Received 08/03/16
Revised 10/03/17
Accepted 12/28/17
DOI: 10.1002/jmcd.12113

African American Historical Trauma: Creating an Inclusive Measure

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Research indicates that race-based discrimination is detrimental to the mental and physical health of African Americans. The authors sought preliminary evidence of internal consistency and factorial validity of an African American Historical Trauma questionnaire administered to 400 participants. Reliability and exploratory factor analyses resulted in 30 items with Cronbach's $\alpha = .91$. Correlations between factors ranged from .32 to .52. These findings provide a step toward an empirical understanding of African American historical trauma.

Keywords: historical trauma, racism, African Americans, discrimination, intergenerational trauma

La investigación indica que la discriminación por motivos de raza es perjudicial para la salud mental y física de las personas afroamericanas. Los autores buscaron pruebas preliminares de consistencia interna y validez factorial de un cuestionario sobre Trauma Histórico Afroamericano administrado a 400 participantes. El análisis de fiabilidad y el análisis factorial exploratorio dieron como resultado 30 ítems con un coeficiente de alfa de Cronbach = .91. Las correlaciones entre los factores variaron de .32 a .52. Estos hallazgos proporcionan un paso adelante hacia la comprensión empírica del trauma histórico de las personas afroamericanas.

Palabras clave: trauma histórico, racismo, personas afroamericanas, discriminación, trauma intergeneracional

Over the last several decades, the classifications and implications of trauma have continued to be thoroughly researched and modified, from the recognition of posttraumatic stress disorder (PTSD) in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*; American Psychiatric Association [APA], 1980) to the inclusion of trauma- and stressor-related disorders in the fifth edition of the *DSM* (*DSM-5*; APA, 2013). The definition of trauma has broadened to include any experience that threatens one's physical and psychological well-being, including ability to cope (Bonanno, Westphal, & Mancini, 2012; Briere, & Scott, 2006; Giller, 1999).

Although this construct of trauma is more inclusive, it does not appear to specifically include stressful events resulting from repeated

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race-based discrimination that is either experienced or witnessed. The *DSM-5* only considers race-based discrimination as traumatic when the person meets criteria for PTSD because of a specific race-based traumatic incident (Carter, 2007; M. T. Williams, 2013). Unfortunately, PTSD does not fully embody the symptoms that can result from the long-lasting effects of trauma stemming from slavery, racism, and discrimination, in addition to the cultural, historical, and intergenerational trauma that African Americans have had to endure (Franklin-Jackson & Carter, 2007; D. R. Williams & Mohammed, 2009). The concept of historical trauma is a more complete characterization of the unique consequences of the aforementioned types of trauma.

historical trauma and african americans

Conceptualized in the 1980s, historical trauma is the "cumulative emotional and psychological wounding over a lifespan and across generations, emanating from massive group experiences" (Brave Heart, 2003, p. 7). Brown (2008) confirmed that "a person whose culture of origin has a history of oppression or genocide may be living with effects of trauma exposure that occurred not to the individual but to their forebearers" (p. 167). Thus, trauma can be passed down through generations, resulting in high rates of child and domestic violence, alcoholism, increased symptoms of mood and trauma-related disorders, a variety of health disparities, and countless other physiological and psychological problems (Brave Heart & DeBruyn, 1998; Mohatt, Thompson, Thai, & Tebes, 2014).

Historical trauma has previously been used to describe the experiences of descendants of Holocaust survivors and Native Americans, whose communities share in a collective grief of a massive group trauma that has been passed down generations (Fast & Collin-Vezina, 2010; Hartmann & Gone, 2016; Whitbeck, Adams, Hoyt, & Chen, 2004). Both groups are victims of genocide and displacement, and their cultures have been disrupted for multiple reasons, including involuntary social changes, treacherous living conditions, and forced parent–child separation (Brave Heart & DeBruyn, 1998). Thus, considering their multigenerational history of slavery, race-based segregation, racism, prejudice, and discrimination, African Americans should also meet criteria for historical trauma.

A specific definition for African American historical trauma is "the collective spiritual, psychological, emotional, and cognitive distress perpetuated intergenerationally deriving from multiple denigrating experiences originating with slavery and continuing with pattern forms of racism and discrimination to the present day" (Hampton, Gullotta, & Crowel, 2010, p. 32). Although slavery legally ended over a century ago, its severity implanted a psychological and social shock in the minds of many African

Americans (Akbar, 1996). African Americans have endured immeasurable race-related traumatic events on a national scale, such as the Rosewood massacre of 1923, the government-sponsored Tuskegee Syphilis Experiment from 1932 to 1972, the Los Angeles riots of 1992, and more recently, overrepresentation in the school-to-prison pipeline and incidents of police brutality (Howard, 2016; Lynch, 2016). In a society that understands grief when the deceased is of close relation, there is little recognition and acceptance for the traumatic sufferings of African Americans and their need to mourn their history (Brave Heart & DeBryun, 1998). Generations later, African Americans continue to carry the mental and social scars of their history, including feelings of inferiority, powerlessness, and problems with self-identity (Carter, 2007).

factors of historical trauma

Sotero (2006) described three phases of historical trauma. The first phase involves the dominant racial group executing mass trauma on nongroup members, resulting in societal, economic, and cultural devastation of that minority group. The second phase includes the minority population's psychological response to the trauma (e.g., depression, PTSD, maladaptive behaviors) that can also result in physiological (e.g., malnutrition) and social (e.g., reduced parenting skills) complications. The third phase occurs when successive generations are negatively affected by the original trauma due to psychological and environmental variables, such as social and legal discrimination (Brown-Rice, 2014; Sotero, 2006). Researchers of historical trauma have worked to understand the association between past and present experiences and its negative impact on groups at the individual, family, and social/community levels (Campbell & Evans-Campbell, 2011; Czyzewski, 2011; Fast & Collin-Vézina, 2010).

individual, familial, and social consequences of historical trauma

Research has shown there are negative physical and mental, acute and chronic consequences of racism for individuals, families, and communities (Dole et al., 2004; Feagin & McKinney, 2003; Sellers & Shelton; 2003). Historical trauma can have biological factors similar to those of other trauma-based disorders, such as PTSD. Past traumatic experiences can reduce the nervous system's ability to distinguish between genuine and perceived threats, resulting in a persistent state of hyperarousal or hypervigilance similar to that observed in PTSD (McEwen, 2000; W. H. Smith, 2010). The chronic stress disrupts the body's natural ability to maintain a state of homeostasis, resulting in allostatic load and an inability to acclimate to reoccurring stressors (McEwen, 2000). This can result in disease and illness of the immune, cardiovascular, and metabolic systems (Sotero, 2006).

Race is the primary biological and/or genetic factor that contributes to historical trauma. African Americans directly and indirectly experience, witness, or perceive threats due to real or misinterpreted racism (W. H. Smith, 2010). Research has revealed that later generations of groups with evidence of historical trauma (e.g., Holocaust survivors) are at a greater risk of developing mental health symptoms (Mohatt et al., 2014). Furthermore, epidemiological studies have demonstrated that this vulnerability may be due to epigenetic factors (i.e., molecules, neurons, cells, and genes; Kaminsky, 2015; Shulevitz, 2014). Per Sotero (2006), multiple studies have shown that trauma can negatively impact genetic function and expression, which can be passed down to subsequent generations. Later generations must also contend with race-based health disparities, such as reduced access to health care, further increasing rates of health concerns (Estrada, 2009). There is an increased risk of health problems with any trauma, but trauma that is purposeful can result in changes to one's cognitive schema regarding self and the world (Sotero, 2006). In addition to the aforementioned effects on one's biological systems, these experiences and the memories that remain have a long-term impact on African Americans' cognitive schema of themselves and their social environments, and changes their ability to cope with future experiences (W. H. Smith, 2010).

The psychological outcomes of historical trauma distinguish it from other forms of trauma (Sotero, 2006). The extent to which an individual is susceptible to the outcomes of historical trauma is partly impacted by his or her level of identity development, exposure to racism, and knowledge of subjugation and denigrating experiences by previous generations (Hampton et al., 2010). According to Cross's (1978) model of Nigresence, African American identity development occurs over four stages (i.e., preencounter, encounter, immersion–emersion, internalization), each of which can trigger a sense of historical trauma. Thus, just being African American imparts knowledge of the discriminatory, racist, and denigrating experiences endured, which is traumatic enough to warrant the development of coping skills to combat its effects (Brown, 2008; Sue, 2003; Thorton, 1997). In 2006, APA released a position statement titled "Resolution Against Racism and Racial Discrimination and Their Adverse Impacts on Mental Health" discussing the need for further research on the detrimental impact of racism on mental functioning, racism's role in mental health disparities, and its eventual elimination. Yet, racism continues to be a central issue that has physical and mental health consequences on the individual, family, and community.

In addition to the historical trauma endured psychologically, a breakdown of the traditional family structure has negatively affected the development of children through displacement, involuntary social change, treacherous living conditions, forced parent–child separation, disease, annihilation, and forced assimilation with the majority population (Brave Heart & DeBruyn, 1998; Kirmayer, Gone, & Moses, 2014; Sarche, Spicer, Farrell, & Fitzgerald,

2011). The loss of culture can also significantly impact the family, particularly when considering parental roles and people's level of a sense of control over themselves, their family, and their own lives (Kirmayer et al., 2014). Research has shown that historical trauma may result in strained parent–child relationships, inadequate parenting skills, impaired communication, increased stress in the home, and an intergenerational cycle of partner and child abuse and neglect (Campbell & Evans-Campbell, 2011; Fast & Collin-Vézina, 2010; Kirmayer et al., 2014). This can result in a collapsed family structure that is passed to subsequent generations, thereby increasing susceptibility to historical trauma while decreasing resiliency (Fast & Collin-Vézina, 2010). Lastly, African American parents must also teach their children to respond to, live in spite of, and survive racism. This difficult task, which can affect children's psychological well-being, is one that nonminority parents do not face (Gaskin, 2015).

For a community to be affected by historical trauma, most of the community must be negatively affected by the traumatic events (Hanna, Boyce, & Yang, 2016). Evidence has shown that historical trauma results in a breakdown of community structures, connectedness, and cultural norms (Schultz et al., 2016). Historical trauma continues to have long-term effects on the African American community, particularly when one considers the long and complex history of slavery and the subsequent disempowerment of African Americans (Sarche et al., 2011). The continued financial impact of slavery on African Americans is just one example of disempowerment that affects the individual, family, and community (Tolman, 2011).

Socioeconomic status plays a formative role in the structure of African American families and communities and increases the likelihood of experiencing additional traumas. A disproportionate number of African Americans have a lower income, making them more vulnerable to a variety of individual and community risk factors (e.g., increased mood symptoms). They are more likely to have several generations living under one roof (Miller, 2008; Newman & Newman, 2014), which may be beneficial in child rearing and socioemotional support (Taylor, Chatters, & Jackson, 1993). A multigenerational or extended family structure seems all-encompassing, but the father is often absent from the household. Although African American fathers are more likely to be financially and emotionally involved in parenting than fathers of other races, 71.4% of African American births were to unmarried women, with most of the children living separately from their fathers (Child Trends Databank, 2015a; Jones & Mosher, 2013). Children living with two married adults have fewer health, behavioral, and emotional problems when compared with children living in other family types (Child Trends Databank, 2015b).

measures of historical trauma

Most of the research on historical trauma has centered on Native Americans (Danzer, Rieger, Schubmehl, & Cort, 2016). Currently, there are two

well-known measures that assess historical trauma in Native Americans. The Historical Loss Scale (Whitbeck et al., 2004) is a 12-item Likert-type scale on which participants rate how frequently they experience a variety of losses. Items are specific to Native American occurrences and cover loss of language, culture, traditional spiritual ways, family ties, self-respect due to poor treatment, family members due to death, respect for elders, traditions, and trust in Caucasians, as well as losses due to alcoholism and government relocation ("Measuring the Burden," 2014). The Historical Loss Associated Symptoms Scale (Whitbeck et al., 2004) asks participants to rate the emotions they experience when thinking about losses measured on the Historical Loss Scale. Emotions covered include sadness, anger, anxiety, shame, rage, fear, mistrust, isolation, avoidance, loss of concentration, loss of sleep, discomfort around European Americans, and feelings that past losses are happening again ("Measuring the Burden," 2014).

Published measures of historical trauma specific to African Americans could not be found. To increase our understanding of the prevalence and impact of historical trauma in the African American community, objective methods of assessment must be developed. Thus, the African American Historical Trauma (AAHT) questionnaire was created. The goal of the measure is to investigate connections among personal experiences of discrimination, memories of the denigrating experiences suffered by previous generations, and current levels of historical trauma.

method

PARTICIPANTS

We recruited 400 participants from among various electronic mailing lists and a clinic in a large, metropolitan, northwestern city. Thirty-four of these participants who indicated their race as non–African American were dropped from the analysis, as well as an additional 24 who indicated that they had never been victims of racial prejudice or discrimination, leaving a total of 342 African American participants who identified as having suffered racial prejudice or discrimination. Of these, 209 (61.11%) were women, 133 (38.89%) were men, and the participants' mean age was 42.28 years ($SD = 10.34$). The vast majority of the sample (323, or 94.44%, of participants) identified as being American-born, whereas another 18 (5.26%) did not. Of those 18, five self-identified as European- or Canadian-born, four reported being born in South America or the Caribbean, and the remaining nine declined to report their nationality.

The largest plurality of participants (137, or 40.06%) reported being raised in the South. One hundred and three (30.12%) reported being raised in the Northeast. Fifty-five (16.08%) reported being raised in the Midwest. Thirty-four (9.94%) reported being raised in the West.

After data collection, we listwise-deleted 31 rows containing missing data, leaving a final pool of 311 participants for analysis.

MEASURES

Because of the lack of assessment tools specific to the African American experience, the AAHT questionnaire was created to determine the level of historical trauma currently endured by African Americans and the level of impact on their daily lives. The goal of the measure was to investigate the connections between discrimination and memories of the denigrating experiences suffered by previous generations with current level of historical trauma. Demographic variables included age, gender, level of current education attainment, and state in which respondents were raised as children at approximately ages 6 through 16. Additional background questions included victimization of racial/discriminatory experience and approximate occurrences. Information was also gathered on receipt of therapeutic and/or psychiatric services.

Forty-two items were initially generated for the AAHT questionnaire and were designed to tap a broad range of affective, cognitive, and attitudinal indicators of historical trauma. Items were rated on a 5-point Likert-type scale, anchored from 1 (typically *never*) to 5 (typically *always*). Seven of these items were reverse-scored to control for participant response set. Participants completed both the 42-item AAHT questionnaire and a brief, one-page demographic questionnaire.

PROCEDURE

Institutional review board certification was received on a consent form for research investigation involving human subjects for a research project through Argosy University, Washington, DC. Male and female participants ages 18 years and older were recruited via electronic mailing lists of various African American subgroups. Individuals indicating a race other than African American were omitted from the study. Participants signed an informed consent form acknowledging that some of the questions may cause discomfort, then anonymously completed a four-part, online survey using Survey Monkey. We used SPSS (Version 18) to conduct statistical analyses.

results

RELIABILITY

Preliminary reliability analysis resulted in the elimination of 12 items with unacceptably low corrected item-total correlations ($rs < .32$). The remaining 30 items exhibited generally adequate levels of internal consistency, with a Cronbach's α of .91 and a mean corrected item-total correlation of .49.

EXPLORATORY FACTOR ANALYSIS

We conducted an exploratory factor analysis on the remaining 30 items to examine the pattern of correlations underlying the items on the AAHT questionnaire, and to ensure that items covaried in a sensible and explainable

way. The assumption of multivariate normality was severely violated, so factors were extracted using the principal-axis factoring method, in accordance with the recommendations of Fabrigar, Wegener, MacCallum, and Strahan (1999). The extracted factors were then rotated using the direct oblimin method ($\delta = 0$). The direct oblimin method is a member of a wider family of oblique rotation methods, which allow rotated factors to be correlated, without requiring that they do so, in contrast with orthogonal methods (such as varimax), which constrain factor correlations to very nearly 0. As there was no sound, theoretical reason to expect the factors comprising the construct of African American historical trauma to be uncorrelated, we preferred here the use of an oblique rotation. There was considerable discrepancy between the indicators of the number of factors to retain, probably owing to the greater difficulty in separating obliquely rotated factors, as noted by Cho, Li, and Bandalos (2006). Cattell's (1983) scree test suggested a relatively small factor structure of perhaps two to four factors. On the other hand, both Kaiser's (1960) little jiffy or K1 criterion, which advises retaining as factors all eigenvectors associated with eigenvalues greater than 1, and Horn's (1965) parallel analysis, which allows generation of confidence intervals for extracted eigenvalues by comparing them to a user-specified number (in this case, 5,000) of randomly generated permutations of the underlying raw data, recommended retention of six factors. Because of the large-scale uncertainty surrounding how well factor retention criteria typically developed for use with principal components analysis extrapolate to common factor analysis, especially in cases in which oblique rotations are applied, a large range of factor structures from two to seven factors were examined for general fitness and interpretability (Bandalos & Boehm-Kaufman, 2009; Cortina, 2002; Worthington & Whittaker, 2006). The considerations used to determine a best-fitting factor structure were both theoretical and empirical. Specifically, the preference was for a factor structure that (a) accounted for the largest amount of variance possible while (b) producing theoretically interpretable and coherent factors and (c) was relatively stable, with all factors containing at least three items and at least two factor loadings at $\geq|.50|$. Ultimately, a four-factor structure accounting for a total of 40.55% of the variance in the measure emerged as simultaneously the most stable and most explanatory solution.

The pattern matrix of factor loadings and corrected item-total correlations by item are reproduced in Table 1; loadings of less than |.32| are not reported. Item communalities—the proportion of variance accounted for in an item by the factor structure (equal to the sum of the item's squared loadings across all factors)—are also reported in Table 1. Correlations between factors are reported on Table 2. Factor 1 (eight items, 27.80% of variance accounted for) was identified as a negative affect and resentment factor, with its constituent items related to negative emotional states such as anger, frustration, or annoyance, as well as resentful rumination on others' perceptions of African Americans. Factor 2 (12 items, 5.40% of the

TABLE 1

Factor Loadings, Corrected Item–Total Correlations (CITCs), and Communalities by Item

Factor and Item	Loading	CITC	h^2
Factor 1: Negative Affect and Resentment			
How often do you feel angry when African Americans say racism doesn't exist?	.81	.61	.68
How often do you feel angry when non-African Americans say racism doesn't exist?	.77	.62	.67
How often do you feel annoyed when people belittle African Americans' contributions?	.55	.63	.53
How often do you feel discouraged when African Americans are discriminated against by other African Americans?	.46	.54	.38
How often do you think about stereotypes/myths that elevate Whites?[a]	.37	.58	.45
How often do you feel frustrated when other African Americans don't feel that African Americans suffered racism?	.37	.55	.40
How often do you think about stereotypes/myths that belittle African Americans?[a]	.35	.61	.48
How often do you think about how history/current events depict African Americans poorly?[a]	.35	.55	.49
Factor 2: Concern for Group Integrity			
How often do you think about breakdown of African American families?	.62	.42	.40
How often do you think about losses African Americans suffered due to addiction?	.60	.35	.35
How often do you think about African American children's disregard for hardship of ancestors?	.60	.37	.38
How often do you think about African Americans' diminished self-respect due to institutional racism?	.56	.49	.45
How often do you think about how history/current events depict African Americans poorly?[a]	.52	.55	.49
How often do you think about African Americans' distrust of each other due to slavery/racism?	.43	.56	.40
How often do you think about February being the only month African American children learn heritage?	.43	.45	.29
How often do you think about the difficulty of African Americans to trust Whites due to slavery?	.40	.55	.37
How often do you think about stereotypes/myths that belittle African Americans?[a]	.39	.61	.48
How often do you think about African Americans being stronger due to overcoming slavery?	.35	.51	.35
How often do you think about stereotypes/myths that elevate Whites?[a]	.33	.58	.45
How often do you think about African Americans being profiled (stopped, arrested, suspected, etc.)?	.32	.62	.42
Factor 3: In-Group Identification			
How often do you believe African Americans' experiences have enriched them in ways others lack?	.59	.43	.39
How often do you feel connected to other African Americans when learning African American history?	.49	.41	.32
How often do you feel strong emotions when watching movies depicting slavery?	.48	.42	.30
How often do you feel your heart race when injustice occurs toward African Americans?	.43	.52	.36
How often do you believe the African American race is superior to others?	.43	.32	.23
How often do you believe African Americans must take more responsibility for the future of the African American race?	.38	.36	.23

(Continued)

TABLE 1 (*Continued*)

Factor Loadings, Corrected Item–Total Correlations (CITCs), and Communalities by Item

Factor and Item	Loading	CITC	h^2
Factor 4: Perception of Discrimination			
How often do you believe life is an uphill battle?	.83	.52	.64
How often do you believe you are constantly being held back?	.83	.46	.62
How often do you believe African Americans typically endure unnecessary hardship due to race?	.61	.51	.45
How often do you believe the world is against you just because you're African American?	.51	.47	.35
How often do you believe it is necessary to work twice as hard to succeed as an African American?	.49	.37	.26

Note. Factor loadings < |.32| are not reported.
[a]Cross-loading item.

variance accounted for) was identified as concern for group integrity and was made up of items relating to concern about the sociological conditions of African Americans and their historical and present treatment by others. Factor 3 (six items, 4.19% of the variance accounted for) was identified as an in-group identification factor describing items related to admiration for, faith in, and connectedness with African Americans as a group. Finally, Factor 4 (five items, 3.16% of the variance accounted for) was identified as perception of discrimination, consisting of items related to the belief that African Americans are routinely held back, oppressed, or treated unjustly because of their race.

Two items failed to load at ≥|.32| on any factor. One item related to feelings of discomfort toward European American people when thinking about African American history, and exhibited a corrected item-total correlation of .54 and a communality of .33. The other item related to belief that racism still exists today, and exhibited a corrected item-total correlation of .40 and a communality of .22. Additionally, three items cross-loaded (i.e., loaded on more than one factor at ≥|.32|), all of them loading simultaneously on Factors 1 and 2. Although factor solutions with nontrivial cross-loading are never ideal, as the desire is for items that discriminate effectively between distinct factors compromising the construct being measured, the solution

TABLE 2

Factor Correlation Matrix

Variable	1	2	3	4
Factor 1: Negative Affect and Resentment	—			
Factor 2: Concern for Group Integrity	.38	—		
Factor 3: In-Group Identification	.38	.35	—	
Factor 4: Perception of Discrimination	.50	.33	.32	—

presented here was nevertheless the cleanest and most coherent solution of all those tested.

Correlations between factors were generally only low to moderate. The six factor correlations ranged from .32 to .50 and reveal theoretically predictable relations between the different facets of the construct of African American historical trauma. They also suggest that the choice of oblique rotation was conceptually and empirically justified.

SCALE SCORE INTERACTIONS WITH DEMOGRAPHIC VARIABLES

Scale scores were calculated by averaging participants' responses to all items (sample-wide $M = 3.46$, $SD = 0.53$, $N = 311$, after listwise deletion of cases with missing data). To assess how African American historical trauma interacts with demographic variables, a series of seven analyses was conducted, including t tests (to examine its relation to sex and three mental health history indicators) and one-way analyses of variance (to examine its relation to highest level of education achieved, the census region in which participants were raised, and self-reported frequency of victimization by prejudice or racism). The Holm–Bonferroni correction to the experimentwise alpha (Holm, 1979) was used to control the familywise error rate to .05. However, of all these comparisons, no differences were statistically significant (ps > .05) with the exception of self-reported perceived frequency of victimization by prejudice or racism. Here, a one-way analysis of variance revealed significant differences in scale scores among the different levels of self-reported victimization, $F(3, 303) = 9.79$, $MSE = 0.26$, $p < .001$, $\eta^2 = .09$. Post hoc analysis using the Tukey–Kramer procedure for unequal sample sizes found that those who responded *always* to the item regarding being victimized exhibited significantly higher levels of trauma ($M = 4.47$, $SD = 0.71$) compared with those who reported *rarely* being victimized ($M = 3.20$, $SD = 0.49$) and those who reported being victimized only *on occasion* ($M = 3.49$, $SD = 0.51$), but similar levels of trauma to those who reported *often* being victimized ($M = 3.64$, $SD = 0.55$). Those who reported being victimized *often* or *on occasion*, in turn, exhibited significantly higher scale scores than those who reported *rarely* being victimized. The very small number of those reporting being *always* victimized ($n = 2$) likely contributed to its strange pattern of relations with the other levels of self-reported victimization.

discussion

The AAHT questionnaire fills a significant need in the literature on historical trauma as it pertains to African Americans who may currently suffer from traumatizing experiences of preceding generations and the individual, family, community, and societal effects of those experiences. Research regarding diagnosing historical trauma with a *DSM* code could not be found. Within the revised fourth edition of the *DSM*, historical trauma could have been included as a culture-bound syndrome or as a V-code if causing significant impairment

in the person's daily functioning (APA, 2000). The *DSM-5* nosology has a Cultural Formulation appendix, which houses Cultural Concepts of Distress, including how "cultural groups experience, understand, and communicate suffering, behavioral problems, or troubling thoughts and emotions" (APA, 2013, p. 758). Although some cultures (i.e., Latino, Haitian, Cambodian) are mentioned in the *DSM-5*'s Appendix Glossary of Cultural Concepts of Distress (APA, 2013), it is not reflective of historical trauma for any culture and it does not discuss etiology or concepts specific to African Americans. Thus, African American historical trauma may be best placed under Other Circumstances of Personal History V15.49 (Z91.49) Other Personal History of Psychological Trauma to describe the source of presenting psychiatric symptoms. Clinicians can add another *International Classification of Diseases, 10th Revision, Clinical Modification* (Centers for Disease Control and Prevention, 2018) code to describe the presenting symptoms (APA, 2013, p. 726).

There remains much to be learned regarding mental health treatment of African Americans and other ethnic minority groups (DeAngelis, 2015). Appropriate treatment may vary by the group of people exposed to the trauma (Korn, 2013). In general, traumatic experiences can lead to changes in neurobiology; maladaptive coping strategies; and impairments in social, emotional, and cognitive functioning, all of which can lead to severe and persistent problems in behavioral and physical health (Huang, Sharp, & Gunther, 2013). Most interventions for PTSD are based on cognitive theories, altering how an individual exposed to trauma perceives the traumatic experience. The ultimate goal is to reduce the individual's positive feedback loop that has been created around the traumatic experience.

Because it is a relatively new phenomenon, evidence-based treatments for historical trauma could not be found. To meet the growing demands of a changing population, it is imperative that all clinicians have an awareness of historical trauma, an understanding of how African Americans are affected, and cultural competence (Brown-Rice, 2014; Sue, Arredondo, & McDavis, 1992). Betancourt, Green, Carrillo, and Ananeh-Firempong (2003) defined a culturally competent health care system as "one that acknowledges and incorporates—at all levels—the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs" (p. 294).

Research has generally found therapies, particularly those that are evidence based, that are culturally aware or modified to fit the appropriate culture are more beneficial than those that are color blind (DeAngelis, 2015; Maxie, Arnold, & Stephenson, 2006; T. B. Smith, Rodriguez, & Bernal, 2011). Unfortunately, African Americans who seek therapy are rarely assessed for race-related concerns and experiences (Carter, 2007). Thus, a full understanding of African American clients' lives is not conceptualized. Furthermore, there is little research regarding how race-related issues should be addressed by European American psychologists (Danzer et al., 2016). However, it should

be noted that further harm may be caused by discussing racial issues if they appear to be irrelevant to the presenting problem. Brown (2008) suggested that clinicians should engage in therapeutic work "with an enhanced awareness of the possibility of the impact of historical trauma on functioning" (p. 167).

Ultimately, clinicians should strive to be culturally competent as a means of maintaining ethical behavior toward their clients. Possessing cultural competence is a means of maintaining ethical behavior because it specifically pertains to Principle A: Beneficence and Nonmaleficence of the American Psychological Association's (2016) *Ethical Principles of Psychologists and Code of Conduct*. Principle A states that psychologists should benefit their clients and seek no harm (American Psychological Association, 2016). However, clinicians who lack cultural competence may be prone to treating all clients in the same manner without considering their cultural, racial, gender, or ethnic backgrounds. This may prove to be a hindrance or even a disservice to clients' psychological well-being.

limitations and implications for future research

The participants-to-item ratio employed in the present study (311 participants, after listwise deletion of cases with missing data, to 33 items, or roughly 9.4:1.0) is considered suboptimal for exploratory factor analysis. Costello and Osborne (2009) estimated empirically that the misspecification rate for an exploratory factor analysis with a 10:1 participant-to-item ratio is approximately 40%, well above the conventional Type I error rate (α) of 5%. For this reason, the factor analysis conducted in this article was not used as a basis for jettisoning any items from the AAHT questionnaire, given the possibility that future analyses will fail to replicate perfectly the results discovered here. Rather, it was intended to provide a tentative first step toward an empirical understanding of the nature and structure of African American historical trauma.

Our study employed a very highly educated and substantially older-than-average sample of participants; thus, future studies should also attempt to extrapolate the present findings to more representative samples of participants. Furthermore, in terms of response rates to the various levels of victimization disclosed, due to the small sample size, it is likely that the current study does not have a representative sample on which to base conclusions. A larger sample size would allow for a confident conclusion to be made regarding the legitimacy of the findings. In general, although this study offers preliminary evidence that the AAHT questionnaire exhibits desirable levels of internal consistency and factorial validity, much work remains to be done to further establish its reliability and validity. Future studies should seek to replicate, to the extent possible, the factor structure observed in this study, or else to uncover a more accurate structure. Ideally, such studies will make use of the gold-standard 20:1

participant-to-item ratio recommended by Costello and Osborne (2009), which will require a minimum of 600 participants without missing data.

Additionally, future research should endeavor to determine the extent to which self-reported historical trauma (as measured by the AAHT questionnaire) associates with other traits and life outcomes in expected ways. We may, for instance, expect that AAHT questionnaire scores associate positively with measures of stress, isolation, and anxiety and negatively with measures of motivation, as well as that they predict relevant life outcomes, such as job satisfaction and performance, or potentially even suicidal ideation. Uncovering patterns of association between the AAHT questionnaire and other, more established measures of psychological traits and dispositions will provide further evidence of its validity as a psychometric measure, and confirming the extent to which it predicts life outcomes can likewise validate its use in community mental health clinics.

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