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CHAPTER 13

Social Injustice and Child Trauma

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The developing child's positive sense of self depends on the caregiver's benign use of power.

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Trauma research tells what *should* be a compelling story: childhood trauma can distort psychological development, precipitate child and adult psychopathology, and skew life trajectories. Yet, in an American society equipped with both this knowledge and vast resources that could be employed to limit trauma's reach, trauma is permitted to play a prominent role in the lives of many children, adolescents, and families. A thorough exploration of this phenomenon requires the acknowledgment of trauma's various forms. Particularly for clinicians, a critical appraisal of traditional psychiatric conceptualizations of trauma's many manifestations is also indicated. Childhood trauma caused by experiences in the home (e.g., physical abuse, sexual abuse, exposure to domestic violence) or by isolated events

(e.g., natural disasters, motor vehicle accidents) are frequently areas of focus for both clinicians and the larger society. This approach, however, overlooks what is often the most pervasive, unrelenting, and pernicious form of trauma affecting marginalized populations: structural trauma.

Interpersonal traumas can be attributed to individual bad actors. Accidents are the result of exceptions or malfunctions. With structural trauma, however, society's systems as they are intentionally configured and regularly operate are the instruments of harm. The social determinants of mental health and the systemic structures that frame them are powerful forces in the psychological development and well-being of children, a vulnerable population that is, by definition, legally dependent on either a family or the child welfare system to meet its basic needs. When it comes to the consideration of these structural issues, both the typical child trauma assessment techniques and psychiatric diagnoses have critical omissions. Just as childhood dysfunction cannot be understood apart from the context of family violence and neglect, family dysfunction cannot be understood apart from the context of societal violence and neglect.

The Adverse Childhood Experiences Studies

One of the most referenced and well-known studies regarding childhood trauma is the Adverse Childhood Experiences Study (ACE Study), originally conducted beginning in 1995. It explored the relationship between childhood abuse and household dysfunction and later-life medical conditions that lead to premature death in adults. The initial study included information from 9,508 respondents, 80% of whom were white and 75% of whom had at least some college education. Participants completed the Adverse Childhood Experience Questionnaire (Table 13–1). Results indicated that adverse childhood experiences (ACEs) were common in this largely middle-class population (Felitti et al. 1998). Although the finding that childhood trauma increases the risk of mental illness was not novel, the ACE Study's demonstration of a dose-response relationship between childhood trauma and a wide range of outcomes in adult physical health, mental health, and psychosocial functioning cemented its status as a landmark study (Centers for Disease Control and Prevention 2020). Key findings of that ACE Study are provided in Figure 13–1.

Following the original ACE Study, a larger study of 214,157 people with greater socioeconomic and racial diversity was conducted in 2011–2014, using a slightly modified version of the ACE questionnaire and data

TABLE 13–1. Original Adverse Childhood Experiences (ACE) Questionnaire

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often**...

   Swear at you, insult you, put you down, or humiliate you?

   or

   Act in a way that made you afraid that you might be physically hurt?

   Yes No If yes enter 1 ___

2. Did a parent or other adult in the household **often**...

   Push, grab, slap, or throw something at you?

   or

   Ever hit you so hard that you had marks or were injured?

   Yes No If yes enter 1 ___

3. Did an adult or person at least 5 years older than you **ever**...

   Touch or fondle you or have you touch their body in a sexual way?

   or

   Try to or actually have oral, anal, or vaginal sex with you?

   Yes No If yes enter 1 ___

4. Did you **often** feel that...

   No one in your family loved you or thought you were important or special?

   or

   Your family didn't look out for each other, feel close to each other, or support each other?

   Yes No If yes enter 1 ___

5. Did you **often** feel that...

   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

   or

   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

   Yes No If yes enter 1 ___

TABLE 13–1. Original Adverse Childhood Experiences (ACE) Questionnaire *(continued)*

6. Were your parents ever separated or divorced?

   Yes No If yes enter 1 ___

7. Was your mother or stepmother:

   Often pushed, grabbed, slapped, or had something thrown at her?

   or

   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?

   or

   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

   Yes No If yes enter 1 ___

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

   Yes No If yes enter 1 ___

9. Was a household member depressed or mentally ill or did a household member attempt suicide?

   Yes No If yes enter 1 ___

10. Did a household member go to prison?

    Yes No If yes enter 1 ___

Now add up your "Yes" answers: _____. This is your ACE score.

Note. The ACE Study looked at three categories of adverse experience: *childhood abuse*, which included emotional, physical, and sexual abuse; *neglect*, including both physical and emotional neglect; and *household challenges*, which included growing up in a household where there was substance abuse, mental illness, violent treatment of a mother or stepmother, or parental separation/divorce or a member of the household went to prison. Respondents were given an ACE score between 0 and 10 on the basis of how many of these 10 types of adverse experiences to which they reported being exposed.

from the Behavioral Risk Factor Surveillance System (BRFSS). Modification included making abuse questions more appropriate for a telephone survey and broadening the question related to intimate partner violence to include any parent or adult. The results reflected an even higher prevalence of childhood abuse and markers of family dysfunction than in the original study. Additionally, traumatic exposures were substantially higher for Black, Latinx, and multiracial respondents, as well as for those with less than a high school education and with less than $15,000 annual family income. Figure 13–2 provides key findings of this modified ACE Study. Of note, approximately 25% of individuals surveyed reported three or more ACEs. This study highlights that although common across groups, the burden of childhood adversity is distributed inequitably (Merrick et al. 2018).

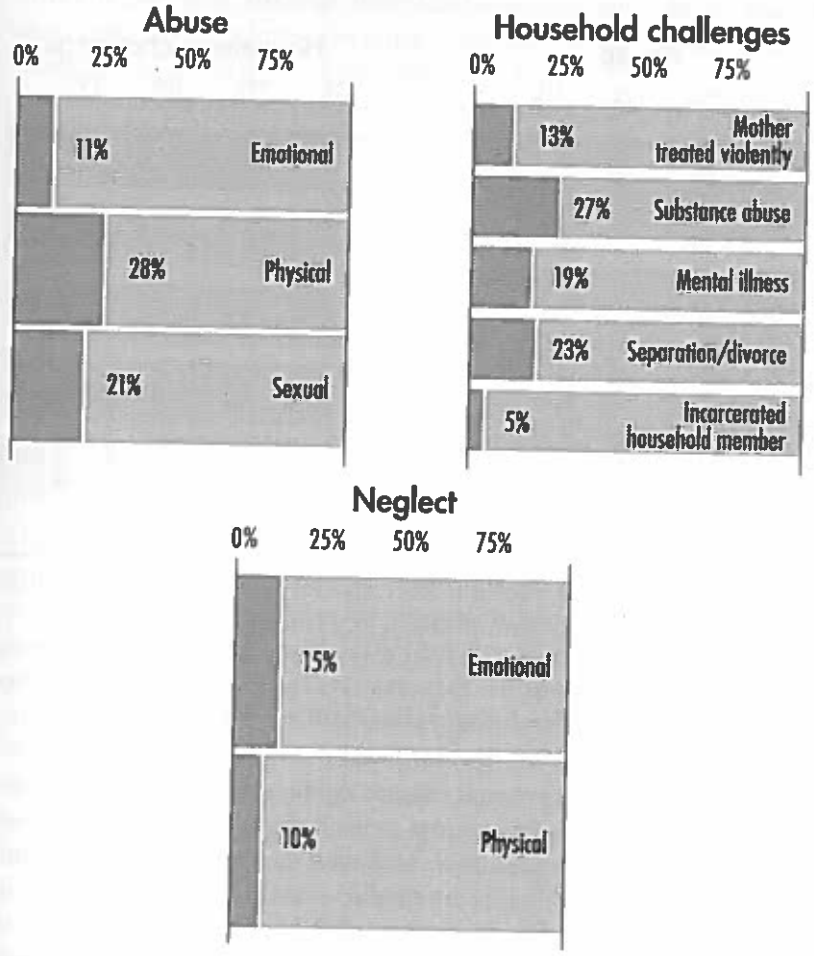

FIGURE 13–1. Adverse Childhood Experiences Study (ACE Study) by Merrick et al. 2018: general findings.

Source. Reproduced from Centers for Disease Control and Prevention, Kaiser Permanente: *The ACE Study Survey Data*. Atlanta, GA, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2016.

Although the ACE Study and BRFSS study have achieved a place of preeminence in the professional and lay discourse regarding trauma, the approach used in these studies does not take into account community vio-

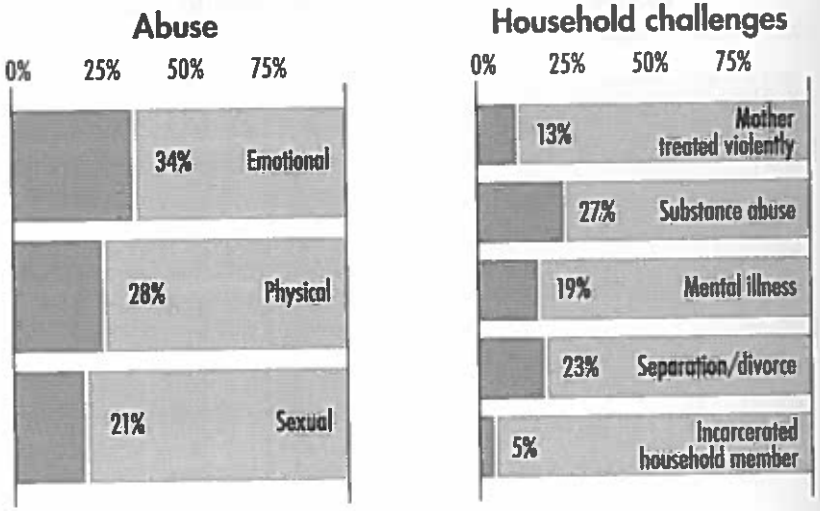

FIGURE 13–2. ACE module from the 2011–2014 Behavioral Risk Factor Surveillance System (BRFSS): key findings.

Source. Merrick MT, Ford DC, Ports KA, Guinn AS: "Prevalence of adverse childhood experiences from the 2011–2014 Behavioral Risk Factor Surveillance System in 23 States." *JAMA Pediatrics* 172(11):1036–1044, 2018.

lence, structural trauma, racial trauma, or the severity and chronicity of trauma. The questionnaire captures individual issues that impair the caregiver (e.g., whether the parent has an alcohol use disorder or mental illness that could hinder proper child care [Felitti et al. 1998]), but it gives no consideration to societal drivers of parental dysfunction (e.g., whether the caregiver's drinking is a method to cope with distress related to his or her own trauma or whether the caregiver has an untreated mental illness because the safety net clinic has a 3-month waitlist). Furthermore, the original questionnaire presumes a family structure in which the mother or stepmother is the primary caregiver. Although these omissions may not have been particularly relevant for the original study's largely white, middle-class study population, they certainly would be for Black, brown, and impoverished children who have faced familial disruption in the context of structural racism and traumatized communities.

Researchers have since looked beyond conventional ACEs, in attempts to understand expanded ACEs affecting socioeconomically and racially diverse populations. These *expanded ACEs* include, for example, witnessing violence, experiencing discrimination, growing up in unsafe neighborhoods, experiencing bullying, and living in foster care (Cronholm et al. 2015). Importantly, although there has been some expansion of the questions used in ACE surveys to more accurately reflect the experiences of marginalized populations (Chen and Burke Harris 2014), in clinical practice and lay discussion, the original 10-question survey of conventional ACEs is the one most widely used.

Community Violence

Community violence includes extreme events such as shootings, stabbings, and sexual assault but also can include less severe, more pervasive events such as drug deals and robberies. Exposure to community violence can be direct (e.g., the child is attacked) or indirect (e.g., the child witnesses a shooting). In communities where violence is routine, both children and the adults entrusted with their care (who may themselves have been exposed as children) are continuously subjected to threats against their well-being. High-quality parenting practices and the reestablishment of a sense of safety are important strategies for protecting children from traumatic exposures and bolstering resilience following adverse events. It can be challenging for parents to provide a sense of safety for their children when the parents also are not safe; therefore, it is hardly surprising that parental trauma, distress, and PTSD diagnoses correlate with an increased risk of children experiencing child abuse or being diagnosed with PTSD (Cross et al. 2018). When rapid brain growth and increased neuroplasticity occur in youth in this context of toxic stress, it follows that such environments can have a direct, negative psychobiological impact on the developing neurological systems of children and adolescents (DeBellis 2001).

Many children in the United States experience community violence; however, urban and poor youth are disproportionately affected. Additionally, young people of color who are already contending with inequities and stressors from structural and interpersonal racism are more likely to live in these environments. Even ACE questionnaires that do not directly ask about these issues capture the disproportionate impact of trauma experienced by minority urban youth; research suggests that Black adolescents are victims of trauma at a rate that is 67% higher than for white adolescents (Sabol et al. 2004). In one study of racially diverse, poor mothers and their children in Massachusetts, more than 30% of children reported having witnessed violence at school or in their neighborhood, 38% reported worrying about a robbery or burglary of their home or family, and 30% reported worrying about their safety where they live (Mohammad et al. 2015). In a study of young Black men ages 18–24 in Baltimore, Maryland, participants reported knowing an average of three homicide victims, the majority of

whom were peers (Smith 2015). Findings from the National Crime Victimization Survey show that the risk of experiencing serious violence is roughly 1.5–2 times greater for Blacks than for whites, and the risk for Latinx people is roughly 1.2–1.5 times greater than for whites (Warnken and Lauritsen 2019). These experiences have psychiatric manifestations, including behavioral and emotional dysregulation, PTSD symptoms, depression, and suicidality, as well as social manifestations, including poor academic performance, higher rates of homelessness, and increased risk for criminal justice system involvement (Carrion et al. 2002; Edalati et al. 2017; Felitti et al. 1998; Roos et al. 2013).

Poverty as a Mediator for Child Social Determinants of Health

Per developmental systems theory, healthy and successful child development is more likely when children can access environmental resources in communities rich in assets aligned with their individual strengths (Benson 2003). This is not the reality for children living in poverty, who make up a significant portion of the U.S. population. Approximately 21% of all children (a number that corresponds to roughly 15 million developing brains) are members of households living below the federal poverty line—a benchmark set at an annual income of $26,200 for a family of four in 2020 (Office of the Assistant Secretary for Planning and Evaluation 2020). Another 43% of U.S. children live in low-income families, defined as having incomes less than twice the federal poverty line (National Center for Children in Poverty 2019). Although more white children live in poverty than any other group, higher proportions of Black, Hispanic, and American Indian/Alaska Native children do; 34% of Black children, 28% of Hispanic children, and 34% of American Indian/Alaska Native children live in poverty, compared with 11% of both white and Asian children (National Center for Education Statistics 2017). However, because these data represent averages across subgroups with substantial heterogeneity, they are misleading for certain subgroups. For example, one in three Hmong children in the United States live in poverty (Asian American Federation 2014), a rate far higher than the broader Asian racial group in which they are categorized.

As highlighted throughout this chapter, social determinants of mental health have clear clinical implications for traumatized youth, and poverty is a frequent and powerful mediator of social determinants. The World Health Organization (Solar and Irwin 2010) identified several key concepts from Finn Diderichsen's model of the mechanisms of health inequality that help explain the relationship between social status and health outcomes:

- Social contexts create social stratification and assign individuals to different social positions
- Social stratification, in turn, engenders a differential exposure to health-damaging conditions and differential vulnerability in terms of health conditions and material resource availability
- Social stratification determines differential consequences of ill health for more and less advantaged groups

This theoretical framework is helpful for understanding and addressing childhood trauma in a society shaped by structural oppression, be it based on gender, race, economic status, or other demographic categories.

The following case introduces a mother and son who both experienced childhood structural trauma. We refer back to this family in the remainder of this section.

Case Example

David, a 4-year-old multiracial boy, is called "defiant" in school because he does not follow teachers' instructions. He reacts impulsively when upset and has hit other children on several occasions. He is referred by his preschool for a mental health evaluation. His mother, Ava, describes him as a bright, energetic, loving son. In the office, he is noted to be pleasant and engaging. On approach, he smiles shyly at the therapist and shows her his stuffed toy. He participates in play with the therapist after some prompting from his mother.

Ava, who had David when she was 21, has been his primary caretaker his entire life. They live with Ava's boyfriend in an apartment in a rough neighborhood—where David regularly hears gunshots and has seen people seriously injured. Three months ago, Ava was fired from her job at a call center. In the past few months, she has vacillated between withdrawal and irritability, which has resulted in far less positive reinforcement for her son. She has also been cutting her upper thigh with a razor in efforts to "feel something." She has harmed herself in the past, with the first instance occurring when she was a child. She tells the therapist that she works hard to be sure that David does not see her upset. Despite this, there have been times when she has unintentionally snapped at him. She tells the therapist, "I know he is just acting like a 4-year-old, but I get so frustrated."

From the age of 3 years, Ava was raised by her Aunt Lucille, who was a domestic worker. Ava's mother was unable to care for Ava because of a highly impairing substance use disorder, and her father was never part of her life. When Ava was 7 years old, Lucille's boyfriend moved into the home. A few months after moving in, he started abusing Lucille, both physically and emotionally. The abuse continued for the next 10 years. Ava's aunt was also raising one of her own children, and she had experienced homelessness in the past. Lucille could not cover the household bills on her own, and her boyfriend brought needed additional income. When he started abusing her, Lucille feared becoming homeless again if she left him.

Ava did well in school academically and generally performed at the top of her class. After her seventh-grade teacher noticed Ava's "attitude" and decreased engagement with her schoolwork, Ava was referred for mental health services. Although Lucille took Ava for her initial assessment, lapses in insurance coverage and inconsistent transportation prohibited regular follow-up. Per the clinic's policy, Ava was discharged after three no-shows.

David's therapist asks Ava to complete an ACE questionnaire for both herself and David, whose scores are 2 and 1, respectively. The case of Ava and David illustrates ways in which traumatic events and societal factors, including many that would not be adequately captured by typical psychiatric diagnostic schemes, contribute to the etiology and perpetuation of mental illness in individuals and across generations.

Multisystem Failure: Intergenerational Trauma, Financial Instability, and Food Insecurity

In the case example, Ava's unaddressed trauma symptoms were intruding not only on her internal life but also on her parenting. The financial insecurity in Ava's childhood home directly contributed to both her traumatic exposures and her inability to engage in treatment, even though there was early identification of a mental health problem. A generation later, following an exacerbation of her own symptoms, Ava found herself unemployed, a circumstance that has a demonstrated link to adverse mental health outcomes, particularly depression, suicidality, and alcohol use disorder. Parental unemployment also correlates to increased risk of child maltreatment (Patwardhan et al. 2017). However, employment, even when full time, does not reliably provide families with financial security.

In the United States, where women are the primary source of income or a co-earner for more than 50% of families with children, a significant contributor to economic instability during childhood is the gender wage gap. In 2018, the gender wage gap for full-time workers was 18%—meaning that women earned $0.82 for every $1.00 that men earned. This gap exists when comparing within racial and ethnic groups (e.g., white women earn less than white men, and Black women earn less than Black men). However, the full-time wage disparity between Black and Latinx women and white men is most striking; Black women earn $0.62 and Latinx women earn $0.55 for every $1.00 that a white man earns (Hegewisch and Tesfaselassie 2019). Many factors likely contribute to this wage gap, including educational attainment, type of employment, location of employment, and level of experience. When researchers control for these factors, the gap appears to lessen, but it remains (Blau and Kahn 2016), pointing to sexism and racism

as a factor. Additionally, because discrimination does not exist solely in how employers pay women, and underrepresented minority women in particular, simply evaluating the numbers misses the bigger picture. By the time a woman enters the labor market, she has potentially been influenced by societal and family expectations of work-family balance and has dealt with subtle pushes away from more technical careers as well as discriminatory hiring practices. The combination of the gender pay gap and having a single income increases the economic hardships that single-mother households face in the United States; these households also are extremely vulnerable to poverty in the setting of job loss or even decreased hours.

Although many workers in the United States make minimum wage, they are not making a livable wage. In Los Angeles, for example, the minimum wage is $12 per hour; however, the calculated living wage for a single adult with one child is approximately $31 per hour (Glasmeier 2020). In this situation, despite working 40 hours per week, a single parent earning minimum wage is still at risk of not having enough money to pay for rent, utilities, and food. The chronic stress of living in an environment of financial insecurity has a significant impact on developing children who are dependent on caregivers to nourish them both physically and emotionally. Even if a child's caregivers work two low-wage jobs and manage to cover the bills, they may be preoccupied with the unrelenting urgency of feeding, clothing, and housing their children and may be less available to meet their child's psychological needs. *Secure attachment* provides a foundation for emotional regulation and distress tolerance, self-worth, and a sense of agency, and its development is threatened when caregivers cannot meet children's needs. In contrast, *insecure attachment* is a risk factor for emotional dysregulation, negative self-concept, and an external locus of control.

Children are navigating all of these stressors with immature brains that may be inadequately fueled for healthy neurocognitive growth. Food insecurity conveys increased risk for developmental delays, growth stunting, and inadequate cognitive development; it has been linked to poorer academic performance, absenteeism, and grade retention. Symptoms of ADHD, particularly hyperactivity and impulsivity, have also been linked to food insecurity. This relationship persists even after adjusting for individual and family characteristics, such as age of the child, race, ethnicity, household income, parental level of education, and parental mental health (Lu et al. 2019). Furthermore, after controlling for other aspects of socioeconomic status, food insecurity is associated with increased risk of mood, anxiety, behavior, and substance disorders in adolescents (McLaughlin et al. 2012). The resultant limitations in function reliably and predictably hamper upward mobility, trapping many individuals in intergenerational cycles of trauma and poverty. In David's case, three generations—he, his

mother, and his mother's primary caretaker—were all impacted. Further exploration may reveal exposure even higher in the genogram. For Ava, David, and many others presenting to their pediatricians and mental health clinicians with "problem" behaviors, it is clear that early, chronic, inescapable traumatic exposure plays a significant role in the perpetuation of trauma and the manifestation of externalizing symptoms.

Professional Neglect of Structural and Complex Traumas

The diagnosis of PTSD was introduced in DSM-III in 1980 with criteria informed by symptoms that emerged in the context of a circumscribed, identifiable traumatic experience (e.g., exposure to war combat, rape) (American Psychiatric Association 1980). This was an important step in diagnostic psychiatric classification because it rooted psychological trauma symptoms in the precipitating stressor rather than individual weakness, as had been the case in previous DSM editions (Friedman 2019). However, the criteria for PTSD, in both previous and current DSM editions, fail to acknowledge traumas commonly experienced by children in marginalized communities. As a result, the psychological and physical impact of racism, oppression, and structural trauma too often is treated as an afterthought and relegated to a V code (ICD-10-CM codes for factors influencing health status and contact with health services), if considered at all (Cooper et al. 2008).

Complex PTSD (C-PTSD) is a potential consequence of exposure to these complex traumas, which occur over extended periods of time and from which the victim is unable to escape. First characterized by psychiatrist Judith Herman (1992), the conceptualization of complex trauma and the related diagnosis of C-PTSD provide a more patient-centered and trauma-informed approach for the diagnosis and treatment of patients such as David and Ava who have been exposed early in life to chronic, repetitive, harmful events that undermine safety, security, and healthy attachment. The captivity component of complex trauma is nearly universal in the traumatic experiences of children who have no power to remove themselves from their home or community environments. In addition to the three symptom clusters of PTSD (reexperiencing, avoidance, and sense of threat), C-PTSD includes three additional symptoms: affect dysregulation, negative concept of self, and difficulties in relationships (World Health Organization 2018). In 2018, C-PTSD was added to ICD-11 as a distinct entity from PTSD; the purpose was to more accurately reflect the pervasive psychological impact inflicted by complex trauma (Brewin et al. 2017). Although DSM-5 (American Psychiatric Association 2013) does not include C-PTSD, a new childhood diagnosis with irritabilty as a core symptom, disruptive mood dysregulation disorder (DMDD) was added. Notably, this diagnosis had far less empirical support than C-PTSD and does not mention trauma (Böttche et al. 2018; Roy et al. 2014).

In DSM-5, PTSD criteria have been added for children ages 6 years and younger, and the criteria for PTSD include new notes about diagnosing this disorder in adolescents and children older than 6 years. Although these additions represent an improvement, DSM-5 still fails to address the omission of the more chronic and pervasive traumatic experiences that affect many disenfranchised youth. In the case illustration, Ava could meet DSM-5 criterion A for PTSD because she directly witnessed physical violence toward her caregiver, yet David could not because his traumatic exposures occurred in his community. If DSM-5 criteria are dutifully applied, David's psychological symptoms stemming from his exposure to community violence, which occurred over time and at a critical developmental stage, may be misinterpreted. Additionally, in working with children, mental health professionals can find it challenging to elicit symptoms described in criteria B (reexperiencing), C (avoidance), and D (negative thoughts and feelings). Limitations in children's language may result in difficulties describing emotions or intrusive thoughts, and avoidance symptoms may be more nuanced because children have little choice in their surroundings. Criterion E, the remaining, most readily identified symptom category in working with children, is characterized by hypervigilance and irritability and therefore overlaps with DMDD and oppositional defiant disorder (ODD).

In DSM-5, criterion A for ODD includes "a pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least 6 months" (p. 462); again, there is no mention of trauma. The ODD diagnosis is liberally applied to chronically traumatized children, whereas, as noted earlier, the diagnosis of C-PTSD has yet to be included in DSM-5. DSM-5's approach is curious, given that the environmental risk factors for ODD mirror commonly occurring and widely understood sources of child trauma: familial psychopathology, maltreatment, neglect, caregiver disharmony, parental maladaptive behavior, exposure to interparental violence, parental alcoholism, divorce, and poverty (Boden et al. 2010; Lynskey et al. 1994; Marmorstein et al. 2009; Odgers et al. 2007).

Exposure to neighborhood violence has been linked to the development of several mental health disorders, including, by strength of association, PTSD, externalizing behaviors, and internalizing disorders such as depression and anxiety. The correlation between community violence exposure and mental health outcomes exists for both direct and indirect exposure and is strongest for victimization (Fowler et al. 2009). When a

clinician sees a child in the office who, like David, presents with externalizing symptoms, assessing the child only for direct trauma or violence in the home may miss the presence and impact of neighborhood trauma. Families like David's often face significant barriers to accessing mental health care. It is lamentable that even when families overcome these barriers, precious opportunities for intervention during critical developmental periods are often squandered by the mental health care system. When mental health professionals do not take into account complex and structural traumas, they might misdiagnose children, which can have numerous, substantial implications: failure to receive the appropriate mental health treatments; decreased likelihood of appropriate caregiver understanding and community support; unwarranted exposure to mood stabilizer and antipsychotic medication side effects; and increased likelihood of negative social outcomes, including school-related problems and incarceration.

When mental health professionals do not recognize the detrimental effects of complex and structural trauma, they may miss the resulting symptoms altogether or misattribute them to diagnoses of ADHD, ODD, DMDD, conduct disorder (CD), or bipolar spectrum disorder. Notably, whereas Black and Latinx males are approximately 40% less likely than white males to be diagnosed with ADHD (Baglivio et al. 2017), Black males are 40% more likely and Black females are 54% more likely than their white counterparts to be diagnosed with CD (Bird et al. 2001; Braun et al. 2008). Although the reasons for these differences are unclear, in diagnoses with significant comorbidity and symptom overlap, children who are disproportionately exposed to structural traumas in the larger society are disproportionately given more stigmatizing diagnoses by mental health professionals.

Moreover, widespread professional failure to recognize the contributions of structural racism to the presentation and diagnoses of youth has implications both within and beyond the clinic. When Black children present with behavioral and emotional dysregulation, often in the form of disruptive behaviors, they are more likely to be given a CD diagnosis and referred to the juvenile justice system than are their white counterparts, who are often diagnosed, appropriately in most cases, with mood disorders or trauma and referred to mental health treatment (Bean et al. 2006; Bird et al. 2001; Burris et al. 2011). The clinical approach to these behaviors in Black children echoes the larger societal narrative of their inherent "badness." All too often, they are feared and treated punitively rather than protected and treated compassionately; after all, the reasoning goes, if they are inherently bad and meet the criteria for ODD or DMDD, there is no need to conduct a thorough exploration of potential traumatic etiologies. Far too often, on contact with the mental health system, these children and families do not have their race-based trauma or its impact on them even acknowledged, let alone addressed. Without this acknowledgment, mental health professionals can perpetuate and inflict further trauma.

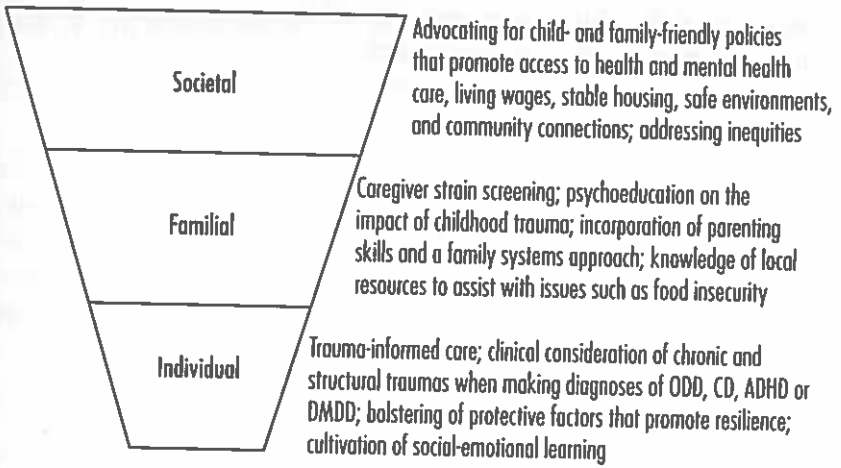

FIGURE 13–3. Potential interventions for childhood trauma.
Abbreviations. CD=conduct disorder; DMDD=disruptive mood dysregulation disorder; ODD=oppositional defiant disorder.
To view this figure in color, see Plate 4 in Color Gallery.

Interventions

Armed with knowledge of the structural determinants of health that disproportionately impact traumatized children and families, mental health clinicians are uniquely positioned not only to identify, diagnose, and treat trauma and complex trauma but also to advocate for children, patients, and communities. Interventions to address the issue of childhood trauma must occur at the societal, familial, and individual levels, as described in Figure 13–3. Of note, the pyramid is inverted as a visual representation of the child and family, who have relatively less power, bearing the weight of the upstream societal problems.

Progress in treating childhood trauma will require a significant paradigm shift within the mental health field, especially in the field of psychiatry—to view youth who need help not merely as biological and genetic entities with internal and external manifestations of psychopathology but as young human beings whose thoughts, feelings, and behaviors must be assessed and addressed in the context of where they live, learn, and play. Although psychosocial interventions to promote resilience and mental health interventions to address illness certainly have their place, true care for so-

ciety's most vulnerable citizens demands structural shifts that prioritize children's safety, security, and opportunity.

Conclusion

"Denial, repression, and dissociation operate on a social as well as an individual level" (Herman 1992, p. 2). For clinicians, acknowledging the rampant existence of chronic childhood trauma is difficult. Acknowledging our role as citizens and clinician bystanders is even harder. A myopic focus on resilience is self-serving in that it places the onus for recovery on the traumatized, frequently underresourced child and family—and requires no change, discomfort, or hardship from the mental health field or society at large. History is repeating itself. Before PTSD was included in DSM-III, the trauma of rape victims and war veterans, for example, was not acknowledged in their diagnoses. Now, despite diagnostic changes to PTSD in DSM-5, we still give symptomatic, traumatized children diagnoses that do not acknowledge their trauma and, in the case of ODD and CD, diagnoses that are stigmatizing and curtail opportunities. Aided and abetted by the field of psychiatry, our broader society has, quite effectively, achieved a comfortable distance from the issue of children's chronic victimization. However, comfort and distance are luxuries that these children do not have. One could postulate that a problem of such reach and magnitude is not being readily acknowledged both because of the troubling reality it tells about our society and because of the status, or lack thereof, of its victims. Children have little power, and children who can be othered because of their race, class, or both have even less. A social justice framework demands that we, as knowledgeable mental health professionals and as privileged members of the larger society are impartial bystanders no more.

Questions for Self-Reflection

1. Which types of traumas do I tend to acknowledge or empathize with, and which types of traumas do I tend to overlook?
2. How might social injustice contribute to a PTSD diagnosis? How might social injustice contribute to a complex PTSD diagnosis?
3. As a clinician, administrator, or citizen, have I served in the role of bystander to the interpersonal trauma of children? To the structural trauma of children?

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