Introduction

Childhood and adolescent trauma can put youth at risk for long-term impairment across several domains of life, including poor educational performance, anxiety, or behavioral problems as late as 2 years after initial trauma exposure (Abramson, Redlener, Stehling-Ariz, & Fuller, 2007). Prevalence rates of childhood and adolescent trauma can vary by the sample investigated, as well as by gender. In an epidemiological study, Kilpatrick and Saunders (1997) found that in adolescents aged 12–17 (% European American), rates of posttraumatic stress disorder (PTSD) were 3.7% for males and 6.3% for females, across several types of trauma exposure. Prevalence of trauma exposure within this sample included witnessing violence (39.4%), experiencing sexual assault (8.1%), and physical assault (17.4%). Similarly, in the National Comorbidity Survey, Kessler, Sonnega, Bromet, Hughes, and Nelson (1995) found higher PTSD prevalence among adolescents and young adults, with females (10.3%) having a higher prevalence in comparison to males (2.8%) in the sample. When considering PTSD prevalence in relation to disasters, Hoven and colleagues (2005) found that after the terrorist attacks on the World Trade Center, in a sample of 8236 children (27.9% African American), 10.6% of children grades 4–12 in New York City public schools met criteria for PTSD.

Rates of PTSD in African American youth are similar to their European American counterparts, suggesting some cross-race similarities; however, trauma exposure may disproportionately impact African American youth. Specifically in a sample of urban youth ranging in socioeconomic status from very poor to low middle class (N=2311; 71% African American), it was found that by age 23, 82.5% of subjects were exposed to any type of trauma, and PTSD prevalence was 7.9% for females and 6.3% for males (Breslau, Wilcox, Storr, Lucia, & Anthony, 2004). Type of trauma exposure for this sample included assaultive violence (i.e., sexual assault, shot/stabbed, mugged; 25.8%), other injuries or shocking events (i.e., car accidents, witnessing killings/serious injury, discovering a dead body; 26.4%), learning of traumas occurring to a close friend or relative (27.3%), and learning about an unexpected death (20.4%).
Sociocultural Context of PTSD in African American Youth

DSM-5 Criteria

The DSM-5 criteria for PTSD include exposure to a traumatic event, including direct experience, witnessing the event, learning the event occurred to a close friend or family member, and experiencing repeated or extreme exposure to the details of a traumatic event (American Psychiatric Association, 2013). Also, presence of one or more intrusion symptoms must be present, including recurrent, intrusive and distressing memories of an event, distressing dreams about the event, dissociative flashbacks about the event, prolonged intense distress when reminded of the trauma by external cues, and physiological reactions to these external cues. Criteria also include avoidance of stimuli associated with the trauma, such as avoidance of distressing feelings, thoughts, or memories about the trauma, or avoidance of external reminders of the trauma. Negative alterations in mood or cognitions may also be present, which may include: negative beliefs or expectations about oneself, distorted cognitions about the trauma, world, or cause of the trauma, persistent negative emotional state, feelings of detachment, inability to experience positive emotions, diminished interest in significant activities, and the inability to remember aspects of the event. Additionally, alterations in reactivity and arousal associated with the traumatic event may be present, such as: irritable behavior, hypervigilance, exaggerated startle responses, self-destructive behavior, problems with concentration, and sleep disturbance (American Psychiatric Association, 2013).

The DSM-5 has been revised to include not only the experiencing of a trauma, but opened up the definition of trauma into four possibilities (direct, witnessing, learning about a trauma occurring to someone close to you, experiencing repeated or extreme exposure to details of a trauma), which provides more clinical utility for individuals experiencing symptoms as a result of experiencing trauma indirectly. Furthermore, the emotional reaction to the trauma was deleted, and the avoidance/numbing symptom clusters were split into two sections. Additionally, changes included specifying responses more salient to children, as children may illustrate re-experiencing symptoms through play, providing more developmental sensitivity to symptom assessment. In light of the changes made to the DSM, it may now be possible to consider more sociocultural factors that influence PTSD symptoms in ethnoracial minorities (i.e., community violence exposure, racial discrimination).

Community Violence Exposure

Extant literature has identified relevant factors that uniquely influence the experience of traumatic stress for African American youth. Mentioned earlier, a core symptom of PTSD is the encountering or witnessing of a traumatic life event, which for certain African American youth disproportionately includes violence exposure. African Americans residing in impoverished neighborhoods may have fewer resources and higher levels of trauma exposure (e.g., community violence), which may present more realistic threats, potentially causing more extreme anxious reactions. African American children and adolescents may be more likely to be exposed to interpersonal trauma, especially if they live in urban settings (Richards et al., 2004), and compared to other ethnic groups, homicide rates are highest among African American adolescents (Centers for Disease Control and Prevention, 2009).

Hunt, Martens, and Belcher (2011) analyzed data from 257 medical records of African American children (M age=11.7 years; 56 % female) from an urban mental health center specializing in treating children exposed to community violence and maltreatment, utilizing evidence based treatments between 2004 and 2007 at John Hopkins in Baltimore. Results demonstrated that community violence was associated with PTSD symptoms, and that physical abuse and being a female was associated with more PTSD symptoms. In addition, results indicated that despite significant traumatic exposures, the current...
sample had a 16% rate of clinically significant symptoms, compared to 25–40% reported in other studies (Fletcher, 1996). This may suggest that African American children may respond differently to traumatic experiences. Given that these children may be more likely to encounter uncontrollable interpersonal trauma, they may resort to emotional coping tactics that may reduce the likelihood of developing PTSD (Edlynn, Gaylord-Harden, Richards, & Miller, 2008). Resilience may have a positive impact on African American youth, buffering the negative effects of violence exposure. Specifically, Jones (2007) investigated the relationship among chronic community violence exposure and PTSD development. Results illustrated that spirituality, combined social support, and formal kinship buffered negative effects of chronic violence exposure among 71 African American children aged 9–11. This study shows the positive effects of several types of buffering factors in African American youth, and illustrates that there may be more than one factor contributing to resiliency for populations exposed to community violence.

Additionally, the multiple occurrences of trauma experienced within African American youth, or cumulative trauma, may predict greater negative outcomes. As mentioned previously, cumulative trauma is the occurrence of several traumas such as witnessing violence, hearing about incidents of violence, and experiencing abuse (Kira, Lewandowski, Templin, & Hammad, 2005), and can impact several developmental experiences, including attachment, individualization, interdependence, achievement/self-actualization, and survival. Furthermore, frequent trauma exposure may lead to stress-related health conditions, negatively impacting life expectancy (Clark, 2003; Peters, 2004). In a sample of 175 African American adolescents, Conner-Warren (2013) found that African American youth were experiencing considerable levels of trauma across both genders. The authors hypothesized that these experiences of cumulative trauma would result in an increase in blood pressure, due to the release of cortisol and epinephrine as a result of trauma exposure. However, this hypothesis was not supported, suggesting that experiences of cumulative trauma may not elicit a physiological response within this population, consistent with previous research finding the absence of a physiological reaction after repeated exposure to chronic stress (Diseth, 2005).

African American children may also experience significant psychological distress as a result of events happening to close family members or friends. Jenkins, Wang, and Turner (2009) found that for African American male children, but not females, having a friend or family member injured or die in a violent incident was related to internalizing behaviors such as anxiety, somatization, and depression. These findings suggest that the overall stress within African American communities, especially for African American males, may produce negative mental health outcomes even when these events are not personally experienced.

Race-Based Trauma

In addition to disproportionate community violence exposure, race-based trauma needs to be considered as a contributing factor to PTSD symptoms in African Americans. Race-based trauma can range from blatant hate crimes and physical assault, to more frequent ambiguous microaggressions. Racial microaggressions are pervasive and subtle acts of racial discrimination against minority groups, including vague insults, non-verbal exchanges, or brief remarks that denigrate people of color (Franklin, 1999; Gaertner & Dovidio, 2005; Pierce, Carew, Pierce-Gonzalez, & Willis, 1978; Sue et al., 2007). When trying to pinpoint the intention of the person committing the microaggression, African Americans may experience stress and a decrease of mental energy. Furthermore, more severe race-based stressors that may actually threaten an individual’s life can directly cause PTSD, while smaller microaggressions may cause constant paranoia or vigilance which can produce PTSD symptoms over time (Carter, 2007).

The conceptualization of incidents of racism as traumatic is a result of an individual being victimized by another powerful individual. Physical

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or verbal racism-related experiences may negatively impact a person’s sense of self, and these experiences may be ambiguous, specific and obvious, or systematic. Bryant-Davis and Ocampo (2005) postulate that racism-related trauma is comparable to emotional abuse, potentially causing PTSD symptoms. There is scant research assessing specific symptoms resulting from race-based trauma, but Carter and Forsey (2010) assessed the psychological reactions to racism in African American survey responders. Their study illustrated that subjects reporting instances of racism experienced more anxiety, hypervigilance, shame, and guilt. Although there have not been many studies conducted on the deleterious effects of race-based trauma in African American youth, the impact of such traumatic experiences is evident in adults. Further, a strong, positive ethnic identity may buffer against anxious and depressive symptoms caused by racial discrimination in African American adults (Williams, Chapman, Wong, & Turkheimer, 2012).

Ethnic identity is a person’s self-concept stemming from membership to a social group, and that person has emotional significance as a part of the membership (Tajfel, 1981); this membership is important to ethnoracial communities (Arce, 1981; Cross, 1978; Makabe, 1979). According to Phinney (1992), ethnic identity begins to develop during early adolescence in simple ways, but during later adolescence and young adulthood it becomes more defined. This process occurs through racial socialization, which are culturally salient messages and behaviors communicated through parents and caregivers concerning cross-race interactions (Bowman & Howard, 1985; Spencer, 1983).

Given that ethnic identity does not fully develop until late adolescence or young adulthood, African American children and adolescents may be more vulnerable to the deleterious effects of race-based trauma. Race-based traumatic experiences may disrupt the development of an individual’s ethnic identity. Ethnic identity is related to how an individual feels in relation to their membership to a social group, so negative information communicated to them through racism in the form of race-based trauma or racial microaggressions, may make it difficult for them to develop positive feelings about belonging to a particular cultural group.

### Treatment for Pediatric PTSD

#### Pharmacotherapy

When considering the psychopharmacological treatment of PTSD, Strawn, Keeshin, DelBello, Geracioli, and Putnam (2010) reviewed literature from the National Library of Medicine to investigate pharmacologic treatments of PTSD in children and adolescents. Articles reviewed included one randomized controlled trials (RCTs) for selective serotonin reuptake inhibitors (SSRIs), three RCT of imipramine, and several open-label studies using other medications (e.g., antiadrenergics, other antidepressants, and second generation antipsychotics). Results suggested that for children and adolescents, empirically supported psychotherapies should be used as first line treatments for PTSD, as opposed to SSRIs, and that there is limited evidence for the use of antiadrenergics, second generation antipsychotics, and several mood stabilizers, all which may reduce PTSD symptoms. In an RCT of SSRIs, Cohen, Mannarino, Perel, and Staron (2007) investigated a sample of 22 adolescents (2.3% African American), randomly assigning subjects to a group utilizing trauma focused cognitive behavioral therapy (CBT) and the SSRI sertraline, or only trauma focused CBT. Results indicated that both groups experienced a significant reduction in PTSD symptoms, however no group differences were found other than child global assessment scale ratings favoring the medication and CBT group. These findings also suggest that SSRIs should not be used as a first line treatment for PTSD in youth, rather they may be most useful in combination with an empirically supported treatment, such as CBT.

Other studies have arrived at conflicting conclusions. In a sample of 26 children and adolescents (30.8% African American), Stoddard et al. (2011) compared sertraline versus a placebo and found significant parent-reported symptom...
reduction over 8 weeks, 12 weeks, and 24 weeks. However, child-reported symptoms did not indicate significant symptom reduction. When considering medication other than SSRIs for PTSD, Steiner et al. (2007) investigated the use of divalproex sodium in adolescents with conduct disorder and PTSD (N=12; no African American subjects). Results indicated that compared to the control group, the treatment group reported reduced core PTSD symptoms (intrusion, avoidance, and hyperarousal), as well as reduced aggression. Although pharmacological treatment for childhood and adolescent PTSD appears promising, more RCTs need to be conducted to better understand which medications are most efficacious. Additionally, RCTs need to include more African American children and adolescents, as the aforementioned studies are made up of primarily non-Hispanic White samples.

**Psychosocial Treatment**

When considering treatment of childhood PTSD, RCTs have revealed that there are a multitude of effective treatments, however it is important to note that an insufficient number of carefully controlled studies have been conducted with African American children and adolescents. Therefore, the following studies lack a useful number of African American subjects, which makes it difficult to draw reliable conclusions about non-White children and adolescents.

There are many effective treatments for childhood PTSD. Gillies, Taylor, Gray, O’Brien, and D’Abrew (2013) reviewed 14 RCTs investigating PTSD treatment in children and adolescents. This review concluded that cognitive behavioral therapy (CBT), psychodynamic, narrative, EMDR, and supporting counseling were all effective in reducing symptoms; however across all studies, the most effective treatment was CBT. This review echoes findings by Dyregrov and Yule (2006), who conducted a similar review of PTSD treatment for children and adolescents, finding that CBT (individual and group) was the most effective and most well documented treatment for PTSD. Furthermore, prolonged exposure (PE) has been extremely efficacious in reducing PTSD symptoms in children and adolescents (Nacasch et al., 2011; Rachamin, Mirochnik, Helpman, Nacasch, & Yadin, 2015). Specifically, Gilboa-Schechtman et al. (2010) compared two types of brief psychotherapy, and found that the behavioral trauma focused components of prolonged exposure enhanced the efficacy of reducing PTSD symptoms, as well as depressive symptoms and global functioning. Furthermore, Ruf et al. (2010) found that narrative exposure therapy in refugee children significantly reduced PTSD symptoms compared to a control group, and these improvements persisted at a 12-month follow-up, echoing the value of behavioral interventions when treating childhood PTSD.

Although CBT and prolonged exposure treatment have been extremely effective in the treatment of childhood PTSD of non-African American populations, there are a number of other treatments that have shown promising results. Research has also supported the efficacy of eye movement desensitization and reprocessing (EMDR) therapy for PTSD in children (Chemtob, Nakashima, & Carlson, 2002; Diehle, Opmeer, Boer, Mannarino, & Lindauer, 2014), suggesting that this treatment is suited for PTSD afflicted youth. Furthermore, findings by Ahmad, Larsson, and Sundelin-Wahlsten (2007) illustrated the effectiveness of EMDR, and noted that improvement in re-experiencing symptoms was the most significant difference between the treatment and control groups.

Anxiety-management training in youth with PTSD has also been shown to be effective in reducing symptoms, and uses cognitive restructuring to alter distorted cognitive biases which may maintain PTSD symptoms (Farrell, Hains, & Davies, 1998). When considering group treatments for PTSD in children, numerous studies have found it to be effective. Specifically, the use of group administered CBT for PTSD in children has been used effectively to reduce symptoms (Chemtob, Nakashima, & Carlson, 2002; Goenjian et al., 1997; March et al., 1998).
Treatment Considerations for African American Youth

Psychological Assessment

When assessing PTSD symptoms, it is essential to consider the psychometric properties of assessment materials being administered. Specifically, clinicians should be knowledgeable as to whether or not a particular measure has been validated in a sample of African American youth. Otherwise, PTSD symptoms may not be accurately assessed, potentially producing misdiagnosis. There have not been many studies assessing psychometric properties of PTSD assessment tools in African American children and adolescents, and much research is still needed to determine appropriate measures for this demographic.

Malcoun, Williams, and Bahojb-Nouri (2015) reviewed the literature concerning the psychometric properties of commonly used PTSD assessment tools for use in African American clients. The authors found that there are many appropriate measures for use in African American adults (e.g., PTSD checklist, Blanchard, Jones-Alexander, Buckley, & Forneris, 1996; Modified PTSD Symptom Scale, Falsetti, Resnick, Resick, & Kilpatrick, 1993; PTSD Severity Scale-Interview Version, Foa, Riggs, Dancu, & Rothbaum, 1993), suggesting that these same measures may be useful in African American youth. However, future research is needed to investigate the psychometric properties of such measures in African American children and adolescents.

Psychosocial Treatment in African American Youth

As noted previously, studies investigating empirically supported and gold standard (i.e., CBT; prolonged exposure) treatments for PTSD utilize primarily non-Hispanic White samples. However, in an RCT with a sample of 65 children aged 3–6 years (59.5% African American), Scheeringa, Weems, Cohen, Amaya-Jackson, and Guthrie (2011) utilized a 12-session trauma focused CBT protocol adapted for sexually abused preschool children and compared the treatment and control groups. Results showed that African American children dropped out at a higher rate than non-Hispanic Whites, but there was significant improvement of PTSD symptoms in the treatment group, but not the control group. Also, a study by Cooley-Strickland, Griffin, Darney, Otte, and Ko (2011) evaluated a school-based CBT anxiety prevention program in a sample of primarily African American children (92%). The program consisted of 13 biweekly hour-long group sessions, and compared to the control group, the intervention group showed significant reductions in life stressors and victimization by community violence, as well as increased mathematics achievement scores. Specifically, the program taught children strategies to cope with anxiety, such as relaxation techniques, self-talk, and engaging in positive feelings and thoughts. Altogether, though many RCTs for PTSD in African American youth are needed, the aforementioned studies offer preliminary evidence that supports the use of CBT-related interventions that may reduce anxiety in relation to community violence. Furthermore, school-based programs may be more plausible to implement within these populations.

Mental Health Stigma and Treatment Seeking

African Americans may endorse a mistrust of psychotherapy and have less access to treatment programs (Alvidrez, Snowden, & Kaiser, 2008; Williams, Domanico, Marques, Leblanc, & Turkheimer, 2012), so it may be more acceptable to use school-based programs that are more accessible. When considering the acceptability of mental healthcare in the African American community, members of this population may be more skeptical of services. In a qualitative study assessing attitudes of mental healthcare in African Americans participating in a study on OCD, participants endorsed concerns of stigma relating to having a mental health disorder. These concerns involved the social consequences of disclosing a mental health disorder, as well as cultural mistrust of providers (Williams, Domanico, et al., m.williams@louisville.edu
2012). Further, subjects reported concerns pertaining to unfair treatment due to being African American, fears of being misunderstood by their providers, and being uncomfortable discussing problems with providers. Participants also had logistical concerns, reporting treatment access and financial burden as barriers to treatment.

**Community Violence and Treatment**

When treating African American youth, clinicians may need to be more aware of the greater variety of traumatic experiences these individuals may encounter when assessing PTSD. When considering children living in urban and/or impoverished neighborhoods, assessing exposure to a variety of traumatic experiences may provide a more thorough assessment of potential PTSD symptoms. These experiences may be normal for some African American youth, so they may not report many traumatic experiences. Gathering comprehensive information about trauma exposure may offset a reluctance to report experiences and symptoms, as well as open dialogue about these experiences. Furthermore, when working with parents, gathering similar information may be informative.

In addition to a more thorough assessment of trauma exposure, clinicians need to be sensitive to the reality that trauma exposure may happen again if an African American youth lives in an area where those experiences are commonplace. For example, cognitive processing of a trauma is used to change a client’s perspective about a trauma, and allows the client to revisit the trauma as an isolated event (Foa, Huppert, & Cahill, 2006). However, when considering that violence exposure may be frequent in these populations, telling a client that a traumatic event is an isolated event may be inaccurate, which may risk retraumatization if an event reoccurs (Williams et al., 2014).

**Race-Based Trauma and Treatment**

Although few RCTs for empirically supported treatments in African American youth have been conducted, there is preliminary evidence suggesting that adapting gold-standard PTSD treatment protocols to include the assessment and treatment for racism-based trauma may successfully reduce symptoms. Specifically, Williams et al. (2014) outlined cultural adaptations to prolonged exposure for African American adults, including more thorough psychoeducation, integrating values that may be more salient to African Americans, and using in vivo exposures that may be more relevant to African Americans. Likewise, these adaptations may also be useful when using prolonged exposure for African American children and adolescents with PTSD.

During psychoeducation, Williams et al. suggested that taking more time to ensure African Americans fully understand the treatment protocol can help in reducing anxiety surrounding mental health care. With cultural mistrust prevalent in the African American community, being transparent becomes essential in therapeutic interactions. Also, taking more time to ensure that clients fully understand the treatment process may take more time, further bolstering a strong therapeutic alliance. The authors also outline culturally sensitive approaches to assessing for racism-based trauma.

As Bryant-Davis and Ocampo (2005) explained, when considering racism as a traumatic event, there may not be a consensus among others about whether or not the event occurred; whereas military combat or natural disasters receive this general consensus. Due to this ambiguity about the occurrence of the event there may be invalidation by others, as Sue et al. (2007) found that experiences of racism are usually met with suspicion. Furthermore, it may be difficult for a non-Hispanic White clinician to understand racism, as it is most commonly experienced by ethnoracial minorities (Chou, Asnaani, & Hofmann, 2012). This lack of understanding may cause clinicians to meet clients reporting racist experiences with ridicule, thus invalidating clients’ experiences and subsequently damaging the therapeutic alliance. When conducting prolonged exposure, Williams et al. (2014) advised clinicians to take a genuine interest in the Black experience and attempt to fully understand whether or not the clinician has personally experienced rac-
Ism (i.e., “I don’t understand but I want to”). Although African American clients may not believe that their non-Hispanic White clinicians understand the experience of racism, being listened to helps to validate their experience and strengthen the therapeutic alliance. Additionally, if the clinician is the same ethnoracial background of the perpetrator, discussing the racist experience may serve to expose the client to feared interactions with that particular race. Given that their experiences of racism are met with ridicule (Sue et al., 2007), discussing the nature and distress of racism with a non-Hispanic White clinician can disconfirm any negative beliefs about their experience being met with skepticism. In addition to discussing the nature of their racism-based trauma, being more collaborative throughout the treatment process (i.e., during exposures, cognitive processing) may help foster a sense of control for African Americans, helping them be more open to adhering to treatment, as well as strengthening the therapeutic alliance (see Williams et al., 2014 for full protocol adaptations).

Conclusion

In order to assess treatment efficacy in African American children and adolescents, a plethora of RCTs utilizing empirically supported treatments for PTSD are needed. The lack of RCTs using primarily African American children and adolescent samples makes it difficult to know whether or not particular treatments for PTSD are effective for these populations. Future research needs to prioritize conducting RCTs of empirically supported treatments for PTSD with these samples, as well as assess the impact of sociocultural factors on symptoms (i.e., community violence exposure, racism-based trauma).

This chapter discussed important sociocultural factors impacting the symptom expression and treatment of PTSD in African American youth. In particular, African American youth residing in impoverished neighborhoods have been found to be exposed to heightened rates of violence (Centers for Disease Control and Prevention, 2009; Richards et al., 2004), which in turn is associated with increased symptoms of PTSD (Hunt et al., 2011). According to a review of available treatments, CBT, prolonged exposure, psychodynamic, narrative, EMDR, and supportive counseling have been shown to improve symptoms of PTSD in children and adolescents (Gillies et al., 2013); however, some evidence suggests that prolonged exposure is most effective (Dyregrov & Yule, 2006). Though research has proposed that psychosocial therapies are the first line of treatment for PTSD (Strawn et al., 2010), it has been determined that SSRIs, antiadrenergics, second generation antipsychotics, and several mood stabilizers may represent viable options as adjunctive therapies (Cohen et al., 2007; Strawn et al., 2010). Similarly, future research is needed to better understand specific treatment considerations for African American youth with PTSD. However, the few studies that have focused on the experiences of African American youth receiving treatment for PTSD demonstrate that CBT does improve symptoms (Cooley-Strickland et al., 2011; Scheeringa et al., 2011), but suggest that African American youth may be more likely to drop out of treatment (Scheeringa et al., 2011). Furthermore, it is worth noting that the school-based protocol designed by Cooley-Strickland and colleagues provides another example of how to adapt treatment to overcome potential barriers.

The adaptations made to the prolonged exposure protocol for PTSD in African Americans by Williams et al. (2014), although aimed at treating adults, may be useful in African American youth. The protocol seeks to assess and treat race-based traumatic reactions and lessen the impact of cultural mistrust of mental healthcare within the African American community when treating PTSD. Given that African American youth are socialized similarly to their adult counterparts, conducting RCTs with this treatment protocol may be worthwhile in finding.
References


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