

Expanding Criterion A for Posttraumatic Stress Disorder: Considering the Deleterious Impact of Oppression

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The latest edition of the *Diagnostic and Statistical Manual of Mental Disorders* (5th edition) includes edits to Criterion A for posttraumatic stress disorder in an attempt to capture a wide variety of potentially traumatic events. However, despite criticism by scholars in the field (e.g., Kira, 2001; Gilfus, 1999; Helms, Nicolas, & Green, 2012) and overwhelming evidence documenting the negative impact of oppression on the mental health of its targets (e.g., Carter, 2007), the way in which Criterion A is written fails to include the insidious trauma of oppression. There is a small but compelling literature base that has demonstrated oppression to be a form of trauma by examining the relationship among various forms of oppression (e.g., racism, sexism, heterosexism) and trauma-related symptoms (e.g., Alessi, Martin, Gyamerah, & Meyer, 2013; Berg, 2006; Pieterse, Carter, Evans, & Walter, 2010). The authors make a case for expanding the current definition of Criterion A to incorporate the full range of oppressive forces by providing empirical support demonstrating the relationship between experiences of oppression and trauma-related outcomes and by arguing that this change is appropriately political and consistent with social justice values held by psychology.

Keywords: PTSD, oppression, racism, sexism, heterosexism

The *Diagnostic and Statistical Manual of Mental Disorders* (fifth edition; *DSM-5*) Criterion A for posttraumatic stress disorder (PTSD) specifies the type of event that constitutes a trauma, from which the remaining clusters of symptoms (pertaining to intrusion, avoidance, negative alterations in cognitions and mood, and hyperarousal) may arise (American Psychological Association [APA], 2013). It requires that the individual endure “exposure to actual or threatened death, serious injury, or sexual violence” through one of several possible means (i.e., direct exposure, witnessing, learning that the event happened to a loved one, or experiencing “extreme exposure to aversive details,” as is the case with first responders; p. 271). In its current form, Criterion A encompasses a variety of traumatic events including various forms of childhood abuse, exposure to war, physical or sexual assault, kidnapping, natural or human-made disasters, and severe motor vehicle accidents. Furthermore, in the *DSM-5*’s last revision, the second part of Criterion A, which specified that the individual must respond to the traumatic event with fear, helplessness, and/or horror was removed, in acknowledgment of the fact that survivors’ reactions can vary considerably. Despite efforts to capture a wide variety of potentially traumatic events, the way Criterion A is currently written fails to include the insidious trauma that is oppression.

Oppression and Its Impact on Marginalized Groups

Oppression can be understood as

a state of asymmetric power relations characterized by domination, subordination, and resistance, where the dominating persons or groups exercise their power by restricting access to material resources and by implanting in the subordinated persons or groups fear or self-deprecating views about themselves. (Prilleltensky & Gonick, 1996, pp. 129–130)

That is to say that oppressive forces subordinate oppressed peoples via both “political, external, and corporal means and also through imbuing internalized, psychological devaluation of the self” (p. 130).

Furthermore, the political and psychological dynamics of oppression can and do play out on various levels from intrapersonal to systemic. Specifically, Prilleltensky and Gonick (1996) posit that oppression can function at the intrapersonal (e.g., internalized oppression, learned helplessness), interpersonal (e.g., verbal/emotional abuse, actual or threatened use of force against the oppressed), as well as occurring on the macrolevel such as via social group (e.g., fragmentation of the oppressed community, dehumanization of victims of oppression), state (e.g., systematic structural inequities/discrimination, determent from challenging authorities), and international (e.g., domination of powerful nations’ agenda in world matters, exploitative economic systems that strip natural or human resources from impoverished nations for the benefit of and perpetuation of dependency on developed nations) levels. The act of subjugation can occur on the basis of a number of identities (e.g., race, gender, sexual orientation, class, ability status) and intersections among them.

Given the complexity and heterogeneity of oppression, the authors will provide several examples that demonstrate the various

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forms oppression can take as well as the impact it has on its victims. Research on internalized heterosexism, which is the process of assuming negative cultural messages and associated emotions of fear and disgust about one's own same-sex attraction (Szymanski, Kashubeck-West, & Meyer, 2008), is an example of social group oppression becoming intrapersonal oppression. Further, there is a well-established relationship between internalized homophobia and psychological distress including lower self-esteem, depression, suicidal ideation, substance abuse, risk-taking behaviors, and interpersonal distress (see Szymanski et al., 2008 for a review). Another example of the internalization process is demonstrated within objectification theory literature, wherein women learn to objectify and value themselves based on their worth as sexual objects due to experiences of repeated exposure to sexual objectification through such means as sexualized depictions of women in the media, catcalls, and unwanted sexual advances (Fredrickson & Roberts, 1997). Objectification has been linked to outcomes such as depression (e.g., Jones & Griffiths, 2015), body dissatisfaction (e.g., Grabe, Ward, & Hyde, 2008), and disordered eating (e.g., Noll & Fredrickson, 1998; Tiggemann & Williams, 2012; Tylka & Hill, 2004).

On the interpersonal level, literature on microaggressions (e.g., Sue, Capodilupo, et al., 2007) and color-blind racial ideology (i.e., denial of racial differences and associated power differentials; e.g., Neville, Awad, Brooks, Flores, & Bluemel, 2013) demonstrate the insidious nature of a modern or contemporary racism, which is often covert and implicit rather than overt or intentionally obtrusive. Microaggressions are "brief, everyday exchanges that send denigrating messages" that invalidate experiences of racism (i.e., microinvalidations) or convey messages to racial/ethnic minorities about deficits of their belonging, intelligence, morality, value, or culture simply based on their belonging to a racial group (Sue, Capodilupo, et al., 2007, p. 273). A microaggression can be perpetrated either intentionally and explicitly (microassaults) or subtly and often unintentionally (microinsults). For example, statements like "pretty for a black girl" or questions like "where are you from?" to an Asian American person convey denigration and a rejection of belonging to the oppressed person that the perpetrator may have not intended, yet has undeniable consequences. Research on microaggressions has been conducted with a variety of populations and has demonstrated to be associated with depression (e.g., Donovan, Galban, Grace, Bennett, & Felicié, 2013; Huynh, 2012; O'Keefe, Wingate, Cole, Hollingsworth, & Tucker, 2014), suicidal ideation (e.g., O'Keefe et al., 2014), anxiety (e.g., Donovan et al., 2013), and somatic symptoms (e.g., Huynh, 2012).

Reisner and colleagues (2015) conducted research demonstrating the impact of state law protections for transgender and other gender minority individuals, which demonstrates oppression at the state level. The authors discussed that while Massachusetts was one of 17 states that did have some protections against discrimination on the basis of gender identity for education, housing, employment, and hate crimes, Massachusetts does not offer protections for public accommodations such as health care and transportation. Their results demonstrated that 65% of their respondents experienced some form of discrimination while utilizing a public accommodation within the past 12 months, that discrimination was significantly and independently related to feeling "emotionally upset," depression, and experiencing physical health symptoms, and that the greater variety of settings the individual experienced

discrimination in the greater their risk for detrimental emotional and physical health symptoms (p. 491).

As psychological research tends to centralize on the internal human experience and pay less attention to inquiries regarding external factors, research that emphasizes the influence of international policy is relatively understudied by psychologists. An example of considering oppression that is perpetuated on international level can be found in the public health literature and primarily seeks to elucidate and deconstruct perhaps unintended or overlooked oppressive international policy, rather than provide evidence of the internal experience of oppressed peoples. Giacaman and colleagues (2011) discussed the political oppression of Palestinians by Israeli military occupation and the subsequent implementation of a patchwork of westernized and medicalized mental health care. The authors acknowledged that while the medicalized trauma model brought international recognition to "the sociopolitical condition of the Palestinian people and the collective traumatogenic nature of Israeli military occupation and repression" (p. 549), it also had unacknowledged or unforeseen negative consequences. The trauma treatment offered by westernized medicine failed to differentiate individualized single-incident experiences from the ongoing collective trauma of the Palestinian people and further, was disempowering in that it failed to incorporate cultural strengths, interpretations, and meanings of their cultural experience. Additionally, Giacaman and colleagues (2011) emphasized that the this medicalized model failed to address the source of the suffering and instead relied on short-term "development" programs, which further undermined sustainable community-based programs and political change noting,

it is crucial to recognize that the entire political and economic arrangement is non-sustainable under military occupation. Given the context, any "development" will not be sustainable until a political solution is achieved. A society operating under checkpoints and economic siege lacks the freedom to "sustain" the services that are created. . . . (p. 566)

While the examples discussed in this section do not represent the full extent of experiences and reactions to oppression, they do serve to more fully explain the construct of oppression and the wide variety of experiences it entails, as well as to assert the notion that oppression, whether explicit and intentional or implicit and unintended, significantly injures its victims.

Oppression, Trauma, and Criterion A

Despite the overwhelming evidence for the deleterious effects of oppression on the mental health of members of subjugated groups (e.g., Huynh, 2012; Reisner et al., 2015; Szymanski et al., 2008), very few forms of oppression have the potential of meeting Criterion A as it is currently written. The wording of Criterion A arguably best lends itself to interpersonal forms of oppression and, even so, has the potential of capturing only a narrow subset of interpersonal oppression (e.g., physically violent hate crimes) while neglecting other frequent iterations (e.g., microaggressions). Criterion A's failure to incorporate oppression, broadly speaking, may be the consequence of the narrow definition of violence, culturally. Indeed, Cassiman (2005) noted that the current definition of trauma conceptualizes violence within the cultural zeitgeist as primarily interpersonal and physical, while widely discounting

systemic, institutional, and psychological trauma. Liberation psychologists have provided a definition of violence, which includes acts of oppression outside of the immediate threat of physical injury or death, but which is theorized to cause death.

Violence is any relation process, or condition by which an individual, or group violates the physical, social, and/or psychological integrity of another person or group. From this perspective, violence inhibits human growth, negates inherent potential, limits productive living, and causes death. (Bulhan, 1985, p. 335)

Relatedly, feminist and multicultural scholars have criticized psychology's approach to trauma as too medicalized and insufficiently political, warning that "if we decontextualize trauma from culture and oppression we miss potential sources of injury" (Gilfus, 1999, p. 1244). Furthermore, there is qualitative evidence to suggest that the specificity of Criterion A may be somewhat arbitrary. For the qualitative portion of their mixed methods study, Alessi, Martin, Gyamerah, and Meyer (2013) collected and analyzed verbal protocols detailing an experience of prejudice-related trauma from eight lesbian, gay, and bisexual adults living in New York City, New York. Analysis of these verbal protocols revealed that there were important themes that emerged from accounts of both Criterion A and non-Criterion A events. Specifically, participants from both groups endorsed experiencing emotional distress, losing their sense of safety and security, and making significant life changes following the event. To this point, one participant who survived harassment that did not meet Criterion A described, "After my mom found out that I was gay, she threw away and damaged my things. Called me a 'faggot' and a 'cocksucker'" and another participant who survived nonlife threatening childhood physical abuse reported that, "One time when it was bad enough that there were marks . . . I quit the swim team rather than show the marks" (Alessi et al., 2013, p. 520). Suggestions have been made to expand the current conceptualization of trauma to include experiences that are emotionally and psychologically injurious, generally, as well as oppression-based stressors, specifically (e.g., Carlson, 1997; Carter, 2007).

It is also important to note that scholars within the medical psychiatric field have also criticized the formulation of Criterion A. In their article outlining changes in diagnostic criterion for PTSD, Brewin, Lanius, Novac, Schnyder, and Galea (2009) highlight the controversy surrounding the definition of Criterion A since its introduction into the diagnostic lexicon. Each iteration of the *DSM* has made changes to the way in which Criterion A has been worded. This controversy and uncertainty in how to frame Criterion A have not abated with the passage of time or with the increased knowledge that has been gained from rigorous research. For example, the original conceptualization of trauma as "generally outside the range of usual human experience" in the *DSM-III* (APA, 1980) was limited when it was determined that the prevalence was higher than originally supposed, followed by the inclusion of learning about a traumatic event happening to someone else in the *DSM-IV-TR* (APA, 1994), and the most recent removal of Criterion A2, requiring a response to involve intense fear, helplessness, and/or horror in the *DSM-5* (APA, 2013).

Indeed, this controversy was also outlined by Guina, Welton, Broderick, Correll, and Peirson (2016) in their piece exploring the implications of the new diagnostic criteria for PTSD in the *DSM-5* for military service members and veterans. In conjunction with the

critiques outlined above, these authors argue that, "trauma is subjective, and is perhaps better defined, not by events, but by the experience of and reactions to events" (p. 6). Further, they note that while the changes in the *DSM-5* were meant to highlight variability in presentations, recent research (e.g., Carlson, Smith, & Dalenberg, 2013) has indicated that limiting trauma to actual or threatened death or injury may be overly restrictive, as severe emotional loss is often sufficient for PTSD. While this article did not directly address the insidious trauma of oppression, it is important in that it represents a critique of Criterion A from professionals within the field of psychiatry, and also the medical model from which the *DSM* is derived. Further, the posited subjective nature of defining what constitutes trauma supports the assertion that there are events outside of the current conceptualization (i.e., oppression) that can produce posttraumatic stress symptomology.

Another article by Miller (2009), offered perspective on the trauma of insidious racism from a psychiatric perspective. In his piece, Miller offers critique of the problems associated with psychiatric diagnosis. Consistent with critiques from the professional psychology perspective, he criticizes the *DSM* for its silence on racial stressors and for its decontextualization of culture, as "diagnosis encourages the study of disease without reference to culture" (Miller, 2009, p. 43). Indeed, Ali (2004) states that diagnoses do not occur in a decontextualized space free from prejudice and discrimination. Therefore concluding that the notion of a fully objective and context-free model for evaluating individuals and their capacities is a fallacy. While Miller (2009) critiques the practice of diagnosing, he also points to its relative importance as the existence of a *DSM* diagnosis implies an official acceptance of a disorder. In the current system, there is temptation not to believe that the symptoms a person is experiencing have psychiatric importance if there is no standard diagnosis to describe the person's suffering. While abandoning the medical model entirely may be unrealistic in the near future, more explicitly acknowledging the influence of culturally specific experiences, such as oppression, within the *DSM* would be an important first step.

It should be noted that other conceptualizations of trauma, outside of the *DSM-5*, provide frameworks that better fit alternative forms of trauma. Kira (2001), for example, describes a taxonomy of trauma that includes several types, only one of which is "single, unexpected and direct" (p. 81) and thus fitting Criterion A. Indeed, Kira notes that Criterion A limits events to primarily survival traumas (wherein a person's life or serious injury are threatened) and sexual violence, but the range of what is considered traumatic is more diverse. The other types acknowledged by Kira (2001) include, but are not limited to, multigenerational transmission of structural trauma (i.e., poverty, hunger, unemployment, mass incarceration) and historical trauma (i.e., slavery, genocide). The inclusion of historical and multigenerational traumas or "soul wounds" (Duran, Firehammer, & Gonzalez, 2008, p. 288), as well as acknowledging the impact of trauma on self-actualization and identity development, recognizes causes and effects of traumatic oppression. Further, the intentional recognition of complex and ongoing trauma is more compatible with a definition of trauma that recognizes the impact of oppression.

Despite these criticisms and call for change, the latest version of the *DSM-5*, released in 2013, did not expand Criterion A nor did it include a new diagnosis to address the experience of oppression-based traumatic stress (APA, 2013). The *DSM-5* does make note

of risk and prognostic factors that impact the development of PTSD. Specifically, it includes the prevalence of PTSD by gender and by race and ethnicity and indicates that minority racial/ethnic status and female gender are potential pretraumatic factors. Although the inclusion of this information is arguably a step in the right direction, it does little to aid in understanding the etiology of the increased risk within these marginalized groups. The mere notation of these statuses as having increased prevalence and as potential risk factors for the development of PTSD necessitates further exploration. In response to these oversights, some have suggested that psychology's failure to acknowledge oppression as a source of traumatic stress is a manifestation of oppression, in and of itself (Carter, 2007). This article will make a case for expanding the current definition of Criterion A and/or adding other diagnostic categories to the *DSM* that incorporate the full range of oppressive forces by providing empirical support demonstrating the relationship between experiences of oppression and trauma-related outcomes and by arguing that this change is appropriately political and consistent with social justice values held by psychology.

Empirical Evidence for Conceptualizing Oppression as Trauma

There is a relatively small but compelling body of literature on the relationship among various forms of oppression (e.g., racism, sexism, heterosexism) and trauma-related symptoms, which has been used as indirect evidence for understanding oppression as a form of trauma (e.g., Alessi et al., 2013; Berg, 2006; Pieterse, Carter, Evans, & Walter, 2010). Empirical evidence has established that members of marginalized groups experience PTSD at a higher rate than their majority counterparts. For example, people of color (POC; i.e., racial and ethnic minorities) are consistently found to have higher levels of PTSD than their white counterparts (Carter, 2007). One explanation for this disparity may be differential exposure such that POC and those of lower socioeconomic status often experience more violence; however this is unlikely the only explanation. To that point, women (13%) are twice as likely than men (6.2%) to develop PTSD despite the fact that women are less likely to experience trauma as currently operationalized (Breslau et al., 1998). While the relative prevalence of PTSD in various groups provides an important foundation, it does not provide much specificity from which to draw conclusions. Do oppressed groups experience more traumatic events due to their relative positions of power, or lack thereof? Does living as a member of a marginalized group impact mental health in a way that leaves them more vulnerable to develop PTSD in response to the traumatic events they experience? Or, is their subjugation, in and of itself, experienced as a trauma uniquely contributing to their PTSD symptoms?

To answer these questions, it is important to turn to the empirical literature that goes beyond establishing prevalence rates of PTSD in various groups, but specifically examines the relationship between various forms of oppression and trauma-related outcomes. Though this body of literature remains somewhat sparse, it can be argued that most attention thus far has been paid to race. In his major contribution on racism and psychological and emotional injury, Carter (2007) makes a comprehensive and compelling case for incorporating race-based traumatic stress into the current understanding of trauma by reviewing the literature on race-related stress, trauma and PTSD, and discrimination. Although he is able

to provide considerable evidence to support his assertions, he acknowledged that few studies, at that point, had explicitly explored the role of racism in relation to trauma-related symptoms among POC. One study that had, examined exposure to race-related stressors in a sample of Asian American Vietnam veterans and found that exposure to these race-related stressors accounted for 20% of the variance in PTSD symptoms, above and beyond that which was explained by combat exposure (Loo et al., 2001).

Since Carter's (2007) major contribution, several other studies have been published that explicitly examine the relationship between discrimination and PTSD symptoms (e.g., Cheng & Mallinckrodt, 2015; Flores, Tschann, Dimas, Pasch, & de Groat, 2010). In a cross-lagged longitudinal study that employed a sample of Mexican American adolescents, Flores and colleagues (2010) found that experiences of racial/ethnic discrimination, when controlling for demographic variables, were significantly related to PTSD symptoms measured 6 months later. These results were successfully replicated in another crossed-lagged longitudinal sample of Hispanic college students such that experiences of discrimination were significantly predictive of PTSD symptoms measured one year later (Cheng & Mallinckrodt, 2015). Although there are considerable strengths of the studies discussed thus far, both individually and when considered in combination with each other, (e.g., diversity in samples, longitudinal designs), a significant limitation in this literature is its exclusive focus on experiences of interpersonal discrimination and neglect of other forms of oppression such as internalized racism, racial climate, and institutionalized racism. The results of one study that did incorporate the latter demonstrated that in a sample of Asian or Asian American college students, both experiences of discrimination (4%) and racial climate (7%) accounted for unique variance in trauma-related symptoms, above and beyond that of general stress, when they were sequentially added to the model (Pieterse et al., 2010). For Black students, experiences of discrimination (10%) predicted unique variance above and beyond that of general stress, but racial climate did not.

In addition to race-based traumatic stress, recent attention has been paid to ways in which sexism may impact trauma-related symptoms. In a sample of 382 community women, Berg (2006) found that 100% of the sample endorsed experiencing some form of sexist behavior (e.g., sexist jokes, sexual harassment, disrespected on the basis of gender). Furthermore, the extent to which women had experienced sexist events in their lifetime and in the past year predicted 11% and 18% of the variance in PTSD symptoms, respectively. Kira, Smith, Lewandowski, and Templin (2010) also sought to examine the impact of gender-based oppression and employed a sample of 160 refugee women across 32 countries who were either primary or secondary survivors of torture. Various types of trauma, personal identity, collective identity survival trauma, secondary trauma, torture trauma, and gender discrimination, as well as PTSD, were measured. Another important construct measured by the authors was cumulative trauma disorder, which was comprised of symptoms of executive function deficits, suicidality, psychosis/dissociation, and depression/anxiety. Results demonstrated that gender discrimination was directly associated with cumulative trauma disorder and indirectly associated with PTSD via cumulative trauma disorder. The results of this study can be interpreted as supporting the claim that gender

discrimination is a nonspecific risk factor for trauma symptoms, broadly.

A third form of oppression that has been explored as having an etiological role in trauma-related symptoms is heterosexism (e.g., Bandermann & Szymanski, 2014; Szymanski & Balsam, 2011). Szymanski and Balsam (2011) conducted a study in which they examined both heterosexist events that would meet Criterion A as it is currently written (i.e., hate crime victimization) as well as those that would not (i.e., heterosexual discrimination). For a sample of 247 self-identified lesbian women, the authors found that both heterosexist discrimination and heterosexist hate crime victimization predicted unique variance in PTSD symptoms above and beyond each other. Bandermann and Szymanski (2014) replicated these results, while expanding their generalizability, by including a sample of lesbian women, gay men, bisexual, and transgender individuals. They also found that hate crime victimization and heterosexist discrimination uniquely predicted PTSD symptoms and that, in combination, the two forms of trauma accounted for 24% of the variance in PTSD in their sample.

Limitations of the Extant Research and Suggested Future Directions

The authors believe that a thorough analysis of the limitations of the extant literature provides necessary context for interpreting the results as well as informs the direction of future research. With only one exception (Alessi et al., 2013), all of the empirical literature summarized in this review relies on quantitative methods. Similarly nearly all studies implemented a cross-sectional design (the only exceptions were Cheng & Mallinckrodt, 2015 and Flores et al., 2010). Future studies should assess the association between oppression and PTSD symptoms longitudinally so that they are able to truly assess whether experiences of oppression are, in fact, *causing* trauma-related symptoms. In the absence of a longitudinal design, it would strengthen authors' conclusions if they were able to demonstrate that experiences of oppression accounted for variance in PTSD symptoms above and beyond other forms of trauma. Notably, some studies (Bandermann & Szymanski, 2014; Loo et al., 2001; Szymanski & Balsam, 2011) did just that when they found that experiences of discrimination predicted PTSD symptoms above and beyond combat exposure or heterosexist hate crime victimization.

A related limitation of this body of literature is the way in which PTSD symptoms are being assessed. PTSD is one of the few diagnoses for which we assess the target event; however, almost all of the aforementioned studies (e.g., Bandermann & Szymanski, 2014; Pieterse et al., 2010) use self-report measures of PTSD that assess psychological symptoms of the aforementioned clusters but do not ask the participant to specify their trauma. If the current evidence was replicated but included specifically asking participants to answer for symptoms that were related to oppression (e.g., intrusive thoughts, avoidance of thoughts and/or feelings, irritability), it would provide further evidence for the causal link that is being theorized. It is possible that some of the aforementioned studies did take these steps; however, if so it was not indicated in their description of measures or procedures.

Further, PTSD measures, which have been created in the United States implementing predominantly White middle-class American samples, may be inappropriate for use with samples that are more

diverse with regards to race, ethnicity, and socioeconomic status (Helms et al., 2012). This is because their usage treats the White middle class's trauma experiences as normative and thus ignores the diversity of racial and cultural experiences among groups and the types of trauma assessed by such measures are not equivalent to experiences with racism and ethnoviolence for POC. Consider the Posttraumatic Stress Disorder Checklist for *DSM-5*, which is the updated version of one of the most widely used self-report measure of PTSD symptoms. Blevins, Weathers, Davis, Witte, and Domino (2015) conducted two studies to assess the psychometric properties of the Posttraumatic Stress Disorder Checklist for *DSM-5* and implemented samples of undergraduate students who had experienced a trauma. Notably these samples were predominantly White, female, and highly educated. Of note, the authors did not report the breakdown of their samples by sexual orientation, socioeconomic status, or age leaving the reader unable to determine how generalizable the results of these studies are. The results of these studies demonstrated strong internal consistency, test-retest reliability, convergent and discriminant validity, and a confirmatory factor analysis demonstrated adequate fit with the *DSM-5*'s four-factor model (Blevins et al., 2015). Although the authors appropriately indicated that "generalizability of the current results are limited with respect to demographic variables" (p. 496), they did not take any measures to ensure the generalizability of the results such as recruit more diverse samples or run their analyses separately as a function of race, ethnicity, gender, and so forth. Indeed, Green, Chen, Helms, and Henze (2011) suggest that improper reporting practices imply that measures are appropriate for use with all populations; however, the magnitude of reliability coefficients are dependent upon the composition of the sample. Results of two studies analyzing reliability reporting practices suggested that reliability coefficients varied across racial, ethnic, and gender subgroups. Further these variations had implications for whether psychological measures should be used across groups. Thus, the authors suggest that reporting reliability for demographic groups could help readers interpret and determine the relevance of findings for their samples.

A final area for expansion in the literature examining the relationship between oppression and trauma-related symptoms is the manner in which oppression was examined. With the exception of Pieterse and colleagues' (2010) inclusion of racial climate, only discrimination was assessed in the aforementioned studies and the ways it was measured were specifically interpersonal. While interpersonal discrimination is certainly an impactful aspect of oppression, it is only one of the many forms it may take (Prilleltensky & Gonick, 1996). This limitation is not specific to the empirical literature. In Carter's (2007) major contribution, he suggested a framework for race-based traumatic stress that incorporated racial discrimination, racial harassment, and discriminatory harassment. The latter construct allows for the conceptualization of structural or institutional racism that would fall into the higher levels proposed by Prilleltensky and Gonick (1996; social groups, state, international); however, as Speight (2007) points out in her rejoinder, internalized racism is another essential piece of the puzzle.

In summary, as authors continue to conduct research in this important area, they should consider implementing longitudinal designs, controlling for other forms of trauma, specifically assessing the target event, reporting reliability results by demographic groups, and expanding their conceptualization of oppression to

include experiences on the intrapersonal, social groups, state, and international levels (Prilleltensky & Gonick, 1996). Additionally, while it is a strength of the body of literature that there are studies examining a wide variety of marginalized groups (e.g., Asian American veterans, international refugee women), there is not sufficient evidence on any one group and it should not be assumed that the way oppression impacts one group manifests itself in the same way in others (Kira et al., 2010; Loo et al., 2001). Consequently, more research should be conducted across the board, including a focus on other forms of oppression including but not limited to classism, ageism, ableism, as well as the intersection of various oppressed identities. This discussion of limitations of the empirical literature is offered not to castigate the efforts made thus far, but to highlight opportunities to use more rigorous methodology in replicating previous results as well as additional research questions that warrant attention. Further, it should be noted that while these limitations are important to address, there are also considerable strengths to this research (e.g., use of diverse and varying samples, examining various forms of oppression) and the existing evidence that demonstrates the relationship between oppression and trauma symptoms remains compelling. Addressing the aforementioned suggestions would only serve to strengthen the conclusions we draw based on empirical results. The authors believe that involvement in the conceptualization of oppression as trauma requires not only practical advances (i.e., expanding Criterion A) but also continued research that is inclusive and methodologically strong.

We Can and Should Expand Criterion A

The aforementioned empirical evidence provides adequate support for the assertion that Criterion A *can* be expanded to include experiences of oppression—it has been demonstrated that non-Criterion A traumatic events are qualitatively similar to Criterion A traumas (Alessi et al., 2013) and that they similarly result in PTSD symptoms (e.g., Berg, 2006; Pieterse et al., 2010). The argument that Criterion A *should* be expanded can be found in feminist and multicultural criticisms of the current system (e.g., Gilfus, 1999) as well as our identity as psychologists. Gilfus (1999) points out that “the trauma paradigm [does] not blame victims of traumatic events for being complicitous in their own victimization” and that this is “a refreshing alternative to the victim-blaming stance of more traditional . . . explanations” (p. 1240). Therefore, by incorporating experiences of oppression into our conceptualization of trauma, we can accurately externalize the sources of symptomology. Not only would this serve to depathologize marginalized groups, but accurately naming the problem (e.g., racism, sexism, heterosexism) is an essential first step to coming up with appropriate solutions (e.g., macrolevel interventions, policy change).

While some may argue that taking action of this nature is inappropriately political, others (e.g., Albee, 2000) would argue that inaction, or failure to expand Criterion A to include experiences of oppression, is also inherently political. Furthermore, the American Psychological Association (APA) acknowledges psychology’s role in social justice work by not only specifying goals of “advancing psychology as a science and profession” in their bylaws but also as incorporating “a means of promoting health, education and welfare” (APA, 2008). Relatedly, our ethics code

(APA, 2010) lists “justice” as one of our five major general principles of our value ethics. In her APA presidential address, Vasquez (2012) asserts that not only is social justice a value that psychology claims to embody, but the field has historically taken a stand on controversial issues such as racial segregation (Tomes, 2004), abortion rights (APA, 2016; Major et al., 2009), and same-sex parenting (Paige, 2005). In 2004, APA issued a statement supporting marriage equality for same-sex couples (Paige, 2005) and in 2005, recognizing the deleterious impact of American Indian mascots, including the negative influence on self-esteem, APA proclaimed that it “supports and recommends the immediate retirement of American Indian mascots, symbols, images, and personalities. . . .” (APA, 2005, p. 2). From these examples, it is evident that expanding Criterion A to more fully incorporate the impact of trauma would be consistent with psychologists’ historical and ongoing commitment to social justice.

Implementing Diagnostic Categories That Account for the Impact of Oppression

It should be noted that although expanding Criterion A so that symptoms that follow experiences of oppression could be diagnosed as PTSD is the option predominantly addressed in the current discussion, it is by no means the only way for the field to acknowledge oppression as a form of trauma. One strength of this option, however, is that it could work within a diagnosis already included in the *DSM-5*. In fact, there is evidence that individuals who survive non-Criterion A events still develop reexperiencing, avoidance, and hyperarousal symptoms (Alessi et al., 2013). Consequently, the only change that would need to be made to the current PTSD criteria, would be to expand Criterion A to include experiences that do not threaten death or result in serious injury but are experienced as traumatic. Notably, in its latest revision “sexual violence” was explicitly added, thus demonstrating a precedence of expanding Criterion A when it has insufficiently captured the range of events known to be experienced as traumatic and result in trauma-related symptoms (APA, 2013, p. 271). Further, if “serious injury” were interpreted to include emotional injury then that would be sufficient to incorporate experiences of oppression.

Another option would be to include a new diagnosis in the next version of the *DSM* that specifically addresses oppression-based trauma. In fact, some leaders in the field prefer this option to working within the PTSD framework. Carter (2007), for example, argues that “it is not appropriate to use PTSD criteria for recognizing . . . race-based stress or trauma because the criteria are too limiting. . . . Furthermore, using PTSD would mean the target of racism is mentally disordered” (p. 33). In response, one could argue that it is the nature of the *DSM-5* diagnostic system to place the disorder within the individual; however, as Gilfus (1999) points out, trauma paradigms at least externalize the cause of the disorder. That being said, Carter’s (2007) suggestion that race-based traumatic stress injury be its own category would accomplish the same goals suggested in this article. Specifically, he proposed a nonpathological race-based traumatic stress injury model in which traumatic events would include racial discrimination (e.g., barring access, exclusion), racial harassment (e.g., interpersonal and verbal assaults, treatment as stereotype), and discriminatory harassment (“White flight”, denial of promotion). The traumatic experience could be a cumulative experience of racism

and/or a “last straw event” (p. 91), and must be experienced as negative, memorable, sudden, and uncontrollable. He posited that similar to a PTSD diagnosis, someone with race-based traumatic stress, would experience symptoms of intrusion, avoidance, and arousal. Additionally, however, he acknowledged that symptoms could also manifest as depression, guilt, and somatic symptoms (e.g., headaches) as well as adaptive coping strategies such as activism and a commitment to being strong. Although his model is specific to experiences of racism, the framework could be applied to other experiences of oppression (e.g., sexism, heterosexism) more broadly.

A third option would be to include oppression as a traumatic event within the framework of Complex PTSD, also referred to as Disorders of Extreme Stress Not Otherwise Specified, which in many ways resembles Kira’s (2001) taxonomy of trauma. Although traumatic events that are chronic in nature (i.e., intimate partner violence) can and do meet Criterion A, a number of authors have argued that PTSD does not sufficiently capture the effects of long-term trauma and that, consequently, a new diagnosis Complex PTSD should be added to the *DSM* (Ford, 1999; Herman, 2015). In addition to the symptoms already included in PTSD diagnosis as it is currently written in the *DSM-5*, Complex PTSD also includes disruptions in emotion regulation, consciousness (e.g., dissociation), self-perception (e.g., stigma, a sense of being completely different from other human beings), perceptions of the perpetrator (e.g., attributing total power to the perpetrator, preoccupation with revenge), relations with others, systems of meaning (i.e., loss of faith; U.S. Department of Veterans Affairs, 2016). When Complex PTSD is discussed it is usually not in reference to experiences of oppression but rather being a prisoner of war, human trafficking, long-term child abuse, and so forth. However, given the insidious and chronic nature of oppression, it is clear how its effects may best be represented through Complex PTSD diagnostic framework.

Ultimately, whether a Criterion A is expanded or new diagnostic categories are created is less important than the need for experiences of oppression to be formally acknowledged as trauma. Empirical evidence clearly demonstrates the impact of various forms of oppression (i.e., racism, sexism, heterosexism) on trauma-related symptoms. Furthermore, the field of psychology has a history of taking a political stance (Vasquez, 2012). Failure to do so is to “align . . . with [a] conservative view of causation” which would necessarily mean that we are “join[ing] the forces that perpetuate social injustice” (Albee, 2000, p. 248).

References

- Albee, G. W. (2000). The Boulder model’s fatal flaw. *American Psychologist*, 55, 247–248. <http://dx.doi.org/10.1037/0003-066X.55.2.247>
- Alessi, E. J., Martin, J. I., Gyamerah, A., & Meyer, I. H. (2013). Prejudice events and traumatic stress among heterosexuals, lesbians, gay men, and bisexuals. *Journal of Aggression, Maltreatment & Trauma*, 22, 510–526. <http://dx.doi.org/10.1080/10926771.2013.785455>
- Ali, A. (2004). The intersection of racism and sexism in psychiatric diagnosis. In P. J. Caplan & L. Cosgrove (Eds.), *Bias in psychiatric diagnosis*. Lanham, MD: Rowman & Littlefield.
- American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.
- American Psychological Association (APA). (2008). *Mission statement for APA*. Retrieved from <http://www.apa.org/about/policy/chap.-6.aspx>
- American Psychological Association (APA). (2010). *Ethical principles of psychologists and code of conduct (2002, Amended June 1, 2010)*. Retrieved from <http://www.apa.org/ethics/code/index.aspx>
- American Psychological Association (APA). (2016). Chap. XII. Public interest (Part 1). In *Counsel Policy Manual* (1980). Retrieved from <http://www.apa.org/about/policy/chapter-12.aspx#abortion>
- American Psychological Association Council of Representatives. (2005). *APA resolution recommending the immediate retirement of American Indian mascots, symbols, images, and personalities by schools, colleges, universities, athletic teams, and organizations*. Retrieved from <http://www.apa.org/pi/oema/resources/policy/indianmascots.pdf>
- Bandermann, K. M., & Szymanski, D. M. (2014). Exploring coping mediators between heterosexist oppression and posttraumatic stress symptoms among lesbian, gay, and bisexual persons. *Psychology of Sexual Orientation and Gender Diversity*, 1, 213–224. <http://dx.doi.org/10.1037/sgd0000044>
- Berg, S. H. (2006). Everyday sexism and posttraumatic stress disorder in women: A correlational study. *Violence Against Women*, 12, 970–988. <http://dx.doi.org/10.1177/1077801206293082>
- Blevins, C. A., Weathers, F. W., Davis, M. T., Witte, T. K., & Domino, J. L. (2015). The posttraumatic stress disorder checklist for *DSM-5* (PCL-5): Development and initial psychometric evaluation. *Journal of Traumatic Stress*, 28, 489–498. <http://dx.doi.org/10.1002/jts.22059>
- Breslau, N., Kessler, R. C., Chilcoat, H. D., Schultz, L. R., Davis, G. C., & Andreski, P. (1998). Trauma and posttraumatic stress disorder in the community: The 1996 Detroit Area Survey of Trauma. *Archives of General Psychiatry*, 55, 626–632. <http://dx.doi.org/10.1001/archpsyc.55.7.626>
- Brewin, C. R., Lanius, R. A., Novac, A., Schnyder, U., & Galea, S. (2009). Reformulating PTSD for *DSM-V*: Life after Criterion A. *Journal of Traumatic Stress*, 22, 366–373. <http://dx.doi.org/10.1002/jts.20443>
- Bulhan, H. A. (1985). *Frantz Fanon and the psychology of oppression*. New York, NY: Springer Science & Business Media.
- Carlson, E. B. (1997). *Traumatic assessments: Clinician’s guide*. New York, NY: Guilford Press.
- Carlson, E. B., Smith, S. R., & Dalenberg, C. J. (2013). Can sudden, severe emotional loss be a traumatic stressor? *Journal of Trauma & Dissociation*, 14, 519–528. <http://dx.doi.org/10.1080/15299732.2013.773475>
- Carter, R. T. (2007). Racism and psychological and emotional injury: Recognizing and assessing race-based traumatic stress. *The Counseling Psychologist*, 35, 13–105. <http://dx.doi.org/10.1177/0011000006292033>
- Cassiman, S. A. (2005). Toward a more inclusive poverty knowledge traumatological contributions to the poverty discourse. *Social Policy Journal*, 4, 93–106. http://dx.doi.org/10.1300/J185v04n03_06
- Cheng, H. L., & Mallinckrodt, B. (2015). Racial/ethnic discrimination, posttraumatic stress symptoms, and alcohol problems in a longitudinal study of Hispanic/Latino college students. *Journal of Counseling Psychology*, 62, 38–49. <http://dx.doi.org/10.1037/cou0000052>
- Donovan, R. A., Galban, D. J., Grace, R. K., Bennett, J. K., & Felicié, S. Z. (2013). Impact of racial macro- and microaggressions in Black women’s lives: A preliminary analysis. *The Journal of Black Psychology*, 39, 185–196. <http://dx.doi.org/10.1177/0095798412443259>
- Duran, E., Firehammer, J., & Gonzalez, J. (2008). Liberation psychology as the path toward healing cultural soul wounds. *Journal of Counseling and Development*, 86, 288–295. <http://dx.doi.org/10.1002/j.1556-6678.2008.tb00511.x>
- Flores, E., Tschann, J. M., Dimas, J. M., Pasch, L. A., & de Groat, C. L. (2010). Perceived racial/ethnic discrimination, posttraumatic stress symptoms, and health risk behaviors among Mexican American adoles-

- cents. *Journal of Counseling Psychology*, 57, 264–273. <http://dx.doi.org/10.1037/a0020026>
- Ford, J. D. (1999). Disorders of extreme stress following war-zone military trauma: Associated features of posttraumatic stress disorder or comorbid but distinct syndromes? *Journal of Consulting and Clinical Psychology*, 67, 3–12.
- Fredrickson, B. L., & Roberts, T. (1997). Objectification theory: Toward understanding women's lived experiences and mental health risks. *Psychology of Women Quarterly*, 21, 173–206.
- Giacaman, R., Rabaia, Y., Nguyen-Gillham, V., Batniji, R., Punamäki, R. L., & Summerfield, D. (2011). Mental health, social distress and political oppression: The case of the occupied Palestinian territory. *Global Public Health: An International Journal for Research, Policy and Practice*, 6, 547–559. <http://dx.doi.org/10.1080/17441692.2010.528443>
- Gilfus, M. E. (1999). The price of the ticket: A survivor-centered appraisal of trauma theory. *Violence Against Women*, 5, 1238–1257. <http://dx.doi.org/10.1177/1077801299005011002>
- Grabe, S., Ward, L. M., & Hyde, J. S. (2008). The role of the media in body image concerns among women: A meta-analysis of experimental and correlational studies. *Psychological Bulletin*, 134, 460–476. <http://dx.doi.org/10.1037/0033-2909.134.3.460>
- Green, C. E., Chen, C. E., Helms, J. E., & Henze, K. T. (2011). Recent reliability reporting practices in Psychological Assessment: Recognizing the people behind the data. *Psychological Assessment*, 23, 656–669. <http://dx.doi.org/10.1037/a0023089>
- Guina, J., Welton, R. S., Broderick, P. J., Correll, T. L., & Peirson, R. P. (2016). DSM-5 criteria and its implications for diagnosing PTSD in military service members and veterans. *Current Psychiatry Reports*, 18, 43. <http://dx.doi.org/10.1007/s11920-016-0686-1>
- Helms, J. E., Nicolas, G., & Green, C. E. (2012). Racism and ethnoviolence as trauma: Enhancing professional and research training. *Traumatology*, 18, 65–74. <http://dx.doi.org/10.1177/1534765610396728>
- Herman, J. (2015). *Trauma and recovery: The aftermath of violence—From domestic abuse to political terror*. New York, NY: Basic Books.
- Huynh, V. W. (2012). Ethnic microaggressions and the depressive and somatic symptoms of Latino and Asian American adolescents. *Journal of Youth and Adolescence*, 41, 831–846. <http://dx.doi.org/10.1007/s10964-012-9756-9>
- Jones, B. A., & Griffiths, K. M. (2015). Self-objectification and depression: An integrative systematic review. *Journal of Affective Disorders*, 171, 22–32. <http://dx.doi.org/10.1016/j.jad.2014.09.011>
- Kira, I. A. (2001). Taxonomy of trauma and trauma assessment. *Traumatology*, 7, 73–86. <http://dx.doi.org/10.1177/153476560100700202>
- Kira, I. A., Smith, I., Lewandowski, L., & Templin, T. (2010). The effects of gender discrimination on refugee torture survivors: A cross-cultural traumatology perspective. *Journal of the American Psychiatric Nurses Association*, 16, 299–306. <http://dx.doi.org/10.1177/1078390310384401>
- Loo, C. M., Fairbank, J. A., Scurfield, R. M., Ruch, L. O., King, D. W., Adams, L. J., & Chemtob, C. M. (2001). Measuring exposure to racism: Development and validation of a Race-Related Stressor Scale (RRSS) for Asian American Vietnam veterans. *Psychological Assessment*, 13, 503–520. <http://dx.doi.org/10.1037/1040-3590.13.4.503>
- Major, B., Appelbaum, M., Beckman, L., Dutton, M. A., Russo, N. F., & West, C. (2009). Abortion and mental health: Evaluating the evidence. *American Psychologist*, 64, 863–890. <http://dx.doi.org/10.1037/a0017497>
- Miller, G. H. (2009). The trauma of insidious racism. *The Journal of the American Academy of Psychiatry and the Law*, 37, 41–44.
- Neville, H. A., Awad, G. H., Brooks, J. E., Flores, M. P., & Bluemel, J. (2013). Color-blind racial ideology: Theory, training, and measurement implications in psychology. *American Psychologist*, 68, 455–466. <http://dx.doi.org/10.1037/a0033282>
- Noll, S. M., & Fredrickson, B. L. (1998). A mediational model linking self-objectification, body shame, and disordered eating. *Psychology of Women Quarterly*, 22, 623–636. <http://dx.doi.org/10.1111/j.1471-6402.1998.tb00181.x>
- O'Keefe, V. M., Wingate, L. R., Cole, A. B., Hollingsworth, D. W., & Tucker, R. P. (2014). Seemingly harmless racial communications are not so harmless: Racial microaggressions lead to suicidal ideation by way of depression symptoms. *Suicide & Life-Threatening Behavior*, 45, 567–576. <http://dx.doi.org/10.1111/sltb.12150>
- Paige, R. U. (2005). Proceedings of the American Psychological Association, Incorporated, for the legislative year 2004: Minutes of the annual meeting of the Council of Representatives. *American Psychologist*, 60, 436–511. <http://dx.doi.org/10.1037/0003-066X.60.5.436>
- Pieterse, A. L., Carter, R. T., Evans, S. A., & Walter, R. A. (2010). An exploratory examination of the associations among racial and ethnic discrimination, racial climate, and trauma-related symptoms in a college student population. *Journal of Counseling Psychology*, 57, 255–263. <http://dx.doi.org/10.1037/a0020040>
- Prilleltensky, I., & Gonick, L. (1996). Politics change, oppression remains: On the psychology and politics of oppression. *Political Psychology*, 17, 127–148. <http://dx.doi.org/10.2307/3791946>
- Reisner, S. L., Hughto, J. M., Dunham, E. E., Heflin, K. J., Bejenyi, J. B., Coffey-Esquivel, J., & Cahill, S. (2015). Legal protections in public accommodations settings: A critical public health issue for transgender and gender-nonconforming people. *The Milbank Quarterly*, 93, 484–515. <http://dx.doi.org/10.1111/1468-0009.12127>
- Speight, S. L. (2007). Internalized racism: One more piece of the puzzle. *The Counseling Psychologist*, 35, 126–134. <http://dx.doi.org/10.1177/0011000006295119>
- Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist*, 62, 271–286. <http://dx.doi.org/10.1037/0003-066X.62.4.271>
- Szymanski, D. M., & Balsam, K. F. (2011). Insidious trauma: Examining the relationship between heterosexism and lesbians' PTSD symptoms. *Traumatology*, 17, 4–13. <http://dx.doi.org/10.1177/1534765609358464>
- Szymanski, D. M., Kashubeck-West, S., & Meyer, J. (2008). Internalized heterosexism: Measurement, psychosocial correlates, and research directions. *The Counseling Psychologist*, 36, 525–574. <http://dx.doi.org/10.1177/0011000007309489>
- Tiggemann, M., & Williams, E. (2012). The role of self-objectification in disordered eating, depressed mood, and sexual functioning among women: A comprehensive test of objectification theory. *Psychology of Women Quarterly*, 36, 66–75. <http://dx.doi.org/10.1177/0361684311420250>
- Tomes, H. (2004, June). The case—and the research—that forever connected psychology and policy. *Monitor on Psychology*, 35, 28. <http://dx.doi.org/10.1037/e373572004-021>
- Tylka, T. L., & Hill, M. S. (2004). Objectification theory as it relates to disordered eating among college women. *Sex Roles*, 51, 719–730. <http://dx.doi.org/10.1007/s11199-004-0721-2>
- U.S. Department of Veterans Affairs. (2016, February 23). Complex PTSD. Retrieved from <http://www.ptsd.va.gov/professional/PTSD-overview/complex-ptsd.asp>
- Vasquez, M. J. (2012). Psychology and social justice: Why we do what we do. *American Psychologist*, 67, 337–346. <http://dx.doi.org/10.1037/a0029232>

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