

Race-Based Trauma: The Challenge and Promise of MDMA-Assisted Psychotherapy

MONNICA WILLIAMS, PH.D.

CHRIS LEINS, M.A.



Monnica Williams, Ph.D.



Chris Leins, M.A.

CURRENT RESEARCH SHOWS PROMISE FOR a new intervention for posttraumatic stress disorder (PTSD) known as methylenedioxymethamphetamine (MDMA)-assisted psychotherapy. This paper explicates the present state of research into clinical trauma related to the experience of racism in America, and the potential contribution MDMA-assisted psychotherapy might make to the efficacy of present interventions.

POSTTRAUMATIC STRESS DISORDER IN MINORITIES

Allen was a young African American man working at a retail store. Although he enjoyed and valued his job, he struggled with the way he was treated by his employer. He was frequently demeaned, given menial tasks, and even required to track African American customers in the store to make sure they weren't stealing. His work experiences consisted mostly of hostile actions intended to communicate his inferior status due to his

race (i.e., racial harassment). He began to suffer from symptoms of depression, generalized anxiety, low self-esteem, and feelings of humiliation. After filing a complaint, he was threatened by his boss and then fired. Allen's symptoms worsened and his interpersonal relationships became strained. He had intrusive thoughts, flashbacks, difficulty concentrating, irritability, and jumpiness—all hallmarks of PTSD. Allen was found to be suffering from race-based trauma (from Carter & Forsyth, 2009).

PTSD is a severe and chronic condition that may occur in response to any traumatic event. The National Survey of American Life (NSAL) found that African Americans show a prevalence rate of 9.1% for PTSD versus 6.8% in non-Hispanic Whites, indicating a notable mental health disparity (Himle et al., 2009). Increased rates of PTSD have been found in other groups as well, including Hispanic Americans, Native Americans, Pacific Islander Americans, and Southeast Asian refugees (Pole et al., 2008). Furthermore, PTSD may be more disabling

for minorities; for example, African Americans with PTSD experience significantly more impairment at work and carrying out everyday activities (Himle, et al. 2009).

CHANGES IN THE DSM-5

Changes to PTSD criteria in the DSM-5 have been made to improve diagnostic accuracy in light of current research (APA, 2013; Friedman et al., 2011). Previously, a person was required to have directly experienced a discrete traumatic event for a diagnosis. Under the new criteria, if a person has learned about a traumatic event involving a close friend or family member, or if a person is repeatedly exposed to details about trauma, they may now be eligible for a PTSD diagnosis. These changes were made to include those exposed in their occupational fields, such as police officers or emergency medical technicians. However, this could be applicable to those suffering from the cumulative effects of racism as well.

The diagnostic requirement of responding to the event with intense fear, helplessness, or horror has been removed in the new version of the DSM. It was found that in many cases, such as soldiers trained in combat, emotional responses are only felt afterward, once removed from the traumatic setting. The criteria have changed from a three-factor to a four-factor model. The proposed factors are now (a) intrusion symptoms, (b) persistent avoidance, (c) alterations in cognition and mood, and (d) hyperarousal/reactivity symptoms. Three new symptoms have also been added: persistent distorted blame of self or others, persistent negative emotional state, and reckless or self-destructive behavior. These symptoms may be also seen in those victimized by race-based trauma.

RACISM AND PTSD

One key factor in understanding PTSD in ethnoracial minorities is the impact of racism on psychological well-being. Racism continues to be a daily part of American culture, and racial barriers have an overwhelming impact on the oppressed. Research has documented that both implicit and explicit racism create barriers to health care (Penner, Blair, Albrecht, & Dovidio, 2014). Much research has been conducted on the social, economic, and political effects of racism, but less research recognizes the psychological effects of racism on people of color (Carter, 2007). Chou, Asnaani, and Hofmann (2012) found that perceived racial discrimination was associated with increased mental disorders in African Americans, Hispanic Americans, and Asian Americans, suggesting that racism may in itself be a traumatic experience.

Bryant-Davis and Ocampo (2005) noted similar courses of psychopathology between rape victims and victims of racism. Both events are an assault on the personhood and integrity of the victim. Similar to rape victims, race-based trauma victims

may respond with disbelief, shock, or dissociation, which can prevent them from responding to the incident in a healthy manner. The victim may then feel shame and self-blame because they were unable to respond or defend themselves, which may lead to low self-concept and self-destructive behaviors. In the same study, a parallel was drawn between race-based trauma victims and victims of domestic violence. Both survivors are made to feel shame over allowing themselves to be victimized. For instance, someone who has experienced a racist incident may be told that if they are polite, work hard, and/or dress in a certain way, they will not encounter racism. When these rules are followed yet racism persists, powerlessness, hyper vigilance, and other symptoms associated with PTSD may develop or worsen (Bryant-Davis & Ocampo, 2005).

Many clinicians only recognize racism as trauma when an individual experiences a discrete racist event, such as a violent hate crime. This is limiting given that many minorities experience cumulative experiences of racism as traumatic, with perhaps a minor event acting as “the last straw” in triggering trauma reactions (Carter, 2007). Thus, the conceptualization of trauma as a

discrete event may be inadequate for diverse populations. Furthermore, minorities may be reluctant to volunteer experiences of racism to White clinicians, who comprise the majority of mental health care providers. Patients may worry that the clinician will not understand, become defensive, or express disbelief. Additionally, minority patients may not link current PTSD symptoms to cumulative experiences of discrimination if queried about a single event.

IMPLICATIONS FOR TREATMENT

Racism is not typically considered traumatic by mental health care providers. Psychological difficulties attributed to racist incidents are often questioned or minimized, a response that only perpetuates the victim’s anxieties. Thus, patients who seek out mental healthcare to address race-based trauma may be further traumatized by micro-aggressions—subtle racist slights—from their own clinicians when they encounter disbelief or avoidance of racially charged material (Sue et al., 2007).

Clinicians assessing ethnoracial minorities are encouraged to directly inquire about the patient’s experiences of racism when determining trauma history. Some forms of race-based trauma may include racial harassment, discrimination, witnessing ethnoviolence or discrimination of another person, historical or personal memory of racism, institutional racism, micro-aggressions, and the constant threat of racial discrimination (Helms et al., 2012). The more subtle forms of racism may be commonplace, leading to constant vigilance, or “cultural paranoia,” which may be a protective mechanism against racist incidents (Whaley, 2001). However subtle, the culmination of different forms of racism may nonetheless result in traumatization.

Racism continues to be a daily part of American culture, and racial barriers have an overwhelming impact on the oppressed.

Unfortunately, many clinicians are unprepared to address cultural issues due to social taboos surrounding racism, discrimination, and White privilege. This will in turn prevent open dialogue with patients about potentially relevant trauma-related experiences. Thus it is important that all clinicians are well trained in the delivery of culturally competent care to enable them to properly serve diverse patients (Miller et al., 2015).

IMPLICATIONS FOR STUDY RECRUITMENT

Identifying the specific aspects of racism that tend to be psychopathogenic for individuals is difficult in light of individuals' tendency to vary in their reactivity to stress and perceptions of racism (Williams et al., 2014). Thus some of the complexities facing modern psychological research and practice include both limiting the misidentification of race-based stress and trauma and continuing research toward the effective and culturally authentic treatment of trauma reactions stemming from the experience of racism (Helms et al., 2010).

Additional complexities pertain to ongoing research and the gathering of new data. Several studies have chronicled the successful recruitment of members of minority groups into clinical trials (e.g., Williams, Tellawi, Wetterneck, & Champman, 2013); these studies highlight the significant underrepresentation of minority group-members involved in current research studies. The importance and clinical necessity of cross-cultural involvement in current research cannot be overstated. Data gleaned from culturally exclusive research studies may reduce treatment success for certain ethnic groups, including African Americans (Williams et al., 2014). However, conducting culturally inclusive studies involves intensive recruitment phases which are complicated by the perception among many minorities that the American healthcare system, including psychological researchers and practitioners within that system, is a racist institution, favoring Whites and perhaps even causing minorities deliberate harm (Suite et al., 2007).

In light of this, barriers to recruiting minorities for research studies are evident. Williams et al. (2013) found that successful recruitment of minorities often involves building personal connections with members and leaders of local communities, and using multiple culturally specific advertising venues. Addition-

ally, compensating participants may encourage the involvement of those who would otherwise be made to take time off of work, and would thus be unable to participate.

Developing therapeutic approaches to the treatment of race-based trauma is an important research goal. Cultural knowledge and sensitivity by the clinician are essential pieces in the understanding and effective treatment of race-based trauma (Chapman et al., 2014; Williams et al., 2014). Indeed, several studies have shown that a strong positive ethnic identity is correlated with higher self-esteem, the development of effective coping skills, the experience of optimism, and fewer psychological symptoms (Smith et al., 1999; Williams, Chapman, Wong, & Turkheimer, 2012). However, individuals with a strong sense

of belonging to their native cultural identity are more likely to experience significant distress in the face of racism (Yip, Gee, & Takeuchi, 2008). Thus, cultivating familiarity with clients' ethnic heritage and demonstrating respect for and sensitivity to their cultural background is an essential part of adapting evidence-based treatments to meet their needs.

Although the clinical efficacy of pharmacological and psychotherapeutic interventions for PTSD is well established (Foa et al., 2009), the literature reveals deficiencies in modern treatment capacity for psy-

chological trauma (Cloitre, 2009). Such deficiencies include a tendency for persons who enroll in clinical trials to prematurely discontinue treatment at an alarmingly high rate (Hembree et al., 2003), and dropout rates for minorities may be higher yet. For example, Lester and colleagues (2010) found that African Americans were 1.5 times more likely to drop out and three times more likely not to initiate PTSD treatment, despite being more hopeful about treatment benefits prior to therapy. The study authors attribute findings to potentially faster improvement among African Americans, stigma related to treatment, and lack of cultural sensitivity in the assessment and treatment process. The latter two attributions are more likely, given the literature surrounding treatment issues and African Americans. Such significant deficiencies in existing approaches to effective treatment raise questions of alternative interventions. Often, the experience of emotional intensity in relationship to traumatic memories precludes the efficacy of psychotherapeutic intervention for trauma symptoms (Jaycox & Foa, 1999).



Monica Williams and a group of her students at the Anxiety and Depression Association of America conference in Chicago, March 2014. The group presented their research and Monica participated in a symposium on cultural competency in research on anxiety and depressive disorders.

THE PROMISE OF MDMA-ASSISTED PSYCHOTHERAPY

Methylenedioxymethamphetamine (MDMA) is a psychoactive drug historically used in conjunction with psychotherapeutic intervention. Although MDMA was classified as a Schedule 1 controlled substance in 1985, several comparatively recent studies have found that the administration of MDMA for the purpose of trauma-related psychotherapy correlated with positive outcomes. Individuals whom were administered MDMA experienced an increase in oxytocin, a hormone implicated in trust and emotional perception (Domes et al., 2007; Kirsch et al., 2005). Also, Dumont et al. (2009) found that elevated oxytocin was associated with greater sociability. That is, the administration of MDMA may help with building human connection, including rapport within the context of psychotherapeutic interventions.

Additionally, MDMA produces temporary modifications in neurological activity. Liechti (2000) found that volunteers who were administered MDMA had increases in activity in the ventromedial frontal and occipital cortexes, and decreases in the left amygdala. Such neurological modifications were associated with a reduced sense of fear as it pertained to trauma-related memories. Thus, the administration of MDMA in conjunction with psychotherapy, Mithoefer et al. (2011) postulated in a recent study, may specifically allow for effective processing of traumatic material. That study comprised two randomized groups, MDMA ($n = 12$) and placebo ($n = 8$). The onset of MDMA-effects was concurrent with psychotherapy for each volunteer. Thus, the research study included both 125 mg of MDMA (or placebo) and two, eight-hour psychotherapy sessions. The primary outcome measure was the Clinician-Administered PTSD Scale (CAPS; Blake et al., 1990), a gold-standard assessment of PTSD used by the military. Clinical response was defined as a greater than 30% reduction in baseline of symptom severity as measured by the CAPS.

A clear divergence emerged between the two groups. 83.3% of those in the MDMA group showed clinical response to treatment, versus 25% of those in the placebo group. Additionally, the ten subjects in the MDMA group no longer met diagnostic criteria for PTSD. Thus, MDMA-assisted psychotherapy was demonstrated to be an effective intervention for PTSD in these participants. In a follow-up study, Mithoefer et al., (2012) found that therapeutic gains were longitudinally

lasting as evidenced by CAPS scores at two-month follow-up and up to 74.3 months following treatment. Thus preliminary data demonstrates that MDMA-assisted psychotherapy can be an effective intervention for successfully treating PTSD and maintaining therapeutic gains over time.

One of the major challenges facing research on MDMA-assisted psychotherapy for the treatment of PTSD is the scant amount of data demonstrating its efficacy in ethnic minority patients. That is, among the published studies involving this experimental treatment for PTSD no participants were ethnic or racial minorities. In recently completed Phase 2 trials, minority

inclusion was improved but still low (15.2%). Further, Mithoefer et al. (2013) did not specifically address the implication of MDMA-assisted psychotherapy for the treatment of race-based trauma. Thus, the degree to which MDMA-assisted psychotherapy can be helpful for race-based trauma has not yet been empirically demonstrated. To further explicate the dilemma, successfully conducting cross-cultural research toward culturally authentic treatments is compounded by the history of racism in the American healthcare system, making stigmatized minorities reluctant to volunteer for clinical trials (Suite et al., 2007; Williams et al., 2013).

While there is apparent promise implicit in the above data, there is also significant challenges inherent in the present research: We are not certain as to how relevant existing data is to the non-White population, including those suffering from race-

based trauma. Additionally, researchers need to employ culturally specific—and sometimes extensive—strategies to ensure stigmatized minorities are included in clinical trials.

SUMMARY

Although changes to the DSM increase the potential for better recognition of race-based trauma, more awareness is needed among clinicians to properly identify it. More research is needed to develop a culturally competent model of PTSD to address how culture may differentially influence trauma experiences of stigmatized minorities. In the meantime, clinicians must be educated about the impact of racism in lives of their ethnic minority patients, specifically the connection between racist experiences and trauma. To that end, interventions to increase awareness and improve clinical dialogue should have the same value as other aspects of medical training (Penner, Blair, Albrecht, & Dovidio, 2014).



Monnica Williams met with state legislators to advocate for mental health reform and increased access as a Diversity Delegate from Kentucky at the American Psychological Association State Leadership Conference on March 1, 2016.

There is an urgent need to develop empirically supported interventions for those suffering the effects of race-based trauma, and MDMA-assisted psychotherapy may be an important next step. Prior research focused on treatment of stigmatized minorities suffers from low inclusion and high dropout rates, although minorities suffer from disproportionately high rates of PTSD. As a compassionate society, we must find or make ways to reach all segments of our society with promising new treatments, so that everyone has an optimal chance of recovery and an excellent quality of life. 🌱

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Monnica T. Williams, Ph.D., is a clinical psychologist and Associate Professor at the University of Louisville in Psychological and Brain Sciences, where she serves as the Director for the Center for Mental Health Disparities. She completed her undergraduate studies at MIT and UCLA and received her doctoral degree from the University of Virginia. Dr. Williams has published over 60 peer-reviewed articles and book chapters, focused on psychopathology and cultural differences. Her work has been featured in several major media outlets, including NPR and the New York Times. She is currently an associate editor of The Behavior Therapist. She can be contacted through her website, monnicawilliams.com.

Chris Leins, M.A., is a clinical counselor with the Louisville OCD Clinic, where he treats people with mental disorders and specializes in treating religious scrupulosity. Chris was trained at Eastern University, attaining a Master of Arts degree in Clinical Counseling. Chris is presently pursuing a Master of Divinity degree at the Southern Baptist Theological Seminary. Chris' research passion is working to combine evidence-based treatments with biblical teaching, with a focus on diverse populations. He can be reached at chrisleins04@gmail.com.

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