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Treatment for Trauma Affected African American Veterans

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African Americans have participated in every war fought by or with the United States and have suffered both during the war and when they return home [1]. Currently, African Americans make up 17% of the total U.S. military fighting force while comprising only 13.60% of the total U.S. population [2]. The stressors that African American military servicemen experience are both multi-layered and interconnected. Like many veterans, African Americans return to American soil often feeling isolated, unsupported and alone. However, for Black soldiers and veterans, the compounded stress of experiencing mental health challenges associated with the horrors of combat, facing institutional racism, and having to struggle to acquire necessary resources and supports upon returning home can be far too much to endure. It is important for clinicians to understand the unique cultural experiences of African American veterans in order for culturally competent treatment to be provided. In this article, we contend that identifying culturally salient components of complex psychological trauma in African American veterans and active duty soldiers contributes to substantial differences in clinical conceptualizations, assessment, and clinical treatment interventions for this population. Additionally, we posit that understanding culturally specific reactions to trauma exposure, namely, the compounded nature of combat-related PTSD and cultural trauma (i.e., 'Post Trauma Slavery Syndrome' or the 'African American Psychic Trauma'), may provide important insights into specific vulnerabilities and expressions of illness that could inform treatment planning and delivery.

While the government does not break down military suicides according to race, the Congressional Research Service Report, [3] *U.S. Military Casualty Statistics: Operation New Dawn, Operation Iraqi Freedom, and Operation Enduring Freedom* provided statistics on the race and ethnicity distribution of OIF and OEF casualties. African American deaths in Operation Iraqi Freedom (OIF) comprised 9.7% of the total military casualties (429 deaths). In Operation Enduring Freedom (OEF), African American deaths accounted for 7.1% of the total military casualties (90 deaths). According to the Congressional Quarterly Weekly, more U.S. servicemen committed suicide than were killed in combat in Afghanistan and Iraq in 2010. As Donnelly reports [4], some 468 servicemen took their own lives and 462 were killed in action. Although the number of African American service men who committed suicide was not specified in this study it has been evidenced that isolation and perceived lack of social support, a common feature of PTSD, is a stable predictor of suicide risk among African Americans [5].

PTSD is an anxiety disorder that follows exposure to an overwhelming traumatic event. The main features are intrusive thoughts including flashbacks, avoidance of things that recall the trauma, hyperarousal, sleeplessness, restlessness, and irritability [6]. While some of these symptoms may be common for most soldiers after experiencing combat-related trauma, the hallmark of PTSD is a failure to recover psychologically from the traumatic event(s), with subsequent impairment of normal functioning. The aforementioned Rand Corp study [7], estimated that nearly 20 percent of military service members returning from Iraq and Afghanistan, about 300,000, reported symptoms of PTSD or some form of depression.

In addition to the combat-related PTSD that African American

soldiers and veterans experience, the residual stress of over 300 years of enslavement and race-based cruelty is largely thought to have resulted in what is defined today as the African American Psychic Trauma [8] or Post Traumatic Slave Syndrome (PTSS), a similar yet culturally specific kind of trauma that is believed to have generationally penetrated through the physical, emotional, psychological and often spiritual lives of many African American people [9]. Logan et al. [10] also highlight the intergenerational impact of slavery, institutional racism, discrimination, and oppression on the emotional and psychological health of African Americans.

African American soldiers have bravely fought in combat since the American Revolutionary War of 1775, experiencing compounded race-related stressors both in civilian life and within the U.S. military structure. It is important to note that racism, oppression, and discriminatory treatment was inherent in military service as it was in the larger American society [11]. For generations, African Americans continually faced this brutal racism which manifested in the form of assaults, mistreatment, and even murder as a result of White violence or by the police [12]. In 1917 there were more than 400,000 African Americans in military service and many were required to serve in segregated units. This legalized discrimination lasted until President Harry Truman enacted Executive Order 9981 in July of 1948 which marked the end of segregated, inherently unequal military units in the United States [1].

In 2010, the U.S. Census Bureau reported 42 million African Americans in the U.S. from the total population of 308.7 million, 13.60% of the total population, while the Department of Defense (2010) reported the African American U.S. military community comprised 17% of the total fighting force, 3,697,646 people. Despite this strong representation, African American soldiers still unfortunately experience racial discrimination in the military today. In June of 2011 it was reported that Specialist Adam Jerrell, a 23 year old African American war veteran was routinely subjected to threats of physical violence and racial insults by fellow soldiers while serving in Afghanistan in 2009. As Pollon reports [13], Specialist Jarrell explained that the harassment began after he reported the physical abuse of two soldiers by an officer. The military's response to Jarrell's harassment was slow at best and he subsequently filed a formal racial discrimination complaint through the American Civil Liberties Union of New Mexico. Additionally, a lawsuit filed by the Common Sense and Veterans United for Truth in July 2008 specifically singled out poor care for African American soldiers. As Ott reports [14], in the suit the organization warned that unless the U.S. institutes systematic and drastic measures to care for injured soldiers,

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the number of broken families, unemployed and homeless veterans, cases of drug abuse and alcoholism, and the burden of the health care and social service systems will be immeasurable.

There is also the issue of military bureaucracy and the various hoops that veterans have to navigate through when seeking services from the Veterans Administration (VA). Many African American veterans lack support from the government upon reentry to civilian life. These "hoops" entail having to fight for disability benefits, proper medical care, employment, and housing when they return to civilian life. Securing these services and resources can be even more challenging when presented with the realities of both overt and covert racism.

Both the combat-related and race-related PTSD experienced by Black veterans can make it difficult to find or hold a job, thus making it a challenge to afford a house or rent an apartment. Some veterans have benefited from the GI Bill of Rights, also known as the Servicemen's Readjustment Act of 1944, which has paid for their education and has helped them buy homes. However, several veterans have not received GI Bill benefits or disability benefits. In examining racial disparities in VA service connection for PTSD, Murdoch et al. [15] identified that the likelihood of African American veterans receiving PTSD disability benefits was significantly lower than that of other veterans. In this study, women were also less likely to receive service connected PTSD disability benefits. The study also found that applicants who were rejected for these disability benefits had higher rates of poverty, homelessness, increased dependence on welfare and food stamps, poorer quality of life outcomes, and lower annual incomes than veterans who were granted disability benefits.

African American veterans have long had a history of being neglected by the Veterans Administration and other military groups. The Veterans Administration admits that hundreds of Iraqi vets already live on the streets [16]. In March 2002, a VA report (VA Programs for Homeless Veterans) stated that one-third of the adult homeless male population and nearly one-quarter (23%) of all homeless adults have served their country in the armed services. Roughly 56% of all homeless veterans are African American or Hispanic, despite only accounting for 12.8% and 15.4% of the U.S. population respectively [17].

Because African American veterans suffer from these and other various forms of combat-related and racial trauma, their treatment needs are unique, specific, and warrant adequately trained health care providers who are prepared to meet these needs. There are several important clinical implications in the treatment of African American veterans. Although mental health services may be provided to African Americans and their families, they may not be provided in a culturally appropriate manner or adapted to the unique needs of this population [18]. Researchers have suggested that the development of non-culturally appropriate services may lead African Americans to underutilize mental health care [19]. Another reason cited for underutilization of mental and behavioral health care is that soldiers and their families are simply not aware of the extent of services to which they have access. At the same time, many African Americans avoid mental health treatment due to being perceived as crazy, weak or unstable. The African American community in its perception that emotional problems are a weakness has only served to reinforce the isolation commonly felt by soldiers and veterans within their community [11]. These perceptions are commonly felt by soldiers and veterans outside of the African American community due to the bureaucratic structure of the military. Many service members who report emotional or psychological problems may feel they are doing so at their own peril. Soldiers are trained to follow orders no matter what,

and the open discussion of psychological issues or disturbances can be perceived as interfering with one's military duties.

When these soldiers return home, they have difficulty adjusting to the society they once knew. They find that there are few that can understand what they have gone through, continue to go through, and few with whom they can discuss it. According to the National Center for PTSD, it is common for PTSD vets to feel that they must keep things private and that they cannot trust family, friends, or the government for help. Additionally there can often be a stigma associated with talking about these problems partly due to the fact that complaints of PTSD and other mental illnesses usually go on military records which can damage careers.

It is also important to note the unique features of PTSD and complex psychological trauma as it manifests in African Americans specifically. Compounded race-related stressors often contribute to both mental and physical ailments in soldiers and veterans of color, which frequently manifest as psychotic and somatic symptoms at disproportionate rates in the Black community.

According to Logan et al. [10] the historical or generational experiences of institutional racism, discrimination, and oppression, has produced a "schizophrenic" type of existence for the enslaved Africans and their descendants. And although religion and spirituality has largely been the core essence of African and African American life, in their groundbreaking book, *Spirituality and the Black Helping Tradition in Social Work*, Martin & Martin [20] argue that Black American life has largely been spiritually out of balance, off-center (de-centered), and the result has been a sort of detachment from the cultural core of the African descendant's personality or a "behavioral incongruence." They label this imbalanced condition as spiritual fragmentation. Spiritual fragmentation is the incongruence between one's personal, moral, religious, and spiritual beliefs and his or her social acts and communal obligations [20].

This "spiritual fragmentation" may be the root cause for the overrepresentation of current clinical conceptualizations of psychotic symptomatology in the African American community. It has been well documented that African-Americans describe their symptoms differently than Caucasians, often leading to an inappropriate diagnosis of psychotic features or disorders [21,22]. Consequently, African-American soldiers and veterans may be more likely to be misdiagnosed and receive antipsychotic medications more than their Caucasian counterparts. These misdiagnoses and cultural variations of perceived pathology may lead to inappropriate [22] and/or prolonged treatment [21]. However, further research would need to be conducted that would examine spiritual aspects of the African American self or core personality. This would take a thorough evaluation of core African-centered values and beliefs as they personally relate to the presenting African American client on a micro level and the African American community at large on a macro or community level.

Additionally, somatic symptoms are an associated feature of anxiety disorders that have received little research attention among non-White samples specifically [23]. Medically unexplained physical or somatic manifestations of depression and other common mental disorders occur across all cultures, and contribute significantly to the under recognition of depression and anxiety in primary care practice [24,25]. Certain cultural groups, including African Americans [26,27], have a tendency to mention somatic symptoms more frequently, or to focus more heavily on these symptoms when consulting their health care providers [28-30]. Brown et al. [27] showed that among depressed

African Americans in the U.S., the severity of somatic symptoms was higher than in their White counterparts.

Somatizations have even been said to be more dominant among patients in Africa and in other developing countries [31-33]. Culturally framed symptom interpretations, concepts of mental health, and social stigmas have been noted as being chiefly responsible for these cultural variations of somatic symptomatology. In some cultures, depression and anxiety have been seen as moral or social problems, rather than mental illness [26,27]. However, physiological or genetic factors, assessing trauma history which may highlight previous traumatic experiences, and examining risk factors increasing a soldier's vulnerability for PTSD may be a cause for the emergence of these somatic and psychotic symptoms. Schnurr et al. [34] identified family instability, severe punishment during childhood, childhood antisocial behavior, and depression as pre-military risk factors for PTSD across all ethnic groups. Arguably, racism, generational trauma, and poverty could also be pre-military risk factors for the development of PTSD. Further research must be conducted to examine these factors which have led to noticeable differences in the manifestation of these symptoms in the African American community.

Treatment and Available Services for African American Soldiers and Veterans

The primary cultural issue for working effectively with African American veterans and African Americans in general is concerned with the clinician's willingness to embrace a paradigm shift that incorporates the world views of this population [10,35]. Scholars on African American family life have conceptualized world views of African Americans as African-centered and strengths-based [36]. Common themes throughout these studies include the importance of (1) Family, community, and collectivism, (2) Spirituality and religion, (3) Self-Empowerment, (4) Empathy and nurturance, and (5) Rituals of healing. The Africentric and strengths-based orientation includes the history, culture, and worldviews of African Americans and proposes a multidimensional or multilevel framework for practice, assessment, and intervention [10,37]. Intervention strategies with this population should be holistic in nature to include the biopsychosocial-spiritual aspects of African American veterans. An emphasis on spirituality and religiosity in treatment may be a cornerstone in reframing perception and constituting behavior [38,39]. According to Peres et al. [40] when people become traumatized they often look for a new sense of meaning and purpose in their lives and religious frameworks and practices may have an important influence on how people interpret and cope with traumatic events.

In addition to understanding Africentric culture, it is essential for practitioners to be well versed in military culture, which is an integral aspect of the world view of African American veterans. In the spring 2009 issue of Contact, Amelia Roberts-Lewis shared that clinicians who are schooled in the discipline and authority of the armed services stand a much greater chance of connecting with veterans than those who are unaware of the structure. She went on to state that clinicians need to understand the military's values, traditions and customs to successfully establish credibility and generate effective treatment [41]. Some of the military's various cultural rules and regulations include the emphasis on punctuality, respect and obedience to authority, physical fitness and unquestioned allegiance. These embedded ideals undoubtedly are difficult for soldiers to detach from when they return to civilian life.

Some of the practice strategies for working with African American veterans include the African-centered genogram, the cultural eco-map,

cognitive restructuring, culturally relevant readings, and family albums [36]. It may also be helpful to facilitate the development of military-centered narratives, readings, and/or eco-maps if the veteran initially identifies more with his or her armed services family. Many veterans have spent years with their battalion units and may have unresolved internal conflicts or separation concerns when a fellow service buddy is killed or wounded in combat. According to Peres et al. [39] building new narratives based on healthy perceptions may facilitate the integration of traumatic mnemonic traces and sensorial fragments in a new cognitive synthesis, thus working to decrease symptoms of PTSD. Perhaps more importantly, narratives and storytelling, namely the oral tradition, are traditional African American methods of passing down information. When these traditional elements are incorporated in the clinical treatment plan of the African American soldier or veteran, treatment outcomes may be more promising and sustainable.

The treatment plan should be based on a collaborative partnership. Logan and Freeman [36] identify the following recommendations: (1) Identify and understand the cultural identity of African American clients and families and their unique history of enslavement and the continuing impact of living in an environment of oppression, racism, and gross inequalities; (2) Assume the existence of strengths, search for exceptions, and support the client's strengths through the inclusion of significant others and through affirmations and an emphasis on solutions; and (3) Walk and work side by side with client systems as partners.

Kane [11] provides recommendations to therapists and other mental health care providers that work with the African American veteran population. Among the recommendations: (1) Therapists should become knowledgeable about racism that impacts the daily lives of African American men and women, (2) Therapists have to consider the treatment needs at each stage of the clinical interaction (intake, conceptualization/diagnosis and treatment), and (3) Therapists must take into consideration transference and counter-transference issues that may also appear at each stage of the clinical interaction. The study goes on to state that the dominant society and the African American community must take responsibility for the current state of "being" in relation to African American veterans. Shouldering this communal responsibility is vital to treating and overcoming the harsh realities of PTSD.

The emotional and psychological trauma experienced by veterans is also likely to have an emotional impact on his or her family members as a result of their interdependence [42]. As PTSD symptoms such as fear, preoccupation with the trauma, emotional numbing (e.g., lack of affection), avoidance, and irritability emerge in the client's interpersonal world, their relationships may become strained, disrupted, or even disintegrate [43]. Adjustment difficulties that military spouses may report after deployment include changes in the soldier's mood or personality, communication within the relationship, disciplining children, and reestablishing roles and household routines. Taylor [43] suggests the implementation of exercises from behavioral couple or family therapies, combined with psychoeducation for significant others about PTSD during clinical treatment.

Additionally, the strain of multiple and prolonged deployments can affect the emotional well-being of a soldier's family according to a Rand study, [7] *Views from the Homefront*. Caregivers in the study sample cited two challenges as the most difficult during deployment: dealing with life without the deployed parent (72%) and feeling overwhelmed by new responsibilities at home (57%). Caregivers cited fitting the returning parent back into the home routine (62%) as the most difficult

challenge during reintegration. Soldiers and their spouses often change during the separation, and they need time to get used to each other again, renegotiate roles, and reorganize their lives together (-).

The larger community is also affected by PTSD and as previously noted the infectious nature of this disorder will end up costing the nation billions if this systemic problem is not appropriately treated. Social workers should advocate for policy changes to be implemented to eliminate VA disability compensation disparities related to race and gender and to expand VA counseling services or to outsource services to civilian providers to diminish the burden of inadequate psychotherapy resources [44]. Without appropriate medical or psychological intervention, veterans with PTSD often numb their emotional pain by using alcohol or illegal substances, overeating, or engaging in risky or criminal behaviors. These are short term fixes which usually lead to more complex problems that not only affect the individual but his or her whole ecology. Engaging in these maladaptive coping mechanisms only allow the traumatic wounds to remain. There are several medical and behavioral health care providers available in the Fort Bragg/Fayetteville community and nationally which are designed to assist military service personnel, veterans, and their families access the services and supports that they need.

In 2008, Fort Bragg hired fifty clinical social workers whose responsibilities included reaching out proactively to enlisted soldiers in social settings (bowling alleys and clubs, for example) and offering them basic counseling and referral services. This case management intervention allows soldiers to receive mental health and other kinds of guidance and referrals on an informal basis. Although this program has shown great promise, more space is needed for its operations [45-55].

To avoid the possibility of stigmatization or labeling, Fort Bragg expanded its Military Family Life Consultants Program. This Army program is designed to provide free, anonymous, confidential support to soldiers and their family members, especially those who are returning from deployments.

Soldiers can also receive counseling and emotional support through the Army Community Services (ACS) Program, which offers a variety of programs and services that can be tailored to address the specific needs of soldiers and their families. There are seven ACS locations on-post and within surrounding local communities. The program provides services associated with relocation, budgeting and personal finance, deployment and reunion, and family relationships.

Cumberland County remains the Fort Bragg region's largest referral center for health care services, particularly for TRICARE enrollees who have access to the Womack Army Medical Center. More than 1,289 health care professional practice in the Fort Bragg region. The majority of these health care providers are located in Cumberland County. Behavioral health services in the region are managed by the Cumberland County Local Management Entity (LME), which will soon become a part of the Durham/Wake County Managed Care Organization (MCO), Alliance Behavioral Healthcare Provider network under the 1915 (b)/(c) Medicaid Waiver, which refers to legislation passed in 2011 as a part of the Social Security Act to restructure the management responsibilities for the delivery of services to individuals with mental illness, intellectual and other developmental disabilities, and substance abuse disorders (MH/DD/SA).

This next phase of mental health reform will especially affect military service men, women, and their families who do not have TRICARE or private insurance and may have to utilize Medicaid for health and behavioral healthcare. The Cumberland County LME has not been able

to fully support the behavioral health needs of the region, particularly the needs of those with chronic and persistent mental illnesses. The support of private providers is essential to the future success of the mental health system. Some of these local private providers include Evergreen Behavioral Management, Inc., Cardinal Clinic LLC, and Cumberland County Communicare, Inc. These providers are CABHA certified and service clients from various racial and ethnic backgrounds [56-69].

Soldiers and veterans can also utilize the medical and behavioral health care services provided for them through their local Veterans Administration Hospital and local Veterans Centers. As the nations' largest integrated health care system, the VA operates more than 1,400 sites of care, including hospitals, community clinics, community living centers, domiciliaries, readjustment counseling centers, and various other facilities [15].

Behavioral health care providers from various disciplines, professional social work can now begin the process of preparing themselves for the influx of soldiers, veterans, and their family members who will undoubtedly need medical, behavioral, and spiritual care by adopting a more holistic, integrated, and trauma-informed system of care to appropriately meet these emergent health care needs. Cultural and linguistic competency is also essential for both understanding and effectively treating culturally specific reactions to trauma exposure. Substantive and appreciable increases in the number of CSWE (Council on Social Work Education) accredited BSW and MSW programs offering military social work specialty curricula, including military behavioral health certificate programs, concentrations, etc., have been noted. To date, approximately twenty-nine programs have self-reported offerings in this regard, and this number will only increase in the very near future. These developments are indicative of the clear, compelling, and unequivocal recognition from the professional social work community that it must engage in a systematic process of educating it's constituents on the need for treatment and service delivery models uniquely tailored to military personnel in general, and to African American combat veterans in particular. Again, this long-awaited acknowledgement was strengthened considerably by the CSWE publication entitled Advanced Social Work Practice in Military Social Work. This work contains guidelines for advanced practice in each of the core competencies specified in the 2008 CSWE approved Educational Policy and Accreditation Standards (EPAS) document. Competency-based outcomes now constitute the required approach to social work education and, significantly enough, practices behaviors specific to social work with military families are now articulated for programs seeking to establish the same among its student population. Central to these standards and the imperatives for remaining cognizant of diversity and differences in practice, which would necessarily include an appreciation for the importance of engaging in evidence-based, and culturally competent practice with African Americans, and by extension, African American combat veterans. Re-conceptualizing health and healing, creating a whole new foundation and rebuilding a solid, sustainable infrastructure to deliver these services is what is needed now. In the months and years to come, we must work together to repair our health care system for the soldiers who so bravely risked their lives for our country's freedom.

This war has imposed an enormous strain on our armed forces. These men and women are serving in harsh, nerve-wracking conditions, in a war where there are no clear front lines. Thanks to advances in battlefield medicine, we are saving many more of the injured than in previous wars. There are 7.5 wounded for every fatality, compared with

a ratio of under 3 in Vietnam and Korea. Many of these grievous injuries that include traumatic brain injury, amputations, burns, blindness, spinal injuries and polytrauma – which is a combination of such things. If you include all those who are wounded in combat, or injured in a vehicle accident or contract a disease, there are 14 casualties for every death. *Hearing on the Economic Costs of the Iraq war, Testimony before the United States House of Representatives Committee on the Budget, October 24, 2007, by Linda Bilmes, Lecturer in Public Policy, John F. Kennedy School of Government, Harvard University.*

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