STRESS-RELATED DISORDERS IN AFRICAN-AMERICAN CHILDREN

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Children exposed to traumatic stress are vulnerable to a variety of stress-related disorders other than classical post-traumatic stress disorder. Several case histories are presented to illustrate some of the diversity of how traumatic stress may manifest in children. African-American children are the main focus of this article as political, economic, social, and morbidity and mortality indicators suggest that African-American children are at high risk for exposure to potentially traumatic stressors. Different presentations of traumatic stress are discussed in an effort to broaden our understanding of the outcome of traumatic stress to fully help traumatized children. (*J Natl Med Assoc.* 1997;89:335-340.)

Key words: stress ◆ trauma ◆ children ◆ African Americans

In 1984, the Community Mental Health Council began work that focused on the agency's catchment area children and their exposure to violence. This effort revealed that a significant number of poor, African-American elementary school-aged children had been exposed to serious violence, ie, 26% reported they had seen a person get shot and 29% reported they had seen an actual stabbing.[1] As the Community Mental Health Council gained more experience in this area, it became clear that children exposed to violence were at risk for developing post-traumatic stress disorder, and we began to focus our work on this presentation of trauma-related stress.[2,3]

Post-traumatic stress disorder is characterized by an exposure to a traumatic event that is persistently reexperienced as unwanted recollections. In addition, there are symptoms of persistent avoidance of stimuli associated with the trauma along with persistent symptoms of increased arousal. The disturbance lasts more than a month and causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.[4] Currently, there are no epidemiologic studies on the incidence or prevalence of post-traumatic stress disorder affecting children and adolescents in the general population, but smaller studies on post-traumatic stress disorder in youth reveal it is a significant problem in some populations.[5]

Other research groups studying the incidence and prevalence of exposure to violence in poor, African-American children found results similar to the Community Mental Health Council's earlier work in the African-American community.[6-9] The Community Mental Health Council's most recent work in this area revealed that almost two thirds of an inner-city high school student sample reported they had seen a shooting and 45% indicated they had seen someone killed. This study illustrated that in addition to classical symptoms of post-traumatic stress disorder, exposure to severe violence was correlated with drinking, drug use, fighting, gun carry-

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ing, knife carrying, and trouble in school[10]–behaviors that are likely to generate an administrative or criminal justice response rather than a treatment response. Thus, by continuing to refine our research, we have learned that focusing on post-traumatic stress disorder as the only sequelae to traumatic stress is a mistake.

This article introduces the concept of stress-related disorders in an effort to move away from the concept that exposure traumatic stress may only cause post-traumatic stress disorder. Case histories are presented of children exposed to traumatic stress who do not have post-traumatic stress disorder, but who do have other trauma-related disorders.

CASE HISTORIES

The following case histories are given as examples of how children, particularly African-American children, exposed to traumatic stress can manifest various symptoms other than classical post-traumatic stress disorder.

Traumatic Stress Resulting in Somatization

A 10-year-old African-American male was referred for having problems with academic performance in school. For more than a year, his grades had been dropping from Bs to Cs and were currently down to Ds. The patient and his mother were at a loss as to why he had begun to do poorly in school as he had always been a B student. He reported he had not been able to concentrate on his homework due to frequently feeling sick to his stomach while studying. When asked what he thought was helping him keep a B average when he had one, he revealed his father used to help him with his homework, and now his father was dead.

When asked about his father's death, the patient reported that he had been with his father when his father died. They had been getting on the elevator when two men began to argue over something, and one of the men began shooting at the other. The patient's father was shot in the stomach before the elevator doors closed. His father was dead before they reached the sixth floor where they lived. He reported the smell had made him sick and he threw up.

This patient's current symptom of nausea during his study time was connected to the nausea and vomiting he experienced during his father's death. Studying was a trigger that evoked intolerable, unpleasant memories of his father's death that were not directly recognized but indirectly experienced through the symptom of nausea. Thus, the focus of therapy was to allow the patient, in a supportive relationship, to reexperience the death of his father and to grieve his loss–something he had not been able to do at the time of his father's death because of his mother's inability to tolerate her son's grief. With this grief work done, it was suggested to the patient that rather than become nauseous at the memory of his father's death, a more apt memorial for his father would be to take those feelings of remorse and transform them into some efforts at getting better grades. Gradually, the patient's grades improved substantially.

Traumatic Stress Resulting in Learning Disorder Not Otherwise Specified

A 13-year-old black female was referred due to a drop in her grades. Two years prior, she had been a straight A student, but for the past 2 years she had been getting Ds. When the patient did not get any results after following her school counselor's suggestion that she devote an additional 2 hours a night to studying, the counselor referred the patient to the Community Mental Health Council for treatment.

Relevant past history revealed that when she was 6 years old, she had been sexually assaulted by her father on two occasions. He had been placed in prison, and she had received therapy for her stressful encounter for about 2 years. Apparently, the therapy worked, as the patient did not show any lingering behavioral problems, and she was an outstanding student who consistently got As. Because the patient had been successfully treated for her stress, neither the mother nor the school counselor thought too much of the patient's sexual assault.

The interview with the patient was unremarkable, and she was free from any overt symptoms of anxiety or depression. She reported that she had tried studying for 2 extra hours but still wasn't able to get good grades. When asked to describe what happened when she would sit down to study, she said she would be attending to the material for a few minutes and then her mind would go blank. When pressed for what she was thinking about, she admitted she would think about what her father had done to her. She reported that when she became 11 years old, she "really understood" what her father had done to her. As a result of her new-found meaning of sexuality, what had happened to her began to really "bother" her to the point that she could not concentrate on her studies. She was provided a sup-

portive relationship with a counselor, and after retelling the story of the abuse and grieving her loss, she began to do well in school again.[11]

Traumatic Stress Resulting in Dream Anxiety Disorder

A 12-year-old white male was referred because since being in his current foster placement for more than a year, the patient had been fighting daily in school. In addition, despite having had decent grades and decent reading and math scores, he was currently failing in school.

The patient had been removed from his mother's home after it was discovered that his stepfather had been beating the patient and making him kneel naked in a closet for several hours during the early morning. The patient was taken from the home and placed with his loving grandmother who died after the patient had been with her for a year. Following the death of his grandmother, the patient was placed with an African-American foster family who were kind and supportive.

The patient didn't have a good reason for his fighting behavior, and he denied any symptoms of post-traumatic stress disorder. He seemed to have grieved the loss of his family and the death of his grandmother, and he seemed to be happy that he was in a safe nurturing environment. He denied any significant impact from his stepfather's torture, except that he was only getting about 2 to 3 hours of sleep a night due to his having nightmares about how his stepfather used to beat him. He was prescribed 25 mg of doxepin at bedtime in an effort to sleep a little better. At his return appointment, the patient was sleeping 8 hours a night, and he reported that he was no longer as irritable as he had been. He stopped fighting in school and had begun to pay more attention to his school work, resulting in better grades.

Traumatic Stress Resulting in Brief Reactive Psychosis

A 25-year-old Latino male was referred after a hospitalization during which he was diagnosed with schizophrenia. He was discharged on haloperidol 20 mg and benzotropine 2 mg at bedtime. He reported that on the day prior to his hospitalization, he had begun to get extremely upset and had begun to hear voices. As a result, he became suspicious that someone was going to try to harm him, and he became combative at home. This was his third hospitalization, and his two previous episodes had been similar in nature, with the first one occurring when he was about 19 years old.

He reported the voices he heard were repeating what Charlie had said before he blew his friend John's head off with a shotgun. Apparently, when the patient was about 17 years old, he and his friend John had been walking down the street when Charlie, who had a grudge against John because of an argument over a girl they were both interested in dating, saw John and decided to shoot him. He vividly described feeling the heat and shock wave from the shotgun blast, and talked about the smell of gunpowder along with some of the flesh from John's head that got on his face and flew into his mouth. He reported frequent flashbacks of the incident, which were triggered by witnessing violence, such as watching a violent movie.

Because he reported feeling drowsy on the medication, the patient was taken off of the haloperidol and started taking a tricyclic antidepressant with much better results. He felt less lethargic resulting in more compliance with the medication, and he had a better response to psychotherapy, which focused on helping the patient tolerate his experience with traumatic stress. Compared with the chemotherapy, supportive psychotherapy, and psychosocial rehabilitation he had been getting before being properly diagnosed, an insightful psychotherapeutic approach was helpful to this patient.

Traumatic Stress Resulting in Depressive Disorder Not Otherwise Specified

A 17-year-old black male was referred because of "a hostile attitude." He was residing in a foster home and had recently dropped out of high school. He was an angry young man who did not seem receptive to the idea of being interviewed. When asked why he had been referred, he angrily replied, "They sent me." When asked who "they" were, he bitterly replied his foster family. When asked about his family of origin, he reported he had been in a stable family environment with his father, mother, and three siblings, but when the patient was 9 years old, his father lost his job and began to sell drugs to support his family. Unfortunately, his mother began to use the drugs his father was selling, and she became unable to properly care for her children.

When the patient was 11 years old, he and his siblings were placed in separate foster homes due

to his mother's neglect. Over the next 6 years, he reported being in five different foster homes causing him to miss a lot of time in school, which resulted in poor grades. Because his Department of Children and Family Services case worker refused to let him visit his siblings until he got his GED, he had not seen any of his three siblings in nearly a year, and he did not know of their whereabouts. He had no information about the whereabouts or health of his father and mother. He had never been exposed to or victimized by serious violence.

Initially, he was a surly, angry, irritable teen, but, as he began to describe what had happened to him, his affect became more sad, and when he talked about not having any idea about how his family doing, he began to cry. He talked about his frustration with his academic performance as he wanted to do well in school but, with the exception of his 2 years in a "good foster home," his multiple placements had made his getting a decent education almost impossible. He was clear that the events in his life had been extremely stressful, resulting in him having crying spells twice a week for an hour before he went to sleep during the past year. He realized he was like this because beneath the "attitude" was the stress and hurt he had experienced in his life, but since he didn't have anyone to talk to about his pain, it had turned into anger.

Traumatic Stress Resulting in Anxiety Disorder Not Otherwise Specified (Excessively Dutiful and Conscientious)

An 11-year-old black female was referred from the Department of Children and Family Services to get therapy on the assumption that she might need some emotional support. When the patient was 7 years old, she had been taken from her mother due to charges of neglect and was placed with her aunt for several years. After the mother had been drug-free for 2 years, the patient was returned to the mother's care. In addition to being separated from her mother, the patient used to witness her mother frequently being battered by the patient's stepfather, who was also a drug user.

The patient seemed to be a dutiful and conscientious 11-year-old child who appeared extremely mature for her age. She was a B+ student and reported never giving her mother any trouble. She denied any anger or upset feelings toward her mother for her abandonment, and when asked about how she felt when she saw her mother get beaten up, she reported that this was not a major concern for her. She reported a greater concern for her was her fear that her mother would go back on drugs. In fact, this particular worry would keep her up at night, causing her to have sleep-onset insomnia. She was afraid if she was "bad," her mother would go back to using drugs and she would be separated from her again. She thought because she had been "bad," she had originally been separated from her mother, and she felt unreasonably guilty. The task of therapy for her was to try to get her to give up her pseudo-maturity, which was secondary to guilt and fear, but to still be a reasonably well-behaved child who was getting good grades.

DISCUSSION

Recently, in the *Diagnostic and Statistical Manual-4th Edition (DSM-IV)*,[4] the American Psychiatric Association made a major step by providing criteria for an acute stress disorder characterized by an exposure to a traumatic event that causes the individual to experience three or more dissociative symptoms during or after the event. In addition, the traumatic event is persistently reexperienced and there is a marked avoidance of stimuli that arouse recollections of the trauma along with marked symptoms of anxiety or increased arousal. Like post-traumatic stress disorder, the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. It lasts for a minimum of 2 days and a maximum of 4 weeks. The disorder occurs within 4 weeks of the trauma and is not due to direct physiological effects of a substance or general medical condition, a brief psychotic disorder, or an exacerbation of preexisting Axis I or Axis II disorder. Hopefully, this new category will improve the identification of stress-related disorders.

Despite the inclusion of this new diagnostic entity in the *DSM-IV*, clinical experience with children who have been exposed to traumatic stress reveals they may suffer from a variety of psychiatric disorders found in the *DSM-IV* related to their traumatic stress. The cases presented provide an example of how the sequelae of traumatic stress can present as:

- somatization disorder,
- learning disorder not otherwise specified,
- dream anxiety disorder,
- brief reactive psychosis,
- depressive disorder not otherwise specified, and
- anxiety disorder not otherwise specified.

In addition, exposure to traumatic stress also may present as:

- multiple personality disorder,[12]
- dissociative fugue,
- dissociative amnesia,
- panic disorder,
- generalized anxiety disorder,[13]
- conversion disorder,
- depersonalization disorder,
- borderline personality disorder,
- antisocial personality disorder,
- conduct disorder,[14]
- oppositional defiant disorder,
- impulse control disorder not otherwise specified,
- attachment disorders of infancy,
- separation anxiety disorder,[15]
- adjustment disorders,
- sexual dysfunctions,
- paraphillias,
- communication disorder not otherwise specified,
- selective mutism,[16] and
- disruptive behavior disorder not otherwise specified.

Disorders of extreme stress not otherwise specified also has been proposed[17] and includes symptoms (somatization, dissociation, and affective symptoms), personality changes (pathological relationships and changes in identity), and harm seeking and revictimization behaviors as constellations of the disorder. In addition, there is comorbidity associated with post-traumatic stress disorder and may include imbedding of the traumatic response into the personality, substance abuse,[18] eating disorders, depression, suicidal behavior, and vocational impairment, all of which may obscure the etiology of traumatic stress.

CONCLUSION

The case histories described here illustrate some of the various forms that stress-related disorders may take in children and illustrate the complexity of how exposure to traumatic stress may manifest. As Pynoos[19] points out, issues of development make understanding traumatic stress in children a particularly difficult subject to fully understand. Despite these difficulties, health professionals must realize the myriad presentations of exposure to traumatic stress to appropriately identify and intervene in these cases. Accordingly, we must broaden our case finding activities and seek to identify traumatized children not only in mental health settings, but also in correctional facilities, special education settings, drug abuse populations, and general medical settings. Further, we need to develop systems of care and intervention for these children as early as possible as waiting only increases morbidity and mortality.[20]

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