.'s (2005) preliminary studies seem to suggest that it is possible that acts of racial hostility may have greater lasting mental health effects than racial avoidance, but more research is needed. The studies do seem to confirm that there are various types of discrimination that people are exposed to and that some types affect people more than others. Carter et al.'s research and Butts's (2002) case description suggest that racism may produce traumatic stress reactions. Nevertheless, unpacking racism to account for specific types and its mental health effects is warranted.

UNPACKING RACISM: A NEW CLINICAL STANDARD FOR RACE-BASED TRAUMATIC STRESS INJURY

The early discussion of definitions of racism offered many ways to think about and describe racism. Racism has been defined as follows: (a) a rational individual process used to justify traditional values (e.g., symbolic racism, modern racism); (b) a form of national pride and a way to evaluate how people who are deemed different meet the standards of the dominant racial–cultural group (Eberhardt & Fiske, 1998); (c) a system of violent oppression (Bulhan, 1985) and a systemic process that denigrates and subordinates on the basis of race (systemic racism, structural racism); (d) the use of power by a dominant racial group that is thought to be superior, to maintain the inferior status of nondominant racial groups (individual, institutional, and cultural racism; Jones & Carter, 1996); and (e) a central principle of power and social relations that changes form and shape as the

political and historical context and purpose of racism changes (i.e., racial formation; Omi & Winant, 1986, 1994). Other scholars have identified racism as an everyday occurrence (Essed, 1991) and as a constant feature of life for people of Color, especially Black people (Feagin & Sikes, 1994; Feagin & McKinney, 2003). These models and typologies of racism do a good job of documenting the types of situations people face year in and year out as well as day in and day out that are often repeated over years and generations. But, a way of clearly connecting the acts and experiences of racism to mental health effects has yet to be found. These scholars have suggested and demonstrated that there are psychological effects associated with experiences of racism. However, few scholars and researchers have focused on how particular types of acts of racism are directly related to emotional and psychological injury and whether the stress associated with that injury produces trauma. One strategy might be to group the types of racism into a few types, each with particular and clear features in an attempt to more directly associate the experience(s) with stress or traumatic reactions.

Carter and Helms (2002) and Carter, Forsyth, Williams, et al. (2005) have noted that racism can and perhaps should be deconstructed into distinct types or classes that encompass the various levels discussed previously (i.e., individual, institutional, cultural) so that the types can be connected to emotional and psychological responses. Doing so might make it easier to document the mental health impact or injury of racism, assist mental health professionals to better aid targets, and offer targets another avenue of redress and recovery from the pain of racism.

The distinct types or classes proposed by Carter and Helms (2002) are racial discrimination and racial harassment. An additional type of racism, *discriminatory harassment,* is being introduced in this article. The rationale for unpacking racism is to reduce some of the ambiguity associated with the various kinds of race-based experiences. Being stopped by the police because of your race (harassment) can produce traumatic reactions of avoidance and intrusion, but not if it is characterized only as individual or institutional racism. If one is ignored by sales people in a store or denied housing (discrimination), as illustrated previously in the case example, the event can be stressful and for some the stress can become traumatic. The experience of being denied promotion(s) at work or having one's abilities and professional skills constantly questioned in subtle ways (discriminatory harassment) may also produce stress and perhaps even trauma. Yet to make the connection to mental health effects, it seems more useful to have types or classes of racism rather than to use broad social definitions or systemic descriptions of racism that include a range of experiences that occur over long periods of time.

Carter and Helms (2002) argued that each type or class is distinct and, as such, might have a different emotional impact. Moreover, people of Color might react and act differently if they used the distinctions proposed. It might not matter to people to know if they were being avoided or harassed or being treated as if they were dangerous because most individuals can recognize these encounters for what they are, but such distinctions could give them language to communicate their experiences and help professionals recognize the acts and associated effects on targets. Knowledge and recognition of the different types or classes of racism will aid targets to cope, and will help mental health specialists and other professionals who work on their behalf to assist them in seeking redress for any injury sustained by acts of racism. It should be noted that while the definitions and distinctions contain common and recognized words, the meaning assigned to each class or type of racism described next are not consistent with legal definitions or common use. For instance, according to federal, state, and many local statutes, racial harassment is an aspect of racial discrimination and the two are not seen as distinct (Bell, 2000).

Racial Discrimination

Racial discrimination is defined as a class or type of avoidant racism that is reflected in behaviors, thoughts, policies, and strategies that have the intended or accidental purpose or effect of maintaining distance or minimizing contact between dominant racial group and nondominant racial group members (Carter, Forsyth, Mazzula, et al., 2005). Racial discrimination, defined in this manner, captures a class of events, acts, and experiences that help dominant racial group members engage in racism without overtly appearing to do so (Essed, 1991).

Essed (1991) grouped the underlying meaning of everyday events into three main categories: *problematizing*, *containing*, and *marginalizing*. Incidents that problematized were characterized by or seemed to express the belief that Black people have "problems" in their biological makeup and culture. In turn, these inherent cultural limitations create social problems. Essed stated that "Black women in the United States . . . are frequently confronted with the attribution of superiority on the basis of White skin color" (p. 182). Some of the women's problematizing encounters involved the denigration of their perspective or personality through pathologizing them or assuming they were being overly sensitive. Other women were characterized by the denigration of their culture through assuming and acting as if they were uncivilized, backward, or deficient in their use of the dominant language or that people in their group were lazy. In addition, problems are attributed to the culture by assuming that group members have less ability or are prone to crime and by sexually objectifying them.

According to Essed's (1991) conceptualization, racism in the everyday context is also designed to contain (i.e., keep them in their place) nondominant group members. This is done by denial of racism through various means such as seeing only extreme racism; expressing anger toward Blacks who point out racism; and managing differences through the majority rule process, cultural nonrecognition, mistrust of Blacks, and so on. Intimidation is also used through physical and symbolic violence. Last, Blacks are marginalized by way of withdrawal, using Whites as the normative group, barring access, discouraging achievement, exclusion, withholding information, and use of deception. Many elements of everyday racism can be grouped into the class of experiences that would be defined as avoidant racism.

Avoidant racism may occur at the individual level (e.g., denial of opportunity or access to a person of Color), the system or institutional level (e.g., lack of access to education or mental health care), and the policy and cultural level (e.g., standards and practices that exclude people of Color, ignoring or denigrating the contributions and cultures or languages of people of Color; Essed, 1991; Feagin & McKinney, 2003).

The researchers cited previously have found that racially based discrimination includes, but is not limited to, exclusion from social and work networks, dismissal or denial of personal achievement(s), and limits or restrictions to opportunities for achievement (e.g., requiring advanced high school courses for college admission while discouraging students of Color from enrolling in them). The research on discrimination and race-related stress that has been reviewed suggests that emotional responses to being discriminated against include fear, tension, anxiety, depression, sadness, anger, aggression, resolve to overcome barriers, social cohesion, and use of the situation as a source of strength. Many of the experiences of discrimination that people of Color encounter, especially Blacks and Native Americans, have powerful historical elements that give meaning and salience to symbolic, subtle, verbal, and nonverbal messages that alone can produce race-based stress.

Racial Harassment

Racial harassment is defined as a type or class of experiences characterized by hostile racism that involves feelings, thoughts, "actions, strategies, behaviors and policies that are intended to communicate or make salient the target's subordinate or inferior status because of his or her membership in a non-dominant racial-group" (Carter & Helms, 2002, p. 5). This would be similar to Essed's (1991) containment and problematization categories. Racial harassment can reflect explicit and implicit institutional permission to commit acts of racism as evidenced in the absence of explicit policies and procedures for filing and handling claims of racial harassment or in the well-documented existence of community violence that disproportionally

traumatizes Black and Hispanic children (Garbarino, Dubrow, Kostelny, & Pardo, 1992).

Racial harassment can occur as quid pro quo pressure to "fall into line" with institutional racial practices and policies as a condition of continued employment, education, or social participation (Carter & Helms, 2002). This form of racial harassment involves quid pro quo (a distinction not currently recognized in the law) arrangements in which the person of Color remains silent or does not act or file formal complaints in return for continued access or opportunity (Feagin & McKinney, 2003; Jones, 1997; Kovel, 1970). One may be pressured with losing their home, job, or education if they report acts of racism.

Feagin, Vera, and Batur (2001) described an incident that illustrates an instance of quid pro quo racial harassment. White employees found out their Black female coworker Sheryl had a birthday, and learned that she was expecting a child. The White coworkers gave her a party, and the cake was decorated with an image of a pregnant dark-skinned woman with the inscription, "Happy Birthday Sheryl. It must have been the watermelon seeds." Sheryl said of the experience, "When I saw the inscription, I just kind of stared at it and said 'Oh, thank you,' I didn't feel I could get angry. I had just found out I was pregnant and I needed my job" (p. 156).

The parallel for racial harassment to quid pro quo sexual harassment is in the threat both contain. With race, the person is expected to grant the "favor" of ignoring racism for the opportunity to work or live. Many types of race-based encounters that participants reported in discrimination studies could be grouped into the class of acts that would be considered racial harassment (e.g., being followed by security in stores).

Researchers cited in the discrimination literature review have found racially based harassment to include physical, interpersonal, and verbal assaults; assuming one is not to be trusted; treating people according to racial stereotypes (i.e., lazy, lacks ability); and assuming one is a criminal or is dangerous. Emotional reactions to hostile treatment include anger, rage, powerlessness, shame, guilt, helplessness, low self-esteem or persistent self-doubt, suspiciousness, and distrust. Other reactions have been positive and adaptive such as resolving to prove people wrong, confronting the person or persons, or using the feelings as a source of personal or group strength. Feagin and Sikes (1994) observed from their interview of middle-class Blacks that

> most [W]hite Americans do not have any inkling of the rage over racism that is repressed by African Americans. . . . Repressed rage over maltreatment is common. . . . The psychological costs of . . . widespread prejudice and discrimination include rage . . . humiliation, frustration, resignation, and depression. (pp. 293-294)

Discriminatory Harassment

The third category emerged from two research projects in which people of Color described critical incidents of discrimination (Carter, Forsyth, Mazzula, et al., 2005; Carter, Forsyth, Williams, et al., 2005). Many of the respondents described complex or multiple experiences or structural racism reflected in health and mental health disparities that were not easily identified as either avoidance (racial discrimination) or hostility (racial harassment), but were combinations and complex mixtures of both. Therefore, the category discriminatory harassment is presented to capture the complex encounters that people reported (Carter, Forsyth, Mazzula, et al., 2005). Discriminatory harassment is a type or class of experiences or encounters with racism that are best defined as aversive hostile racism, which involves thoughts, behavior, actions, feelings, or polices and procedures that have strong hostile elements intended to create distance among racial group members after a person of Color has gained entry into an environment from which he or she was once excluded. Once a person of Color enters a system (e.g., job), he or she is avoided in hostile ways; thus, discrimination as aversion and hostility as harassment are combined. The aversion may occur at individual, institutional, and cultural levels. Consider the situation of a person who has been given access to a job, yet after being hired is treated with distain and is not trained to do her job well. Subsequently, she is often subjected to poor evaluations and is reprimanded for minor infractions. This situation contains both avoidance (coworkers and supervisors ignore or shun her) and acts of hostility (critical feedback and the denigration of her work and presence in the workplace). Green (1995) wrote about a court case that

> applied to the racial discrimination and harassment a black female bank teller suffered after a credit union hired her. Brenda Patterson's supervisor stared at her, assigned her cleaning duty, made racists remarks in her presence, and refused to train or promote her. (p. 295)

Some types of discriminatory harassment are captured in the work of Dovidio and Gaertner (1998) and other scholars (e.g., McConahay, 1986). They noted that over time racism has changed and become more symbolic, subtle, and hidden within the guise of nonprejudicial or nonracist behavior, thought, and justification. According to these scholars, strong negative feelings toward people of Color operate on the subconscious level of awareness. While they are often not communicated as open hostility, such feelings and beliefs exist and manifest themselves in colorblind beliefs and practices, as well as by expressions of discomfort, disgust, and fear.

When people or organizational leaders can justify their actions by claiming that factors other than race were responsible for their acts or decisions,

then racism at individual, institutional, and cultural levels can occur without challenge. The person who made claims that racial discrimination took place is then made to look foolish or overly sensitive.

Dovidio, Gaertner, Kawakami, and Hodson (2002) pointed to research that has shown that some forms of racism do not occur in situations when justification can be offered that is not racial. The reality is that the behavior appears to people who it is directed at as inconsistent and unpredictable and as such "could erode Blacks [or any person of Color's] confidence . . . which then leads to interpersonal and . . . interracial distrust" (p. 98). Because the behavior is not conscious, the actor will deny any hostile or discriminatory intent, thereby intensifying possible racial conflict. The potential for miscommunication is high in these instances, and the behaviors most influenced by the aversive hostile racism are often, but not always, subtle, indirect, and nonverbal. The result is that mixed messages (positive overt behavior and hostile nonverbal behavior) are communicated while the actor thinks he or she is being consistent. As Dovidio et al. stated,

> To the extent that Blacks and other minority group members may, for historical reason or personal experience be . . . sensitive to signs of rejection, dislike, or discrimination, they are likely to weigh the negative signals more heavily than the positive overt behaviors or even view the communication of mixed messages as evidence of ingenuous or deceitful motivations. (p. 99)

Solorzano, Ceja, and Yosso (2000) reported an African American math student's experience at a predominately White university that reflects the type of mixed message that communicates both aversion and hostility (e.g., "You do not belong here and could not have done well unless you cheated"). The student describes the event this way:

> We took a first quiz . . . and I got a 95 . . . he [the professor] was like "Come into my office. We need to talk" and I was like "okay" I just really knew I was gonna be [told] "great job," but he [said] "We think you've cheated . . . we just don't know, so we think we're gonna make you [take the exam] again" . . . I took it with just the [graduate student instructor] in the room . . . and I got a 98 on the exam. (p. 70)

The new definitions of different types or classes of racism can facilitate recognition by targets and others of systematic, covert, subtle, and unconscious forms of racism. For instance, it is easier to recognize denial of service or acts or racial profiling as acts of avoidance and hostility than to simply subsume both under the rubric of racism or generic racial discrimination. The definitions can guide mental health professionals in their analysis and assessment of race-based experiences. The distinctions are important for mental health professionals who may be consulted by targets for psychological relief

or legal redress. Furthermore, the definitions might serve to enhance investigations of the mental health effects of racism. Finally, it would be of value to use the distinctions presented as the basis for a new mental health standard for assessing and identifying race-based stress, traumatic stress, or both.

Mental Health Standards

To understand the various forms, classes, and effects of racial discrimination, harassment, and discriminatory harassment, one should go beyond the strict psychological criteria used in counseling and psychological practice. Mental health standards are often applied in a color-blind, universal fashion that does not consider race. As such, these standards promote the interest of White society in sustaining a system of racial stratification and a denial of the mental health effects of racism (Johnson, 1993; Thompson & Neville, 1999). Hansen et al. (2006) investigated how often psychologists used specific behaviors that reflected recognition of the racial–cultural issues for clients. In the study, most professional psychologists reported respecting the racially different client. However, the researchers found that these psychologists did not use cultural formulations, did not make culture-specific diagnoses, and did little to improve their racial-cultural skills.

To understand the client's perceptions of therapist and mental health services, Sanders-Thompson, Bazile, and Akbar (2004) used focus groups made up of 200 Black participants. These researchers found that, in general, the participants' perception was that psychologists were typically White men "who were unsympathetic, uncaring, and unavailable . . . and impersonal." They also distrusted therapists and expressed the view that "most therapists lacked an adequate knowledge of African American life and struggles to accept and understand them. They discussed the stereotypes of African Americans in the larger society and challenged the ability of psychologists to remain unbiased" (pp. 26-27). Another concern expressed by the participants was cultural sensitivity, in that they thought many therapists regardless of race would be biased and unable to relate to them. Moreover Sanders-Thompson et al. found that "participants with psychotherapy experience noted that problems, such as experiences with racism, discrimination, and the stress of . . . life and exposure to community trauma, were avoided because of fears that the therapist would not understand" (p. 28). These studies provide support for the contention that race-specific standards are needed for mental health professionals, such that the services they provide can be psychologically appropriate and culturally relevant for clients of Color.

To ignore race and racism in counseling and mental health practice means that mental health professionals fail to capture all of the complex and dynamic aspects of racism and its effects in the form of race-based stress

(Comas-Diaz, & Jacobsen, 2001; Johnson, 1993; Williams & Williams-Morris, 2000). Reliance on the universal, color-blind, or multicultural principles and standards typically used to account for differences in the experiences, perceptions, behaviors, and attitudes of members of various racial–cultural groups will not help mental health professionals understand or assess race-based stress or trauma. If White cultural views, practices, and beliefs continue to dominate the mental health field, efforts to comprehend racism's mental health impact will be sidelined. For the most part, racism will continue to be ignored as a significant source of stress or trauma for people of Color. It is clearly imperative that clinicians be provided with the necessary and appropriate tools that can help them recognize and assess race-based experiences and reactions. Consider that when Blacks, people of Color, and Whites are asked about the presence and incidence of racial bias, researchers (e.g., Biasco et al., 2001; Dovidio et al., 2002; Hite, 2004) have reported that Whites and Blacks have, for more that 40 years, held opposite views about the presence and incidence of racism. For instance, 67% of Whites think Blacks are treated as well as Whites in society, and 72% of Blacks hold the opposite view. Hite (2004) found that "the majority of Black women managers (71%) reported fewer career opportunities for women of Color, while the majority of White women managers (71%) reported women of Color as having the same opportunity as White men (p. 136)." Biasco et al. found that most students perceived discrimination in society as being infrequent, yet 66% of the students of Color and 41% of the White students thought minority students experienced discrimination. According to the many Whites and people of Color who share their perspective, new mental health standards would not be warranted.

Psychological Injury

It is rare for mental health professionals to assess clients for exposure to race-related experiences. This circumstance is troubling given that racism has been demonstrated by many scholars to be involved in many aspects of daily living for people of Color. Thus, race and racism are involved in the developmental process, in presenting problems, life adjustments, and the stress of social status—any of which can compromise mental health. Researchers and scholars have reported that in the majority of studies on stress, PTSD, and discrimination, people of Color experience a range of signs and symptoms, many of which are associated with existing criteria for mental distress and possible disorders such as stress-related adjustment reactions, mood and anxiety disorders, as well as PTSD (Butts, 2002; Johnson, 1993).

It may be more accurate to assess the effects of racism (e.g., harassment, discrimination, and discriminatory harassment) as a psychological and emotional injury rather than as a mental health disorder(s) because the effects of

racism come from the sociocultural environment and are thus situational and not dispositional (i.e., intrapsychic). Racism can and does create damage to one's psyche and personality in the same way that being subjected to community violence, being held captive, or being psychologically tortured can create emotional damage (Herman, 1992; Johnson, 1993; Wallace & Carter, 2003). Even in the case of these types of traumas, mental health professionals who are influenced by dominant American cultural patterns tend to focus on how the individual must adjust to her or his circumstances, thereby viewing the individual's difficulties as dispositional or characterological as opposed to being a result of situational stress (Herman, 1992). It is difficult to overcome the dominant American cultural lens that tends to locate people's problems in their personal failures. Nevertheless, the mental health impact of racism should be thought of and assessed as psychological, and emotional injury as a way to recognize that situational factors and circumstances can create stress, distress, and trauma for targets.

The *Merriam-Webster Collegiate Dictionary*'s (2003) definition of disorder is "an abnormal physical or mental condition or not functioning in a normal healthy orderly way" (p. 360), or mental illness that requires psychiatric or psychological treatment. In contrast, the dictionary defines injury as "an act that damages or hurts and is a violation of another's rights for which the law allows an action to recover damages" (p. 1040). It can be argued that racism disrupts normal functioning and leaves the person harmed and ill. At the same time, it is also the case that classes of racism can result in psychological and emotional effects and that these effects may not reflect a pathological process. Rather, racism violates one's rights such that a person should be able to sue to recover for damages. It is proposed that psychological and emotional pain or injury is part of a nonpathological process and set of reactions that have associated with them symptom clusters and reactions that can impair a person's functioning. The assessment category of race-based stress or trauma can be used to identify reactions that integrate the situational (external) and dispositional (internal) elements in the context of an individual's life history and experiences.

In spite of the fact that researchers know people are harmed by racism and that people of Color experience these events as stressful, there still is inadequate information for mental health professionals to use when assessing how someone is affected by racism. However, two studies (Carter, Forsyth, Mazzula, et al., 2005; Carter, Forsyth, Williams, et al., 2005) did find that, in general, the emotional and psychological effects reported by respondents were consistent with Carlson's (1997) model of traumatic stress. In addition, the results revealed that there are differences in the reactions that people have when they encounter the class of experiences that constitute racial harassment and racial discrimination. The studies found that each class or type has a somewhat different emotional impact; therefore, the

symptom clusters varied. It is important to note that the vast majority (98%) of the participants in Carter, Forsyth, Mazzula, et al.'s (2005) and Carter, Forsyth, Williams, et al.'s (2005) studies did not experience an actual or threatened physical assault. Carlson posited that for an experience(s) to qualify as a traumatic reaction, it needs to be perceived as negative (cause emotionally pain or threat of pain), be sudden, and uncontrollable.

In the section on stress, it was noted that events experienced as negative, out of one's control, sudden, ambiguous, and repeated increase an individual's stress response. In turn, these events deepen emotional pain and can lead to traumatic responses. This fact coupled with the addition of the Slavin et al. (1991) racial–cultural stress process suggests that important aspects of a people of Color's lives are permeated with stress reactions and assessments. Participants in the Carter et al. (2005) and Essed (1991) studies, as well as the Feagin and Sikes (1994) study reported experiences of racism that were perceived as negative, out of their control, and, from their descriptions, unexpected. In addition, racial discrimination, racial harassment, and discriminatory harassment may be experienced indirectly or through symbols or coded language as illustrated by these investigations (Feagin & McKinney, 2003). Each type or class of racism that has been presented and reported by the participants in numerous studies qualifies as having the potential to produce traumatic reactions (see Table 1).

As noted, the symptom manifestations of race-based traumatic stress include having reactions of intrusion (reexperiencing), avoidance (numbing) of stimuli associated with the trauma, and increased arousal or vigilance. In the case of racial discrimination, racial harassment, or discriminatory harassment, the client's subjective appraisal of the experience is valid. It is also possible that this verification can be used to file and succeed with organizational and court complaints and lawsuits.

Typically, the psychological stress or assault may involve one powerful insult that triggers the trauma, but more often than not the process might be more subtle and prolonged with a "last straw encounter or experience that increases the level of stress to the threshold of trauma. In another instance, racial avoidance, aversion, or hostility may be communicated indirectly by use of symbols or coded language or actions (Delgado, 1982; Feagin & McKinney, 2003). For example, Feagin and Mckinney (2003) reported that in 1996 a U.S. Court of Appeals for the Federal Circuit found that Whites' use of language such as "another one," "one of them," and "poor people" in reference to Black coworkers constituted racially coded and discriminatory language that created a hostile work environment. In a society characterized by racism such as the United States, symbolic language and images exist that can communicate threat to subordinated racial group members without

making overt reference to race. In addition, many people of Color have knowledge and experience of these events and practices as part of their life course.

Threats communicated and experienced through symbols and coded language may not be understood by many Whites. For instance, many Whites are not targets of racism and may attach different meaning to the subtle language and symbols used to communicate racial messages. Consequently, actions that may not appear threatening to a dominant group member may appear so to members of the threatened group. Overt race-specific physical and psychological tortures carried out for centuries have and continue to be associated with unspoken and accepted racial beliefs and stereotypes. Racial beliefs and attitudes are often embodied in symbols (a noose, the confederate flag, media portrayals of Blacks and Hispanics as violent and criminal, Asians as devious, etc.), as well as coded and demeaning language, such as the use of the "N" word or reference to "boy," "at risk," "inner city," and so forth. Language, symbols, or attitudes and actions directed at people of Color are based on long-held stereotypes that disregard individual characteristics and are attached to someone based exclusively on physical markers of racial group membership. This type of thinking has led to policies that are used to justify actions like racial profiling (racial harassment). Also, subtle racism is reflected in actions that involve treating a person on the basis of a stereotype or as if he or she, a unique person, is invisible (Franklin, 2004). These acts can produce a form of trauma or race-based traumatic stress.

Racial Trauma

The notion that racism is associated with trauma has been proposed by many scholars (e.g., Bryant-Davis & Ocampo, 2005; Butts, 2002; Comas-Diaz & Jacobsen, 2001; Johnson, 1993; Loo et al., 2001; Scurfield & Mackey, 2001). For instance, Loo et al.'s study of PTSD among Asian veterans found that race-related stress was a strong and significant predictor of PTSD. They 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). Their findings are consistent with the body of research previously cited regarding the relation between discrimination and psychological symptoms, and they extend the effects of racism beyond African Americans. Comas-Diaz and Jacobsen (2001) argued that

> ethnic and sociocultural emotional injuries can cause profound changes in the sense of self, . . . Exposure to racism can result in psychological affliction, behavioral exhaustion and physiological distress . . . [it] wounds healthy narcissism and impairs coping because racism often causes confusion, disillusionment and racial mistrust. (pp. 246-247)

Scurfield and Mackey (2001) argued, "Exposure to race-related trauma, in and of itself, may be the primary etiology factor in the development of an adjustment or stress disorder" (p. 28). For these authors, race-related stressors are environmental in nature and include structural circumstances such as poverty and residential segregation, work-related experiences, assault, and life event stress. However, they point out that stressors vary in severity, frequency, and onset of exposure.

Severity of exposure to racism was discussed by Scurfield and Mackey (2001) who proposed that severity could range from life-threatening physical violence or assault that results in physical injury (e.g., hate crime) to the application of indirect stereotypes. For them, the most severe acts would be physical violence, while moderately severe acts are related to direct exposure to race-based stressors in the form of verbal abuse or interpersonal racial encounters. Milder acts were described as those that were indirect and stemmed from stereotypes. Thus, the most severe race-based stressors are physical in nature, which is consistent with the parameters for PTSD.

According to these scholars, onset of exposure may take three forms (Scurfield & Mackey, 2001). The first type of exposure is *discrete* (single) or repeated experiences that have a lasting impact (memorable). The second type of exposure is *more covert and subtle*. The third type that they describe is *insidious exposure*, which is chronic and pervasive exposure to racism:

> Over time subjective experience of repetitive and cumulative exposure could be traumatically impactful. Such insidious exposure can reinforce assumptions that the world and life are unfair to people of particular races, that the dominant White race is at best unconcerned and at worst malevolent, and one's life has little positive worth and meaning. (Scurfield & Mackey, 2001, p. 30)

Bryant-Davis and Ocampo (2005) argued that racist incidents are traumatic and have similar features as rape and domestic violence. Therefore, racism, or what they call "racist incidents," produce trauma because they are a form of victimization and as such can produce posttrauma-like symptoms. They contend that physical and verbal assaults and threats to one's livelihood that are race based 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, or direct and specific and can be perpetrated by a person (individual racism), institution (institutional racism), or cultural oppression and power (cultural racism). Regardless of the form racism takes, for Bryant-Davis and Ocampo, racist incidents are a form of emotional abuse and therefore can be traumatic. Moreover, they highlight an important parallel between racism, rape, and domestic violence, which is the notion that all three are motivated by power or the need to impose one's sense of power over someone who is less powerful.

To sustain power and domination, it is necessary to communicate and convince people that the victim or target of acts of oppression is unworthy, lazy, or somehow deserving of differential or abusive treatment. Also, as is true of domestic violence, targets live with fear and are isolated from support and thus are usually unaware of when the next violation will occur. Such concerns contribute to anxiety and hyperarousal for both forms of emotional abuse (racism and domestic violence) according to Bryant-Davis and Ocampo (2005).

Other parallels they discussed have to do with the effects of racism, rape, and domestic violence. They contend that there are consequences to how one thinks, feels, and functions when subjugated to either form of abuse. People subjected to these experiences may have headaches, body pains and aches, trouble sleeping, and difficulty remembering. They may engage in self-blame or have feelings of confusion, shame, and guilt (Carlson, 1997).

Bryant-Davis and Ocampo (2005) also suggested parallels in the consequences for the perpetrators of acts of racism, rape, and domestic violence. Among these are failure to assume responsibility, lack of social or legal reprisals for their actions, and social and legal focus on the victim's role in causing the assault, all notions that were found in the study by Essed (1991). Regarding racist incidents, Bryant-Davis and Ocampo stated that "if the person of Color is 'arrogant,' does not know his or her place, 'is trying to get more than he/she deserves,' is viewed as overly sensitive or has a criminal record" (p. 490), then the incident is not viewed as racist or as a violation of the person's right and is thus dismissed or minimized. Also, perpetrators use cognitive distortions and project a range of emotions such as fear, anxiety, discomfort, and anger onto their targets as a way to disassociate from their acts. Societal responses for the different types of abuse are also similar in that the victim is usually blamed in some way. Legal and other types of societal sanctions are most often focused on the character or actions of the victim or target as in the cases of rape, domestic violence, and racism.

Johnson (1993) proposed that a diagnostic category of racial encounter distress disorder be used for understanding the race-based reactions of children because it is more precise and because it helps direct and form an appropriate treatment plan. Whether used for a child or an adult, all of the models of race-related trauma rely on PTSD to indicate race-based traumatic stress injury. In relying on PTSD, the result is that the target or victim of racism is described in terms of pathology and the role of emotional pain is not fully acknowledged. While it is clear that the person who is emotionally and psychologically impacted by a racial insult may be harmed and may become ill or impaired, it seems less helpful to characterize that harm as only dispositional pathology. Rather, a way to recognize and assess the injury that accounts for both the situational harm and the emotional/ psychological harm is needed and warranted. Therefore, a nonpathological category is needed to

avoid the pitfalls and to help targets verify their experience beyond their subjective feelings, which are important but often challenged when administrative complaints and legal action are taken.

RACE-BASED TRAUMATIC STRESS INJURY: A NONPATHOLOGICAL ASSESSMENT CATEGORY

The nonpathological race-based traumatic stress injury that is being proposed involves emotional or physical pain or the threat of physical and emotional pain that results from racism in the forms of racial harassment (hostility), racial discrimination (avoidance), or discriminatory harassment (aversive hostility). The target may and does experience significant emotional reaction(s), and symptom clusters emerge that reflect that reaction, but the racial component or encounter(s) is important in recognizing and connecting the racism to the emotional distress and pain (see Figure 1).

The events that may produce race-based traumatic stress reaction(s) occur in many different forms, as have been previously discussed and described throughout the article. Racial encounters may be direct or subtle and ambiguous. They can occur on an interpersonal level (microaggressions, verbal assaults, use of symbols or coded language), and can be the effect of structural or systemic acts. Racism may occur on an institutional level, as an application of racial stereotypes or as encounters and assault(s), and it may occur through cultural racism. Some examples of cultural racism are when people of Color are treated as if they are not American because of their race or language. People often assume that Asians or Hispanics are foreigners and treat them with surprise when they speak English or disgust when they use their native language. Another manifestation of cultural racism is the failure to recognize and remedy the myriad forms of harm and damage brought to the descendants of those directly held in bondage who were denied access and opportunity by slavery and legal segregation. In reference to cultural racism, Sue (2003) observed that "it is White folks who dominate and control the institutions and social policies that create and enforce American cultural values and norms. Relative to White people, persons of Color are relatively powerless on a societal level" (p. 31).

Race-based events that may be severe or moderate, and daily slights or microaggressions, can produce harm or injury when they have memorable impact or lasting effect or through cumulative or chronic exposure to the various types or classes of racism. The most severe forms may not be physical attacks. In the section on physiological reactions to racism, blatant

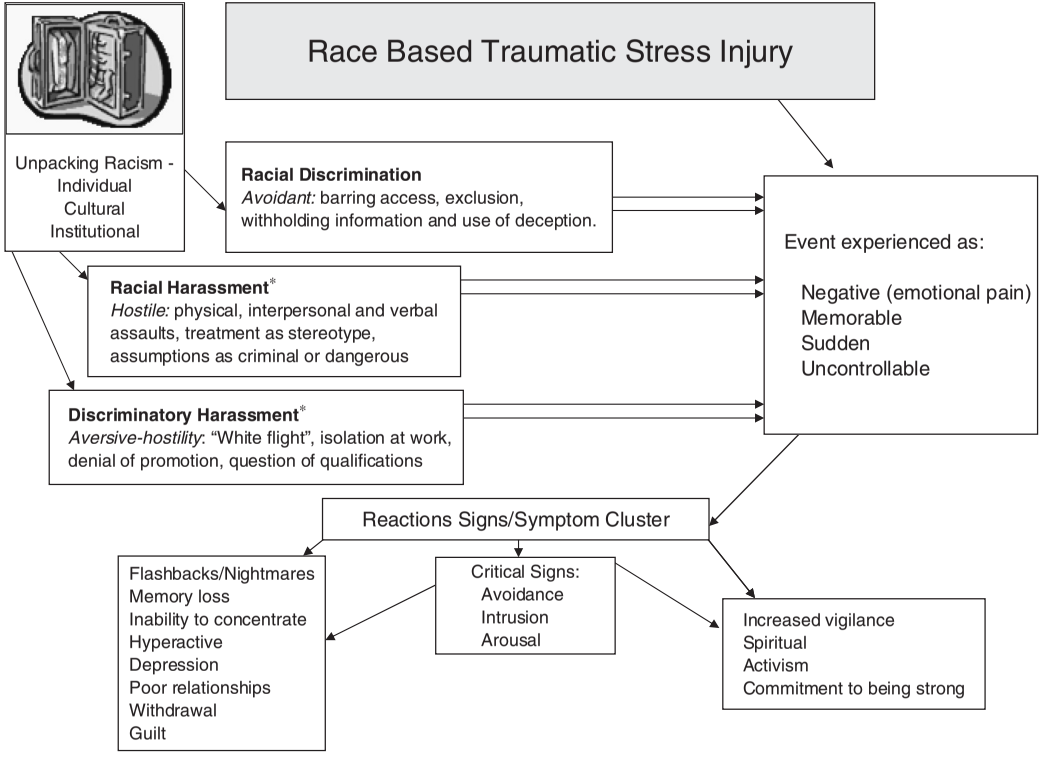

Figure 1 Race-Based Traumatic Stress Injury
*May be more harmful.

forms of discrimination were not as often related to rises in heart disease risk, but rather more subtle acts were related to potentially harmful physical reactions.

Instead, the severity of a race-based event should be determined by the strength and intensity of the person's reaction and the symptom cluster that emerges. Because many aspects of racism can occur throughout one's life, severity may be a consequence of the cumulative effects of numerous events. For example, one seemingly innocuous or minor event could be the last straw in a series of accumulated racial incidents, causing a person to feel that he or she can no longer manage the stress and pain of encounters with racism (Slavin et al., 1991). Recall that duration, number of life events, and the nature of the type of social support before and after an event, as well as the person's physical vulnerability, all contribute to the severity of a particular event (Carlson, 1997).

For race-based traumatic stress to be present, one must perceive the class of racism event(s)—racial discrimination, racial harassment, or discriminatory harassment—as *negative* (*emotionally painful*), *sudden*, and *uncontrollable*. Furthermore, one should have some elements of the following reactions: intrusion, avoidance, or arousal. When there may be greater presence of the intrusion and avoidance elements, because they contribute to the arousal features of the trauma, the reactions may be manifested physiologically, cognitively, behaviorally, and through emotional expression. They can also be manifested as anxiety, anger, rage, depression, compromised self-esteem, shame, and guilt. Alternately, the reactions can be adaptive and positive, as reflected in coping strategies that aid in moderating the effects of the race-based traumatic stress (Ani, 1996). As discussed previously, some people use formal means and others confront racial encounters as a way to cope, while other people use the energy and anger as fuel to achieve and "show them they were wrong."

The reactions are usually unique to the person and may blend and combine in ways that vary from person to person. Coping and racial identity status will be factors that influence the blend of symptom clusters and forms of expression. Therefore, how race-based stress or traumatic stress may be manifested in signs, symptoms, and reactions depends on the individual and a number of personal and social factors, which, again, were discussed and described previously. The person's racial–cultural, social, familial, and community as well as personal attributes and unique perspective and way of understanding his or her life are critical aspects needed to recognize and assess race-based traumatic stress. However, some general trends can be discussed.

For most traumatic experiences, people show signs of reexperiencing (intrusion) the event(s). In the case of race-based traumatic stress, the

encounters may be clustered or cumulative, and perhaps a last straw event may serve as the trigger for the trauma. For example, one may be stressed, but the level of stress may not reach the threshold for being traumatic until the trigger or last straw. In such an instance, the trigger experience may be a minor or major event.

Many people of Color may report that their stress is not because of one event, but they might say that a series of emotional wounds and blows were experienced. Others may report that slight cuts and scratches in time grew into gaping wounds and that these larger wounds might be the basis of her or his race-based traumatic stress injury. Cose (1993) described the experiences of Anita Allen, who was a law school professor and had earned her law degree and a doctoral degree from prestigious universities:

> One year when she was a teaching fellow she was confronted by a White male student who asked her "what gives you the right to teach this class?" She assumed a similar challenge would not have been made had she been male and white. Indeed the man who recruited her . . . told her, in effect, that she would not have been hired had she been white. "I'm not sure you have the power we're looking for," she recalls him saying, in assessing her intellectual ability and drive. (p. 21)

Allen shrugged off the slight and threw herself into her work. But she found herself experiencing "a sense of irrelevance" at the law school where the work was difficult and demeaning. Yet Cose (1993) observed that

> her academic struggle was compounded by a sense of being subjected to heightened scrutiny, by what she calls "the pressure of being a black person under the microscope." The pressure became so intense that she suffered depression and migraine headaches, and her physician put her on anti-seizure drugs. After law school the racial tension did not abate . . . as a law professor she again absorbed racial blows after an address . . . she found herself talking to a middle-aged white man who explained that she should not take offense at being called a jungle bunny because "you are cute and so are bunnies." On another occasion a white scholar said she reminded him of his "family's maid." (pp. 21-22)

The slights and blows Allen experienced continued. It is not clear if she experienced race-based traumatic stress injury, but this example does illustrate many of its features and highlights the types of experiences many people of Color endure. The depression and severe headaches do seem to be symptom clusters that could very well signal race-based traumatic stress injury. The example also shows how many experiences return in various ways throughout one's life, illustrating the cumulative elements described previously.

The sign of reexperiencing may take the form of thoughts or images. Perhaps Allen had flashes of the event(s) return to her consciousness, or she may have had thoughts that intruded on her during the day without warning. Traumatic experiences by definition are painful, so much so that the person relives that event (last straw) in various ways, yet at the same time works psychologically to avoid the memory (avoidance) and the pain it causes. Thus, one is left with a pervasive feeling of vulnerability like a wound that will not heal. The reactions can manifest as depression, general anxiety, irritability, hostility, poor social and interpersonal relationships, lack of trust in people, self-blame, or various combinations of all these reactions.

There may have been manifestations of reexperiencing an affect that took the form of anger, a common and acceptable from of emotional expression for many men (and women) of Color, or anxiety as reflected in the sense of feeling irrelevant. One may also experience increased irritability. For issues associated with race, one's interpersonal relationships may suffer as the field of people you can trust narrows or as the strain of the stress begins to put you on edge. Relationships could become strained, or the person might be more distant than he or she was prior to the trigger event(s). There may be simply a feeling of discomfort or a knot in the stomach as one returns to the area or has a memory of the event(s). This reaction can also be expressed in one's action or behavior through being extremely active or through aggression either toward oneself or others.

For some, somatic or physiological reactions, such as the headaches Professor Allen experienced in law school, may be the primary form of reaction to the trauma(s). The person of Color might also develop physical problems such as high blood pressure, become overweight, or highly reactive to things that are reminders of the stress or trauma. Recall the Epstein (2003) description, in the section on stress, about people of Color who were physically ill from their neighborhood environments. Many of these individuals' health improved when they moved to less stressful communities.

It is also possible that one's reaction to trauma is expressed through several modalities: The reaction may (a) be in the person's subconscious and come to consciousness by way of flashbacks or nightmares; (b) make it difficult for the individual to focus or concentrate, or (c) make the person feel restless and become frustrated easily. For example, many men of Color must be hypervigilent for the sake of survival as they move through their day because of the stress and trauma of racism. As discussed in the review of physiological studies, racism causes people to rehearse reactions, responses, and defensive actions. The review also suggests that anxiety and worry were associated with the efforts to cope and that the mental states associated with racism can lead to greater physical problems such as increases in heart rate, blood pressure, and blood sugar.

Avoidance of a traumatic experience can be manifested in several ways. One way is cognitive in that one may forget or treat the experience(s) as unreal or as something other than racism (distortion).

One man described is denial this way:

> You become a chameleon. You take on the characteristics of what's going on there. It goes everything form patterns of speech, your philosophies. Because I don't think all the time your openly, I mean your not totally honest. You know what [White] people want to hear and more than anything else you give them back your feedback; you regurgitate back to them what you think they need to hear. (Feagin & Sikes, 1994, p. 280)

To live through a lifetime of racism in many areas of one's life requires a certain amount of denial. When the denial becomes loss of memory for the event(s), this could be a sign that the event was traumatic. On an emotional level, one can become numb to the impact of the constant or sudden assaults to one's dignity or sense of self. Thus, one's capacity to feel a range of emotions may be compromised. Or it may be that the person splits the experience(s) from her or his emotions and attaches few feelings to the event(s) as a way to avoid the emotional pain. One may elect to avoid things and the people that contributed to the trauma or stress, and may retreat physically or psychologically into a safer world where it is difficult to be reached by the pain of racism.

These reactions may also occur with depression, aggression, shifts in self-esteem, racial identity confusion, complicated interpersonal relationships, and strong feelings of shame and guilt. Targets might feel responsible for the circumstances that they find themselves in, perhaps without being aware that racism played a major role. Alternately, targets might be aware of racism but might feel helpless to deal with its presence or impact.

IMPLICATIONS FOR TRAINING AND PRACTICE

The ideas presented here would unlikely be taught currently as part of most mental health training programs. It is not apparent how much attention programs give to racial issues in assessment or intervention courses. Nevertheless, the specific issue of psychological harm from racism should be included in mental health and counseling psychology training programs. However, the model being presented here advocates for considering specific types of experiences as outlined previously rather than the broad use of the term *racism*. Also, training should highlight the fact that stress from racism is a valid and significant mental health concern regardless of whether the experiences can be "objectively" confirmed or are subjectively experienced

or reported by the target. Research has indicated that both types of experiences have a recognizable and measurable mental health impact. Training and practice that includes consideration of race-based traumatic stress injury should focus on the often hidden and subtle aspects of racial discrimination, racial harassment, and discriminatory harassment and should not rule out these experiences, even in instances in which both the actors and targets were people of Color. Training mental health professionals to identify specific, subtle, and indirect forms of racism is important because doing so may enable clinicians to assist clients in minimizing the self-blame that occurs when such incidents are misinterpreted as the result of personal failings. In addition, training needs to highlight a fact revealed in research that people from different racial groups may experience and express their emotional reactions in very distinct ways. Therefore, the variation of emotional expression for particular racial groups needs to be a core aspect of any training program for students or professionals.

Perhaps programs might integrate such training into general multicultural courses or into assessment courses, paying specific attention to racism as a particular source of stress and trauma. The topic of racism should not be confused with prejudice because the two are quite distinct, as noted previously. Integration of racism into mental health and counseling psychology training programs would also require attention to both its health and mental health impacts. Moreover, it would be necessary to go beyond individual experiences and incorporate consideration of systemic, institutional, and cultural elements of racial inequity. The training programs would require that the complexity of racism and its associated health and mental health disparities might need a course of its own or comprehensive infusion of the topic in various courses. This topic could be included as an aspect of a social-justice-oriented curriculum when the issue is part of course offerings.

Practice issues emerge from some of the points noted previously about training, with the added dimension that most practicing professionals are working outside of training situations. For these professionals, they would need to attend continuing education courses or workshops to learn the latest approach to assessing race-based traumatic stress injury. In addition, for these specific individuals, there also would be a need to broaden their perspectives to social issues that create stress for clients and patients, which would mean less reliance on the strict models of assessment offered by *DSM–IV–TR* and would also require giving more meaning and salience to the clients' reports of the various sources of stress and trauma. Those individuals participating in the training program would need to attend to her or his own racial identity status development so that one's own racial identity status does not function as a barrier to the assessment of race-based traumatic stress injury. Professionals could work to document and advocate for

organizational and institutional guidelines for racial harassment in schools and work settings. A more specific characterization of the experience of racism as discriminatory harassment, racial discrimination, or racial harassment can be used to help clients cope and grasp their experience more clearly. In addition, workshops for organizations might be developed to help them understand and recognize the hidden and subtle forms of acts of avoidance, aversive hostility, and hostile racism.

RESEARCH IMPLICATIONS

There are several implications for research that come from the ideas presented in this article. One is the need for trauma researchers to consider racial–cultural contexts and the role of racism in the development of PTSD. Researchers might work to develop instruments for measuring specific types of racism. Many studies used a few items to measure discrimination. It would be of value to assess the impact of discrimination in particular developmental periods to determine the relative impact of such experiences on the developmental process. Some studies indicated that families, adolescents, and young adults are affected by such experiences. However, it is not clear if the experiences of one's life are cumulative or if the experiences are distinct given one's level of maturity. Researchers might consider how race-related stress and trauma are connected. Many measures of discrimination and race-related stress use lifetime and past year as time periods for documenting the stress of racism. Additional instruments are needed that use more recent encounters with racism to assess stress and trauma. The model of the specific classes or types of experiences as discrimination, harassment, and discriminatory harassment might lead to research on the specific mental or health effects of each, thus helping to document the relative impact of the various types of experiences. Also, it would aid the assessment of race-based traumatic stress if an instrument were available to assess how specific encounters with racism become traumatic.

SUMMARY AND CONCLUSION

In this article, an overview and integration of the research and scholarship on racism, stress, trauma, discrimination, racial identity, and coping was presented, and a new strategy for assessing and recognizing race-based traumatic stress injury was introduced. It has been argued that specific forms or classes of racism, racial discrimination, racial harassment, and discriminatory harassment be used to understand people's race-based experiences and

to determine the relative mental health effects of each. Race-based traumatic stress injury is presented as a nonpathological category to be used by mental health professionals to identify and assess people of Color's encounters with racism that produce stress and trauma. Mental health scholars and practitioners have neglected the experience of race-based traumatic stress in the lives of people of Color, and thus it is argued that a race-specific mental health standard be used.

To fully understand race-based traumatic stress, it is necessary to employ a system-focused perspective that considers the helping professional and client in a racial and historical context that is interactive and mutually influencing. At the same time, within racial group psychological variability is a critical aspect of how researchers and professionals assess people's racial experiences. It is imperative that the psychological and emotional experience of racism not be overlooked, even if there is considerable effort in our society to hide racism and to keep targets silent. The distinction between the three types of racism and the nonpathological category is important for mental health professionals because they may be consulted by people of Color for help in coping with or to redress race-based violation(s).

REFERENCES

Abdullah, A. S. (1998). Mammy-ism: A diagnosis of psychological misorientation for women of African descent. *Journal of Black Psychology*, *24*(2), 196-210.

Adams, M., Bell, L. A., & Griffin, P. (Eds.). (1997). *Teaching for diversity and social justice: A sourcebook.* New York: Routledge Press.

Akbar, M. (1984). *Chains and images of psychological slavery.* Jersey City, NJ: New Mind Productions.

Allison, K. (1998). Stress and oppressed social category membership. In J. K. Swim & C. Stangor (Eds.), *Prejudice: The target's perspective*. New York: Academic Press.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorder* (4th ed., text rev.). Washington, DC: Author.

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist*, *58*(5), 377-402.

Ani, M. (1994). *Yurugu: An African-centered critique of European cultural thought and behavior.* Trenton, NJ: African World Press.

Ani, M. (1996). The Afrikan asili. In J. Ladner & S. Gbadegisin (Eds.), *Ethics, higher education, and social responsibilities* (pp. 1–14). Washington, DC: Howard University Press.

Bell, D. (2000). *Race, racism and American law* (4th ed.). Gaithersburg, MD: Aspen Publishers.

Bennett, G. G., Merritt, M. M., Edwards, C. L., & Sollers, J. J. (2004). Perceived racism and affective responses to ambiguous interpersonal interactions among African American men. *American Behavioral Scientist, 47*(7), 63-76.

Biasco, F., Goodwin, E. A., & Vitale, K. L. (2001). College students' attitudes towards racial discrimination. *College Student Journal, 35*, 523-529.

Boone, M. L., Neumeister, D. W., & Charney, C. L. (2003). In R. J. Usano & A. E. Norwood (Eds.), *Trauma and disaster: Responses and management* (pp. 1-30). Washington, DC.: American Psychiatric Publishing.

Bowser, B. P., & Hunt, R. (Eds.). (1996). *Impacts of racism on White Americans* (2nd ed.). Thousand Oaks, CA: Sage.

Braithwaite, R. L., & Taylor, S. E. (Eds.). (2001). *Health issues in the Black community* (2nd ed.). San Francisco: Jossey-Bass.

Branscombe, N. R., Schmitt, M. T., & Harvey, R. D**.** (1999). Perceiving pervasive discrimination among African–Americans: Implications for group identification and well-being. *Journal of Personality and Social Psychology, 77,* 135-149.

Breslau, N. (2001). The epidemiology of posttraumatic stress disorder: What is the extent of the problem? *Journal of Clinical Psychiatry, 62,* 16-22.

Broman, C. L., Mavaddat, R., & Hsu, S. (2000). The experience and consequences of perceived racial discrimination. *Journal of Black Psychology*, 26(2), 165-180.

Brondolo, E., Rieppi, R., Kelly, K. P., & Gerin, W. (2003). Perceived racism and blood pressure: A review of the literature and conceptual and methodological critique. *Annals of Behavioral Medicine, 25,* 55-65.

Brown, D. R., & Gary, L. E. (1988). Stressful life events, social support networks, and physical and mental health of urban Black adults. *Journal of Human Stress, 13*, 165-173.

Brown, T. N. (2001). Measuring self-perceived racial and ethnic discrimination in social surveys. *Sociological Spectrum, 21*, 377-392.

Bryant-Davis, T., & Ocampo, C. (2005). Racist-incident-based trauma. *The Counseling Psychologist, 33*(4), 479-500.

Bulhan, H. A. (1985). *Frantz Fanon and the psychology of oppression*. New York: Plenum Press.

Butts, H. (2002). The black mask of humanity: Racial/ethnic discrimination and post-traumatic stress disorder. *Journal of the American Academy of Psychiatry and the Law, 30,* 336-339.

Caldwell, C. H., Kohn-Wood, L. P., Schmeelk-Cone, K. H., Chavous, T. M., & Zimmerman, M. A. (2004). Racial discrimination and racial identity as risk or protective factors for violent behaviors in African American young adults. *American Journal of Community Psychology*, *33*, 91-105.

Carlson, E. B. (1997). *Trauma assessments: Clinician's guide*. New York: Guilford.

Carter, R. T. (1995). *Race and racial identity in psychotherapy: Toward a racially inclusive model*. New York: Wiley.

Carter, R. T. (2004). *Disaster response to communities of Color: Cultural responsive intervention* (Technical Report for the Connecticut Department of Mental Health and Addiction [DMHAS]). Retrieved from http://www.dmhas.state.ct.us

Carter, R. T. (2005). Uprooting inequity and disparities in counseling and psychology: An introduction. In R. T. Carter (Ed.), *Handbook of racial–cultural counseling and psychology: Theory and research* (Vol. 1, pp. xv-xxviii). New York: Wiley.

Carter, R. T., Forsyth, J., Mazzula, S., & Williams, B. (2005). Racial discrimination and race-based traumatic stress. In R. T. Carter (Ed.), *Handbook of racial–cultural psychology and counseling: Training and practice* (Vol. 2, pp. 447-476). New York: Wiley.

Carter, R. T., Forsyth, J., Williams, B., & Mazzula, S. (2005). *Racism as a predictor of psychological injury: Implications for psychology and the law.* Manuscript submitted for publication.

Carter, R. T., & Gesmer, E. (1997). Applying racial identity theory to the legal system: A case of family law. In C. Thompson & R. T. Carter (Eds.), *Racial identity theory: Applications to individual, group, and organizational interventions* (pp. 219-236). Mahwah, NJ: Erlbaum.

Carter, R. T., & Helms, J. E. (2002, September). *Racial discrimination and harassment: A race based traumatic stress disorder*. Paper presented at the American College of Forensic Examiners Conference, Orlando, FL.

Carter, R. T., Helms, J. E., & Juby, H. (2004). The relationship between racism and racial identity profiles. *Journal of Multicultural Counseling and Development, 30*, 19-29.

Carter, R. T., & Pieterse, A. L. (2005). Race: A social and psychological analysis of the term and its meaning. In R. T. Carter (Ed.), *Handbook of racial–cultural psychology and counseling: Theory and research* (Vol. 1, pp. 41-63). Hoboken, NJ: Wiley.

Chapleski, E., Kaczynski, R., Lichtenberg, P. A., & Gerbi, S. A. (2004). American Indian elders and depression: The effects of life events over time. *Journal of Applied Gerontology*, *23*(1), 1-18.

Clark, R., Anderson, N., Clark, V. R., & Williams, D. R. (1999). Racism as a stressor for African Americans: A biopsychosocial model. *American Psychologist, 54*, 805-816.

Coard, S. I., Breland, A. M., & Raskin, P. (2001). Perceptions of and preferences for skin color, black racial identity, and self-esteem among African Americans. *Journal of Applied Social Psychology, 31*, 2256-2274.

Cohen, J. I. (2000). Stress and mental health: A biobehavioral perspective. *Issues in Mental Health Nursing, 21*, 185-202.

Cohen, S., & Williamson, G. (1988). Perceived stress in a probability sample in the United States. In S. Oskamp (Ed.), *The social psychology of health* (Vol. 13, pp. 123-128). Newbury Park, CA: Sage.

Collins, J., David, R., Handler, A., Wall, S., & Andes, S. (2004). Very low birth weight in African American infants: The role of maternal exposure to interpersonal racial discrimination. *American Journal of Public Health, 94,* 2132-2138.

Comas-Diaz, L. (1994). An integrative approach. In L. Comas-Diaz & B. Greene (Eds.), *Women of Color: Integrating ethnic and gender identities in psychotherapy* (pp. 287-318). New York: Guilford.

Comas-Diaz, L., & Jacobsen, F. M. (2001). Ethnocultural allodynia. *Journal of Psychotherapy Practice and Research*, *10*(4) 246-252.

Contrada, R. J., Ashmore, R. D., Gary, M. L., Coups, E., Egeth, J. D., Sewell, A., et al. (2001). Measures of ethnicity-related stress: Psychometric properties, ethnic group differences, and associations of well-being. *Journal of Applied Psychology, 31*, 1775-1820.

Cose, E. (1993). *The rage of a privileged class*. New York: HarperCollins.

Danoff-Burg, S., Prelow, H. M., & Swenson, R. R. (2004). Hope and life satisfaction in Black college students coping with race-related stress. *Journal of Black Psychology, 30,* 208-228.

Deitch, E. A., Barsky, A., Butz, R. M., Brief, A. P., Chan, S. S. Y., & Bradley, J. C. (2003). Subtle yet significant: The existence and impact of everyday racial discrimination in the workplace. *Human Relations, 56,* 1299-1324.

Delgado, A. K. (1982). On being black. In F. X. Acosta, J. Yamamoto, & L. A. Evans (Eds.), *Effective psychotherapy for low-income and minority patients* (pp. 109-116). New York: Plenum Press.

DeLongis, A., Coyne, J. C., Dakof, G., Folkman, S., & Lazarus, R. S. (1982). Relationship of daily hassles, uplifts, and major life events to health status. *Health Psychology, 1,* 119-136.

Din-Dzietham, R., Nembhard, W. N., Collins, R., & Davis, S. K. (2004). Perceived stress following race-based discrimination at work is associated with hypertension in African–Americans: The Metro Atlanta Heart Disease Study, 1999-2001. *Social Science and Medicine*, *58*, 449-461.

Dohrenwend, B. P. (2000). The role of adversity and stress in psychopathology: Some evidence and its implications for theory and research. *Journal of Health and Social Behavior, 41*, 1-19.

Dovidio, J. F., & Gaertner, S. L. (1998). On the nature of contemporary prejudice: The causes, consequences and challenges of aversive racism. In S. T. Fiske & J. L. Eberhardt (Eds.), *Racism: The problem and the response* (pp. 123-134). Newbury Park, CA: Sage.

Dovidio, J. F., Gaertner, S. L., Kawakami, K., & Hodson, G. (2002). Why can't we just get along? Interpersonal biases and interracial distrust. *Cultural Diversity & Ethnic Minority Psychology, 8,* 88-102.

Eberhardt, J. L., & Fiske, S. T. (Eds.). (1998). *Confronting racism: The problem and the response*. London: Sage.

Epstein, H. (2003, October). Ghetto miasma: Enough to make you sick. *The New York Times Magazine, 56,* 10-16.

Essed, P. (1991). Understanding everyday racism: An interdisciplinary interdisciplinary theory. Newbury Park, CA: Sage.

Feagin, J. R. (2000). *Racist America: Roots, current realities, and future directions*. New York: Routledge Press.

Feagin, J. R., & McKinney, K. D. (2003). *The many costs of racism*. Lanham, MD: Rowman and Littlefield.

Feagin, J. R., & Sikes, M.P. (1994). *Living with racism: The black middle-class experience.* Boston: Beacon Press.

Feagin, J. R., & Vera, H. (1995). *White racism*. New York: Routledge Press.

Feagin, J. R., Vera, H., & Batur, P. (2001). *White racism* (2nd ed.). New York: Routledge Press.

Fisher, C. B., Wallace, S. A., & Fenton, R. E. (2000). Discrimination distress during adolescence. *Journal of Youth and Adolescence*, *29*(6), 679-695.

Forman, E. A. (2003). A sociocultural approach to mathematics reform: Speaking, inscribing, and doing mathematics within communities of practice. In J. Kilpatrick, W. G. Martin, & D. Schifter (Eds.), *A research companion to principles and standards for school mathematics* (pp. 333-352). Reston, VA: National Council of Teachers of Mathematics.

Franklin, A. J. (1999). Invisibility syndrome and racial identity development in psychotherapy and counseling African American. *Counseling Psychologist, 27*, 761-793.

Franklin, A. J. (2004). *From brotherhood to manhood: How black men rescue their relationships and dreams from the invisibility syndrome.* New York: Wiley.

Franklin, D. C., & Carter, R. T. (2007). *Racism related stress, racial identity and psychological health for Black Americans*. *Journal of Black Psychology, 33*(1).

Freire, P. (1993). *Pedagogy of the oppressed* New York: Continuum.

Frueh, B. C., Brady, K. L., & de Arellano, M. A. (1998). Racial differences in combat-related PTSD: Empirical findings and conceptual issues. *Clinical Psychology Review*, *18*(3), 287-330.

Frueh, B. C., Hamner, M. B., Bernat, J. A., Turner, S. M., Keane, T. M., & Arana, G. W. (2002). Racial differences in psychotic symptoms among combat veterans with PTSD. *Depression and Anxiety, 16*(4), 157-161.

Garbarino, J., Dubrow, N., Kostelny, K., & Pardo, C. (1992). *Children in danger.* San Francisco: Jossey-Bass.

Gary, L. E. (1995). African American men's perceptions of racial discrimination: A sociocultural analysis. *Social Work Research, 19*, 207-217.

Gleser, G. C., Green, B. L., & Winget, C. (1981). *Prolonged psychosocial effects of disaster: A study of Buffalo Creek*. New York: Academic Press.

Goldberg, D. T. (Ed.). (1990). *Anatomy of racism.* Minneapolis: University of Minnesota Press.

Goto, S. G., Gee, G. C., & Takeuchi, D. T. (2002). Strangers still? The experience of discrimination among Chinese Americans. *Journal of Community Psychology*, *30*(2)*,* 211-224.

Green, L. (1995). Race in the twenty-first century: Equality through law? In K. Crenshaw, N. Gotanda, G. Peller, & K. Thomas (Eds.), *Critical race theory: The key writings that formed the movement* (pp. 29-45). New York: Free Press.

Guthrie, B. J., Young, A. M., Williams, D. R., Boyd, C. J., & Kintner, E. K. (2002). African American girls' smoking habits and day-to-day experiences with racial discrimination. *Nursing Research, 51,* 183-189.

Guyll, M., Matthews, K. A., & Bromberger, J. T. (2001). Discrimination and unfair treatment: Relationship to cardiovascular reactivity among African American and European American women. *Health Psychology, 20,* 315-325.

Hansen, N. D., Randazzo, K. V., Schwartz, A., Marshall, M., Kalis, D., Frazier, R., et al. (2006). Do we practice what we preach? An exploratory survey of multicultural psychotherapy competencies. *Professional Psychology: Research and Practice, 37*(1), 66-74.

Harrell, J. P. (2000). A multidimensional conceptualization of racism-related stress: Implications for the well-being of people of Color. *American Journal of Orthopsychiatry, 70,* 42-57.

Harrell, J. P., Hall, S., & Taliaferro, J. (2003). Physiological responses to racism and discrimination: An assessment of the evidence. *American Journal of Public Health, 93*(2), 243-248.

Helms, J. E. (1990). *Black and white racial identity: Theory, research and practice*. Westport, CT: Greenwood.

Helms, J. E. (2001). An update of Helms's White and people of Color racial identity models. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed., pp. 181-198). Thousand Oaks, CA: Sage.

Helms, J. E., & Cook, D. (1999). *Using race and culture in counseling and psychotherapy*. Needham, MA: Allyn & Bacon.

Helms, J. E., Jernigan, M., & Mascher, J. (2005). The meaning of race in psychology and how to change it: A methodological perspective. *American Psychologist*, *60*, 27-36.

Herman, J. L. (1992). Trauma and recovery: *The aftermath of violence from domestic abuse to political terror*. New York: Basic Books.

Hite, D. (2004). A random utility model of environmental equity. *Growth and Change*, *31*, 40-58.

Jackson, J. S., Brown, T. N., Williams, D. R., Torres, M., Sellers, S. L., & Brown, K. (1996). Racism and the physical and mental health status of African Americans: A thirteen year national panel study. *Ethnicity and Disease, 6*(1-2), 132-147.

Jackson, V. A., Palpepu, A., Szalacha, L., Caswell, C., Carr, P. L., & Inui, T. (2003). "Having the right chemistry": A qualitative study of mentoring in academic medicine. *Academic Medicine, 78*(3), 328-334.

Jaynes, G. D., & Williams, R. M. (1989). *A common destiny: Blacks and American society.* Washington, DC: National Academies Press.

Jefferson, S. D., & Caldwell, R. (2002). An exploration of the relationship between racial identity attitudes and the perception of racial bias. *Journal of Black Psychology, 28*(2), 174-192.

Johnson, R. (1993). Clinical issues in the use of the *DSM–III–R* with African American children: A diagnostic paradigm. *Journal of Black Psychology, 19*(4), 447-460.

Jones, J. M. (1972). *Prejudice and racism.* Reading, MA: Addison Wesley.

Jones, J. M. (1997). *Prejudice and racism* (2nd ed.). New York: McGraw-Hill.

Jones, J. M. (1998). The essential power of racism: Commentary and conclusion? In J. L. Eberhardt & S. T. Fiske (Eds.), Confronting racism*: The problem and the response* (pp. 280-294). Thousand Oaks, CA: Sage.

Jones, J. M., & Carter, R. T. (1996). Racism and white racial identity: Merging realities. In B. Bowser & R. Hunt (Eds.), *Impacts of racism on white America* (2nd ed., pp. 1-23). Thousand Oaks, CA: Sage.

Kanner, A. D., Coyne, J. C., Schaefer, C., & Lazarus, R. S. (1981). Comparison of two modes of stress measurements: Daily hassles and uplifts versus major life events. *Journal of Behavioral Medicine, 4,* 1-39.

Kerner, O. (1968). *Kerner report: The 1968 report of the National Advisory Commission on Civil Disorders*. Washington, DC: Knopf.

Kessler, R. C. (1997). The effects of stressful life events on depression. *Annual Review of Psychology*, *48*, 191-214.

Kessler, R. C., Mickelson, K. D., & Williams, D. R. (1999). The prevalence, distribution and mental health correlates of perceived discrimination in the United States. *Journal of Health and Social Behavior, 40,* 208-230.

Kessler, R. C., Mickelson, K. D., & Zhao, S. (1997). Patterns and correlates of self-help group membership in the United States. *Social Policy, 27*, 27-46.

Klonoff, E., & Landrine, H. (1999). Cross validation of the schedule of racist events. *The Journal of Black Psychology, 25,* 231-254.

Klonoff, E., & Landrine, H. (2000). Is skin color a marker for racial discrimination? Explaining the skin color–hypertension relationship. *Journal of Behavioral Medicine, 23*(4), 329-338.

Klonoff, E. A., Landrine, H., & Ullman, J. B. (1999). Racial discrimination and psychiatric symptoms among Blacks. *Cultural Diversity and Ethnic Minority Psychology, 5*, 329-339.

Kovel, J. (1970). *White racism: A psychohistory*. New York: Pantheon.

Kubany, E. S., Leisen, M. B., Kaplan, A., & Kelly, M. (2000). Validation of a brief measure of post traumatic stress disorder: The Distressing Event Questionnaire (DSQ). *Psychological Assessment, 12*, 197-209.

Kulka, R. A., Schlenger, W. E., Fairbank, J. A., Hough, R. L., Jordan, B. K., Marmar, C. R., et al., (1990). *The national Vietnam veterans readjustment study*. New York: Brunner Mazel.

Landrine, H., & Klonoff, E. A. (1996). The schedule of racist events. *Journal of Black Psychology, 22*, 144-168.

Lazarus, R. S. (1999). *Stress and emotion: A new synthesis*. New York: Springer.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal and coping*. New York: Springer.

Levy, R. L., Cain, K. C., Jarrett, M., & Heit-Kemper, M. M. (1997). The relationship between daily life stress and GI symptoms in women with irritable bowel syndrome. *Journal of Behavioral Medicine*, *20,* 177-193.

Liang, C. T. H., Li, L. C., & Kim, B. S. K. (2004). The Asian American racism-related stress inventory: Development, factor analysis, reliability, and validity. *Journal of Counseling Psychology, 51,* 103-114.

Loo, C. M., Fairbank, J. A., Scurfield, R. M., Ruch, L. O., King, D. W., Adams L. J., et al., (2001). Measuring exposure of racism: Development and validation of a race-related stressor scale (RRSS) or Asian American Vietnam Veterans. *Psychological Assessment, 13,* 503-520.

Marger, M. (2003). *Race and ethnic relations: American and global perspectives* (6th ed). Belmont, CA: Wadsworth/Thomson Learning.

Martin, J. K., Tuch, S. A., & Roman, P. M. (2003). Problem drinking patterns among African Americans: The impacts of reports of discrimination, perceptions of prejudice, and "risky" coping strategies. *Journal of Health and Social Behavior, 44,* 408-425.

Martin, R. A. (1989). Techniques for data acquisition and analysis in field investigations of stress. In R. W. J. Neufeld (Ed.), *Advances in the investigation of psychological stress*. New York: Wiley.

McConahay, J. B. (1986). Modern racism, ambivalence, and the modern racism scale. In J. F. Dovidio & S. L. Gaertner (Eds.), *Prejudice, discrimination and racism* (pp. 91-126). New York: Academic Press.

McLean, D. E., & Link, B. G. (1994). Unraveling complexity: Strategies to refine concepts, measures, and research designs in the study of life events and mental health. In W. R. Avison & I. H. Gotlib (Eds.), *Stress and mental health: Contemporary issues and prospects for the future* (pp. 15-42). New York: Plenum Press.

McNeil, D. W., Porter, C. A., Zvolensky, M. L., Chaney, J. M., & Marvin, K. (2000). Assessment of culturally related anxiety in American Indians and Alaska natives. *Behavior Therapy, 31,* 301-325.

Merriam-Webster's collegiate dictionary (11th ed.). (2003). Springfield, MA: Merriam-Webster.

Monroe, S. M., & Peterman, A. M. (1988). Life stress and psychopathology. In L. Cohen (Ed.), *Life events and psychological functioning: Theoretical and methodological issues* (pp. 25-36). Thousand Oaks, CA: Sage.

Mossakowski, K. N. (2003). Coping with perceived discrimination: Does ethnic identity protect mental health? *Journal of Health and Human Behavior, 44,* 318-331.

Murry, V. M., Brown, P. A., Brody, G. H., Cutrona, C.E., & Simons, R. L. (2001). Racial discrimination as a moderator of the links among stress, maternal psychological functioning, and family relationships. *Journal of Marriage and the Family, 63,* 915-926.

Mustillo, S., Krieger, N., Gunderson, E. P., Sidney, S., McCreath, H., & Kiefe, C. I. (2004). Self-reported experiences of racial discrimination and Black–White differences in preterm and low-birth weight deliveries: The CARDIA Study. *American Journal of Public Health, 94*(12)*,* 2125-2131.

Neighbors, H., & Williams, D. R. (2001). Racism, discrimination and hypertension: Evidence and needed research. *Ethnicity & Disease, 11*, 800-816.

Neville, H. A., Heppner, P. P., & Wang, L. F. (1997). Relations among racial identity attitudes, perceived stressors, and coping styles in African American college students. *Journal of Counseling and Development, 75*, 303-311.

Nghe, L., & Mahalik, J. R. (2001). Examining racial identity statuses as predictors of psychological defenses in African–American college students. *Journal of Counseling Psychology*, *48*, 10-16.

Noh, S., & Kaspar, V. (2003). Perceived discrimination and depression: Moderating effects of coping, acculturation, and ethnic support. *American Journal of Public Health, 93*, 232-238.

Norris, F. (1992). Epidemiology of trauma frequency and impact of different potentially traumatic events on different demographic groups. *Journal of Consulting and Clinical Psychology, 60*(3), 409-418.

Norris, F., Friedman, M., & Watson, P. (2002). 60,000 disaster victims speak: Part II. Summary and implications of the disaster mental health research. *Psychiatry, 65,* 240-260.

Norris, F., Friedman, M., Watson, P., Byrne, C., Diaz, E., & Kaniasty, K. (2002). 60,000 disaster victims speak: Part I. An empirical review of the empirical literature, 1981-2001. *Psychiatry, 65,* 207-239.

Norris, F. H. (1990). Epidemiology of trauma frequency and impact of different potentially traumatic events on different demographic groups. *Journal of Consulting and Clinical Psychology, 60*, 409-418.

Omi, M., & Winant H. (1986). *Racial formation in the United States: From the 1960s to the 1980s*. New York: Routledge Press.

Omi, M., & Winant H. (1994). *Racial formation in the United States: From the 1960s to the 1990s* (2nd ed.). New York: Routledge Press.

Pak, A., Dion, K. L., & Dion, K. K. (1991). Social–psychological correlates of experienced discrimination: Test of the double jeopardy hypothesis. *International Journal of Intercultural Relations*, *15*, 243-254.

Pearlin, L. I. (1989). The sociological study of stress. *Journal of Health and Social Behavior, 30*, 241-256.

Perilla, J. L., Norris, F. H., & Lavizzo, E. A. (2002). Ethnicity, culture, and disaster response: Identifying and explaining ethnic differences in PTSD six months after hurricane Andrew. *Journal of Social and Clinical Psychology, 21,* 20-45.

Perkins, D. V. (1982). The assessment of stress using life event scales. In. L. Goldberger & S. Breznitz (Eds.), *Handbook of stress* (pp. 320-331). New York: Free Press.

Pierce, C. (1974). Psychiatric problems of the Black minority. In S. Arieti (Ed.), *American handbook of psychiatry* (pp. 512-523). New York: Basic Books.

Piotrkowski, C. S., & Brannen, S. J. (2002). Exposure, threat appraisal, and lost confidence as predictors of PTSD symptoms following September 11, 2001. *American Journal of Orthopsychiatry, 72,* 476-485.

Plummer, D. L., & Slane, S. (1996). Patterns of coping in racially stressful situations. *Journal of Black Psychology, 22*, 302-315.

Prelow, H. A., & Guarnaccia, C. A. (1997). Ethnic and racial differences in life stress among high school students. *Journal of Counseling and Development, 75*, 442-450.

Prilleltensky, I. (1994). *The morals and politics of psychology.* Albany: State University of New York Press.

Prilleltensky, I. (1995). The politics of abnormal psychology: Past, present, and future. In N. R. Goldberger & J. B. Veroff (Eds.), *The culture of psychology reader* (pp. 652-673). New York: New York University Press.

Prilleltensky, I., & Gonick, L. (1994). Politics change, oppression remains: On the psychology and politics of oppression. *Journal of Political Psychology*, *17*, 127-148.

Robin, R. W., Chester, B., Rasmussen, J. K., Jaranson, J. M., & Goldman, D. (1997). Prevalence and characteristics of trauma and posttraumatic stress disorder in a southwestern American Indian community. *American Journal of Psychiatry*, *154*(11), 1582-1588.

Romero, A. J., & Roberts, R. E. (2003). Stress within a bicultural context for adolescent of Mexican descent. *Cultural Diversity and Ethnic Minority Psychology, 9,* 171-184.

Rosenbloom, S. R., & Way, N. (2004). Experiences of discrimination among African–American, Asian–American, and Latino adolescents in an urban high school. *Youth & Society, 35,* 420-451.

Ruef, A. M., Litz, B. T., & Schlenger, W. E. (2000). Hispanic ethnicity and risk for combat-related posttraumatic stress disorder. *Cultural Diversity and Ethnic Minority Psychology, 6*, 235-251.

Ruggiero, K. M., & Taylor, D. M. (1997). Why minority group members perceive or do not perceive the discrimination that confronts them: The role of self-esteem and perceived control. *Journal of Personality and Social Psychology, 72*, 373-389.

Sanders-Thompson, V. (1996). Perceived experiences of racism as stressful life events. *Community Mental Health Journal, 32,* 223–233.

Sanders-Thompson, V. L. (2002). Racism: Perceptions of distress among African Americans. *Community Mental Health Journal*, *38,* 111-118.

Sanders-Thompson, V. L., Bazile, A., & Akbar, M. (2004). African–Americans' perceptions of psychotherapy and psychotherapists. *Professional Psychology: Research and Practice, 35,* 19-26.

Schneider, K. T., Hitlan, R. T., & Radhakrishnan, R. (2000). An examination of the nature and correlates of ethnic harassment experiences in multiple contexts. *Journal of Applied Psychology, 85*(1), 3-12.

Schwarzer, R., & Schulz, U. (2003). Stressful life events. In A. M. Nezu, C. M. Nezu, & P. A. Geller (Ed.), *Health psychology* (Vol. 9, pp. 27-49). New York: Wiley.

Scurfield, R. M., & Mackey, D. W. (2001). Racism, trauma and positive aspects of exposure to race-related experiences: Assessment and treatment implications. *Journal of Ethnic and Cultural Diversity in Social Work, 10,* 23-47.

Sellers, R. M., & Shelton, J. N. (2003). The role of racial identity in perceived racial discrimination. *Journal of Personality and Social Psychology, 84*, 1079-1092.

Slavin, L. A., Rainer, K. L., McCreary, M. L., & Gowda, K. K. (1991). Toward a multicultural model of the stress process. *Journal of Counseling and Development, 70*, 156-163.

Smedley, B. D., Stith, A. Y., & Nelson, A. R. (Eds.). (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care.* Washington, DC: National Academies Press.

Smith, E. M. J. (1985). Ethnic minorities: Life stress, social support, and mental health. *The Counseling Psychologist, 13*(4), 537-539.

Solorzano, D., Ceja, M., & Yosso, T. (2000). Critical race theory, racial microaggressions, and campus racial climate: The experiences of African American college students. *Journal of Negro Education, 69,* 60-73.

Spangenberg, J. J., & Pieterse, C. (1995). Stressful life events and psychological status in Black South African women. *Journal of Social Psychology, 135*(4), 439-445.

Steele, C. M. (1997). A threat in the air: How stereotypes shape intellectual identity and performance. *American Psychologist, 52,* 613-629.

Sue, D. W. (2003). *Overcoming our racism: The journey to liberation*. San Francisco: Jossey-Bass.

Sue, D. W., & Sue, D. (2003). *Counseling the culturally diverse* (4th ed). Hoboken, NJ: Wiley.

Taylor, J., & Turner, R. J. (2002). Perceived discrimination, social stress, and depression in the transition to adulthood. *Social Psychology Quarterly, 65*(3), 213-225.

Taylor, S. E. (1999). *Health psychology* (4th ed). Boston: McGraw-Hill.

Tennant, C. (2000). Life events, stress and depression: A review of recent findings. *Australian and New Zealand Journal of Psychiatry, 36*, 173-182.

Thompson, C. E., & Carter, R. T. (1997). *Racial identity theory: Applications to individual, group, and organizational interventions.* Mahwah, NJ: Erlbaum.

Thompson, C. E., & Neville, H. A. (1999). Racism, mental health, and mental health practice. *The Counseling Psychologist, 27,* 155-223.

Troxel, W. M., Matthews, K. A., Bromberger, J. T., & Sutton-Tyrrell, K. (2003). Chronic stress burden, discrimination, and subclinical cardiovascular (citation states carotid artery instead of cardiovascular) disease in African American and Caucasian women. *Health Psychology*, *22*, 300-309.

Turnbull, H. R., III, & Turnbull, A. P. (1998). *Free appropriate public education: The law and children with disabilities* (5th ed.). Denver, CO: Love Publishing Co.

Ulbrich, P. M., Warheit, G. J., & Zimmerman, R. S. (1989). Race, socioeconomic status, and psychological distress: An examination of differential vulnerability. *Journal of Health and Social Behavior, 30*, 131-146.

U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity: A supplement to mental health: A report of the Surgeon General.* Washington, DC: Author.

Utsey, S. O. (1997). Racism and the psychological well-being of African American men. *Journal of African American Men, 3*, 69-87.

Utsey, S. O. (1999). Development and validation of a short form of the Index of Race-Related Stress (IRRS) Brief Version. *Measurement and Evaluation in Counseling and Development, 32,* 149-166.

Utsey, S. O., Chae, M. H., Brown, C. F., & Kelly, D. (2002). Effect of ethnic group membership on ethnic identity, race-related stress, and quality of life. *Cultural Diversity and Ethnic Minority Psychology, 8,* 366-377.

Utsey, S. O., & Ellison, C. M. (2000). Utility of an African-centered support group for African American men confronting societal racism and oppression. *Cultural Diversity and Ethnic Minority Psychology, 5,* 156-165.

Utsey, S. O., & Payne, Y. A. (2000). Differential psychological and emotional impacts of race-related stress. *Journal of African American Men, 5,* 56-72.

Utsey, S. O., Payne, Y. A., Jackson, E., & Jones, A. M. (2002). Racism, quality of life indicators, and life satisfaction among elderly African Americans. *Cultural Diversity and Ethnic Minority Psychology, 32,* 149-166.

Utsey, S. O., & Ponterotto, J. G. (1996). Development and validation of the index of race related stress. *Journal of Counseling Psychology, 43*, 490-501.

Utsey, S. O., Ponterotto, J. G., Reynolds, A. L., & Cancelli, A. A. (2000). Racial discrimination, coping, life satisfaction, and self-esteem among African Americans. *Journal of Counseling and Development, 78*, 72-80.

Wallace, B. C., & Carter, R.T. (Eds.). (2003). *Understanding and dealing with violence: A multicultural approach.* Thousand Oaks, CA: Sage.

Watts, R. J., & Carter, R. T. (1991). Psychological aspects of racism in organizations. *Group and Organization Studies, 16,* 328-344.

Williams, D. R., Neighbors, H. W., & Jackson, J. S. (2003). Racial/ethnic discrimination and health: Findings from community studies. *American Journal of Public Health*, *93*(2), 200-208.

Williams, D. R., & Williams-Morris, R. (2000). Racism and mental health: The African American experience. *Ethnicity and Health, 5*, 243-268.