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Race-Based Traumatic Stress, Racial Identity Statuses, and Psychological Functioning: An Exploratory Investigation

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To understand the impact racial experiences have on people of color, it is important to consider both whether there are any race-based traumatic stress symptoms (RBTS) and within-group psychological differences as reflected in one's racial identity status attitudes (RISA). Moreover, if the combination of RBTS reactions and racial identity status attitudes are related to their psychological functioning? The current study explored the relationships between a person's reactions to memorable racial encounters as assessed by the Race-Based Traumatic Stress Symptoms Scale, their racial identity status attitudes measured by the People of Color Racial Identity Attitude Scale, and psychological functioning (i.e., distress and well-being). Data from 282 adult community-based participants were used to examine the combined associations between RBTS, racial identity status attitudes, psychological well-being and psychological distress. A hierarchical cluster analysis was conducted to examine the relationships between race-based traumatic stress reactions and racial identity status attitudes. A two-cluster group solution was found that showed associations between externally defined or less mature racial identity status attitudes and higher RBTS symptoms and psychological distress. Internally defined or more mature or differentiated racial identity statuses were related to decreased psychological distress and RBTS symptoms. The findings were not expected in that lower racial identity statues were associated with higher levels of RBTS. Clinical implications and future research directions are discussed.

Keywords: racism, racial identity, race-based traumatic stress, psychological health

The negative psychological and emotional impact of experiences with racism and racial discrimination (e.g., anxiety, depression, low self-esteem, and race-related stress) is well known and has been documented by researchers for decades (cf. Pascoe & Smart Richman, 2009; Williams & Mohammed, 2009). More recently, scholars have begun to speculate about the severity of

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reactions that racial discrimination can bring about—rising from stress to trauma (Bryant-Davis & Ocampo, 2005; Carter, 2007; Helms, Nicolas, & Green, 2010).

Stress and trauma terminology are often used interchangeably across disciplines to describe the biological, psychological, and social interaction of external events (stressors). *Stress* is the appraisal (by the person) of an event as positive, unwanted, negative, and/or taxing, that requires one to adapt or cope in some way (Lazarus & Folkman, 1984). *Trauma* is a more severe form of stress that overwhelms a person's ability to cope (Pearlman & Saakvitne, 1995). *Traumatic stress* differs still, referring to a form of stress resulting from emotional pain, as opposed to a life-threatening event or series of events, as the core stressor (Carlson, 1997). Stress, trauma, and traumatic stress are further complicated by the subjective nature of such experiences: An event or enduring condition can be experienced as stressful or traumatic by one person, whereas another person undergoing the same or similar experience may not feel the same way.

A diagnosis of trauma for mental health professionals is determined by the criteria for posttraumatic stress disorder (PTSD) in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM–5*; American Psychiatric Association, 2013). The *DSM–5* criteria for traumatic events to be associated with PTSD revolve around "exposure to actual or threatened death, serious injury, or sexual violence . . . by directly experiencing, or witnessing, (the) traumatic event" (p. 271).

This definition of trauma is problematic for some (i.e., Carlson, 1997), as it is not sufficient to address the array of experiences that can cause traumatic stress reactions, and many severe stress experiences may not threaten death or serious physical injury (i.e., homelessness, poverty, emotional abuse, neglect, racism).

Furthermore, the research on stress, life events, discrimination, and race-related stress supports the assertion that the perception of racial stimuli as stressors can initiate stress reactions (Pascoe & Smart Richman, 2009). Researchers examining life-event trauma for civilians and veterans have found that people of color experience higher rates of PTSD compared with their White counterparts when exposed to a variety of potentially stressful life events (e.g., hurricanes, violence, assaults, traffic accidents, etc.)—a relationship not fully explained by the event or other factors (Norris et al., 2002; Perilla, Norris, & Lavizzo, 2002).

Carter (2007) theorizes that high rates of PTSD for people of color could be related to racism or racial discrimination—an association eluded to by trauma researchers, yet one that has not been a focus of research (Loo, Fairbank, & Chemtob, 2005). When scholars (e.g., Bryant-Davis & Ocampo, 2005; Roberts, Gilman, Breslau, Breslau, & Koenen, 2011) have connected racism to trauma, they have usually done so by adhering to the definition of trauma as PTSD, thereby relating racism to physical danger and pathology. There is evidence, however, that the stress associated with racism (usually not threatening death or serious physical injury) affects people of color adversely (e.g., Paradies et al., 2015; Pieterse, Todd, Neville, & Carter, 2012).

Prior to the introduction of the race-based traumatic stress (RBTS) model, a specific link to an experience of racism and the symptoms associated with it did not exist (cf. Carter, 2007; Carter & Sant-Barket, 2015; Carter et al., 2016). Carter (2007) asserted that a racial encounter that is emotionally painful, sudden, and out of the individual's control results in reactions, some of which overlap with PTSD symptoms (e.g., hypervigilance, intrusion, and/or avoidance) and also involve other criteria unrelated to PTSD (e.g., processing and understanding race and racism) that can result in a RBTS injury (i.e., emotional pain after an encounter).

The ability to recognize racism is dependent on a person's racial identity statuses. Racial identity theorists (e.g., Helms, 1995; Sellers, Caldwell, Schmeelk-Cone, & Zimmerman 2003; Thompson & Carter, 2013) assert that the varied manner in which individuals view the world, their affective states, and their behaviors can be linked to the various racial identity statuses that individuals embrace or reject throughout a lifetime: Individuals may be ambivalent about their race, racial group, and the dominant racial group, whereas others may be more invested, and these feelings can ebb and flow throughout a lifetime. Racial identity ego statuses can vary from an "external," dominant racial group identification (conformity), to "internal," own-racial-group identification (internalization) in a range of configurations that are nonlinear (i.e., not a developmental or progressive stage process).

For people of color, reaching a predominant internally defined racial identity is characterized by the abandonment of reliance on White culture for self-definition and the development of a positive racial identity as a member of a minority racial group. For instance, regardless of racial group, individuals who have an "externally" defined racial identity status (i.e., characterized as color blind; conformity) may not believe race is a salient factor in their everyday lives, and the lives of others both inside and outside of his or her racial group or are in transition (dissonance). As such, in order to have a subjective experience of race-based encounters as being related to issues of racism, individuals would need to have an "internally" defined racial identity status (Thompson & Carter, 2013).

Therefore, peoples' awareness of the role of race becomes an important factor in understanding and evaluating race-based trauma. This notion has been supported by a variety of research (cf. Burrow & Ong, 2010; Pillay, 2005; Sellers et al., 2003; Sellers, Copeland-Linder, Martin, & Lewis, 2006). As such, in order to assess whether an encounter with racism resulted in race-based trauma, it would be necessary to know if the person exposed was able to appraise the incident as being race-related. Understanding the role of racial identity becomes important for scholars and clinicians as they attempt to identify the specific psychological outcomes associated with experiences of racial discrimination; however, individuals' awareness of the role of race as a psychological variable has yet to be tested in understanding and evaluating RBTS.

Furthermore, in the examination of the effects of racial discrimination, it is important to consider within-group racial differences and "not to treat members of racial groups as monolithic or psychologically similar in regards to their experiences and understanding of racism" (Carter, 2007, p. 57). More often than not, racial discrimination and trauma researchers use sociodemographic racial categories to infer social and psychological outcomes from racial experiences (Helms, Jernigan, & Mascher, 2005; Smedley & Smedley, 2005). In doing so, researchers make the assumption that people from a particular racial group are also psychologically invested in the groups' race and culture in similar ways, as if there were no differences between or among them. When trauma researchers have studied people of color and racial

discrimination, they seldom examine within-group racial variation such as ethnic or racial identity or acculturation.

The current study was designed to investigate two main areas of inquiry: (a) to determine whether stress related to racial encounters is associated with racial identity status attitudes, and (b) to identify any associations between RBTS symptoms, racial identity status attitudes, and psychological distress and well-being.

RBTS theory suggests there should be a relationship, direct or indirect, between high levels of RBTS scores and racial identity status attitudes, and that the "externally" defined racial identity statuses (e.g., conformity and dissonance) may relate differentially to RBTS than the "internally" defined or highly integrated statuses (e.g., immersion-emersion, internalization). It was hypothesized that higher levels of RBTS would be associated with racial identity status attitudes, in particular with "internally" defined racial identity statuses, and that "internally" defined racial identity statuses will be related to increased psychological distress as opposed to psychological well-being.

Method

Participants

The 282 adult participants in the study self-reported the following demographic information. There were 141 males (50%) and 141 females (50%). Participant ages ranged from 18 to 65 years ($M = 39.4$, $SD = 13.5$). Two hundred six participants (73%) were Black, 42 were Hispanic (14.9%), 19 were Asian (6.7%), three were Native American (1.1%), and 12 were biracial (4.3%). Participants reported the following socioeconomic statuses: 68 were lower class (25.1%), 80 were working class (24.8%), 46 were lower middle class (15.8%), 52 were middle class (19.3%), 18 were upper middle class (9.3%), three were upper class (0.7%), and 15 did not report social class. With regard to religion, participants most frequently identified as Christian (65.5%), followed by Muslim (15.2%). Participants, on average, completed 13.3 years of education, with the majority completing between 11 and 15 years (60.6%).

Measures

The Race-Based Traumatic Stress Symptom Scale (RBTS; Carter et al., 2013) uses an open-ended response section for participants to describe at least three experiences of racism that were memorable. They select one event and indicate (yes–no) whether that incident was emotionally painful (negative), out of his or her control, and sudden in its occurrence. Then they follow the instructions,

> Below is a list of reactions or feelings that people sometimes have after an upsetting event. After each reaction circle the option that best describes your feelings right *after the event* (within one month) and *more recently* when thinking about the event.

Examples of reaction items include "As a consequence of the memorable encounter I had with racism," "I felt sad," or "I experienced tiredness and lack of energy." Respondents use a 5-point Likert scale with the following response options: 0 (*does not describe my reaction*) to 4 (*this reaction would not go away*). Items are summed for each of the seven scales, in which high scores indicate greater presence of that reaction. In the current study, the Cronbach's alphas for the seven Immediate Reaction scales were as follows: Depression, $\alpha = .90$; Intrusion, $\alpha = .87$; Anger, $\alpha = .88$; Hypervigilance, $\alpha = .88$; Physical, $\alpha = .90$; Low Self-Esteem, $\alpha = .87$; and Avoidance, $\alpha = .73$. For the purposes of this study, only the Immediate Reaction scales were used.

The Person of Color Racial Identity Attitudes Scale (POCRIAS; Helms, 1995) is a 50-item measure that has four scales: Conformity, Dissonance, Immersion-Emersion, and Internalization. The scales assess racial identity statuses ranging from externally defined to internally defined. Responses to each item are scored using a 5-point Likert scale ranging from 1 = *strongly disagree* to 5 = *strongly agree*. Cronbach's alphas in the study were as follows: Conformity, $\alpha = .83$; Dissonance, $\alpha = .80$; Immersion-Emersion, $\alpha = .79$; and Internalization, $\alpha = .90$.

The Mental Health Inventory (MHI-38; Veit & Ware, 1983) is comprised of five scales that make up two global scales. Participants report the frequency of psychological symptoms for the past month for Psychological Distress, including Depression, Anxiety, and Loss of Control; and Psychological Well-Being, including Positive Affect and Emotional Ties. In the current study, Cronbach's alpha for the Psychological Distress scale was .94, and for the Psychological Well-Being Scale was .92.

Procedure

Study participants were recruited through college psychology courses; several community health centers that provided a range of services such as medical care, alcohol and substance abuse treatment, and dentistry; as well as community settings such as barber shops and beauty salons in the Northeast. Student participants were given extra credit toward their course grades as incentive to participate. Community participants were compensated either with a $10.00 (service agencies) or $20.00 (barber shops/salons) gift card.

Results

Data Analysis Plan

We approached data analyses in steps: The first step was to determine whether participants were similar and had no significant demographic differences. We used multivariate analysis of variance (MANOVA) to look for differences in responding to the measures in the study on the basis of race, gender, age, and SES. The second analysis involved cluster analysis that is similar to factor analysis, in that both attempt to account for similarities among data by grouping the observations together. All cluster analyses place participants into common groups such that they are more similar to one another than to members of any other possible cluster group. Factor analysis groups are based on covariance, whereas cluster analysis is "used to group people together based on their scores across a set of variables" (Gore, 2000, p. 299). Hierarchical cluster analysis was selected, as it allows the researcher to discover groups that exist within data, rather than predefining the groups. Our hierarchical cluster analysis was conducted to create groups of participants that shared similar configurations of RBTS reactions and racial identity status attitudes. We then conducted another MANOVA in which we sought to determine whether the

groups varied in terms of their scores on the MHI-38 scales of Psychological Well-Being and Distress.

Preliminary Analyses

A MANOVA was conducted as a preliminary analysis to determine demographic differences; independent variables were age, gender, socioeconomic status, and race. Race was included as an independent variable because of the racial heterogeneity of the sample. The RBTS symptom scales of, Avoidance, Intrusion, Depression, Hypervigilance, Physical symptoms, Low Self-Esteem, and Anger were dependent variables, as well as MHI Psychological Distress and Well-Being scales, and the POCRIAS (Conformity, Dissonance, Immersion-Emersion, Internalization) scales. Results of the MANOVA revealed no significant differences in racial identity status attitudes, psychological well-being, psychological distress, or RBTS reactions by age (Wilks' $\lambda = .01$, $F[572, 1237.80] = .95$, $p = .73$, $\eta^2 = .30$), gender (Wilks' $\lambda = .93$, $F[13, 95] = .54$, $p = .89$, $\eta^2 = .07$), race (Wilks' $\lambda = 64$, $F[52, 370.04] = .87$, $p = .72$, $\eta^2 = .11$), or socioeconomic status (Wilks' $\lambda = .40$, $F[78, 529.90] = 1.23$, $p = .10$, $\eta^2 = .14$).

Primary Analyses

To examine how RBTS reactions and racial identity status attitudes are associated with and/or varied on mental health outcomes, a hierarchical cluster analysis was conducted to create groups of participants that share similar scores of RBTS reactions and racial identity status attitudes. Following the hierarchical cluster analysis, a MANOVA was conducted to determine whether there were significant differences between the cluster groups on psychological distress and well-being. Although data reduction is recommended prior to cluster analysis when some of the variables are highly correlated (Gore, 2000), as is the case with the current study, we contend that RBTS and racial identity are multidimensional constructs that we would expect to be correlated. Therefore, we refrained from reducing the variables to avoid limiting the information provided in the analyses.

Hierarchical Cluster Analysis

Using the seven RBTS reaction types and four racial identity status attitudes as the clustering variables, an agglomerative hierarchical cluster analysis using Ward's clustering method with squared Euclidean distance was conducted. This method grouped the participants based on their reported RBTS reactions and racial identity status attitudes in order to create clusters to further analyze. We followed recommendations to examine agglomerative hierarchical cluster analysis when no a priori information is available about the likely number of cluster groups to expect when the sample is relatively small (Gore, 2000). Upon inspection of the agglomerative schedule, which provided a proximity coefficient of the within-group sum of squared error at each stage of the clustering procedure, a two-cluster solution was found to be the optimum number of clusters, with each cluster group having an adequate number of cases for further analyses.

One-way follow-up ANOVAs indicated that there were significant differences between the two cluster groups on all of the clustering variables: RBTS Depression, $F(1, 190) = 174.88$, $p < .001$; RBTS Anger, $F(1, 190) = 207.33$, $p < .001$; RBTS Physical, $F(1, 190) = 187.71$, $p < .001$; RBTS Avoidance, $F(1, 190) = 249.44$, $p < .001$; RBTS Hypervigilance, $F(1, 190) = 258.55$, $p < .001$; RBTS Intrusion, $F(1, 190) = 170.07$, $p < .001$; RBTS Low Self-Esteem, $F(1, 190) = 79.18$, $p < .001$; POCRIAS-Conformity, $F(1, 190) = 34.09$, $p < .001$; POCRIAS-Dissonance, $F(1, 190) = 23.10$, $p < .001$; POCRIAS-Immersion-Emersion, $F(1, 190) = 9.42$, $p < .002$; POCRIAS-Internalization, $F(1, 190) = 8.86$, $p < .003$. Results indicated that there were significant between-cluster group differences on all of the clustering variables, which suggested that the clusters were interpretable and sufficient for further analysis. The means and standard deviations of the RBTS and racial identity scales for the two clusters are shown in Table 1.

The first cluster group—Low RBTS, Internalization—was characterized by "low" RBTS scale scores, with each scale score at least one half a standard deviation below the sample mean. With respect to racial identity status attitude scores, the first cluster group relied primarily on Internalization status attitudes and moderately on Conformity, Dissonance, and Immersion-Emersion status attitudes. This was revealed in the higher relative Internalization score (slightly above the mean) compared with the remaining racial identity mean scale scores that were each just below the sample mean. As seen in Figure 1, RBTS scores showed a flat pattern, with very little difference existing between levels of each RBTS symptom.

The second cluster group—High RBTS, Conformity, Dissonance, Immersion-Emersion—was characterized by a pattern of RBTS reactions, in which each scale was at least one half a standard deviation above the sample mean. Notably, Self-Esteem was lower than the other RBTS scores for this cluster group. In the second cluster group, Conformity, Dissonance, and Immersion-Emersion racial identity status attitudes scores were above the

Table 1
People of Color Cluster Group Means and Standard Deviations for Race-Based Traumatic Stress Scales, Racial Identity Status Attitudes, Psychological Distress, and Psychological Well-Being

Cluster group	*M*/*SD*	DEP	ANG	PHY	AVO	HYV	INTRU	LSE	CONF	DISS	IMEM	INT	DIST	WB
Low RBTS, INT ($n = 106$)	*M*	43.63	43.74	43.56	42.91	42.96	43.45	44.39	46.25	46.43	48.00	52.79	49.23	55.88
	SD	4.59	6.32	6.31	4.62	5.15	4.47	5.06	7.84	10.16	10.54	8.79	16.85	11.96
High RBTS, CONF, DISS, IMEM ($n = 86$)	*M*	57.81	58.63	58.10	58.56	58.46	57.14	55.07	53.87	52.99	52.27	48.83	59.83	50.53
	SD	9.80	8.00	8.39	8.82	8.12	9.61	11.01	10.24	8.35	8.27	9.61	16.41	13.04

Note. RBTS = Race-Based Traumatic Stress Scale; DEP = Depression; ANG = Anger; PHY = Physical; AVO = Avoidance; HYV = Hypervigilance; INTRU = Intrusion; LSE = Low Self-Esteem, CONF = Conformity; DISS = Dissonance; IMEM = Immersion-Emersion; INT = Internalization; DIST = Psychological Distress, WB = Psychological Well-Being.

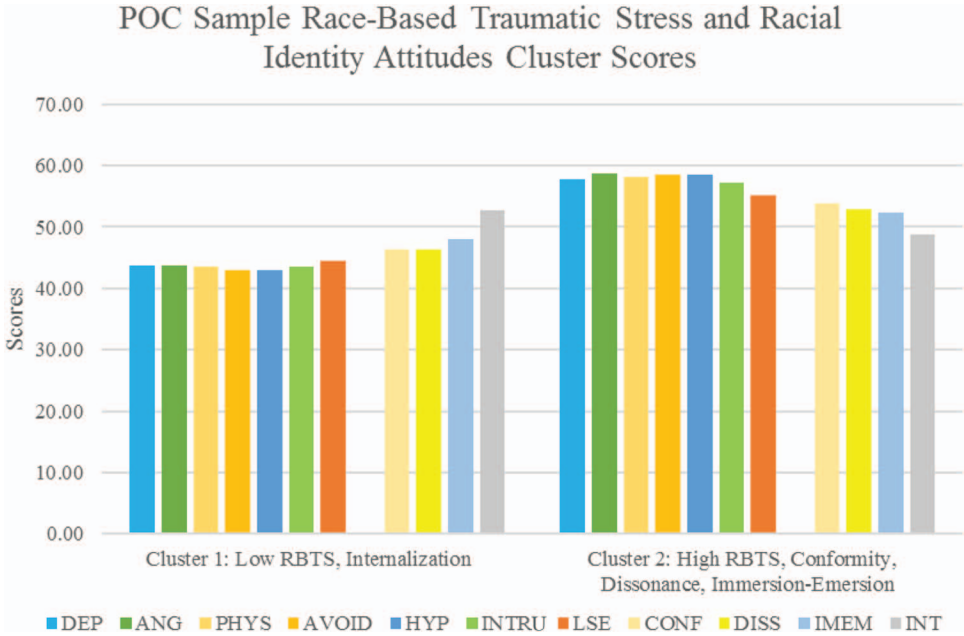

Figure 1. Race-Based Traumatic Stress Scale (RBTS) scores and People of Color Racial Identity Attitudes Scale (POCRIAS) scores by cluster group. DEP = RBTS Depression; ANG = RBTS Anger; PHYS = RBTS Physical; HYP = RBTS Hypervigilance; INTRU = RBTS Intrusion; LSE = RBTS Low Self-Esteem; CONF = POCRIAS Conformity; DISS = POCRIAS Dissonance; IMEM = POCRIAS Immersion-Emersion; INT = POCRIAS Internalization. See the online article for the color version of this figure.

sample mean, whereas Internalization scores fell below the mean. Cluster means for RBTS reactions and racial identity status attitudes are shown in Table 1.

Differences Between Cluster Groups on Mental Health Outcomes

In order to determine whether the two clusters were significantly different from each other with respect to psychological distress and well-being, a MANOVA was run with the two cluster groups as independent variables, and MHI-38 psychological distress and well-being as dependent variables. The results of the omnibus test indicated that there were significant differences between the two cluster groups on the dependent variables, Wilks $\lambda = .906$, $F(2, 168) = 8.722$, $p < .001$, $\eta_p^2 = .09$. Inspection of the follow-up univariate analysis revealed significant cluster group differences on both psychological distress, $F(1, 169) = 17.25$, $p < .001$, $\eta_p^2 = .09$, and well-being, $F(1, 169) = 7.84$, $p < .01$, $\eta_p^2 = .04$. Cluster group means and standard deviations for the mental health outcomes are shown in Table 1. Participants in the "Low RBTS, Internalization" cluster group endorsed less psychological distress ($p < .01$) and higher well-being ($p < .01$) than did those in the "High RBTS, Conformity, Dissonance, Immersion-Emersion" cluster group. Conversely, the High RBTS, Conformity, Dissonance, Immersion-Emersion group reported higher psychological distress ($p < .01$) and lower well-being ($p < .01$) compared with the participants in the Low RBTS, Internalization cluster group.

Overall, these results suggested that the cluster group characterized by lower than average RBTS reactions and greater relative reliance on internalization racial identity attitudes was associated with less psychological distress and greater well-being. On the other hand, the cluster group characterized by elevated RBTS reactions and primary reliance on conformity and dissonance racial identity attitudes was associated with greater psychological distress and compromised psychological well-being.

Discussion

A body of research has documented the adverse effects of racism and racial discrimination (Pascoe & Smart Richman, 2009; Williams & Mohammed, 2009), and researchers have proposed that stress associated with racial incidents can rise to the level of traumatic stress (Bryant-Davis & Ocampo, 2005; Helms et al., 2010; Loo et al., 2001). Carter's (2007) model of RBTS and scale remain the only method of linking specific racial incidents with its resulting psychological symptoms (Carter et al., 2013).

Researchers have argued that in order to experience RBTS, an individual must possess some understanding of race in their life. Racial identity researchers (Comas-Díaz, 2016; Phelps, Taylor, & Gerard, 2001; Pillay, 2005; Sellers et al., 2003) have shown that a person's racial identity status attitudes comprise a lens that is used to evaluate and determine the psychological and emotional impact associated with life events and racial incidents. Accordingly, it has also been argued that an individual must have an integrated, "internally" defined racial identity to be able to appraise an event as race-related (Carter, 2007). Therefore, the purpose of the current investigation was to

explore the relationships between RBTS and racial identity status attitudes. Further, we attempted to understand how these two variables were associated with psychological distress and well-being. We hypothesized that higher RBTS would be associated with "internally" defined racial identity statuses, and that "internally" defined racial identity statuses will be related to increased psychological distress as opposed to psychological well-being.

In an effort to ensure that the participant group did not differ based on their demographic characteristics, a MANOVA was conducted to determine whether demographic differences existed for our participants on their racial identity and RBTS symptoms. The scale scores were not significantly different. We conducted hierarchical cluster analysis based on individuals' RBTS symptoms and racial identity status scores. We found two distinct cluster groups, which we named "Low RBTS, Internalization" and "High RBTS, Conformity, Dissonance, Immersion-Emersion."

Low RBTS, Internalization

The Low RBTS, Internalization cluster group consisted of individuals whose racial identity status attitudes were characterized by the ability to define oneself by internal attributes and to have a positive commitment to one's racial group. The use of an internalization racial identity status attitude reflects an ability to recognize the impact of racism on people of color, while allowing for interactions with dominant and nondominant group members that are less defensive and more flexible in thinking about racial climates (Helms, 1995; Sue & Sue, 2015).

These individuals' low RBTS scores may be a product of their ability to recognize, understand, anticipate, and cope effectively with racial incidents, along with an increased ability to understand ambiguous situations. The combination of confidence in the face of race-based incidents and broader use of effective coping strategies may explain the low psychological distress and high psychological well-being in this group. This is consistent with current research on racism-related coping and racial identity. For instance, Forsyth and Carter (2012) found that those utilizing internalization status attitudes also used more effective coping strategies to deal with racial incidents, and thus suffer from less psychological distress associated with these events (Bryant-Davis & Ocampo, 2005).

High RBTS, Conformity, Dissonance, Immersion-Emersion

The High RBTS, Conformity, Dissonance, Immersion-Emersion cluster group consisted of individuals with reliance on conformity, dissonance, and immersion-emersion racial identity status attitudes. This group seems to encompass a group of individuals who vary in their orientation to their racial group memberships as conformity, dissonance, and immersion-emersion status attitudes represent an array of attitudes. Conformity racial identity status attitudes are characterized by defining one's racial group by external dominant cultural norms, which results in devaluing their own group in favor of dominant group preferences (Sue & Sue, 2015). Use of these status attitudes corresponds with the viewpoint that race is an inconsequential factor in their life; therefore, those characterized by this status are unaware of racial differences and concerns. Dissonance racial identity status attitudes represent a transition into increased awareness of racial differences and the meaning associated with that membership (Helms, 1996). Further, immersion-emersion status attitudes reflect a desire to get a better understanding of race as it relates to one's life, and can go from a staunch attachment to one's racial group membership and rejection of the dominant group, to a desire to understand the complexities of race that is less "us versus them" (Helms, 1995).

Forsyth and Carter (2012) have posited that integrated racial identity is necessary for one to experience RBTS, as the individual would need to have an understanding of race as well as how race impacts them and society at large. However, contrary to our hypothesis, the results showed that RBTS reaction scores were high within this cluster. This suggests individuals may still be psychologically harmed by racial incidents, despite little understanding of racial dynamics in the United States (Comas-Díaz, 2016).

The relationships in this cluster group may be explained through the ways in which these individuals process racial incidents without a sophisticated understanding of race. Experiencing intrusive thoughts or memories of the incident may recur due to the individual's inability to make meaning of the event or interaction. The person who does not see race as an important factor in their lives may be particularly susceptible to internalizing the cause of the event, perhaps attributing it to being some personal flaw or characteristic of their own (Comas-Díaz, 2016). Hypervigilant behavior following this event may be the only resource the person can rely on due to anticipatory fear that the event will occur again. Their lack of understanding of race dynamics may also leave them disarmed without coping strategies specific to racial encounters (Bryant-Davis & Ocampo, 2005). Further, these individuals may be on alert for threats in a wide array of situations rather than solely in similar and appropriate situations. Individuals who have recently recognized that race may play a role in how society functions may experience a lot of confusion around racial incidents (Helms, 1995). They may oscillate between internalizing feelings associated with the incident and externalizing their feelings onto others, all the while not being entirely confident in either of these assessments. Those who have developed a rigid concept of race, choosing to surround themselves with members of their own racial group and denigrate dominant group members may experience overwhelming emotions associated with the racial incident. These overwhelming emotions may stem from the realization that members of their racial group have historically faced hardships as well as that they will inevitably interact with dominant group members (Comas-Díaz, 2016).

Findings indicate that those relying on externally defined racial identity status attitudes have higher RBTS reactions scores and compromised psychological functioning. Conversely, those using internally defined racial identity status attitudes had below average RBTS scores and higher relative psychological well-being.

Clinical Implications

The findings of this study have important clinical implications. Racial identity is an important internal characteristic that influences who may develop elevated levels of RBTS reactions and who may ultimately develop race-based trauma (Bryant-Davis &

Ocampo, 2005). Clients with predominantly "external" racial identity status attitudes (conformity, dissonance) may be at greater risk of developing RBTS due to their lack of understanding about race, its impact on their lives, and coping strategies associated with racial incidents (Comas-Díaz, 2016). For these individuals, it is important to assess their level of awareness to negative encounters as racial in nature. It will also be helpful for clinicians to suggest how individual, cultural, and institutional racism may be impacting ambiguous incidents (Helms, 1996). This strategy may help to clarify confusing incidents and also may interrupt the process of internalizing feelings associated with the incident or blaming oneself.

Clinicians may also need to be vigilant about the symptoms of race-based trauma that a client may be displaying, despite his or her assessment of the client's capacity to accurately label racial incidents as such (Sue & Sue, 2015).

Training in multicultural competence should include the importance of considering racial identity when assessing and understanding RBTS symptomology. Further, clinicians should have a good understanding of the implications of one's race in their own lives. One difficulty that practitioners may face is their own confusion about the various forms racism can take in the United States, causing them to miss signs of RBTS when it enters the therapy room.

Study Limitations

There are several study limitations, one is that the measures are self-report instruments and rely on participants' recall, the RBTS use of recall could introduce possible bias into the study. The methods may not ensure that the racial identity attitude status of the participant that was reported coincides with their racial identity attitude status at the time of the memorable racial experience. In addition, self-report data can have limitations because of the deterioration of memory and emotional impact over time. Furthermore, participants were offered compensation for being part of the study, which could have compromised their motivation and responses to the study's measures. It could also be argued that the compensation was a recognition and acknowledgment of the value of participants' time.

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