Overview of PTSD

Posttraumatic stress disorder (PTSD) is a severe and chronic anxiety condition that may occur after experiencing or witnessing traumatic events. Among the general population, 60.7% of men and 51.2% of women are estimated to experience a traumatic event in their lifetime (Kessler et al. 1995), and a significant proportion of these develop PTSD. PTSD is characterized by reexperiencing, avoidance, and hyperarousal symptoms that occur over time and lead to significant disruption in one’s life (American Psychiatric Association 2000). Although first acknowledged among combat veterans and rape victims, symptoms of PTSD are now recognized among those who survive auto accidents, sexual assaults, terrorist attacks, natural disasters, and even in first responders and medical professionals who care for those who have experienced a trauma (Friedman et al. 2011; Williams et al. 2010).

Epidemiology of PTSD in African Americans

It is important to note that the prevalence of PTSD differs by race and ethnicity. The National Comorbidity Survey-Replication (NCS-R) and National Survey of American Life (NSAL) found that, while non-Hispanic Whites are at higher risk for most anxiety disorders, African Americans show a 9.1% prevalence rate for PTSD versus 6.8% in non-Hispanic Whites (Himle et al. 2009). Among African Americans aged 55 and older, PTSD is the most prevalent disorder (Ford et al. 2007). Additionally, African Americans may become more impaired by PTSD than non-Hispanic Whites. African Americans showed significantly greater impairment in productivity and out-of-role domains, reflecting difficulty carrying out everyday activities (Himle et al. 2009).

Cultural Considerations for Diagnosing PTSD

Comorbidity

Among those with PTSD, the most common comorbid diagnoses are depressive disorders, substance use disorders, and other anxiety disorders (Brady et al. 2000). There is a substantial overlap between PTSD and symptoms of several other psychiatric disorders, which can contribute to missing the primary diagnosis of PTSD when trauma histories are not obtained (Brady et al. 2000).
This problem may be particularly true for African Americans in mixed race counseling dyads, as the development of trust needed to disclose a trauma may be lacking in the absence of strong therapeutic alliance (i.e., Constantine 2007).

The comorbidity of PTSD with substance use disorders is complex because a substance use disorder may often develop as an attempt to self-medicate the distressing symptoms of PTSD. People with PTSD are at higher risk for nicotine dependence and drug abuse, although African Americans are not at a higher risk than European Americans (Breslau et al. 2006). Binge eating and obesity, both of which have been associated with PTSD, occur among African Americans at rates that are the same as or higher than those for European Americans (Franko 2007; Pagoto et al. 2012). Harrington et al. (2010) found a particularly strong link between PTSD and binge eating in African American women, related to the “strong Black woman” stereotype. Because the experience of PTSD can be dependent on cultural factors, it is important to conduct a proper, thorough assessment to accurately determine what is driving the symptoms.

Trauma Cognitions

PTSD changes the way people think about themselves, others, and the safety of the world. Research indicates that cognitions about these constructs may differ by race. For example, African Americans have lower expectations about the benevolence of the world in general (Zoellner et al. 1999). In a study of adults dually diagnosed with alcohol dependence and PTSD, it was found that African Americans had more negative thoughts about the safety of the world, fewer thoughts about self-blame, and similar levels of negative thoughts about the self (Williams et al. 2012). In addition, negative thoughts about one’s self and self-blame about the trauma were connected to harmful patterns of drinking that impacted all areas of life broadly in African Americans, but this relationship was not evident in European Americans in the same study.

Treatment Seeking and Barriers to Treatment

The National Comorbidity Survey found that among respondents with PTSD there was an elevated risk of high school and college failure, becoming a teen parent, marital instability, and unemployment compared to people without PTSD (Brunello et al. 2001), although it is not clear if this is greater among African Americans. Given the greater overall difficulties faced by those with PTSD, accessing treatment is reasonably expected to be more challenging. Barriers to treatment among African Americans with PTSD include transportation difficulties, finances, family disapproval, and unfamiliarity with procedures for accessing treatment (Davis et al. 2008). Additionally, African Americans have higher feelings of stigma and more negative attitudes toward mental health treatment in general (Abdullah and Brown 2011), which is also a factor in reduced help-seeking.

One clinical study found that African Americans were significantly less likely to complete PTSD treatment compared with European Americans (Lester et al. 2010). African Americans had a 1.5 times greater likelihood of dropping out and a three times greater likelihood of never starting therapy. African American clients were more optimistic about the benefits of treatment prior to starting therapy. Furthermore, they were doing as well in treatment as their European American counterparts prior to dropout, even after accounting for demographic variables such as income and education, so lack of benefit from treatment does not explain this finding. The authors of the study attribute findings to the fact that many African Americans improved more quickly, stigma surrounding treatment, and lack of cultural sensitivity in the assessment and treatment process.

Racism and PTSD

One major factor in understanding PTSD in African Americans is the impact of racism on emotional and psychological well-being. The current criterion for a PTSD diagnosis implies that the
event causing the distress must be negative and uncontrollable, and an individual’s physical well-being is threatened (American Psychiatric Association [DSM-IV-TR] 2000). Although this description may address many forms of race-related trauma, it may not take into account ongoing low levels of racism that can lead to a general sense of distress and uncontrollability (Carter 2007). The latter experiences, though not physical in nature, attack the individual’s identity and force the individual to relive traumas associated with their race or culture’s history (Helms et al. 2011). Chouet al. (2012) found that perceived racial discrimination was associated with increased mental disorders in African, Hispanic, and Asian Americans, suggesting that perceived racism may in itself be a traumatic experience. Currently, the DSM recognizes racism as trauma only when an individual meets DSM criteria for PTSD in relation to a discrete racist event. This is problematic given that many African Americans experience cumulative experiences of racism as traumatic, with a discrete event acting as “the last straw” triggering trauma reactions (Carter 2007). Thus, current conceptualizations of trauma as a discrete event may be limiting for African Americans.

Moreover, existing PTSD measures aimed at identifying an index trauma fail to include racism among listed choice response options, leaving such events to be reported as “other” or fit into an existing category that may not fully capture the nature of the trauma (e.g. physical assault). This can be especially problematic since African Americans may be reluctant to report experiences of racism to European American therapists (Carter 2007; Constantine 2007), who comprise the majority of mental health clinicians (U.S. Department of Labor 2012). African American clients also may not link current PTSD symptoms to a single experience of racism if their symptoms relate to cumulative experiences of discrimination. For these reasons, therapists using existing PTSD measures with African Americans are encouraged to directly inquire about the client’s experiences of racism when assessing trauma history. To ensure appropriate and accurate diagnoses, therapists must evaluate reactions to both discrete and cumulative experiences of racism.

If a mental health professional is not cognizant of race-based trauma, the symptoms and behavior may be misattributed to stereotypes about the client’s race or culture (avoidance of strangers, aggressive reactivity; Helms et al. 2011).Because racism has not typically been considered a PTSD criterion A trauma, symptoms attributed to racist incidents may be downplayed or questioned, a mistake that only perpetuates the victim’s anxieties (Carter 2007). Thus, clients may seek out mental healthcare to address race-based trauma, only to face further microaggressions (ambiguous racial slights) from their therapist (Sue et al. 2007).

Although it has been found that African Americans show more distress in response to racial harassment than they do to racial discrimination (Carter et al. 2005), knowledge of both kinds of experiences is essential to accurate assessment of PTSD in African Americans. Some forms of race-based traumas may include, but not be limited to witnessing ethnoviolence or discrimination of another, historical or personal memory of racism, institutional racism, microaggressions, and the constant threat of racial discrimination. The more subtle forms of racism mentioned may be predictable and commonplace, leading to constant vigilance, or “cultural paranoia,” which may be considered a protective mechanism against the incidents (Carter 2007; Whaley 2001).

However subtle, these different forms of racism may result in victimization of an individual parallel to that induced by physical or threatened trauma. For example, Bryant-Davis and Ocampo (2005) addressed similar courses of psychopathology between rape victims and victims of racism. Similar to rape victims, race-related trauma victims may respond with dissociation, or shock, which can prevent them from responding to the incident in a functional manner. Victims 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 (Bryant-Davis and Ocampo 2005). In the same investigation, a parallel was drawn between race-related trauma victims and victims of domestic violence. In both cases, survivors may feel shame over allowing themselves
to be victimized. For instance, if those who experience a racist incident are told that if they work hard, dress a certain way, and get along well with others, they will not experience racism again. When these rules are followed, and racism still occurs, powerlessness, hyperarousal, and other symptoms associated with PTSD may set in or worsen (Bryant-Davis and Ocampo 2005).

PTSD Assessment Measures

Diagnosis and Assessment

PTSD is typically diagnosed in an individual who survived or witnessed actual or threatened death or serious injury, and experiences the following symptoms for a duration of greater than 1 month: (1) one or more reexperiencing symptoms (e.g., recurrent, distressing thoughts, images, flashbacks or dreams, intense emotional distress, or physical reactivity when reminded of the event); (2) three or more forms of trauma-related avoidance (e.g., trauma reminders, trauma-related thoughts and feelings, emotional numbing, inability to recall an important aspect of the trauma, markedly diminished interest in usual life activities, feeling detached or estranged from others, restricted emotional range, and a sense of a foreshortened future) and (3) at least two or more hyperarousal symptoms (e.g., sleep difficulties, irritability or outbursts of anger, hypervigilance, difficulty concentrating, and exaggerated startle response). Chronic PTSD is diagnosed in individuals with symptoms lasting greater than 3 months, while PTSD with delayed onset is diagnosed in those whose symptoms are triggered at least 6 months post trauma (American Psychiatric Association 2000).

Standardized clinical interviews and self-report questionnaires are used conjointly to assess (1) immediate reactions to the trauma (e.g., Immediate Stress Reaction Checklist, ISRC; Fein et al. 2001; Peritraumatic Dissociation Experiences Questionnaire, PDEQ-SR; Marmar et al. 1997); (2) evaluate the presence and severity of PTSD symptoms (e.g., Clinician-Administered PTSD Scale, CAPS; Blake et al. 1990; PTSD Symptom Scale Interview Version, PSS-I; Foa et al. 1993; PTSD Diagnostic Scale, PDS; Foa 1996); (3) allow the clinician to objectively assess trauma severity and differentiate symptoms such as remembering vs. reexperiencing (flashbacks) the event (e.g., PSS-I, Foa et al. 1993); and (4) evaluate previous trauma history (e.g., Standardized Trauma Interview, STI; Resick et al. 2008; Childhood Trauma Questionnaire, CTQ; Bernstein et al. 1994). In addition to identifying trauma history and yielding a DSM diagnosis, the assessment process provides a therapeutic element by allowing the patient to begin relaying the details and impact of the trauma in a structured, gradual manner. Self-report measures are used in evidence-based treatment protocols, such as prolonged exposure therapy (Foa et al. 1997), to track changes in symptoms over the course of treatment and provide feedback on treatment progress and efficacy. In addition to its research utility, symptom tracking may encourage and provide feedback to patients in therapy asking them to face and discuss their traumatic memory.

This chapter summarizes measures designed solely for assessing PTSD in adults and children, focusing on their psychometric properties relevant to African Americans. Given the scope and focus of this chapter, comprehensive structured clinical interviews (e.g., Structured Clinician Interview for DSM-IV Axis I Disorders, SCID-I; First et al. 2002) and measures focusing on trauma-associated symptoms without evaluating PTSD (e.g., Dimension of Stressful Events Rating Scale, Fletcher 1996b; Posttraumatic Cognitions Inventory, Foa et al. 1999) are not included.

Clinician Administered Interviews

Clinician Administered PTSD Scale

The Clinician Administered PTSD Scale (CAPS; Blake et al. 1990) is a 30-item structured interview providing a current (past month) or lifetime diagnosis of PTSD, and may be used to assess symptoms during the past week. This measure evaluates 17 PTSD symptoms; symptoms related to social and occupational functioning; symptom changes since a previous CAPS administration,
PTSD severity, response validity; and severity of five trauma-related symptoms (behavioral guilt, survivor guilt, lapses in consciousness, depersonalization, and de-realization). Criterion A is assessed using the Life Events Checklist (LEC), which identifies traumatic events experienced, with CAPS items asked in reference to up to 3 events. The CAPS can be administered by clinicians, researchers, and appropriately trained paraprofessionals. Standardized questions with probes are provided. The full interview takes 45–60 min to administer, but certain sections may be omitted (e.g., associated trauma symptoms). The measure was initially validated with 23 combat veterans, 19 of whom had previously been diagnosed with PTSD; however their race was unspecified. Internal consistency was acceptable for reexperiencing, numbing and avoidance, and hyperarousal (α=0.77, 0.85, and 0.73, respectively; Blake et al. 1990).

The CAPS is regularly used to provide evidence of convergent validity and as a screening tool to detect PTSD across race (Goldmann et al. 2011; Frueh and Kinder 1994; Kubany et al. 2000). In a study of traumatized, low-income African Americans, 21% of the sample received a current PTSD diagnosis and 49% received a lifetime PTSD diagnosis, with the highest rates in “severe” and “severe without amnesia” profiles, suggesting adequate validity (Nugent et al. 2012). In a mixed race sample of 126 male veterans (62.1% European American, 37.9% African American) previously diagnosed with PTSD, CAPS internal consistency was adequate (α=0.91), and no significant differences were found across race (Monnier et al. 2002). Similarly, Frueh et al. (2004) studied PTSD and co-morbid disorders in a small sample of male veterans (57.1% European American, 42.9% African American) and found no significant differences in PTSD scores across race. Another study addressing VA service use by male veterans found similar results. In a sample with 35% African Americans and 65% European Americans, 12% met the criteria for PTSD on the CAPS, with no significant racial difference in diagnosis or severity (Grubaugh et al. 2006). These results should be considered in light of study limitations, such as small sample size, short-term assessment period, and failure to control for trauma type (Monnier et al. 2002).

While the CAPS is commonly used in studies with African Americans, none have adequately examined the validity and reliability of this measure in this population. Clinicians may choose to use this measure with their African American clients with this in mind. However, future research should focus on establishing the content validity of this measure before it can be confidently recommended for use in African Americans.

**PTSD Symptom Scale-Interview Version**

The PTSD Symptom Scale-Interview Version (PSS-I; Foa et al. 1993) evaluates the presence and severity of the 17 PTSD symptoms related to a single traumatic event. A 4-point scale is used to measure the severity of each symptom during the past 2 weeks. A PTSD diagnosis is made if an individual scores 1 or greater on one or more reexperiencing symptoms, 3 or more avoidance items, and 2 or more hyperarousal items. A total score between 10 and 20 is moderate, 21–28 is moderately severe, and above 28 is severe. Subscale scores for reexperiencing, avoidance and hyperarousal can also be summed.

The original validation sample was 71% African American and had acceptable internal consistency for the total test (α=0.85; Foa et al. 1993). Sample means were not reported. Powers et al. (2012) conducted a recent validation study of the PSS-I on a primarily African American sample (64.1%) diagnosed with alcohol dependence and chronic PTSD. Internal consistency was satisfactory for the total severity (α=0.90) and subscale scores (α=0.74–0.85). PSS-I sample means were not reported in this study. Schumm et al. (2005) also documented excellent internal reliability (α=0.94–0.95) in a study using the PSS-I with a community sample of mainly African American, low-income women who experienced sexual or physical childhood abuse.

The PSS-I has been used in several studies with African Americans as a diagnostic tool to determine eligibility for participation in clinical research studies (Zoellner et al. 1999). Since African Americans comprised of two validation...
samples, the PSS-I is acceptable for use with this population. An examination of its psychometric properties specific to African Americans would further substantiate its use with this group.

Self-Report Questionnaires

Childhood Trauma Questionnaire
The Childhood Trauma Questionnaire (CTQ; Bernstein et al. 1994) was originally a 70-item questionnaire assessing history of childhood abuse and neglect. The CTQ was developed from analyses of related material and is intended for adults and children in clinical settings. Participants were recruited from Mount Sinai Medical Center in New York City and the Veterans Affairs Medical Center in the Bronx. The CTQ consists of 4 scales (emotional/physical abuse, emotional neglect, sexual abuse, and physical neglect). Items assess the extent to which traumatic experiences were true when the respondent “was growing up,” using a 5-point scale ranging from never (0) to very often (4). The validation sample for the original version was predominantly African American (51.2%) and male (85.3%) with a history of substance abuse. Average raw total and scale scores were: total M = 110.8 (34.1); emotional/physical abuse M = 48.3 (18.6); emotional neglect M = 35.7, (12.5); sexual abuse M = 8.8 (5.3); and physical neglect M = 17.5 (6.2). Total and individual scales all showed acceptable internal consistency (α = 0.79, 0.95) and good test-retest reliability for total and scale scores was found when readministered to a randomly selected group of participants 2–6 months later (0.80–0.88).

Bernstein and colleagues later developed the 23-item CTQ brief version, in which a fifth scale was added by dividing physical and emotional abuse. Internal consistency was acceptable for the total score (α = 0.80) and scale scores (α = 0.79, 0.95). This screen was found to be generalizable across multiple samples (Bernstein et al. 2003). The CTQ brief version also demonstrated acceptable internal consistency in a study assessing history of child abuse in African American women residing in an urban setting (α = 0.79–0.95; Bradley et al. 2005). Based on the validation data, both versions of the CTQ are acceptable for use with African Americans. Further research into the psychometric properties with respect to African Americans and to subgroups within this ethnoracial population is needed to further substantiate its use among this group.

Davidson Trauma Scale
The Davidson Trauma Scale (DTS; Davidson et al. 1997) is a 17-item questionnaire assessing PTSD symptoms during the past week. Five point frequency (0 = not at all, 4 = every day) and severity scales (0 = not at all distressing, 4 = extremely distressing) evaluate PTSD in relation to an index trauma. Frequency and severity for overall PTSD and for each symptom cluster (intrusive reexperiencing, avoidance, hyperarousal) are totaled.

The DTS demonstrated good test-retest reliability (r = 0.86, p < 0.001), and excellent internal consistency for the overall test (α = 0.99), and for frequency and severity subscales, (α = 0.97, 0.98) in a validation sample of European American trauma survivors. Participants diagnosed with PTSD using the SCID had a mean raw score of 62.0 (SD 38.0), while those without a PTSD diagnosis had a mean of 15.5 (SD 13.8). Good internal consistency across scales was also documented in two separate studies of African American women who experienced a trauma (α = 0.88–0.90, Bliss et al. 2008; α = 0.79–0.90; Bradley et al. 2005). These studies support its use with African American women; however, no studies to date have examined its psychometric properties in African American men.

Distressing Event Questionnaire
The Distressing Event Questionnaire (DEQ; Kubany et al. 2000) is a 38-item self-report measure assessing DSM criteria A2-F for PTSD. Since the DEQ was designed to be used in conjunction with the Traumatic Life Events Questionnaire (Kubany et al. 2000), criterion A1 (exposure to actual or threatened death or serious injury) is assumed and therefore omitted. Remaining criteria are evaluated using a 5-point scale in 4 parts. Test developers found that the content validity of the
DEQ was representative and relevant to PTSD, however cutoff scores were inconsistent across groups (e.g., 26 for male combat veterans, 18 for female abuse survivors). These findings suggest that the psychometric properties for this measure need to be evaluated relevant to a specific population for which it is intended to be used. Given that African Americans were underrepresented overall, and that all African Americans (7%) in the validation sample were veterans (Kubany et al. 2000), the DEQ is not recommended for use with this group. Moreover, there are better alternatives that have been more extensively researched with African Americans.

**Impact of Event Scale-Revised**
The Impact of Event Scale-Revised (IES-R; Weiss and Marmar 1997) is a 22-item measure of perceived distress in relation to a specific traumatic event. Respondents report degree of distress by experienced in the last week by each “difficulty” listed using a 5-point scale (0 = not at all, 4 = extremely). The IES-R yields a total score (0–88) and subscale scores (intrusion, avoidance, and hyperarousal). While the IES-R is not used to diagnose PTSD, cutoff scores for a preliminary diagnosis of PTSD have been cited in the literature.

The developers examined the psychometric properties of the IES-R in emergency personnel who had responded to natural disasters in Los Angeles and San Diego and 1994 Northridge, CA earthquake survivors. High internal consistency was found across subscales in both groups (α=0.79–0.92). Cut points and the ethnorracial composition of the validation sample were not specified. This measure displayed excellent internal consistency (α=0.96) in a sample of 67 HIV-infected African American women (ages 18–45) from urban New Orleans (Kimmerling et al. 1999). Approximately 35% of the sample met criteria for PTSD using the IES-R, a number exceeding the general population (Kimmerling et al. 1999). Due to the size and medical status of the sample, these findings cannot be generalized. Further research is needed to substantiate validity of the IES-R in African Americans generally. Nonetheless, because the subscales are calculated, and the respondent can name and explain the triggering event; this measure may be of value in investigating symptoms associated with under-researched traumatic events, such as race-based incidents.

**Los Angeles Symptom Checklist**
The Los Angeles Symptom Checklist (LASC; King et al. 1995) is a 43-item measure of PTSD and related symptoms in adolescents and adults. The LASC does not focus on a specific trauma, rather it generally inquires about problems in the past month. The 17 DSM-IV PTSD symptoms are embedded among other items that assess general psychological distress. Items are rated using a 5-point scale (0 = no problem, 4 = extreme problem). A preliminary diagnosis of PTSD is given using DSM-IV criteria for symptoms rated 2 or higher. A severity score is computed by summing the ratings of the 17 PTSD symptoms. An index reflecting global assessment of distress and adjustment problems related to trauma exposure is obtained by summing all 43 items.

King et al. (1995) analyzed the psychometric properties of the LASC by aggregating data from 12 studies using multiple samples, including male Vietnam veterans, female survivors of intimate partner violence, and high-risk adolescents. Males and females were near-equally represented (52% female) in the pooled sample, but the ethnorracial composition was not reported. The LASC was highly internally consistent for aggregated sample and across groups varying on gender, age, and military versus civilian background for the PTSD (0.88–0.94) and full scale (0.94–0.95) indices. Sample means for the PTSD index were reported for samples and not for the pooled group and ranged from 12.3 (SD 9.0) for a sample of mixed gender adolescents (Burton et al. 1994) to 49.8 (SD 107.9) for male Vietnam Veterans (King et al. 1995). A study by Foy et al. (1997) found high internal consistency in a large sample of male and female adolescents for the 17-item PTSD index and the 43 item full scale (α=0.90, 0.95). The sample was 25.8% African American and 48.5% Latino. Means for PTSD and full-scale indexes were 16.2 (SD 12.6) and 37.9 (SD 28.2) respectively. Normative
information was provided for various adult and adolescent samples. The LASC has potential for use with various trauma groups; however, its psychometric properties relevant to African Americans have not been investigated. Further research is needed to determine if it can accurately assess PTSD and associated features across race.

**Modified PTSD Symptom Scale-Self Report Version**

The 17-item Modified PTSD Symptom Scale-Self Report Version (MPSS-SR; Falsetti et al. 1993) is a modification of the PSS-I (Foa et al. 1993). Major changes to the previous version are: (1) items are not linked to a specific event, and (2) severity ratings are included for each item. Items are rated using 4-point frequency (0 = not at all, 3 = five or more times per week) and intensity scales (0 = not at all upsetting, 3 = extremely upsetting). Respondents rate items relevant to the past 2 weeks and link each symptom to a specific event when possible. The MPSS-SR can be used to make a preliminary determination of the diagnosis of PTSD using DSM-III-R criteria or a frequency, severity, or total score cutoff score, and can be interpreted as a continuous measure of PTSD symptom severity. Total and subscale (reexperiencing, avoidance, and hyperarousal) scores are computed by summing items.

Validation studies examined cutoff scores for treatment and community samples. Frequency cutoff scores were 23 for the treatment group and 15 for the community sample, severity cut points were 47 for the treatment group and 32 for the community sample, and total cutoff scores were 71 for the treatment group and 46 for the community sample. Internal consistency was excellent for both groups (treatment $\alpha = 0.96$, community $\alpha = 0.97$). The ethnocracial makeup of the groups was unspecified; however, the PSS-I, on which the MPSS-SR is based, was validated on a primarily African American sample (70.7%). Good internal consistency ($\alpha = 0.92$) was also found in a study of low-income African American trauma survivors (Gapen et al. 2011) and in a study assessing differences in PTSD symptoms across race of hurricane victims ($\alpha = 0.85$; Ai et al. 2011). While there is preliminary data suggesting that this measure is acceptable for use with African Americans, focused research on the psychometric properties of this measure specific to African Americans is needed.

**Penn Inventory for Posttraumatic Stress Disorder**

The Penn Inventory for Posttraumatic Stress Disorder (Penn Inventory; Hammarberg 1992) is a 26-item inventory assessing PTSD symptoms relevant to multiple traumas. This measure addresses PTSD symptoms that may not be specific to one event, and can be used with veterans, non-veterans, clinical populations, and nonclinical populations. Like the Beck Depression Inventory (BDI; Beck et al. 1961, 1988), respondents select the best fitting statement among four options per item. Each sentence measures the presence and severity or frequency of the related symptom and is scored 0–3. Scores range from 0–78, with a clinical cutoff score of 35 (Hammarberg 1992).

Excellent test-retest reliability ($r = 0.96$, $p < 0.001$) and internal consistency ($\alpha = 0.94$) were found in a mixed sample of veterans and non-veterans during and post treatment. Nearly half of the treatment (44%) and posttreatment (48%) groups were African American. In all, 20% of veterans and 19% of non-veterans were African American. Of those diagnosed with PTSD in the sample, 90% were correctly identified using the Inventory, and a replication for cross-validation found 98% sensitivity with the same groups (Hammarberg 1992). This measure appears to be acceptable for use with African Americans, and may be useful for assessing PTSD in relation to the cumulative impact of multiple race-based events, although further evaluation of the psychometric properties is needed.

**Posttraumatic Diagnostic Scale**

The PTSD diagnostic Scale (PDS; Foa 1996) is a 49-item measure used in clinical and research settings to evaluate PTSD in relation to an index trauma. The PDS assesses DSM-IV PTSD criteria A-F and requests a description of the index trauma. Symptoms during the last month are evaluated, though the assessment period may be modified for different purposes. The PDS con-
Assessment of Posttraumatic Stress Disorder with African Americans

sists of four sections. Part 1 is a trauma checklist that includes the option to endorse and specify some “other (unlisted)” traumatic event. In Part 2, respondents identify their most distressing traumatic event. Part 3 assesses the 17 PTSD symptoms using a 4-point scale (0 = not at all/only once, 3 = five or more times a week/almost always). Part 4 assesses symptom interference in major areas of life functioning. The PDS yields a total severity score (0–51) mainly reflecting the frequency of PTSD symptoms. A PDS Profile Report summarizes DSM-IV PTSD diagnostic status, totals the number of symptoms endorsed, and rates symptom severity and degree of impairment of functioning (Foa et al. 1997).

Approximately one third of the validation sample was African American (31%). The mean total score was 33.6 (SD 10.0) for participants meeting criteria for PTSD and 12.5 (SD 10.5) for those who did not. Internal consistency was acceptable for the total (α=0.92) and scale scores (α=0.78–0.84). A study conducted by Hood and Carter (2008) also documented high internal consistency (α=0.87) in a sample of 67 African American female abuse survivors. This tool may be useful for identifying race-based PTSD given that participants are given an opportunity to identify a traumatic event not included on the checklist. We recommend that assessors inquire about race-based trauma when completing the trauma checklist (Part 1), since African American clients may hesitate to volunteer incidents racism to White clinicians (Carter 2007; Constantine 2007). Otherwise, the PDS is likely an acceptable measure for use with African Americans, due to the large African Americans representation in the validation sample and subsequent work.

PTSD Checklist

The PTSD Checklist (PCL; Weathers et al. 1993) screens individuals for PTSD and measures symptom change during and after treatment. There are three versions of the PCL. The PCL-M (military) evaluates symptoms relevant to “stressful military experiences” in active Service Members and Veterans. The PCL-C (civilian) measures symptoms in relation to “stressful ex-

periences” and can be used with any population in relation to multiple events, while the PCL-S (specific) assesses symptoms in relation to an identified trauma. A diagnosis can be derived in three ways: determining the presence of DSM-IV criteria, determining whether the severity score exceeds the clinical cutoff score, or combining these methods to confirm that an individual has the necessary pattern and sufficient severity symptoms required by the DSM-IV. A severity score is obtained by summing ratings across the 17 items corresponding to PTSD symptoms. The PCL is used in clinical and research settings.

The psychometric properties of the PCL were examined by Blanchard et al. (1996), who found that the instrument was a good brief screening measure for PTSD in a sample of 40 motor vehicle accident survivors and sexual assault victims. All items were significantly correlated with the CAPS. However, no information was provided about the ethnoracial composition of the sample.

The PCL showed good specificity and good sensitivity—correctly identifying 4 cases of PTSD, with 1 false positive, and 13 false negatives—in a sample of 51 trauma-exposed African Americans in the Detroit Neighborhood Health Study (Goldmann et al. 2011). More research is needed into the psychometric properties of all versions of this measure for African Americans in order to justify its use within this population. Clinicians may choose to use this measure with their African American clients with this in mind.

Screen for Posttraumatic Stress Symptoms

The Screen for Posttraumatic Stress Symptoms (SPTSS; Carlson 2001) consists of 17 items assessing PTSD relevant to multiple traumas. It was developed for screening PTSD symptoms in clinical and research settings. Respondents rate items using an 11-point frequency scale (0 = never, 10 = always). An overall score is computed by averaging ratings across the 17 items and subscales (reexperiencing, avoidance, and arousal). Since the items are not linked to a specific event, the SPTSS is appropriate for individuals with a history of multiple traumas or whose trauma history is unknown. An alternate version offers a response format assessing symp-
tom frequency using a 5-point scale (0 = not at all, 4 = more than once a day).

A validation study was conducted with a sample of newly admitted psychiatric inpatients at a private hospital during a 3.5-year period. Participants were between the ages of 30 and 45, with 18 % identifying as African American and 79 % as European American. The mean overall score was 5.8 (SD 2.2). When an SPTSS cutoff score of 5.0 was established, sensitivity and specificity were adequate (0.85, 0.73), indicating good predictive validity (Carlson 2001). To date, the psychometric properties of the SPTSS with respect to African Americans have not been investigated, thus it is not recommended for this population. However, since this measure addresses multiple traumas, it has the potential for evaluating the cumulative impact of race-based incidents. Moreover, evidence suggesting that this is not an appropriate measure for use with African Americans is lacking.

**Trauma Symptom Checklist-40**
The Trauma Symptom Checklist-40 (TSC-40; Elliot and Briere 1992) is a 40-item measure of posttrauma reactions, used exclusively for research purposes. Respondents use a 4-point scale (0 = never, 3 = often) to rate how frequently each symptom was experienced in the last 8 weeks. The TSC-40 has 6 subscales (anxiety, depression, dissociation, sexual abuse trauma index, sexual problems, and sleep disturbances) and yields a total score ranging from 0–120. Validation sample data for this measure is currently unavailable.

The TSC-40 has been used in diverse samples, including educationally disadvantaged women enrolled in a residential treatment program. The sample included 50 African American women and 52 European American women and demonstrated good internal consistency (a = .93; Ghee et al. 2010). Scores on the TSC-40 did not differ significantly between the African American and European American women (M = 47.2 [SD 23.0], M = 48.9 [SD 23.1], respectively; Ghee et al. 2010). A 5-factor model (negative mood, interpersonal problems, sleep disturbance, dissociative-like symptoms, and sexual problems) was determined to fit the African American and European American women in this sample better than the original 6-factor model, suggesting that the original factor structure may not be generalizable in diverse populations. These findings provide some support for using this measure with a subgroup of African American women. Further investigation of the psychometric properties of the TSC-40 specific to African Americans will further substantiate its use with other groups within this population.

**Trauma Symptom Inventory**
The Trauma Symptom Inventory (TSI; Briere 1996) is a 100-item global measure of trauma symptoms unrelated to a specific event. The TSI is intended for use in both clinical and research settings. The measure contains items corresponding to DSM-IV PTSD symptom criteria but does not specifically evaluate these criteria. Respondents rate frequency of each item in the past 6 months using a 4-point scale (0 = never to 3 = often). The TSI evaluates ten clinical scales corresponding to trauma related symptom domains (arousal, depression, anger/irritability, intrusive experiences, defensive avoidance, dissociation, sexual concerns, dysfunctional sexual behavior, impaired self-reference, and tension reduction behavior). Response validity using 3 scales is also provided (atypical responses, response level, and inconsistent response). Raw scores are converted to T scores for the clinical and validity scales using separate norms based on gender and age.

Briere et al. (1995) found acceptable internal consistency in a clinical validation sample consisting of 6.2 % African Americans. Alphas ranged from 0.74–0.90 across the 10 scales, with a = 0.87. Means are available for each scale score, but total score means were not reported. Phelps et al. (2006) also documented good internal consistency for all scales (a = 0.87–0.91) in a hospital-based study of 35 African American mothers of child abuse survivors. Additional studies psychometric properties of this measure are needed due to the small sample size and the potential bias of a convenience sample.
## At-a-Glance Summary Table—Adult PTSD Measures

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Disorder or symptoms assessed</th>
<th>Recommendation(s) and/or relevant research findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood Trauma Questionnaire (CTQ; Bernstein et al. 1994)</td>
<td>Severity of abuse and neglect in childhood (retrospective)</td>
<td>Originally validated in a majority African American sample. Acceptable internal consistency in a sample of African American women for total ($\alpha=0.80$) scale and subscales ($\alpha=0.79–0.95$; Bradley et al. 2005)</td>
</tr>
<tr>
<td>Clinician-Administered PTSD Scale (CAPS; Blake et al. 1990)</td>
<td>PTSD diagnostic interview</td>
<td>While the CAPS has shown little to no difference in scores across race (Monnier et al. 2002; Frueh et al. 2004; Grubaugh et al. 2006), its psychometric properties specific to African Americans are unknown</td>
</tr>
<tr>
<td>Davidson Trauma Scale (DTS; Davidson et al. 1997)</td>
<td>PTSD symptoms</td>
<td>In a clinical sample of African American women, the severity and frequency scales of the DTS, as well as the total scale, showed strong internal consistency ($\alpha=0.79$, 0.89, 0.90; Bradley et al. 2005)</td>
</tr>
<tr>
<td>Distressing Event Questionnaire (DEQ; Kubany et al. 2000)</td>
<td>PTSD symptoms</td>
<td>No studies of this measure have been conducted with African Americans</td>
</tr>
<tr>
<td>Impact of Events Scale-Revised (IES-R; Weiss &amp; Marmar 1997)</td>
<td>Distress caused by traumatic events</td>
<td>Strong internal consistency in a small sample of HIV infected African American women ($\alpha=0.96$; Kimerling et al. 1999)</td>
</tr>
<tr>
<td>Los Angeles Symptom Checklist (LASC; King et al. 1995)</td>
<td>Distress caused by traumatic events</td>
<td>No studies of psychometric properties with respect to African Americans</td>
</tr>
<tr>
<td>Modified PTSD Symptom Scale (MPSS-SR; Falsetti et al. 1993)</td>
<td>PTSD symptoms in adults</td>
<td>Good internal consistency in low-income African American sample ($\alpha=0.92$; Gapen et al. 2011)</td>
</tr>
<tr>
<td>Penn Inventory for Posttraumatic Stress Disorder (Penn Inventory; Hammarberg 1992)</td>
<td>PTSD symptoms</td>
<td>Appeared to accurately identify cases of PTSD in a sample of mixed race veterans (Hammarberg 1992)</td>
</tr>
<tr>
<td>Posttraumatic Diagnostic Scale (PDS; Foa et al. 1997)</td>
<td>Severity of PTSD symptoms</td>
<td>Acceptable internal consistency with African American female survivors of abuse ($\alpha=0.87$; Hood &amp; Carter 2008)</td>
</tr>
<tr>
<td>PTSD Checklist (PCL; Blanchard et al. 1996)</td>
<td>PTSD symptoms</td>
<td>Good internal consistency ($\alpha=0.93$) in an African American sample and demonstrated 0.97 specificity and 0.24 sensitivity when administered along with the CAPS (Goldmann et al. 2011)</td>
</tr>
<tr>
<td>PTSD Severity Scale-Interview Version (PSS-I; Foa et al. 1993)</td>
<td>Severity of PTSD symptoms</td>
<td>Excellent internal consistency within a sample of low-income, predominantly African American women ($\alpha=0.94$ and 0.95; Schumm et al. 2005)</td>
</tr>
<tr>
<td>Screen for Posttraumatic Stress Symptoms (SPTSS; Carlson 2001)</td>
<td>PTSD symptoms</td>
<td>No studies of psychometric properties with respect to African Americans</td>
</tr>
</tbody>
</table>
The Children’s Impact of Traumatic Events Scale-Revised (CITES-2; Wolfe et al. 1991) is the most recent version of the CITES, a 78-item clinician-administered scale developed to assess the effects of sexual abuse on youths aged 8–16 years old. The CITES-R is comprised of 4 main factors and 11 subscales: (1) PTSD (intrusive thoughts, avoidance, hyperarousal, sexual anxiety), (2) Social Reactions (negative reactions from others, social support), (3) Abuse Attributions (self-blame and guilt, empowerment, personal vulnerability, dangerous world) and (4) Eroticism. Items are rated on a 3-point scale (0 = not true, 1 = somewhat true, 2 = very true). In addition to the CITES-2, the 25-item CITES-Family Violence Form (CITES-FVF) assesses the effects of family violence on the child.

The internal consistency of the CITES scales were found to be moderately acceptable, with a mean alpha of 0.69 ($\alpha=0.56–0.79$) in a validation sample of sexually abused children that were 75% female and 25% African American. Given that the psychometric properties of the CITES-R subscales are inconsistent and have not been investigated specific to African American children, it is not recommended for use with this population.

The Child Posttraumatic Stress Reaction Index (CPTS-RI; Nader 1996) is a 20-item interviewer-administered scale for children aged 6–17 assessing PTSD symptoms as well as guilt, impulse control, somatic symptoms and regressive behaviors. Items are rated on a 5-point scale (0 = none, 4 = most of the time) reflecting symptom frequency, with total scores ranging from 0–80. Severity ranging from “doubtful” to “very severe” is based on the total scale score. Child and parent report versions are available and this measure is widely used in research and clinical practice. The CPTS-RI Revision 2 (also referred to as the PTSD Index for DSM-IV; Rodriguez et al. 2002) was developed to increase sensitivity for screening trauma exposure and criteria A1–A2, and provides more guidance for the assessor and child throughout the interview. There are several reaction index variations. Frequency response choices match to severity items.

The CPTS-RI demonstrated excellent internal consistency ($\alpha=0.97$) in 110 African American children (Thompson and Massat 2005). Remaining psychometric properties with respect to Africans Americans still require investigation, thus it is not yet clear if this would be an acceptable measure to use with African Americans. Clinicians should use this measure with these limitations in mind.
Child PTSD Symptoms Scale

The Child PTSD Symptoms Scale (CPSS; Foa et al. 2001) is a 26-item version of the Posttraumatic Diagnostic Scale (PDS; Foa et al. 1997) for use with youth aged 8–18. The CPSS assesses PTSD diagnostic criteria in clinician administered (CPSS-I) and self-report (CPSS-SR) forms. It includes 2 event items, 17 symptom items, and 7 functional impairment items. Symptoms are rated on a 4-point frequency scale (0 = not at all, 3 = five or more times a week) and functional impairment items are scored dichotomously (present or absent). The CPSS yields a total symptom severity scale score (0–51) and a total severity-of-impairment score (0–7). Scores can also be calculated for each of the three PTSD symptom clusters.

Foa et al. (2001) documented high internal consistency in a sample of primarily European American children (α=0.70–0.89). Mean scores were 7.6 (SD 8.1) for the total scale, 1.9 (SD 2.7) for reexperiencing, 2.7 (SD 3.4) for avoidance, and 2.7 (SD 2.7) for arousal. Gillihan et al. (2013) found both versions of this measure to have variable internal consistency in a sample of female adolescent sexual abuse survivors, the majority of whom were African American (64%). Alphas ranged from 0.58–0.83 for the CPSS-SR and 0.50–0.81 for the CPSS-I. There is data supporting the use this measure with African American female sexual assault survivors (Gillihan et al. 2013); however further research is needed to substantiate its use with African American male adolescents and in younger African American children.

Children’s PTSD Inventory

The Children’s PTSD Inventory (CPTSDI; Saigh et al. 2000) is a clinician-administered scale for children aged 6–18 for assessing exposure to and symptoms related to a traumatic event. Examples of traumatic (“scary”) experiences are described, and then the child is asked if he or she has ever experienced a scary event and, if so, if he or she felt upset when it happened and/or if the child felt he or she could do nothing to stop it from happening. If an event meets screening criteria then reexperiencing, avoidance/numbing, and arousal symptoms are assessed in reference to that event. Questions related to duration of symptoms are also asked.

The instrument yields dimensional and categorical scores to indicate severity and presence of a diagnosis of PTSD. In addition, scores on 5 subscales (Situational Reactivity, Reexperiencing, Avoidance and Numbing, Increased Arousal, and Significant Impairment) are provided. The CPTSDI can be used in either research or clinical settings. This measure is also available in Spanish. This instrument showed moderate to high alphas as (0.53–0.89) for the subscales and high internal consistency at the diagnostic level (α=0.95) in a sample of trauma exposed
youth aged 7–18 (M = 13.8, SD = 2.9). Approximately 17% of the validation sample was African American and the majority of participants were Hispanic American (65.7%). Further research is needed to support use of this tool for assessing PTSD for African American youth.

**Trauma Symptom Checklist for Children and Trauma Symptom Checklist for Young Children**

The Trauma Checklist for Children (TSCC; Briere 1996) is a 54-item self-report scale designed for assessing trauma symptoms related to sexual abuse and other traumatic events in children aged 8–16. It consists of two validity scales (over- and underreporting of symptoms) and 6 clinical scales (Anxiety, Depression, Posttraumatic Stress, Sexual Concerns, Dissociation, and Anger). Items are rated on a 4-point frequency scale (0 = never, 3 = almost all the time). The TSCC is written at an 8-year-old reading level and has been normed for boys and girls. It is useful for evaluating of children who have experienced a range of traumatic events. The TSCC is available in two versions: the full 54-item test that includes 10 items tapping sexual symptoms and a 44-item alternate version (TSCC-A) that makes no reference to sexual issues. The instrument is suitable for individual or group administration, and it is suggested that a score of 60 or above is of clinical significance (Hunt et al. 2011; Briere 1996).

The Trauma Symptom Checklist for Young Children (TSCYC; Briere 2005) is a 90-item caretaker-report instrument that can be used to assess PTSD symptoms in children aged 3–12. It consists of 8 clinical scales (Anxiety, Depression, Anger/Aggression, Posttraumatic Stress—Intrusion, Posttraumatic Stress—Avoidance, Posttraumatic Stress—Arousal, Dissociation, and Sexual Concerns) as well as a summary PTSD scale (PTSD Total). A PTSD diagnostic worksheet provides a possible PTSD diagnosis in children aged 5 and older. It also contains two validity scales to assess caretaker over- and underreporting of the child’s symptoms. Items are rated on a 4-point scale (1 = not at all, 4 = very often) in reference to the previous month. The TSCYC is normed separately for boys and girls within three separate age groups (3–4, 5–9, and 10–12). The TSCC and TSCYC can be administered and scored by paraprofessionals. Validation sample data, including sample means and cut points, is currently not available.

Hunt et al. (2011) administered the TSCC to a sample of African American children presenting at an urban mental health center from 2004 to 2007. The mean score was 48.1(SD 10.0), with 16% placed in the clinically significant range. While these instruments have been used with African American youth, more research is needed to substantiate its use with this population.

**The UCLA PTSD Index for DSM-IV**

The UCLA PTSD Index for DSM-IV (UPID; Pynoos et al. 1998) is a revision of the CPTS-RI. This 48-item semistructured interview assesses exposure to 26 traumatic events and DSM-IV PTSD diagnostic criteria, and associated symptoms (guilt and fear of event’s recurring). Severity scores of 38 or above are clinically significant. Steinberg et al. (2004) found this measure to be internally consistent (α = 0.90) across numerous studies in the USA and internationally.

Hunt et al. (2011) administered the UPID to a clinical sample of 257 African American children. The measure showed good convergent validity when correlated with other measures of PTSD (TSCC), although internal consistency was not reported in this sample. More research is needed to determine the validity of the UPID across race.

**When Bad Things Happen Scale**

The When Bad Things Happen Scale (WBTH; Fletcher 1996c) is a 95-item self-report inventory. The questions in this scale exactly parallel the questions in the Childhood PTSD Interview and can be used as a complement to the interview. It includes 63 DSM-IV symptom items (3–6 per
symptom) and 32 associated symptom items (2–5 questions per associated symptom).

Items are rated on a 3-point frequency scale (0 = never, 1 = some, and 2 = lots). The WBTH yields a categorical diagnosis of PTSD as well as a continuous severity score (a scoring system template is provided with the scale). It has a third-grade reading level and includes a parent report version. It is appropriate for use in either a research or clinical setting. However, there is no information available about the use of this measure in African American children.

**At-a-Glance Summary Table—Child PTSD Measures**

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Disorder assessed</th>
<th>Recommendation(s) and/or relevant research findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Posttraumatic Stress Reaction Index (CPTS-RI; Nader 1996)</td>
<td>PTSD symptoms in children aged 6–17</td>
<td>High internal consistency (α = 0.97) in a sample of African American youth (Thompson Jr. and Massat 2005)</td>
</tr>
<tr>
<td>Child PTSD Symptom Scale (CPSS; Foa et al. 1997)</td>
<td>PTSD severity in children aged 8–18</td>
<td>High internal consistency found in mostly African American sample of female sexual assault survivors (α = 0.58–0.83 for CPSS-SR, α = 0.50–0.81 for CPSS-I; Gillihan et al. 2013)</td>
</tr>
<tr>
<td>Childhood PTSD Interview (Fletcher 1996a)</td>
<td>PTSD diagnostic interview for children aged 7–18</td>
<td>No studies of this measure have been conducted with African American children</td>
</tr>
<tr>
<td>Children’s Impact of Traumatic Events Scale-Revised (CITES-2; Wolfe et al. 1991)</td>
<td>Effects of sexual abuse in children aged 8–16</td>
<td>No studies of this measure have been conducted with African American children</td>
</tr>
<tr>
<td>Children’s PTSD Inventory (CPTSDI; Saigh et al. 2000)</td>
<td>PTSD diagnostic interview for children aged 6–18</td>
<td>No studies of this measure have been conducted with African American children</td>
</tr>
<tr>
<td>Trauma Checklist for Children (TSCC; Lanktree et al. 2008)</td>
<td>Trauma symptoms in children aged 8–16</td>
<td>M = 48.1 (10.0) in a clinical sample of African American youth (Hunt et al. 2011)</td>
</tr>
<tr>
<td>Trauma Symptom Checklist for Young Children (TSCYC; Lanktree et al. 2008)</td>
<td>PTSD symptoms in children aged 3–12</td>
<td>No studies of this measure have been conducted with African American children</td>
</tr>
<tr>
<td>The UCLA PTSD Index for DSM-IV (Pynoos et al. 1998)</td>
<td>Exposure to trauma in children aged 7–13 (Revision of Child PTSD Reaction Index)</td>
<td>Has been used with African American children with PTSD but not validated. (Hunt et al. 2011)</td>
</tr>
<tr>
<td>When Bad Things Happen Scale (WBTH; Fletcher 1996c)</td>
<td>PTSD symptoms in children aged 7–14 (at least a 3rd grade reading level)</td>
<td>No studies of this measure have been conducted with African American children</td>
</tr>
</tbody>
</table>
Utility of Existing Measures to Assess PTSD in African Americans

Of the 14 adult measures described in this chapter, 3 were validated in PTSD studies with a primarily African American sample. The psychometric properties of 8 have been investigated with respect to this population; however, typically only internal consistency was measured. Of the 9 child measures, none were validated using a primarily African American sample and psychometric properties of only 4 have been investigated relevant to this group. Thus, many PTSD measures have been used extensively in African American populations despite the lack of basic validation research. Clearly, many more studies investigating the reliability and validity of these measures are needed to substantiate the use of them with African American adults and children. Researchers should take deliberate steps to recruit adequate numbers of African Americans to ensure that measures can be validated in these and other ethnoracial populations (Williams et al. 2013).

Changes to the PTSD Criteria in DSM-5

Changes to the PTSD criteria for the DSM-5 have been made to ensure accurate diagnoses with new considerations. The first section involving the trauma experience has changed moderately, reflecting findings in clinical experience as well as empirical research. It is now within 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 (American Psychiatric Association 2013). The latter alteration was made to include those exposed in their occupational field, such as police officers, to remove ambiguities and strengthen the definition of a traumatic event (Friedman et al. 2011). A2 criterion, responding to the event with intense fear, helplessness, or horror has been removed. 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 (Friedman et al. 2011).

The most notable change to the criterion is from a three to a four-factor model. The DSM-5 factors are intrusion symptoms, persistent avoidance, alterations in cognition and mood, and hyperarousal and reactivity symptoms. These factors encompass the many facets of PTSD and were included based on empirical evidence (American Psychiatric Association 2013). These alterations will help distinguish PTSD from other conditions with similar symptomology, such as depression or acute stress disorder, while simultaneously expressing the condition on a spectrum (Friedman et al. 2011). Three new symptoms have been added—persistent distorted blame of self or others, persistent negative emotional state, and reckless or self-destructive behavior.

Two subtypes, acute and chronic, have been removed for lack of empirical evidence supporting the distinction (Friedman et al. 2011). In their place, a subtype has been proposed to include preschool children who may be experiencing and reacting to trauma differently than children over 6 years old. A second subtype addresses PTSD with Prominent Dissociative symptoms. This subtype includes those who may be putting more emphasis on avoidance behavior regarding the trauma, and so may not meet the original criteria. Recent rape victims may be a good example of this population (American Psychiatric Association 2013).

It is worth noting that many assessment instruments are administered by clinicians, which may be problematic when assessing PTSD cross-culturally. African Americans may express themselves nonverbally, and Parham (2002) suggests that nonverbal communication (e.g., body language and unexpressed emotion) should be measured when assessing African Americans, something that is rarely considered. Since language bias is a natural source of error in assessment, interviewers should be well-educated about cultural differences to accurately assess and diagnose the respondent.

As of this writing, no measures have been developed based on DSM-5 criteria, although new and revised measures will be developed in the coming months and years, with DSM-5 considerations in mind. Some of the DSM-5 changes open
the door toward a broader understanding of PTSD and race-based trauma. New models are needed that incorporate this facet of the human experience, which are properly developed and evaluated with diverse populations in mind (Williams et al. 2014). The current state of scholarship in this area is unacceptable and calls for urgent action.

References

Assessment of Posttraumatic Stress Disorder with African Americans


Monnier, J., Elhai, J. D., Fruhe, B. C., Sauvageot, J. A., & Magruder, K. M. (2002). Replication and expansion of findings related to racial differences in veterans with combat-related PTSD. *Depression and Anxiety, 16*(2), 64–70.


