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Anxiety-Related Disorders in the Context of Racism

M. Myriah MacIntyre[1] · Manzar Zare[1] · Monnica T. Williams[1]

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Abstract

Purpose of Review The literature on racism and anxiety-related disorders, especially social anxiety, specific phobia, and generalized anxiety disorder, is notably lacking. This report aims to review recent evidence demonstrating the link between racial discrimination and various anxiety-related disorders.

Recent Findings Anxiety-related disorders were the most significant mediator for daily discrimination and suicidal thoughts, above both depression and substance use. Further, studies showed that racial discrimination promotes posttraumatic stress and racial trauma among people of color. Systemic racism puts people of color at a higher risk for anxiety disorders than White people. Clinical case examples provide lived evidence of diverse racial and ethnic individuals suffering from anxiety-related disorders, with the development and worsening of symptoms due to racism and microaggressions.

Summary There is a prominent need for recent research on anxiety-related disorders and racism. Recommendations for clinicians and future research directions are provided. These actions are required to address bias and mental health inequities and empower people of color.

Keywords Anxiety · PTSD · OCD · Race-based anxiety · Racism · Racial trauma

Introduction

While experiences of anxiety are common across all individuals, anxiety disorders arise when such experiences are persistent and interfere with daily life. A systematic review of 204 countries identified a global prevalence of 4% for anxiety disorders, or 301.4 million people worldwide [1]. These numbers do not include OCD and PTSD, estimated to afflict 1.3% and 3.9% of the population, respectively [2, 3]. Overall, anxiety-related disorders are one of the most prevalent mental health issues and result in social, interpersonal, and economic implications [1, 4].

While there are several types of anxiety-related disorders listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5), the six, we will review are as follows:

1. Obsessive–compulsive disorder (OCD), which is a chronic disorder whereby individuals experience *obsessions* and/or *compulsions* that are time-consuming, clinically distressing, and/or result in functional impairments.
2. Generalized anxiety disorder (GAD), which is characterized by excessive anxiety and worry about everyday life activities. Symptoms, such as irritability and restlessness, are difficult to manage and interfere with daily life.
3. Specific phobia, which is an anxiety disorder that entails persistent and irrational fear or anxiety about a specific object or situation despite no legitimate danger.
4. Panic disorder, which is an anxiety disorder that features repetitive, unexpected panic attacks regardless of legitimate danger and is characterized by physical symptoms, such as increased heart rate, dizziness, and fear of losing control.
5. Social anxiety disorder (social phobia), which is characterized by the chronic and persistent fear of being watched and judged by certain types of people.
6. Posttraumatic stress disorder (PTSD), which is a psychiatric disease that can arise in people who have encountered or witnessed a traumatic event such as a natural catastrophe, a severe accident, a terrorist attack, war/combat, or rape, or who have been threatened with

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✉ Monnica T. Williams
Monnica.Williams@uOttawa.ca

[1] School of Psychology, University of Ottawa, 136 Jean-Jacques Lussier, Vanier Hall, Ottawa, ON K1N 6N5, Canada

death, sexual violence, or serious injury (Criterion A; one required); other criteria include, but are not limited to: recurrent, unwanted and distressing memories of the traumatic event; avoidance of trauma reminders; feeling detached from others; hypervigilance; and, functional impairment.

Although OCD and PTSD are no longer classified as anxiety disorders in the DSM-5 [5], they remain relevant to this discussion for their key feature of anxiety. Because of the chronic nature of anxiety-related disorders, a comprehensive understanding of their characteristics is required in order to develop effective treatments that target the manifestation of symptoms as well as their continued presence. In addition to age and sex differences, other demographic correlates, such as race and ethnicity, must be considered for their impact on symptom expression, treatment efficacy, and access to care.

Racism

Race pertains to the division and categorization of people (e.g., Black, Asian, Native American/Indigenous, White) based on phenotypes (i.e., skin complexion) and presumed heritage [6•]. While *race* is a social construct, the consequent systemic and interlocking systems of oppression referred to as racism is a legitimate, lived experience of people of color (POC) in the Western world. Racism pertains to the ideology that one racial group is superior (White people) and the corresponding active processes whereby other groups of individuals (POC) are individually and systematically oppressed via societal and political mechanisms.

There are various kinds of racism that individuals and/or groups can employ as a behavior to oppress and subordinate "othered" groups. These include but are not limited to direct racism, symbolic racism, systemic racism, and subtle racism referred to as *microaggressions*. Table 1 provides an in-depth explanation of each type of racism and the corresponding literature on its relation to anxiety disorders.

As previously mentioned, anxiety-related disorders alone can be debilitating; this, in conjunction with and perpetuated by experiences of racism, can result in mental fatigue and challenges in everyday life. Even vicarious racism can lead to increased vigilance, heightening symptoms of anxiety [7, 8]—an issue that had been particularly salient during the COVID-19 pandemic [9•]. This paper outlines the current literature on racial discrimination specific to various anxiety-related disorders. We also provide some illustrative case examples from people of color from interviews with the UConn Racial/Ethnic Stress & Trauma Survey (UnRESTS) [10, 11] and other personal accounts.

Obsessive–Compulsive Disorder

Recent literature has addressed the exclusion of racial and ethnic diversity in OCD research and examined the intersectionality between race, racism, and obsessive–compulsive disorder (OCD). Across numerous studies, experiences of racial discrimination have been found to predict and exacerbate OCD symptoms and access to care [e.g., 12]. For instance, Wadsworth and colleagues [13] examined having multiple marginalized identities with OCD symptoms and intensive residential treatment response and found that those with more marginalized identities had an increased severity of fear of contamination concerns. Further, possessing multiple marginalized identities was associated with heightened OCD symptoms at both admission and discharge from the treatment program. Considering this, there is a disparity in terms of the efficacy of intensive OCD treatment among individuals with at least one marginalized identity [13].

In line with these findings, a review of OCD research involving the Black American population revealed consistent findings concerning the impact of racial discrimination on OCD symptom expression. For example, Willis and Neblett [14] conducted the first OCD study pertaining to racial discrimination in a first-year university student sample of African Americans and found that greater experiences of discrimination were associated with significantly heightened levels of OCD-related distress. In addition, a variety of racial identity beliefs moderated this association; while some acted as vulnerability factors (e.g., race-focused racial identity pattern); others (e.g., multiculturalist and humanist racial identity patterns) were found to have a protective effect in the contexts of OCD symptoms. Also, one study identified everyday racial discrimination as a significant predictor of elevated six OCD symptom dimensions (e.g., harm, contamination, repeating, washing, ordering, counting) [15]. This was the first OCD and racial discrimination study to survey Black Caribbean American adults, and it did not find any significant differences in obsessions and compulsions in comparison to African Americans. Despite the fact that one in fifty participants met the criteria for OCD, obsessions were reported by 10.8%, and compulsions were reported by 17.5%. Results also displayed gender differences, being that Black Caribbean American men had heightened OC symptoms (e.g., unacceptable thoughts; arranging, repeating words) in comparison to women. Likewise, another study, which surveyed African American adults, identified racial discrimination, but not non-racial everyday discrimination (e.g., gender, sexual orientation) as a predictor of higher OCD symptoms and severity [16].

Cumulatively, these studies highlight racial discrimination as a distinctive predictor of higher OCD symptom

Table 1 Types of racism and research on associated anxiety disorders

Type	Definition	Disorder reported	Findings
Aversive racism	Employing racist behaviors and thoughts that contradict one's stance for supporting "racial equality and justice" [69] (Synonym: *left-wing racism*)	No research identified	Due to the lack of literature, this highlights a need for research that examines aversive racism in the context of anxiety disorders
Direct racism	The overt prejudicial and negative treatment of an individual due to ethnic heritage, skin color, or perceived race (Synonym: *overt racism)*	• Anxiety [8] **internet-based direct racism* • Anxiety [7]	Direct individual discrimination (discrimination directed explicitly at the individual), whether online or offline, was found to be associated with anxiety symptoms
Dominative racism	Racist treatment based on the belief that White people are innately superior to POC including racial stereotypes, slurs, and acts of violence [69]. (Synonym: old-fashioned racism; Example: *linguistic racism*)	• Social anxiety disorder (SAD) [38]	Studies have linked exposure to dominative racism to increased levels of SAD symptoms
Everyday racism	The systematic process whereby individuals experience racism on a daily basis, which upholds power inequality between races [69]. Everyday racism may include racial microaggressions	• Social anxiety disorder (SAD) [39] • Anxiety-related disorders (panic disorder (PD), social anxiety disorder (SAD), generalized anxiety disorder (GAD), post-traumatic stress disorder (PTSD)) [21]	Daily exposure to racism has been linked to social anxiety disorder (SAD), post-traumatic stress disorder (PTSD), generalized anxiety disorder (GAD), and panic disorder (PD)
Internalized racism	The negative, racist views towards POC exhibited as self-hatred by POC who believe being White is superior and as a consequence, reject their community and identity as a POC [69] (Example: *colorism*)	• Anxiety arousal [41] • SAD [40] • Agoraphobia with and without PD, GAD, PD, SAD [22]	Internalized racism (e.g., colorism) is from internalization of oppression that results in POC experiencing self-hatred and rejection of their community and identity. This internalization is documented to be associated with symptoms related to anxiety disorders
Institutional racism*	Inequality with regard to socioeconomic accessibility and opportunity due to racial identity [6•]	• OC symptoms [17] • Depression [59••]	Institutional racism (e.g., racial profiling) targets POC and creates socioeconomic barriers which result in various disadvantages, including the detrimental impact on mental health (e.g., obsessive–compulsive and depressive symptoms)
Micro-aggressions	The use of negative, race-based statements or behaviors to convey insulting, aggressive, and derogatory language and foster hostile environments for POC [69]	• Anxiety [42, 67] • PTSD symptoms [61] • Traumatic stress [60] • Anxiety-related trauma symptoms [52]	Microaggressions foster a hostile environment for POC which puts them in an uncomfortable and taxing situation, leading to low self-esteem and symptoms of anxiety, traumatization, and stress
Structural racism*	The systematic process whereby policies, practices, procedures, and laws are instituted to the social, political, educational, economic, and environmental detriment of POC in order to uplift, maintain, and allocate power to White people [6•, 69, 70]	• Depression due to traumatization [59••]	Structural racism is the result of the systemic process and enables inequitable White power to the detriment of POC. Depressive symptoms have been noted as an implication of this harmful process
Subtle racism	Concealed acts of racial discrimination which are seemingly unconscious and detrimental to the psychological well-being of POC albeit small acts [60] (Synonym: microaggressions)	• Anxiety (see *microaggressions literature)* • Depressive and anxiety symptoms [71] • PTSD [60]	Over time, events of subtle racism result in a cumulative impact on psychological well-being and in some cases, result in traumatization and dysregulated emotional stability

Table 1 (Continued)

Type	Definition	Disorder reported	Findings
Symbolic or modern racism	Stereotypical, negative attitudes, beliefs, and perceptions of POC (Synonym: right-wing racism; Example: denoting POC as 'lazy') [69]	No research identified	Research has yet to examine the association between symbolic/modern racism and anxiety disorders, which highlights an area for future research
Systemic racism	Emphasized by the term *racism* itself which refers to the process where entire systems (e.g., criminal justice system; health care system) operate to facilitate and maintain the differential treatment of POC [6•, 70]	• PTSD [46] • Depression; Panic episodes [36•]	The persistent and cumulative impacts of systemic racism contribute to negative mental health symptoms and traumatization (e.g.,, low affect; inability to regulate emotions), which may result in diagnoses of PTSD, depression, and panic-related disorders
Vicarious racism	Distress and traumatization following the events of racism and discrimination which was not experienced by the individual themself but by a family member, close friend, or stranger [64]	• Anxiety [9•, 64, 72]	Experiencing vicarious racism (e.g., witnessing a close friend being called a racial slur) has been documented to contribute to symptoms of anxiety

This table outlines the various types of racism and some of the documented associated with anxiety in recent literature. There were other studies which analyzed racism which were excluded for their lack of differentiation between the type of racism experienced; such differentiation is critical to gaining a comprehensive understanding of the subsequent clinical mental health implications for Black, Indigenous, and People of Color. For those without literary examples, these call for more research in that specific context

* The term *structural racism* is also used interchangeably with *institutional racism* but these have separate definitions as well

severity [also 17]. Notably, however, the focus of these investigations is on the Black American population, so further research is required to replicate these findings in Canada and other countries. Nonetheless, researchers have recently extended upon these findings to provide inclusive, anti-racist and culturally informed guidelines for those working with OCD clients [see 18•]. These include *specialty knowledge*, including "the connection between discrimination and OCD" and the corresponding impact of perceived fears (e.g., stigma, shame, discrimination) on OCD symptom expression and maintenance, in addition to *specialized skills*, such as collaborating with traditional healers. In sum, the preceding findings highlight how clinicians must be wary of the cultural differences in OCD symptom presentation and educate themselves to accurately adapt treatment to align with their specific needs, worldview, and racial experiences [18•].

Case Example

An example of OCD symptom presentation impacted by racism was evident in the account of Almah, an African American woman, whose experience of OCD was embedded into encounters with racial discrimination [19]. When she was 10 years old, Almah was shopping, and a White woman cashier accused her of stealing a button; Almah even showed her empty pockets to the cashier. To avoid further distress and gaslighting, Almah proceeded to pay the cashier the cost of the item, being one dollar. Following this event, she experienced intrusive and unwanted thoughts (e.g., "What if slap this stranger?") which contributed to her self-surveillance behaviors, including rituals. Almah started to engage in rehearsal strategies to examine the possibility of a dangerous event and checking repetitively. Other factors included becoming hypervigilant of her surroundings (e.g., checking for unlocked doors, then locking and unlocking repetitively) and becoming increasingly focused on her own thoughts.

Later, Almah was diagnosed with OCD, as she surpassed the clinical threshold on the Yale-Brown Obsessive Compulsive Scale. Symptoms included "checking for harm to others" and "checking for mistakes." She recognized how isolating this diagnosis was as a Black person, albeit validating. Almah's experience of OCD was distinct in terms of being intersectional as anti-Black oppression and trauma exacerbated her obsessions. Almah's OCD symptoms arose whenever she was in stores; as a result, she always ensured that shopkeepers could see her and avoided the back of stores. For example, while visiting Ireland, she avoided going into stores altogether. Additionally, Almah constantly rechecked if she had certain items (e.g., keys) with her. For instance, whilst doing so in a Lyft, she was anxious and concerned about whether she looked suspicious. This was connected to another racist encounter with a police officer when she

was in the back seat of the police car; he ordered her to stop going through her bag as he feared that she was searching for a weapon. Overall, Almah's case exemplified the harms of the prevalent anti-Black surveillance culture of racism, which leads to Black people constantly checking themselves for unacceptable behaviors, thoughts, and actions, and the exacerbation of symptoms and unique symptom presentations [20]. Thus, considering the intersectionality of racism in the context of OCD is imperative to the diagnosis, prognosis, and treatment of OCD across race and ethnicity.

Generalized Anxiety Disorder

There is a lack of recent studies exclusively focusing on the connection between GAD and racial discrimination. Instead, studies of GAD have primarily been conducted within the framework of anxiety disorders in general. For example, Kwon and Han [21] explored the association between racial/ethnic discrimination and suicidal ideation, among Latinx adults in the USA. The researchers found that racial discrimination on a daily basis was linked to an increased risk of anxiety-related disorders, which included panic disorder, social phobia, generalized anxiety disorder, and post-traumatic stress disorder. They also discovered that anxiety-related disorders are more salient in mediating the link between everyday discrimination and suicidal thoughts (16.5%) than depression (7.0%) or substance use (8.4%). In a similar study, a large random sample of Black American adults was part of an investigation of the link between perceived colorism and psychiatric problems and also examined anxiety disorders overall [22]. Findings showed that in-group colorism was linked to a higher lifetime risk of psychiatric disorders. Interestingly, anxiety disorders (agoraphobia with and without panic disorder, generalized anxiety disorder, panic disorder, social phobia) were found to be linked to both in-group and out-group colorism in this study.

In another study, police brutality was found to be associated with both depressive mood and GAD among Black adults. Heightened vigilance moderated this association, accounting for 11% of the total effect of police brutality on depressive mood and 21% of the total effect of police brutality on GAD [23]. In this study, nearly a third of the sample met the criteria for both GAD (32.7%) and depressive mood (31.1%), and negative police encounters were reported by more than half of the sample. While the depressive mood was increasingly related to unnecessary negative police encounters, GAD was not. This unforeseen finding could be a result of desensitization wherein individuals no longer exhibit a psychological response to unnecessary negative police encounters over time. Another hypothesis was the normalization of police brutality to Black bodies which provided context for this lack of anxious arousal [23]. Similarly, GAD, but not depression nor substance dependence/abuse, was found to be significantly related to bias-related victimization (BRV) among lesbian, gay, bisexual, transgender, and two-spirit Alaska Natives and Native Americans [24]. BRV referred to inherent trait-based discrimination (e.g., ethnicity, sexual orientation) and was experienced by the majority of the sample (84.4%). Further, the GAD risk for participants with the greatest amounts of BRV was nearly threefold (2.79 times) greater than for participants without BRV. In all, this sample displayed the nuances regarding intersectionality and GAD symptom expression. For example, bisexual and two-spirit participants had heightened SAD symptoms in comparison to other identities [24].

There are two interesting studies that focus specifically on GAD, and although not as recent are worth noting here [25, 26]. In a study by Soto and colleagues [26], including 3570 African Americans, 1438 Afro Caribbeans, and 891 non-Hispanic Whites, non-race-based discrimination predicted GAD for all groups, while race-based discrimination was related to considerably increased odds of endorsing lifetime GAD, only for African Americans. The other study examined how GAD in a Black population might be mitigated by church-based social support [25]. In this study, anxiety arousal and stress (general anxiety) symptoms, church-based social support, and exposure to racist incidents were assessed in 50 Black participants. When there was a low amount of social support from one's church, there was a significant positive correlation between having experienced racism and having experienced stress symptoms (such as general anxiety). Similarly, a study by Ai and colleagues [27] found that while discrimination predicted GAD in Asian Americans, family cohesion was protective against it.

Another noteworthy study was conducted by Joy and Bartholomew [28], who investigated the ways in which therapists' assessments of GAD were impacted by the client's environment, including social context and identification characteristics such as class and race. Regardless of the client race or social status, therapists' views of the client concerns and anxiety diagnosis were identical, and were unrelated to claimed colorblindness or just world beliefs. The authors ultimately admitted that these results might be, in fact, due to the limitations of the vignette used in this study. Therefore, this finding needs to be evaluated in light of these constraints, particularly the potential priming effect that reading customer demographics could have on the results.

Specific Phobia

There is no current literature on the interactions between specific phobia and racism. Of the few studies available, one employed a confirmatory factor analysis of the Fear Survey

Schedule-Second Edition (FSS-II) to examine specific phobia across 221 undergraduate students who were African American and White American [29]. While there were similarities in terms of endorsing general domains of specific phobias (e.g., animal-related phobias), African Americans reported more specific phobias than White Americans. In a follow-up study, researchers conducted a cross-validation of items from the previous model [29, 30]. While the model failed to fit for the community sample, this study identified similarities in terms of social and specific phobias for both African American samples. The phobia domains for animal-related fears were quite similar as they shared the endorsement of the same items except for one (fear of stinging insects). Both groups endorsed greater specific phobia items overall, notably fears of strange dogs, snakes, spiders, and rats and mice. Some interesting race-related reasons for these specific fears were suggested, namely, the fear of dogs was theorized to be related to the lived or vicarious experiences of racism. During the Civil Rights march, African Americans were victims of police brutality via police dogs, and others were marked by witnessing or learning about these attacks; this event exemplifies how a racist act could manifest into a conditioned fear which, in turn, triggers an animal-related specific phobia. However, given that this community sample mostly identified as female (91%), there is a need for further investigation of specific phobia with male African American community samples. Thus, these results suggest a cultural difference in phobia expression that is unique to this ethnic group [30].

In the wake of the COVID-19 pandemic, there has been heightened interest in what has been termed "vaccine hesitancy" and its possible causes. POC have exhibited greater vaccine hesitancy, due in part to historical and current experiences of medical racism [31, 32], but the role of blood-injection-injury phobia has been underexamined. In a UK study, Freeman and colleagues [33] found that those with blood-injection-injury phobia were also much more likely to be vaccine hesitant and being Black or Asian was a significant predictor of fear of injection, which partially explained their hesitancy. The cause of the racial differences was not explored, but given that racialized persons have a greater distrust of medical institutions and the government, this combined with a blood-injection-injury phobia may exacerbate vaccine hesitancy or refusal.

Panic Disorder

There is little research on panic disorder and people of color [e.g., 34]. A study by Levine and colleagues [35] provided insight into racial disparities in mental health services usage and symptom expression for panic disorder across three ethnoracial categories. In comparison to African Americans and non-Hispanic Whites, Black Caribbeans utilized mental health services less despite their increased functional impairment. Overall, lifetime panic disorder was expressed and reported by non-Hispanic Whites at greater rates. It was also suggested that the low reports by the Black groups may be relative to the inclination to attribute symptoms towards physical ailments in addition to cultural conceptions of mental health.

A recent case study by Wallace and colleagues [36•] demonstrated the effectiveness of cultural adaptations of CBT interventions for panic episodes and depression among African American women. This study highlighted the impact of stigma and individual and systemic racism on panic episodes and depression. This case illustrates how the therapist incorporated the client's spirituality into treatment by providing space for the client to share a gospel song during each session and discuss her stressors with respect to the song. This client-focused adaptation aided in the development of culturally responsive coping strategies according to the client's preferences. Further, this case study provided a framework for cultural competency in panic treatment and highlighted the importance of validating client concerns and anxiety surrounding sociocultural factors and experiences of racism as they relate to the expression of panic episodes and underlying anxiety [36•].

Social Anxiety Disorder

The connection between social anxiety and racism has been widely discussed yet remains to be extensively researched [e.g., 37]. However, one study recently reviewed ethnographic interviews to examine linguistic racism among nine international students in Australia [38]. Regarding linguistic racism, other factors evaluated ethnic accent bullying and linguistic stereotyping. Dovchin found that linguistic racism had a negative impact on the interviewees' mental health, with numerous participants reporting suicidal ideation and social withdrawal. Additionally, some participants reported SAD as a consequence of their experiences of linguistic racism [38]. Further, SAD was investigated with respect to everyday and major discrimination across African Americans, Black Caribbeans, and Non-Hispanic Whites [39]. Everyday discrimination was found to predict SAD for all racial groups, and both the African American and Black Caribbean groups reported racial discrimination above other kinds.

We identified another study that looked into the association between different types of anxiety disorders, including SAD, with racial microaggressions and internalized racism in a sample of 182 Black university students [40]. In this study, internalized racism was found to be a significant predictor of social anxiety in linear regression models, which is consistent with research [see 41]. These findings are similar

to a study by Liao and colleagues [42] as racial microaggressions predicted anxiety symptoms in 126 Black American university students.

Many POC have acquired a fear and avoidance of police and other law enforcement personnel, which may stem from both personal and vicarious experiences of racism (e.g., the police murder of George Floyd). For example, fear of the police was found to be significant among Black Americans but not White Americans, and was significantly higher than the other racial groups in this study; past experiences of mistreatment by police mediated this relationship and were reported more by Black participants [43]. Fear was also observed in a study of 18–24-year-old Black men who were interviewed on their experiences of police violence; these participants reported the subsequent stress after viewing the media of violent police brutality against Black men [44]. As a result of experiencing and witnessing police violence, and grieving personal encounters of police violence, common issues for many included persisting fear, grief, and hypervigilance, which contribute to chronic and traumatic stress. Consequently, fear of police led to isolation; this, in turn, limits the ability to obtain higher education, employment, and engage socially [44].

Case Example

Social anxiety was evident in Vincent (pseudonym), a Black Latino college student who immigrated to Canada from the Caribbean as a child to live with his father. Vincent's experiences of racism began when his White father forced him to do household chores and not his other White siblings because he was the Black one. Because of his sexual orientation, his father also sent him to conversion therapy, where he experienced both homophobia and racism. As an adult, Vincent recalled social anxiety and heart-racing as a result of a racism-related assault in a restaurant in southern Ontario, where he had an object thrown at him, and another experience where he was told to "go back to Africa" by people in Québec. Vincent experienced persistent intrusive thoughts, flashbacks, and anxiety, which, like Solange, contributed to an overall belief that the world is a dangerous place. These experiences have hindered his social interactions due to his consequent vigilance and reported belief that others will not want to be his friend because he is Black.

Posttraumatic Stress Disorder

Racial discrimination has also been shown to be linked to elevated PTSD symptoms in numerous studies. For example, in a longitudinal investigation of the relationship between experiences with discrimination and risk for PTSD among a clinical sample of 139 Latinx and 152 African American adults with anxiety disorders, Sibrava and colleagues [45] found that the frequency of reported discrimination was associated with a greater likelihood of PTSD diagnostic status, though it did not predict any other anxiety or mood disorder. They also discovered that over the course of 5 years of follow-up, the chances of African American and Latinx PTSD patients fully recovering from their initial episode were 35% and 15%, respectively. While demonstrating the chronic course of PTSD in African American and Latinx individuals, these findings underscore the major impact that racial and ethnic discrimination may have on the development of PTSD among these populations.

Based on a review of existing research, Douglas and colleagues [46] suggested that exposure to oppressive systems (such as systemic racism) that disproportionately affect POC is associated with an elevated risk of developing mental health disorders in the wake of traumatic events. Accordingly, they hypothesized that race/ethnicity could predict trauma and grief outcomes in youth through processes such as polyvictimization, the loss of multiple loved ones, and exposure to a violent death. They found polyvictimization and violent death exposure among Black adolescents resulted in considerably higher posttraumatic stress and maladaptive grief symptoms compared to their White counterparts, which in turn, can cause an increased risk of developing psychological disorders in this population.

Likewise, Gran-Ruaz and colleagues [47] examined the disparities in sex and ethnicity between 3570 African Americans and 1623 Black Caribbeans across the USA regarding trauma exposure, PTSD diagnosis and symptoms, and help-seeking. They found that living in terror as a civilian was more prevalent for Black Caribbeans than for African Americans. Furthermore, assaultive violence trauma was found to be the greatest predictor of lifelong PTSD diagnosis among Black Americans. Additionally, African American women were more likely to experience PTSD symptoms than males, although there were no significant differences between Black Caribbean men and women. There were higher rates of PTSD for Black compared to White participants in this sample [48], and the differences may have been further pronounced if trauma due to racism and oppression had been included as a response option. Gran-Ruaz et al. [47] suggested that future PTSD-related research should consider the varying experiences of potentially traumatic events among different Black communities.

A study on Black American emergency department patients who were traumatically injured found racial discrimination as a predictor of PTSD severity [49••]. Racial discrimination had a significant, negative effect on both the onset and prognosis of PTSD and, at a six-month follow-up, resulted in increased severity of PTSD symptoms regardless of demographic controls (i.e., age, gender, previous psychiatric diagnosis, social support, lifetime trauma history). In

light of these results, the authors called for further research into the feasibility of identifying racial discrimination as a potential *traumatic event* in DSM-5 Criterion A for PTSD [49••].

Case Example

Solange, an Ethiopian woman, was one of the only Black people in her university classes; she felt isolated and uncomfortable discussing current issues, such as institutional racism. Solange stated that this resulted in her overall education being "not an enjoyable experience," and she "questioned why she went to university in the first place." Her earliest experiences of racism were in third grade when a teacher threw blocks at her when she got an answer wrong; prior to this, other White classmates had answered incorrectly, and the teacher had not reacted in this way. Other reported incidents included being called a "terrorist" by classmates and her teachers threatening her as well as the loss of her close friend—a Black man who experienced racism and severe mental health issues. He told Solange that he was ignored due to institutional racism in health care. Such racism resulted in Solange's friend committing suicide, which she stated especially traumatized her.

Cumulatively, Solange reported experiencing significant distress because of her experiences of racism. In fact, during the interview portion of the racial trauma evaluation, she stated she was "emotionally disturbed just thinking about the question" when asked to report an event of vicarious racism. Solange met the criteria for a diagnosis of PTSD with symptoms related to *racial trauma.* Symptoms included intrusive thoughts pertaining to racism-related events, which are persistent, resulting in her being "always emotionally upset." Her experiences of racism resulted in a negative schema of the world being dangerous and her constant feelings of anxiety, fear, and anger; this led to self-isolation as these symptoms bother her every day, and it is "something [she] has to work through." Solange's case exemplifies the need for immediate change and inclusion in the way we conceptualize PTSD to encapture the detrimental effects of racism and how this can result in traumatization and distressing symptoms of anxiety that interfere with everyday life.

Racial Trauma, aka Race-Based Traumatic Stress

Racial trauma has been defined as a psychological injury caused by the mistreatment of a person due to their race, ethnicity, or skin color [50–52]. It may take the form of a severe interpersonal stressor that endangers one's health or even one's life, or it may be caused by an institutional stressor that is motivated by racism and causes considerable continuous pain. Racial trauma is thought to be distinct from posttraumatic stress disorder in that it entails continuous individual and collective injuries as a result of repeated exposure to race-based stress [51].

Because of its accumulative nature, racial trauma eventually causes an individual's capacity for coping to become exhausted, as illustrated in the case of Solange [52]. Those of any race, ethnicity, or group of people can experience racial trauma since it is tied to their social identity. Some experiences of racial trauma, such as being physically assaulted in the context of a hate crime, would qualify as trauma according to the DSM-5's criteria ("exposure to an actual or threatened death, serious injury, or sexual violence;" [5] p. 271). Other symptoms of racial trauma (e.g., persistent exposure to racial microaggressions, vicarious trauma through graphic media coverage of police brutality) may not meet the aforementioned requirement, yet, nonetheless, be experienced as traumatic [53]. In spite of this, such experiences have been included in our definition of racial trauma because previous research has shown that the prevalence and severity of PTSD symptoms do not vary as a function of whether the event met Criterion A [e.g., 54, 55], and such experiences are associated with symptoms above and beyond Criterion A events [e.g., 56].

Although PTSD, as described in the DSM-5, is caused by discrete events such as assault, combat, or natural disasters, research indicates that experiences of racism can have the same debilitating psychological effects on POC. As such, racial trauma can be defined as the cumulative experiences of racism throughout a person's lifetime that lead to severe mental and emotional injury [57]. Sufferers may exhibit symptoms of intrusion (e.g., recurrent nightmares, upsetting thoughts), avoidance behaviors, negative changes in cognition and mood (e.g., distorted blame, embarrassment, isolation, dysphoria), and alterations in arousal and reactivity (e.g., self-destructive behaviors, hypervigilance, sleep issues) [10].

A number of studies have investigated the generational impact of racial trauma. Symptoms of PTSD have been found to be heritable through epigenetic mechanisms, which has particular implications for certain groups, such as Indigenous people in North America, who have been subject to historical genocide but may today be further traumatized by a continuation of this atrocity via forced and coerced sterilization in modern hospitals [e.g., 58]. Hankerson and colleagues [59••] developed a theoretical framework for understanding how intergenerational depression might be caused by fundamental factors such as institutional racism and accumulated trauma. They argued that understanding the risk of mental health problems, particularly its intergenerational reach, necessitates accounting for the traumatic ongoing institutional racism commonly endured by people of color.

Another study investigated the associations between racial microaggressions, racially or culturally associated trauma, and trauma symptoms using a correlational, cross-sectional methodology with a racially diverse sample of individuals of color ($N = 254$) [60]. According to the results, the most common type of microaggression related to traumatic symptoms was racial, and those who experienced more of these incidents were more likely to suffer from PTSD as a result [60]. Similarly, Abdullah and colleagues [61] investigated the connection between the frequency and distress of experiencing racial microaggressions and the symptoms of PTSD in a sample of Black Americans. A specific type called *invisibility microaggressions* were analyzed, which refer to the total disregard, devaluation, and mistreatment of Black people. A higher frequency of invisible microaggressions was associated with a stronger endorsement of PTSD symptoms, regardless of age, gender, or education. Furthermore, the distress brought on by invisibility microaggressions was found to be related, over and above the frequency of microaggressions, to heightened symptoms of PTSD.

Additionally, in a systematic overview of studies that examined the relationship between racial discrimination and trauma, increased trauma symptoms were found to be statistically linked to racial discrimination in 70% of the 44 associations analyzed [62]. Notably, the association between racial discrimination and trauma symptoms has led to the development of the Racial Trauma Scale (RTS), which quantifies trauma-related symptoms that arise from the race-based maltreatment of individuals of color [63••].

Case Example

Alexis was a college student who lived in residence at a university in southern Ontario. Being a Filipino woman, she reported the especially detrimental impact of seeing anti-Asian hate and violence in the media during the peak of COVID-19. In addition to this vicarious racism, Alexis stated that she was called racial slurs, followed, and experienced microaggressions, such as being compared to Japanese media (e.g., animé doll). After her experiences of being followed, Alexis avoided the location where this occurred and has developed the tendency to excessively check her surroundings, especially whenever walking down streets. One of these experiences occurred at the dining hall in her residence, where a White male would make discriminatory statements, which included racial stereotypes, towards Alexis. Following this, Alexis recounted that whenever she walks past this location, she begins to worry and experiences significant physical reactions (i.e., body shakes, dysregulated breathing). Alexis also reported blaming herself for how she managed this interaction and for not speaking up about it. Overall, this case provides a lived example of how personal and vicarious racism can contribute to traumatization and symptoms of anxiety.

Recommendations for Practitioners and Researchers

Good mental health care can help mitigate the impact of racism [64], and understanding the interactions between anxiety and racism can help practitioners better understand their clients with differing cultural or ethnic backgrounds. Clinicians should embrace *cultural humility* wherein they reflect upon their biases and privilege in addition to considering the individual and systemic oppression of others [65]. To become *culturally responsive* to all clients, recommendations are as follows:

- *Cultural knowledge*: Seek out a greater understanding of a client's culture by engaging in self-education. Resources from that specific community provide insight; however, do not burden the respective community with the responsibility of your education. In doing so, ensure that Indigenous or alternative epistemologies are examined and respected.
- *Cultural-competency and humility training*: This will differ across sociocultural contexts. Cultural competency provides a foundation towards interacting with clients from a different background and reducing bias. Humility is process-oriented and includes sharing power [65].
- *Specialized measures*: In order to adequately assess with respect to race and culture, culturally adapted tools and interventions are necessary. Utilizing measures that assess the impact of racism ensures these symptoms are not missed or misattributed [e.g., RTS; 63••].
- *Specialized interventions*: Treatments developed to address the impact of racism may be required [e.g., 50, 66].

These recommendations in action may influence help-seeking behaviors for underserved populations and aid clinicians in enhancing rapport with their clients.

With respect to research, while the aforementioned studies have provided some insights towards the impact of racism on anxiety, further research is needed, especially specific to ethnic differences within racial categories. This was exemplified by the study of Black Caribbean Americans which identified ethnic differences in OCD symptom expression [15]. Recommendations are as follows:

- *Utilize an anti-racism lens:* Researchers must employ an anti-racism lens to oppose and eliminate the barriers of systemic racism. Addressing systemic racism, in addition to other forms, includes a critical analysis of

the interlocking power inequalities, and thus, informs the efforts towards justice and equity. This approach uplifts and centers differing perspectives and identities to create an inclusive environment.

- *Ethnically diverse samples:* In response to recent findings of ethnic differences across certain anxiety-related disorders, researchers must conduct studies with samples that are diverse. This must be set as the standard to ensure that future empirical research and recruitment methods result in samples that are representative of the corresponding populations and allow for the cultural adaptation of existing interventions. When conducting subgroup analyses, it may be necessary to oversample people from underrepresented ethnic groups to ensure sufficient statistical power. This recommendation is for the purpose of having culturally sensitive measures and practices, and thus, it is imperative to take into account the psychological implications of racism when considering these developments.
- *Respectful representation:* Employ writing styles that provide accurate representations of marginalized populations without perpetuating stigma nor generalizations. As mentioned by researchers [60, 67], research regarding such areas of racism and microaggressions is crucial to informing policy within psychology in practice.
- *New interventions*: In order to adequately treat diverse people who have anxiety-related disorders caused or worsened by racism, suitable empirically supported interventions are needed. Few, if any, interventions focused on the effects of racism have been empirically validated.

Further, the accounts of POC provide insight to the probable interactions between symptoms of anxiety-related disorders, racism, and racial trauma. While recent literature has examined the interactions between racial discrimination and anxiety, there are few empirical studies that investigate anxiety-related disorders other than PTSD in the context of racial trauma. Given the increasing empirical support for the construct of racial trauma [68], this should be investigated to aid in the development and cultural adaptation of frameworks specific to anxiety-related disorders, among other clinical mental health factors.

Conclusion

Existing literature has identified the detrimental impact of racial discrimination and other forms of marginalization on overall mental health and specifically, across various anxiety-related disorders. Considering racism with respect to these disorders is critical to providing effective treatment options and care for communities of color. To address the dearth of recent literature on racism and anxiety, especially for certain disorders (e.g., specific phobia; panic disorder), the authors call for more research that examines the various kinds of racism as a demographic correlate of anxiety-related disorders (i.e., SAD to law enforcement due to vicarious racism for Black, Brown, and Indigenous populations). Training for mental health practitioners and more research regarding racism and culturally-informed care are essential.

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Declarations

Conflict of Interest The authors declare no competing interests.

Human and Animal Rights and Informed Consent All reported studies/experiments with human or animal subjects performed by the authors have been previously published and/or complied with all applicable ethical standards (including the Helsinki declaration and its amendments, institutional/national research committee standards, and international/national/institutional guidelines).

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