



TRAUMA AND POSTTRAUMATIC STRESS DISORDER IN ETHNIC MINORITIES

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Common Types of and Prevalence Estimates for Exposure to Traumatic Stressors

- **Any Trauma:** Lifetime prevalence of exposure to any trauma for racial/ethnic minorities varies by ethnic group: African-Americans (76.37%), Asian/Hawaiian/Pacific Islanders (66.38%), and Hispanics (68.17%; Roberts et al., 2011).
- **Posttraumatic Stress Disorder (PTSD):** The lifetime prevalence of PTSD is highest among African-Americans (8.7%), followed by Latina/os (7.0%), and lowest among Asians (4.0%; Roberts et al., 2011).
- **War-Related Trauma:** Lifetime prevalence of exposure trauma resulting from exposure to war, political violence, or war-related event is as follows (women/men): Asian/Hawaiian/Pacific Islanders (10.6%/19.14%), Latina/os (3.94%/10.3%), and African-Americans (2.09%/13.66%; Roberts et al., 2011).
- **Natural Disaster:** Lifetime prevalence of trauma due to a natural catastrophe (e.g., hurricanes, earthquakes, flood, fire) or man-made disaster (e.g., nuclear explosion) are highest among Latina/os (15.92%), followed by Asian/Hawaiian/Pacific Islanders (13.56%), and African-Americans (12.97%; Roberts et al., 2011).
- **Intimate Partner Violence:** Lifetime prevalence of being a victim of intimate partner violence (e.g., rape, physical violence, or stalking by an intimate partner) varies by gender (women/men): Multiracial individuals (53.8%/39.3%), American Indians/Alaska Natives (46%/45.3%), African-Americans (43.7%/38.6%), and Latina/os (37.1%/26.6%). Asian/Pacific Islanders have the lowest collective rates at 19.6% (Breiding et al., 2014).
- **Rape:** Lifetime prevalence of trauma due to rape for women is highest among American Indians/Alaska Natives (34.1%) followed by Multiracial women (24%), African-Americans (18.8%), and Asian/Pacific Islanders (6.8%). Research on prevalence rates for men is limited but existing data does demonstrate highest rates for Multiracial men (4.4%) followed by African-Americans (3.3%; Thoennes & Tjaden, 2006).
- **Physical Assault:** Lifetime prevalence of trauma due to physical assault varies by racial/ethnic group and gender (women/men) with American Indians/Alaska Natives having the highest rates (61.4%/75.2%), followed by Multiracial individuals (57.7%/70.2%), African-Americans (52.1%/66.3%), and Asian/Pacific Islanders (49.6%/58.8%; Thoennes & Tjaden, 2006).
- **Suicide:** The highest suicide rates are among American Indians/Alaska Natives (10.9%) followed by Latina/os (6.3%), Asians and Pacific Islanders (5.9%), and African-Americans (5.5%; Suicide Statistics, 2016).



- **Child Maltreatment:** Prevalence rates for child maltreatment is highest among African-Americans (15.3%), followed by American Indians/Alaska Natives (13.4%), Multiracial individuals (10.6%), Latina/os (8.8%), Pacific Islander (8.6%), and lowest among Asians (1.7%; U.S. Department of Health & Human Services, 2016).
- **Violent Crime:** The average annual rate of victim of violent victimization (rape/sexual assault, robbery, aggravated assault, simple assault) committed by strangers is highest among American Indian/Alaska Natives (28.2%) followed by Multiracial individuals (27.6%), African-Americans (13.3%), Latina/os (9.8%), and lowest among Asian/Pacific Islanders (5.9%; Harrell, 2012).
- **Hate Crime:** Racial/ethnic hate crimes are highest among African-Americans (62.7%), followed by Latina/os (47.4%), Asians (6.2%), American Indian/ Alaska Natives (4.6%), Multiracial individuals (3.7%), and lowest among Native Hawaiian/Pacific Islanders (.1%; U.S. Department of Justice, 2015).
- **Historical Trauma:** Historical trauma refers to the cumulative emotional and psychological wounding, as a result of group traumatic experiences that is transmitted across generations within a community. Existing prevalence rates for historical trauma are lacking, however this has been identified as an important issues among Native Americans (Ehlers et al., 2003; Heart, 2003; Sotero, 2006).

Behavioral and Physical Health Impact of Trauma on Ethnic Minorities

- Behavioral:
 - PTSD, a common outcome of trauma, has been linked to perceived discrimination, race-related verbal assault and racial stigmatization, combat experience, and interpersonal violence (Basset et al., 2013).
 - PTSD has also been linked to immigrant populations, including pre-migration trauma for Southeast Asian refugees and pre and post migration trauma among Latina/o immigrants (Beristianos et al., 2016).
 - Latina/os report higher rates of daily psychological distress (nervousness, sadness, hypervigilance, anxiety, depression) and lower quality of life as compared to other racial/ethnic groups (Bryant-Davis & Ocampo, 2006; Torres et al., 2011).
 - African-American men report greater negative cognitions including anger and fear and greater aggression compared to other groups (Smith & Patton, 2016).
 - Somatization of symptoms is common racial/ethnic minorities (Turner et al., 2016).
 - Trauma has also been linked to increased tobacco and substance use among racial/ethnic minority populations, with the highest rates among Native American populations (Ehlers et al., 2013).
- Physical:
 - Cardiovascular disease and other physical health conditions can be especially prevalent among immigrant populations (Alegria et al., 2008; Koo et al., 2014; Li, 2015).



- African -Americans exposed to traumatic events are more likely to suffer physical health problems (Graves et al., 2010).
- Factors that increase the risk and severity of adverse reactions for ethnic minority populations include:
 - Interpersonal factors such as intellectual disability, physical illness, prior suicidal behavior and ideation, impulsivity and aggression, low self-esteem, depressive thoughts, anxiety, and perfectionism (World Health Organization, 2015).
 - Social and situational factors such as poverty, witnessing community violence and/or domestic violence, experience abuse, number of traumatic experiences, association with violent peers, unmet basic needs, immigration status, unemployment, and incarceration (Turner et al., 2016; Vega & Rumbaut, 1991; World Health Organization, 2015).
 - Cultural and environmental factors such as racism, discrimination, intragroup marginalization, colorism, historical trauma, limited access to resources, and sociopolitical violence (Castillo et al., 2009; Chae, et al., 2008; Kessler et al., 1999; Perez et al., 2008; SAMSHA, 2015).
- Protective factors that decrease the risk and severity of adverse reactions for ethnic minority populations include:
 - Having a high locus of control, hopefulness, problem-solving skills, self-efficacy, social support, family cohesion, the use of community resources, social connectedness, positive racial identity, spiritual support and religious involvement, strong familial and cultural values (Neblett et al., 2012; Turner et al., 2016).

New Developments in Research on the Impact of Trauma on Ethnic Minorities

- Ethnic minorities are exposed to higher rates of trauma and are less likely to receive adequate mental health treatment due to service barriers and the lack of culturally informed treatment providers (Turner et al., 2016).
- Recent research has found positive associations between trauma and the following symptomology in ethnic minorities:
 - Delinquency
 - Aggression
 - Truancy
 - Somatic symptoms
 - Binge eating
 - Substance use
 - Suicidal thoughts
 - Risky sexual behavior
 - Depression
 - Psychotic symptoms
 - Anxiety



Clinical Considerations for Practitioners Treating Traumatized Ethnic Minorities

- Cultural variations in reactions to trauma and clinical presentations exist.
- Brief screening tools assess trauma across five domains often overlooked by health care providers: perceived discrimination, sexual abuse histories, family adversity, intimate partner violence, and trauma histories.
- Culturally informed trauma assessments take into consideration a targeted population's immigration history, religion, level of acculturation, language, health literacy, trust issues, logistical considerations, the family system, and a broader range of traumas including racism.
- Assessment should include careful attention to the cultural context in which the traumatic event occurred, the meaning ascribed to the event by the client as well as the client's culture, and culturally-informed coping strategies.
- It is important for providers to assess for potentially traumatic life events that may not fit the specific stipulations of a traumatic event as outlined by the Diagnostic and Statistical Manual for Mental Disorders-5 (e.g., culturally significant events with widespread community impact, immigration experiences, race-based trauma).
- Ethnic and racial minorities are less likely to seek treatment for PTSD and they face several barriers to psychotherapy, including mental health stigma, poor access to service facilities, lack of financial resources, mistrust of mental health professionals, perceptions of racial or ethnic bias in care providers, and preference for informal support resources (e.g., family members, church community).
- Special outreach efforts may be required to engage ethnic and racial minorities in treatment.
- When working with ethnic and racial minority clients, providers should consider the following strategies for retention: engage in behaviors that foster trust and mutuality in the therapeutic relationship, incorporation of culturally relevant sources of recovery (e.g., bolstering spiritual health and strengthening social support networks), open conversations about cultural differences that exist between client and therapist, and self-awareness of the therapists' culture and its impact on therapeutic assumptions and case conceptualization.

Information for Families and Friends of Traumatized Ethnic Minorities

- Offer support and listening without judging or pressuring the individual to talk about the traumatic event(s).
- Be careful not to pressure individuals to talk about the event—if they are not ready it may further frighten or re-traumatize them.
- Avoid giving advice or trying to solve their problems.
- Give them time, space, and patience.



- Don't try to talk individuals out of their reactions, minimize the event, or try to get them to look on the bright side. This may lead them to think you cannot understand their feelings and create more distance in your relationship.
- Help them find support in their other parts of their life such as their spiritual community, support groups in their community, or other supportive people in their existing social network. Offer suggestions, but not pressure.
- Know when to seek additional help to ensure stress does not linger unnecessarily or lead to further problems
 - They may need additional help if:
 - Recovery has stalled
 - Physical or other symptoms are causing concern
 - They have no one to talk to or relationships are being affected
 - They have continuing emotional numbness, depression, or anxiety
 - They have continued disturbed sleep and nightmares
 - They're unable to handle the intense feelings
 - They are increasing use of drugs and alcohol
- Resources:
 - Mental Health Treatment Facility Locator: Toll-Free: 1 (800) 789-2647 (English & español); TDD: 1 (866) 889-2647
 - <http://findtreatment.samhsa.gov/MHTreatmentLocator>
 - Asian Americans: Website that has information for Asian American therapists all over the U.S.: <http://www.mysahana.org/resources/>
 - Native Americans: Native American survivor and caregiver resources: <http://www.giftfromwithin.org/html/amindian.html>
 - Latinos: Website focused on trauma within the Latina/o community: <http://transformation-center.org/home/community/community-sub-page-2/latino/trauma-brochure-english-01-08-15/>
 - African Americans: Therapist resource directory under the Association of Black Psychologists: <http://www.abpsi.org/find-psychologists/>

Resources for Professionals Seeking More Information about Traumatized Ethnic Minorities

Journal Articles:

- Ford, J. D. (2008). Trauma, posttraumatic stress disorder, and ethnoracial minorities: Toward diversity and cultural competence in principles and practices. *Clinical Psychology: Science & Practice*, 15(1), 62-67. doi:10.1111/j.1468-2850.2008.00110.x
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- Roberts, A. L., Gilman, S. E., Breslau, J., Breslau, N., & Koenen, K. C. (2011). Race/ethnic differences in exposure to traumatic events, development of post-traumatic stress disorder, and treatment-seeking for post-traumatic stress disorder in the United States. *Psychological Medicine, 41*(1), 71–83.

Online Resources:

- Brown, L. S. (2011). Cultural competence in trauma treatment. American Psychological Association Continuing Education On-Line Video Series Retrieved from <http://www.apa.org/education/ce/icr0004.aspx>
- Brown, L.S. (2011). Emotional and cultural competence in the trauma-aware therapist. <http://www.continuingcourses.net>.
- The National Child Traumatic Stress Network: Culture and Trauma Resources. Retrieved from http://www.nctsn.org/resources/topics/culture-and-trauma#q1_2
- Loo, C.M. (2016). PTSD Among Ethnic Minority Veterans. U.S. Department of Veteran Affairs. Retrieved from <http://www.ptsd.va.gov/professional/treatment/cultural/ptsd-minority-vets.asp>
- The National Center for PTSD. (2016). Cultural Considerations. U.S. Department of Veteran Affairs. Retrieved from <http://www.ptsd.va.gov/PTSD/professional/treatment/cultural/index.asp>

Books and Book Chapters:

- Brown, L. S. (2008) Cultural competence in trauma therapy: Beyond the flashback. Washington DC: American Psychological Association.
- Herbert, J. D., & Forman, E. M. (2010). Cross-cultural perspectives on posttraumatic stress. *Clinician's guide to posttraumatic stress disorder. Hoboken, NJ: Wiley, 235-261.*
- Yeomans, P. D., & Forman, E. M. (2009). Cultural factors in traumatic stress. In S. Eshun & R. Gurung (Eds.), *Sociocultural influences on mental health* (pp. 221 – 244). Boston: Blackwell.

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