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Understanding the Psychological Impact of Oppression Using the Trauma Symptoms of Discrimination Scale

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Abstract

Oppression refers to systemic discrimination where the injustice targets or disproportionately impacts specific groups of people. The Trauma Symptoms of Discrimination Scale (TSDS) is a self-report measure designed to assess the traumatizing impact of discrimination broadly by measuring anxiety-related symptoms of trauma due to discriminatory experiences. This may include symptoms arising from racism, homophobia, sexism, poverty, or other forms of marginalization. Almost all studies of the TSDS have examined its use in marginalized ethnoracial groups, primarily African Americans. This paper will extend prior work to help us better understand racial trauma across groups by reporting and comparing TSDS mean scores across ethnoracial identities in a diverse national sample (n = 923). It also explores trauma with other marginalized identities and demographic dimensions, including gender, sexual minority/LGBQ status, education, and income. The relationship of TSDS scores to clinical psychopathologies are examined, including stress, depression, anxiety, and PTSD. We also examine the unique risks associated with intersectionality, and how having multiple marginalized identities may increase traumatization. Clinical implications and future directions are discussed.

Keywords

oppression, intersectionality, minority stress, racism, homophobia, sexism

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Introduction

Oppression-Based Stress and Trauma

Oppression describes an asymmetrical power dynamic characterized by domination and subordination of a group by restricting access to social, economic, and political resources.[1] Subordinated groups experience fear, stress, and may develop negative views of themselves. As a chronic stressor, oppression can lead to poor mental health. Studies consistently link poverty and lower socioeconomic status (SES) with increased vulnerability to negative physical and mental health conditions, including schizophrenia, major depression, panic and phobic disorders, as well as antisocial personality disorder.[2–4]

Oppression based on race, sexual orientation, and other identities predicts poor mental health. A meta-analysis of 66 studies concluded increased exposure to stress from racial discrimination was a stronger predictor of depression and anxiety for African Americans.[5] Similar findings exist for intersectional oppressions based on class, sexual orientation and race.[6] In a study of 376 Black, Latino, and multiracial sexual minority males, English and colleagues[7] found gay rejection sensitivity, racial discrimination, and emotional regulation difficulties were significantly linked, which in turn predicted higher anxiety and depressive symptoms.

As chronic experiences, oppression can even be traumatizing. Although the DSM-5 conceptualizes traumatic experiences as discrete events,[8] Holmes and colleagues[9] argue this approach fails to capture the harm of chronic oppression-

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based experiences, such as racism, sexism, homophobia, and poverty. In support of this argument, Kira and colleagues[10] found expanding trauma assessment models using Criterion A increased the predictive validity of chronic trauma on vulnerability to PTSD. Based on a cross-cultural combination of clinical and non-clinical samples experiencing political and economic oppression (total N = 2754), chronic stressors such as collective identity trauma (eg, oppression and discrimination) along with attachment or betrayal trauma "increased the predictive model of PTSD six times over what Criterion A explained alone" (,[10] p. 2672). As such, a more appropriate model of PTSD should include systemic discrimination along with secondary, abandonment, and betrayal traumas for more accurate and predictive assessment as well as effective treatment particularly for minoritized, non-Western communities.

Despite the growing evidence showing oppression-based stress can be traumatic and relates to symptoms of PTSD, research on oppression-based stress and trauma is limited. Specifically, one of the most widely-studied forms of oppression is racism, as racial discrimination is consistently linked with traumatization.[11] Yet, a recent meta-analysis found a lack of validated psychological measures that adequately capture the distress associated with racism and an inability of the current literature to account for other forms of oppression-based trauma.

Trauma Symptoms of Discrimination Scale (TSDS)

The Trauma Symptoms of Discrimination Scale (TSDS) is a 21-item self-report measure that broadly assesses the traumatizing impact of discrimination by focusing on anxiety-related symptoms of trauma.[12] Participants report the frequency of their experience of discriminatory distress regarding trauma (eg, "Due to the past experiences of discrimination, I often worry too much about different things") on a 4-point scale ranging from 0 (Never) to 3 (Often).

In the original paper introducing this measure, the psychometric properties of the TSDS were examined in 123 African American monoracial and biracial university undergraduates.[12] The TSDS was found to have concurrent and predictive validity and excellent reliability (Cronbach's $\alpha = .94$ for total score). It was positively correlated to measures of discrimination and psychopathology (eg, $r = .48$ for the Everyday Discrimination Scale, and $r = .52$ for the abbreviated Penn State Worry Questionnaire, $p < .001$ for both).[13,14] This preliminary evidence supported the validity of the TSDS for the measurement of anxiety-related trauma symptoms due to racial discrimination but called for more studies to extend the findings to other marginalized groups.

The TSDS has been used in several subsequent studies of racism. For example, Maxie-Moreman and Tynes[15] conducted a study of exposure to online racial discrimination and traumatic events in Black adolescents and young adults, centering the TSDS and its four subscales in its analyses. Reliability analysis indicated high internal consistency in the subscales (α's from .78 to .93), and the experience of online racial discrimination was significantly correlated to each subscale (r's from .35 to .49, $p < .001$ for all).

The TSDS was used as the primary outcome measure in a series of studies examining psychedelics and racial trauma.[16–18] The retrospective study included 313 diverse Black, Indigenous, and other People of Color (BIPOC) in the U.S. and Canada who reported a memorable psychedelic experience that helped them cope with racial trauma. There was a significant decrease in symptoms, using the TSDS, before and after the psychedelic experience. Internal consistency reliability for the TSDS was excellent ($\alpha = 0.95$), which was found with Asian American/Canadian ($n = 92$; $\alpha = .94$) and Indigenous/Native American ($n = 66$; $\alpha = .97$) subsamples as well.

In a nationwide survey study on racial trauma, the TSDS served as a benchmark for convergent validity for the Racial Trauma Scale (RTS 1;1). Diverse participants across the U.S. ($n = 923$) were included in this racial trauma scale validation study. Of these, a subset completed clinical interviews of racial trauma, and the TSDS was found to reliably identify clinically relevant racial trauma, with a sensitivity of .77 and 1-specificity of .16 when using a cut-off score of 40.

Intersectionality and Oppression

Experiences of discrimination do not occur uniformly across marginalized groups. For example, Chou and colleagues[19] found that African Americans experienced more discrimination than other major racialized groups. Further, multiple oppressed identities are theorized to be linked to more interactive discrimination and, in some cases, subsequent traumatization (eg, [20]). Root[21] pointed to women of color's "double jeopardy" status, with many subsequent studies demonstrating their exposure to gender and racial discrimination and how it negatively affected their well-being in a variety of ways.[22–24] Notably, Moody and Lewis[25] found that a higher frequency of gendered racial microaggressions was significantly correlated with more severe traumatic stress symptoms in a national sample of Black women.

Research on LGBTQ populations and queer persons of color have also reflected parallel findings. In one of the largest national LGBTQ college campus studies to date with a sample size of over 5000 respondents, Rankin et al[26] found that "multiple minoritized identities (eg, racial identity and sexual identity; racial identity and gender identity) lead to encounters of multiple forms of oppression" (p. 11). For example, while sexual orientation identity was indicated as the primary basis of observed harassment for both respondents of color and White respondents (75% and 76%, respectively), respondents of color were ten times more likely to attribute the perceived harassment to racial profiling. Moreover, trans- and gender-nonconforming

respondents of color were more likely than cis-gendered respondents of color to experience on-campus hostility, exclusion, or harassment ([26] pp. 10-11). From their national online survey (n = 200), Sutter and Perrin[27] found that LGBTQ-based discrimination had a significant impact on the psychological functioning of sexual and gender minority persons of color, particularly suicidal ideation risk. Diaz et al's[28] study of gay and bisexual Latino men demonstrated negative mental health outcomes (eg, depression, sleep issues, suicidal ideation) that were associated with both lifelong and current experiences of social discrimination based on their sexual orientation and racial/ethnic identity as well as financial hardship due to acute unemployment and poverty.

Purpose of This Study

Almost all studies of the TSDS focus on the experience of racism, primarily among African Americans. This paper will extend prior work to understand trauma across ethnoracial groups as well as other marginalized identities and several demographic dimensions, including gender, LGBTQ status, income, and education. We examine the TSDS and its relationships to clinical symptoms of depression, anxiety and stress, as well as PTSD using the data from Williams et al[29] in a cross-sectional survey study. We also examine the unique risks associated with intersectionality, and how having multiple marginalized identities may increase traumatization.

Methods

Participants

Recruitment for this study was conducted online through Amazon Mechanical Turk (mTurk) Prime, now Cloud Research. Participants (Turk Workers) register to join the platform in exchange for opportunities to do online tasks for compensation. TurkPrime was designed as a research platform that integrates with MTurk and supports tasks that are common to social and behavioral sciences, such as survey data collection.[30] Tasks that can be implemented with TurkPrime include selecting participants with specific characteristics and excluding participants on the basis of previous participation. For this study, eligibility criteria included: over 18 years of age; identify as African American/Black, Asian American, Latine/Hispanic American, or White/European American; spent most of childhood in the U.S.; and able to read and speak English.

Only eligible Turk Workers were able to view the posted recruitment invitation and, if they accepted the invitation, they were then able to complete the consent form and online battery containing the study surveys. The participant population of mTurk has similar demographics to the general U.S. population in geographical location and gender distribution,[31] and participants were recruited to be a nationally geographically representative sample. The study was approved by the University of Connecticut's IRB. All participants were provided with local mental health resources in the event they felt distress from participating in the study. For the online survey, participants received $9 as compensation. The raw data consisted of a diverse sample of 1001 participants. For the purpose of validation, participants who were missing all the study measures (n = 49) or their racial identity (n = 11) were excluded.

In terms of demographics, the mean income level was somewhat lower than the U.S. national average.[32] Demographic details of the sample are shown in Table 1.

Measures

Trauma Symptoms of Discrimination Scale. As noted, the TSDS[12] is a 21-item scale that evaluates discriminatory distress for anxiety-related symptoms of trauma. The measure assesses uncontrollable arousal, feelings of alienation, worries about future negative events, and perceiving others as dangerous. Participants were asked to report the frequency of their experience of discriminatory distress regarding trauma on a 4-point scale ranging from 0 (Never) to 3 (Often). At the end of the scale, respondents divide the percentage of their discrimination across various sources (eg, racial/ethnic, gender, sexual orientation, religion, age, etc). This scale has excellent internal consistency and test-retest reliability and revealed good concurrent validity.[12] Reliability was excellent ($\alpha = 0.97$). Most (97%) respondents of color indicated that some or most discrimination experienced was "Racial/Ethnic" in nature. Other sources of discrimination experienced by POC participants that contributed to traumatic distress included gender (36%), sexual orientation (81%), religion (68%), disability (86%), social class (38%), and age (56%).

General Ethnic Discrimination Scale. The GEDS[33] was designed to evaluate the frequency and severity of discrimination in education, employment, the legal system, healthcare, or community settings due to one's race/ethnicity. It includes 17 multi-part questions wherein participants are asked to rate the frequency of a specific discrimination experience on a 6-point scale ranging from 1 (Never) to 6 (Almost all the time), and then rate the severity of their stress due to each experience on a 5-point scale ranging from 0 (Not at all stressful) to 4 (Extremely stressful). The sections are scored separately to provide a frequency and a stress score. For the past month and lifetime frequency as well as the stress scores had good reliability ($\alpha = 0.96$ for each).

Racial Microaggressions Scale. The RMAS[34] was used to measure the frequency of ongoing racial microaggressions; these are small automatic/unintentional racist acts that are not clearly racially motivated and yet reinforce harmful stereotypes and communicate exclusion to POC. It contains 32 items, rated from 0 (Never) to 3 (Often/Frequently), with

Table 1. Demographics of sample

	White (Non-Hispanic)	Black American	Asian American	White Hispanic	Non-White Hispanic
N (%)	N = 276	N = 289	N = 199	N = 80	N = 79
Gender					
Male	155 (56%)	125 (43%)	118 (59%)	48 (60%)	47 (60%)
Female	121 (44%)	163 (56%)	79 (38%)	33 (40%)	32 (40%)
Other/Nonbinary	0	1 (0.3%)	2 (1%)	0	0
Nativity					
USA	273 (99%)	277 (96%)	141 (71%)	73 (91%)	74 (94%)
Other	3 (1%)	12 (4%)	58 (29%)	7 (9%)	5 (6%)
Marital Status					
Married	113 (41%)	65 (23%)	74 (37%)	27 (34%)	35 (44%)
Never Married	98 (36%)	151 (52%)	106 (53%)	32 (40%)	33 (42%)
Divorced/Separated/ Widowed	25 (9%)	29 (10%)	4 (2%)	1 (1%)	2 (2%)
Living with Partner	40 (15%)	44 (15%)	15 (8%)	20 (25%)	9 (11%)
Language Fluency					
English	271 (98%)	281 (97%)	146 (73%)	57 (71%)	57 (72%)
Bilingual English/ Spanish	1 (0.4%)	1 (0.3%)	2 (2%)	22 (28%)	20 (25%)
Bilingual English/Other	1 (0.4%)	6 (2%)	48 (24%)	0	2 (3%)
Other	3 (1%)	1 (0.3%)	1 (1%)	1 (1%)	0
Household Income, Annual					
Less than $20,000	40 (15%)	40 (14%)	18 (10%)	7 (9%)	8 (10%)
$20,000–$39,999	66 (24%)	89 (31%)	34 (17%)	20 (25%)	22 (28%)
$40,000–$59,999	60 (22%)	67 (23%)	35 (18%)	20 (25%)	22 (28%)
$60,000–$79,999	43 (16%)	47 (16%)	34 (17%)	14 (17%)	16 (20%)
$80,000–$99,999	33 (12%)	19 (7%)	23 (12%)	11 (14%)	4 (5%)
$100,000–$150,000	25 (9%)	23 (8%)	28 (14%)	6 (8%)	3 (4%)
More than $150,000	9 (3%)	4 (1%)	27 (13%)	2 (3%)	4 (5%)
Education					
Not complete HS	1 (0.4%)	1 (0.3%)	0	0	1 (1%)
HS or equivalent	34 (12%)	27 (9%)	8 (4%)	8 (10%)	7 (9%)
Part college or 2 year degree	99 (36%)	128 (44%)	41 (21%)	27 (34%)	22 (28%)
Graduated 3–4 year degree	107 (39%)	107 (37%)	97 (49%)	37 (46%)	38 (48%)
Graduate/ professional degree	35 (13%)	21 (7%)	53 (27%)	8 (10%)	11 (14%)

Note: The frequency of each demographic characteristic is listed with the percentage in parentheses. In addition to the five ethnoracial groups listed in the table, there were 18 participants who indicated "other" or listed multiple ethnoracial identities, not presented in the table.

higher numbers indicating more frequent experiences of microaggressions. There are 12 categories of microaggressions included in the total scale, which correspond to several of Sue et al's[35] taxonomy and include items about feelings of invisibility due to race, assumptions of criminality by others, being low-achieving or part of an undesirable culture, being a foreigner or not belonging, and environmental omissions, as well as additional categories such as erotization. For example, the item, "People act like they are scared of me because of my race" represents the microaggressive theme of criminality. The RMAS exhibited excellent reliability ($\alpha = 0.95$).

Race-Based Traumatic Stress Symptom Scale (Short Form). The RBTSSS-SF[36] is a 22-item clinical tool for the assessment of distress in responses to experiences of racism. It consists of seven subscales: Depression, Anger, Physical Reactions, Avoidance, Intrusion, Hypervigilance/ Arousal, and Low Self-Esteem. The measure begins with an open-ended section in which participants are asked about three memorable experiences with racism. In reference to their most memorable experience, participants answer a series of yes/no questions to assess psychological reactivity. In reference to the same event, participants rate a series of reactions on a 5-point Likert-type scale to assess emotional reactivity, which ranges from 0 (does not describe my reaction) to 4 (this reaction would not go away). We rated severity race-based discrimination by summing all items. The reliability for the RBTSSS-SF was excellent ($\alpha = 0.96$).

UConn Racial/Ethnic Stress & Trauma Survey. The UnRESTS[37] is a clinician-administered interview for racial trauma. It includes 6 questions to assess ethnoracial identity development, a semi-structured interview to probe for a variety of racism-related experiences, and a checklist to help determine whether the individual's racial trauma meets DSM-5 criteria. The interview guides the clinician in asking questions about experiences with explicit and obvious racism toward them, racism experienced by loved ones, being vicariously impacted by racist experiences that

were learned about, and experiences with subtle forms of racism or microaggressions. The checklist at the end provides a DSM-5 diagnosis for PTSD caused by experiences of racism. Interviews conducted on a subset of the sample, and 80 of these were used for analysis.

PTSD Civilian Checklist-5. The PCL-5[38] is a measure developed by the U.S. Department of Veterans Affairs National Center for PTSD that assesses for the presence and severity of symptoms of PTSD. The PCL-5 assesses re-experiencing of a traumatic event, avoidance, changes in cognitions and mood, arousal and reactivity, and distress and interference. The reliability for this measure was excellent ($\alpha = 0.97$).

Posttraumatic Cognitions Inventory. The PTCI[39] is a questionnaire that is designed to assess negative cognitions about self, negative cognitions about the world, and self-blame. Participants are asked to rate the extent to which they agree or disagree with each item on a 7-point scale ranging from 1 (totally disagree) to 7 (totally agree). The PTCI has excellent internal consistency, good test-retest reliability, correlates well with other measures of trauma-related cognitions, and discriminates well between traumatized people with and without PTSD.[39] The reliability was excellent ($\alpha = 0.96$).

Beck Anxiety Inventory. The BAI[40] is a 21-item self-report measure used to assess anxiety in adults. The BAI focuses on somatic symptoms of anxiety, such as nervousness, dizziness, and inability to relax.[41] Participants are asked to rate the extent to which they have been bothered by each symptom within the past week on a 4-point Likert-type scale ranging from 0 (not at all) to 3 (severely). The BAI is psychometrically sound with good convergent validity, internal consistency, and test-retest reliability.[41,42] The reliability was excellent ($\alpha = 0.96$).

Beck Depression Inventory II. The BDI-II[43] is a 21-item self-report measure that is designed to assess the severity of depression. Examples of items are, "I am sad all the time" and "I am disappointed in myself." The BDI-II has been validated through numerous studies across many different populations and ethnic groups. It has been used in a multitude of treatment outcome studies and with individuals with a history of trauma exposure. The reliability for this measure was good ($\alpha = 0.95$).

Analyses

A series of statistical tests were used to examine the relationship between racial trauma, microaggressions, racism, and psychopathology. Correlations were used to map the links between all the study variables. Group comparisons were made using t-tests and ANOVA. A t-test was used to compare TSDS between those with and without racial trauma. Regression analysis was used to examine the predictive relationship between racial trauma and other marginalized identities and various other demographic dimensions.

Marginalized identity values were computed based on demographic characteristics and identities associated with race, ethnicity, gender, sexual orientation, level of education, and income. Participants were coded as 0 if their identity represented a marginalized group and 1 if their identity represented a privileged group. Composite marginalization scores were computed by summing individual values for each demographic characteristic or identity and ranged from 0 to 5. Differences were compared using an ANOVA and Tukey's HSD post-hoc test.

Results

Relationship to Experiences of Racism

The bivariate relations between the trauma symptoms of discrimination (TSDS) and measures of frequency and stress related to ethnic discrimination (GEDS), experiences of microaggressions (RMAS), and race-based traumatic stress symptoms (RBTSSS-SF) were as expected and are found in Table 2. For general experiences of discrimination, TSDS related more strongly to lifetime ($r = 0.71$) experiences than recent experiences ($r = 0.64$). TSDS was also related to the amount of stress associated with experiences of discrimination ($r = 0.67$). Similarly, TSDS was related to reports of microaggressions ($r = 0.65$) and race-based traumatic stress symptoms ($r = 0.69$).

Relationship to Psychopathology

The bivariate relations between the trauma symptoms of discrimination (TSDS) and measures of psychopathology, including PTSD symptoms (PCL-5), traumatic cognitions (PCTI), symptoms of anxiety (BAI) and depression (BDI) are shown in Table 3. The correlations show trauma symptoms of discrimination were associated with higher levels of depression ($r = 0.55$) and anxiety ($r = 0.63$) symptoms,

Table 2. Correlation table for the TSDS and racial constructs

Measures	Mean (SD)	Correlation to TSDS (r)
Trauma Symptoms of Discrimination Scale (TSDS)	36.57 (16.09)	—-
General Ethnic Discrimination Scale (GEDS)		
Frequency - Past Year	32.21 (17.40)	0.64**
Frequency – Lifetime	39.23 (17.49)	0.71**
Stress	46.70 (24.78)	0.67**
Racial Microaggressions Scale (RMAS)	62.99 (23.01)	0.65**
Race-Based Traumatic Stress Symptom Scale (RBTSSS-SF)	33.90 (15.68)	0.69**

Note: $^{**}p < 0.001$.

traumatic cognitions (r = 0.65), and PTSD symptoms (r = 0.69).

An independent samples t-test was used to examine mean differences in TSDS in individuals with racial trauma (n = 22, M = 49.06, SD = 14.09) and those without (n = 58, M = 29.10, SD = 11.04) based on the UnRESTS interviews. The t-test revealed a significant mean difference between those with and without racial trauma, t(78) = -6.672, p < 0.001.

Comparisons of Ethnoracial Groups

Levels of discrimination and trauma differed across ethnoracial groups, as shown in Table 4. An analysis of variance (ANOVA) test was used to examine differences on the TSDS. There was a statistically significant difference between the ethnoracial groups, F(9154) = 18.93, p < 0.001, suggesting mean levels of trauma symptoms of discrimination were not equal across the five groups. The Tukey's HSD test for multiple comparisons examined specific differences between pairs of means. The post hoc comparisons found the mean for White non-Hispanic was significantly lower than the means of the other four groups. Specifically the mean for Hispanic non-White (p < 0.001, 95% C.I. = 8.85, 19.40) and Black non-Hispanic (p < 0.001, 95% C.I. = 5.80, 12.76) were significantly higher than White non-Hispanic. To a lesser degree, White Hispanic was different from White non-Hispanic (p = 0.035, 95% C.I. = 0.25, 11.21). The mean for Hispanic non-White (p < 0.001, 95% C.I. = 2.49, 13.48) was significantly higher than Asian non-Hispanic and this group (p = 0.006, 95% C.I. = 1.72, 15.06) was also higher than Hispanic White.

The remaining comparisons were not significantly different. There was no statistically significant difference between Hispanic non-White and Black non-Hispanic (p = 0.07). There was no statistically significant difference between Asian non-Hispanic and both Black non-Hispanic (p = 0.21) and White Hispanic (p = 1.0). Lastly, Black non-Hispanic and White Hispanic were not different (p = 0.42).

Table 3. Correlation table for the TSDS and psychopathology

Measures	Mean (SD)	Correlation to TSDS (r)
PTSD Civilian Checklist-5 (PCL-5)	38.76 (19.40)	0.69**
Posttraumatic Cognitions Inventory (PCTI)	100.83 (47.98)	0.65**
Beck Anxiety Inventory (BAI)	31.13 (12.37)	0.63**
Beck Depression Inventory (BDI)	35.06 (14.40)	0.55**

Note: **$p < 0.001$.

Participants varied in the proportion and type of discrimination they experienced. An independent sample t-test was used to examine mean differences in the percentage of traumatic racial discrimination BIPOC and White participants reported, with respect to all discrimination experienced. Specifically, BIPOC participants (M = 55.10, SD = 28.39) significantly differed from White participants (M = 20.78, SD = 26.87) in the percentage of racial discrimination they experienced with an average mean difference of −34.32, t(931) = −17.00, p < 0.001 [95% C.I. = -38.28, −30.36].

Gender and Sexual Orientation

T-tests were used to examine mean level differences on the TSDS related to discrimination for gender and sexual minority status. There were no statistical differences between male and female participants. However, the t-test results show a statistically significant difference based on sexual orientation, t(924) = -4.273, p < 0.001. The mean for those with LGBQ identities was significantly higher than those who identified as hetersexual.

T-tests were used to examine mean level differences in the percentage of discrimination experienced due to gender and sexual orientation. For gender, female participants significantly differed from male participants in the percentage of discrimination they experienced with an average mean difference of −19.03, t(931) = −14.32, p < 0.001 [95% C.I. = -21.65, −16.43]. For sexual orientation, LGBQ participants significantly differed from hetersexual participants in the percentage of traumatic discrimination they experienced with an average mean difference of −16.35, t (924) = −18.97, p < 0.001 [95% C.I. = -18.05, −14.66] (Table 5).

Intersectionality and the TSDS

A marginalization index was computed by summing individual values for each marginalized demographic characteristic or identity. A point (value of 1) was given for each of the following dimensions: non-White, sexual minority, female, less education (less than or equal to highschool), and low income (less than $19,999 annually). The 3 trans/nonbinary people were omitted due to low numbers. As such, scores ranged from 0, not having any marginalized identity, to 5, identifying with all the marginalized identities. The majority of participants identified with at least one (n = 353) or two (n = 338) marginalized identities.

An ANOVA test was used to compare levels of trauma symptoms related to discrimination across multiple marginalized identities. There was a statistically significant difference between the number of marginalized identities, F(9284) = 10.09, p < 0.001, suggesting mean levels of trauma symptoms are not equal across the groups. The Tukey's HSD test for multiple comparisons examined differences across marginalization scores. The mean level for those with no marginalizing identities were significantly lower than those

Table 4. Comparisons of ethnoracial groups

Ethnoracial Group	N	TSDS Mean	Std. Dev.	GEDS (lifetime) Mean	Std. Dev.
White Non-Hispanic	270	30.61	13.53	29.40	13.13
Black Non-Hispanic	288	39.78	16.83	45.04	16.28
Asian Non-Hispanic	200	36.75	14.79	39.25	14.56
White Hispanic	77	36.34	15.56	39.37	15.83
Non-White Hispanic	85	44.73	18.20	52.51	24.45
Total	*920*	*36.60*	*16.11*	*39.23*	*17.48*

Table 5. Comparisons of gender and sexual orientation

Gender	N	TSDS Mean	Std. Dev.	% Mean	Std. Dev.
Male	495	36.32	16.11	9.81	16.01
Female	435	36.82	16.07	28.85	24.20
Sexual Orientation	**N**	**TSDS Mean**	**Std. Dev.**	**% Mean**	**Std. Dev.**
Heterosexual	798	35.62	15.44	1.39	5.18
LGBQ	128	42.09	18.57	17.75	20.69

Table 6. Comparisons of marginalization scores

Marginalization Index	N	TSDS Mean	Std. Dev.
0 Marginalized Identities	113	28.99	11.96
1 Marginalized Identity	353	35.75	15.48
2 Marginalized Identities	338	38.79	17.02
3 Marginalized Identities	115	40.29	16.24
4 Marginalized Identities	14	34.21	15.38

with one ($p < 0.001$, 95% C.I. = -11.42, −2.10), two ($p < 0.001$, 95% C.I. = -14.48, −5.11), or three ($p < 0.001$, 95% C.I. = -17.01, −5.58) identities. (Table 6).

A linear regression was used to predict trauma symptoms of discrimination based on marginalization scores. A significant regression showed $F(1, 931) = 28.74$, $p < 0.001$ with an R squared of .03. Participants' level of trauma symptoms due to discrimination increased by 3.06 for each additional identity of their marginalization score.

Discussion

Trauma Symptoms, Racism, and Psychopathology

This study shows trauma symptoms increased with recent and past experiences of discrimination, racial microaggressions, and multiple forms of psychopathology. Consistent with Williams and colleagues,[12] this finding indicates both implicit and explicit acts of racism contribute to traumatization. This link is attributed to the fact that implicit acts, such as microaggression, occur more frequently.[12,44] Notably lifetime discrimination was more strongly related to trauma symptoms than recent (past year) experiences, underscoring the cumulative nature of trauma. For psychopathology, the TSDS was most strongly related to established measures of PTSD (PCL-5, PTCI) as well as measures of depression and anxiety. Williams, Kanter, and Ching[44] also found a similar relationship between the TSDS and measures of anxiety. Anxiety and depression are separate disorders and often linked to discrimination, yet they both share symptoms with PTSD (eg, [45,46]).

Ethnoracial Groups Differ in the Degree of Symptoms

Ethnoracial groups clearly differ in their experiences of trauma symptoms with non-White Hispanic and Black Americans reporting the highest rates, followed by Asian Americans and White Hispanic Americans. The lowest symptoms were found among non-Hispanic White participants. This finding is consistent with a national study, Chou and colleagues[19] found that African Americans reported a significantly higher degree of racial discrimination than Asian or Hispanic Americans, who did not differ significantly from each other in level of perceived discrimination. However, that study did not separate White and non-White Hispanics in their analysis. Similarly, a study by Lee and colleagues[47] using data from the Pew Research Center, found when comparing Black, Hispanic, and Asian Americans, Black people reported the most racism among the groups analyzed.

Gender

In our analysis of gender differences, we found that being female alone does not increase the risk for trauma symptoms

from discrimination, which is counterintuitive. One would assume that female gender would increase the risk of discrimination due to greater gender-based traumatization, as the literature tends to find greater trauma exposure and PTSD among women.[48] Our findings could be a reflection of decreasing sexual harassment and abuse of women due to increased social appropriation of sexism, greater empowerment of women, and increased legal protections in the U.S. (cf, [49]). Notably, even current studies on trauma and gender differences often use datasets that are decades old, and do not show consistent gender differences for people of color.[48,50] Newer studies show fewer gender differences in traumatization, such as among low-income African Americans (eg, [51]).

Our findings are somewhat consistent with McClendon and colleagues,[52] who investigated ethnoracial and gender differences in discriminatory stress and PTSD severity in veterans. The authors found only small gender-related differences in discriminatory distress, despite large gender (and racial) differences in PTSD. Additionally, there were significant positive correlations between discriminatory stress and PTSD symptom severity for all ethnoracial groups but with small effect sizes.

Sexual Orientation

In our analysis of sexual orientation differences, we found being a sexual minority significantly increases the risk for trauma symptoms of discrimination. There is not much research on the connection between minority stress and trauma symptoms in LGBQ populations. Most of the literature focuses on minority stress and its connections to depression, suicidality, and substance use.[53,54] Empirical studies about trauma focus on victimization and abuse. Nonetheless, there is emerging scholarship on LGBQ minoritization and trauma due to the cumulative nature of their identity-specific stressors. Cardona and colleagues[55] conceptualize ongoing discriminatory stress as chronic and even traumatic invalidation that interferes with emotion processing when the environment prevents an individual's emotional needs from being met. This chronic invalidation results in greater sensitivity and avoidance. Eventually, the individual begins to feel their sexual minority related emotions are harmful and wrong, leading to internalization and the conclusion that something is wrong with them. It is clear being a sexual minority continues to be difficult in our society as evidenced by the greater levels of traumatization, and both implicit and explicit aspects of discrimination contribute to harms.

Intersectionality and Risk for Trauma Symptoms of Discrimination

We found intersectionality and multiple stigmatized identities increases risk for trauma symptoms, which is somewhat consistent with the literature. Currently, the generalizability of studies involving intersectionality with multiple marginalized identities poses a challenge due to basic data availability. More specifically, a "Catch-22" has yet to be truly surmounted regarding intersectional data collection on the most cross-marginalized populations, who are usually more invisibilized and less accessible to reach for sustained data collection.[56] Others have similarly observed the paucity of available data involving dual minority status (eg, ethnicity-race/sexual orientation) and corresponding interventions.[53]

Notwithstanding such limitations, research is mixed on the intersectional impact for sexual and gender minority POC populations. In Cochran et al's[53] analysis of the National Latino and Asian American Survey (NLAAS) (n = 4498), the LGB or same gender partner-identified subsample (n = 245) reflected a lower prevalence of depressive, anxiety and substance use disorders as compared to sexual orientation minorities more generally speaking, mirroring prevalence rates reported by Latine and Asian Americans populations when compared to non-Hispanic Whites. At the same time, while male sexual minority participants were more likely to report a recent suicide attempt and less likely to report substance abuse or dependency than their heterosexual male counterparts, queer female participants were more likely than heterosexual females to have had recent drug use histories and depressive disorders.[53]

Similarly, Meyer and colleagues[57] found that Black and Latine sexual minorities reported a greater number of serious suicide attempts than White sexual minorities, while at the same time not exhibiting a higher prevalence of disorders. The observed lower prevalence rate was surmised in part to be due to the closer or tighter knit ethnoracial cultures of which Black and Latine LGB are a part. And while LGBTQ-based discrimination and racism were clearly associated with one another and exerted a direct impact on mental health, it was only the former (ie, LGBTQ discrimination) that demonstrated a significant indirect effect on suicidal ideation in another study.[27] The researchers observed that LGBTQ discrimination tended to "overpower" the variable of racism, possibly due to both inter- and intra-cultural homophobia that queer persons of color confront in their ethnoracial and sexual minority communities. To sum up briefly, more work is needed to better understand how multiply marginalized individuals experience various forms of discrimination. As one example inquiry into multiple marginalization, greater attention must be paid to how being both a sexual minority and person of color shape discriminatory experiences differently than being a sexual minority or person of color separately.[20]

Clinical Implications

People with more marginalized identities are more likely to have trauma symptoms, with the largest impact seen in non-White Hispanic Americans and sexual minorities. These identities alone were associated with comparable or greater discriminatory trauma than non-specific intersectional

identities. Nonetheless, clinicians should be aware that greater intersectionality is more likely to signal cumulative trauma, and it also can be an impediment to treatment, as has been seen with other disorders as well (eg, [58,59]).

A culturally-informed approach to care is critical. Despite the increased availability of literature for cultivating practitioner cultural competency (eg, [60]), its practical application in the clinical field is still debated. Since the 1990s and earlier, the American Psychological Association (APA) has steadily supported initiatives tied to diversity and cultural awareness.[61] The APA Ethical Code of Conduct includes standards surrounding the need for culturally responsive and respectful interventions that can mitigate risk of harm to diverse clients.[62,63] Likewise, the 2014 American Counseling Association's (ACA) Code of Ethics calls for multicultural/diversity competence and social justice advocacy. Moreover, such guidelines recognize clinicians as cultural beings who bring their own beliefs and attitudes that influence clinical and empirical conceptualizations and their work with clients ([64], p. 26).

Social justice-oriented critics of clinical psychology, however, sharply rebuke the field for its lack of institutionalized support of an intersectional awareness competency, particularly its failure to integrate core diversity perspectives (eg, critical race, feminist, and social justice theories) and the role of structural inequalities to client pathology.[63] Indeed, despite clear mandates for culturally-informed approaches, clinicians are not trained to assist clients experiencing distress due to marginalized identities. Many if not most clinical training programs do a poor job of preparing students to work with these clients on any dimension of diversity, much less intersectional identities (eg, [65,66]). To solve these problems, we must examine the larger structures that dictate which clinical issues are worthy of attention, and as such, this will require addressing the biases of faculty, supervisors, researchers, and administrators who wield power and privilege within these contexts.[67]

Therapists should assess all minoritized clients for PTSD symptoms from discrimination. They may need to ask specifically about these experiences which may not be conceptualized as "traumas" by clients, who may be used to having these experiences dismissed by others as unrelated.[37] Some recommended treatment approaches include empirically-supported PTSD treatments adapted to use with people with marginalized identities (eg, [68]) or evidence-based protocols specific to issues like racial trauma or minority stress (eg, [69,70]). Coping skills should be tailored to address the client's unique intersectional stressors, however coping should not be a substitute for empowerment, as treatment should also explore reducing discrimination in the person's daily environment.[71]

Kira and colleagues[10] also emphasize that proactive strategies can serve to inoculate against the effects of the cumulative buildup of abandonment/betrayal traumas and systemic discrimination. In building a therapeutic alliance with such clients, therapists can first assist with safety plans, working with clients to distinguish safe and unsafe behaviors as well as engage in any needed advocacy at systemic levels to address actual or emerging dangers.[70–72] Identity threats can also be buttressed by innovations such as group-based emotional regulation (GBER), which works with stereotyping, self-esteem, and anxieties about identity annihilation. In-group and out-group studies from social psychology have demonstrated the tremendous influence that not only threats to personal identity but also those to social identity have on self-esteem and one's basic sense of self.[72,73]

Limitations & Future Directions

In terms of demographics, there were not many participants in the lowest education or income brackets which impeded our ability to explore the traumatizing impact of poverty-related oppression. Likewise, there were not enough trans participants to explore this dimension of marginalization. Although the effects of multiple marginalized identities may compound traumatization, our index of marginalization is undoubtedly oversimplified. Confounding or effect modifying relationships may exist between certain demographic dimensions. Larger samples are needed to develop more precise predictors of traumatization. Trauma symptoms resulting from other forms of intersectionality also should be explored, such as sexual minority status and a stigmatized religious tradition.[74] The TSDS and RTS may be equally good as a screener for racial trauma, but cut-off scores for the TSDS need to be established for other kinds of oppression-based trauma.

Conclusions

Our research found oppression in all its forms is traumatizing, although some dimensions of oppression are more traumatizing than others based on differing identities and intersectionalities. Clinicians should consider all of these in clinical practice, individually and in combination. Intersectionality may require unique treatment approaches, which is an area sorely in need of more research.

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