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Extended Abstract

Variations in PTSD Characteristics among Trauma-Exposed Urban Black and Non-Black Youth

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Introduction: The main treatments for post-traumatic stress disorder (PTSD) are psychological therapies and medication. Traumatic events can be very difficult to come to terms with, but confronting your feelings and seeking professional help is often the only way of effectively treating PTSD. It's possible for PTSD to be successfully treated many years after the traumatic event or events occurred, which means it's never too late to seek help.

Before having treatment for PTSD, a detailed assessment of your symptoms will be carried out to ensure treatment is tailored to your individual needs. Your GP will often carry out an initial assessment, but you'll be referred to a mental health specialist for further assessment and treatment if you have had symptoms of PTSD for more than 4 weeks or your symptoms are severe. There are a number of mental health specialists you may see if you have PTSD, such as a psychologist, community psychiatric nurse or psychiatrist. If you have mild symptoms of PTSD, or you have had symptoms for less than 4 weeks, an approach called watchful waiting may be recommended. Watchful waiting involves carefully monitoring your symptoms to see whether they improve or get worse.

It's sometimes recommended because 2 in every 3 people who develop problems after a traumatic experience get better within a few weeks without treatment. If watchful waiting is recommended, you should have a follow-up appointment within 1 month. If you have PTSD that requires treatment, psychological therapies are usually recommended first. A combination of a psychological therapy and medication may be recommended if you have severe or persistent PTSD. Cognitive behavioural therapy (CBT) is a type of therapy that aims to help you manage your problems by changing how you think and act. Trauma-focused CBT uses a range of psychological techniques to help you come to terms with the traumatic event. Some people find it helpful to speak about their experiences with other people who also have PTSD. Group therapy can help you find ways to manage your symptoms and understand the condition. Antidepressants, such as paroxetine, sertraline, mirtazapine, amitriptyline or phenelzine, are sometimes used to treat PTSD in adults. Of these medications, only paroxetine and sertraline are licensed specifically for the treatment of PTSD. If medication for PTSD is effective, it'll usually be continued for a minimum of 12 months before being gradually withdrawn over the course of 4 weeks or longer. If a medication is not effective at reducing your symptoms, your dosage may be increased. Trauma-focused CBT is usually recommended for children and young people with PTSD. This normally involves a course of 6 to 12 sessions that have been adapted to suit the child's age, circumstances and level of development.

Post-traumatic stress disorder (PTSD) may affect your ability to drive safely, so you should inform the Driver and Vehicle Licensing Agency (DVLA) about your condition.

Background: Trauma exposure is a common occurrence among urban children and adolescents. To date, few studies have examined comparative data on the prevalence and effects of trauma-related distress among trauma-exposed Black youth. The purpose of this study was to investigate the association between trauma exposure attributes such as index trauma type and post-traumatic stress disorder (PTSD) symptom clusters, and sociodemographic characteristics such as race and gender using the Child PTSD Symptom Scale for DSM-5 (CPSS-5). Urban, socially disadvantaged individuals are at high risk for traumatic event exposure and its subsequent psychiatric symptomatology. This study examined the association between race/ethnicity and symptom severity of posttraumatic stress disorder (PTSD), generalized anxiety disorder (GAD), and depression in an urban clinical sample of 170 trauma-exposed adults. In addition, this study investigated the role of socioeconomic position (SEP) and coping style in the relationship between race/ethnicity and post trauma psychiatric symptom severity. Hierarchical regression analyses indicated that Blacks had lower depression symptom severity compared to Whites. No significant relationship was found between racial/ethnic group status and indices of SEP, PTSD, or GAD symptom severity. Adjustment for trauma exposure, gender, positive reframe coping, avoidance coping and negative coping accounted for 3%, 3%, 8%, 4%, and 3% of the variance in depression severity, respectively; however, Black race remained significantly associated with decreased depression symptom severity accounting for a statistically significant 5% of the variance in lower depression symptom severity. These preliminary findings and their clinical implications are discussed.

Method: The study included 64 children and adolescents (29.7% White, 45.3% Black, 14.1% Hispanic/Latino, and 9.4% biracial) between the ages of 8-18 years who had experienced a DSM-5 Criterion A trauma. The participants completed the interviewer version of the CPSS-five in community sites and clinics, as part of a larger psychometric study of the CPSS-5.

Analysis: A Chi-square test with post hoc comparisons was used to determine whether gender and racial minority status were related to type of trauma. PTSD cluster symptom scores were subjected to a one way analysis of variance (ANOVA) with race or gender status, and a two way analysis of variance (ANOVA) for the interaction effects of gender and racial status.

Results: Black youth less frequently endorsed index traumas involving serious injury or death than non-black youth (4.2% vs. 26.5%, $\chi 2=12.135$, $p<0.033$). Black youth also endorsed lower levels of re-experiencing symptoms (3.75 vs 6.03, $F(1, 56)=4.40$, $p<0.04$) and fewer difficulties with anhedonia, attention, and sleep (all p-values<0.028) than non-Black youth. In addition, there were

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no significant interaction effects between race and gender with PTSD cluster symptoms. Trauma-exposed black youth also reported significantly less life interference from PTSD symptoms when doing chores and duties at home, hobbies, and schoolwork (all p-values<0.047). There was no significant difference in all other variables tested.

Conclusions: The results suggest that Black youth are possibly more resilient than non-Black youth after exposure to trauma. Black youth may have unique protective factors to cope with traumatic distress and experience fewer PTSD symptoms and life interference. Future studies should examine the specific sociocultural factors that may influence resilience in Black youth after traumatic experiences