

PTSD in Children and Adolescents: The Aftermath of Parental Incarceration among Children  
and Adolescents within the African-American Community

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### **Introduction**

Much of the literature on posttraumatic stress disorder (PTSD) focuses on children and adolescents that have been exposed to a one-time traumatic event (e.g. school shooting, natural disaster), neglecting chronic traumatization that is characterized by exposure to traumatic stressors within the same overall context over a period of time ranging from months to years (Anderson, 2005). However, most of the children between the ages of 5-18 have been exposed to multiple instances of trauma within their homes and communities such as domestic violence, shootings, physical injury, physical abuse/sexual abuse and parental incarceration. Due to the complexity and duration of the trauma, these children are vulnerable to psychopathology. PTSD is the result of chronic exposure and more times than not many of these children are left untreated. As a result, the child's overall functioning and development is compromised.

Although there are several instances of trauma mentioned above, parental incarceration will be the focus of this paper as the researcher is interested in the evolution of PTSD in children who has one or both parents incarcerated. In spite of catastrophes that turn their world upside down, most children will have a normal reaction to the stress that resolves over time. However, some children will be unable to cope with the trauma; their coping skills may be overwhelmed, the mind and body may become extremely hyper-reactive due to chronic stress and the child may ultimately develop posttraumatic stress disorder (Grogan, 2011).

### **PTSD History**

Figley (1985) suggests that while scholars have found references to traumatic stress and related psychological reactions perhaps as early as 2100 B.C. (Ben-Ezra, 2004), the Western study of traumatic stress began in the late 19th century (Goodman, 2011). The Western study of

traumatic stress began in Europe when English surgeon John Eric Erichsen published a report about the victims of railway accidents (Weisaeth, 2002). Halpern & Tramontin, 2007; Weisaeth, 2002 reports that Erichsen (1866) observed that despite having no physical injuries, the victims exhibited symptoms including loss of memory, difficulty concentrating, anxiety, and nightmares. Although Erichsen incorrectly attributed these symptoms to an organic rather than a psychological cause, his work laid the foundation for the study of traumatic stress (Goodman, 2011). Trimble, 1981 reports that in 1883, surgeon Herbert Page published a rebuttal to Erichsen's conclusion, positing that the symptoms were of a psychological nature and terming this condition "nervous shock" (Goodman, 2011).

Halpern & Tramontin, 2007 reports that also in the late 1800s, French neurologist Jean-Martin Charcot began exploring hysteria, which at the time was used to connote patients' unexplained physical or emotional symptoms (Goodman, 2011). Charcot theorized that the symptoms were the result of the emotional impact of a traumatic incident. After studying with Charcot, physician Pierre Janet and psychiatrist Sigmund Freud and their colleagues expanded Charcot's theories of hysteria (Goodman, 2011). Hysteria is a once popular name for a mental disorder characterized by emotional outbursts, fainting, heightened, suggestibility, and conversion symptoms such as paralysis, nowadays generally not viewed as a coherent syndrome but rather as aspects of conversion disorder, dissociative disorders, and histrionic personality disorder (Colman, pg 360). According to Trimble, 1981, Janet believed that hysteria developed because of mental weakness, while Freud, who was working in collaboration with Viennese psychoanalyst Josef Breuer, believed that hysteria resulted from repressed memories of traumatic

events. It was not long thereafter when the field of traumatic stress evolved and became known as “traumatic neurosis” (Goodman, 2011).

It was through the study of the impact on which World War I and World War II had upon the psychological well-being of their veterans that the development of traumatic neurosis came into existence. Furthermore, the work of Abram Kardiner, an American physician served as the framework from which the description of posttraumatic stress disorder evolved. The field of trauma was further developed by the work of Charles Figley (1967) and Robert Lifton (1978). Traumatic stress continued to receive attention over the years through the Vietnam veterans and the women’s movement between the 1960’s and 1970’s. It was through these movements and other extraneous factors that signified the significance of and promoted an awareness of traumatic stress, which eventually lead to the diagnostic impression of posttraumatic stress disorder (PTSD) in the Diagnostic and Statistical Manual (DSM) (Goodman, 2011).

Wethington et al., 2008 describes PTSD as a specific type of anxiety disorder that can occur after a horrifying traumatic event. The characteristics of PTSD are re-experiencing the trauma through vivid memories, flashbacks, or nightmares, avoiding anything related to the trauma, numbing of emotions (dissociation) and hyperarousal, such as constant scanning for threats and irritability (Grogan, et al. 2011). Although PTSD has been widely reported in children and adolescents, the DSM-IV criteria were developed from and field tested on adult samples- no individuals 15 years of age or younger were included (Kirkpatrick et al. 1998; Scheeringa, et al. 2010). Until recently, there were few data available about the

symptomatology of children less than 18 years old and almost no data on the symptomatology of children less than 12 years who have been traumatized (Scheeringa, et al. 2010).

Morrison & Anders (2006) suggest that children can express PTSD symptomatology differently than adults, depending on the developmental level of the child. Young children or children with developmental delays are more likely to develop PTSD symptoms. He or she may have regressive behaviors, such as thumb sucking, bedwetting, immature speech, and muteness. Sleep disturbances such as frightening dreams, with no specific content other than monsters or sheer terror, may occur. Insomnia or early wakening may also become a difficult problem. However, children usually do not experience flashbacks (Grogan & Murphy, 2011).

According to APA (2000) the child usually doesn't feel they are reliving the past, but their play may also be affected with repetitive, grim reenactment of the trauma through the use of dolls or other forms of trauma-play (Grogan & Murphy, 2011). The child may be extremely alert to their environment, manifested with a rapid heart rate and a brisk startle response. Irritability, anger, and feelings of detachment are common, as well, along with other signs of mental distress. Concentration is impaired, and memory of the event may be clouded. Somatization can occur with increased headaches and stomachaches. He or she may regress behaviorally, or engage in risk-taking behavior. Substance abuse and other psychiatric disorders such as depression frequently occur and should be specifically address (Morrison & Anders, 2006). APA (2000) suggest the child may also have a sense of a foreshortened future and not expect to live to adulthood (Grogan & Murphy, 2011).

### **Literature Review**

The consequences of incarceration on children have received least attention in academic research, prison statistics, public policy, and media coverage. If we fail to consider potential impacts of incarceration on children, we risk neglecting at-risk youth, which may contribute to crime problems in the next generation. This is an important potential negative externality and unintended consequence of criminal justice policy, with parental incarceration imposing larger social costs than merely the prison cost (Johnson, 2007). Mass incarceration has had significant and long lasting impacts on American society, and particularly on communities of color. There is now a growing awareness that parents who go to prison do not suffer the consequences alone; the children of incarcerated parents often lose contact with their parent and visits are sometimes rare. Children of incarcerated parents are more likely to drop out of school, engage in delinquency, and subsequently be incarcerated themselves (Dalliere, 2007).

In 2007 there were 1.7 million children in America with a parent in prison, more than 70% of whom were children of color. Parents held in the nations prisons were 52% of state inmates and 63% of federal inmates reported having children under the age of 18, accounting for 2.3% of the U.S. resident population under age 18 (Glaze & Maruschak, 2010). Sending parents to jail or prison can exacerbate the adversity in children's lives and negatively affect their well-being independent of other factors. For example, the arrest and incarceration of parents can affect children's ability to form relationships with other people, precipitate feelings of grief and anxiety, and spawn symptoms of post-traumatic stress (The Sentencing Project, 2012).

Children of incarcerated parents live in a variety of circumstances. In state prison, parents reported living previously in homes of two parent families (18%) in the month before arrest, where the non-incarcerated parent can assume primary responsibility for the children.

Many children, especially in cases of women's incarceration, were in single parent homes (42%) and are then cared for by a grandparent or other relative; if not in foster care (Estrin & Mustin, 2003). Most of these children are young, low-income, and black or Hispanic. These children face significant uncertainty in nearly every aspect of their lives. Temporary, informal care arrangements may permanently separate children from their imprisoned parent, their family, and their friends. The expense and discomfort of prison visits may limit the contact between parent and child needed to maintain a relationship during incarceration. Dramatic reductions in parental income and resource-strained caregivers may lead to significant financial hardship (LaVigne, Daview, Brazzell, 2008). This hardship only aggravates the trauma and stigma that often accompany the incarceration of a parent. Children typically display short-term coping responses to deal with their loss, which can develop into long-term emotional and behavioral challenges, such as anxiety, depression, posttraumatic stress disorder, problems with school, delinquency, antisocial behaviors and drug use.

Children of incarcerated parents are also subject to significant uncertainty and instability, as many incarcerated parents repeatedly cycle in and out of prison. Moreover, while most children have a means of personal contact with a parent who is absent because of marital separation, the barriers to communication between a child and his or her incarcerated parent are tremendous and are complicated by the fact that caregivers may be reluctant to facilitate such contact (LaVigne, Daview, Brazzell, 2008). Half of the parents in state prison reported that they

had a family member who had been incarcerated. Mothers in state prison (58%) were more likely than fathers (49%) to report having a family member who had also been incarcerated. Parents in state prison most commonly reported a brother (34%), followed by a father (19%). Among mothers in state prison, 13% reported a sister and 8% reported a spouse. Six percent of fathers reported having a sister who had also been incarcerated; 2%, a spouse. Mothers in state prison were more likely than fathers to report homelessness, past physical or sexual abuse and medical and mental health problems (Estrin & Mustrin, 2003).

Seventy percent of young children with incarcerated mothers had emotional or psychological problems. The impact of incarceration on boys is that boys tend to exhibit externalizing behaviors while girls are more likely to display internalizing problems. Children exhibit internalizing problems, such as anxiety, withdrawal, hyper vigilance, depression, shame and guilt (Fergus & Zimmerman, 2005). They exhibit somatic problems such as eating disorders. And, perhaps most clearly young children exhibit externalizing behaviors such as anger, aggression, and hostility toward caregivers and siblings (Fergus & Zimmerman, 2005).

School age children of incarcerated parents exhibit school related problems and problems with peer relationships. Over 50% of children of incarcerated parents had school problems, such as poor grades or instances of aggression. In addition, 70% showed poor academic performance and 5% exhibited classroom behavior problems. Also among adolescents, suspension and dropout rates are higher for these children (The Sentencing Project, 2009). Additionally, recent research has shown that “children of incarcerated parents are six times more likely than their peers to become criminally involved” (Council on Crime & Justice, 2006).

In 2007, 92% of incarcerated parents were fathers and 8% were mothers. Since 1991, the number of incarcerated fathers has increased 76% while the number of incarcerated mothers increased 122%. Also during this time, one in 15 (6.7%) Black children, one in 42 (2.4%) Latino children, and one in 111 (0.9%) White children had an incarcerated parent (Sentencing Project, 2009). Twenty two percent of the children of state inmates and 16% of the children of federal inmates were age 4 or younger. For both state (53%) and federal (50%) inmates, about half their children were age 9 or younger. Children of female state inmates were slightly older than children reported by state inmates. More than half (53%) of the children reported by women were between age 10 and 17, compared to 47% of the children reported by men (Estrin & Mustin, 2003). These children are exposed to many risk factors and that the effects of parental incarceration on children are subject to a host of variables (Shader, n.d.).

Children and families of prisoners often share common characteristics and life circumstances. Many are poor. Some live in suburban and rural communities, but most live in inner city neighborhoods. Most are likely to experience addictions and domestic or community violence. Within that profile, however, there are many variations and continuum of risk. At one end of the continuum there are families in grave danger. On the other hand are those with adequate support systems that are coping fairly well. In between are large numbers of children and families that are barely managing under pressure (Estrin and Mustrin, 2003).

### *Risk Factors*

Research has helped us to understand the continuum of risk and has identified behaviors and characteristics that put youth and families at risk. Although parental incarceration is a risk factor, there are usually other risks factors involved. They often endure poverty, substandard

educational environments, violent neighborhoods, inadequate parenting or care and various forms of institutional and interpersonal racism. These risks create for cycles of failure which can ultimately lead to poor school/ work performance and cause a loss of respect. When we talk about risks factors, children often express feelings of hopelessness, loss and defeat and/or rage and resentment. The pursuit of numbness (via drugs/alcohol) that follows in the wake of trauma and hopelessness can lead to the criminal behaviors (Estrin & Mustrin, 2003). It is at this point where PTSD is experienced, but not realized. They become more vulnerable to other risk factors and trauma based incidents. Often times, their vulnerability leads to their own incarceration, resulting in transgenerational transmission of trauma.

Parental incarceration is associated with greater risk of anxiety and depression from adolescence into adulthood. Boys who have experienced the incarceration of a parent are more likely to exhibit a number of antisocial behaviors later in life, including criminal conviction, violence and drug-taking (Eddy & Poehlmann, 2010). However, we must understand that incarceration of a parent affect each child differently. Every child, family and circumstance is different. Some children are used to parents who were not around much before their incarceration (Estrin & Mustrin, 2003).

Some children have parents who are unpredictable because of mental illness or drugs/alcohol abuse. Other children's parents were actively involved with them before they went to jail or prison. Some children may have been traumatized by witnessing a violent arrest or may have a history or traumatizing experiences. Some children of prisoners may have no contact with their parents; while others may talk to their incarcerated parent often. There are several

factors that influence the intensity of a child's reaction to parental incarceration. These factors include, but are not limited to development, temperament, family dynamics and capacity, trauma, details of the crime and incarcerations and available supports (Estrin & Mustrin, 2003).

In some instances, the arrest itself is traumatic because the children may have been present when their parents were arrested, with no explanation provided to the child of what is happening. More distressing, children may be left by themselves after the arrest without a social support system and fall through the cracks (Sacks and Seidel, 1978; San Francisco Children of Incarcerated Parents Partnership, 2005; Williams, n.d.). There have been incidents where the parent is arrested and the child is left alone without systemic intervention from social services and the criminal justice system. In other cases, the child may be taken to a shelter, placed in foster care, or placed with relative (San Francisco Children of Incarcerated Parents Partnership, 2005; Williams, n.d.).

When a parent is incarcerated, it has lasting social, emotional, and developmental impacts that manifests in economic strain, socialization and attachment issues, stigmatization from peers and other adults, and traumatic stress. Unless these impacts are addressed, these children will be lost (Williams, n.d.). Investigations of the quality of early attachment experiences between caregivers and children on later mental health and emotional disturbance began with the work of John Bowlby (1969). Based on his ethological studies of the biological and survival needs of young primates and his observational studies of neglected children, Bowlby showed the critical importance of stable or secure attachment in humans as well as in primates. Such attachment,

based upon responsiveness and availability of the caretaker, offers protection from over-stimulation and threat, and teaches social interaction and other life skills, enables both physiological and psychological development and regulation, and provides the foundation for healthy development, a secure base from which the child explores the world and to which she or he returns for refuge when overwhelmed or threatened in some way (Pearlman & Courtois, 2005).

Children face many challenges during the incarceration of their parent. Major challenges faced by youth impacts their development. Jeremy Travis (2005) suggests that during early childhood years (2-6 years), children have a greater ability to perceive events around them, but have not yet developed the skills to process traumatic occurrences. Children at this age have not yet completely separated themselves from their parents, so they tend to perceive threats or harm to their parents or caregivers as directed at themselves. In the middle childhood years (7-10 years), when children are developing their social skills and a sense of independence, separation from a parent creates a sense of loss because a role model has been taken. The impact of incarceration on adolescents (11 to 18) is quite different. Adolescence is a time when young people test boundaries, begin to navigate the world of romantic relationships, exercise more independence, explore the adult world of work, and develop a sense of self. The arrest and incarceration of a parent can derail those transitions to adulthood. These children may question the authority of the incarcerated parent and doubt the parent's concern for them. They may take on new roles as parent figures to fill the void left by the incarcerated parent (Williams, n.d.).

*Response to Trauma*

When young children experience developmental obstacles, such as events that are negative, sudden, and/or out of control (Goodman & West-Olatunji, 2008; Wolfgang, et al., 2011), they can experience developmental challenges. These experiences are often complex and difficult to assess in those affected (Follette, Palm, & Pearson, 2006; Wolfgang, et al., 2011), as the effects are often multidimensional and impacting numerous domains of life (Follette & Vijay, 2009; Wolfgang, et al., 2011). When children cannot make sense of their sensory information due to chronic stress, they often exhibit acting out behaviors and distress (Johnson, 1997; Wolfgang et al., 2011). In the long-term, chronic stress or trauma can confuse understanding and make transitions in peer relationships difficult. Children's attempts to cope may present as increased aggression, enuresis, sleep disturbances, nightmares, extreme fear of the dark and of enclosed spaces, and intense hypervigilance in anticipation of another traumatic event (Lipovsky, n.d.; Macy, Macy, Gross, & Brighton, 2003; Wolfgang, et al., 2011).

Traumatic experiences often result in symptoms that appear at times unrelated to crisis (Johnson, 1997; Wolfgang, et al., 2011). During extreme stress the result can be faulty memory encoding and retrieval and over- or under-responsiveness to stress. The emotional responses acquired this way become highly resistant to extinction (Suomi & Levine, 1998; Wolfgang, et al., 2011). Social stressors during early childhood and basal cortisol levels (stress hormones) show a significant inverse relationship, thus the higher the stress the lower the child's ability to respond to social conditions (Nuru-Jeter et al., 2010; Wolfgang, et al., 2011). Chronic stress can interrupt higher cognitive functions such as planning, working memory, and mental flexibility, interrupting children's sense of sequence, context, and story (Johanson, 2006; Wilkerson, Johnson, & Johnson, 2008; Wolfgang, et al., 2011) around an event or experience. (Wolfgang et al. 2011)

After exposure to a traumatic life event, short term distress is almost universal. Children and adolescents vary in the nature of their responses to traumatic experiences. The reactions of individual youths may be influenced by their developmental level, ethnicity/cultural factors, previous trauma exposure, available resources, and preexisting child and family problems. However, nearly all children and adolescents express some kind of distress or behavioral change in the acute phase of recovery from a traumatic event. Not all short-term responses to trauma are problematic, and some behavior changes may reflect adaptive attempts to cope with a difficult or challenging experience (APA, 2008).

Many of the reactions displayed by children and adolescents who have been exposed to traumatic events are similar or identical to behaviors that mental health professionals see on a daily basis in their practice. These include: the development of new fears, separation anxiety (particularly in young children), sleep disturbance, nightmares, sadness, loss of interest in normal activities, reduced concentration, decline in schoolwork, anger, somatic complaints and irritability. Functioning in the family, peer group, or school may be impaired as a result of such symptoms. Therefore, when working with children who may display these types of reactions, the clinician must make a careful assessment of possible exposure to trauma (APA, 2008).

The majority of children and adolescents manifest resilience in the aftermath of traumatic experiences. This is especially true of single-incident exposure. Youths who have been exposed to multiple traumas, have a past history of anxiety problems, or have experienced family adversity are likely to be at higher risk of showing symptoms of posttraumatic stress. Despite exposure to traumatic events and experiencing short-term distress, most children and adolescents

return to their previous levels of functioning after several weeks or months and resume a normal developmental course. This resilience typically results in a reduction in both psychological distress and physiological arousal (APA, 2008).

Research has provided evidence about predictors of trauma recovery, although there are no perfect predictors. Recovery can be impeded by individual and family factors, the severity of ongoing life stressors, community stress, prior trauma exposure, psychiatric comorbidities, and ongoing safety concerns. Also, poverty and racism can make this recovery much more difficult. Caretakers are affected by children's exposure to trauma, and their responses affect children's reactions to trauma. On a positive note, individual, family, cultural, and community strengths can facilitate recovery and promote resilience. Social, community, and governmental support networks are critical for recovery, particularly when an entire community is affected, as when natural disasters occur (APA, 2008).

Although most return to baseline functioning, a substantial minority of children develop severe acute or ongoing psychological symptoms (including PTSD symptoms) that bother them, interfere with their daily functioning, and warrant clinical attention. Some of these reactions can be quite severe and chronic. Most children and adolescents with traumatic exposure or trauma-related psychological symptoms are not identified and consequently do not receive any help. Even those who are identified as in need of help frequently do not obtain any services. This is especially true for children from ethnic and racial minority groups and for recent immigrants, who have less access to mental health services. Even when children are seen for mental health services, their trauma exposure may not be known or addressed. For those children who do receive services, evidence-based treatment is not the norm (APA, 2008).

*Treatment Interventions*

Many of the treatments that traumatized children and adolescents receive have not been empirically studied. Although it is possible that some of these unexamined treatments could be helpful, it is also possible that some pose a risk for those who receive them. Despite the fact that diverse samples are included in many studies, there has been little work to understand the way in which culture affects the experience of trauma and the impact of treatment. Cognitive-behavioral therapy (CBT) techniques have been shown to be effective in treating children and adolescents who have persistent trauma reactions. CBT has been demonstrated to reduce serious trauma reactions, such as PTSD, other anxiety and depressive symptoms, and behavioral problems (APA, 2008).

Most evidence-based, trauma-focused treatments include opportunities for the child to review the trauma in a safe, secure environment under the guidance of a specially trained mental health professional. CBT and other trauma-focused techniques can help children with cognitive distortions related to the trauma, such as self-blame, develop more adaptive understanding and perceptions of the trauma. Like all clinical work, the quality of the therapeutic relationships among therapist, child, and parents/caretakers is the foundation for treatment of trauma. Safe, secure, and trusting therapeutic relationships support recovery processes and encourage children and parents/caretakers to do the hard work of dealing with the impact of traumatic exposure. Developing these trusting therapeutic relationships is particularly challenging but critical for children and parents/caretakers from ethnic and racial minority groups. This may stem in part from distrust associated with racism and poverty and also from mental health providers who may

not fully understand the child's and family's cultural context. Culturally responsive efforts to engage families in treatment can be effective in meeting those challenges (APA, 2008).

Although CBT approaches have been discussed, there are other evidenced based therapies (i.e. relational/cultural psychotherapy, sensorimotor psychotherapy, emotional-focused therapy) that have been used in treating trauma-based issues and have been effective in doing so. The CBT approach has been effective in treating trauma related issues, however; it along with other traditional models of therapy have not paid much attention to attachment as they put emphasis particularly on changing cognitions and behaviors. Failing to address the premise of attachment can be detrimental to the client's growth. Effective treatment of complex early attachment trauma must consist of addressing a conglomerate of things; such as cognitions, behaviors, relational skills, somatic functioning and spiritual concerns in order that the outcome of treatment is beneficial to the client.

### *Pharmacotherapy*

Psychotropic medications may be prescribed when needed to stabilize children, although the FDA has not approved any medications for children with PTSD, due to very few controlled studies. The effect of early and prolonged exposure to psychotropic medications on the developing brain has not been systematically studied. Research has shown that the developing brain is very sensitive to exogenous factors such as medications, but also to the endogenous stress response. Most medications will be prescribed "off-label", simply because there are so few approved by the FDA for the pediatric population (Gleason et al., 2007; Grogan & Murphy, 2011). Trauma focused psychotherapies should be first-line treatments for children with PTSD,

unless there are comorbid disorders or psychotherapy has not resolved the PTSD symptoms (Cohen et al., 2010; Grogan & Murphy, 2011).

Serotonin reuptake inhibitors (SSRIs) are usually the first-line drug in children with PTSD due to safety, efficacy, and tolerability. SSRIs are approved for use in adult PTSD, and have shown to be effective in all three symptom clusters unique to PTSD, including the re-experiencing, avoidance, and hyperarousal (Cooper, Carty, & Creamer, 2005; Grogan & Murphy, 2011). Fluoxetine (Prozac) is FDA-approved for children ages 8 and older with major depressive disorder (MDD). Escitalopram (Lexapro) and the tricyclic, doxepin (Sinequan), are FDA-approved for children ages 12 and older with MDD (NIMH, 2010; Grogan & Murphy, 2011). Research suggests the use of TF-CBT prior to implementation of psychotropic medication. In the event, that TF-CBT alone, does not prove beneficial, it is at that time that an SSRI can be added to enhance therapeutic outcome.

Children with comorbid disorders such as major depressive disorder, general anxiety disorder, or obsessive-compulsive disorder may benefit from adding an SSRI earlier in the treatment (Cohen et al., 2010; Grogan & Murphy, 2011). Tomiramate, carbamazepine, valproate, gabapentin, lamotrigine, and lithium are used in clinical practice, specifically with the kindling process; however, there are no randomized controlled clinical trials for children with PTSD to show efficacy. Alpha adrenergics such as clonidine, guanfacine, and prazosin have been used clinically for hyperarousal (Cooper et al., 2005; Grogan & Murphy, 2011).

Trazadone and nefazadone have shown efficacy in symptom relief in adults, and one open-label trial of adolescents treated with nefazadone showed clinical improvements in the

PTSD symptom clusters, anger, and aggression (Strawn et al., 2010; Grogan & Murphy, 2011). Benzodiazepines have not been found to relieve PTSD symptoms. Other medications such as atypical antipsychotics, nonSSRI antidepressants, and opiates have some evidence of efficacy in randomized controlled studies (Grogan & Murphy, 2011).

The Preschool Psychopharmacology Working Group (PPWG) of the American Academy of Child and Adolescent Psychiatry does not recommend psychopharmacologic intervention for preschoolers because of the lack of randomized controlled studies. Instead, psychotherapeutic interventions such as preschool CBT and CPP are recommended, with the statement that this may not reflect actual clinical practice (Gleason et al., 2007; Grogan & Murphy 2011).

#### *Implications for Research*

It is known that incarceration disproportionately affects families of color. In order to address the needs of children whose parents are incarcerated, criminal justice practices must recognize an offender's status as a parent. Policy makers, politicians and community organizers need to become sensitive to the needs to this focus group and promote funding opportunities (grants) for research and program development. Clinicians need to not only be more aware of the impact of incarceration on minority youth, but also be able to demonstrate cultural competence in their clinical approaches. Often times, PTSD goes unrealized in the school systems and is often mistaken for deliberate opposition and defiance. Therefore, educators and educational administrators need to be more aware of the issues affecting children and adolescents when making decisions and designing alternative programs.

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