Comparison of Racial Groups on Trauma and Post-Trauma Functioning

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ABSTRACT. A paucity of literature exists on racial/ethnic differences in post-trauma functioning on samples other than combat veterans. Overall, the results of this literature are unclear in terms of the nature and direction of differences in trauma exposure and post-trauma functioning. In the present study, African American and Caucasian treatment seeking women were assessed on structured clinical interviews and self-report measures. Results indicated no differences in overall degree of trauma exposure. In terms of mental health variables, Caucasians reported greater distress on several measures and were more likely to be

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Journal of Trauma Practice, Vol. 5(2) 2006
Available online at http://jtp.haworthpress.com

doi:10.1300/J189v05n02_02

diagnosed with post-traumatic stress disorder. African Americans reported more sibling sexual abuse, multiple incidents of abuse, and more acquaintance physical abuse. The finding that Caucasian participants reported greater distress is dissimilar to most other published data. Potential explanations for these findings are discussed. doi:10.1300/J189v05n02_02

KEYWORDS. Trauma, ethnic differences, interpersonal functioning, sibling abuse, mental health

Investigators have paid increasing attention to the detrimental effects of exposure to a traumatic event. Despite the multitude of trauma-focused studies, little information is available regarding racial and ethnic differences related to exposure to traumatic events and trauma impact. Theories of trauma impact and treatment assume that individuals have similar responses irrespective of race, ethnicity, and culture (Barker-Collo, 1999). Several limitations exist in the current literature. First, of the studies that compare trauma exposure across race or ethnicity, most sample a limited range of trauma experiences and do not explore potential differences in trauma characteristics. Second, the majority of research examining racial or ethnic differences in trauma impact was conducted with male veterans and the extent to which these results may generalize to nonveteran populations is unknown. Third, regarding trauma impact, studies tend to focus on differences in post-traumatic stress symptoms, often neglecting other trauma outcomes. Attention to these relative voids in the literature is imperative in order to develop and provide adequate assessment and treatment of potentially disparate needs due to cultural differences.

Research on rates of exposure to traumatic events is equivocal. Statistics reported by the U.S. Department of Justice (2002) indicated that Caucasians report less exposure to crimes of violence than African Americans (see also Breslau, Davis, & Andreski, 1995; McGruder-Johnson et al., 2000). In a large-scale investigation of the prevalence and impact of nine types of traumatic events, however, Norris (1992) found that Caucasians reported more instances of traumatic events compared to African Americans across several categories. Specifically, Caucasians reported greater

lifetime prevalence of robbery, physical assault, other disaster, other hazard, and tragic death, whereas African Americans reported greater prevalence of past-year motor vehicle accidents.

Similarly, in studies that focus on one type of trauma, results are unclear. For example, some studies found rates of exposure to sexual abuse to be comparable across countries (Finklehor, 1994) and racial/ethnic groups (e.g., Wyatt, 1992), whereas others reported significant group differences (Barker-Collo, 1999; Hanson et al., 2003; Koss, Gidycz, & Wisniewski, 1987). The broader child maltreatment literature also finds little aggregation among studies (Lau et al., 2003; Sedlak & Broadhurst, 1996; U.S. Department of Health and Human Services, 2003). In contrast, the literature on domestic violence appears less contrariant in that partner abuse appears to be more prevalent among low-income partners and to vary by race within that group (Jasinski & Kaufman Kantor, 1997). Other studies find higher rates of partner abuse by particular racial or ethnic minority groups (e.g., Gelles, 1993; Rennison & Welchans, 2000); however, race and socioeconomic status are often confounded (Vogel & Marshall, 2001). Overall, the literature on differences in prevalence of trauma by race is equivocal. The nature of the differences in prevalence rates may be related to the specific sample included, the informant, the types of acts assessed, the definitions of maltreatment, and/or the manner in which the information was gathered. Unfortunately, little information is available regarding the prevalence of other types of traumatic events (e.g., physical assaults).

Research indicates that, overall, minority groups in the United States may experience distress and psychopathology at rates exceeding those found in the Caucasian majority group (e.g., Robins & Regier, 1991). Research investigating trauma sequelae among racial groups find variable results. Norris (1992) found that despite the lower lifetime trauma exposure reported by African Americans, this particular racial group seemed more negatively affected by trauma, reporting higher levels of stress as a result of violent trauma and exposure to hazards. Research suggests that the lifetime prevalence estimates for PTSD after-trauma exposure between both African Americans and Caucasians is approximately 1% to 12% of the population, whereas Hispanic men show a significantly greater rate of 28% (Trent et al., 2000; Zoellner et al., 1999). Zatzick, Marmar, Weiss, and Metzler (1994) found that African American veterans were significantly more likely to report dissociative symptoms than were Caucasians or Hispanics. A study by Frueh and colleagues (2002) found that African American veterans with PTSD were more likely to endorse positive symptoms of psychosis, including

paranoia and dissociation, than were Caucasian veterans. However, the effect sizes were modest, and significant differences were not found on a more general assessment of disturbed thinking (i.e., MMPI-2 scale 8). No racial differences were found regarding anxiety, depression, or general PTSD symptomatology. Other studies on combat veterans have shown little or no differences between races (Monnier et al., 2002; Trent et al., 2000).

Research examining racial differences in symptoms following rape suggests that African Americans and Caucasians report similar levels of long-term disturbance (Wyatt, 1992). However, studies examining reactions to natural disaster (Perilla, Norris, & Lavizzo, 2002), such as Hurricane Andrew, have found significant racial differences in the presentation of PTSD symptoms. This study found that Caucasian disaster victims had the lowest rate of PTSD (15%), followed by English-preferring Latinos (19%), African Americans (23%), and Spanish-preferring Latinos (38%). Although the degree of personal and community exposure and particular vulnerability factors (e.g., fatalism) explained some of the variance in post-trauma outcomes, they did not completely account for the racial differences. In a study of undergraduates, McGruder-Johnson et al. (2000) found that African Americans scored higher on particular subscales of the Trauma Symptom Inventory (Briere, 1995) including sexual concerns, dysfunctional sexual behavior, intrusion, and avoidance, but did not differ on PTSD symptoms assessed via interview. Further analysis revealed that the differences were directly related to trauma exposure rather than race. Finally, Vogel and Marshall (2001) compared low-income members of three racial groups on PTSD symptoms. They found no differences in symptoms among African American, Caucasian, and Mexican American women. Thus, similar to research on exposure to trauma, results of studies investigating racial differences in trauma impact are inconclusive.

A review of the literature indicates several areas devoid of information regarding racial differences in trauma prevalence or impact. The purpose of the current study was to examine the nature, prevalence, and outcome of trauma in a sample of adult treatment-seeking women. Assessment of trauma outcome included current psychiatric diagnoses, general distress, trauma specific symptoms, intimacy and sexual functioning, and sexual history. Although previous research is equivocal on these issues, we decided to base our hypotheses on the findings of the majority of studies reviewed for this paper. The following hypotheses were generated: (1) Caucasian participants would report a greater number of traumatic events than African American participants; and (2) African

American participants would report greater distress across mental health variables than Caucasian participants. Exploratory analyses examined specific trauma characteristics between the racial groups.

METHOD

Participants

Archival data were gathered from the charts of 94 consecutive clients who presented themselves for services at an outpatient clinic specializing in the treatment of trauma victims. The clinic is located in an urban area in the southeast region of the United States. As the clinic specializes in trauma treatment, it serves a wide geographical area. Clients are referred by a variety of sources including physicians, psychiatrists, psychologists, and social service agencies. The clinic works on a sliding scale and accepts a variety of types of insurance, including Medicare and Medicaid. Institutional Review Board approval was obtained from the medical university that housed the clinic. As part of the standard intake assessment, clients were asked to complete a clinical interview and self-report measures. Participants included 88 women (93.6%) and 6 men (6.4%). Although previous research indicates that trauma outcome may differ by gender (e.g., Norris, Foster, & Weisshaar, 2002), the current sample did not include enough men to conduct gender comparisons. Therefore, this study reports on responses from women only. Seventy-two percent of the participants were Caucasian, 21% African American, 1% Hispanic, and 4% self-identified as "Other." The sample did not include enough participants of races other than Caucasian and African American to conduct meaningful comparisons, thus the current study was restricted to comparisons of the two most frequently endorsed races, representing 88% of the total sample. Excluding clients due to the gender and racial conditions specified above resulted in retention of 82 participants. The mean age of participants was 36.12 (SD = 9.75). The majority (60%) of the participants reported having a high school degree or some college, 23% reported having a college degree or higher, and 17% did not graduate high school. One-quarter of the sample was divorced/separated, 21% were married, 13% were cohabitating, and 39% were single or dating. The groups were statistically equivalent with the exception that more African Americans (36.8%) reported not earning a high school degree than Cauasians (11.1%), χ^2 (2, N = 82) = 7.58, p = 0.02.

Measures

Structured Clinical Interview for DSM-IV (SCID; Spitzer, Williams, & Gibbon, 1995). The SCID-IV is a formulized diagnostic interview developed to assess and closely follow the criteria within the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition-Text Revision* (DSM-IV-TR; American Psychiatric Association (APA), 2000). Researchers have found the SCID to be a valid and reliable instrument in following diagnostic criteria set forth by the DSM (e.g., Davidson, Smith, & Kudler, 1989). The panic-disorder, depressive-disorder, and post-traumatic-stress-disorder modules of the SCID-IV were administered. The SCID was administered by a psychologist, post-doctoral fellow, or psychological intern in each case. All assessors had previously been trained to administer this interview and the post-docs and interns conducted the assessments under the supervision of licensed psychologists.

Trauma Symptom Inventory (TSI; Briere, 1995). The TSI is a 100-item questionnaire designed to assess post-traumatic symptomatology associated with various types of acute and chronic traumatic events. This measure includes 10 clinical scales that assess a wide range of immediate and long-term psychological sequelae of trauma. The clinical scales include Anxious Arousal, Anger/Irritability, Depression, Defensive Avoidance, Dissociation, Dysfunctional Sexual Behavior, Intrusive Experiences, Impaired Self-Reference, Sexual Concerns, and Tension Reduction Behaviors. Additionally, the TSI includes three validity scales–Atypical Response, Inconsistent Response, and Response Level to aid in the detection of invalid profiles. Participants rate how frequently they experienced each item in the prior six months. The mean reliability of the individual scales was .84 for a college population and .87 for a clinical sample. The scale has reasonable convergent, predictive, and incremental validity (Briere, 1995). Data in the charts contained only the subscale totals, thus reliability analyses were not conducted.

Risk in Intimacy Inventory (RII; Pilkington & Richardson, 1988). The RII is a 10-item scale developed to assess perceptions of risk in intimacy. Participants indicate the extent to which they agree with each statement (e.g., "I prefer people that keep their distance from me.") on a six-point Likert scale. The RII demonstrated good reliability (Cronbach's alpha = 0.86) and validity in samples of college students (Pilkington & Richardson, 1988). Cronbach's alpha for the current sample was 0.89.

Sexual Functioning and History. Several questions on sexual functioning and sexual history were developed for this study. The sexual

functioning section consisted of one question that assessed whether the individual was sexually active currently or in the past, followed by six questions assessing for symptoms of sexual dysfunction (i.e., hypoactive desire, aversion, arousal, orgasmic, pain), listed in the *DSM-IV-TR* (APA, 2000). If the participants responded affirmatively to a particular disorder, they were then asked, "Is this a problem for you?" to assess distress or interpersonal difficulty. The sexual history questions assessed sexual orientation, same-gender sexual experiences, age of first consensual intercourse, number of sexual partners of both genders, the shortest amount of time knowing someone before engaging in sexual intercourse, and unintentional pregnancy.

Impact of Events Scale (IES; Horowitz, Wilner, & Alvarez, 1979). The IES is a 15-item questionnaire that assesses intrusion and avoidance symptoms related to a specific trauma. Participants rate the frequency of each symptom on a 4-point scale ranging from 0 (Not at all) to 5 (Often). Research indicates that the IES demonstrates good split-half, test-retest, internal reliability, and good validity (Horowitz, Field, & Classen, 1993). Data in the charts contained only total scores, thus reliability analyses were not conducted.

Trauma History. Trauma history was gathered via clinical interviews by clinical psychology post-doctoral fellows or clinical psychology predoctoral interns, supervised by licensed clinical psychologists. Trauma history included an assessment of child sexual abuse, child physical abuse, domestic violence, adult sexual assault, nondomestic violence, and adult physical assault. Incident characteristics were assessed for each type of trauma including age of victim, age of perpetrator, relationship of victim and perpetrator, number of perpetrators, and total number of incidents per type of trauma. For sexual abuse, participants were asked to indicate specific acts involved (e.g., fondling, penetration).

Data Analyses

Caucasian ($n = 63$) and African American ($n = 19$) clients were compared on demographic variables, types of trauma reported, trauma characteristics, intimacy functioning, sexual history and functioning, and psychological distress (as measured by the TSI, BDI, and IES) and psychiatric diagnoses. Categorical variables were examined via Chi-square analyses. Continuous-scaled variables were examined via one-way ANOVAs.

RESULTS

Type of Trauma

Table 1 displays the type and frequency of trauma exposure by race. As the sample was drawn from a clinic specializing in treating victims of trauma, all participants reported at least one trauma. Overall, more than half of the participants reported experiencing child sexual abuse, domestic violence, or adult sexual assault. The groups did not differ on exposure to any type of trauma. The total number of types of traumatic events was summed; an ANOVA indicated no difference between African Americans ($M = 2.37$, $SD = 1.07$) and Caucasians ($M = 2.84$, $SD = 1.47$), $F\ (1, 81) = 1.69$, $p = 0.19$.

Trauma Incident Characteristics

Assault characteristics were explored by racial group within the type of trauma. Few between-group differences were found. For those individuals reporting child sexual assault, chi-square analysis revealed a greater risk of sibling sexual assault for African Americans (30%) compared with Caucasian participants (0%), $\chi^2\ (1, N = 46) = 11.55$, $p = 0.001$. African Americans (80%) were also more likely to report experiencing multiple incidents of sexual abuse than Caucasians (30%), $\chi^2\ (1, N = 35) = 4.59$, $p = 0.03$. In terms of child physical abuse, African Americans (17%) were more likely to report abuse by an acquaintance than were Caucasians (0%), $\chi^2\ (1, N = 35) = 4.97$, $p = 0.03$. No significant differences were found for characteristics of domestic violence, adult sexual assault, or adult physical assault characteristics.

TABLE 1. Trauma History for African American and Caucasian Clients

Trauma Type	Total $n = 82$		Caucasian $n = 63$		African American $n = 19$		χ^2
	N	%	*N*	%	*N*	%	
Child sexual abuse	46	56.1	36	57.1	10	52.6	0.12
Child physical abuse	35	42.7	29	46.0	6	31.6	1.25
Domestic violence	43	52.4	34	54.0	9	47.4	0.26
Adult sexual assault	44	53.7	34	54.0	10	52.6	0.01
Adult physical assault (not domestic violence)	23	28.0	19	30.2	4	21.1	0.60
Other victimization	33	40.2	27	42.9	6	31.6	0.77

Mental Health

Table 2 presents means, standard deviations, significance information, and effect sizes for all mental health variables by race. Chi-square analyses revealed that significantly more Caucasians were diagnosed with post-traumatic stress disorder than African Americans. Univariate ANOVAs on mental health measures indicated several between-group differences. Analysis of the TSI found that Caucasians reported greater distress on the Anxious Arousal, Depression, Dissociation, and Intrusive Experiences subscales. Although these differences were statistically significant, several of the effect sizes were small.

TABLE 2. Mental Health Symptoms by Racial Group

Mental Health Variables	Caucasian $n = 63$		African American $n = 19$			
	N	%	*N*	%	χ^2	Φ
Panic disorder	15	23.8	3	15.8	0.55	0.08
Depressive disorder	32	50.8	8	42.1	0.44	0.07
Post-traumatic stress disorder	37	58.7	6	31.6	4.32*	0.23
	M	*SD*	*M*	*SD*	*F*	η^2
Beck Depression Inventory	23.88	13.53	20.35	11.59	0.95	0.01
Impact of events scale–intrusion	24.07	11.52	25.43	9.97	0.16	0.002
Impact of events scale–avoidance	24.43	9.06	24.50	11.17	0.001	0.000
Impact of events scale–total	49.33	16.72	50.64	19.82	0.06	0.001
Trauma symptom inventory subscales t-scores						
Anxious arousal	66.87	10.93	54.79	13.83	15.64***	0.17
Anger/irritability	57.61	11.65	54.68	11.53	0.92	0.01
Depression	61.94	9.97	56.26	12.19	4.23*	0.05
Defensive avoidance	64.45	7.79	63.63	12.08	0.12	0.002
Dissociation	64.55	11.68	57.11	13.61	5.47*	0.07
Dysfunctional sexual behavior	54.27	13.81	57.47	13.07	0.79	0.01
Intrusive experiences	67.92	11.50	61.26	12.93	4.59*	0.06
Impaired self-reference	59.34	10.34	54.95	12.83	2.34	0.03
Sexual concerns	58.50	12.70	56.26	11.64	0.47	0.006
Tension reduction behaviors	57.94	12.99	60.16	14.54	0.40	0.005

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

Interpersonal Functioning

One-way ANOVAs revealed no differences on the RII scale (see Table 3). In terms of sexual orientation, 87% of the sample identified themselves as heterosexual, 2% as homosexual, 7% as bisexual, and 4% were unsure. Orientation did not differ by racial group. The remaining sexual functioning questions indicated no differences between the groups. One difference was found in sexual history, in that Caucasian participants reported having sexual intercourse after knowing a person for a shorter period of time.

Given the relatively few significant differences we found, and our relatively small group sizes, we conducted a post-hoc power analysis. Assuming alpha = 0.05, two-tailed, we found few analyses that met the minimum threshold for adequate (80%) power (Cohen, 1990). However, the majority of effect sizes for nonsignificant variables were small (0.1 effect size for dependent categorical variables, and 0.1 effect size for dependent continuous variables). Moreover, the smallest effect sizes we obtained for our significant variables were in the

TABLE 3. Interpersonal Functioning by Racial Group

Interpersonal Functioning Variables	Caucasian N = 63		African American N = 19			
	N	%	*N*	%	χ^2	Φ
Problems with sexual desire	26	46.4	9	52.9	0.22	0.06
Problems with sexual aversion	17	27.0	4	25.0	0.03	0.02
Problems with sexual arousal	26	44.8	4	22.2	2.94	0.19
Problems with orgasm	28	47.5	10	55.6	0.36	0.07
Problems with pain during sexual activity	12	20.7	4	22.2	0.02	0.02
Time before intimacy[a]	26	53.1	2	16.7	5.14*	0.29
Unintentional pregnancy	35	57.4	5	38.5	1.54	0.14
	M	*SD*	*M*	*SD*	*F*	H^2
Risk in Intimacy Inventory	29.89	12.56	27.53	12.41	0.52	0.006
Age at first consensual intercourse	16.21	3.17	16.69	3.24	0.28	0.004
Lifetime number of male sexual partners	8.94	8.20	6.14	4.89	1.48	0.02
Lifetime number of female sexual partners	1.12	2.19	0.60	1.07	0.53	0.01

[a]Length of time knowing someone before engaging in sexual intercourse. Numbers and percentages refer to those individuals who reported engaging in sexual intercourse with someone they have known less than one month.

* $p < 0.05$

medium range (F of roughly 0.25), suggesting that although many analyses did not achieve 80% power, adequate power was present in detecting at least a medium effect size.

DISCUSSION

This study addresses some of the limitations of previous research through assessing a wide range of interpersonal traumas, utilization of a female clinical sample, and assessing various mental health variables. The results of this study suggest that in a distressed, treatment-seeking sample of adult female trauma victims, Caucasian participants report greater distress than African American participants on several measures of mental health functioning. Specifically, Caucasian individuals reported higher scores on Anxious Arousal, Depression, Intrusive Experiences, and Dissociation subscales on the TSI. Caucasians were also more likely to be diagnosed with PTSD and reported having sexual intercourse after knowing a person for a shorter period of time than did African Americans. Interpretation of these results must consider that although the differences were significant, the effect sizes were quite small.

These findings are contrary to almost all other published reports of post-trauma functioning, in that previous studies found either no difference between racial groups or observed greater distress among minority groups. One possible explanation for greater distress reported by Caucasians is the possible cumulative impact of trauma (e.g., Davis, Combs-Lane, & Jackson, 2002; Follette, Polusny, Bechtle, & Naugle, 1996), however, in the present study, no differences were found for prevalence of type of trauma or number of different types of trauma. It is also possible that Caucasian women experienced more noninterpersonal traumas, which were not assessed in the present study, more often than the African American individuals. Future studies will need to explore both interpersonal and noninterpersonal traumas to determine if the type or number of traumas contributes to reported symptomotology.

A second possible explanation for the present findings is differences on trauma characteristics. Research suggests that particular trauma characteristics may result in greater distress including age of victimization, relationship of victim and perpetrator, duration, etc. (e.g., Kroll, 2003). Results of comparisons on trauma characteristics yielded several differences. Specifically, of those participants who reported sexual

abuse, African American participants reported a greater prevalence of sibling sexual abuse than did the Caucasian participants. Research has shown that sibling abuse is related to more severe forms of abuse (i.e., penetration; Cyr, Wright, McDuff, & Perron, 2002); however, no differences in rates of reported penetration were found in the present study. In this same subgroup, African Americans also reported higher prevalence of multiple incidents of sexual abuse. As stated above, previous studies report that multiple experiences of trauma result in greater distress in previous studies (e.g., Davis et al., 2002), which is inconsistent with the findings of the present study. Finally, of those individuals reporting child physical abuse, African Americans were more likely to report abuse by an acquaintance than Caucasians. Again, little information was found that might assist in the interpretation of this finding. Thus, the findings of the present study would seem to indicate that African Americans would report higher distress, based on findings of previous research. However, this was not found.

A third potential explanation for greater post-trauma distress is that those individuals with fewer resources would experience greater difficulties. The present study did not assess for income level; however, educational attainment was assessed and was thought to correspond closely with socioeconomic status (South, Baumer, & Lutz, 2003). The results of the present study, that 37% of African American participants did not complete high school compared to 11% of Caucasian participants, do not support this explanation. It is possible that cultural factors (e.g., family make-up, socioeconomic status) or regional factors (Southern state) may contribute to the findings of the present study. For example, it may be that African Americans have greater social support than Caucasians, which may serve as a protective factor against post-trauma distress. Future studies need to investigate both risk (e.g., trauma history, previous psychiatric history) and protective factors (i.e., adaptive coping strategies, above average intelligence) to determine their association with race and contribution to post-trauma functioning.

A final explanation is that the mental health symptoms assessed may not be related to trauma, but rather may reflect preexisting [i.e., pre-trauma] difficulties. Future studies should include designs that may address this limitation in the current study. For example, prospective studies, which include a pre-trauma assessment of mental health, could address this issue. Of course, prospective studies are quite challenging in the trauma field, particularly when examining noncombat trauma, as the occurrence of trauma is impossible to predict. Another method to

address this limitation would be to include a control group of Caucasian and African American women without trauma histories. This would not be an ideal assessment of the question of post-trauma differences, but would provide some helpful information.

Limitations

Several limitations of the present study should be noted. Overall, the sample was relatively small, suggesting that there may be concerns with power. In particular, this was noted in several of the Chi-square analyses that yielded expected cell counts less than 5. The results should be interpreted with caution. The present sample may not be representative of trauma victims in general. As a clinical sample, it is assumed that these individuals were experiencing sufficient distress to motivate them to seek treatment. Only data from women clients were reported in the present study due to the limited number of male clients in this sample. The majority of information on men at this point comes from veteran samples. More research is needed with male nonveteran trauma victims. Similarly, this sample was restricted to Caucasians and African Americans. Additional research is needed on more diverse samples. Also, little information is available on the validity of these measures for diverse samples. Numerous works have outlined the difficulties of overpathologizing or mischaracterizing mental health symptoms of the members of minority groups. It is possible that the assessment instruments–both self-report and interview–utilized in the current study did not adequately capture the nature of mental health status of the African American participants. Future studies need to ascertain the cultural validity of assessment instruments (APA, 2003). Finally, this study assessed only interpersonal traumas. Future studies should also assess noninterpersonal traumas to attain a more comprehensive understanding of racial differences in post-trauma functioning.

CONCLUSIONS

Although the participants in the current study may not be representative of nonclinical trauma victims, it is likely that they represent those individuals whom the clinicians are most likely to see in practice. Results of this and previous studies indicate that equivalence of trauma exposure and homogeneity of trauma response can no longer be assumed. It is important for clinicians and researchers to gain a better understand-

ing of the differences in post-trauma functioning among racial and cultural groups. Further investigations of this nature may yield results with significant implications for clinical practice and future research efforts.

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RECEIVED: 11/13/04
REVISED: 05/02/05
ACCEPTED: 05/05/05

doi:10.1300/J189v05n02_02