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# Posttraumatic stress disorder in African Americans: A two year follow-up study

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ABSTRACT

The present study was a prospective, naturalistic, longitudinal investigation of the two year course of posttraumatic stress disorder (PTSD) in a sample of African Americans with anxiety disorders. The study objectives were to examine the two year course of PTSD and to evaluate differences between African Americans with PTSD and anxiety disorders and African Americans with anxiety disorders but no PTSD with regard to comorbidity, psychosocial impairment, physical and emotional functioning, and treatment participation. The participants were 67 African Americans with PTSD and 98 African Americans without PTSD (mean age 41.5 years, 67.3% female). Individuals with PTSD were more likely to have higher comorbidity, lower functioning, and they were less likely to seek treatment than those with other anxiety disorders but no PTSD. The rate of recovery from PTSD over two years was 0.10 and recovery from comorbid Major Depressive Disorder was 0.55. PTSD appears to be persistent over time in this population. The rates of recovery were lower than what has been reported in previous longitudinal studies with predominantly non-Latino Whites. It is imperative to examine barriers to treatment and factors related to treatment engagement for this population.

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## 1. Introduction

Few studies have examined the relationship between posttraumatic stress disorder (PTSD) and racial group status, and the limited research that has been conducted has produced mixed findings (Norris, 1992; Frueh et al., 2004; Seng et al., 2005; C'De Baca et al., 2012). There is some evidence to suggest that African Americans[1] may experience higher rates of PTSD than individuals from other racial/ethnic groups (Kulka et al., 1990; Kessler et al., 1999; Breslau et al., 2004; Himle et al., 2009; Roberts et al., 2011). For example, a study using data from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) (Roberts et al., 2011) found that African Americans had significantly higher lifetime prevalence rates of PTSD (8.7%) than Whites (7.4%), and that the risk for developing PTSD was 1.2 times higher among African Americans compared to Whites, after adjusting for characteristics of trauma. While comparative studies can provide group estimates of risk, within group studies can provide important information with regard to factors related to illness among members of a specific demographic.

Several studies have examined the factors associated with racial differences for PTSD. Combining two epidemiological surveys (National Comorbidity Survey-Replication [NCS-R] and National Survey of American Life [NSAL]), Himle et al. (2009) reported that increased risk for African Americans developing PTSD in comparison to Whites was attributable, at least in part, to increased exposure to major trauma such as crime. Similarly, a study of pregnant women found that higher rates of both lifetime and current PTSD among African Americans in comparison to Whites were explained by greater trauma exposure (Seng et al., 2011). Recent results from the Detroit Neighborhood Health Study showed that 87.2% of a predominantly African American sample reported at least one Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)(APA, 1994) criteria A type lifetime traumatic event and that 17% of those who experienced a trauma met criteria for probable lifetime PTSD (Goldmann et al., 2011). Other studies of PTSD that have included comparisons between African Americans and Whites have also found that African Americans were exposed to more serious traumatic events (e.g., assaultive violence) (Roberts et al., 2011), and had fewer economic resources than Whites to cope with these events (Norris, 1992). The NESARC

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[1] Different researchers use different terms but for the sake of clarity and uniformity we use the term “African American” throughout.

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study (Roberts et al., 2011) showed that African Americans had significantly higher exposure to child maltreatment (due primarily to higher rates of witnessing domestic violence) and to assaultive violence (e.g., unwanted sex, physical attacks/beatings, or kidnappings); 14.0% and 29.3% respectively, compared to Whites (11.4% and 26.1% respectively). Therefore, greater prevalence of severe traumatic events among African American (vs. White) individuals may be one factor that accounts for higher rates of PTSD within this population.

Overall, little is known about within-group clinical characteristics of PTSD in African Americans. For example, in the general population, PTSD is associated with high rates of comorbid major depression and other anxiety disorders such as generalized anxiety disorders, panic disorder, social anxiety, and agoraphobia (Kessler et al., 1995; Kessler et al., 2003), but there is scarce evidence about PTSD comorbidity in the African American population, especially with major depressive disorder (MDD). The NSAL study showed that the lifetime prevalence estimate of MDD in African Americans is 10.4% and that it is a chronic and debilitating disorder for this population (Williams et al., 2007). In an earlier epidemiological study, African Americans were found to be significantly less likely to have a mood disorder than White Americans but had higher odds of persistence of the disorder than their counterparts (Breslau et al., 2005). Exploration of within-group differences regarding MDD in African American individuals is also needed (Lincoln et al., 2011). A comprehensive framework of multilevel factors (e.g., socioeconomic status, stressors, kinship and social support, quality healthcare) influencing depression in African Americans, especially men, have been recently proposed (Watkins, 2012). Most of the studies examining comorbid PTSD and depression among African Americans combine this group with other minority groups (generally because African American samples are usually small) to allow meaningful analyses (Alim et al., 2006a). An exception to this is a study conducted with Vietnam War veterans showing that although rates of PTSD were similar for White and African American veterans, White veterans were significantly more likely to receive a diagnosis of a depressive disorder than African Americans (Frueh and Gold, 1997).

To the best of our knowledge, there is no extant study that prospectively evaluates the course of PTSD in an African American sample with a longitudinal design with the exception of a study of posttraumatic stress symptoms (PTSS) after Hurricane Katrina in a predominantly African American sample (83.5%) (Paxson et al., 2012). The study revealed that 45.4% of low-income mothers reported severe PTSS in the first survey (between 7 and 19 months after the hurricane) compared to 32.7% in the second survey (between 43 and 54 months after the hurricane), and the sample with scores suggesting probably PTSD was 33% (Paxson et al., 2012). Examining the course of a disorder using a longitudinal design is needed to better understand the natural course of the disorder and the clinical predictors of rates of recovery and recurrence. Most longitudinal studies with mostly White participants have used self-report scales to assess the severity and persistence of PTSD symptoms (Dirkzwager et al., 2001; Koren et al., 2001; Heinrichs et al., 2005). A more accurate assessment of the course of a mental disorder requires rigorous structured clinical interviews (Blacker, 2005). A within-group longitudinal study of PTSD among African Americans that utilizes clinical interview data with multiple time points and short intervals would provide specific evidence necessary to understand how the illness unfolds in this population. This type of study also may help unpack some of the questions raised by comparative, correlational data on race differences.

Although there is little evidence about the course of PTSD in African Americans, it is reasonable to expect a low recovery rate from PTSD and comorbid conditions for this population given some evidence that African Americans have decreased resources for mental health treatments (Roberts et al., 2011); ineffective coping strategies to handle traumatic experiences (Seng et al., 2011); high likelihood of exposure to severe traumas, especially child abuse (Seng et al., 2011); high levels of stress in traumatized individuals (Norris, 1992), and over representation in lower socioeconomic and disadvantaged communities (Cutrona et al., 2005). Crime-related traumas are more likely to occur in urban areas where minority populations are overrepresented (Census-Bureau, 2007). Furthermore, experiences of negative life events in neighborhoods high in social disorder and economic disadvantages, have a higher impact in individuals' mental health (Cutrona et al., 2005)

In the current study, we provide the first prospective report of the course of PTSD in African Americans. The study objectives were to examine the two year course of PTSD and to evaluate differences between African Americans with PTSD and anxiety disorders and African Americans with anxiety disorders but no PTSD. This comparison included comorbidity, psychosocial impairment, physical and emotional functioning, and treatment participation. This comparison is important because it may help guide treatment planning for anxiety disorders in this population by advancing the understanding of their complexities and by strategizing integrative treatments for individuals experiencing more than one anxiety disorder. The study examines the course of PTSD in comparison with the course of MDD. These comparisons will allow contrasting clinical characteristics and course of PTSD with other disorders in this population. Because this was an exploratory study and the literature did not support a strong directional statement about the course of PTSD in African Americans, we thought that we did not have enough of a foundation to formulate hypotheses. Together, these analyses provide a more complete clinical picture of PTSD among African Americans than has been available in the literature to date and offer guidance to the diagnosis and treatment of PTSD for this population.

## 2. Method

### 2.1. Participants

The current sample included 165 African Americans diagnosed with an anxiety disorder at baseline and participating in HARP-II, which is a prospective, naturalistic, and longitudinal study of 439 adults with a current or past history of anxiety disorders. Inclusion criteria included at least 18 years of age at intake and a past or current diagnosis of at least one of following index disorders: PTSD, panic disorder, panic disorder with agoraphobia, agoraphobia without history of panic disorder, generalized anxiety disorder, or social anxiety disorder. Exclusion criteria included the presence of an organic brain syndrome, a history of schizophrenia, or current psychosis at intake. Participants were recruited via referral by local mental health providers, advertisements in newspapers, internet postings, and on mass transportation. Potential participants were first briefly screened over the telephone. Those endorsing anxiety symptoms were invited for an intake interview and paid $60.00 following the interview as compensation for their participation. Each participant who completed a follow-up interview was similarly compensated. All participants provided informed consent before the intake interview. The study was fully approved by the Institutional Review Board of Brown University. The methods are described in detail elsewhere (Weisberg et al., 2012).

### 2.2. Procedure

All intake assessments were conducted in person after participants were briefly screened over the telephone. Data were collected via structured diagnostic interviews administered at intake that included assessment of current and lifetime history of relevant psychiatric conditions using the Structured Clinical Interview of DSM-IV Axis I Disorders, Non-Patient Version (SCID-NP) (First et al., 1996). Traumatic events at baseline were assessed using a revised version of the Trauma Assessment for Adults (Resnick et al., 1993). Participants were asked about lifetime traumatic events and to identify their most stressful trauma. PTSD symptoms were assessed in response to that event with the SCID-NP.

Interviews were conducted by clinical interviewers with a bachelor's or master's degree in psychology or a related field. Interviewers completed a rigorous training program (Warshaw et al., 2001), before being certified to conduct intake

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