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Racial and ethnocultural considerations in the treatment of combat related post-traumatic stress disorder with servicemembers and veterans of color

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Nada A. Michael
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Post Traumatic Stress
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ABSTRACT

Research from past wars has shown that veterans of color have significantly higher rates of PTSD than their white counterparts and a higher prevalence over their lifetime. Studies have sought to explain these differences and have found that while there are perhaps no racial genetic predispositions to the development of PTSD, ethnocultural factors which are often associated with race play a significant role in the etiology and treatment of PTSD and therefore are important to consider when working with this population.

This purpose of this study was to assess the extent to which clinicians who work with servicemembers and veterans of color of Operation Enduring Freedom and Operation Iraqi Freedom with a combat related PTSD diagnosis consider race and culture in their treatment. Twelve clinicians who work with servicemembers and veterans in a variety of practice settings were interviewed for this study. Findings indicate that clinicians feel that race and culture do impact PTSD development and treatment. They also indicate that while they factored ethnocultural considerations into treatment, they also expressed a lack of training in this topic. Ten of the twelve participants indicated strongly a need and desire for further training and discussion among their colleagues on how to more effectively work with this treatment population.

RACIAL AND ETHNOCULTURAL CONSIDERATIONS IN THE TREATMENT OF
COMBAT RELATED POST TRAUMATIC STRESS DISORDER WITH
SERVICEMEMBERS AND VETERANS OF COLOR

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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CHAPTER I

INTRODUCTION

Since the start of the Operation Enduring Freedom (OEF) in Afghanistan in 2001 and Operation Iraqi Freedom (OIF) in 2003 there have been reports of high rates of post traumatic stress disorder (PTSD) among returning soldiers (Miles, 2005; Tanielian & Jaycox, 2008). Over 1.6 million servicemembers have been deployed to Iraq and Afghanistan with reports showing that 19 to 21 percent of returning troops develop PTSD, depression or anxiety disorders with PTSD being more prevalent (Miles, 2005; Tanielian & Jaycox, 2008). Given the ongoing nature of these conflicts, social workers and other mental health professionals will undoubtedly experience an increase in working with the veteran population. Increased knowledge and sensitivity to the issues that veterans are facing and how to provide appropriate treatment will be a necessary area of development in the field of social work.

One phenomenon from past wars that has been the subject of much research has been the disparity in prevalence of PTSD in combat veterans of color. According to the National Vietnam Veterans Readjustment Study, one of the most comprehensive studies conducted on veteran populations, Blacks and Hispanics had significantly higher rates of PTSD. In 1990, at the time of the study, 20.6% of Black veterans and 27.9% of Hispanic veterans met criteria for PTSD compared to 13.7% of White veterans (Kulka et al., 1990). Some research studies have pointed out that while there are perhaps no racial genetic predispositions to the development of PTSD, there is no doubt that racial groups differ

and that socio-cultural factors which are often associated with race are important to consider when working with this population (Frueh, Gold, de Arellano & Brady, 1997; Frueh, Hamner, Bernat, Turner, Keane & Arana, 2002; Lewis-Fernandez, Turner, Marshall, Turse, Neria, & Dohrenwend, 2008). Furthermore, researchers acknowledged that psychopathology is often embedded in cultural frameworks and so the experience of PTSD may be experienced differently in different cultures (Marsella, Friedman, & Spain, 1992). Using demographic information from the Army in 2006, 37.1% of soldiers are people of color (Maxfield, 2006). This means a potential of 86,000 servicemembers and veterans of color will develop PTSD as a result of combat in the current conflict.

There has been a lack of research looking to understand what role racial and ethnocultural factors play in the treatment of PTSD with combat veterans and how clinicians incorporate cultural factors into the assessment and treatment of PTSD. This study was conducted in that vein. This qualitative study interviewed clinicians who currently treat OEF/OIF servicemembers and veterans with PTSD to explore from their perspective the impact of race and culture on PTSD development and treatment for veterans and servicemembers of color and the extent to which race and culture influence treatment.

Given the continued nature of Operation Enduring Freedom and Operation Iraqi Freedom and the impending consequences in terms of rates of PTSD in returning servicemembers, the social work profession will likely experience increased incidence of working with servicemembers and veterans. This project hopes to better understand what is currently happening in the treatment of this population and to potentially make recommendations for further research and/or treatment based on the findings.

CHAPTER II

LITERATURE REVIEW

The lasting effects of war and combat have long been documented throughout history from ancient Greek mythology to cases of “war neurosis”, “combat fatigue” and “shell shock” after the wars of the modern era. But it was not until 1980 that Post Traumatic Stress Disorder (PTSD) was included as a mental disorder in the Diagnostic and Statistical Manual (DSM) giving a more comprehensive view of the disorder and its onset, symptoms, duration, and potential causes. Since then much research has been conducted on the phenomenon of PTSD and its many manifestations in a search for effective treatment strategies.

PTSD is classified as an anxiety disorder and has as one of its defining features that it develops following exposure to “an extreme traumatic stressor” such as military combat or personal assault. Some of the resultant psychological symptoms include intrusive recollections of the event, intense distressing dreams, flashbacks, emotional numbing, hypervigilance, and avoidance of any stimuli associated with the traumatic event. These symptoms often lead to significant social and occupational distress and impairment (APA, 2000). While any person exposed to extreme traumatic stressors is at risk for developing PTSD, research with combat veterans has shown they have high rates of developing PTSD following their combat exposure. Research from previous wars, such as the Vietnam War, has suggested that approximately 15 % of veterans develop PTSD (Kulka et al., 1990).

Research has found that there are known risk factors that increase the likelihood for developing combat related PTSD, the primary one being the intensity and duration of exposure to combat (Dohrenwend, Turner, Turse, Lewis-Fernandez & Yager, 2008). Troops who are exposed to combat at higher rates develop PTSD at higher rates than their counterparts. Other risk factors found to increase likelihood to develop PTSD include age at the time of combat, education level, a background of academic difficulty, an unstable or problematic family, a father who has been in combat, problems with authorities, illegal drug use, and lower scores on the Armed Forces Qualification Test,. (Dohrenwend et al.,2008; Friedman& Marsella, 1996).

One additional risk factor that has been much researched due to the notable differences in prevalence of PTSD is that of race and ethnic identity (Dohrenwend et al., Friedman & Marsella, 1996; Frueh et al. 1998; Frueh et al.,1997). Much of the literature on race and combat veterans with PTSD seeks to understand the substantial disparity in rates of PTSD among Black and Latino veterans versus their White counterparts. According to the National Vietnam Veterans Readjustment Study, one of the most comprehensive studies conducted on veteran populations, Blacks and Hispanics had significantly higher rates of PTSD (Kulka et al., 1990). In 1990 at the time of the study, 20.6% of Black veterans and 27.9% of Hispanic veterans met criteria for PTSD compared to 13.7% of White veterans.

Impact of Race and Culture on prevalence of PTSD

Historically when looking at veterans of color populations, researchers have largely attributed the differential rates to exposure to combat and the other risk factors cited earlier in this review though they have also acknowledged the need for further study

of socio-cultural factors that could be at play (Frueh and Gold et al., 1997; Frueh et al., 2002; Lewis-Fernandez et al., 2008). While study results have pointed to a somewhat straightforward and concrete explanation for the disparity in incidence of PTSD, there have also been reports of differences in the expression of PTSD symptoms among veterans of different racial backgrounds. Black and Hispanic veterans tend to self report greater maladjustment than their White counterparts (Frueh et al., 1998). Several studies have attempted to examine factors such as cultural expressiveness and its impact on the endorsement of PTSD symptoms by Hispanic veterans (Lewis-Fernandez et al. 2008; Frueh et al, 1998; Penk & Allen, 1991). While one such study determined that cultural expressiveness was not a contributing factor to the more severe symptom presentation of PTSD among this group of veterans, it did posit that perhaps the cultural context in which veterans experienced symptoms might enhance the risk of PTSD onset and persistence (Lewis-Fernandez et al., 2008).

In addition, another study determined that while Black and Caucasian veterans may not differ in their experience of the symptoms of PTSD, they did differ in their description of the symptoms which often led to inappropriate diagnoses and treatment for Black veterans (Frueh et al., 2002). This was cited as one of the possible explanations for why Black veterans are more likely than White veterans to receive antipsychotic medications, not due to actual differences in prevalence of psychotic features but rather a difference in how veterans explained what they were experiencing (Frueh et al., 2002). Yet another study raised the possibility that there is “a culturally sanctioned increased tolerance for symptom severity” for Black veterans leading to a higher tolerance of symptoms and treatment seeking when symptoms are quite severe (Frueh et al., 1997).

The above findings highlight the further need to explore and understand cultural context and its role in the diagnosis and treatment of PTSD for veterans of color.

PTSD Treatment with People of Color

In recognition of this need to better understand culture and its impact on diagnosis and treatment of veterans of color, many articles, studies and assessment tools have been written since the Vietnam War. A review of literature conducted by Marsella, Friedman and Spain (1992) found studying PTSD from an ethnocultural perspective offers the opportunity to “identify the universal and culture specific aspects of the PTSD experience by comparing ethnocultural group differences in the distribution, expression and treatment of PTSD” (p. 2). They highlight the importance of understanding expressions of distress in the culture of the person being assessed and state that until researchers and clinicians consider “ethnocultural sensitivities” we will continue to misdiagnose and misunderstand the PTSD experience (Marsella, et al., 1992). Penk and Allen (1991) continue in this vein and stress the importance of assessing a veteran’s experience in the military and in combat as that of a “minority”. They cite seminal work by Parson (1985) that provides guidelines for clinicians who work with Black veterans from the Vietnam War that recommends focusing on understanding the following:

1. How the veterans view their symptoms; 2. What they define as a symptom; 3. The veteran’s experiences of their own stress related problems vis-à-vis the Vietnam experience; 4. Their attitudes about sharing their problems with therapists and other helpers; 5. Their personal experience of pain; 6. The expected type of treatment they believe will meet their needs; and 7. How they understand the causes of their difficulties. (Parson as cited in Penk & Allen p. 58)

Building on these recommendations, more recently Stamm and Friedman (2000) also introduced the idea of treatment context being an important factor to consider in working

with people of color with a PTSD diagnosis. They cite examples such as the clinician's age or gender and the impact these factors may have on treatment compliance and success. They reference cultural beliefs about wisdom and healing ability coming with age as a consideration for many people from traditional cultures that believe that healing abilities and clinical wisdom emerge later in life. They also highlight other considerations such as the style of the interview process which is often question and answer in format not being compatible with more narrative styles of expression in more traditional cultures. Additionally, Hutchinson and Banks-Williams (2006) discuss the barriers to treatment that nonwhite veterans and their families may experience particularly if they come from cultures that do not believe in psychiatric diagnoses and treatment.

Multiple authors attempted to explain the reason for the importance of factoring in racial and ethnocultural identities into treatment based on the understanding that ethnicity and culture are central to how people organize their experiences and make sense of their world(Allen, 1996; Friedman & Marsella, 1996; Gerrity & Solomon, 1996; Gusman, Stewart, Young, Riney, Abueg & Blake, 1996; Hutchinson & Banks-Williams, 2006; Lewis-Fernández et al, 2008; Marsella et al. 1992; Marsella et al. 1996; Penk & Allen, 1991; Stamm & Friedman, 2000; Whealin, 2007) As such, ethnicity becomes central to understanding the client- how they seek help, how they define their problem and what causes it. Edwin Parson (1985) goes on to say that,

Ethnicity also shapes how the client views his or her symptoms, and the degree of hopefulness or pessimism toward recovery. Ethnic Identification, additionally determines the patient's attitudes about sharing troublesome emotional problems with therapists, attitudes toward his or her pain, expectations of the treatment, and

what the client perceives as the best method of addressing the presenting difficulties. (Parson as cited in Penk & Allen, 1991 p. 59).

Other authors who argue similar points of view also state that there is much literature that suggests that ethnocultural identity “is a more important predictor of the way an individual will respond to a situation or treatment than genetic, familial or social factors” (Stamm & Friedman, 2000, p.80) and even more specifically that a client’s position on the individualism –collectivism spectrum appears to have important implications for assessment and treatment of post traumatic and other psychiatric syndromes (Stamm & Friedman, 1992). These authors are careful to say that it is not that PTSD is an invalid framework or theory, but wonder if perhaps there are not better conceptualizations of trauma responses that better reflect the distress people from certain ethnocultural groups may experience and express and therefore different treatment protocols that would ensue (Stamm & Friedman, 2000).

Seemingly in response to some of the above findings, the National Center for Post Traumatic Stress Disorder (n.d.), which is a part of the Department of Veterans Affairs, has published a series of videos and online trainings for both treatment providers and veterans on the effects of combat and PTSD . These videos provide cross cultural considerations in assessment and treatment for veterans of African American, Latino, Asian and Pacific Islander, and American Indian descent. They also give a historical perspective of their involvement in the military. Additionally they have produced a series of online course modules as part of their PTSD 101 series for clinicians, on general cross cultural considerations in PTSD treatment which aims to “enhance provider’s

understanding of cultural factors and how to incorporate cultural factors into the assessment of and treatment of trauma-related disorders.” (Whealin, 2007).

Operations Enduring Freedom and Iraqi Freedom and PTSD

Operations Enduring Freedom and Iraqi Freedom (OEF/OIF) have seen 1.6 million servicemembers deployed to Iraq and Afghanistan (Miles, 2005; Tanielian & Jaycox, 2008). Because of the ongoing nature of these conflicts and the sometimes delayed onset of mental health disorders that can arise from combat exposure, it is difficult currently to fully know the impact on service members, though some studies show that 19 to 21 percent of returning troops develop PTSD, depression or anxiety disorders with PTSD being more prevalent (Miles, 2005; Tanielian & Jaycox, 2008). In one study, 15 to 17 percent of the veterans surveyed were diagnosed with PTSD (Miles, 2005; Goldberg, 2007). This is consistent with studies from past wars such as the Vietnam War that show that 15.2 % of veterans from that conflict developed PTSD (Kulka, Schlenger, Fairbank, Hough, Jordan, Marmar, 1990). At that rate, it can be estimated that approximately 233,000 veterans of the OEF/OIF will develop PTSD. The Army is currently reporting that 20% of their active duty soldiers were African American, 10% were Hispanic, 3.7% Asian, and 3.4% other (Maxfield, 2006) potentially leading to about 88,000 veterans of color from OEF/OIF developing PTSD.

Furthermore, servicemembers of all racial and ethnic backgrounds have more of the risk factors cited earlier in this literature review than veterans of previous wars. In terms of exposure to combat, studies conducted by the Army Surgeon General’s Mental Health Advisory Team in 2006 and 2007 respectively, 82.8% and 78.4% of service members experienced receiving incoming artillery, rocket or mortar fire during their tours

of duty in Iraq or Afghanistan. In addition the current conflict is notable because service members are being deployed to combat zones for longer periods of time and multiple tours of duty which increases the likelihood of their exposure to combat. According to data from the United States Army, as reported in The New York Times, 40% of current service members have been deployed more than once and 13% have been deployed 3 or more times (McLean, Shanker, & Tse, 2008). Studies have found that 11.9% soldiers deployed on their first tour of duty reported mental health concerns, this number increased to 18.5% for soldiers on their second deployment, and jumped to a startling 27.2% for soldiers on their third deployment (United States Army Office of the Surgeon General, 2008).

In terms of age, education and scores on the Armed Forces Qualification test, all found to contribute to risk for developing PTSD, according to an Army Demographics report published in 2006, 68% of all enlisted active duty soldiers are under the age of 29 with 30% being between the ages of 21 and 24 (Maxfield, 2006). According to the same report, 89.2% of enlisted soldiers have a high school diploma or GED. In addition, a report released in 2007 by the Office of Army Demographics notes that applicants scoring in the top three test score categories on the Armed Forces Qualification Test have decreased over the past ten years (Maxfield, 2007). These numbers indicate that many service members deployed to OEF/OIF have many of the risk factors for developing PTSD.

At the same time as developments in scholarship and interest in effective treatment for veterans with PTSD are growing, and while increased attention to understanding and effectively treating veterans of color with PTSD is encouraging, there

are no studies that this researcher could find assessing the degree to which clinicians working with servicemembers and veterans of color who have a PTSD diagnosis from the current conflicts are incorporating these developments into their work with this population. Given the current impact of Operations Enduring Freedom and Iraqi Freedom and their impending consequences in terms of rates of PTSD in returning servicemembers and veterans of color, this is a gap in the knowledge base of the field. It is in this vein that this research study will be conducted.

CHAPTER III

METHODOLOGY

This purpose of this study was to assess the extent to which clinicians working with servicemembers and veterans of color with a PTSD diagnosis consider race and culture in their treatment. The research questions for this project were: From the clinician's perspective, what role do race and culture play in the diagnosis and treatment of servicemembers and/or veterans of color with PTSD? And, to what degree are clinicians incorporating ethnocultural considerations into treatment of PTSD with servicemembers and veterans of color? The study was exploratory in design and used flexible methods for research in order for participants to more openly share their experiences in relation to the research topic.

Sample

Study participants were limited to mental health professionals who were English speakers, over the age of 25, who worked with servicemembers or veterans of the current conflicts with a PTSD diagnosis and were recruited on a volunteer basis. The inclusion criteria included: a) mental health professional (clinical social worker, psychologist, counselor, etc); b) currently providing treatment with servicemembers and/or veterans of the current conflicts in Iraq and Afghanistan with a PTSD diagnosis; and c) currently treating or has treated servicemembers or veterans of color from the current conflict with a PTSD diagnosis. Clinicians from military settings, VA treatment facilities and private practice were targeted for participation.

A nonprobability technique of snowball sampling was used to recruit study participants. The researcher emailed a study recruitment letter (see Appendix A) to personal contacts who work with servicemembers or veterans. Contacts were asked to forward this letter to colleagues and other potential study participants or to recommend potential participants to the researcher. In addition, the recruitment letter was sent out to clinicians around the country through Give an Hour's volunteer database (see Appendix B), and was posted on the Washington School of Psychiatry's member listserv.

Once potential participants responded to the recruitment letter via email, the researcher contacted them via phone and email to determine eligibility, answer any questions they had about participation and schedule an interview time. At the close of each interview participants were asked if they knew anyone else who might be eligible to participate in the study and received contact information for potential participants. These participants were then contacted via phone and email. Efforts were made during the recruitment and selection process to ensure racial and ethnic diversity, diversity in practice settings, and to promote a gender balance.

Participants

There were 12 participants in this study with representation from the following mental health disciplines: social work (n=8), psychology (n=2), marriage and family therapy (n=1), and registered nurse, advanced practice (n=1). There was diversity in the participant pool by gender, age, and race. There were 8 female clinicians and 4 male clinicians. Racial and ethnic diversity included Caucasian (n=7), African American (n=4), and Southeast Asian (n=1). The mean age was 42.25, with a range from 28-65.

The number of years in practice ranged from 1-40 with 16.42 years being the mean and 18 being the median number of years in practice.

Data Collection

Data was collected via semi structured open ended questions during private interviews (see Appendix C). The majority of the interviews (n=9) were conducted on the phone. The rest (n=3) were conducted at the participants' place of employment. The interview questions began with a collection of demographic data and went on to ask about PTSD development and treatment with servicemembers and veterans of color allowing for study participants to openly discuss their observations and experiences working with this population. All interviews were conducted between March 20, 2009 and April 30, 2009 and were recorded using a digital recorder and were transcribed at a later time. All identifying information was deleted or disguised in the transcription process.

Prior to each interview each participant was emailed, and if requested mailed a hard copy, of the Informed Consent form (Appendix D) which describes their participation in the study and the risks and benefits of participation. All Informed Consent forms were reviewed with each participant prior to the start of each interview and the researcher received signed consent forms from all participants. All Informed Consent forms will be securely stored separate from the data for a period of three years, at which point they will be destroyed unless needed for further research in which case they will continue to be securely stored.

Data Analysis

All interviews were digitally recorded and transcribed and each interview was coded by number in order to ensure anonymity. Data from each interview was reviewed for relevance to the two original research questions. That data was then analyzed for common themes and grouped accordingly. Quotes were organized under major themes and were reviewed for key words, commonalities, ideas and any outlier responses. The major themes found for each research question form the basis of the Findings chapter to follow.

CHAPTER IV

FINDINGS

The purpose of this study was to identify from the clinicians' perspective the role of race and culture on the development and treatment of Post Traumatic Stress Disorder (PTSD) with servicemembers and veterans of color from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). It also explored the extent to which clinicians who work with this population were incorporating ethnocultural considerations into their treatment. The findings of this qualitative study are based on interviews with 12 clinicians who currently treat servicemembers or veterans of OIF and OEF with a PTSD diagnosis. The interviews were designed to elicit the clinicians' understanding and perception of the role race and culture play in PTSD development and treatment and how they approach their work with servicemembers and veterans of color in the treatment of PTSD. The data from these interviews is organized in the following way: demographic information, perceptions of the role race and culture play in PTSD development, perceptions of the role race and culture play in PTSD treatment, and the ways in which clinicians are incorporating ethnocultural considerations in their treatment with servicemembers and veterans of color, if at all.

Demographic Data

There were 12 participants in this study with representation from the following mental health disciplines: social work (n=8), psychology (n=2), marriage and family therapy (n=1), and registered nurse, advanced practice (n=1). There was diversity in the participant pool by gender, age, and race. There were 8 female clinicians and 4 male

clinicians. Racial and ethnic diversity included Caucasian (n=7), African American (n=4), and Southeast Asian (n=1). The mean age was 42.25, with a range from 28-65. The number of years in practice ranged from 1-40 with 16.42 years being the mean and 18 being the median number of years in practice.

The majority of clinicians provided treatment to servicemembers or veterans in an outpatient setting (n=10) in a Department of Defense Military Treatment Facility or in a Veterans Affairs Hospital (n=8). Several of the clinicians provided treatment in a PTSD specific clinic or treatment program (n=5). The most common primary treatment approach for PTSD cited by the study participants was Cognitive Behavioral Therapy (CBT), (n=9) with half citing exposure therapy, a specific form of CBT, as their preferred treatment approach. Other theoretical orientations mentioned were EMDR (n=1) and multi-phase psychodynamic trauma based psychotherapy (n=2). Though a few of the participants (n=5) stated that there was some mention of ethnocultural considerations in professional trainings they had attended on PTSD treatment, all of the participants (n=12) stated that they had never attended a training specific to race and culture in PTSD treatment.

Race and Culture in PTSD Development

This section contains findings from participants' observations on the role of race and culture in the development of PTSD. The opinion most commonly expressed (n=10) is best summed up by two participants answers,

Speaking from opinion and a research background, anyone is really vulnerable to development of PTSD. I think about the impact of race and culture, I think certain cultures might be at increased risk for development but that's more related to environmental factors or even sociopolitical factors... but in general, anyone is vulnerable to the development.

and

I think the direct development of it, no. I think it's based on the trauma and how you're seeing things. We really don't know why or how someone gets PTSD so to sit there and say its race and culture its kind of difficult to point that finger but I think when it comes to that avoidance piece [common in communities of color where mental health treatment is stigmatized] that pushing it away and not really dealing with it... can kind of perpetuate it and help the development of it...

Many then went on to elaborate on what some of those risk factors may be in addition to common cultural norms within communities of color that may also contribute to PTSD development. The data that emerged from those reflections are presented in the following subtopics: premorbid exposure; meaning making and behavior responses; help seeking attitudes; and developmental stage.

Premorbid Exposure

Participants tended to discuss possible premorbid exposure for people of color in a number of ways. A few (n=3) specifically mentioned levels of exposure to violence in the home or in their communities when growing up. One participant stated that it depended on whether or not they “have experienced some other traumatic events, gang violence, violence in the home, neighborhood kinds of things...so I suspect they might be a little bit more susceptible or likely to have had that kind of exposure.” Another related it more to home life and talked about the “conditioning” that happens in families and how that impacts stress responses later in life,

The degrees of violence that were there, the discipline management, to me that is more grounding and to me determines how behavioral management was done, what kinds of exposure was there ...to me that will tell me what kind of stress management there was and what kind of coping skills will develop in people who are for example reared in different cultures.

One clinician contradicted these views saying that prior history of exposure to violence led to an increase in susceptibility to developing PTSD by stating that “it has to do with pre exposure to trauma before going into the military and if they have some sort of an exposure, I would say sometimes they can have a better handle on the situation.” She went on to clarify though that if the exposure was of a more serious and abusive nature and rises to the level of trauma, then “I see when they have PTSD, their situation is much more complex.”

Other of the participants tended to think about premorbid exposure from the perspective of the impact of racism.

My sense is that if a person had been the recipient of some levels of racism, or sexism or homophobia or any of the other isms, if they had been the recipient of that and they were to go into a setting where they are in a war setting that their experiences of the war at some levels if they were to think about it would also parallel some of their experiences living as a person of color in this country.

This was further expanded on by two other participants who spoke specifically of racism within the military setting and the possibility of how contributes as well. One said,

A lot of our vets are depressed but when you add on the combat experience plus what race and culture and the negativity that came along with that from being a servicemember as a person of color it kind of compounds a lot of things.

Another expressed it as a reflection of why there is a higher proportion of people of color with PTSD in the military,

The reason why we see a disproportionate number of minorities with PTSD, a lot of it has to do with some of the fragmentation from their past. And I’m not talking about conditions of race although we have generational transmissions but um.... I think ...about the history of African Americans in the military. I focus on the military aspect. A lot about the segregation they experienced and some of the other things that they experienced.

Finally one clinician discussed the potential impact of racism and its possible connection to a higher incidence of exposure to combat which leads to an increased chance of PTSD development,

People of color are more likely to be infantry meaning they're on the front lines and they're more susceptible to coming into combat situations, IED blasts things like that. Whether or not that's due to their race or how they're recruited in I don't know but I would guess that it has something to do with race.

Meaning Making and Behavior Responses

Another theme that was discussed by some (n=5) of the clinicians had to do with worldviews and how different cultures engage in meaning making differently and how those beliefs then affect how one interprets the events experienced and the behavior that then follows. One participant stated,

Your racial and cultural background and what you're exposed to effects you know how you experience things throughout life in particular as a young adult. So I feel like different people will have different reactions to trauma and near death experiences whether its war... is going to vary based on your race, your age, your religious beliefs.

Another participant offered up an example that highlights the above statement,

An older man, African American in the service for a very long time and I think that he's had at least four or five deployments...he's older...and he had a flashback that he shared in group. He had a flashback in the middle of the night and punched his wife in the face and she woke him up after this and he was really torn up about it. He expressed it from a place of rage and anger turned inwards, like all of it from him. Whereas other people in the group were trying to lead him back to but you have PTSD, this is going to happen, it's happened to all of us you know its a similar experience. And he was very set on no this is my brokenness this my... I need to be able to control myself. So less able to see it as the result of his experiences and more as a failure of his own self...so I see a lot more of the problem being internalized...like I said before they'll draw things back to how its effected their familythey failed their family, they've failed their group...their unit. A lot more personal responsibility taken on.

Another participant framed it a bit differently and spoke again of early life experiences related to family and exposures to violence and how that affects how you interpret your experiences and the behavior responses that are available.

I think they [veterans of color who are exposed to violence in the home] tend to develop different potentials and perspectives around the way they use their bodies, the way they understand their thoughts, the way they understand themselves in crisis mode and how they decide how they think about coping and how they've been conditioned to do that...I'm more interested affective responses, options of behavioral responses, understanding of behavioral choices. And as for PTSD what does it mean, and what drives it and what triggers it because I don't think PTSD is understood. I don't think people understand the interpersonal and family dynamic and the relationship dynamic that drive the decompensation.

Lastly two participants highlighted beliefs around trauma and ideas of health and disease that may impact how a veteran of color understands how trauma can or should affect them,

The difference is you know in some ways people were taught that if you have trauma of any kind it toughens you up and you can handle other trauma easily ... so they are programmed for stress and sometimes they make the best soldiers but they also have a cumulative anxiety and it may show up later on...

and how stress responses are then understood by the veteran. There is a “difference in terms of mindset, if you will, of what is health and what is disease,” which the participant went on to say leads to a different sense of what merits treatment or help.

Helpseeking attitudes

Helpseeking attitudes were mentioned frequently among the study participants. Most (n=8) discussed this as the biggest difference that they could account for in terms of the role of culture influencing PTSD development, largely because they felt that the longer veterans delayed getting treatment for their symptoms the more severe and entrenched their symptoms became.

I think the stigma associated in a lot of people of color communities about therapy and mental health treatment in general and because of that stigma they avoid a lot of things. Avoid any kind of idea that something is wrong with them or even that PTSD or the trauma they saw is affecting them. And so a lot of times if you're avoiding that stuff it's really what's keeping the PTSD going. You may not have a name to what's going on in your mind or why its affecting you ... but because they don't really think about mental health or really getting that kind of help in the communities because its really frowned upon I think that that stigma can really play a big part in people of color communities because of that.

This theme was continued by another clinician who emphasized the reluctance to seek help, especially for men of color. She described it as “machismo”:

[It] definitely affects the progression of the disease but not only that because my biggest challenge is some of the racial backgrounds would have so much reluctance as far as getting them convinced that they need the treatment because there is such machismo with their own culture. That they feel they can handle it and they feel this is something I wanna stay away and I can handle it on my own.

And another talked about in terms of fulfilling the “manhood” role.

I've definitely noticed a difference, not necessarily in the symptoms but in the way they approach their symptoms or the way that they seek help for their symptoms... hesitancy around seeking treatment... but that has more to do with their upbringing... you know they've been taught that you don't cry wolf. You don't talk about your injury...that it's weak to do that.... that being injured was not an excuse for not working or fulfilling the manhood role.

And yet another framed it as reluctance to have their “illness” interfere with fulfilling their responsibilities,

I would have to say that um you know that working is a very very high priority for people of color. And I think that anything that would interfere with that they would be less likely to participate even in spite of their own illness.

Developmental Stage

The last theme that emerged in connection to the development of PTSD, which strayed a bit from the original focus on race and culture, was that of age. A few (n=3) of the study participants referenced how for the veterans and servicemembers of OEF and

OIF age was a big factor in both PTSD development and the likelihood of identifying their symptoms as problems.

They're at an age group where they want to stay away from as much as possible being identified as a patient. That's the last thing they wanna do. Because they're in their 20s... in very productive years in their lives. They wanna move on with school, their family lives, have children... not realizing that they need treatment and they put treatment on the back burner.

Another clinician talked about the perspective of the effect that war has on a young person's development.

All the guys that come back from service have had their developmental level interfered with. They go in at 17 years old, they're taught how to kill and they hold their own development aside... so when they come back they're still kids...and young guys are tough. They didn't get killed there they're not going to get killed at home. So that's why they do all the bikers and all of that stuff.

Race and Culture in PTSD Treatment

This section contains findings from participants' observations on the role of race and culture in the treatment of PTSD. This topic generated the most emphatic answers from those who agreed that race and culture do indeed impact PTSD treatment (n=12).

The data that emerged from those reflections are presented in the following subtopics:

Openness to treatment; Trust in the clinician and/or treatment protocol, and Interpretation and Empathy. The general response is best summed up by this participant's answer:

I think that for a lot of people who are already skeptical of mental health treatment believing that talking about this is going to be helpful is difficult... a lot of time they're skeptical and you think about Tuskegee and everything else that happened and so a lot of times they're skeptical that people really have their best interest at heart. At the VA there are a lot of research studies going on and people are like you just want to use me as a guinea pig. So yeah, I think that buying into that rationale can be difficult for a lot of ethnic minorities, folks who are not from this country and who don't believe in it. That really impacts treatment because if you can't really buy into that or believe that its going to help you and give it your all and believe it can be significant in reducing your PTSD symptoms that's going to be half the battle.

Openness to treatment

Many study participants (n=8) identified a lack of openness to treatment as being one of the primary ways race and culture impacted treatment. They cited stigma about mental health as a factor in many communities of color as one of the primary reasons veterans of color are not open to treatment.

You're still coming having that perception of it or stigma if I go get mental health treatment I'll be seen as crazy or you know my family is not really going to approve that really plays a part of who comes in to get treatment and who's gonna get better and get the help they need.

Another participant continued to add that this stigma is amplified by military culture and the stigma there about getting mental health treatment,

There's aspects of the culture, stigma, particularly stigma that has been a very prevalent issue in treatment of PTSD. I think more so than when I worked with other populations. The stigma in terms of specifically feeling weak for having PTSD. And this is a major barrier to treatment and progress. There's a bit of acceptance that's needed to proceed with treatment.

Stigma around mental health treatment was also connected by participants (n=2) to notions in certain racial and ethnic communities that problems should be handled within the family or community setting and that talking to an outsider about one's problems is taboo.

Hispanic people are more likely to ...maybe this is cultural... not want to participate in treatment and may be more resistant based on their beliefs that uh not every Hispanic culture but many Hispanic cultures involve family reliance and things like that. And it's kind of taboo to sit and tell an outsider a psychologist or psychiatrist in training you know this what happened on the battlefield in Fallujah. Uh I do see that difference quite often....

And,

for a lot of other communities of different ethnic backgrounds whose religion or even whose people feel that you should talk to...we have a lot of people who come in who are African who are like we're supposed to talk to our family members not to the treatment team...

Though in the examples above the reference to family was that of the cultural expectation being to look to them for support for problems, clinicians also talked about how many veterans felt that if they did overcome their own stigma around getting mental health treatment, another contributing factor to their ability to be open to treatment was their fear of their family's judgment. One therapist stated that a client told her, "my mother will not let me come here because she feels like I can tough this one out." Another therapist stated,

A lot of our Asian clients one guy in particular told his therapist I can't tell my family about this because they're feeling that I'm weak if I do this and that I should be stronger and not need help.

The impact of this need for secrecy on treatment and the willingness to engage in treatment is referenced in the following excerpt where a clinician is talking about what some of her clients tell her about why they do not want to be in treatment and cannot do the homework assignments that are part of the exposure therapy protocol,

By the way I'm trying to hide it from my family anyways that I'm going to therapy so I can't really do what you're asking me. They're going to keep asking me why I'm going to Wal-Mart and sitting for 45 minutes or why you going to the bathroom and listening to this tape and why can't I listen to it. What are you doing? How do you explain that? So that part is really significant.

Trust in the Clinician and/or treatment protocol

Several clinicians (n=7) identified the therapeutic alliance as an important factor to engaging servicemembers or veterans in treatment, specifically to gain trust in either the clinician themselves or in the treatment protocol. One clinician explained it in this way,

I think there's another piece here about this history of mistrust that happened particularly in the African American community where people have over time learned that going to the hospital means you're going to get mistreated and/or

misinterpreted which ends up being mistreated. So as a result if I feel mistreated on the Front, I'm not going to come back and trust you again to see if you're going to mistreat me twice unless I have some support to reinterpret what I saw.

This sentiment is expanded on by another clinician who acknowledges an attitude of distrust for mental health professionals particularly in communities of color and the possibility of looking to build up trust in the community by getting referrals from within the community,

There is the distrust of mental health professionals and that can be incorporated with stigma but I know it sometimes plays a role in certain cultures. Often times treatment is at least approached better if you are referred by somebody the individual knows through their culture, community, family, something like that.

The remaining clinicians stated very plainly that they knew that race especially played an issue in building a trusting relationship. One Caucasian clinician talked about how one of his African American clients was very honest with him about a lack of trust and how he knows now that if he does not address this issue with his other veterans of color he will not be able to effectively engage them in treatment,

I'm currently working with an African American veteran who self identifies as Black Muslim. So we have the religious issue and he articulates greater distrust of a Caucasian therapist because of my race. With other African American veterans if I didn't get them involved I didn't get results. We didn't connect.

Another clinician who is African American spoke about this as well from her own perspective as being a person of color and how that has informed her awareness of how race and culture impact the treatment relationship,

Its a reality for me that someone's culture, someone's race is going to play a part into how they're looking at treatment, how they're looking at me, what our relationship is going to be like. So for me its important.

Another clinician who is also African American spoke to the cultural issues within the African American community but also referenced a distrust of civilian therapists whom

veterans often feel will not understand them and how the combination of those factors makes it even more difficult to build an alliance with a veteran of color,

African Americans, for instance, which is what I can speak about with the most experience, typically don't engage in treatment very well. They have a concept of not wanting to air their dirty linen, they are typically not trustful of clinicians and then to add onto that soldiers don't typically like to talk to civilians because they feel that they have not been to war and they don't have a frame of reference and therefore can't be effective clinicians... some of the African American soldiers withdraw from treatment early or are not likely to get the full benefit because they don't choose to engage.

Lastly, two participants talked about trust in the treatment protocol. One clinician who uses exposure therapy as her primary treatment modality expressed that veterans of color are very skeptical of it and that it takes a good measure of explanation and trust in her for them to finally agree to start the protocol. She stated, "I think that for a lot of people who are already skeptical of mental health treatment believing that talking about this [their traumatic incidents] is going to be helpful is difficult." Another clinician talked about how African American veterans in particular are skeptical of some of the communication strategies that they are taught in CBT and in Anger Management sessions. They often are reluctant to try the interventions out because they feel that they are not geared for the way people in their families and communities speak to one another, she said this,

They [African Americans] are not trustful of the communication strategies that we would teach them because they typically say that that is for white folks, you know black people don't talk that way. So they're less inclined to try the suggestions and interventions we try with them because they feel they were created for just one race and not for them.

Interpretation and empathy

Another theme raised by study participants around the role of race and culture in PTSD treatment was the issue of accurate interpretation and empathy by the clinician of

the client (n=7). Clinicians talked about their awareness of possible misinterpretation of symptoms, one clinician stated that they knew that culture can impact symptom expression, “it [culture] could also impact symptom expression. And so it’s possible that people may not end getting proper treatment or diagnosis depending on how they are expressing their symptoms.” Another clinician with the same concern talked about how suffering can look differently from culture to culture,

The majority of the clinicians that provide treatment, that get the specialized training to provide the treatment are Caucasian and typically males and a lot of them are civilians and so then they have an impression about what suffering looks like. They're not always as sensitive to the sociocultural differences between the races and so they assume that PTSD looks the same for each race and they don't pay attention to the fact that there are possible differences in presentation.

Yet another talked about the history of misinterpretation of people of color in the mental health system and how it leads to clients not trusting that their therapist can really help them,

Experiences that persons of color have get misinterpreted by the majority of mental health providers because of the difference in terms of mindset, if you will, of what is health and what is disease. So as a result what ends up happening is that things that are described by a person of color as difficult, in a majority and I would even venture to say a western trained psychotherapist may very well miss because they don't understand what the dynamics are behind being a person of color all the time. So as a result what ends up happening is the person that is a mental health worker misses a whole bunch of cues that the person of color who is the recipient is giving them about what their life experience is and as a result that makes the person of color go, ‘God you really don't feel me at all. How can I have a discussion with you?’ And so then the result is not only will the mental health worker misinterpret what's going on and perhaps misdiagnose the client but the client loses faith in the mental health worker's ability to see them at all. And if you can't see me you can't help me.

While the above statements reference the overall experience of being a person of color and how culture may influence the communication of experience and the clinician’s ability to accurately interpret and empathize with the experience, a few (n=4) mentioned

specific factors such as appearance, specific experiences or beliefs that could be misinterpreted and lead to misdiagnosis and improper treatment. Three of the four participants mentioned cultural or religious beliefs that some groups have that they can speak to their ancestors or have conversations with the deceased. They noted that while this can seem like psychosis, and may indeed often be diagnosed as such, that is not necessarily what is happening. It is important for the clinician to really understand the etiology of this experience.

And so a lot of people who, lets say, in their culture it is acceptable to talk to their ancestors, to people who others might say is a ghost. Or if it is a religious thing they talk to their ancestors or people come and visit them and tell them things, they have conversations with them and that's normal in their culture. On my team they automatically want to label them that they're having hallucinations which is attributed to the PTSD and the flashbacks and for them [the treatment team] it's not something that can be considered normal. They deem it to be abnormal and a symptom of PTSD when for me it is racially or culturally significant for them [the veteran] and it has something to do with their ancestors or their religion and their belief and we really don't take that into consideration.

Another clinician used one more example from his own experience as an African American and how he is often followed in department stores. He points out that that may sound paranoid and once again, a clinician needs to know how to ask questions to try and understand what is really happening in this situation,

Well, I think it's not knowing what to look for...For instance if I as an African American male were to say I'm having a problem because every time I walk into a department store somebody follows me you can take that one of two ways you could say, "oh don't pay attention to that, its not a big deal" or you could say "you're paranoid". Now if you say I'm paranoid you and I are done, ok. If you say don't worry about it, you and I are done, because what you did is disavow that I told you I was worried because my worry is legitimate. What's hard is, I think, for anyone not just majority professionals but professionals of color also is to piece out whether or not that person is actually paranoid from whether or not that's an actual experience. So my response is that's probably a real experience you're not crazy, ok. But when you're not in the department store are you also worried that

people are following you? That's a little different experience. But you have to know to ask that next question.

As highlighted in this section, the influence of race and culture can not only affect the veteran or servicemembers' attitude and openness towards treatment but also how the clinician is attuned or not attuned to the information the veteran is disclosing.

Ethnocultural Considerations in Treatment

This section contains findings from participants' reflections on the ways in which their specific work is impacted by race and culture when working with servicemembers and veterans of color with PTSD and how they factor ethnocultural considerations into their treatment approach. Though the majority of clinicians in the study indicated that they do factor race and culture into treatment (n=10), the findings in this section saw a greater difference between clinicians of color and Caucasian clinicians. While most of the Caucasian clinicians stated that they factored race and culture into their treatment with veterans of color (n=5), their answers indicated that while they thought about race or culture, it was not a major influence in their treatment planning or approach. This is best illustrated by the following statement:

I think I try to maintain an awareness of the difference between myself and the patient. Sometimes it might seem a bit more acute or more evident that there's a cultural difference, for example if I have a patient from Africa or Asia then I would tend to be more in tune to the cultural difference as opposed to an American born soldier whether he was African American or Caucasian. Or sometimes if there's a specific issue like grief I might think about how culture informs that. So I think it's in my mind, but across the board it would be hard to say. I know that I'm a white educated male social worker and I'm aware of that when I sit down with a client regardless of their background but those lines begin to melt even in the initial meeting or they become an issue.

Clinicians of color on the other hand (n=5), with the exception of one, were much more emphatic in their responses to the same question:

Of course I do. Because its a reality for me that someone's culture, someone's race is going to play a part into how they're looking at treatment, how they're looking at me, what our relationship is going to be like. So for me it's important.

Or

I have to be honest that I embed myself in notions that race and gender and culture and the other identities matter. They matter a lot. For me I can't do the work unless I also consider those issues...I think that what that makes me is somebody who you might be able to locate and say, God this guy really thinks about race and culture and gender all the time. There are other of my professionals who think about it as a side note as opposed to putting it in the front as a piece of identifying information that we pay attention to right off the bat and that to me causes problems.

The data that emerged from these reflections are presented in the following subtopics: therapeutic alliance, treatment modifications, and therapist's identity and use of self.

Therapeutic alliance

Many clinicians (n= 8) identified the therapeutic alliance as a major factor in treatment considerations when it came to working with veterans of color. This notion came up primarily in two ways, trust and understanding. Some clinicians (n=3) talked about issues of gaining the trust of a servicemember or veteran. One Caucasian therapist spoke about it in this way,

I initially have to get past issues of being in the dominant culture. There is distrust...the bonding process seems a little slower when there seems to be distrust. The fact that I'm an older male Caucasian therapist, when I can get past that and get into my therapeutic bond, I don't notice that much difference...

Another clinician, who is African American, spoke about gaining trust from a different perspective, though she also highlights the role her own race plays in gaining the trust of a servicemember or veteran of color.

I think I'm more sensitive to what other people's perceptions about mental health are. Everyone is not going to accept what you give them blindly. What could someone be thinking who's from a similar background as me coming into this? Are they going to be open and honest and let me just share my heart with you or

are they going to think we've been guinea pigs all these years I don't trust people cause they're going to tell me my values and beliefs are crazy. So I really take it into consideration. So you just have to get them to the place where you can say I just need you to trust me. I have use myself a lot of the time, I'm here to help you, believe me. It doesn't hurt that I'm African American. It does not hurt at all.

Another way therapeutic alliance was discussed by study participants as it relates to ethnocultural considerations in treatment was the ability of the clinician to convey to the servicemember or veteran of color understanding of their identity and experiences, both as people of color and as soldiers.

They need lots of encouragement and I guess some proof that you're culturally competent and know something about their background and I find it's just helpful to ask. What country are you from, what are some of the cultural norms from your country, how has it been different since you've been here, how long has your family been here, so I try to make myself aware of what they're backgrounds are in order to be respectful.

And

I think really trying to understand how their culture is important to the patient and then including that in treatment planning is how to go. And I think that could range from spiritual aspects... [to] the army and military as a culture.

And

I frequently use the phrase "do I understand you?" So I'm joining a lot and clarifying frequently whether I'm getting the message or not. And I think that frequently that erodes the distinction and prejudicial potential... I probably have to overdo the joining a little bit so that there is no experience of condescension because I don't want them to perceive that there's a color issue. I mean there is but there's no way around that but then you move beyond that and hopefully that's what we're working towards. Hopefully if we understand the dynamic and cancel it, then I think we do get past it.

Treatment Modifications

A large number of the study participants (n=9) were able to articulate specific ways race and culture influenced their approaches and/or caused them to modify their treatment protocol when working with servicemembers or veterans of color. Responses in

this section tended to be discrete with little overlap among respondents. Data in this section discusses some of those approaches clinicians had with servicemembers or veterans of color.

One clinician discussed initially spending more time with veterans of color making a case for therapy and helping to frame it in a way that does not minimize their cultural norms of turning to family for support,

I may spend more time pushing therapy on someone who's lets say of a Hispanic background cause they may be more resistant you know they want to talk to their dad or cousin who may not understand or may not have any experience with it or may not want to hear it or so I may uh kinda push that a little bit encourage it and show them there's nothing to be afraid of and doesn't take away from speaking to family its just another resource.

Another discussed wanting to draw on components from servicemembers or veterans of color's culture that would be helpful in the therapy,

Whichever I work with, Native American clients I use more of their traditional tribal and cultural values. I talk about the beauty path and about how they can work to reintegrate with their own belief systems... with Hispanic clients I am more likely to address the impact on the family and the relationships. With my African American clients I am more likely to emphasize recovery through integration with their religious and family affiliations than I would be with my Caucasian clients.

Yet another gave a more concrete example of how a cultural belief would inform a necessary treatment modification,

I think about the core of my orientation, the core treatment method, wouldn't necessarily change those but I think you have to be sensitive to whatever cultural differences there might be and trying incorporate those in if necessary. [For example] in some cultures they have views about death, Native Americans from my understanding, one is not supposed to speak the name of someone whose deceased. That would be actually one specific way if I was doing exposure treatment on somebody that I would need to alter the treatment. I would alter they way of doing it, not the actual treatment itself.

Overall, clinicians attempted to understand the role culture played in a servicemember or veteran of color's life and worked to consider how it might influence their stance in treatment. Once again, clinicians of color were a bit more emphatic in their responses regarding the importance of really understanding this dynamic as is seen in the following two comments,

So I believe it informs things up front [race and culture]. Other people who are trained differently don't buy that. I think sometimes that causes problems because we're looking at a medical model that says the problems are of a medical biological nature and all we have to do is figure out the biological puzzle. Okay but if we don't include the social puzzle inside of that we're going to miss some things that will inform how the biological puzzle gets taken care of.

And, "I like to highlight their race and ethnicity. I don't like to erase it. I like to highlight it because I want them to know that I see them. I mean I really see them. I think we're all different." This mirrored to some degree what other participants were getting at but was much more direct.

Another topic that emerged centered around language and understanding. One clinician talked about "translating" for servicemembers and veterans of color so that they understand their symptoms and distress in a way that is culturally relevant to them.

I find that I can be true to a treatment intervention but be culturally sensitive and do my best to make it real for the patient in terms of helping them understand different terms and different symptom complexes and giving them enough information so that they have some biological basis for why they are struggling some psychological basis for why they are struggling and some emotional basis for why they are struggling so that...and the physical piece. So that they can factor all those things in at one time so they are less likely to engage in self blame and more likely to engage in treatment because they understand its not an issue of fault but its how you dealt with the circumstances that put you in the problem that you're in.

Another talked about language differences and the potential connotative differences that can often differ from culture to culture, "the other issue that might effect what I would

measure is language style. If there are differences there-connnotations are going to be different.” Lastly, another clinician talked about her attention to language when a servicemember or veteran is not a native English speaker. She offered up this case example where a veteran had learned English in 2003 while on tour in Iraq. Another clinician at her agency, who had transferred the case to her, did not gather this piece of information and so did not understand why he was not engaging in treatment. She said this about it,

I wish someone else would have done a better job on taking all these factors into consideration because he would have probably been further along in treatment and he would have been to his appointments earlier. He kept missing appointments and he wouldn't fill out the paperwork because the paperwork was like 20 pages long and he couldn't read through it...

So while there were several examples of the kinds of treatment modifications clinicians were making, there were a couple of clinicians who though they acknowledged that they are aware of race and culture, still stated that that is not an influence in their treatment with veterans or service members of color,

I take into consideration the person....where they are in the scheme of things. Because knowing a culture in itself gears me in certain ways but I don't use it to generalize. So on the one hand the answer could be yes because I do need to know about the culture but on the other hand I don't need to use it, you know, without individualizing the treatment.

And, “I keep in mind the cultural issues they may be having, but when you talk about an Iraqi veteran, they’re an Iraqi veteran to me. Race or ethnicity has nothing to do with it as far as what they need.”

Therapist’s identity and use of self

The majority of study participants (n=9) talked about some of the ways that their own racial and cultural identity impacts their relationship and treatment with veterans or

servicemembers of color and how they negotiate this in the treatment relationship. There was again in this grouping of responses a difference between Caucasian clinicians and clinicians of color. Many of the Caucasian clinicians talked about being aware of the difference in experiences and how that may effect their ability to understand or empathize with their clients.

Having to be mindful of differences in race and culture in terms of how I'm communicating with others. but I mean I think we're all a product of our backgrounds but I think for me, its just trying to be mindful of the influences I may have had and making sure they're not blurring how I'm interpreting and understanding a patients experience.

And,

I constantly have to remind myself that not only is my culture different because I'm a civilian and I have no military experience and this person has seen war and I haven't. But also the very basic and complex tenant that I'm different from them and their experience because I've never had to face those things down when growing up like they did... whether its poverty or racial bias throughout childhood and early adulthood But it's definitely a huge implication of how a therapeutic relationship can go.

Other Caucasian clinicians wondered about the impact of their race on the client's ability to "use" them.

I think I'm aware from a standpoint of how is this person going to perceive me because I'm not their color. And I'm more concerned about what they're going to perceive and how they will be able to use it and introject what I can offer ... how are they going to be able to use this?

And,

I've noticed that in my individual work there's not as much shame or guilt in sharing one on one as within a group. But I wonder how my race either encourages or discourages that sharing. I don't know.

Clinicians of color, on the other hand, talked about how they felt that their race and culture was an asset in their work with servicemembers and veterans of color. Two clinicians talked about how it allows them to engender a bit more trust in the relationship

early on given the many treatment barriers discussed earlier in this chapter. One clinician talked about it generally saying,

I have clients who I basically say to them, 'I know that this is something that you're not used or even something that you expected that you'd ever have to deal with and its probably totally out of the realm of things that you think will work but sometimes you just have to use blind faith.' Cause there's nothing else I can actually give them to say I know you know about supportive therapy because they don't have anything to actually base it on. So you just have to get them to the place where you can say, I just need you to trust me. I have use myself a lot of the time, I'm here to help you, believe me. It doesn't hurt that I'm African American. It does not hurt at all.

Another African American clinician gave a specific case example with an African American servicemember that highlighted a similar sentiment to the above citation,

I used cognitive behavioral techniques, I did some Socratic questioning and I really challenged him about his thinking, his distorted thinking. And he was able to say, 'nobody's really pushed me this far to ask me these things and to make me look at it in this way' and its because he trusted me and he said because I was African American that I probably understood his desire to succeed and why he was so driven better than a lot of people. And so since I didn't have to break that barrier, it gave me license to then work on those other issues sooner than I would have if I had to do more rapport building.

Other responses from clinicians of color talked about the influence of their identities on their experiences and how that gave them both an awareness and a comfort level that allowed them to more easily engage around issues of race and culture.

I have such a diverse history... I think that patients appreciate the fact that I'm well rounded... I think its a plus in the sense that I'm so diverse and my office space reflects that. I also think they appreciate the honesty of what I don't know. And I'm very happy to share with patients sometimes...I say to them tell me what that's like or what does this mean? They're happy that they can teach me something and I'm happy that I can learn something from them. There's no question that being racially and culturally diverse plays a huge role. Huge role.

And,

Because I am who I am, because I have the background I have, because I'm African American, because I grew up in different parts of the country in different environments, I'm able to use those things. And I can use myself in many

different ways so that it's helpful for the vet and I think that a lot of people aren't able to do that. They just regurgitate what's in the book.

Summary

These findings indicate that clinicians feel that race and culture do impact PTSD treatment with servicemembers and veterans of color. Clinicians also indicated that to a certain extent they factored ethnocultural considerations into treatment though they also expressed a lack of training in this topic. Ten of the twelve participants indicated strongly a need and desire for further training and discussion among their colleagues on how to appropriately work with this treatment population. The following chapter will discuss the implications of these findings.

CHAPTER V

DISCUSSION

This purpose of this study was to assess the extent to which clinicians working with servicemembers and veterans of color with a PTSD diagnosis consider race and culture in their treatment. The research questions for this project were: From the clinician's perspective, what role do race and culture play in the development and treatment of servicemembers and/or veterans of color with PTSD? And, to what degree are clinicians incorporating ethnocultural considerations into treatment of PTSD with servicemembers and veterans of color? The study was exploratory in design and used flexible methods for research in order for participants to more openly share their experiences in relation to the research topic. This chapter will discuss major findings in comparison to existing literature and make recommendations for practice and future research.

Major Findings

The following are major findings which will be discussed in the sections to follow. One major finding of this study is that the majority of clinicians interviewed (n=10) felt that race and culture contribute to PTSD development. They were quick to note though that this was more likely an aspect of a combination of risk factors that tend to be higher in populations of people of color rather than directly related to race and culture, indicating that this was perhaps a result of the racism often experienced by communities of color. There was also a strong indication that clinicians find that race and culture do play a role in PTSD treatment based on their responses. All of the study

participants (n=12) indicated that based on their experience working with servicemembers and veterans of color that race and culture play a significant role in treatment.

Most study participants (n=10) felt that they incorporated ethnocultural considerations into treatment with veterans of color though the majority of the sample pool (n=10) also stated a desire for further training on the implications of race and culture on PTSD treatment and in treatment for psychiatric disorders in general. It is a noteworthy finding of this study that despite a few clinicians (n=5) stating that there was some mention of ethnocultural considerations in professional trainings they had attended on PTSD treatment, all of the participants (n=12) stated that they had never attended a training specific to race and culture in PTSD treatment. Seventy five percent of the clinicians (n=9) also felt that their own racial and cultural identity impacted their relationship and treatment with servicemembers or veterans of color.

Role of race and culture in PTSD development

While clinicians were careful to say that anyone is vulnerable to the development of PTSD in a combat situation, many of them (n=10) highlighted some of the ways they thought about the role of race and culture influencing PTSD development in terms of premorbid exposure, meaning making and behavior responses, helpseeking attitudes and developmental stage. Clinicians tended to talk about the impact of racism on the lives of servicemembers and veterans of color as a premorbid exposure. This is interesting because clinicians indicated an understanding of the significant stress that racism can add to a person of color's life and how those experiences may have increased their vulnerability to developing PTSD. The implication that servicemembers of color may be

at higher risk for PTSD because of the pervasiveness of racism in the United States and the likelihood that servicemembers of color have had considerable exposure to racism prior to their combat experiences is important. It was noteworthy, too, that a few of the clinicians specifically talked about the impact of racism in the military and the effect that had on servicemembers in terms of the additional stress that places on a servicemember. Their analysis of the conflict it places servicemembers in, to be relying on a unit where they may be on the receiving end of discrimination and having to trust those same people to protect or even save you in the event of attack and the fact that servicemembers of color are asked to defend a country that has historically marginalized them was astute. Another way one clinician felt that servicemembers of color experienced racism was in their assignment to their Military Occupational Specialties (MOS). Servicemembers of color are in infantry MOS's at higher rates than their white counterparts which not only increases their likelihood of exposure to combat, risk of death and injury, it also increases their vulnerability to PTSD.

Another set of responses related to the role of race and culture in PTSD development focused on meaning making and behavior responses. Clinicians talked about how culture shapes a veteran's understanding of their experiences and their reactions to it. This allows the possibility for the many different events or situations that could have been potentially interpreted as a trauma by the veteran. It can also help to explain the delay in seeking treatment that is common with veterans of color by considering the different cultural notions of what health and disease are and what kinds of symptoms and severity merit treatment. This understanding can also give a insight into what is sometimes seen as treatment resistance in veterans of color with PTSD.

Building on this idea, clinicians discussed the role of helpseeking attitudes as another function of the ways in which race and culture can influence PTSD development. Sixty seven percent of clinicians (n=8) discussed this phenomenon as the biggest difference they could account for in terms of the role race and culture play in PTSD development. They cited stigma in communities of color around mental health treatment, notions around masculinity and the need for male veterans to be able to handle their troubles on their own, and the high value in communities of color for work and the resistance to engage in anything that would interfere with the ability to continue working. This observation was interesting in that it was not necessarily the helpseeking belief itself that contributed to PTSD development but the effect of this belief, which was often to delay treatment until their symptoms were so severe and entrenched that what might have started as an acute stress response or acute PTSD that could have resolved with a short course of treatment, had the opportunity to develop into a more severe and chronic case of PTSD.

Finally clinicians felt that servicemembers' young age, on average between 20-29, was yet another contributing factor to PTSD development. Like helpseeking attitudes, they felt it served to delay treatment. This was largely attributed to the desire to focus on developmental tasks associated with their age such as education, family life, and children. This stage in development is also not typically associated with illness or disease, and certainly not with the experiences of near death, violence and trauma that they have likely experienced in combat, so they tend to want to avoid focusing on that part of their experience which they would need to discuss in treatment. Similar to the effect of avoidance due to helpseeking attitudes, age and developmental stage serve to delay

treatment, leading to more severe and entrenched symptoms, in addition to possible other destructive coping mechanisms such as substance use.

Taken in combination these findings point to the influence that identity factors can have on vulnerability to PTSD and how culture shapes the reactions and behaviors veterans have in the aftermath of combat which can contribute to the development and severity of the disorder. Friedman & Marsella, (1996) cite several research studies that have mirrored some of the above findings; they cite the following risk factors for PTSD in veterans of color from the Vietnam war: “A background of academic difficulty, an unstable or problematic family, a father who has been in combat, problems with authorities, illegal drug use, and ethnic minority status.” Dohrenwend et al. (2008) add to this list from their study, age at the time of combat, education level, and lower scores on the Armed Forces Qualification Test. In this regard, findings from this study line up with previous research and expand the discussion specifically on the role of racism as a risk factor.

Additionally, Friedman and Marsella (1996) touch on the issue of helpseeking and the role having someone to support the veteran with their troubles can have on PTSD development. They report that,

The quality of the post trauma recovery environment may also determine long term clinical outcome. There is also reason to believe that social support, availability of help, and availability of someone in whom to confide about the trauma can reduce the likelihood of developing PTSD.

This statement supports this study’s findings of the effect a delay in helpseeking behaviors has on PTSD development.

Race and Culture in PTSD Treatment

The findings on the impact of race and culture in PTSD treatment in this study were quite robust. Clinicians were much more emphatic in their opinions that race and culture influence treatment and all the clinicians in the study (n=12) discussed the various ways they experienced this in their work with servicemembers and veterans of color. Openness to treatment (n=8) and trust in the clinician and/or treatment protocol (n=7) were the most mentioned themes. While stigma was cited as one contributing factor to a lack of openness to treatment, the issue of cultural norms around whom you seek help from and for what reasons loomed large. Veterans of color were caught feeling like they should not go outside the family to discuss their struggles for fear that they would be seen negatively by their families for seeking mental health treatment. Having overcome the stigma associated with mental health treatment, once in treatment there continued to be pressure to hide treatment from their families which then set up another barrier to treatment for them. Given the influential role of the family in cultures that tend to be more collectivist than dominant United States' culture, the clinician needs to understand the role of the family from the veteran's cultural context and address in treatment in order to attend to potential barriers.

Similarly the issue of distrust that clinicians' named as another barrier to treatment with servicemembers or veterans of color seemed connected to a larger cultural context that needed to be attended to based on the veteran's cultural context in order to establish an effective therapeutic relationship. The history of mistreatment and misdiagnosis in communities of color, especially in the African American community, often have an impact on a veteran's of color ability to trust in the clinician and the

treatment protocol. A few clinicians mentioned the legacy of the Tuskegee syphilis experiment and its effects on the African American community's ability to trust their health care providers. It is important not to interpret this level of mistrust as paranoia on the part of veterans of color because of the historical and ongoing basis for its existence. This leads into the next theme that emerged, that of accurate interpretation and empathy by the clinician.

Accurate interpretation and empathy were raised by seven of the study participants; it was interesting to note that all of the clinicians of color (n=5) were among the seven. This theme more than others saw a greater difference in the responses between Caucasian clinicians and clinicians of color both based on the percentages of each who noted this as a key issue in treatment, 29% versus 100%, and in the emphasis that the issue was given. Clinicians of color identified being misunderstood or misinterpreted as a common issue in treatment with veterans of color and also indicated that this awareness was based on some of their own experiences as people of color. They went on to discuss the history of misdiagnosis of people of color by primarily Caucasian clinicians and how that not only contributes to the mistrust of the mental health system but also to inappropriate treatment. They attributed this to a lack of cultural knowledge about norms that may exist in other cultures in addition to the missing of cues of distress; this finding was in line with Marsella, Friedman and Spain (1992) who emphasized the understanding of expressions of distress in the culture of the person being assessed lest clinicians and researchers continue to misdiagnose and misunderstand the PTSD experience.

The use of the Diagnostic and Statistical Manual as the primary diagnostic tool for PTSD leads one to look for a very specific set of symptoms which come from a Western perspective. Gerrity and Solomon (1996) point out the need for sensitivity for ethnocultural and religious factors because of their potential effects on the symptoms of PTSD which can be associated with emotions, the attitudes about expression of need and distress and a sense of personal responsibility. Clinicians also discussed the importance of understanding some of the routine experiences people of color have interacting within a racist society that may sound paranoid to clinicians who likely have not experienced such incidents and the potential for misdiagnosis and misunderstanding around these issues as well, which they felt could be crucial in establishing a therapeutic alliance.

Findings from this study are largely in line with previous research and literature in that clinicians in this study identified many of the same potential barriers to treatment in working with servicemembers or veterans of color, especially where there are issues of a cross cultural relationship. Edwin Parson (1985) reflected much of the similar sentiment as the clinicians in this study:

Ethnicity also shapes how the client views his or her symptoms, and the degree of hopefulness or pessimism toward recovery. Ethnic Identification, additionally determines the patient's attitudes about sharing troublesome emotional problems with therapists, attitudes toward his or her pain, expectations of the treatment, and what the client perceives as the best method of addressing the presenting difficulties. (Penk & Allen, 1991 p. 59)

Ethnocultural Considerations in Treatment

The findings on ethnocultural considerations that clinicians made when working with servicemembers and veterans of color varied widely. While the majority of the study participants (n=10) stated that they did factor race and culture into treatment with veterans of color, two study participants stated that they did not. Those that indicated that they did factor ethnocultural considerations into treatment had a range of different approaches to the work, including: spending more time in the alliance building process, varying very specific aspects of the treatment protocol, simply holding the idea that the veteran or servicemember is of a different background and being careful to not let their own cultural influences “blur” what they are hearing from clients, and finally there were clinicians who believe that race, ethnicity, and culture are central organizing frameworks for the therapeutic relationship and treatment and who started from that perspective regardless of the race, ethnicity or culture of the client. What emerges from these findings is that clinicians are sensitive to the potential impacts of race and culture but there is no common understanding or approach to addressing the impact of race and culture in the treatment of PTSD. While this might be expected across theoretical frameworks based on the variety of treatment approaches and considerations that arise from different theoretical orientations, the majority of the clinicians in this study (n=9) identified cognitive behavioral therapy as their primary theoretical approach.

The literature reflects this lack of common understanding, approach or recommendations on treatment protocol with servicemembers and veterans of color with a PTSD diagnosis. One issue has been the difficulty of conducting research that can effectively measure the dimensions and impact of ethnicity and culture (Marsella, Friedman, & Spain 1996). In the absence of this, it becomes difficult to know about “the

relationship between ethnocultural factors and the etiology, epidemiology, onset, diagnosis, course, outcome and assessment and treatment of PTSD” (Marsella et al 1996 pg. 107). Gusman et al. (1996) also discuss the additional difficulty in treatment with the ethnic minority patient with PTSD. They draw attention to the avoidance and isolation symptoms of PTSD which often make the patient feel like no one understands them. They go on to say that for an ethnic minority in the United States, their status as a member of the non-dominant culture often raises issues of belongingness and safety, which is then amplified by the experience of trauma and the symptoms of PTSD. Gusman et al (1996) go on to say that this interacts “to produce a heightened sense of isolation, disenfranchisement, and shame. The treating therapist is aided significantly by adopting a working model that addresses these multiple and interactive factors that contribute to subjective experience” (p.444). They conclude by saying that,

It is clear to us that PTSD professionals have only begun to recognize the considerable influence of culture on trauma recovery. As with most constructs, recognition is a first and necessary step toward fuller understanding. It is our hope that with our growing awareness of cultural influences will come more efficacious treatment for this multifaceted and multicultural disorder. (p. 455)

Conclusions

The goal of this study was to explore from the clinician’s perspective the role race and culture play in the treatment of servicemembers and veterans of color with combat related PTSD and the extent to which they incorporated ethnocultural considerations into treatment. The findings from this study and the literature both clearly call for a need for the development of both research and clinical applications for diagnosis and treatment of PTSD with veterans and servicemembers of color that integrates the neurobiological aspects of the disorder with the ethnocultural aspects of the disorder. Future research is

needed that examines how various aspects of complex cultural identities interplay with reactions to trauma with a goal of developing treatment recommendations and interventions. Research comparing treatment models for PTSD from other countries and cultures for cultural fit in the United States with veterans of color may help influence practice with that population. And finally, further research examining the influence of a clinician's race or culture on the treatment relationship with veterans or servicemembers of color with PTSD would clarify some of the differences in responses found in this study between clinicians of color and Caucasian clinicians. In addition to further research and development of clinical application models, widespread training for clinicians working with servicemembers and veterans is needed on the ethnocultural aspects of trauma.

There were several limitations noted in this study. This study was a qualitative evaluation of a topic that has little research or discussion available in the literature. There is limited research and literature with which to compare the findings of this study. In addition the small sample size limits the generalizability of the findings of this study. This study was exploratory in design and as such sought to elicit participants' ideas, perceptions, opinions and experiences. The results of such a design are that not all participants were thinking and talking about the concepts of race and culture in exactly the same ways. Lastly, this study looked at ethnocultural considerations in treatment from the clinician's perspective. This did not allow for the experience of the client, the servicemember or veteran of color, and their perspectives and opinions to be considered as it relates to the role of race and culture in treatment for combat related PTSD.

Strengths of the study include diversity in the study population along a number of factors. The sample was racially diverse with 5 of 12 of the study population being

people of color. The sample also had diversity in terms of professional affiliation with representation from clinical social workers, psychologists, a marriage and family therapist and an advanced practice nurse. There was diversity in terms of treatment setting with representation from inpatient psychiatry, residential treatment, intensive outpatient programs, PTSD specialty clinics, and private practice. Clinicians also represented a diverse array of theoretical frameworks for treatment ranging from Cognitive Behavioral Therapy, Exposure Therapy, EMDR, Psychodynamic Psychotherapy, and trauma based supportive therapy. There was also some gender diversity in the study sample with 4 men and 8 women participating.

This study contributes to the social work profession by exploring a topic that is understudied and gives voice to some of the challenges and questions clinicians are facing in providing treatment to returning servicemembers and veterans of color with a PTSD diagnosis. This study highlighted observations and concerns regarding effective treatment with this population and contributes to raising the awareness of practitioners and researchers alike to the importance of ethnocultural considerations in PTSD treatment with servicemembers and veterans of color. This topic is timely as Operation Enduring Freedom and Operation Iraqi Freedom continue on their eighth and sixth year respectively. To date 1.6 million servicemembers have been deployed to Afghanistan and Iraq and reported rates of PTSD for those servicemembers are between 12-21% with even higher rates reported for those who have had the multiple deployments common in these wars (Miles, 2005; Tanielian & Jaycox, 2008; Goldberg, 2007; United States Army Office of the Surgeon General, 2008). Servicemembers of color make up 37% of the Army's soldiers (Maxfield, 2006). Undoubtedly, this population will need treatment that

can effectively address the multiple biopsychosocial issues they will be facing. The social work profession will be called on to do so in a manner that addresses treatment in an effective and informed way. This study aimed to contribute to that endeavor.

References

- Allen, I. (1996). PTSD among African Americans. *Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications* (pp. 209-238). Washington, DC US: American Psychological Association.
- American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders*. (4th ed.) Arlington: American Psychiatric Association.
- Dohrenwend, B., Turner, J., Turse, N., Lewis-Fernandez, R., & Yager, T. (2008, April). War-related posttraumatic stress disorder in Black, Hispanic, and Majority White Vietnam veterans: The roles of exposure and vulnerability. *Journal of Traumatic Stress*, 21(2), 133-141.
- Friedman, M., & Marsella, A. (1996). Posttraumatic stress disorder: An overview of the concept. *Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications* (pp. 11-32). Washington, DC US: American Psychological Association.
- Frueh, B., Brady, K., & de Arellano, M. (1998). Racial differences in combat-related PTSD: Empirical findings and conceptual issues. *Clinical Psychology Review*, 18(3), 287-305.
- Frueh, B., Gold, P., de Arellano, M., & Brady, K. (1997, June). A racial comparison of combat veterans evaluated for PTSD. *Journal of Personality Assessment*, 68(3), 692-702. Retrieved July 2, 2008.
- Frueh, B., Hamner, M., Bernat, J., Turner, S., Keane, T., & Arana, G. (2002). Racial differences in psychotic symptoms among combat veterans with PTSD. *Depression and Anxiety*, 16(4), 157-161. Retrieved June 24, 2008.
- Gerrity, E., & Solomon, S. (1996). The treatment of PTSD and related stress disorders: Current research and clinical knowledge. *Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications* (pp. 87-102). Washington, DC US: American Psychological Association.
- Goldberg, M. (2007, October 17). Projecting the costs to care for veterans of U.S. military operations in Iraq and Afghanistan. Congressional Budget Office Testimony before the Committee on Veterans' Affairs, USA.
- Gusman, F., Stewart, J., Young, B., Riney, S., Abueg, F., & Blake, D. (1996). A multicultural developmental approach for treating trauma. *Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications* (pp. 439-457). Washington, DC US: American Psychological Association.

- Hutchinson, J., & Banks-Williams, L. (2006, March). Clinical issues and treatment considerations for new veterans: Soldiers of the wars in Iraq and Afghanistan. *Primary Psychiatry*, 13(3), 66-71. Retrieved July 20, 2008.
- Kulka, R., Schlenger, W., Fairbank, J., Hough, R., Jordan, B., Marmar, C., et al. (1990). Trauma and the Vietnam war generation: Report of findings from the National Vietnam Veterans Readjustment Study. Philadelphia, PA, US: Brunner/Mazel.
- Lewis-Fernández, R., Turner, J., Marshall, R., Turse, N., Neria, Y., & Dohrenwend, B. (2008, April). Elevated rates of current PTSD among Hispanic veterans in the NVVRS: True prevalence or methodological artifact? *Journal of Traumatic Stress*, 21(2), 123-132. Retrieved June 24, 2008.
- Marsella, A., Friedman, M., & Spain, E. (1992, Spring). A selective review of literature on ethnocultural aspects of ptsd [Electronic version]. *PTSD Research Quarterly*, 2(3) 1-7. Retrieved October 1, 2008.
- Marsella, A., Friedman, M., & Spain, E. (1996). Ethnocultural aspects of PTSD: An overview of issues and research directions. *Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications* (pp. 105-129). Washington, DC US: American Psychological Association.
- Maxfield, B. (2006). Army profile FY06. Office of Army Demographics. Retrieved October 5, 2008 from <http://www.armyg1.army.mil/HR/docs/demographics/FY06%20TriFold%20with%20the%20Education%20Chart.pdf>
- Maxfield, B. (2007). The changing profile of the army. Office of army demographics. Retrieved October 1, 2008 from <http://www.armyg1.army.mil/HR/docs/demographics/Changing%20Profile%20report%20December%202007.pdf>
- McLean, A., Shanker, T., Tse, A. (2008, April 5). Tracking deployments. *New York Times*. Retrieved October 10, 2008 from http://www.nytimes.com/interactive/2008/04/05/us/nationalspecial/20080405_MILITARYCOUNT_GRAPHIC.html
- Miles, D. (2005, July 28). Officials report progress, challenges in treating combat stress. American Forces Press Service. Retrieved on October 10, 2008 from <http://www.defenselink.mil/news/newsarticle.aspx?id=16538>
- National Center for Post Traumatic Stress Disorder (n.d.). Course modules: Special Populations. Retrieved April 4, 2009 from <http://www.ncptsd.va.gov/ptsd101/modules/index.html#4>

- Penk, W. and Allen, I. (1991). Clinical assessment of post-traumatic stress disorder among American minorities who served in Vietnam. *Journal of Traumatic Stress*. 4(1), 41-66.
- Schlenger, W., & Fairbank, J. (1996). Ethnocultural considerations in understanding PTSD and related disorders among military veterans. *Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications* (pp. 415-435). Washington, DC US: American Psychological Association.
- Stamm, B. and Friedman, M. (2000). Cultural diversity in the appraisal and expression of trauma. In Shalev, A., Yehuda, R., & McFarlane, A. (Eds.), *International handbook of human response to trauma* (pp.69-85). New York: Plenum Publishers.
- Tanielian, T. and Jaycox, L.H. (Eds.). (2008) *Invisible wounds of war: Psychological and cognitive injuries, their consequences and services to assist recovery*. Santa Monica: RAND Corporation. Retrieved on October 1, 2008 from <http://veterans.rand.org>
- United States Army Office of the Surgeon General (2008). *Mental Health Advisory Team V Report*. Retrieved October 4, 2008 from http://www.armymedicine.army.mil/reports/mhat/mhat_v/mhat-v.cfm
- Whealin, J. (2007). PTSD: General cross cultural considerations. National Center for PTSD. Retrieved October 4, 2008 from http://www.ncptsd.va.gov/ptsd101/modules/whealin_cultural.html

APPENDIX A

Recruitment Contact Letter

Dear Potential Research Study Participant,

My name is Nada Michael, and I am a graduate student at Smith College School for Social Work. I am conducting a research project designed to explore from the clinician's perspective, the role race and culture play in the diagnosis and treatment of servicemembers and veterans of color with post traumatic stress disorder and the extent to which clinicians are incorporating ethnocultural considerations into treatment when working with this population. This study is being conducted for the Masters of Social Work degree at Smith College School for Social Work and may be used in future presentations or publications on the topic.

Participants in this study should be mental health professionals who are currently treating servicemembers or veterans of the current conflict with a PTSD diagnosis and have treated or are currently treating servicemembers or veterans of color from the current conflict with a PTSD diagnosis. Participants will be asked about their experiences and treatment approaches in working with this population. Participants will also be asked to provide demographic information about themselves.

The interview will be conducted at a mutually agreed upon time on the phone or face to face at a mutually agreed upon time and location. The interview will last between 30- 45 minutes. All interviews will be kept confidential and information collected during the interview will be kept secure. After three years, if participants' information is no longer needed it will be destroyed.

Participants will receive no financial benefit for involvement in this study. However, participants may benefit from knowing they are contributing to the further understanding of PTSD treatment for people of color.

Please contact me if you have any further questions or you would like to refer someone, including yourself, for an interview.

Sincerely,
Nada Michael
nmichael@email.smith.edu

APPENDIX B

Permission Letter from Give an Hour



P.O. Box 5918
Bethesda, MD
20824

info@giveanhour.org
www.giveanhour.org

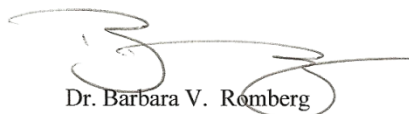
February 15, 2009

Smith College
School for Social Work
Lilly Hall
Northampton, MA 01063

To Whom It May Concern:

Give An Hour gives permission for Nada Michael to recruit participants for her research study through this agency. We do not have a Human Subjects Review Board and, therefore, request that Smith College School for Social Work's (SSW) Human Subject Review Committee (HSR) perform a review of the research proposed by Nada Michael. Give an Hour will abide by the standards related to the protection of all participants in the research approved by SSW HSR Committee.

Sincerely,



Dr. Barbara V. Romberg
Founder and President
Give an Hour

APPENDIX C

Interview Guide

You are free to skip any question you wish. Please remember not to use names or identifying information when discussing case material. Thank you.

Demographic Information:

Age:

Gender:

Race:

Licensure:

of years in practice:

1. Please describe the practice setting that you work with servicemembers or veterans in.
2. Please describe your theoretical orientation and/or treatment approach for PTSD.
3. Have you ever attended or been given any training about race/culture and PTSD? If yes please describe.
4. From your personal experience and opinion do race and culture impact PTSD development and/or treatment?
5. In your experience working with veteran populations have you noticed any differences between groups of people and their symptoms? Their treatment results?
 - Women
 - People of color
 - Older vs. younger
6. Do race and culture factor into your treatment planning when working with veterans of color? Why or why not?
7. How do you identify racially and culturally? How do you think your own racial/cultural identity informs your treatment with servicemembers or veterans of color?
8. Can you think of specific cases where race/culture may have played a role in treatment, if so please describe.

9. What additional support or training, if any, might you want in order to further your understanding of this topic?
10. Are there any questions that I should have asked you or that you had expected me to ask that I didn't?
11. Do you know of anyone else who may be interested or willing to participate in the study?

APPENDIX D

Informed Consent Form

January 5, 2009

Dear Potential Research Participant:

My name is Nada Michael. I am conducting a qualitative study of the ethnocultural considerations in the treatment of a PTSD diagnosis for servicemembers and veterans of color from the clinician's perspective. This research study for my thesis is being conducted as part of the requirements for the Master of Social Work degree at Smith College School for Social Work and possible future presentations and publications.

Your participation is requested because you are a clinician who treats servicemembers and veterans with a PTSD diagnosis. If you choose to participate, I will interview you about your experience working with servicemembers and veterans of color with a PTSD diagnosis. Also, I will ask you to provide demographic information about yourself. The interview will be conducted on the phone or face-to-face and will last for approximately 30-45 minutes. Interviews will be tape recorded with your consent, and tapes will be coded numerically to ensure your confidentiality. After three years have passed, tapes will be destroyed after the interviews have been transcribed. If I use a transcriber, he/she will sign a confidentiality pledge.

You will receive no financial benefit for your participation in this study. However, you may benefit from knowing that you have contributed to the understanding of treatment considerations for servicemembers and veterans of color with a PTSD diagnosis and for others with combat related PTSD. It is my hope that this study will help clinicians working with servicemembers and veterans have a better understanding of treating and communicating with people of color who have a combat related PTSD diagnosis. You may also benefit from receiving the opportunity to share your experience and gain a new perspective. There is minimal risk anticipated from participating in the study. You may become minimally uncomfortable expressing challenges in your work with some of the clients discussed.

Strict confidentiality will be maintained, as consistent with federal regulations and the mandates of the social work profession. Your identity will be protected, as names and identifying information will be changed in the reporting of the data. Please refrain from using names or identifying information during the interview when discussing case material. Your name will never be associated with the information you provide in the questionnaire or the interview. Your confidentiality will be protected by coding the information and storing the data in a locked file for a minimum of three years and after three years it will be destroyed unless I continue to need it in which case it will be kept secured.

Your participation is completely voluntary. You are free to refuse to answer specific questions and to withdraw from the study at any time before May 30, 2009. If you decide to withdraw, all materials pertaining to you will be immediately destroyed. If you have additional questions about the study or wish to withdraw, please feel free to contact me at the contact information below. If you have any concerns about your rights or about any aspect of the study, I encourage you to call me or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

Nada Michael
nmichael@email.smith.edu

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

SIGNATURE OF PARTICIPANT

SIGNATURE OF RESEARCHER

DATE

DATE

Please return this consent form to me prior to the interview to indicate your intention of participating in the study (I suggest that you keep a copy of this consent form for your records).

Thank you for your time, and I greatly look forward to having you as a participant in my study.

APPENDIX D

HSR Approval Letter

February 20, 2009

Nada Michael

Dear Nada,

Your revisions have been reviewed and all is now in order. We are happy to give final approval to your most interesting study.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Caroline Hall, Research Advisor