Addressing the Impacts of Racism-Based Traumatic Stress on Youth

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Racism-related experiences are a ubiquitous reality for youth of color, with research indicating that some youth may encounter as many as five incidents of racial discrimination daily.[1] These experiences reinforce profound ethnoracial health disparities across the lifespan and have been linked to psychological symptoms including suicidal thoughts, depression, and anxiety.[2] Further, racism exposure can trigger biological and psychological stress responses such as avoidance and hypervigilance, otherwise referred to as symptoms of racism-based traumatic stress (RBTS).[3,4] Despite concerns regarding the impact of RBTS on development, RBTS has received limited recognition in clinical practice. We provide concrete recommendations for formally acknowledging the impact of RBTS on these populations, as failing to identify and address RBTS symptoms may compromise the quality of mental health services received by youth of color.

ASSESSMENT

Successful diagnosis and treatment of RBTS symptoms hinges on the use of validated assessments. However, there are critical gaps preventing the accurate assessment and diagnosis of RBTS symptoms in youth. First, exposure to RBTS in youth is currently assessed with measures of constructs that are related to, but distinct from, RBTS (eg, racial discrimination) (Table 1[5-50]). Furthermore, these measures capture exposure to racism-related events but not traumatic-stress responses to these experiences. There are currently no validated, published measures assessing RBTS symptoms in youth, underscoring a key shortcoming in research and clinical practice. The first and only measure of symptoms in youth of color was recently developed and is awaiting review and publication (Chardee Galan *et al.*, 2024, unpublished).

Second, exposure to RBTS and related constructs are assessed using measures developed for, and validated in, adults, which have then been applied to youth (Table 1). Youth experiences, clinical presentations, and outcomes differ from those of adults and require unique assessments. Whereas adults may be able to verbalize their feelings of worry and helplessness in response to racially traumatic events, children and adolescents may lack the precise language or sociopolitical awareness to spontaneously disclose their feelings without being prompted in a developmentally appropriate manner. Indeed, focus groups with youth 12 to 17 years of age found that many adult measures of RBTS symptoms were difficult for youth to understand (Chardee Galan *et al.*, 2024, unpublished).

Instruments for assessing RBTS symptoms in youth must be established to consider the developmental timing of RBTS exposure (ie, the earlier trauma occurs, the more detrimental the impacts), the cognitive and emotional capacities of youth, the cumulative impact of both direct and vicarious racism, and contemporary forms of racism-related experiences such as online discrimination. The lack of youth-focused RBTS assessments contributes to limited awareness and misdiagnosis of RBTS symptoms, as well as slowed progress toward identifying effective interventions for a vulnerable population.

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TABLE 1 Definitions, Examples, Correlates, and Assessment Tools for Racism-Based Trauma and Stress and Related Constructs

Term	Definition	Example	Correlates/effects	Assessment tools	Validated on youth? (Y/N)
Racism[5]	Systemic bias at the interpersonal, structural, and systemic level that perpetuates the idea that some racial groups are inferior to others and assigns power and value based on these socially constructed categories	Historical and ongoing anti-Blackness in the United States (including Slavery, Jim Crow laws, and housing discrimination via redlining) aimed at reinforcing inequity	Individual: Adverse mental and physical health outcomes (eg, low-birthweight, depression, anxiety) and overrepresentation of groups in some diagnostic categories[6,7] *Systemic*: Inequity in access to power and opportunity; devaluing certain cultures via centering groups in power[8]	Measures of individual racist experiences • Perceived Racism Scale[9] • Perceived Online Racism Scale[10] • Perceptions of Racism Scale[11] • Schedule of Racist Events[12] Proxy measures of structural racism[13,14] • Area Deprivation Index • Redlining Index • Racial Bias in Mortgage Lending Index	N N N N N/A N/A N/A
Racial discrimination[15]	Social inequity on the basis of race that can be experienced at the personal/interpersonal level (eg, individual exposure to prejudice and unfair treatment) and institutional level (eg, unfair treatment in housing, education, health care)	Racial slurs and name-calling, being suspected of doing something wrong when they had not, threats of physical harm, and exclusion from peer activities	*Individual:* depression, self-esteem, self-efficacy, hopelessness, anger, anxiety, physiological reactivity to stress[16] *Systemic*: policies perpetuating inequity in a variety of systems including education, housing, and healthcare[17]	Daily Ethnic/Racial Discrimination Perceptions of Racism in Children and Youth (PRACY)[18] Perceived Discrimination Scale[19] Spencer Discrimination Scale Modified Padilla Social, Attitudinal, Familial and Environmental (SAFE)—Revised Short Form[20] Adolescent Discrimination Distress Index[21] (*See Table 1 in Braddock et al., 2021, for additional measures.*[22])	Y Y Y Y Y
Racism-based trauma/ stress (RBTS) or ethnic—racial trauma[23]	Trauma or stress reaction to experiences of racism and/or ethnic or racial discrimination	Feeling sad or avoiding engaging in cultural traditions after hearing a race-related microaggression (eg, not speaking native language after facing comments about being an English learner)	Emotional distress (eg, fear, helplessness),[24] social withdrawal, internalized racism, adverse physical health (eg, blood pressure, insomnia, muscle tension)[25], risky behaviors (eg, risky sexual decisions, substance use)[26]	The UConn Racial/Ethnic Stress and Trauma Survey (UnRESTS)[27] Index of Race Related Stress[28] Race-Based Traumatic Stress Symptom Scale-Short Form[29] Racial Trauma Scale (RTS)[30] Youth-Racism-Based Traumatic Stress Symptom Scale (YRaBTSSS) (Galan *et al.*, 2024, unpublished)	N Y N N Y

(*continued*)

TABLE 1 Continued

Term	Definition	Example	Correlates/effects	Assessment tools	Validated on youth? (Y/N)
Ethnic—racial socialization[31]	Verbal and nonverbal communication about racial dynamics and/or experiences	Caregiver messages to children that instill a sense of racial pride or how to cope with discrimination (eg "the talk" Black parents often have with their children about how to interact with police)	Construction of stable identity; heighten, buffer, or moderate experiences of racism and racial discrimination; foster sense of belonging and connectedness or disconnect[32]	Cultural Mistrust Inventory[33] Cross Racial Identity Scale[34] Africentric Home Environment Inventory (AHEI)[35] Teenager Experience of Racial Socialization (TERS)[36] Adolescent Racial and Ethnic Socialization Scale (ARESS)[37] Cross Ethnic-Racial Identity Scale—Adult[38] Racial Socialization Competency Scale[39]	Y Y N/A Y YN N/A
Vicarious trauma[40]	The experience of distress following the indirect exposure to prejudice and discrimination experienced by friends/family; can occur pre-birth or post-birth	Maternal experiences of discrimination and subsequent depressive symptoms (*pre-birth*); a child witnessing a racist remark made to a caregiver (*post-birth*)	Altered worldview of the world as unsafe, emotional distress (eg, helplessness, despair)[40]	**Pre-birth** • Experiences of Discrimination (EOD) Scale[41] • Everyday Discrimination Scale (EDS)[42] **Post-birth** • Negative Life Events Scale (NLES)[43]	N Y Y
General childhood trauma or adverse childhood experiences or early life adversity[44]	A range of negative environmental experiences that can result in an increased stress response and subsequently adversely affect development	Experiencing caregiver abuse or neglect; witnessing the death or severe injury of a loved one; exposure to motor vehicle accident	Higher rates of psychopathology (eg, mood, anxiety, and behavioral disorders), lower academic achievement, altered cognitive abilities, dysfunctional emotion regulation, increased allostatic load and subsequent impacts on physical health[44]	Trauma History Questionnaire[45] Pediatric ACEs and Related Life-events Screener (PEARLS; freely available at https://www.acesaware.org/learn-about-screening/screening-tools/)[46] Traumatic Events Screening Inventory—Parent Report Revised (TESI-PRR)[47] Child and Adolescent Trauma Screen (CATS)[48] K-SADS PTSD section[49] UCLA PTSD Reaction Index for *DSM-5*[50]	Y Y Y Y Y Y

Note: *N/A = not applicable; K-SADS= Kiddie Schedule for Affective Disorders and Schizophrenia.*

Third, the absence of explicit integration of RBTS in trauma screening tools leads to underreporting of trauma-based symptoms and, subsequently, potentially misinformed treatment targets and case conceptualizations. Most trauma screening tools for adolescents do not include questions about racism-related exposure (see Table 1, General childhood trauma). Furthermore, youth need not have been exposed to a racist event to experience RBTS symptoms, as research shows that historical racial injustices (eg, slavery) and the anticipation of future racism can be psychologically and physiologically harmful.[51] Therefore, RBTS symptoms are likely to be under-detected without explicit assessment. As we await the continued development and publication of specific tools capturing RBTS symptoms, we encourage clinicians to routinely employ general trauma screening tools that have been validated with youth populations and that ask about experiences of racism (eg, the PEARLS tool; linked in Table 1), as well as specific measures of constructs adjacent to RBTS such as racial discrimination.

Finally, even in circumstances in which RBTS exposure is partially assessed in youth (via tools capturing adjacent constructs and/or designed for adults), relevant symptoms are not encapsulated by prevailing diagnostic systems. This results in an increased likelihood of misdiagnosis of youth of color who are experiencing psychopathology and associated consequences. Current diagnostic options in the *DSM-5-TR* do not adequately address the often-cumulative nature of racism-related experiences; rather, traumas are defined as discrete past events. Many experiences that may give rise to RBTS symptoms, such as repeated microaggressions, are not considered traumas based on "Criterion A" in the *DSM-5.* This omission excludes individuals with RBTS symptoms from receiving a *DSM-5* post-traumatic stress disorder (PTSD) diagnosis, even though the adverse impact of racism can be just as severe as that of other forms of psychosocial trauma. Although "Z-codes" such as [Z60.5] "Target of (Perceived) Adverse Discrimination or Persecution" may be used to add context to an existing *DSM-5-TR* disorder, they do not capture the symptoms and functional impairment characteristic of RBTS.

Research indicates that RBTS gives rise to a distinct profile of PTSD-type symptoms in adults, including depression, intrusion, anger, and low self-esteem.[52] This symptom profile may also be seen in youth of color. Compared with White youth, youth of color are less likely to receive internalizing diagnoses and are more likely to receive externalizing diagnoses such as psychotic, conduct, or other disruptive behavior disorders.[53] Failure to consider RBTS exposure during diagnosis can impair a clinician's case conceptualization and cascade to inappropriate treatment decisions.[3] Furthermore, the limited diagnostic validation for race-based trauma–related and stressor-related disorders in our present medical model contributes to the problem of misdiagnosis, as many treatments require diagnostic codes for insurance and medical leave.

INTERVENTION

The absence of assessment tools to measure RBTS symptoms in youth has precluded the development of interventions specifically targeting these symptoms. Accurate operationalization of this construct is the first step toward demonstrating a need for effective interventions for RBTS symptoms in youth and facilitating the inclusion of RBTS in conceptualizations of psychopathology. In addition, clinician-specific factors such as discomfort talking about racism and a limited awareness of RBTS can lead clinicians to misinterpret or invalidate clients' presenting symptoms. Multiple studies have found that some clinicians experience discomfort when race or culture are broached, and that this discomfort can lead to the invalidation and under- or over-pathologizing of client experiences.[54]

Clinicians' oversight of RBTS symptoms can erode the therapeutic relationship and lead to suboptimal clinical outcomes, leaving youth and families understandably feeling invalidated or misunderstood. For instance, cognitive restructuring, a technique commonly used in evidence-based psychotherapies, involves identifying and challenging unhelpful and inaccurate thoughts. Although cognitive restructuring can facilitate client progress when applied to the treatment of anxiety and depression, this practice can have detrimental effects on client engagement and clinical outcomes if used to inappropriately challenge a client's perception of whether they faced a microaggression. To this end, we encourage clinicians to acknowledge the reality of racism and the impact of racism on mental health with youth of color, as well as how individual, family, community, and societal factors may contribute to clients' experiences. Furthermore, training programs should strive to teach clinicians to recognize microaggressions and other forms of racism as potential precursors to trauma symptoms.

Clinicians would benefit from knowing how to effectively support youth of color struggling with RBTS symptoms within empirically supported frameworks; however, extant treatments have focused on adults. Existing adult interventions involve practicing from an ethnopolitical or biopsychosocial–cultural framework, calling on clinicians to be aware of the social, political, and cultural systems in which clients are embedded and to focus on resilience and empowerment.[55] Preliminary studies indicate that these interventions may be helpful for adults with RBTS

symptoms; however, guidance on treating RBTS symptoms in youth has been predominantly conceptual. In the absence of empirically supported interventions for youth, clinicians may consider adapting evidence-based trauma interventions to target racial stressors and incorporate racial socialization practices (eg, promoting racial pride) into treatment. At minimum, clinicians should broach racism-related discussions with clients of color and attempt to integrate these experiences into case conceptualizations (Galán *et al.*[56] provide guidance on broaching race-related topics with youth clients of color). Until efficacious practice guidelines for treating RBTS in youth have been established, we encourage clinicians to engage in routine outcome monitoring to ensure that their actions are helping rather than further marginalizing ethnoracially minoritized youth.

CONCLUSION

We call on clinicians to consider RBTS exposure and symptoms in decisions related to the assessment, diagnosis, and treatment of youth of color, and to advocate for systemic change. Professional organizations including the American Psychological Association and the American Psychiatric Association have resources to expand knowledge of RBTS symptoms in clinical care. For example, the *DSM* Task Force (housed within the American Psychiatric Association) should consider amending the criteria for trauma- and stressor-related disorders to explicitly include RBTS. In addition, professional associations should collaborate with policymakers and corporations to expand insurance coverage to support treatment for RBTS. By embracing these collective efforts at the individual and system levels, we can foster a more inclusive and responsive mental health care system that acknowledges and addresses the profound impact of RBTS on youth.

CRediT authorship contribution statement

Isabella Kahhalé: Writing – original draft, Conceptualization, Writing – review & editing, Investigation, Project administration. **Kaela Farrise:** Conceptualization, Investigation, Writing – original draft, Writing – review & editing. **Akanksha Das:** Writing – original draft, Conceptualization, Investigation, Writing – review & editing. **Jeanne McPhee:** Conceptualization, Investigation, Writing – original draft, Writing – review & editing. **Chardée A. Galán:** Writing – review & editing. **Alayna Park:** Conceptualization, Investigation, Writing – original draft, Writing – review & editing.

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