

**AFRICAN-AMERICAN VETERANS AND COMMUNITY:
POST-TRAUMATIC STRESS DISORDER AND RE-
LATED ISSUES**

HEARING
BEFORE THE
SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS
OF THE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES
ONE HUNDRED THIRD CONGRESS
FIRST SESSION

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SEPTEMBER 15, 1993
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AFRICAN-AMERICAN VETERANS AND COMMUNITY: POST-TRAUMATIC STRESS DISORDER AND RELATED ISSUES

TUESDAY, SEPTEMBER 15, 1993

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 9:10 a.m., in room 311, Cannon House Office Building, Hon. Lane Evans (chairman of the subcommittee) presiding.

Present: Representatives Evans, Montgomery, Waters, Kennedy, Bishop, and Rangel.

OPENING STATEMENT OF CHAIRMAN EVANS

Mr. EVANS. The chair would like to thank everyone for their attendance this morning and officially start the hearing at this point.

This morning the Subcommittee on Oversight and Investigations is meeting to examine a very important and timely subject—African-American veterans and the community: post-traumatic stress disorder and related issues.

Last week President Clinton and Vice President Gore unveiled their proposal to reinvent our federal government. Like the President, I strongly believe our federal government can and must be more responsive to our citizens. In veterans affairs, there are clearly many opportunities for improving services to the men and women who have served in our armed forces. Expanding the Vet Center program and improving PTSD-related services are only two of the needed improvements I strongly support. And in the very near future I intend to introduce legislation to bring about these needed improvements.

Among today's witnesses other improvements in veterans' services may be recommended and these recommendations will be very helpful to us, I believe, in fashioning that legislation.

Many individuals are scheduled to testify this morning and we look forward to receiving each of their presentations. Our witnesses today represent many different vocations, interests and experiences. We appreciate their willingness to come forward and participate today. Other individuals who could not be present today have been invited to submit a written statement for inclusion in the printed record of this hearing.

As many here may know, this hearing has been scheduled to coincide with the annual Congressional Black Caucus legislative

weekend. The annual CBC legislative weekend is an especially appropriate time to focus attention on issues of particular concern to African-American veterans. This subcommittee appreciates the cooperation it has received from the CBC, the Black Veterans Braintrust and Corrine Brown, Charlie Rangel, and Sanford Bishop, the three Members of Congress who co-chair the Braintrust.

This subcommittee especially wishes to acknowledge and thank Congressman Bill Clay, Chairman of the House Committee on Post Office and Civil Service and the staff of that committee for their assistance and cooperation. In addition to making this room available to us for today's proceeding, Chairman Clay and his staff have been particularly accommodating and helpful and we greatly appreciate their cooperation and contributions.

Lastly but not least, I want to particularly acknowledge the contributions of Ron Armstead, who has greatly assisted us in preparing for this hearing. He deserves a round of applause.

Before calling our first witness, it is my honor to introduce to you the Chairman of the full Veterans' Affairs Committee, Chairman Sonny Montgomery from Mississippi for any remarks he may wish to make.

Mr. MONTGOMERY Thank you. I want to commend you as the Chairman for the Oversight and Investigations Subcommittee for holding this hearing this morning. It is very, very important. As we have learned from PTSD, the large percentage of African-Americans who participated in the Vietnam War have had some problems in the area of PTSD. And I certainly commend you for having this hearing.

We had an informal meeting over donuts and coffee, I guess you would call it, before this meeting. I learned a lot. I learned more about Vet Centers and I want to thank those that participated in that informal meeting this morning.

I will stop with that and say it is good to see the Senator from Minnesota, Paul Wellstone. I know you worked late last night. I was watching you on C-SPAN until about 10 o'clock and I left you after that. I know that you believe in human rights for all people and you probably are the best athlete in the U.S. Senate, so thank you for being here today and testifying before this subcommittee. Thank you.

Mr. EVANS. Thank you, Mr. Chairman. We are very pleased and honored to welcome as our first witness Senator Paul Wellstone from Minnesota, well known for his outstanding interest and concern about domestic violence. Senator Wellstone has introduced S. 869, the Violence Reduction Training Act. Its major provisions include support for public education in the consequences of violence and training for health care workers to recognize and interview with victims of domestic violence and sexual assault.

I am very pleased he will be working with me to introduce post-traumatic stress disorder legislation in the Senate. I hope this will be one of many Wellstone-Evans legislative initiatives.

Senator, thank you for taking time out of your busy schedule. I know that you were in late last night, and we recognize you at this time.

**STATEMENT OF HON. PAUL WELLSTONE, A U.S. SENATOR
FROM THE STATE OF MINNESOTA**

Senator WELLSTONE. Thank you, Chairman Evans and Chairman Montgomery. I am honored to be here to testify on the issue of post-traumatic stress disorder and its effect on veterans and their families. I commend you for your work in this area and I support your efforts to develop more comprehensive treatment programs for those affected by this debilitating disease.

I am distressed by the fact that the VA is treating only about ten percent of veterans with service-connected PTSD. I do plan to introduce legislation with you, Chairman Evans, and I very much appreciate your leadership in this area. The legislation will expand and improve VA outpatient and inpatient care for PTSD victims. At the same time, I will push for Senate hearings on this pressing issue and I believe that we will have support in the Senate.

I know your focus today is on African-American veterans who statistics show are disproportionately affected by PTSD. That is an unpleasant truth that we cannot and should not hide from. But I also want to state that the PTSD symptoms of violence, abuse and neglect are not unique to the African-American community. It can affect any soldier, without regard to the color of his skin or gender. It is a disease that affects the whole family and may impact on the entire community.

Although I am certainly not an expert, Mr. Chairman, on the technical relationship of PTSD to violence, through my work and the work of my wife Sheila on the whole range of issues affecting domestic violence, I can testify to the deep and lasting impact on families that are victims of violence, abuse, and neglect. It is the link between the veterans who suffer from PTSD and the violence, abuse, and neglect they may inflict upon their families that brings me here today. It is this cycle of violence and abuse that I think we must work to curb. And treatment for those who suffer from PTSD is one important way to break that cycle of violence.

We need to understand at this hearing today that PTSD can and does affect the entire family, not just the veteran himself or herself. Veterans who suffer from PTSD often neglect and/or abuse their families. And the effects of this disease can have serious consequences for the children and even the grandchildren of veterans who suffer from PTSD. I have talked to a psychotherapist in Minnesota who works with vets who suffer from PTSD and she has told me that she is now treating not only the adult children but sometimes the grandchildren of Vietnam veterans who have grown up in violent homes.

The story of one Vietnam vet is a vivid example of the effects of PTSD on vets and their families. He physically and verbally abused his wife and children for two years. He exhibited symptoms of paranoia, severe irritability and flashbacks. He was diagnosed as suffering from PTSD. He has now completely withdrawn from his family and his life.

And I want to read a poem written by his 13-year-old daughter that was sent to me which was really the beginning of our involvement with this family.

For someone to share
Is only to care.

He was in the war
 And never opens his door.
 He lives in a shell
 And that must be like hell.
 He used to be my dad,
 But now he looks so sad.
 If only he knew
 It makes me feel blue.
 I know he loves me.
 Why won't he hug me?
 My mom says "he's numb."
 What will I become
 Without my father to guide me?

Common symptoms of this disease include angry outbursts, irritability, difficulty sleeping, and flashback experiences that feel real. Vets who suffer from PTSD often respond to the people at home as if they were in combat. This can lead to a veteran becoming violent toward a member of his family. For children it often affects their ability to learn, to function at home and at school, and their ability to relate to others.

Neglect, abuse, and even just witnessing abuse can leave devastating scars. Unless we begin to treat this disease, Mr. Chairman, it will continue to affect future generations. Recently, I had the opportunity to speak to a Minnesota veteran of both Korea and Vietnam who is African-American. He has a background as a counselor and learned only in 1989 that he was suffering from PTSD. I would like to share a few of his insights regarding the needs of African-American veterans who have PTSD.

In his view, many African-American veterans who are afflicted by PTSD refuse to acknowledge that they even have the disease and seek to cope with its effects on their own. They "stuff it," however unsuccessfully. He emphasized that the VA health system is currently not meeting the needs of these veterans and to do so it must institute outreach programs tailored to the needs of African-American veterans, hire more African-American counselors and other professionals to work their PTSD treatment units, and expand the number of "hassle-free" Vet Centers that are accessible to African-American veterans. I will work to fully examine these suggestions and others to some of the other testimony today, Mr. Chairman, as we begin to develop this legislation and work to get it passed.

Many of the veterans who come to my office for help ask that PTSD get a higher rating. They are frustrated by delays. They are stuck in the backlog of claims in the VA adjudication and appeals systems. Indeed, they are frustrated that parts of the VA are slow to recognize PTSD as an illness or that it is an illness whose effects can be every bit as devastating as any physical ailment.

The development of treatment programs for PTSD is still in the early stages. The first step is for the VA to recognize the traumatic effects of PTSD on both veterans and their families. User-friendly treatment programs need to be expanded and given the highest priority by the VA. The programs should be available to both vets and their families.

Therefore, I cannot urge you enough to act quickly to introduce the legislation, Mr. Chairman, as I will do the same, so that we can begin to help veterans and their families deal with this devastating disease.

Thank you for your efforts on this issue. I thank you for all of your work with veterans. I have a tremendous amount of admiration and respect for what you do. It is going to be an honor to work with you and to work with my colleagues in the Senate. And I know that there is going to be testimony that follows mine that will be much more powerful and I think much more important, but I am here to learn from other people and these are not just words and this is not just symbolic. I am committed to working very, very hard on this issue. Thank you.

[The prepared statement of Senator Wellstone appears on p. 49.]

Mr. EVANS. Thank you very much. I appreciate your comments. I don't have any questions, but I want to emphasize what you said. We want to build outreach to the minority communities, not just the African-American communities, but the Hispanic communities that have had the highest rates of PTSD, and to help their families as well.

We will be receiving very good testimony, and if you are able to stay longer, you may join us if you wish.

Senator WELLSTONE. I am going to stay 15 or 20 minutes because I must then go to the Senate floor. I apologize to those who I won't be able to hear, although I will have a chance to read all of their testimony.

Mr. EVANS. Thank you, Senator. We are now being joined by Congresswoman Maxine Waters and as soon as she has a chance to get situated we will recognize her for any comments she would like to make.

OPENING STATEMENT OF HON. MAXINE WATERS

Ms. WATERS. Thank you very much. Mr. Chairman, I am delighted to be here today and I would like to commend you for putting together an impressive array of witnesses for this hearing. I am happy to see organizations represented here today that probably would not qualify as regulars before this committee. Their comments will be extremely helpful. As we try to make the veterans health care system more responsive to the needs of African-American veterans, there is a fundamental need for increased attention for veterans in this country, especially African-American and women veterans.

Strict eligibility rules and chronic funding shortfalls of the 1980s have created a deficiency within the VA to provide an adequate level of service to the veteran population. We all know that most veterans are not rich. They depend upon the care provided by the VA. They have been told that care and assistance will be there for them. When we talk about helping veterans we are talking about helping disproportionately lower income and minority populations.

When we talk about how veterans care is not working we are talking about how it is not helping the poor and minorities. I hear from veterans all the time how difficult it is to receive service. But when you are either lower income, a minority or both, matters go from bad to worse.

I have spoken in many cities on veterans issues and I am constantly bombarded by veterans, African-American, Latino and others, who are desperate for assistance. Not only are they desperate for things as veterans health care, housing, PTSD assistance, et cetera, they are desperate for a VA that understands their problems. Those veterans that are suffering from PTSD are at a greater disadvantage.

Many African-American veterans were given bad paper discharges during the Vietnam era. As a result they are not able to receive treatment from the VA for PTSD. Private physicians do not always properly diagnose PTSD so the disease goes untreated. These veterans have a higher incidence of unemployment, family problems, alcohol and drug-related problems and homelessness. As the percentage of minorities continues to grow in our armed services, so will the minority percentage of our veterans' population. Twenty-eight percent of the troops in Desert Storm were African-Americans, up from 22 percent during Vietnam. Almost half of the women currently in the military are African-American.

Earlier in the year, the National Association for Black Veterans dropped by my office and presented us with a very good briefing package on issues that need to be addressed. We have a platform. We have good ideas. I sit here willing to work with you to pull these ideas together and push forward.

Mr. Chairman, thank you for accommodating my schedule and allowing me to participate in the opening remarks of this committee. I am delighted to be here with you, and I am delighted that the chairman of our committee is sitting here. I feel as if I am sitting between the left and the right here. And so that means I have to pull it together. Thank you.

Mr. EVANS. Thank you, Congresswoman Waters. We appreciate your leadership. Since coming to the committee you have been a real dynamo and we appreciate all of your hard work. You have put these issues on the map and we appreciate your leadership and look forward to working with you in the future.

Dr. Irving Allen, Dr. Erwin Parsons, Mr. Clyde Poag, Dr. Robert Rosenheck and Robert Blackwell are the members of our first witness panel.

Dr. Allen is a psychiatrist with Harvard University Health Service and he has worked with veterans for 25 years.

Dr. Parsons is a clinical psychologist with the VA Medical Center, Perry Point, MD. He has testified before this subcommittee before and we appreciate his participation today.

Clyde is Chairman of the African-American Working Group, Re-adjustment Counseling Service, Department of Veterans Affairs and serves as team leader for the Grand Rapids, MI Vet Center.

Dr. Rosenheck is the Director of the Northeast Program Evaluation Center, National Center for PTSD at the VA Medical Center in West Haven, CT.

Robert is a veteran from Tyler, TX.

Dr. Allen has advised the subcommittee his arrival will be delayed. He will be recognized following his arrival.

The prepared statement of each witness will be made part of the record and so I invite you to summarize your prepared statement. Dr. Parsons we will start with you today.

STATEMENTS OF DR. ERWIN PARSONS, CLINICAL PSYCHOLOGIST, VA MEDICAL CENTER, PERRY POINT, MD; CLYDE POAG, M.S.W., CHAIRMAN, AFRICAN-AMERICAN WORKING GROUP, READJUSTMENT COUNSELING SERVICE, DEPARTMENT OF VETERANS AFFAIRS AND TEAM LEADER, GRAND RAPIDS, MI VET CENTER; DR. ROBERT ROSENHECK, DIRECTOR, NORTHEAST PROGRAM EVALUATION CENTER, NATIONAL CENTER FOR PTSD, VA MEDICAL CENTER, WEST HAVEN, CT; AND MR. ROBERT BLACKWELL.

STATEMENT OF DR. ERWIN PARSONS

Dr. PARSONS. Chairman Lane Evans and Chairman Montgomery, Congresswoman Waters and distinguished members of the subcommittee, ladies and gentlemen, I feel exceedingly grateful for the opportunity to testify before this subcommittee once again. I am grateful because the subcommittee is a body that gets things done and because it is results-oriented.

On behalf of America's veterans, Mr. Chairman, to me the title of this hearing, "African-American Veterans and Community: PTSD and Related Issues" suggests that a potential exists for a relationship between African-American veterans and the community. This relationship has not always been a supportive, mutually sustaining one, but fraught with conflict, mistrust and alienation. But this has been changing. And veterans have much to contribute to inner city youths who often grope in the darkness of violence and are in need of a way out.

The more we know about veterans, Mr. Chairman, the more we realize that what they want more than anything else is to serve again. I made this statement 11 years ago in New York City's City Hall and I am convinced even more today that this is true. Who is more suitable, in my estimation, to help our violent youth today than veterans? What qualifies veterans to be brokers of change for violent youths is not only that veterans employed violence themselves in the line of duty while they themselves were exposed to the enemy's violent actions, but also because most veterans have succeeded in controlling violence within themselves.

This is one of the greatest lessons of all. We now know, Mr. Chairman, that the "a violent veteran" is a myth. Veterans are too often overcontrolled, not too undercontrolled or impulsive. What I have been seeing in veterans is a capacity to talk to young people. Many veterans remember themselves as teenagers, as bitter, alienated and alone, distrustful of authority, persons and institutions, and fearful of their deadly impulses.

Veterans, as unusual human beings, are ready once again to take on another tough challenge. This challenge is another battlefield, the domestic scene. Veterans know well that violent youths do not respond well to lectures, that what they need and respond to best are living human relationships with people who have credibility. Veterans have tremendous credibility with our inner city youth. Veterans are now in their mid years and experience a deep desire to leave a legacy and they show concern for the welfare of the next generation.

Being back, myself, Mr. Chairman, on the front lines of direct service to veterans at the VA Medical Center in Perry Point, MD,

I am in the business of helping veterans to get better in order to serve again. Viewing psychiatric care as a prelude to service is a very helpful concept because it contains an essential nuclei of truth that veterans' have value to society even in times of peace. Veterans with PTSD can be helped to give up pain, fear, terror, rage, and self-pity.

For many, psychiatric care is very critical, since veterans can only contribute to society again if they themselves are fit for the job. Psychiatric dollars are critically needed to assist veterans to overcome PTSD, alcohol and drug abuse, anxieties and depression. It is important to keep in mind that, though the veteran may have PTSD and other psychological problems, the lessons he or she learned in the crucible of the war zone experience is learned forever and is never erased from memory.

What I mean is that the same brain that learned so much about pain, loss, abandonment and fear is the same organ that learned important lessons; those about leadership, about compassion, about teamwork, genuineness, the bottom line orientation, and making tough decisions under difficult circumstances.

When I worked in New York City's Wall Street many years ago, Mr. Chairman, I learned a number of words and terms which the corporate world found very important. One of these words is ROI, ROI or return on investment. Providing additional funds for veterans to do well and become fit for service is good business, and in the process creating a cadre of empowered human capital.

In addition to the veteran youth encounter, there are other important ways African-American veterans are contributing to America to include becoming research subjects from which much of today's PTSD technology has been derived. With this wonderful technology in hand, we have an obligation to ensure that it is available to the masses in American and world communities. The VA Readjustment Counseling Service, directed by Dr. Arthur Blank, has demonstrated incredible versatility in using this veteran-originated technology to assist survivors of Hugo, Iniki and many other disasters not only in America, but around the world.

It is very important that this technology is available to African-American inner city children, youths and families exposed to violence. They need PTSD technology as much or more than other distressed and traumatized groups. Additionally, this information needs to be exported to the Third World countries pummeled by war and misfortune for years (e.g., to Somalia). These are ways that veterans continue to contribute to the welfare of others in need.

We are often reminded, Mr. Chairman, that a significant body of unanalyzed data from the 1988 congressionally-mandated National Vietnam Veterans Readjustment Study still exists. More knowledge about PTSD and African-American veterans is needed. Especially since the research studies have for the past 12 years, at least, consistently reported higher rates of post-traumatic stress disorder in this group. Their rates of PTSD is estimated to be 20.6 percent while nonminority veterans have a rate of 13.7 percent.

This significant differential calls for equally significant action like never before. Therefore, a congressional initiative of awarding a contract to the Research Triangle Institute to analyze the data

is needed. The need for co-principal scientific investigators for this project who are African-Americans is extremely important and cannot be overemphasized here this morning. Thank you, Mr. Chairman.

Mr. EVANS. Thank you very much for your testimony.

[The prepared statement of Dr. Parsons appears on p. 55.]

Mr. EVANS. Mr. Poag.

STATEMENT OF CLYDE POAG

Mr. POAG. Thank you, Mr. Chairman. Good morning. And good morning to Chairman Montgomery and Congresswoman Waters.

My name is Clyde Poag. I am the team leader of the Vet Center in Grand Rapids, MI. I have been a team leader for the past 11 years, and I am currently the Chairman of the African-American Working Group of Readjustment Counseling Service and serve on the Department of Veterans Affairs Bioethics Committee.

In regard to the issue of post-traumatic stress disorder in African-American veterans, I would first like to respond in my capacity as a team leader of more than 11 years, and as a social worker with more than 22 years of experience.

During that time, I have had the opportunity to provide counseling service to many veterans and have seen firsthand the issues and problems faced by those who have borne the burden of war, and have been adversely affected by it.

For the benefit of those who may not know what post-traumatic stress disorder is, I would like to give a brief description of what this psychological condition is and what the consequences are for those experiencing it.

Post-traumatic stress disorder is a psychological condition that people sometimes experience after they have been exposed to an overwhelming stress or trauma. People are exposed to stress everyday, on the job, in the family, and in their day to day activities.

What I am describing is stress and trauma that is outside the normal range that people experience such as situations in which a person narrowly escapes death, sees friends or loved ones killed or nearly killed, being in national disasters such as floods, hurricanes, or are victims of rapes and the horrors of war.

People who are exposed to those things sometimes exhibit symptoms such as rage, unpredictable explosions of aggressive behavior, inability to express angry feelings, and many other debilitating symptoms.

As a clinical social worker, I have had the opportunity to assess many veterans who have this disorder and to talk about the extent of PTSD, and African-American veterans, I would like to refer to you the study that was commissioned by Congress and conducted by the Research Triangle Institution which was completed in November, 1988.

Dr. Parsons has cited some of the statistics regarding African-American veterans, and we know that there are high rates of diagnosable PTSD in African-Americans and Hispanic veterans.

Overall the study shows that African-American veterans and Hispanics have experienced more mental health and life adjustment problems subsequent to their service in Vietnam than Caucasian and other veterans.

Among African-Americans, in addition to PTSD, the more serious problems appear to be social readjustment, particularly educational and occupational achievement, marital instability, and involvement in the criminal justice system. The study recommended more research and study regarding these findings.

These statistics are borne out by the numbers of African-American veterans who are homeless, incarcerated, divorced, unemployed, and involved with the drug culture.

Mr. Chairman, many African-American veterans are experiencing readjustment problems as a result of high exposure to the war and trauma. There are implications for the society at large.

A recent article in Newsweek showed on the cover an African-American boy. The caption read: "A world without Fathers." As the study pointed out, there are many African-American veterans who have serious problems parenting and many other readjustment issues.

The article didn't mention veterans. It just cited that some veterans, while women were in colleges, many males were at war.

We also are aware that many of the problems of society of course are not caused by boys who do not have fathers in the home. It is a fact that African-American soldiers comprised a large percentage of the frontline troops in Vietnam and were subjected to racism and discrimination while they were fighting in Vietnam, water hoses and dogs were attacking their friends and family members at home.

These men and women had to adjust not only to the larger society but also to their own culture, often being told that they were fools to fight for a country in which they were not treated as citizens.

In addition to the trauma and stress of the war, they had the additional adjustment problems of youth. And they continue to come to Vet Centers. We see them for alcohol, drug abuse, and homelessness and many other problems.

The unemployment rates for African-American males is double that of the general population according to Department of Labor statistics.

The African-American Working Group has as one of its goals the completion of a paper on the historical issues confronting African-American veterans. The paper will also discuss various treatment approaches. We are also planning to promote a national conference to bring together experts in the field of African-American life and culture and develop effective approaches to the treatment of African-American veterans.

The working group is concerned about the fact that many of the approaches to the treatment of African-American veterans are conducted by therapists who not only are not African-American, but have not been trained in African-American family life and culture. It is much like the flesh colored Band-Aid which was not formulated by or for African-Americans.

We also have a goal promoting increased recruitment of African-American counselors, team leaders, regional managers, and Central Office staff within readjustment counseling service. There is a need for direct input into the delivery of services to all veterans and to have the staff reflect the population it serves.

The Department's Bioethics Committee is charged with providing recommendations to the Secretary regarding ethical issues, including ethics in resource allocation.

I presently serve on the Resource Allocation Subcommittee. Considering the high prevalence of PTSD in African-American Vietnam veterans, one of the issues of interest is the prevalence of the rate at which African-Americans are awarded service-connected disabilities and the rate at which those disability ratings are awarded.

The Department also has a National Center of Traumatic Stress Studies, but there has been no study of the effects of PTSD on African-Americans.

Part of the problem may be the fact that there are no African-Americans involved in a decision making capacity at the center and that this particular issue has not been a priority.

In closing, I would like to see resources of the Department of Veterans Affairs brought to focus better on the problems of African-American veterans. They have paid for such service and have a right to expect nothing less.

I would like to thank you for the opportunity to appear before you, and I am glad that you are from Illinois because I am from East St. Louis, and I am very proud of that.

[The prepared statement of Mr. Poag appears on p. 69.]

Mr. EVANS. Thank you. I wanted to ask when the working group paper will be completed.

Mr. POAG. We hope to have it within the next three months.

Mr. EVANS. Thank you.

We will go next to Mr. Blackwell.

STATEMENT OF ROBERT BLACKWELL

Mr. BLACKWELL. Congressman Evans, Congresswoman Waters and Congressman Montgomery, I want to thank you for the privilege of being here to testify today.

I understand that PTSD is the focus of this committee, and I am primarily here to testify as to the extent of PTSD that I have suffered and traumatic event that occurred.

I am a 100 percent post-traumatic stress disorder combat Vietnam veteran, and I have gone through nine months of the most extensive PTSD treatment that was available at the Dallas VA Medical Center in 1986. This was during the time when PTSD could not even be mentioned in the domiciliaries.

Fortunately for myself, by the grace of God, I had an excellent psychologist that performed wonders in working with me and many other veterans. So I am very proud to say that under that program I received an awful lot of treatment that has, at this time, been very helpful to me.

My testimony goes a step farther, and I want to read a letter that I wrote to you, Congressman Evans some time ago; and unfortunately I didn't even receive a return form letter. This is my experience, and this is what occurred.

Dear Congressman Evans:

As Chairman of the House Veterans' Affairs Subcommittee on Oversight and Investigations, you, along with Representatives John Bryant and Pete Geren were scheduled to conduct hearings in Dallas a few years ago regarding the activities and operations of the

Dallas VA Medical Center. Unfortunately, the outbreak of Desert Storm prevented your attendance and the conduct of the official hearing.

Now, perhaps more than ever, an investigation of the negligence, malpractice, medical incompetence, and gross insensitivity that prevails the Dallas VA Center demands justice and readiness by your subcommittee.

Notwithstanding at least three other cases involving other veterans and the Dallas VA Medical Center, who are prepared to testify, I beg to share with you here on my personal experience.

As a committee chair, appointed, of the Black Congressional Caucus Veteran Brain Trust/POW-MIA Committee, I had just returned from California following my testimony before Congresswoman Maxine Waters at the Western Regional Mid Conference Black Caucus. Upon my return of March 19, 1992, I entered the Dallas VA Hospital for my weekly PTSD counseling session with my psychologist of seven years, Dr. Jack Fudge.

I explained to Dr. Fudge that I was going to the emergency room for the removal of a painful boil that had risen on my butt. I have had these boils before, but I had never before sought treatment at the VA hospital for this minor procedure.

It is worth mentioning to you that up to this time my relationship and rapport with the Dallas VA Medical Center and its staff had been positive and admirable, although many of my veteran friends were experiencing serious problems.

Congressman Evans, little did I know or realize that the lancing of a boil by the Dallas VA Hospital would nearly be fatal, put me in a coma, cause permanent damage to my lungs and inflict incalculable mental anguish upon me, my wife, and my family.

Since suffering at the hands of these medical incompetents, the Dallas VA has lied, deceived, covered up, falsified records and signatures, and removed many of my medical records in an effort to obstruct justice. These matters I, of course, seek to remedy under the law in Federal court.

Congressman Evans, for the sake of other veterans who have been and are continuing to be killed, injured, and mentally damaged by a broken and dangerous health system for veterans, I implore you and the Texas Members of the Veterans Affairs Committee to conduct an investigation and hearing with regards to the Dallas VA Medical Center. You would do well to also investigate the Houston and San Antonio Medical Centers as well, no less compelling, these horror stories keep emerging from them also.

I am enclosing some of my medical records and the names of some fellow veterans who are willing to provide their stories. As a POW-MIA Committee Chair for the Congressional Black Caucus Veteran Brain Trust and member of several veterans' organizations, the DAV, VFW, VVA, and the American Legion, I urge you and your subcommittee to act on these matters of most importance.

I want to say to you that I brought a briefcase full of medical evidence that would terrify you. You can read them for the rest of your life, and it will not tell what really happened to me.

These people have falsified doctors' signatures—which is the same as if they were lying to Congress—to cover up the magnitude of what have occurred to me.

I want you to know that I am crushed. I have encountered every obstacle that you can imagine in trying to pursue this case. Attorneys are reluctant to look into my case. Hospital staff and even veterans' organizations have turned their back because they didn't want to kick in the door at the VA.

There wasn't a veteran in America that supported the VA hospital system as much as I did. Because, for the last seven years, I have undergone extensive PTSD counseling by my doctors, I was on the road to recovery. I started to have a normal life. I was off of drugs and alcohol. I was starting to have a relationship with my family. I was able to get along with my community and my fellow veteran friends.

All of a sudden, I am slammed back into that same traumatic event more horrible than Vietnam because the VA has decided that they are not going to be accountable for what has happened to me.

I have a lot of questions that I do want to ask. And hopefully I can get some answers if not now, before I leave Washington, DC.

First of all, can the VA face criminal offenses for what has happened?

Secondly—give me a moment to get my composure, please.

Can a VA doctor forge medical evidence and medical records?

Can a law suit and not a tort claim be filed against the Department of Veterans Affairs?

Do I ever have to again be at the hands of the VA?

And the VA is a discriminatory process that won't allow veterans to go seek any other medical treatment outside. They do what they want to with us. They are in complete control. There is nothing that a veteran can do, about what the VA has to offer.

Our President is talking about a health care plan for this country, and he has not once mentioned the veterans. We are suffering because patient health care is not a priority with this system. It is research and—they hate this word—experimental.

But what happened to me wasn't research. It takes years for research. What happened to me was experimental, and that is what they were doing. They were experimenting on me for a couple of hours. This is what occurred.

I am asking you, sir, for you to please send a field team to Dallas and investigate these charges. You will find that I am telling you the truth.

Thank you for your time and your patience. And I am emotionally disturbed right now, and I hope you understand.

[The prepared statement of Mr. Blackwell appears on p. 119.]

Mr. EVANS. Thank you. Mr. Blackwell, I would be glad to meet with you after this hearing has been concluded and talk about your individual case. How you were treated and what evidence you have. If you have the opportunity to stay, I would be glad to meet with you. Thank you very much.

Ms. WATERS. Mr. Chairman, I want to take a moment to thank Mr. Blackwell for sharing his soul with us. It is a very precious moment.

I want you to feel good that you were able to come here and do this today. This is what we need in these halls, we need to hear from real people with real problems. You have allowed yourself to be vulnerable. Thank you very much.

Mr. EVANS. Thank you, Mr. Blackwell.
Dr. Rosenheck.

STATEMENT OF ROBERT ROSENHECK

Mr. ROSENHECK. I am Dr. Robert Rosenheck of the VA's Northeast Program Evaluation Center, which is the evaluation division for the division of PTSD.

The national center was established in 1984 to bring together the best research in the VA with clinical care. The goal of the national center was to unite our best minds and our best scientific resources to devote them to improving services for veterans with PTSD. The national center has conducted a number of studies and has a number of studies in process involving further analyzes of the NVVRS as well as other studies on the care of African-Americans in the VA.

At this time, the national center, last summer, convened a national conference of experts on the care of ethnic minority Americans. And a book will be coming out which will summarize the findings of that difference.

But the goal of the national center and of the Northeast Program Evaluation Center is to unite scientific research with direct clinical care. My mission is to monitor the care and the effectiveness of care at every one of the specialized PTSD programs. When the NVVRS emerged, this body became aware that there were severe problems of PTSD in the United States of America, and since that time has contributed substantial funds to developing programs.

We live in an era of health care accountability. When money is spent, we need to know, is it being spent where it belongs; are the programs serving the people they are supposed to be serving; and is the treatment effective?

And it is my job to monitor those activities, and I will share some findings with you. I am, in a certain sense, an antimanaged care person. Managed care is the way in which we deliver less services to save money. What I do, and what we do, is to make sure that more services go to those suffering from PTSD and that those services are effective.

Let me say first—and I appreciate very much what Dr. Parsons said—veterans, Vietnam veterans have great strengths, much as we need to attend to their problems. They are, first of all, Americans. That is why they entered the military, and that is why they fought in Vietnam.

African-American veterans are particularly subject to factors that affect all Americans who are African-American. And I must say that in the last year we have seen a cascade of articles in the leading medical journals showing that the differences in health status between the well to do in this country and the poor in this country has gotten worse. That gap has expanded.

While the health of Americans generally has improved considerably in recent decades, the health of the poor has shown less improvement. We have seen a number of articles, and these are not about VA, and these are not mental health, showing that African-Americans get less health care services than other Americans. And they often get less effective services.

Against this record, the VA is doing quite well, and I have some good news. But I also have some disconcerting news that needs further exploration.

Because of the rich data available from the NVVRS, we have undertaken to analyze that data to find and develop all findings of relevance for planning of programming for the VA.

First, we studied the question of whether African-American veterans choose the VA or non-VA services when they have a choice?

And it appears that when one takes into account differences in income, differences in illness, differences in where you live, African-Americans choose the VA rather than non-VA providers for their mental health care.

African-Americans are more likely to use VA mental health services than other veterans, and they are substantially less likely to use non-VA services.

In a discussion of this finding with a well-known black psychiatrist, he suggested that while African-Americans such as himself always expect and anticipate prejudice, that as an institution of the Federal Government, there is more chance for recourse and there is more chance for a fair hearing.

The second finding is that black Vietnam veterans seeking help from VA for PTSD are poorer and have more substance abuse problems than other veterans. We were heartened to see that these veterans more than others get additional services specifically targeted at substance abuse. And in our outcome study we found that African-American veterans showed more improvement in their employment than did other veterans.

I should say also that it appears from our data that black veterans using VA services are as satisfied with services as other veterans.

We found also, however, that black veterans participate in treatment somewhat shorter than other veterans and get somewhat fewer services. When they are treated by black clinicians, these differences are smaller. This, we feel, is evidence that supports current efforts to recruit minority clinicians.

I should say in closing that among the most important of our findings are that clinical improvement is similar for black and nonblack Americans and that we are continuing our studies to identify areas where VA can improve its health care for all veterans.

[The prepared statement of Dr. Rosenheck appears on p. 72.]

Mr. EVANS. Thank you, doctor.

I want to address a few issues. First, I am pleased that Jesse Brown has met with Mrs. Clinton. I don't know all the details of the national health care plan that will be announced, but Secretary Brown is seeking eligibility reform as part of this package and the goal is to give veterans a choice in their local communities between going to VA if it is there locally, or to a community based provider. So at least that is a general outline, from what I understand.

My question is will most veterans choose to go to local facilities or will they stay with the VA?

I believe you alluded to that.

Mr. ROSENHECK. Our data showed that really, without question, the veterans with PTSD overwhelmingly choose to go to the VA for

services. Minority veterans, in general, choose VA over non-VA services.

There are other studies when you talk about the elderly in looking for medical care, they may be likely to seek services from both types of providers.

Mr. EVANS. I neglected to yield to the two Members who have joined us. Mr. Bishop and Mr. Kennedy, if you have any opening remarks, we will be glad to recognize you at this time.

OPENING STATEMENT OF HON. SANFORD BISHOP

Mr. BISHOP. Mr. Chairman, I am pleased to be here today to participate in this hearing on post-traumatic stress disorder.

As you know, I represent a large veteran population, and I am very interested in the welfare of all veterans and particularly those of African-American descent.

I am here to learn all I can about PTSD, and I am most interested in signing on as cosponsor with Mr. Evans to get legislation passed on this matter.

The general health and welfare of those veterans who are affected by PTSD is both crucial to the preservation of our families.

Domestic violence has to be stopped, and our children and their families must know that life can exist without the presence of family violence.

Several months ago, CNN did a special on domestic violence in Albany, GA. And the high rate of incidence was appalling. And I would like to know specifically, if possible, how much of this violence is related to post-traumatic stress disorder.

Stress can be brought about by many factors, but I want to do whatever I can to reduce the high rate of incidence in our district and in the country.

If it is war-related, I feel that we, as a committee, and as a Congress, we have an obligation to investigate the issue and see to it that the resources are provided by the Department of Veterans Affairs to assist all affected individuals.

And with that, Mr. Chairman, I want to thank you for convening the hearing, particularly at this time during the incidence of the Congressional Black Caucus weekend.

And I would like to welcome all of the veterans who have come to share in this weekend. And I think this is a very substantive issue and very timely. And I am happy to be a participant and to have so many folks come to Washington to participate.

Mr. EVANS. Thank you very much. We look forward to working with you.

Congressman Kennedy.

OPENING STATEMENT OF HON. JOSEPH P. KENNEDY II

Mr. KENNEDY. Thank you. First of all, I want to apologize for being late. And I have to leave the hearing early today, but I want to thank you in particular for having this hearing and thank Chairman Montgomery for being here.

I think it is important to recognize that this hearing occurs really because of Lane Evans' deep commitment and long-standing commitment to Vietnam-era veterans, to veterans that all too often do

not have their issues brought forward here in Washington. And I thank him.

And I want to thank the Congressional Black Caucus for pushing for this hearing and the Congressional Black Veterans Brain Trust.

I have always wanted to meet a Congressman who was a member of a brain trust, but Sanford happens to be a member along with Corrine Brown and Charlie Rangel, all of which have shown a deep commitment to getting at some of the causes of the difficulties that black veterans in particular have faced.

I see Ron Armstead, and I saw Gunny Branch in the audience earlier. There are a number of groups in the country that deal with the problems that black veterans have faced. Black veterans served in Vietnam and many other conflicts that this country has been involved with in tremendous and very courageous fashion.

The incidence of PTSD with Vietnam veterans has been much higher for black veterans than any other race, and yet we have not necessarily seen the VA designate appropriate resources, given the higher incidences that have occurred. So I think that there are lots of steps that can be taken.

We have heard of programs this morning from several of the panelists. I want to thank them for their testimony.

And, Lane, I just wanted to let you know that I look forward to following up on some of the ideas that we hear put forth this morning in terms of legislative action if needed. If not, working with Jesse Brown and making sure that the black veterans' needs are addressed.

And I want to particularly thank so many of the groups and organizations that operate throughout the country looking out for the interests of black and other minority veterans that have not necessarily been addressed by the Congress and by the VA.

So thank you all very much.

And, Chairman Evans, thank you.

Mr. EVANS. Thank you, Congressman.

Does anyone else have questions of this panel?

Mr. Chairman.

Mr. MONTGOMERY. Thank you, Mr. Chairman.

Mr. Poag made the comment about African-Americans comprising a large percentage of the frontline troops in Vietnam. I am proud that I went to Vietnam as a Member of Congress more than any other Member of Congress. At that time, Members steered away from Vietnam, for what reason I do not know.

But I did go there many times, and I went to the front lines and what you said is exactly right. A large percentage of those that were carrying the rifles were African-Americans and it makes sense when you are right there so close in combat that you would have more PTSD. I appreciate you pointing that out this morning.

Mr. POAG. Thank you very much, Mr. Chairman. I appreciate it.

Mr. EVANS. We have a number of written questions that we will submit to you. I understand that Minority Counsel will also be submitting some questions. Your answers to those questions will be made a part of this hearing record.

(See p. 121.)

Mr. KENNEDY. Excuse me. I want to ask one brief question. I have understood that despite this sort of anecdotal information,

and Chairman Montgomery has confirmed as well, that there have not been any epidemiological studies done by the VA on this issue.

Do any of you want to comment on this?

Mr. ROSENHECK. Yes, there have been. The NVVRS. The findings—the source of that data was that there was a higher incidence of PTSD among black veterans along with adjustment problems and problems of violence, particularly since there was concern about violence.

Violence is one of the problems that we are most effective in treating. We see the most dramatic improvement in that area.

Mr. EVANS. The Research Triangle study showed that there was need for further study.

Mr. KENNEDY. I understood that there was further need for study on that issue.

Mr. POAG. The study showed a higher relationship to combat and the high prevalence of post-traumatic stress disorder. There wasn't any kind of shortcoming on the part of African-American veterans. That was a relationship between high exposure to stress and war or combat in relation to the incidence of diagnosable post-traumatic stress disorder.

Mr. KENNEDY. But was there not at least the need for some further study of the issue, Mr. Poag?

Mr. POAG. Absolutely. The Research Triangle Institute made that recommendation.

Mr. KENNEDY. Based on what? Explain that.

Mr. POAG. That their findings and reasons and the causes for those findings needed to be looked into.

Mr. KENNEDY. Okay. Fine.

Thank you, Mr. Chairman.

Mr. EVANS. As Congresswoman Waters said, there were more combat participants among African-Americans in the Persian Gulf.

Mr. POAG. We are starting to see Persian Gulf veterans coming into the centers and in Grand Rapids. We have Persian Gulf veterans who are already amongst the homeless. We have had parades just recently, but now we are starting to see them among the homeless population.

Mr. EVANS. Experiencing in many cases specific illnesses as well which are related to the Persian Gulf?

Mr. POAG. Experiencing readjustment problems, post-traumatic stress disorder, and some of the same kinds of problems that we see with Vietnam veterans.

Mr. EVANS. That suggests further studies of those particular issues as well.

We want to thank you all for testifying today, and we appreciate your very powerful testimony.

The members of our second panel are Dr. Alyce Gullattee, Carmen Wilson, Michael Kocher, and Dr. James Woodard.

We invite them to come forward at this time.

Dr. Gullattee is with the National Medical Association and appears before the subcommittee today to present the statement of Dr. Carl Bell of the Community Mental Health Council, Chicago, Illinois.

Carmen serves as Executive Director of Project COURAGE, Indianapolis, Indiana.

Michael is the Director of Amerasian Resettlement Program, InterAction, Washington, DC.

Dr. Woodard is an Assistant District Director for Congressman Joseph Moakley in Boston, Massachusetts.

Each of your statements will be made a part of the record. You may summarize as you wish.

Doctor, we will start with you. Please pull the microphone directly in front of you.

STATEMENTS OF DR. ALYCE GULLATTEE, NATIONAL MEDICAL ASSOCIATION, REPRESENTING DR. CARL C. BELL, COMMUNITY MENTAL HEALTH COUNCIL, CHICAGO, IL; CARMEN W. WILSON II, EXECUTIVE DIRECTOR, PROJECT COURAGE, INDIANAPOLIS, IN; MICHAEL KOCHER, DIRECTOR, AMERASIAN RESETTLEMENT PROGRAM, INTERACTION, WASHINGTON, DC; AND DR. JAMES W. WOODWARD, ASSISTANT DISTRICT DIRECTOR, OFFICE OF CONGRESSMAN JOSEPH MOAKLEY, BOSTON, MA

STATEMENT OF DR. ALYCE GUALLATTEE

Dr. GULLATTEE. Thank you for the opportunity to present Dr. Carl Bell's document.

I am Alyce Gullattee from the National Medical Association. I am a practicing psychiatrist, and I am an Associate Professor of Psychiatry at Howard University College of Medicine and the Director of the Institution of Substance Abuse at Howard University. I practice addiction medicine.

Sigmund Freud predicted that human beings were destined to repeat an endless cycle of identifying and forgetting the effects of traumatic stress on human life. He proposed this cycle would occur because of our narcissistic need to pretend we are in control of our existence. Surely, it is painful for us to recognize that we have no control over our environmental circumstances, which like traumatic stress, could cause significant alterations in one's mental life. True to Freud's prediction, human beings have repeatedly identified traumatic stress as a major factor in human life, only to disregard it later.

The problem of traumatic stress was first clearly identified in World War I as "shell shock" also known as "traumatic neurosis." In World War II and the Korean War, it was reidentified as "combat fatigue." Following the Vietnam War, we have rediscovered traumatic stress in the form of "post-traumatic stress disorder."

Despite rediscovering traumatic stress in the form of PTSD, we still have not proven psychological mature enough to appropriately address this important dynamic in human life. Post-traumatic stress disorder continues to be a second-class diagnosis. For example, mental health centers in Illinois cannot bill the Medicare Clinic Option for services rendered to a patient so diagnosed. Further, the diagnosis conditions to be unidentified in various populations, namely, military and civilian, misdiagnosed, and underestimated regarding its significant impact on individual daily life. Even its existence as a legitimate psychiatric disorder has been questioned.

Society needs to be greatly concerned with this issue but that concern needs to extend further than the military populations that

we know are at high risk to being exposed to a traumatic stressor. The American Psychiatric Association Diagnostic and Statistical Manual, Third Edition, Revised, defined a traumatic stressor as a psychologically distressing event that is outside the range of usual human experience and as a stressor which would be markedly distressing to almost anyone and is usually experienced with intense fear, terror, and helplessness. There are many people within the United States that are exposed to traumatic stressors of a magnitude that could cause them to have post-traumatic stress disorder. Similar to the problems veterans experience, these populations' needs are going unaddressed by the society.

The traumatic stress of witnessing violence or being the victim of violence has caused a population of African-American children to suffer PTSD. Concern regarding these children spurred research at the Community Mental Health Council. Ten years ago, we were aware of the levels of violence within the African-American community and were cognizant that African-American children were often exposed to violence reflected in national statistics. As a result of our concern, we began researching issues concerning African-American children exposed to violence. The article "Community Violence and Children on Chicago's Southside" in *Psychiatry*, Volume 56, February of 1993, provides a detailed summary of our original research, but, for the purpose of this congressional record, I will highlight our findings in our early work.

Our first survey completed in 1984, explored children and violence via a survey of 536 elementary schoolchildren in the second, fourth, sixth, and eighth grades at three inner city grade schools. One in four children witnessed a shooting, and 30 percent had seen someone get stabbed. A retreat using a smaller subgroup of the original sample of children was conducted in order to explore intervention methods for the children's trauma and to discover prevention methods to avoid future violence. Different methods of teaching children, conflict resolution skills, and ways to avoid violence were successful. But it was important to first debrief the child who was exposed to violence. Only then did it become possible to talk to them about issues related to the prevention of violence. Family violence was the factor that encouraged these children's propensity towards violence, their exposure to violence on TV nor whether their peers encouraged them to be violent.

Dr. Robert Pynoos at UCLA coined the term "dose exposure" which refers to a child's amount of direct exposure to violence the dose exposure is a major determining factor in the sequelae of that exposure. Dr. Pynoos studied the impact of a playground shooting at a Los Angeles grammar school. Children were exposed on three levels, children on the playground being shot and shot at; children in the school who heard the shots; and children who were away from school that day but heard about the shooting. Children directly exposed to the violence suffered the greatest impact of the stress, and some developed PTSD. Children who heard the shots from their classrooms but were not directly exposed became upset and concerned, but their distress did not qualify as PTSD. Children who heard about the shooting reacted similarly to children in the classroom who were not directly exposed.

There were exceptions to these general findings. First some directly exposed children used the experience as a major motivating factor and obtained more control over their lives. They found the distress of income a helpless situation untenable and instead of collapsing, they gained skills to prepare for the future. Some children firmly decided to pursue careers as physicians in order to treat victims if they were ever again in an attack situation.

Major distress symptoms were also seen in children not directly exposed to the violence in the playground. They either only heard the shots or heard about the shooting. These children had previously directly experienced significant violence, and the school ground incident caused their old traumatic memories and fears to resurface.

Finally, children not directly exposed but who were good friends of the children shot and killed were at risk of having severe grief reactions. Thus, Pynoos's studies confirm our observations that direct exposure to family violence has the potential to produce a negative coping response to violence, that is, to become violent as the best defense is a good offense, or the development of PTSD.

While TV violence or peer support of violence are probable factors encouraging violence, society and government must deal with a child's direct exposure to be successful in an intervention. Pynoos's work explored inoculating factors which cause some children exposed to significant stressors not to succumb and other factors which cause other children not directly exposed to significant stressors to still have unhealthy coping responses.

In 1990, the Community Mental Health Council screened 1035 students from four high schools and two elementary schools who participated in violence prevention workshops sponsored by the Council's Victims Services Program. An article on the program entitled "Advocacy, Research, and Service to Prevent Violence and Treat Victims," in *Hospital and Community Psychiatry Journal*, 43, page 1134 to 1136 in 1992, and is attached and sent to those of you who received this document. Nearly half of the students had been personally victimized, which included being threatened with a weapon, with 11 percent reporting they had been shot at, three percent having been shot, and four percent having been stabbed. Threats of attack with a gun, 17 percent or a knife, 23 percent, were the most frequent types of victimization.

Further, nearly one in four of these children reported they had personally witnessed a murder. In addition, one-third of the students reported that they had carried a weapon, usually a knife, with 12 percent indicating that they had injured someone with a knife or a gun.

An examination of factors related to exposure to violence found the strongest predictor of witnessing, victimization, and perpetuation was carrying a weapon. Thus, we again discovered evidence that exposure to violence and perpetration of violence may be related and addressing one without addressing the other is short-sighted.

The Community Mental Health Council has also screened psychiatric and medical outpatients regarding personal experiences of physical and sexual assault. Twenty-three percent of mentally ill youth and 12 percent of medical clinic youths knew of someone who

had been raped, and 19 percent of the medical patients and 14 percent of the psychiatric outpatients knew of someone who had been murdered. Six percent and two percent of the psychiatric and medical outpatient youth respectively reported being victims of sexual assault. And 37 and 18 percent reported being victims of physical assault.

In summary, our early work surveying children and adolescents on the Southside of Chicago revealed that some of these children have considerable exposure to violence either as victims or as witnesses and survivors, having close others victimized.

Most recently in 1992, my colleague, Dr. Esther Jenkins, Ph.D., professor of psychology at Chicago State University, and I have completed research on a sample of 203 African-American students from a public high school on Chicago's Southside. This study, which will be published in *Anxiety Disorders in African-Americans*, edited by S. Friedman, New York, Springer Publishing Company, found that almost two-thirds of the students indicated that they witnessed a shooting, and 45 percent reported they had seen someone killed. Further, one quarter reported witnessing a shooting, stabbing, and a killing.

Our theory of why these percentages have increased from our earlier studies is that during our most recent study, violence in Chicago was reaching record levels, while previous studies were being done while violence was waning.

This last study clearly indicated that boys and girls respond differently to exposure. Girls report significantly higher levels of distress, while boys were significantly more likely to report that they carried a gun and were prepared to fight in self defense. We found significant relationships between psychological distress and all four types of violence exposure.

The bottom line of the research is that the severity of the exposure to violence that some African-American children experience is great enough to be classified as a traumatic stressor, capable of inducing PTSD. Contrary to popular belief, children do not become immune to exposure to violence. Rather, they are at greater risk for other sequelae ranging from engaging in high risk-taking behaviors, having a foreshortened sense of their future, using drugs, having school performance problems, getting depressed, et cetera.

Currently, efforts are being made to address this problem nationwide. Because of the advocacy of African-American physicians, the issue of responding to violence in the Nation has taken a different turn.

In the late 1970s, African-American physicians involved in public health began to examine the issue of violence from a public health perspective to determine if such an approach could assist in the prevention of certain forms of violence. Clearly, the criminal justice system approach is to intervene after the violence has occurred, while a public health approach would seek to prevent certain forms of violence. Thus, based on a firm understanding of the circumstances of violence, African-American physicians have been suggesting that predatory violence, such as violence in which the perpetrator consciously initiates behavior that can result in violence such as taking a gun out of the house with the intent to rob someone, be handled by the criminal justice system as its motiva-

tion is certainly in nature, while interpersonal altercation violence, such as violence that begins as a harmless argument which escalates into physical violence, and possibly homicide and in which neither party to the violence had prior intent to do violence, such as a husband and wife argument that ends up in a homicide, be addressed through various public health prevention strategies. The Nation has been slow in adopting this perspective, but there is now some movement towards this approach.

The National Institutes of Health has issued several grants to sites around the country in order to develop curriculum designed to address students' risk-taking behaviors such as inappropriate sexual behavior, drug use, and violence.

One of the issues being explored is children's exposure to stressors that may promote their increased likelihood of taking dangerous risks. National institutions and private foundations have placed violence on research agendas and are interested in providing resources to address the problem.

The National Medical Association understands the need to address this problem and in 1986 began to design public policy to build an infrastructure in a myriad of institutions. More recently, the American Medical Association addressed the physicians' responsibilities in identifying and addressing family violence.

I want the House Veterans' Affairs Subcommittee to understand that some children in America suffer from PTSD due to exposure to family and community violence. The PTSD experienced by the children and postwar veterans is similar. When the subcommittee addresses PTSD in African-American veterans, they should seek the opportunity to address the same issue of PTSD African-American children. Studies have shown that African-American veterans who developed PTSD did so in the context of being previously exposed to violence either as victims or witness to violence as children.

The subcommittee can prevent further PTSD development in future American veterans by addressing the issue of early exposure to violence and other traumatic stressors in African-American children.

Of course, the same logic applies to other ethnic groups in society, but public health logic dictates you first place the most resources where they would do the most good. There is evidence that nonwhite veterans suffered more PTSD than did white veterans due to previous exposure to violence or other traumatic stressors. Combining resources devoted to addressing PTSD in African-American veterans with funds designated for other residents of the community would be more efficient and economically effective.

Finally, the summarizations of the research completed by the Community Mental Health Council on traumatic stressors demonstrates the usefulness of our findings in relation to resolving the issues of PTSD in veterans. But unless the subcommittee links the issues of traumatic stressors impacting veterans with the issues of traumatic stressors impacting the community two sources of research information useful to both sides may never meet and the opportunity for synergy will be lost.

Thank you for the opportunity to provide testimony on the issue of traumatic stressors as I feel facing this issue early on gives us

the one clear opportunity to prevent damaging consequences later. Certainly our experience in dealing with traumatic stressors on the front lines of war has shown the rapid and direct approach to be a valid one.

This is the conclusion of Dr. Bell's statement written and sent to you. I should like, however, to call to your attention the following incidence in which I have been personally involved. We understand that those persons who now have the greatest problems with PTSD are the baby boomers, those who were in the Vietnam War, but now have children of their own.

There is such a phenomenon that is called Specific Incident Traumatic Stress Disorder where someone who has PTSD being exposed to a stressful situation will have what is called an "anamnesic reaction" and will behave as if he or she were experiencing the initial stressor and, as a result, the action may be one of violence.

There is the phenomenon of depersonalization that occurs in those who suffer from post-traumatic stress disorder where acts are carried out without conscious and cognitive involvement on the part of the individual where it is as if the individual is watching the act at a distance, although he or she may be actually carrying out that act.

Recently I had a young man who has PTSD tell me that he has often thought now, since shooting has become so common, what it would be like to see a head cut off and to watch it roll and would not be the person be surprised to recognize that they were without their head.

For those who are in readiness for combat, I have been told that the level of anxiety when they are first placed on watch and wait for attacks builds up to momentous capacity and although in time they can manage this if they do not go into fighting for up to four months, that by five months they have to do something to minimize their anxiety, psychological pain, and the stress. So they may begin drinking, smoking marijuana. And if they go up to a year without actually fighting, that it is possible that if other opiate drugs are available to them, that they will then use them.

Mention was made of the Desert Storm veterans. We see some of them. Although they do not go to the VA hospital, they may come to us. And the kinds of problems that they have far outweigh the kinds that has been defined as post-traumatic stress disorder because it not only includes the psychological impact of what that particular war did to them but the medical overlay and the once-again mysterious notions of what illnesses have impacted upon them and what that will do to them in the years to come.

Many of these people are younger than those who were part of the Vietnam veteran war era. It grieves me to think what the year 2000 is going to bring in terms of individuals who by then will possibly be in their early 50s, followed by a group of young people who have essentially experienced, in an obtuse way, a similar phenomenon as that which was experienced by those that went to the Vietnam War, namely our Desert Storm and now our country being the watchdog for democracy for the rest of the world and being the peace keeper, for all of those who are anticipating being sent.

I have a grandson that suffered post-traumatic stress disorder. I have a grandson who is in the service who indicated that he has

been put on wait to possibly go to Bosnia-Herzegovina. And I can already hear the anxiety in the mind of this highly intelligent young man. This verifies not only that which Dr. Bell has studied, but that which I have seen as a practicing physician. And I implore you to look carefully at what your actions will be as they relate to providing adequate funds to study the evolution, the triggers of violence, and tragedy of post-traumatic stress disorder. It is never going away. We have only now named it. But it will be there in perhaps some other form in the year 2000.

I thank you.

[The prepared statement of Dr. Gullattee appears on p. 80.]

Mr. EVANS. Thank you very much. I want to commend your testimony to each and every member of our committee. It is a good summary of where we have been, where we are now and, hopefully, where we are going to go. We appreciate it very much. And I will have a few questions for you.

At this time, I am very pleased to introduce and recognize Congressman Charlie Rangel who started the Veteran's Brain Trust when no one else was paying attention. Charlie Rangel is deeply and personally involved himself in these issues. It is because he is a good legislator, he cares and he is a veteran. We are very pleased to recognize him at this time.

OPENING STATEMENT OF CHARLES B. RANGEL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. RANGEL. I first came here to welcome you. As much as we think we know here in the Congress, unless we have this exchange and listen to the people that attempt to help or have been the victim of different types inequities, then we will be reading and carrying out our own press releases. And so you have no idea how important it is that you would come participate. Because you don't do it just for yourself. You do it for so many others. Some that cannot get here. Some that cannot afford to be here. Some that are physically impaired and some that just don't know that their presence and political force can make a difference. And of course, for the witnesses that take the time to share their eloquence but more importantly their expertise with us so we just don't feel sorry, but so that you can motivate us and point us in the right direction as to what we can and should be doing.

And lastly is to talk about Chairman Lane. I don't know how you think we operate in the Congress, but most of the time we pay a lot of attention to those people that we are trying to persuade to get their vote. There are two people that are really left alone that you don't talk to and you don't lobby with. And that is the group that you know that, no matter what you did or said or proved, that they are not going to change their minds and give you support.

And the other group that you don't talk with, unfortunately, are those people when you come for the vote you find out that they are ahead of you and they are doing something more progressive than your idea that you are asking for support with. Lane Evans falls into that category. Long before the veterans had demanded that they get to the agenda—this is not a profile in courage, Lane—during the Black Caucus weekend, the chairman as a part of Veterans'

Affairs was providing that leadership in making certain that those that fought, that served, that advanced our national interests, that when the service was completed that they not be discarded as you would a weapon that has served its usefulness, that you had a particular obligation to those people that not only put their lives, their mental and physical conditions on the line, but they did it for their families, they did it for their communities, and they did it for our country.

And so, if we are going to be believed by any other nations, we can only be measured by how we treat our own. And what is the level of morality that is involved in how we take care of them. So for those people that believe that—that I advocate giving veterans an unfair advantage, they are right. Because they were treated unfairly in being selected or being forced to volunteer and to take unfair risks while other people, not only were not made uncomfortable, but some actually benefited.

So it just seems to me that whatever you can ask us to do, that it just makes my job a lot easier to know that Lane is one of those people that is way ahead of us in doing it.

Now, some people have said as related to the caucus of veterans thing that I am not in charge any longer. Well, at 64 years old for those people who have reached that age where you have to be able to develop the technique to allow young aggressive people to believe that they are in charge and then at the same time, be there. So you won't see my name in a lot of speeches. Bishop will be out there doing his thing. But don't think that you are going to get rid of me that easily. I am still going to be there.

Thank you.

Mr. EVANS. Thank you, Congressman Rangel. We know that we can continue to count on you in the future for all the help that you have given us in the past.

Mr. Wilson, we will proceed with you.

STATEMENT OF CARMEN W. WILSON II

Mr. WILSON. Thank you. I would like to start by thanking Congressman Lane Evans for this opportunity. It is the ultimate opportunity to discuss a subject near and dear to my heart. Thus, I hope to provide some insight by discussion.

During 1968 and 1969, I served in Vietnam. My initial experience in service delivery to veterans was as a veterans' counselor. Subsequently, I served as director and deputy director of Veterans Affairs for the State of Indiana.

Over the last 20 years, I have observed changes in the Federal Department of Veterans Affairs. These changes have provided some veterans access to the best medical care available. At the same time, other veterans are denied medical care that the Federal Government had contracted to provide.

Countless experts have concluded, as a result of scientific research and other observations, that many young men and women who went from high schools, factories, colleges and street corners to Vietnam jungles within 12 months were psychologically scarred.

A study was ordered by Congress and conducted by the Research Triangle Institute. That report found that 15 percent of those who served were still suffering from PTSD. The length of war, stress

from exposure to a life-threatening situation, emotional instability, and the war's unpopularity were factors contributing to the disorder.

A quick calculation reveals that 15 percent of the approximately three and one-half million servicemen and women leaves 450,000 veterans who may be suffering from PTSD.

However, the Department of Veterans Affairs is paying compensation for PTSD to only 40,456 veterans. Of that number, 603 veterans have less than a ten percent disability rating. Clearly the greatest percentage of veterans suffering from PTSD are not being compensated for their disability.

The effects of PTSD have been devastating to America. Most of the experience caused by this human suffering has resulted in a psychological and financial burden to local governments. A substantial proportion of indigent patients receiving care at locally funded medical facilities are eligible for treatment at veterans facilities. However, a lack of training in the diagnosis of PTSD by personnel at community medical centers allows the illness to go untreated.

Making matters worse, many families have been torn apart and destroyed because this illness has remained untreated. Large percentages of criminal behavior and substance abuse are nothing more than manifestations of untreated cases of PTSD. Further research may reveal a relationship between the increase of violent activity among teens and the effects of PTSD on families.

Although the veterans community has started to heal, recent events often exacerbate the sense of frustration and resentment many former GIs have. Many veterans felt betrayed when the United States granted asylum to Vietnam refugees. They were entitled to welfare, food stamps, and medical care. Ironically, Vietnam combat veterans were denied these same benefits under various circumstances.

Some veterans were displeased when the United States ceremoniously forgave Vietnam for killing approximately 60,000 Americans during the war. The two countries have agreed in principle to normalize relationships and to pursue business opportunities.

A disproportionate percentage of African-American veterans are experiencing tremendous difficulty in obtaining gainful employment because they were issued other than honorable discharges for minor incidents. Reports from several national organizations clearly indicate institutional racism more than likely was a key motivating factor in substandard service.

A substantial amount of veterans are outraged at reports of asylum being granted to Iraqi prisoners and soldiers who surrendered in the Persian Gulf conflict. Three thousand four hundred and forty-two Iraqis were granted refugee status. In 1993, 4,600 Iraqis were resettled in the United States.

In spite of these facts, African-American veterans have been able to grow from their experiences. They are currently involved in programs that positively inspire and motivate at-risk children. They have been able to establish rapport primarily because of their military experience and reputation in the African-American community. These efforts have been good for the veterans because it bolsters and establishes self-esteem.

Although those veterans cannot change the past, they can and are doing some things to improve the negative perceptions that society has of Vietnam veterans.

Previously rejected veterans are finding out that they can be especially useful in areas of prevention, education, and reintegration of incarcerated youths between the ages of eight and thirteen years of age. Helping at-risk youth is extremely important to the healing process.

The National Association of Black Veterans, NAACP, and Tuskegee Airmen are examples of African-American veterans' organizations that have been actively involved in providing services to at-risk youth in Indianapolis, Indiana. In Wisconsin the National Association of Black Veterans have implemented several programs that bring veterans and at-risk youth together.

Another example of an organizational approach is the Indianapolis chapter of Tuskegee Airmen that adopted a group of school-children in grade school last year.

Currently, in Indianapolis, Indiana, I serve as Executive Director of Project COURAGE. Project COURAGE represents the efforts of the Marion County Prosecutor and Governor of Indiana to reduce incidences of illegal gang activity and violence. It coordinates the operations of law enforcement, social-service agencies, community-based and grassroots organizations and dedicated individuals.

Vietnam was a difficult war for America. One of the ways this difficulty manifested itself was in a higher incidence of PTSD among Vietnam vets. Not withholding this phenomenon, the citizens who served in Vietnam gained valuable experience that can be shared with society's youth. With the continued support of the government, many Vietnam veterans can begin to recover and heal.

I thank you.

Mr. EVANS. Thank you Mr. Wilson.

[The prepared statement of Mr. Wilson appears on p. 88.]

Mr. EVANS. We will proceed with Dr. Woodard.

STATEMENT OF DR. JAMES W. WOODARD

Dr. WOODARD. Chairman Evans, I might have comments that do not speak directly to the issue of post-traumatic stress disorder. However, my comments do speak to the role of African-American veterans and African-Americans in the nation-building process of the United States.

I appreciate this opportunity to share my views on the role of the military in U.S. foreign policy. My brief statement will address three areas of concern: the role of African-Americans and other minorities in helping to formulate foreign policy; the use of military force in the conduct of foreign policy; and a change in the focus of foreign policy considerations.

My remarks, as an African-American Vietnam veteran, are tempered by my knowledge of the negative attitudes that governmental policy makers have historically exhibited toward black Americans who express opinions about U.S. foreign policy.

From my studies, I remember the treatment of W.E.B. DuBois and Paul Robeson. I witnessed firsthand what happened to Malcolm X Shabazz when he sought to internationalize the unjust plight of African-Americans. And I was traumatized by the assas-

sination of Dr. Martin Luther King, Jr., after he began criticizing American involvement in Vietnam. I vividly remember sitting and staring at the South China Sea for hours wondering what I was doing in Vietnam.

President Jimmy Carter set a precedent by choosing Congressman Andrew Young for the highly visible position of U.S. Ambassador to the United Nations. His tenure, however, was short lived for publicly talking to the Palestine Liberation Organization. Yet recent events confirm that Israel was doing so in private all of these years while they and the United States Government refused to recognize the legitimacy of the PLO.

While secrecy and diplomacy is essential for trust among nations, as often as is plausible, our government should operate in the sunshine. If Ambassador Young had been allowed to continue his efforts, he may well have followed in the footsteps of Dr. Ralph Johnson Bunche, who, while Under Secretary of the United Nations, was awarded the Nobel Peace Prize for mediating the first Arab-Israeli Conflict.

There needs to be a continuing role for African-Americans and other minorities in the conduct of foreign policy. I implore you to use your positions to facilitate that participation.

American foreign policy based upon the use of military force to promote and protect American big business interests needs to be reevaluated. Our foreign policy should, instead, promote what we espouse; that is, democracy around the world, human rights for individual citizens of all countries, and a sense of community among nations.

For almost 100 years, U.S. foreign policy has been based on "dollar diplomacy." John Boothe described it as using U.S. businessmen as agents of foreign policy and "using the Department of State to promote U.S. business interests."

More than business persons and members of the State Department promoted dollar diplomacy, however Marine Major General Smedley D. Butler stated in 1935 that, "I spent 33 years and 4 months in active service as a member of our country's most agile military service, the Marine Corps. I spent most of my time being a high-class muscleman for big business, for Wall Street, and for the bankers. I helped to make Mexico safe for American oil interests in 1914. I helped to make Haiti and Cuba a decent place for the National City Bank to collect revenues in. I helped purify Nicaragua for the international banking house of Brown Brothers in 1909 through 1912. I brought light to the Dominican Republic for American sugar interests in 1916. I helped make Honduras right for American fruit companies in 1903."

Despite our claim that we are not colonialists in the sense that European countries were, we have, since the Spanish American War, treated Latin America as our plantation and most of the world consider us to be the world's quintessential imperialistic nation. After all, we inhabit eight percent of the earth's surface; we have eight percent of the world's population, yet we use one-third of the earth's resources.

I am proud of my military service, but I am ambivalent about my Vietnam experience. I know that the United States, England, and France conspired to ensure a return of French control over Indo-

china after Vietnamese freedom fighters had supported allied efforts against Japan during World War II. The ARVN captain who was my Vietnamese counterpart told me that despite fighting alongside the Americans and the French, he considered Ho Chi Minh to be the father of his country.

Soldiers who fought in Granada, Panama, Iraq, Kuwait, and those now in Somalia have and will have questions about the legitimacy of the causes for which they were sent into combat.

Academicians who know our history and the reasons for our behavior and public officials who formulate policy have an obligation to educate the average citizen to the contradictions between our espoused theory of our behavior, what we say, and the actual implementation of our policy, what we do.

The jingoism which our leaders encourage to foster nationalism during times of crises is too often misplaced. My country, right or wrong, is not necessarily in the best national security interests of the United States. Why not, "Our country, let's make it right."

Thank you.

Mr. EVANS. Thank you, doctor.

[The prepared statement of Dr. Woodard appears on p. 100.]

Mr. EVANS. Mr. Kocher.

STATEMENT OF MICHAEL KOCHER

Mr. KOCHER. Mr. Chairman, ladies and gentlemen, my name is Michael Kocher, and I am Director of the Amerasian Resettlement Program for InterAction.

I want to also thank you for the opportunity to testify here today on the topic of Vietnamese Afro-Amerasians and issues involving African-American veterans and community.

I want to thank Mr. Ron Armstead of the Veterans Brain Trust for befriending me as we addressed this topic.

InterAction is a membership organization for the 154 U.S.-based private voluntary organizations engaged in humanitarian assistance. For the past four years, InterAction has been partner to a cooperative agreement with the Office of Refugee Resettlement/U.S. Department of Health and Human Services for the purpose of supporting local community efforts to enhance the services provided to Vietnamese Amerasians and their families.

This is a relatively new group in this country, and included in this group are thousands of Afro-Amerasians. They are the offspring of Vietnamese women and U.S. personnel stationed in Vietnam during the war.

When the U.S. left Vietnam in 1975, thousands of Amerasian children were left behind. While some men tried and succeeded in bringing their children to this country, the overwhelming majority of these children remained in Vietnam. While many were raised by their mothers or relatives, others were abandoned and forced to live in orphanages, foster homes, or in the streets.

Historically, Vietnam is a racially homogeneous society. For a variety of cultural and political reasons, Amerasians are often severely discriminated against and made to live on the poorest margins of that society.

Interviews in Vietnam and resettlement experience in this country suggest that Afro-Amerasians generally receive the harshest treatment in Vietnam, including violence.

While studies in this area are lacking, I submit to you that many of these young people exhibit symptoms of PTSD. I would like to refer all of you to an attached *New York Times* article written in November, 1992, which explores this matter in some length.

By way of background, and briefly, in 1982, the U.S. began accepting small numbers of Amerasians under the Orderly Departure Program. In 1984, Secretary of State George Schultz announced that the U.S. would accept all Amerasian children and their qualifying family members.

In September, 1987, the U.S. and Vietnam reached agreement under a bilateral program allowing increased resettlement of Amerasians.

In December of 1987, Congress passed the Amerasian Homecoming Act allowing Amerasians and family members admission to the U.S. as immigrants. The legislation took effect in March, 1988, with the expectation that at most 25,000 to 30,000 individuals would resettle here under its provisions. To date, approximately 80,000 individuals have come to the United States under this legislation with an additional 3,500 expected in fiscal year 1994. This includes approximately 20,000 Amerasian young adults of which approximately 5,000 are Afro-Amerasian.

Once here, these young people, who now average 21 years of age, resettle in numerous cluster sites around the country where they are met and receive services from voluntary resettlement agencies. In my role with InterAction, Mr. Chairman, I work closely with these resettlement agencies and communities as they welcome and serve this population.

Briefly, all immigrants and refugees, regardless of ethnicity and country of origin, must make significant adjustments when they move to the U.S. Amerasians, however, and due to their unique circumstances, especially Afro-Amerasians, have several different issues which cause strain to themselves and those around them.

(1) Low self-esteem and identity confusion—As noted, Amerasians grew up markedly different in homogenous Vietnamese society. Marginalized, generally quite poor, and lacking any social group to confer a positive identity, Afro-Amerasians may have low self-esteem resulting in self hatred and an attempt to deny their African-American heritage.

The *New York Times* article goes into this in some detail. This might be heightened upon arrival in the United States with realization that cultural and language barriers keep them isolated from African-American communities and that U.S. society possesses severe racial problems of its own.

(2) Low education levels and few transferable job skill—Though not officially denied access to schools in Vietnam, few Amerasians entered the United States with education. Most Amerasians had little formal schooling and most do not attend American high schools. Illiteracy in both Vietnamese and English is commonplace, with local service providers reporting that illiteracy is of special concern regarding Afro-Amerasians.

Similarly, most arrive in the U.S. without appropriate job skills. While local agencies do tell us that employment counseling is provided and most report that Amerasians go to work soon after arrival, vocational training opportunities are few, and Amerasians face the prospect of minimum wage work as their only long-term option.

(3) Unrealistic expectation of reunion with their father. Amerasians grew up without a father in a strict patrilineal society which confers identity from the father's family and ancestors. Those of you who spent time in Vietnam know this better than I. Many harbor hopes of finding their fathers in the United States, while most have little information to do this. This is an extremely complex, emotional area involving agency caseworkers and local Red Cross staff trained to counsel as well as carry out the actual tracing.

To date, roughly three percent of the Amerasian population have located their fathers.

It should be noted, Mr. Chairman, that Red Cross workers provide Amerasians with a located father's phone number only with the father's consent. Obviously, whether ultimately successful or not, the father search issue is a difficult one for all involved. Amerasians may have to deal with unfulfilled dreams or tensions with the biological mother or siblings.

Similarly, a father who is located may have unresolved feelings about his experience in Vietnam, as well as his own family which may or may not welcome the knowledge that he left a child behind in Vietnam. I believe the father search issues will increase in importance as local agencies staff report most Amerasians express a strong interest in finding their fathers. Some Amerasians resettled three to five years ago are only now letting it be known that they do have information about their fathers and wish to try to find them.

Without question, Mr. Chairman, Vietnamese Amerasians and especially Afro-Amerasians face problems here in the U.S. Similarly African-American veterans in communities face difficulties in welcoming these young people to their communities.

But there have been successes, and initiatives do exist which are working. Mentor programs, for example, matching African-Americans and African-American veterans with Afro-Amerasians can be beneficial. Local resettlement experience shows that these matches when carefully screened can have a positive effect. It is only through exposure and positive reinforcement that the young Afro-Amerasian is able to embrace both halves of their heritage.

Additionally, African-American veterans now serving as volunteers have told me that they value highly their mentor relationship with these young people. Some have stated that the mentor relationship has aided not only the youth but themselves as well as they have been able to come to terms with their time in Vietnam as a result. I strongly believe that veterans groups must be encouraged to reach out to these young people.

Parallels between Amerasian young adults and other disadvantaged minority groups in this country suggest that Amerasians and Afro-Amerasians are excellent candidates for inclusion in Federal, State, and local youth and young adult initiatives. Illiteracy and unemployment are critical areas of concern.

In conclusion, Mr. Chairman, I urge you and your colleagues to remember the Vietnamese Amerasians as a whole and Afro-Amerasians specifically as you continue to address issues involving African-American veterans and community.

Thank you, Mr. Chairman, for the opportunity to testify here today. I will be happy to answer questions.

[The prepared statement of Mr. Kocher appears on p. 93.]

Mr. EVANS. Dr. Woodard, we don't normally receive testimony about foreign affairs before this committee. I think it is helpful. If you don't have a foreign policy people feel proud of, that doesn't live up to the best ideals, people come home with that notion and I think it is a contributing factor in post-traumatic stress disorder. If you practice gun boat diplomacy, you can expect boat people in your harbors. We have seen that as a result of the Vietnam experience and other interventions.

Then you see the corresponding problems that Mr. Wilson talked about where veterans of other wars feel that they are not being treated as well as other casualties of the war, kids or what have you, I think was instructive, and I appreciate you summarizing what you see as the problem with our foreign policy.

We thank you all very much. I do have some specific questions. I will start with Dr. Gullattee.

Dr. Bell in his testimony talked about some inoculating factors on page two of that testimony. Can you give us some examples of some inoculating factors that may prevent the development of post-traumatic stress disorder in the youths that are exposed to violence?

Dr. GULLATTEE. I think he probably had two things in mind. As you notice, he was quoting the work that had been done by Dr. Robert Pynoos. Inoculation would imply, based on what he has said here, those kinds of factors that would diminish the violence in individuals, instructions on how to manage conflict resolution, instruction on how one would go about observing violence and not having it negatively impact on one's psyche. There are mechanisms that individuals can put in place where they would not be traumatized to the point where they are panic stricken by what occurs around them.

If this were not true, black Americans in this country could not survive, particularly that large number who live in the city, because there are very few children even today who do not see trauma and violence of some sort on an everyday existence. I give as an example a youngster who said—he is 13, asked if he took a gun to school, he said yes. Why? Because I have to have something there just in case I need to defend myself. He has not experienced direct violence, but he feels that this is the only way he can defend himself.

My generation would beat you up or challenge with you a stick, but the modern generation uses the modern technology for conflict resolution. So if one were inoculated with methodologies that would help you utilize other skills to overcome interaction in violence that means at least the impact of the stress would be less. And children have to be taught that.

I think we overlook the fact that no one teaches children how to resolve conflict. You learn by example, and therefore that is why violence perpetuates violence.

Mr. EVANS. We have not seen the details yet of the national health care plan that is going to be proposed by the President soon, but I have read press accounts that said that the mental health coverage will be limited.

The veterans programs have been limited to themselves, but would you see it detrimental if mental health coverage is not as expansive as possible in dealing with the children?

Dr. GULLATTEE. Absolutely. Absolutely. Simply because if one were to think that the only person impacted by post-traumatic stress disorder was the individual who had the diagnosis, then we will have missed the impact of what that individual has upon his or her partner or upon his or her children or extend it even farther than that, upon the community in which he or she might live.

And if not other than only to isolate the problem and treat it in isolation, then you have missed whatever the other problems are that go along with it.

So I think—for the longest time I remember when I was in training, veterans used to come to St. Elizabeth's Hospital. Before we had the veteran's hospital system. And then when you veterans took on that responsibility, veterans no longer came to St. Elizabeth. They were distributed throughout the various places. But at least they were there if they had significant others in their lives, those others were privy to whatever the necessary therapeutic modalities were. They were available to them.

Once you go into the VA hospital, only the veteran is treated but no one sells a part of it. Case management might oblige you to interact with the other persons in order for you to develop a plan of resolution or a plan of transition back into the family. But it means then that the individual is treated but the family has to put up with whatever the problems were that they lived with along with the veteran coming back to it.

It is wrong to diminish or dilute or minimize the need for mental health care in this country. We are one enormous volcano of emotional debris. And it is just—and we see it all around us, no matter where we look. We see it happening right now.

It is unreasonable to think that people in Florida, with all the trauma and deprivation there, might not think that the only way, to get against these, have the leisure and the monies to come and look in a voyeuristic way in this country would not be exposed to the violence of robbing them.

It doesn't make it right. But the mentality is such. The same is with the veteran. He suffers from the traumatic stress, but that emanates forth and radiated out into every area of the human enterprise surrounding him or her. And if you don't treat the family, you have not treated the Nation. You have just treated the individual.

We cannot minimize mental health. And it is not about bucks. It is about our having a generation that will be work productive in order to institutionalize and protect that what we say we believe in, egalitarianism and democracy.

And if you have a group of individuals who are psychologically out of synchronization or in a time warp that will not allow them to possibly understand what is going on around them, we are not going to have a world. We are not going to have that.

And I think that we have done our veterans a disservice. As a result, veterans do what? They leave home; they become homeless. If they cannot find it applicable to them because of insensitivity on the part of treaters, they treat themselves with liquor, drugs, aggressive acting out behavior, and isolation and paranoia.

So to even not consider allowing mental health provisions to be available for those who are in the service and those who are out of service and especially for those who have been exposed to the impact of war and who still live every single day with that, every single day.

I am a fifth generation of people who have been in the Armed Forces for this country. And there is not one day that I have not, in my lifetime, heard about something having to do with a specific war in which that individual participated, even to the Civil War with a slave who had to participate in the Civil War and that had been passed down.

It is incomprehensible to me, unconscionable, that we would even consider not providing all the necessary treatments and services available to the people who have put their life on the line in order for us to enjoy that when that is what we call the United States of America.

So if we are saying anything at all about minimization or diminishing mental health services, we are essentially giving ourselves a death threat in this country.

Mr. EVANS. Thank you very much.

Mr. Wilson, concerning discharges, do you have any statistics? Other people have reported that bad paper discharges are disproportionately given to minority veterans. Do you have any figures?

Mr. WILSON. I don't have any figures with me.

I might throw out numbers that are unsubstantiated. I would say that as much as a fifth of United States Marines, the National Association of Black Veterans published approximately 20 to 25 percent U.S. Marines, were issued dishonorable discharges. I suppose a similar figure for all of the other branches of the military.

If you were to look at the nature of the discharges, you would find out in most cases there were incidents or offenses that, had that veteran pursued or rebutted would, have kept them into the military.

Mr. EVANS. We received testimony from Dr. Jonathan Shay at the annual hearing held on Vietnam-era veterans' issues who indicated that a good many of the offenses committed by Vietnam veterans who receive bad paper discharges were at least partially caused by service-connected PTSD.

Do you have any evidence in this regard?

Mr. WILSON. That evidence would be new because we are having to go back in history and reconstruct situations. PTSD is a rather recent—is rather recently acknowledged by the Department of Veterans Affairs.

Initially, after the Vietnam War there was a situation where these veterans were just considered problem individuals. So the research is new, and we are having to go back and reconstruct the situations and compare the psychological profiles. A lot of it we really won't be able to do because people change.

At times, there were discharges for reasons that really didn't exist, just a situation where the CO or first sergeant didn't get along with that soldier. It is similar to a plea bargain situation: rather than to fight the system, give me a discharge, I am tired and frustrated; I will go home; it was nothing for me to exhibit abnormal behavior over there; and now you want me to pretend that I am in West Point and I didn't have that training; you do not have time to spend to debrief me or train me how I should soldier in a peacetime situation or in a United States environment; so just let me go home.

A lot of times, the soldier doesn't realize the consequences of that decision. I mean, that paper follows him and, quite frankly, puts anymore a worse situation than a civilian counterpart. A civilian counterpart can get busted for drugs in college, and that is not going to affect his employability 20 years down the road. I mean if he is a minor, it could be expunged from his record. It could be reduced to a misdemeanor.

However, that military service person committing a lesser offense and then discharged will have difficulty if not impossibility of seeking Federal employment. And quite frankly, I did things 20 years ago when I was in Vietnam that I don't know today. So it may not even be fair to even—you know, what is the relevance of a facility record if I apply for a job and you ask me what I did 20 years ago. I don't do those things anymore. I am not in Vietnam anymore. I did a lot of things in Vietnam that I would not do in the United States. I am using myself as an example. I can't speak for others. But I am sure that there are veterans who did things while in Vietnam that should not inhibit their opportunity for seeking a job today. And there is no consideration in any of our forms of redress.

Mr. EVANS. Thank you very much.

Doctor, I want to send you a copy of a speech that I wrote called "A Populist Foreign Policy." The CBC has been helpful in assisting us to fashion a noninterventionist foreign policy. I want you to know that these ideas will help Ron Dellums and his associates in developing that kind of policy.

Mr. Kocher, we appreciate your work. Vietnam veterans are getting older. When I was in Vietnam, I met an Amerasian grandchild. They now average age 21. For some of the people who have been reunited with their children, I understand that it has been very therapeutic for them to go through that process and help them deal with the guilt that they faced as a result of being in that war.

I thank all of you for your excellent testimony. It is valuable to us, and it will be available to us as we fashion legislation that deals with some of the problems that you raised.

Our next panel is comprised of representatives from the Department of Veterans Affairs. Following a five minute recess, we will ask them to come forward.

(Recess.)

Mr. EVANS. If everyone could please be seated. We will resume with the final witness panel which represents the Department of Veterans Affairs.

Dr. David Law is Acting Associate Deputy Chief Medical Director for Clinical Programs. He is accompanied by Dr. Arthur Blank the Director of Readjustment Counseling Services and Dr. Larry Lehman, Associate Director of Psychiatry and Mental Health Behavioral Sciences Service.

You may proceed, Dr. Law.

STATEMENT OF DR. DAVID LAW, ACTING ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR, CLINICAL PROGRAMS; ACCOMPANIED BY DR. ARTHUR BLANK, DIRECTOR, READJUSTMENT COUNSELING SERVICES; AND DR. LARRY LEHMAN, ASSOCIATE DIRECTOR, PSYCHIATRY, MENTAL HEALTH BEHAVIORAL SCIENCES SERVICE

Dr. LAW. Thank you, Mr. Chairman. It is a pleasure to appear before the subcommittee to review the incidence of post-traumatic stress disorder in African-American veterans and the Department of Veterans Affairs efforts to respond to the needs of these veterans.

VA has created a full range of programs for the care of veterans suffering from PTSD, including African-Americans, and has led the nation and the world in developing the understanding and treatment of this disorder.

Our specialized programs provide a continuum of care ranging from intensive long-term inpatient treatment to specialized outpatient care in VA medical centers, clinics, and Vet Centers. VA is expanding these programs with special funding from our fiscal year 1993 appropriation and has requested additional expansion resources from Congress for fiscal year 1994.

VA's National Center for PTSD carries out a broad range of multidisciplinary activities in research, education and training. The National Center established in 1989 is a consortium of six sites. Also, since 1984, VA's PTSD programs and VA ability to provide PTSD care has been monitored by the Chief Medical Director's Special Committee for PTSD.

The National Vietnam Veterans Readjustment Study, completed in 1988, found that PTSD could be diagnosed in 15.2 percent of male Vietnam veterans, approximately 480,000 veterans. And there were an additional 11 percent or 341,000 veterans who had three to five symptoms of PTSD. Fifty percent of these Vietnam theatre veterans with PTSD had other psychiatric disorders such as depression, substance abuse, or anxiety disorders. This study showed that 20.6 percent of African-American Vietnam veterans were suffering from PTSD.

A current study of Persian Gulf veterans at five VAMCs shows an overall lower rate of PTSD among the Persian Gulf veterans. However, African-American veterans are experiencing a slightly higher rate of PTSD than the overall Persian Gulf veteran population.

VA is also tracking African-American veterans' utilization of special PTSD and readjustment counseling programs. Our spring 1993 data shows that approximately 19.8 percent of our PTSD unit inpa-

tients were African-American. Previous studies have shown that 17 percent of veterans seen in our special outpatient PTSD programs are African-American, and 24 percent of Vietnam theatre veterans seen in Vet Centers are African-American.

These findings are consistent with VA-wide experience in which approximately 20 percent of the patients treated in all VA medical centers are African-American. Nationwide 8.6 percent of all veterans are African-American and African-Americans as a whole account for 12 percent of the U.S. population.

VA continues studying how the needs of African-American veterans with PTSD can best be met. The National Center for PTSD is developing a proposal to apply the methodologies developed in the epidemiologic study of native Americans, native Hawaiians, and Asian Pacific Islander veterans to better understand PTSD in African-American veterans. This is by designing more ethnically sensitive and better diagnostic strategies and treatment approaches.

VA has paid special attention to the large numbers of homeless African-American veterans in designing these programs. African-Americans make up 40 percent of the more than 70,000 homeless veterans that have been treated in the VA homeless veterans programs. While those problems are similar to those faced by other veterans, African-Americans are generally younger and more likely to have drug abuse problems, but less likely to have severe psychiatric problems.

Since the early 1980s, Readjustment Counseling Service has had eight special population working groups composed of Vet Center staff representatives of the respective populations. They work to improve recruitment and retention of staff from special populations being treated and assure adequate outreach and counseling services to those identified groups. RCS African-American veterans working group, for an example, provides educational workshops to Vet Center staffs, develops recruitment strategies, and serves as consultants on the special needs of African-American veterans.

We are very proud of the working group that will be participating in the agenda of the Black Caucus this very week.

To enhance recruitment, the RCS field staff maintains a booth at the National Annual Conferences of the African-American Social Workers and Psychologists to provide programmatic and career-related information to this group.

The Readjustment Counseling Service is currently carrying out, in collaboration with the VA National Center for PTSD, a prospective study on a sample of new Persian Gulf cases at 82 Vet Centers in order to assess in the years ahead the impact of wartime duty on readjustment and other aspects of psychological functioning.

This is the first prospective study of war veterans' adjustment carried out by the VA. The initial phase has demonstrated an overall PTSD prevalence of 11.5 percent. Fifteen percent of the veterans represented in the sample were African-American. Upon completion of all three phases of this study, data will contain unique information regarding PTSD in the African-American Persian Gulf population.

Mr. Chairman, we are proud of the accomplishments of our Vet Center and our special PTSD programs. But we are determined to do better. The data show that African-American veterans utilize

these programs in proportionately greater numbers than white veterans.

There have been ongoing efforts to recruit minority professional staff to work in these programs and to train all staff to recognize the importance of cultural difference when treating minority veterans.

The National Center is undertaking further studies of the influence of cultural differences with the goal of continuing to improve treatment approaches to African-American veterans.

This concludes my testimony. My colleagues and I will be pleased to respond to questions.

[The prepared statement of Dr. Law appears on p. 103.]

Mr. EVANS. Thank you very much, doctor.

What is the status of the study on the Persian Gulf veterans?

Dr. BLANK. The first phase, the intake phase of the study, has been carried out and it is an ongoing study. There will be periodic follow-up, reinterview of folks over time.

Mr. EVANS. Do you know when we might get some initial analysis?

Dr. BLANK. We can get you a report of intake phase at this point.

And, secondly, the first follow-up data which came after several months is now being worked up by the National Center and I think will be available in the next several weeks.

Mr. EVANS. Several witnesses have commented on the small percentage of African-American veterans awarded compensation for service-connected PTSD.

Why are veterans with service-connected PTSD not receiving compensation for their disability? Is an African-American veteran less likely to be diagnosed with PTSD than a white veteran?

Dr. LEHMAN. I will need to look up the exact numbers of the veteran service-connected with PTSD who are African-American. I know that there are about 50,000 veterans of all groups service-connected for PTSD by this point.

And I think we need to look up and can respond later specifically to those questions about the numbers who are service-connected. Based upon the numbers of individuals in treatment where we are seeing proportionately higher numbers of African-Americans in our treatment programs, it seems like we are doing well within the terms of treatment issues. The issues are different, and we will need to get back to that more specifically.

(This information was not provided by the Department.)

Mr. EVANS. Does anyone else have a comment on that?

Let me ask you, if roughly only ten percent of veterans are either getting treatment or compensation, is it a failure of the VA to outreach to these veterans? Are there not enough resources? What is the problem?

Dr. BLANK. I would like to say, first of all, that I think the ten percent figure is out of date and has been overtaken by events.

The interviews of the NVVRS study were conducted in 1986 and 1987. And the study was reported at the beginning of 1988. In the last five or six years, Vet Centers have seen more clients per year each year. There are more new clients seen over the last several years. And the number of PTSD outpatient treatment programs and inpatient programs in the medical facility is greatly increased

and accelerated. And I think that if the survey of utilization of VA services by PTSD veterans were done today, that that percentage would be much higher.

Mr. EVANS. What would you expect it to be?

Dr. BLANK. I would say that it is well over 25 percent now and perhaps higher. That would be my guess.

Mr. EVANS. In the overall general population, do you know what it would be for African-American veterans?

Dr. BLANK. No, I do not have an estimate of that.

Mr. EVANS. Could you provide us an estimate of that? We are going to introduce legislation, and it will be helpful to have reliable statistics in that regard. VA has a working group on African-American veterans who are suffering from PTSD and I understand that a report will be issued within a couple of months by the working group.

Is that right?

Dr. BLANK. The working group is not a data gathering effort. It is an analytical effort which will be producing recommendations for management.

Mr. EVANS. Doctor, it is noted that while African-Americans participate less in PTSD treatment than white veterans, they report similar levels of satisfaction with their services. Could lower initial expectations explain the satisfaction reported by African-Americans?

Dr. LEHMAN. I don't know exactly what is responsible for the incidence of patient satisfaction as reported. One possibility may be that some of the problems that the veterans are identifying as treatment issues such as problems with substance abuse as well as problems with employment, which we do know our African-American veterans do utilize in our specialized outpatient programs, are seeking these treatments in higher numbers proportionately than their white counterparts.

Perhaps the fact that they are receiving satisfaction in these areas that are of significance and importance to them may reflect the equivalence of satisfaction reported by the two different groups.

Mr. EVANS. We are in the process of downsizing the military, and this is something that is going to continue. Many people who expected to make the military a career will not be able to do so. Many of them have not reported any symptoms of PTSD out of fear that if they did, that by itself, would jeopardize their careers.

In fact, the ones that may stay in the Armed Forces with the competition to stay in are hesitant to bring up the issues.

Do you think that we will need any special programs to treat those people being discharged from the military with PTSD that has been submerged for so many years? Have you given any thought to that?

Dr. BLANK. I think that our efforts with newly discharged, long-time veterans who, however, may be leaving in a premature way such as you describe, have greatly increased since the time of the Persian Gulf War when the liaison between Readjustment Counseling and Mental Health and Social Work in Central Office and at field levels around the country was greatly accelerated.

For example—just to give one somewhat related example of that, we are currently conducting, in an ongoing way, debriefings for re-

turning troops from Somalia at two locations in collaboration with active duty elements around the country. And Dr. Lehman may have some further comment on this, but I think between Readjustment Counseling, Mental Health, Social Work, and veterans' benefits efforts in connection with the military such as they have been developed, we are in a much better position than we were before the Persian Gulf War.

Mr. EVANS. With the huge number of people being discharged and the fact that African-Americans are disproportionately represented in particularly the higher enlisted ranks because they have the higher reenlistment rates than white veterans, are you prepared to have the centers or resources available at the centers adequate to meet the need, generally, with the numbers of people coming back and, specifically, with the high numbers of African-Americans coming back home?

Dr. BLANK. I can only speak for Vet Centers on that question. We have high levels of African-American staffing in Vet Centers, 17 percent of team leaders and 24.5 percent of counselors. That is nationwide. I think we are in a good position as regards the Vet Centers.

Mr. EVANS. But overall, in terms of numbers of employees, are you going to be able to meet this new demand?

Dr. BLANK. We are able to keep up at this point in time with reaching discharges from the military.

Mr. EVANS. Dr. Law, in your written statement you talked about a Manhattan health center with an outreach station, I understand, in Harlem. Is that something you are going to try to do elsewhere, and what has been the benefits of that arrangement at this point?

Dr. LAW. Dr. Blank can speak to this better than I, but I think it is important to note that we established a single-person out-station in Harlem because it was an area grossly underserved. The response to this has been so dramatic that one person staff was doubled soon thereafter, and just this year the decision has been made to locate a full Vet Center there, a four-person Vet Center. This was done on the basis of recognized need.

I would hope that where other areas of recognized need arise, that we would be able to duplicate this. But Dr. Blank, I think, perhaps has more information.

Dr. BLANK. We expect to have a full-fledged Vet Center up on 125th Street in Harlem, New York in the next three or four months. And that effort began through the initiative of Congressman Rangel and Secretary Derwinski, in the first place, a couple of years ago. And this year, I and our regional manager, Clyde Waite, proposed and recommended to the Veterans Health Administration that there be additional resources added to upgrade it to a full-fledged Vet Center. And Dr. Law and Dr. Farrar, the Acting Chief Medical Director, made the decision to do that.

Mr. EVANS. In East St. Louis, IL, a Vet Center exists that I visited many years ago. I understand that resources have been cut back there. Is there any plan to help East St. Louis, which is going through very difficult times, acquire additional services?

Dr. BLANK. We are very aware of that and we don't have the bucks in sight at this point in time to do anything additional there.

Mr. EVANS. How much would you need?

Dr. BLANK. Staff, additional staff costs run in the neighborhood of \$45,000 per person per year.

Mr. EVANS. Let me ask you, Dr. Blank, can the information gained by effective treatment of service-connected PTSD be applied to treating youth who have witnessed or been victims of crime?

Dr. BLANK. I think both Dr. Lehman and I would agree that the answer to that is yes, and that I find—personally find Dr. Parsons' statement with reference to that, Dr. Erwin Parsons' statement quite fetching and interesting, and we will be looking at that.

Mr. EVANS. Dr. Bell suggests combining the resources used to treat African-American veterans with funds used to treat community residents. Is this a good idea, and if it is, what could we do to help facilitate that?

Dr. LEHMAN. Could you repeat the question again, please?

Mr. EVANS. Dr. Bell indicated in his written testimony that we should combine resources used to treat African-American veterans, the VA, essentially, with funds used to treat community residents to help their children who might be suffering from PTSD.

Has the VA considered this as a way of interacting and working in partnership with community organizations or with community-based mental health centers? Have you given any thought to it whatsoever?

Dr. LEHMAN. Certainly one of the things we do with regard to the families of our veterans with PTSD is to attempt counseling for them along with the veteran in a number of our specialized PTSD programs as well as our general mental health programs.

The degree to which we can assist community programs right now is limited to two ways, but they are two ways that are actively used: Consultation, education of community programs which are carried out, I am sure, by Vet Centers as well as PTSD clinical teams and the National Center for PTSD has participated in developing some media, some materials that could be used for this and as well in some cases perhaps with sharing agreements that are reached.

Mr. EVANS. Do you have some sharing agreements at this point or is that something you are going to look at?

Dr. BLANK. I do not know of any sharing agreements that we have that go in the direction Dr. Bell has written about.

Mr. EVANS. Dr. Bell has raised some interesting issues which VA should examine. If you could formally respond to us in writing we will make your response part of the record. I think it will be helpful.

As we look at national health care reform, I think we have to be as innovative as possible and involve the VA in this process. And I know you have many plates spinning with all the different problems we are having, but it just seems to me that the lessons that were learned from our experiences in Vietnam and that we have learned subsequently can be used to help these kids. I think we have to, in reinventing government, look for these kinds of inter-governmental and interagency partnerships. I really hope that you see that on your radar screen in the near future. If you could give us a more formal answer, we would appreciate it.

(This information was not provided for the record by the Department which has indicated it does not maintain centralized data on such sharing agreements.)

Dr. LEHMAN. There have been some projects in that direction. I can think of one in particular in one of the northeast mental health projects pilots begun probably in 1986 under the direction of Dr. Errera that involved a collaborative effort between the VA medical center in White River Junction and some State community mental health centers in Vermont. And I believe that project won a special award from the American Psychiatric Association.

Dr. LAW. There are other approaches that can be taken also aside from direct therapy or direct treatment of individuals. Certainly, VA would have the opportunity to play a role in consultation, direct training, education so that we can increase the pool of useful therapists in a given area without having to provide the actual treatment to the nonveteran.

Mr. EVANS. I really think the VA should take a leadership role in this area. VA has the expertise. I was very proud of the leadership VA took in local AIDS task force even before the epidemic reached great numbers. I think the VA will exercise similar leadership in working with others in partnerships in the future. I think that would provide a lot of good help to the kids and to the veterans themselves if they can be involved in the process.

I don't have any other questions. We appreciate your testimony. I will be submitting some written questions and, of course, your responses to those written questions will be made part of the record as well.

Thank you very much.

Dr. LEHMAN. Thank you.

Dr. LAW. Thank you.

Mr. EVANS. We are very pleased that Dr. Allen has joined us now. He is a psychiatrist with Harvard University Health Services. His clinical experience has included service to veterans for nearly 25 years and, doctor, thank you so much for joining us.

As soon as you are seated and collect yourself and your thoughts, you may proceed.

**STATEMENT OF DR. IRVING ALLEN, HARVARD UNIVERSITY
HEALTH SERVICES, CAMBRIDGE, MA**

Dr. ALLEN. I would first like to say I am very honored to have been asked to come and speak here today.

African-Americans participated extensively and probably disproportionately in the United States military during the Vietnam War. There is growing evidence that residual psychological and physical trauma suffered during the war continue to be suffered disproportionately by the collective African-American population even now two decades since the end of the war.

Two large scale studies—the Legacy study and the more recent NVVRS Study—have been completed which show the extent of psychological symptoms which persist among the African-American as well as the Hispanic population. As of 1981, the Legacy Study showed that 70 percent of African-American heavy combat veterans remained stressed years after the war compared to 40 percent of European-American veterans. Further, 40 percent of all African-

American combat vets remained stressed compared to 20 percent of European-American combat veterans.

The 1988 NVVRS Study has found that the prevalence rate for African-American combat troops is 20.6 percent compared to 13.7 percent for European-Americans and 27.9 percent for Hispanic veterans.

Further, this study, as did the Legacy Study, showed that African-Americans and Hispanic Americans were assigned to combat duties much more frequently than European-Americans. It appears to me that if it were not for extensive statistical analysis, the prevalence rate difference reported in the NVVRS Study would be even more pronounced since exposure to combat is the most important variable in predicting Post-Traumatic Stress Disorder.

Also those studies showed that African-Americans and Hispanic American combat vets continue to experience significantly increased adjustment problems such as marital disturbances, jail time, violence, alcohol, drug problems, unemployment and physical health problems.

Moreover, usage of physical and mental health services is lower than predicted for these populations and equally disturbing, the awarding of service-connected compensation to African-Americans and Hispanic Americans is less despite the higher PTSD rates.

These are grim facts which pertain not just to the inevitable rigors of war but also to an adverse climate to which all Vietnam veterans returned but which particularly impacted negatively on these veterans for reasons of race and culture and class.

African-American soldiers of the Vietnam era, unlike their European-American counterparts, were better educated and more accomplished than their civilian counterparts. Whitney Young proudly called them the best and the brightest and praised them for their volunteerism which included combat assignments.

Many of these young people, usually under 20 years, entered the military with high hopes of improving their lives because of the lack of opportunity in civilian life.

It is indeed a tragedy of epic proportions if the high hopes and idealism of these young people of the Vietnam era have been dashed because of shortsighted, miserly, and rejecting policies which have neither consistently nor adequately addressed the readjustment needs of these veterans.

It is certainly an inexcusable tragedy if the African-American and Hispanic American communities are worse off because of their volunteerism during the war.

While the troubles of our cities are caused by complex factors, one must certainly consider the possibility that contributing factors may relate at several levels due to the Vietnam War.

For example, the loss of thousands because of death and injury of these best and brightest and the withdrawal simultaneously of appropriate societal supports from these communities during the post-war atmosphere of conservatism and racism. Could these factors be causally related to the waves of violence that have plagued our cities since the end of the war?

As a clinician who has served veterans for almost 25 years, I continue to see even now from the private practice perspective over the last ten years the excessive efforts minority vets who have

served their country must make just to get along. I have witnessed several stages in the treatment of veterans since 1969 when I left the military to begin psychiatric training.

I was a clinician in the VA system 11 years before it was officially recognized in 1980 that the Vietnam War produced psychiatric trauma casualties. I have also struggled as a clinician during the early 1970s when many employees of the VA system were especially antagonistic toward Vietnam vets, and in the adverse racial climate of our cities, especially so to veterans of color. This antagonism was reflected in the behavior of employees at all levels including medical staff.

I have also witnessed efforts to correct that past with such innovative programs as the Vet Centers which started with such idealism and seemed to me at some point to flounder in the "body count" mentality.

Since leaving the VA system, I continue to see combat veterans who at times are forced to go to preposterous extremes to "prove" their war-related injuries, and sometimes even have to change an incorrect diagnosis given to them years before the VA system even recognized the impact of trauma.

The troubles that they experienced impacted severely on their lives, but it seems obvious to me that their troubles ultimately impact adversely on the entire society because the costs in psychological and physical illness keep rising when adequate services, social as well as economic as well as medical, are not available.

If my relatively current small sample of patients has any broader relevance, it means that there are many thousands of African-American combat vets experiencing major difficulties procuring services of which they are deserving and to which they are entitled.

As one who has gladly treated all races and ethnic groups and classes of veterans, I must emphasize that the efforts of the entire veteran population are not demeaned by deliberate consideration of the underserved minority veterans.

Various approaches to address urgently the needs of the minority veteran population are needed. They should be well considered and undertaken not at the apparent expense of any other group, but for the benefit of all recognizing that even in veterans' affairs, minorities have not always been included in "the all" when it has been time to elaborate policies, start programs, erect facilities, and staff thoroughly integrated programs.

A new direction based on new vision is urgently needed to at long last provide adequate supports to the veteran population which so idealistically responded to the Nation's call.

Thank you.

[The prepared statement of Dr. Allen appears on p. 52.]

Mr. EVANS. Thank you, doctor. I appreciate your testimony.

Could you describe to us some of the components of the new direction that you would have us go in, what you would be looking for?

Dr. ALLEN. Well, as a clinician, I think I am best suited to speak to that. And I will have to speak impressionistically based on local area, Boston area thoughts. It strikes me that clinically there may be some, let's say, diminution, lack of enthusiasm or decreasing en-

thusiasm in providing the day-to-day, week-to-week, close-in clinical care for the veteran population.

And I don't mean just the minority veteran population. I am under the impression that there are actually cutbacks in the psychotherapy, the behavioral therapy kinds of services to which—which are very helpful to many people in favor of medication treatments, in favor of store-type mentality in which people are shuttled in or out for 10 or 15-minute interviews basically to monitor medications.

I am not—I wouldn't say I am best suited to discuss the broader programs. But the impression I have is that programs that provide housing, economic assistance, employment training, all may be lagging at this point. In my experience, they have always been problematic even when I was in the VA system.

Mr. EVANS. At the breakfast earlier, Gunny Branch brought up the fact that veterans should look toward funding from their State governments which I think everybody should be encouraged to do, which the Veteran Benefits Clearinghouse has done in the past.

Although it is still a federal responsibility to deal with veterans, would you think that part of the solution to the problem lies in nontradition-based community organizations for housing for maybe PTSD treatment and training opportunities?

Dr. ALLEN. Absolutely. Absolutely.

Mr. EVANS. I appreciate your testimony and look forward to working with you in the future.

Dr. ALLEN. Thank you.

Mr. EVANS. With that, we will conclude our hearing.

I want to thank everyone who participated and Ron Armstead, again, for his excellent assistance in arranging this hearing. This is one of the best hearings we have ever had on this committee and we will continue to work with you in the future.

Thank you all for coming and we appreciate your efforts in being here today.

[Whereupon, at 12:01 p.m., the subcommittee was adjourned.]

APPENDIX

Statement of

Honorable Lane Evans, Chairman
Subcommittee on Oversight and Investigations

African-American Veterans and the Community:
Post-Traumatic Stress Disorder and Related Issues.

September 15, 1993

(47)

This morning the Subcommittee on Oversight and Investigations is meeting to examine a very important and timely subject -- African-American Veterans and the Community: Post-Traumatic Stress Disorder and Related Issues.

Last week President Clinton and Vice-President Gore unveiled their proposal to "reinvent" our federal government. Like the President, I strongly believe our federal government can and must be more responsive to our citizens. In veterans affairs, there are clearly many opportunities for improving services to the men and women who have served in uniform. Expanding the Vet Center program and improving PTSD-related services are only two of the needed improvements I strongly support and in the very near future I intend to introduce legislation to bring about these needed improvements. Among today's witnesses, other improvements in veterans' services may be recommended. These contributions will be particularly welcome.

Many individuals are scheduled to testify this morning and we look forward to receiving each presentation. Our witnesses today represent many different vocations, interests and experiences. We appreciate their willingness to come forward and participate today. Other individuals who could not be present today have been invited to submit a written statement for inclusion in the printed record of this hearing.

As many here may know, this hearing has been scheduled to coincide with the Annual Congressional Black Caucus Legislative Weekend. The annual CBC legislative weekend is an especially appropriate time to focus attention on issues of particular importance to African-American veterans. This subcommittee appreciates the cooperation it has received from the CBC, the Black Veterans Braintrust, and Corrine Brown, Charlie Rangel and Sanford Bishop, the three Members of Congress who co-chair the Braintrust.

The Subcommittee especially wishes to acknowledge and thank Congressman Bill Clay, Chairman of the House Committee on Post Office and Civil Service and the staff of the Committee, for their assistance and cooperation. In addition to making this hearing room available for today's proceeding, Chairman Clay and his staff have been particularly accommodating and helpful. The Subcommittee greatly appreciates their contributions and cooperation.

Last, but certainly not least, I want to particularly acknowledge the contributions of Ron Armstead, who has gladly assisted the Subcommittee prepare for this hearing. Thank you very much, Ron, for your help, your cooperation and your continuing service and support.

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Testimony of Senator Paul D. Wellstone
before the
Veterans' Affairs Committee
Subcommittee on Oversight and Investigations
U.S. House of Representatives
on
African American Veterans and Community:
Post-Traumatic Stress Disorder and Related Issues

September 15, 1993

Mr. Chairman, members of the committee, I am honored to be here today to testify on the issue of Post Traumatic Stress Disorder and its effects on veterans and their families. I commend you for your work in this area. And I support your efforts to develop more comprehensive treatment programs for those affected by this debilitating disease. I am distressed by the fact that the VA is treating only about 10% of veterans with service-connected PTSD and I plan to introduce legislation that will expand and improve VA outpatient and inpatient care for PTSD victims. At the same time, I will push for Senate hearings on this pressing issue.

I know your focus today is on African American veterans who statistics show are disproportionately affected by PTSD, but I must state that the PTSD symptoms of violence, abuse, and neglect are not unique to the African American community. It can affect any soldier, without regard to the color of his skin or gender. It is a disease that affects the whole family and may impact on the entire community.

Although I am certainly not an expert on the technical relationship of PTSD to violence, through my work and the work of my wife Sheila on the issue of domestic violence, I can testify to the deep and lasting impact on families that are victims of violence, abuse and neglect. It is the link between the veterans who suffer from PTSD and the violence, abuse and neglect they may inflict upon their families that brings me here today. It is this cycle of violence and abuse that I am working to curb. And treatment for those who suffer from PTSD is one important way to break that cycle of violence.

We need to understand that PTSD can and does affect the entire family, not just the veteran himself. Veterans who suffer from PTSD often neglect and/or abuse their families. And the effects of this disease can have serious consequences for the children and even grandchildren of veterans who suffer from PTSD. I have talked to a psychotherapist in Minnesota who works with vets who suffer from PTSD. She has told me that she is now treating the adult children, and sometimes the grandchildren, of Vietnam veterans who have grown up in violent homes.

The story of a Vietnam vet is a vivid example of the effects of

PTSD on vets and their families. He physically and verbally abused his wife and children for two years. He exhibited symptoms of paranoia, severe irritability, and flashbacks. He was diagnosed as suffering from PTSD. He has now completely withdrawn from his family and his life.

Let me just read a poem written by his 13 year old daughter:

For someone to share
 Is only to care.
 He was in the war
 And never opens his door.
 He lives in a shell
 And that must be like hell.
 He used to be my dad
 But now he looks so sad.
 If only he knew
 It makes me feel blue.
 I know he loves me
 Why won't he hug me.
 My mom says "he's numb."
 What will I become
 Without my father to guide me.

Common symptoms of this disease include angry outbursts, irritability, difficulty sleeping and flashback experiences that feel real. Vets who suffer from PTSD often respond to the people at home as if they were in combat. This can lead to a veteran becoming violent toward a members of his family. For children it often affects their ability to learn, to function at home and at school, and their ability to relate to others.

Neglect, abuse, and even just witnessing abuse can leave devastating scars. Unless we begin to treat this disease it will continue to effect future generations.

Recently, I had the opportunity to speak to a Minnesota veteran of both Korea and Vietnam who is an African-American. He has a background as a counselor and learned only in 1989 that he was suffering from PTSD. I would like to share a few of his insights regarding the needs of African American veterans who have PTSD. In his view, many African American veterans who are afflicted by PTSD refuse to acknowledge they have the disease and seek to cope with its serious effects on their own, however unsuccessfully. He emphasized that the VA health system is currently not meeting the needs of these veterans, and to do so it must institute outreach programs tailored to the needs of African-American veterans, hire more African-American counselors and other professionals to work in their PTSD treatment units, and expand the number of "hassle free" Vet Centers that are accessible to African American veterans. I will work to fully examine these suggestions and others made at this hearing.

Many of the veterans who come to my office for help ask that PTSD get a higher rating. They are frustrated by delays. They are stuck in the backlog of claims in the VA adjudication and appeals systems. Indeed, they are frustrated that parts of the VA are slow to recognize PTSD as an illness or that it is an illness whose effects can be every bit as devastating as any physical ailment.

The development of treatment programs for PTSD is still in the early stages. The first step is for the VA to recognize the traumatic effects of PTSD on both veterans and their families. User friendly treatment programs need to be expanded and given high priority by the VA. The programs should be available to both vets and their families.

Therefore, I can not urge you enough to act quickly to introduce legislation, as I will do the same, so we can begin to help veterans and their families deal with this devastating disease.

Thank you for your efforts on this issue. I look forward to working with you and members of the Senate.

STATEMENT OF

DR. IRVING ALLEN

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS

COMMITTEE ON VETERANS' AFFAIRS

SEPTEMBER 15, 1993

African Americans participated in the VietNam War extensively and perhaps disproportionately in the United States military during the VietNam War. There is growing evidence that residual psychological and physical trauma suffered during this war are also suffered disproportionately by the collective African-American population, even now two decades since the end of the war.

Two large-scale studies, the Legacy Study, and the more recent NUURS Study, have been completed which show the extent of the psychological symptoms which persist among the African-American and the Hispanic populations. AS OF 1981, THE Legacy Study showed that 70% of African-American heavy combat veterans remained stressed years after the war compared to 40% of European-American veterans. Further, 40% of all African-American combat veterans remained stressed compared to 20% of European-American veterans.

The more recent NUURS Study has found that the prevalence rate for African-American combat veterans is 20.6% compared to 13.7% for European-Americans and 27.9% for Hispanic veterans. Further, this study, as did the Legacy Study, showed that African-Americans and Hispanic-Americans were assigned to combat duties much more frequently than European-Americans; it appears to me that if it were not for extensive statistical analysis, the prevalence rate difference between the European-Americans, African-Americans, and Hispanic Americans would be even more pronounced, since exposure to combat is the most important variable in predicting PTSD (Posttraumatic Stress Disorder).

Also, these studies showed that African-Americans and Hispanic-American combat veterans experience significantly increased adjustment problems such as marital disturbances, jail time, violence, alcohol and drug problems, unemployment, and physical health problems. Moreover, usage of physical and mental health services was lower than predicted for these populations, and equally disturbing, the awarding of service-connected compensation to African-Americans and Hispanic-Americans is less despite the higher PTSD rates.

These are grim facts which pertain not just to the inevitable rigors of war but also to an adverse climate to which all VietNam veterans returned, but which particularly impacted negatively on these veterans for reasons of race and culture and class. African-American soldiers of the VietNam Era, unlike their European-American counterparts, were better educated and

more accomplished. Whitney Young proudly called them "the best and the brightest" and praised them for their volunteerism which included combat assignments. Many of these young people (usually under 20 years old) entered the military with high hopes of improving their lives because of the lack of opportunity in civilian life.

It is indeed a tragedy of epic proportions if the high hopes and idealism of these young people of the VietNam Era have been dashed because of short-sighted, miserly and rejecting policies which have not adequately addressed the re-adjustment needs of these veterans. It is certainly an inexcusable tragedy if the African-American and Hispanic-American communities are worse off because of their volunteerism during the war. While the troubles of our cities are caused by complex factors, one must certainly consider the possibility that contributing factors may relate at several levels to the VietNam War; the loss of thousands because of death and injury of "the best and the brightest", and the withdrawal of appropriate societal supports from these communities during the post-war atmosphere of conservatism and racism.

As a clinician who has served veterans for almost 25 years, I continue to see even from a clinical practice perspective the excessive efforts minority veterans who have served their country must make just "to get along." The troubles that they experience impacts severely on their lives, but it seems obvious to me that their troubles ultimately impact adversely on the entire society because the ultimate costs in psychological and physical illness keep rising when adequate services, social and economic as well as medical, are not available.

As one who has gladly treated all races, ethnic groups, and classes of veterans, I must emphasize that the efforts of the entire veteran population are not demeaned by deliberate consideration of the underserved minority veteran populations. Various approaches to address urgently the needs of the minority veteran population are needed. These should be well-considered and undertaken not at the apparent expense of any group, but for the benefit of all, recognizing that even in veterans' affairs, minorities have not been always included in "the all" when it has been time to elaborate policies, start programs, erect facilities, and staff truly integrated facilities. A new direction based on a new vision is urgently needed to at long last provide adequate supports to the veteran population which so idealistically responded to the nations' call.

**Statement of Erwin Parsons, Ph.D., Clinical Psychologist
VA Medical Center, Perry Point, Maryland
Before the Subcommittee on Oversight and Investigations
of the
U.S. House Committee on Veterans Affairs**

Mr. Chairman, distinguished members of the Subcommittee, ladies and gentlemen. I feel exceedingly grateful for the opportunity to testify before this very important Subcommittee once again. I am grateful because the Subcommittee is a body that gets things done for veterans. It is results oriented: this makes me feel that the time spent here this morning will push progress forward to contribute meaningfully to veterans' welfare. The Subcommittee has amply demonstrated that it can listen to diverse testimonies, and distill them down to the bottom line: helping veterans to get the services they need to get well and do well, and to then encourage them to go out and face the world to serve once again.

Mr. Chairman, in my 15 years of working with veterans in the capacities of administrator, clinician, consultant, and advocate in the public and private sectors -- in areas of health care, the courts, and employment/labor markets, I find one tremendous, predictable human trait in the veteran; namely, the prosocial impulse to serve humanity once again. Because service is a deeply imbedded desire and response in the heart and consciousness of veterans, they can probably be relied upon to perform a job for society once again on another difficult front -- the domestic service front. Men and women who served in the Armed Forces during the 1960s and early 1970s have an indelible service imprint upon their psyches, and it is now an integral part of their identities -- who they really are. They are now in the fourth decade of their lives. This hearing, Mr. Chairman, is titled, "African American Veterans and Community: Post-Traumatic Stress Disorder and Related Issues." To me this title seems to suggest that perhaps African American veterans have something meaningful to contribute to inner city communities.

My years of corporate world experience on Wall Street taught me to see veterans in a different way: I saw veterans using their war zone experience to better their families, their communities, and the nation. Many applied their hard-earned insights into the nature of human

experience to how leadership works, to how good team-building is done, to how a job is done well the first time, and to how to protect the helpless and needy among us in various American communities.

From these veterans I learned quite a bit about how military service, particularly the maturation-enhancing advantages of combat experience, prepare men and women to walk the path of peace, and to appreciate and value life, while eschewing conflict and violence. I have noticed tremendous strengths and insights in problem-solving and in decision-making, not only in successfully adjusted veterans, but also in those whose personalities have been distorted by war and homecoming negativity, and the impact of PTSD and other lingering psychological conflicts.

I focus on the concept of "veteran-youth positive coaching" (V-YPC), a "value-added" approach to enriching the lives of youth in trouble, and why I believe veterans are among the best candidates to serve as brokers for change in the lives of disillusioned, rageful, fearless, uncommitted (to family, community, school, or to life itself), and violent children, youth and young adults in our nation today. "Coaching" and "value-added" are two concepts I encountered while I consulted on Wall Street; they have important applications to the quality of the relationships veterans and our youths can share. Mr. Chairman, I believe that the time has come for a bold step to be taken to help our inner city youths. Many of these youths are children of veterans who, often because of paternal PTSD, have been unable to receive essential parental support and guidance.

For too many of our youths, violence has become a way of life. A way to feel strong. A way to feel loved, secure and important. A way to feel empowered. A way to increase self-esteem. They are exposed to the toxic effects of violence perpetrated by others against them, and violence perpetrated against others by them. They are trapped; they feel alone and abandoned by family, community, and nation. They are bitter and fearlessly vengeful toward most authorities -- most adults, parents, teacher, ecclesiastical figures, police, and the entire criminal justice system -- whom they have come to distrust, and view as "irrelevant agents" to their welfare.

Many of these young people do not trust most adults. They see adults' interactions with them as a form of "pseudorelating mechanics" associated with what Lifton has called "counterfeit nurturance." Many youth feel suspicious of adult nurturing initiatives, and so remain alienated from them. As long as our youth remain alienated from the world of authority and adults, the less capable they will be to use aggression-modifying influences ordinarily associated with having relationships with adults. Some youth in trouble have never had the opportunity to bond with another human being, and attachment behavior was never developed in relation to a protective adult.

Many have a deep conviction that they will not live to be fully matured adults, and so many of them do not care, either for self or others. Often psychological abuse and neglectful relationships by adults produce in children an impulse to self-abuse, the behavioral preamble to violence, and to sibling-abuse, child-abuse, wife-abuse, and elderly-abuse. Can veterans turn around the "abuse learning chain?"

Mr. Chairman, I remember another group of Americans who felt alienated from the corpus of society, and I am certain you do as well. These were the teen-age veterans returning from war in Vietnam to what many felt was an ungrateful nation.

Like today's inner city youth, these veterans were also young, bitter, and many found that violence was the only way to maintain control over fear and feelings of hurt and humiliation that were generated in an environment they felt to be antagonistic, hostile, and non-nurturing. Many of these veterans have achieved developmentally natured perspectives, and are ready to put them to work for our youth today. Our young people are seeking viable models to emulate and to internalize. Veterans can be these models for our young people. Many youths find that, as adults, veterans have credibility. For they were the ones that, having been trained in military arms, have had to use destructive force and sanctioned violence against an equally violent enemy. They have seen friends killed, just as young people have seen their friends and relatives killed in the home or in the violent streets.

Many veterans have had to hurt human beings in the line of duty, giving them a profound understanding of the effects of violence on human life.

Veterans can talk to youngsters about techniques of surviving hostile environments, about the experience of being lonely and filled with terror, about the ultimate benefits of getting and maintaining human relationships and building trust in others, and about the virtues of discipline in their lives. Young people can relate to the genuineness, candor, gentleness and insights into life and death veterans portray in their behavior. Helping violent youths may ultimately require one who's been there. But, in my judgment, veterans' success with young people may not only require exposure to war's violent moments, but also to the lessons learned about self-control (I respectfully refer you to my recent article, "Low Intensity Warfare" in the Inner City: Veterans' Self-Control Strategies May Ameliorate Community Violence Among Youth" (Trotter Review, Spring 1993)). We often hear authorities saying that what inner city youths need is education. Cognitive education about strategies and techniques will not work: they need a relationship. Helping violent youths to develop self-control will never be achieved by lectures, but perhaps through living, human relationships with genuine people who care. Educating the emotions is required, and this is only achieved, in my opinion, when the teaching and learning are done in the context of meaningful human relationships. Veterans fit the bill here.

Veterans appear to know how to talk to young people, and the fact that they (veterans) are progressing through middle age makes them even more suitable to help our youths. One of the things that naturally happens during the mid-years is that the individual has an almost organic need to pass down a legacy, to do something special for the next generation. Helping our youth would give veterans a sense of self-worth and increased self-esteem, while fulfilling the impulse to serve America once again. What this means, Mr. Chairman, is that for many veterans personal well being -- psychologically, socially, culturally, spiritually, and economically -- may be contingent upon whether the veteran finds expression for his/her natural impulse to serve and help others. This makes veterans a natural in engaging young people in countering violence in their lives.

The inner cities are in deep trouble. Random violence has reached epidemic proportions. The United States is said to have surpassed other industrialized countries in terms of violent crimes to include homicides. Homicides have increased in African American populations, and are the leading cause of death among African American men and women ages 15 to 34, a 39 percent increase since 1984. Eyewitnessing of violence by young children are also on the increase. Such exposure to violence results in PTSD. PTSD is a psychiatric disorder which comes from psychological trauma ("wound to the mind"). It fills the person with uncertainty about self and world, as intrusive ideas, emotions, and memories supplant one's sense of inner security. Some 20.7 percent of African Americans who served in Vietnam have PTSD today, according to the National Vietnam Veterans Readjustment Study (NVVRS). Here is another common ground for credibility and understanding between the veteran and inner city youth: PTSD.

In addition to the concept of V-YPC is another way veterans can help inner city children and youths; namely, through the application of findings from veterans' studies to resolving the pain of psychic trauma and PTSD. In a recent book chapter, "Inner City Children of Trauma: Urban Violence Traumatic Stress Response Syndrome (U-VTS) and Therapists' Response," I discuss the effects of violence upon the minds and bodies of inner city children. Not very well known to most people who associate my personal and professional work with veterans' affairs is the fact that I have many years of working with inner city children and youths from Jamaica, Brooklyn and from other areas of New York City, parts of Nassau and Westchester Counties. I learned quite a bit from these Americans as well. I know that the trauma these children and youths have suffered can be alleviated by the technology we've learned from veterans' studies.

The Department of Veterans Affairs (VA) can play a vital role in bringing veterans PTSD technology developed over the years to assist inner city children and youths in managing and resolving U-VTS or PTSD. Through its Readjustment Counseling Service (RCS), VA has been at the forefront in spearheading the development of this important technology for the masses of Americans in need of post-disaster psychiatric and

psychosocial assistance. RCS has proven over the years that the VA can be effective in transporting knowledge gained from veterans' studies pertaining to psychological trauma and its sequelae to ameliorating the effects of catastrophe and disaster both in American and world communities.

PTSD technology was also applied to the local community in wake of the 1991 Perryville Explosion, in which the Perry Point VA Medical Center was spiritedly mobilized, and took center stage in effecting relief to a devastated community, under the leadership of Mr. Wilfred Kingsley, Mr. James Brophy, John D. Lipkin, M.D., and Lee D. Crump, Ph.D. I personally participated in this operation as I did in the San Francisco earthquake of 1989. The VA has been conducting outreach into the Sisseton-Wahpeton Sioux Reservation since 1979, and has been a steadfast agent in alleviating distress in survivors of Inike, Hugo, and other natural and man-made disasters.

I propose that the VA transport PTSD technology into the inner cities to help ethnocultural group children and youth suffering from psychological and social traumata. It is important that, since many parts of the world is today enjoying the benefits of this technology, developed primarily in the context of American veterans, that VA consider exporting this technology to help African nations that are engaged in either low-intensity warfare or full blown conventional or guerrilla warfare. The citizens of these countries need our expertise. Highly commendable work by VA has already begun in Central American where children and other civilian populations have been pummeled by war stress for many years. Here are the specifics in terms of what I believe Congress can do. First, provide additional psychiatric funding resources to ensure that veterans are fit to serve inner city youths. Since every mission, whether military or domestic, requires the participants to be fit, the excellent work done here at the Perry Point VA Medical Center by Chief of Staff, John O. Lipkin, M.D., who recently testified before the Senate for additional psychiatry dollars, and the indefatigable efforts of Drs. Errera, Lehmann, and Barnes in VA Central Office in Washington, DC, on behalf of veterans are exemplary. My current professional involvements here at Perry Point VA Medical Center in direct care of veterans, places me once

again on the frontline of making veterans fit for service. Veterans, like any others, can only be effective when they take the time to prepare themselves adequately for the mission. For many veterans with long-standing, chronic PTSD and related health problems, psychiatric care is clearly essential for success on the domestic service front. Being fit first is important in order to serve. Many veterans need to first overcome PTSD, depression, fear, avoidance, alcoholism, and drug abuse in their lives. This will require more psychiatric dollars.

Second, I believe it is vitally important that psychiatric services in VA add a cross-cultural perspective when treating distressed ethnocultural group veterans. Much more needs to be done in this area. The issue of racio-cultural factors are important. This is what this hearing is all about. We're all familiar with the saying that there is no difference between minority and non-minority veterans, that all veterans are the same. But the statistics continue to tell a different story in terms of the higher rates of PTSD and related psychological and social maladies.

Empowering African American veterans to serve may be seen in terms of what I view as a service-to-service sequencing in which psychiatric services provided to veterans by VA's Mental Health and Behavioral Sciences Service create a "service chain for social healing" (or helping veterans to help).

Third, we need the unanalyzed data from the 1988 Congressionally-mandated, VA supervised National Vietnam Veterans Readjustment Study (NVVRS). Though the reports so far since 1988 have been helpful, no indepth analyses have been done on the vast amount of untapped information on our nation's veterans. The research agency, Research Triangle Institute (RTI) of North Carolina, headed by Drs. Kulka, Schlenger, and Fairbanks have repeatedly requested additional funding to continue to unravel the mysteries of PTSD and its impact on human welfare. Information is particularly needed as it relates to inner city African American veterans whose rate of PTSD, as noted before, is 20.6 percent compared to 13.7 percent for veterans classified as "white/other."

We need to know the implications of this relatively high rate of the disorder, so pervasively implicated in dysfunctional parenting, sleep disturbance, irritability, avoidance, work inhibitions, marital discord and high rates of divorce, suicide, and, in general, in lost human capital. It is important that a contract be granted to RTI, and that co-principals in the data-reanalysis process be African Americans. The new analyses could conceivably assist the National Center for PTSD, directed by Matthew Friedman, M.D., Ph.D. of White River Junction, Vermont, to create culture-relevant research, training, and education relevant to African Americans throughout its seven divisions, to include the Pacific Division in Honolulu, Hawaii.

Fourth, it is important that mechanisms be developed to "export" PTSD technology to Third World nations whose citizens are exposed to the devastation of war and natural disasters.

Fifth, it is also important to support and encourage the development of mechanisms to establish a National Veteran-Youth Positive Coaching Program that mobilizes the expertise and resources of ethnocultural group veterans' organizations serving various inner city communities around the nation.

Once again, Mr. Chairman, I am grateful for the opportunity. Thank you.

"Low-Intensity Warfare" in the Inner City: Veterans' Self-Control Strategies May Ameliorate Community Violence Among Youth

by

Erwin Randolph Parson, Ph.D.

But there is another set of lessons learned by the men and women who served in the war: resilience, working under pressure, knowledge of teamwork, leadership, tough-mindedness, and aspects of maturity (Parson 1989a).

The use of weapons in various inner-city communities in America is comparable to Nicaraguan "low-intensity warfare" whose objective was the mass terrorization of civilians by the Contras. Low-intensity warfare theory is defined as "total war at the grassroots level" (Summerfield and Toster 1991, 85). Violence in the inner cities has been defined in similar ways by many authorities and observers. Although urban violence may not damage the infrastructure of communities to the same extent that low-intensity warfare does, its immediate and long-term impact is nonetheless devastating to human life and to a sense of security. In essence, it is a war being waged within the minds and souls of our youth, and in the concrete jungles of our urban centers. In inner-city low-intensity warfare, the most likely candidate to successfully teach survival skills is perhaps one who has "been there."

While there is a social epidemic of violence raging across the landscape of the nation and world (Ford and Rushforth 1983; Parson, in press), in society's search for meaningful approaches to solving the problem of violence, there is one group of individuals who is ostensibly missing from the discussions where the issue of violence and its control are contemplated. I am referring to veterans who served America in Vietnam as teenagers.

The point of view of this article is that veterans, given their own exposure to violence in their late teens, have a point of view that may be useful to society—to the violent and would-be violent youth and families, to communities, to law enforcement officials and to public authorities. Veterans should be allowed to serve America—once again—this time by using their knowledge about inner self-control of violence to help communities being overrun by a ferocious epidemic of violent incidents.



The Epidemic of Violence

Person-on-person violence is the focus of this article. This form of violence is interpersonal violence seen in acute or chronic spousal and child abuse, "gang-banger" violence, and the wanton, random violence in the streets, parks, schools, playgrounds, and homes taking place in many inner-city communities.

Violence is America's number one social problem. It is also this country's number one public health problem, due to the adverse health effects it generates for men, women, boys, and girls within the context of family, community, school, and friendships. Violence may be distinguished from aggression and anger. Aggression refers to nonphysical, coercive action to harm, while anger is an emotion that may motivate adaptive action or fuel aggressive responses.

Violence is the egregious behavior used by an individual that, in effect, exerts great noxious force against another person with the malevolent intent of injuring, damaging, and destroying physical integrity through harmful behavior. Like a huge, roaring inferno injuring, maiming, damaging, and destroying everything in its path, violence devastates our inner cities as crimes of murder, rape, robbery, aggravated assault, and burglary rise.

The number of deaths by violence exceeds deaths caused by emphysema, bronchitis, and asthma combined (*Monthly Vital Statistics Report* 1984). So violent has America become that in 1974 it was said that a boy born in this country was more likely to die from murder than an American GI in World War II (Morris and Hawkins 1977). West (1984) used the term, "epidemic of violence" to capture its utter pervasiveness. After a period of decline, statistics on homicide in the inner city among African-American males show that murder has increased dramatically since 1985 (Bell and Jenkins 1990).

In their discussion of the psychological impact on children who witness violence, Bell and Jenkins (1991)

mention a Washington, D.C., politician, who, projecting from the first six months of homicide statistics in 1990, referred to that year as the "bloodiest year in American history" (estimated to have 2,000 homicides over the previous year's figures).

Bell and Jenkins also reported that "the homicide rate among black males is seven times that of white males; homicide is the leading cause of death for black men and women ages fifteen to thirty-four, showing a 39 percent increase for black males since 1984" (p. 177). The Uniform Crime Reports and the National Criminal Justice Information Service (for the United States), the European Committee on Crime Problems, and Criminal Statistics (England and Wales), Statistics Canada, and other international crime reports, reveal that violence is an international problem of great significance. The United States continues, however, to lead the free world in terms of the "chronically dysfunctional environment" (Dyson, 1990) social and community violence spawns.

Wornis Reed (1991), in a *Trotter Institute Review* article, "Crime, Drugs, and Race," compiles a number of alarming statistics associated with inner-city violence. He writes that despite the fact that blacks comprise 12 percent of the general population, they produce the following unfavorable violence statistics:

- 40 percent of death row inmates are black;
- 50, or 43 percent, of persons executed in the 1980s were black;
- Blacks are 42 percent of the jail population and 45 percent of the state and federal prison population;
- Blacks are 31 percent of arrestees;
- Blacks are 49 percent of all murder and non-negligent homicide victims;
- Black males in the United States are incarcerated at a rate four times higher than black males in South Africa—3,109 per 10,000 in the population compared to 729; and,
- In 1986, the total number of black men of all ages in college was 426,000, while the number of black men between the ages of 20 and 29 under the control of the criminal justice system (incarcerated, on parole, or on probation) was 609,690 (p. 3).

The Violent Veteran: Myth and Reality

What about veterans, where do they fit in? Of relevance here is Ron Armstead's (1992) research on the formation, development, and general viability of black veterans' service organizations. He found veteran organizational leaders to be very concerned about their community, and saw their current service-delivery models as having continuity with their past military service. These leaders also saw "organizing and servicing black [and other ethnocultural group veterans] as a continuation of their efforts at addressing community problems" (p. 4). Like many other veterans, these leaders demonstrated their natural philanthropic impulse to serve others and to better their communities and the world (Parson 1989b).

Contrary to the commonly accepted stereotype, the veteran is a model of courage and self-management. In May 1992, Parson testified before Congress on inner-city

African-American veterans and the positive role models they may make for our inner-city youth. He noted that:

The inner-city African-American veteran needs to be included in solving our nation's violence. I have said this many times before: only few persons have more experience than veterans with violence. Veterans have had to generate violence in war; they've had to protect themselves and their friends from violence meted out by the enemy. And, most importantly, they have had to control violence within themselves to maintain equilibrium. The inner-city veteran remains an untapped human resources pool, with skills and talents in leadership and in team-building (Parson 1992, 6).

The War Experience

Like all wars, the Vietnam War was a violent encounter in which young men and women were exposed to a hostile environment. This milieu produced unspeakable suffering and violence that affected both Americans and Vietnamese. In the war, soldiers experienced ubiquitous environmental violence lurking even in the least suspected places, making "the constant threat of annihilation" an ever present possibility (Lipkin et al. 1982; Parson 1984). Soldiers experienced the horror of violent deaths, the intense terror of life-threatening fire fights, and enemy assaults with rockets, mortars, booby traps, punji sticks, snake pits, land mines, snipers, and sapper attacks. Some soldiers were wounded, others were killed. "Trucks drove up to buildings...and blew them up with plastique, kids threw grenades into your jeep...mines blew up your truck on a road that had been safe for a year..." (Lipkin et al. 1982, 909).

As Lipkin also noted, "...everyone learned watchfulness. In the daytime watching the trees, watching the peddies, the grass; at night watching the dark. In the towns and cities, watching all the people: who had the grenade? Watching the children: who had the grenade?" (p. 909).

Applying the Experience

Many soldiers who made it back home have never forgotten the lessons they learned in the war. In addition to having learned so much about such highly valued human qualities as resiliency, competence, discipline, self-respect, regard for others, leadership, teamwork ability, and enhanced functional perceptiveness (i.e., making successful adaptation to the war's terrain and reality), the soldiers internalized into their psyches the "logic" of the war's socioecology. This internalization may have adaptive value as we seek to discover the logic inherent in America's violent environments. To function successfully in this dangerous environment required control—control over one's self. As one veteran put it, "Control was everything." Therefore, loss of control could have had disastrous consequences.

Surviving the hostilities taught veterans certain truths about themselves, and about others—profound lessons about human relationships, about courage under fire, about human resourcefulness and the capacity for change

and survival. Most of these veterans learned to put personal terror, societal disapproval, institutional neglect, moral uncertainty and confusion, shame, guilt, and pride into some kind of tolerable personal perspective.

This gives veterans an edge in terms of teaching America's youth the techniques of violence control within themselves. They had to struggle against the forces of violence in Vietnam to remain alive, and then had to survive the bitter experiences of institutional neglect and cultural vilification at the homecoming. This has strengthened many veterans who are today eager to share their experiences with our youth.

The building of effective barriers within the self against the expression of violence against other people is a lesson most veterans have had to learn over the years. This has been revealed in many studies (for example, Robert et al., 1982) which have failed to support the stereotype of the violent veteran by showing a higher incidence of violence among veterans compared to nonveterans. Even studies (such as Strange and Brown, 1970) which showed that combat-experienced veterans may have more violent thoughts than others, veterans were less likely to act on these impulses, demonstrating control over these feelings and impulses. This level of self-control is consistent with what is known about the veteran's successful transfer of military experience to the civilian sector (Armistead 1992; Parson 1989a; Hall-Sheehy 1984). As Parson (1989a) notes:

Since the Vietnam War, veterans have been digging new trenches and courageously making it though a dense jungle of a different kind—the contemporary economic jungle. This jungle required the same skills in hypervigilance, attention to details, self-confidence, and commitment demanded by Vietnam's guerrilla milieu (p. 3).

Learning self-control over violent feelings requires extraordinary effort, both in the war and after the war. Society can be reassured that veterans' self-management skills may be extended to contemporary sociocultural affairs. This is because lessons learned are never truly lost. For "the brain that learned so much about trauma and pain [in Vietnam] is the same organ that stores . . . positive and valuable skills" (Parson 1989a, 3).

Gaining psychological equilibrium and putting personal bitterness aside has not been easy for many veterans (Lipkin et al. 1982). Many worked hard at self-rehabilitative efforts in the absence of government-sponsored debriefing programs. Many other veterans, however, did reach out for help: they realized they could not do it alone.

Given this experience, veterans are in the position to help solve the problem of violence in two ways: first, through "hardware technology" (i.e., active instruction and guidance in violence-management); and secondly, through "software technology" (i.e., using the "personal lessons of control" approach for violence regulation). The latter strategy is the preferred one, and the focus of this article.

The negative image of veterans seems to be the one lingering concern that may have the potential to derail veterans' efforts towards ending violence in their communities. Although studies have shown that "controls against violence can be deconditioned by warfare" (Haley 1978, 278), no study has as yet conclusively demonstrated that veterans of any era are more violent than their nonveteran counterparts. The negative image of veterans in recent years has been shaped more by harmful, unfortunate stereotypes partly propagated by the media functioning as the right arm of a culture which has sought and found exculpatory targets—scapegoats—in its veterans in order to shield itself from the painful realizations surrounding the nation's war experience.

Principles of Violence-Management: Self-Control Strategies from Veterans' Experience in the Military

Violence against people may be seen in terms of the motivational intent behind the expression of violence behavior. Zillman (1979) mentions two classes of motivations: "Annoyance-motivated" violence and "incentive-motivated" violence. Annoyance-motivated violence accounts for three-fourths of all homicides. They are the result of acute conflict or trivial arguments stemming from such conflicts as lover's quarrels, jealousy, narcissistic insults and injury, and personal humiliation. If individuals involved in annoyance-motivated violence could learn how to control their fiery emotions there would be less explosive incidences causing injury and harm. The following control principles are an outcome of this writer's clinical observations of veterans, and of the clinical and nonclinical strategies they employ to gain control in their own lives. These control principles have sound theoretical and applied bases in cognitive and behavioral psychologies, known for their value in assisting people gain control and perspective in their lives.

These violence-management principles are: creating a sense of belonging; transforming self through change in thinking; self-abuse management; courage under fire; overcoming the me-first cultural orientation; and coming to terms with emotional hurt caused by parents and authority persons.

Creating a Sense of Belonging

Inner-city children and youths are often described as alienated, confused, bitter, and economically and politically disenfranchised. The association of large-scale drug abuse and random violence with inner-city youth has led many Americans to see these young people as subhuman. Actually, these descriptions are, to some extent, accurate: people who murder and engage in lawlessness and wanton disregard for life and the general welfare of others are in deep trouble. They behave as though they have lost their humanity and all "natural affection" for humankind.

Like survivors of European death camps described by Terrence Des Pres (1976), these American youths have lost faith in the capacity of human beings for goodness.

Moreover, there is a "broken connection" (Lifton 1980)—a "severed connectivity" (Parson 1988) between self and other. This lack of faith and trust in family, church, community, nation, and world, makes it "easy" to be violent, and to use the option of violence in solving problems and in regulating self-esteem.

When this degree of bankruptcy in human connectivity occurs, nothing less than radical departures from "ordinary" programmatic procedures will suffice. Although a specific program for assisting urban children and youth is beyond the scope of this article, this writer believes that any program organized to help inner-city youths must include opportunities for Buberian *I-Thou* dialogue between veterans and youths. Such a program would call for engaging young people on a one-to-one basis (I-Thou), and later in a group-interactive format. The I-Thou form of human relating originates in the philosophical writings of Martin Buber (1970).

Buber's I-Thou concept highlights a form of human relating in which two people as a basic unit are free to be themselves, engage the other in meaningful dialogue, and derive mutual impact and benefit. Moving beyond empathy (a feeling "into" the other person's experience), the I-Thou mutuality offers a humanizing experience for both. For "There is no 'I'...only the basic word 'I-Thou'" (p. 54).

Over the years, many veterans have expressed to me their regret that there were no opportunities for such dialogue when they came home over twenty years ago from the war in Southeast Asia. Human communication is vital to managing violence in youth, and clearing up miscommunications is a key to dealing with violence-generating inner turmoil. The "Big Brother" model is one of several that may be adopted here if such a program for inner-city youth were to be developed.

Another important tool in establishing a feeling of belonging is the collective group setting. Veterans know the value of the family feeling, as well as the life-saving value of a cohesive group of people working toward shared goals and objectives. They also know that without discipline very little constructive action is possible. The core organizing principle here has to do with human relationships. After or in conjunction with I-Thou dialogue, the group interactive component becomes very important. Organizing meaningful academic, recreational, and cultural trips may also offer youths an alternative to feelings of isolation and to the "conviction of expendability"—the feeling that no one cares for them.

Acquiring the sense of belonging is one step in assisting young people to manage reactive rage and violence. Feeling cared for, confirmed, and respected precedes the acquisition of discipline and self-control. Veterans can assist young individuals to establish closeness in an environment of trust, safety, and positive mutual regard. The group may also become a source of pride, self-worth, and positive group identification for these youths.

Veterans may also be able to help young people to develop a sense of competence. Many violent young people often tell of feeling incompetent in just about everything they do. As young Americans in the war zone,

veterans were given a great deal of responsibility, and many "proved" themselves to be competent and efficient. These feelings of incompetence and a lack of effective behavior for coping with the real world may propel young people towards violence.

Transforming Self Through Change in Thinking

Based on their own experience, veterans believe that people can change and have an innate appreciation for transformational processes. They have experienced first hand how military training transformed the young, naive recruit into a combat-effective individual through a change in thinking. The drill instructor, sergeant, and commanding officers were the agents of this change. This article suggests that veterans can potentially become these agents of change for our young people.

Military service also taught veterans that achieving an objective may require more than one way of thinking; it may require multiple strategies. This ability to generate options, or possibility thinking, opens up a whole new world to individuals who feel they have little or no options in life, are frustrated, and feel "boxed in."

Teaching techniques of self-instruction to inner-city youths may provide yet another avenue to regulating potentially violent ideas and actions. Most people talk to themselves to give self-instructions, directions, and guidance in solving problems and self-soothing. This is a normal process. Meichenbaum's (1977) theory of self-instruction holds that direct verbalizations of meaningful and positive self-instruction can manage aggression and violence. Veterans have used this and other techniques to maintain self-control and perspective while on dangerous and frightening military missions.

Veterans may also be able to engage young people in healthy mutual disputations on specific issues to help them acquire trust and comfort with older persons who respect their views. Disputation sessions may focus on issues of burning importance to young people pertaining to their families, communities, and to the society at large. This procedure has been found to lend itself to various forms and levels of moral reasoning (Carbarino et al. 1991; Tapp 1971), and to the amelioration of rage, cynicism, and suspiciousness.

Finally, urban youth with impulsive tendencies believe that they have no choice but to react to stimuli in an all-or-none manner—in total extremes—with no intermediary gradations of emotional expression. They are often oblivious to options in their lives. The technique of scaling reaches individuals to see emotional expressions on a continuum in order to help them gain control and perspective. The veteran had to use this principle to operate safely and effectively in a guerrilla war environment.

Self-Abuse Management

Violence toward others begins with violence toward oneself. Youth who experience psychological hurt, abandonment, physical abuse, and humiliation, will force others to experience the same. Taking drugs to quell the torment within, "living on the edge," along with a general

absence of self-caring skills are precursor signs of violence against others. Many inner-city children and youth this writer has seen in clinical therapy were taught how to abuse themselves by negative, harmful interactions with significant people in their lives.

Self-abuse is a consequence of chronic self-hatred, self-punishment, self-pity, self-blame, depression, and the rigidifying of one's perception of the world as a persecutory, oppressive place to live. The resultant guilt, anxiety, and apathy flare up into violence in order for the individual to cope with self-abuse in its many forms. Veterans may have the ability to challenge the young person's irrational beliefs about self and others, and to teach skills that will help them manage the taunting, haunting thought that "you're no good, you'll never 'mount to 'nothin'."

Young people, like most adults, have a number of ideas about self, other people, and situations that may be called irrational. Examples of irrational beliefs are: "Everyone should love and approve of me"; "I am mad with everybody because they all see me as no good"; or "I am black; white Americans owe me a lot." Such ingrained beliefs shape attitudes and values toward self and others.

Racism is a form of American institutional violence against the ethnic minority person. Obviously, this is a reality that cannot be negated. However, when it comes to assisting urban youth in violence-management, only individual responsibility (as opposed to the collective responsibility of society) will produce the needed controls. Irrational beliefs generate anxiety, tension, inner stress (Ellis 1985), and self-abuse, resulting in the erosion of internal controls. This makes it highly probable that, with little instigation, violence will flare up.

Violent people have irrational beliefs which make their capacity to control violent impulses very difficult. Veterans have had to deal with society's irrational beliefs about them, and their own irrational beliefs about their self-worth and value to a society which lost its ability to distinguish between the soldier as a human being and the flawed policies of a war machine gone out of control. Developing rational thinking bolsters self-esteem and helps strengthen internal controls.

Cognitive psychological theory expounds the idea that an individual's dysfunctional thoughts and beliefs get them into emotional trouble, and once in this state of mind they are vulnerable to violent explosions. Stopping a nagging, anxiety-provoking idea makes it possible to focus on control-bolstering thoughts and actions. Here too, veterans have the ability to instruct youth in the procedures that help promote self-control through suspension of the flow of anxiety- and depression-provoking thought processes.

Socially anxious youngsters tend to become aggressive to protect themselves from feelings of internal weakness and vulnerability. Assertiveness training gives instruction in the social techniques of asking others for whatever one needs; this makes it unnecessary to get angry and violent in response to the frustration of not getting one's needs met. Many veterans have had to adopt these techniques in

order to overcome self-abuse in their lives. For many, self-abuse led to spousal abuse, child abuse, and to chronic dysfunctional behavior. Veterans know about self-abuse: they may be able to help our young people because they have credibility.

Courage Under Fire

Undertaking dangerous military assignments requires a high level of self-confidence and intrepidity. It may take the communication of this level of danger-defiance to assist your youth to successfully "just say no" to powerful peer pressure to use drugs, join violent youth gangs, and commit violent crimes against people and property.

Overcoming the Me-First Cultural Orientation

Me-first behavior is learned from parents and others in the young person's life. Many of them see themselves as me-last in terms of parental and societal priorities. The me-last feeling generates a me-first orientation in young people. Me-first fixated youth are probably most likely to act violently when situations thwart self-gratification. Veterans, particularly those with combat experience, have had to put aside the me-first orientation in an effort to protect their buddies.

Coming to Terms with Hurt and Disappointment Caused by Adults and Other Authority Persons

Most violent youth learn violence through their interactions with people. Often they are victims of psychological and physical violence, and of witnessing violence. Neglect by fathers and mothers, and by society in general, creates alienation, rage, and vendetta preoccupations against adults and authority persons. These children and youth are easy prey for drug dealers, gang-banger recruiters who reward violence and offer them prestige, status, and a sense of belonging. Unfortunately, these negative, violent elements have often eclipsed the positive influence of fathers, mothers, pastors, teachers, principals, law enforcement officers, and public officials.

Veterans are idealizable to young people; they are, for the most part, admired and respected by many. This is in part because, though there are studies on veterans' deficits in social, mental, and occupational functioning, no similar interest in understanding the positive view young people have toward veterans has been demonstrated. Evidence comes from anecdotal reports from people who have worked with and observed veterans directly for decades. Dr. John Wilson, a psychology professor at Cleveland State University who is highly acclaimed for the historic Forgotten Warrior Project of 1970, states on the idealizability of veterans to young people: "These veterans are natural teachers; I use them to teach my classes every year." He went on to state that students admire and "look up to" veterans as a special group of people with unique experiences that have relevance for teaching courage, tenacity and success. In searching for meaning in their lives, many of the "twenty-something"

generation view veterans as trustworthy—as a group that “didn’t sell out” but has maintained incorruptibility and non-commercialistic values when compared to a group they claim to despise for their narcissism and wanton materialism: the so-called “baby boomers.”

This makes it possible for the veteran to serve as a kind of bridge between alienated youths and the world of adults and authority figures. Most youth feel they have little or no reason to trust adults, whom they see as narcissistic. Most veterans of the Vietnam era now live in the “age of authority” by virtue of their location in the life cycle. This makes them not only adults who are in the enviable position to impart valuable knowledge to our young people about courage and self-management, but who are themselves authority persons in their own right.

Veterans have learned life lessons in relating to and appreciating authority; they have suffered the torment of distrusting their elders, of feeling disconnected from adults while secretly longing for better relations with them. Perhaps random, wanton violence in youthful populations is incompatible with healthy adult-child relations. A good, supportive, and trusting relationship with adults is the best antidote for self-hatred and a diminished ethic of caring. Mutual trust and respect between youth and elders could have the potential to usher in a “violence-modifying influence” among lost, bitter, alienated, and violent youth.

Summary and Conclusions

Veterans comprise a hidden resource pool America needs to use in order to address and help solve the problem of violence. Violence is an epidemic in our nation and world. The random violence of the inner cities cries out for effective solutions. Because veterans were trained for national defense purposes, they have learned much that may be of value to violent and potentially violent youth. Most violent episodes between individuals resulting in the loss of life are of the “annoyance” variety, and are referred to in the courts and legal system as voluntary manslaughter—the unlawful killing of another in a sudden heat of anger, without premeditation, malice or depravity” (Wolfgang, quoted in Zillman 1979, 301). Through sharing their experiences and teaching specific self-management skills veterans may have the capacity to make a major contribution to what Egendorf has referred to as “community healing” (Egendorf 1982), and to the installation of hope, confidence, discipline, control, responsibility, and self-worth in our young people.

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September 15, 1993

Statement of Clyde A. Poag to the House Veterans' Affairs
Subcommittee on Oversight and Investigations

To Chairman Evans, and subcommittee members; good morning and thank you very much for the opportunity to appear before you.

My name is Clyde Poag, I am the Team Leader of the Vet Center in Grand Rapids, Michigan. I have been the Team Leader for the past eleven years. I also am currently the Chairman of the African American Working Group of Readjustment Counseling Service, and serve on the Department of Veteran Affairs Bioethics Committee.

In regard to the issue of Post-Traumatic Stress Disorder (PTSD) and African American veterans, I would first like to respond in my capacity as a Team Leader of more than eleven years, and as a social worker with more than twenty two years of experience. During that time I have had the opportunity to provide counseling service to many veterans and have seen first hand the issues and problems faced by those who have borne the burden of war, and have been adversely effected by it.

For the benefit of those who may not know what Post Traumatic Stress Disorder is, I would like to give a brief description of what this psychological condition is, and what the consequences are for those experiencing it. Post Traumatic Stress Disorder, is a psychological condition, that people sometimes experience after they have been exposed to an overwhelming stress or trauma. People are exposed to stress everyday, on the job, in the family, and in their day to day activities. What I am describing is stress and trauma, that is outside the normal range that people experience; such as situations in which a person narrowly escapes death, sees friends or loved ones killed, or nearly killed, being in natural disasters, such as floods, hurricanes, or are victims of rapes, and the horrors of war.

People who are exposed to those things sometimes exhibit symptoms such as rage, unpredictable explosions of aggressive behavior, inability to express angry feelings, and many other debilitating symptoms.

As a clinical social worker, I have had the opportunity to assess many veterans who have this disorder. To talk about the extent of PTSD, and African American veterans, I would like to refer you to the study that was commissioned by Congress and conducted by the Research Triangle Institute (RTI) which was completed in November 1988.

Of the veterans who served in Vietnam approximately 11% (about 350,000) were African American. The RTI study showed that among male Vietnam Veterans (Theater Veterans) the current rate of PTSD among African Americans is 20.6 percent (38.2% for those with high war stress exposure).

In addition, all veterans with partial PTSD account for another 11.1 percent. This represents more than 830,000 veterans who have trauma related symptoms. The study further stated that nearly half of all veterans who ever had PTSD still have it today. There are other statistics which I would like to point out for veterans who have PTSD: 70% have been divorced (35% two times or more), 49% have high levels of marital or relationship problems, 55% have problems parenting, 34% have been homeless, and 11.5% have been convicted of a felony. The study also showed a strong relationship between alcohol, drugs, and other post war psychosocial problems.

Overall the study showed that African Americans and Hispanics have experienced more mental health and life adjustment problems subsequent to their service in Vietnam than Caucasian and other veterans.

Among African Americans, in addition to PTSD, the more serious problems appear to be social readjustment. Particularly educational and occupational achievement, marital instability, and involvement with the criminal justice system. The study recommended more research and study regarding these findings. These statistics are borne out by the numbers of African American veterans who are homeless, incarcerated, divorced, unemployed, and involved with the drug culture.

Mr. Chairman, many African American veterans are experiencing readjustment problems as a result of high exposure to the stresses of war and trauma. There are implications for the society at large. A recent article in "NEWSWEEK" showed an African American boy on the cover. The caption read "A World Without Fathers". As the study pointed out, there are many African American veterans who have serious problems parenting, and many other readjustment issues. We also are aware that many of the problems of society are not caused by boys who do not have fathers in the home.

It is a fact that African American soldiers comprised a large percentage of the front line troops in Vietnam, and were subjected to racism, and discrimination. While they were fighting in Vietnam, waterhoses and dogs were attacking their friends and family members at home. These men and women had to adjust not only to the larger society, but also to their own culture. Often being told that they were fools to go and fight for a country in which they were not treated as citizens.

In addition to the trauma and stress of war, they had the additional adjustment problems of youth. They continue to come to the Vet centers. We see them for alcohol, drug abuse, and homelessness, and many other problems. Unemployment creates for African American males is double that of the general population according to Department of Labor statistics.

In Grand Rapids, we have a homeless veterans program. This program provides shelter and treatment for 30 homeless veterans. Fifteen of the veterans in the program are African American. These veterans are estranged from family and friends. Many have substance abuse problems and are re-offenders. This "Shelter Plus Care" program, is a joint effort between the Department of Veteran Affairs, HUD, and the Grand Rapids YNCA. The program has been cited as a model program and has been visited by representatives of several other cities for possible duplication.

The African American Working Group has as one of its goals the completion of a paper on the historical issues confronting African American veterans. The paper will also discuss various treatment approaches. We also plan to promote a national conference to bring together experts in the field of African American family life and culture, and develop effective approaches to the treatment of African American veterans. The working group is concerned about the fact, that many of the approaches to the treatment of African American veterans are conducted by therapists, who not only are not African American, but have not been trained in African American family life and culture. It is much like the flesh colored bandaid which was not formulated by or for African Americans. We also have a goal, promoting increased recruitment of African American counselors, Team Leaders, Regional Managers, and Central Office staff, within Readjustment Counseling Service. There is a need for direct input into the delivery of services to all veterans, and to have the staff reflect the population it services.

The Department's Bioethics Committee is charged with providing for recommendation to the secretary regarding ethical issues, including ethnics in resource allocation. I presently serve on the Resource Allocation subcommittee. Considering the high prevalence of PTSD in African American Vietnam Veterans, one of the issues of interest is the prevalence of and rate at which African American veterans are service connected for PTSD. However, data regarding the number of claims submitted, the number rated and at what level for African American veterans is needed. The Department also has a National Center for Post Traumatic Stress Studies. To date however, there has been no study of the effects of PTSD on African American veterans.

Part of the problem may be in the fact that there are no African Americans involved in a decision making capacity at the center, and that this particular issue has not been a priority.

In closing, I would like to see resources of the Department of Veteran Affairs, brought to focus better on the problems of African American veterans. They have paid for such service and have a right to expect nothing less.

Thank you for the opportunity to appear before you, and I would be happy to answer any questions.

**Statement of Robert Rosenheck, M.D.
Director of Northeast Program Evaluation Center (NEPEC)**

**Department of Veterans Affairs
Before
Subcommittee on Oversight and Investigations
House Committee on Veterans' Affairs**

September 15, 1993

**Oversight and Investigations Hearing on African American Veterans
and Community: Post-Traumatic Stress Disorder and Related Issues**

I am Robert Rosenheck M.D., Director of the Department of Veterans Affairs (VA's) Northeast Program Evaluation Center (NEPEC), the Evaluation Division of the National Center for Post-Traumatic Stress Disorder (PTSD). This testimony was prepared jointly with Matthew J Friedman, M.D., Ph.D., Executive Director of the National Center and Alan Fontana, Ph.D., of NEPEC.

The National Center for PTSD was mandated by the United States Congress in 1984 under Public Law-98-528 to carry out a broad range of multi-disciplinary activities in research, education and training. The current National Center, which was established in 1989, is a 7-part consortium with divisions located in White River Junction, Vermont; West Haven, Connecticut; Menlo Park, California, Boston, Maine; and Honolulu, Hawaii.

The Center is a world leader in research on psychological, psychophysiological and neurological aspects of PTSD. In collaborative work with VA's Mental Health and Behavioral Sciences Service it also plays a central role in evaluating, monitoring, and developing approaches to improving services provided to veterans who suffer from PTSD at VA medical centers. A sample of projects currently underway include:

- * developing physiological methods to assist in the diagnosis of PTSD;

* studies of health status, symptom presentation and treatment of female veterans;

* an epidemiological study of the prevalence of PTSD among American Indian, Native Hawaiian, and Asian American Vietnam veterans;

* testing of the effectiveness of new medications for the treatment of PTSD;

* evaluating an innovative treatment for veterans diagnosed with both PTSD and substance abuse;

* evaluating and monitoring the effectiveness of PTSD treatment provided by over 100 Congressionally funded VA programs for the treatment of PTSD.

As a service to researchers and clinicians world-wide, the National Center has developed a computerized data base, the Published International Literature of Traumatic Stress (PILOTS), that includes 5,400 titles to date; and publishes two newsletters: the NCP Clinical Newsletter, focusing on issues related to the treatment of PTSD, and the PTSD Research Quarterly focusing on current research topics.

Several projects, summarized below, focus directly on issues concerning services provided to African-American veterans.

Under Public Law 101-144, the National Center was charged with the responsibility of carrying out research, educational, and consultative activities concerning female and ethnic minority Vietnam veterans. Research and educational activities regarding female veterans were presented in testimony last year and culminated in the establishment of the Women's Health Sciences Division of the National Center in October, 1992. Our Congressional mandate under Public Law 101-144 was expanded under Public Law 101-507, which directs the National Center to carry out an epidemiological study of the prevalence of PTSD among

Native Americans and Asian American Vietnam Veterans. That study (the Matsunaga Study) is currently in progress and is surveying four distinct cohorts: Navajo, Sioux, Native Hawaiian and Japanese American Vietnam veterans.

National Center studies that focus on African Americans include the following:

- 1) an examination of the relationship of ethnocultural group membership to the use of VA health care services;
- 2) an examination of the relationship of clinician-client ethnocultural matching and both participation and outcome of treatment among Vietnam veterans suffering from PTSD;
- 3) outcome studies of differences in the effectiveness of VA inpatient and outpatient treatment among black, white and hispanic veterans;
- 4) epidemiologic studies of the prevalence and causes of homelessness among veterans of different ethnocultural groups (40% of homeless veterans are African-American), and among female veterans;
- 5) treatment outcome studies of ethnocultural differences in participation and benefit from special programs for homeless veterans;
- 6) development of instruments for diagnosing PTSD that are sensitive to ethnocultural differences;
- 7) planning a follow-up component to the National Vietnam Veterans Readjustment Study; and
- 8) development of a national network of experts to focus on developing research, educational and clinical programs that focus on African American veterans.

Among the first results of these efforts was a week-long conference of international experts that specifically addressed ethnocultural issues in the diagnosis and treatment of PTSD. This conference was held on June 28-July 2, 1993, in Honolulu, Hawaii under the leadership of Dr. Friedman; Raymond Scurfield, DSW, Director of the National Center's Pacific Islands Division, VA Outpatient Clinic Honolulu, Hawaii; and Professor Anthony Marsella of the University of Hawaii. The conference covered a wide range of topics on cross-cultural psychology and medical anthropology as it pertains to PTSD. Issues pertaining to African Americans were addressed specifically in several presentations. In recognition of the importance of this conference, the American Psychological Association has agreed to publish the conference proceedings as a book which should come out in early 1994.

I turn now to the primary subject matter of this hearing: the delivery of health care services to African Americans. During the past year, we have seen in our leading medical journals, a parade of scientific studies demonstrating the poor and deteriorating health of African Americans and documenting their restricted access to health care services in the general US health care system. One study showed that the health status of residents of Harlem in New York City, was more like that of the citizens of much poorer countries than like that of other Americans. Another showed that the health status of impoverished Americans deteriorated steadily in recent decades, in parallel to their declining economic fortunes. Several studies have shown that African Americans are more likely to suffer cardiac arrest than other Americans and that they are less likely to survive such events. Many studies, including a recent review of the use of complex cardiological treatments in VA, have shown that blacks tend to receive fewer health care services than other Americans, in spite of their poorer health overall.

The National Vietnam Veterans Readjustment Study, funded by VA and conducted in 1987-88, demonstrated a high prevalence of PTSD (15.2%) among Vietnam Theater veterans, but an even higher prevalence (20.6%) among African American Vietnam veterans.

Many empirical studies conducted in recent decades have suggested that ethnocultural minorities make less use of both physical and mental health services than other Americans, either because they lack the resources needed to pay for such services, or because they are personally reluctant to use such services, or because they have encountered service providers who are insensitive to their distinctive values and traditions. In view of these studies, we have sought to determine how successful VA has been in delivering mental health care and other benefits to veteran members of ethnocultural minorities.

We live in an era in which health care accountability is more important than ever before. Those who provide health care, and especially those doing so in public agencies like VA, are responsible for providing an accounting of their activities and for demonstrating their continued efforts to improve the effectiveness and efficiency of the services they provide. In recognition of the readjustment problems of Vietnam veterans, the Congress has provided VA with funds to expand mental health services for these veterans. VA's Mental Health and Behavioral Sciences Service has charged the Evaluation Division of the National Center for PTSD, of which I am Director, with providing an account of the work of the specially funded PTSD Clinical Teams, Substance Use PTSD Clinical Teams, Specialized Inpatient PTSD Units and other Congressionally funded medical center programs for the treatment of PTSD. Our first three progress reports, prepared by Alan Fontana Ph.D., have been transmitted to Congress and I will not repeat their conclusions, except to say that these programs have been successfully implemented as planned and are providing effective services to a very severely troubled group of war zone veterans -- a group that has suffered from PTSD for over two decades, on average.

As part of our evaluation effort, we have paid special attention to treatment provided to services provided to minority veterans. Our studies, several of which are not yet completed, suggest the following conclusions:

1. Black Vietnam era veterans are more likely than whites to use VA mental health services. When all other factors are held equal (severity of illness, finances, insurance, etc.), African American Vietnam veterans are more likely than whites to turn to VA for mental health services, while white veterans are more likely to choose non-VA services. In a discussion of the meaning of this finding, one well-known black psychiatrist (not currently employed in VA) suggested that blacks may feel that they can get a fairer hearing from a federal program than from a local one.

2. Black Vietnam veterans seeking help from VA are poorer and have more substance abuse problems than other veterans. A study of over 5,000 veterans receiving help for PTSD from VA showed that black veterans identify needs for vocational counseling and specialized substance abuse treatment more often than whites. Available data indicate that, consistent with their self-assessed needs, black veterans make more use of substance abuse treatment services than other veterans. In contrast to other mental health systems, in which there have been indications that blacks may be over-medicated, blacks in VA are somewhat less likely than other veterans to receive medications, perhaps because of their concomitant substance abuse problems. Blacks report past use of specialized VA PTSD services at the same rate as whites.

3. Participation of blacks in treatment for PTSD is of shorter duration than whites, but blacks report similar levels of satisfaction with services. Blacks participate in treatment about 1 month (20%) less than whites on average and have five (20%) fewer sessions than whites. In their treatment, they spend less time focusing on war traumas, and more time addressing substance abuse problems, a finding that is consistent with their expressed needs. Evidence of shorter involvement in VA treatment among black veterans is similar to findings for blacks in other mental health care. Black Vietnam veterans report similarly high levels of satisfaction with VA services as white veterans.

4. Black veterans show greater participation when treated by black clinicians than when treated by white clinicians.

About 6% of clinicians in VA specialized outpatient programs (PTSD Clinical Teams) are black. When treated by black clinicians, the duration of clinical involvement and number of sessions among black veterans rises to be equal to the levels for white veterans. There is also evidence of somewhat greater clinical improvement in some domains when black veterans are treated by black clinicians. Even when treatment by black clinicians, and the profession of the clinicians is taken into consideration, blacks show lower levels of participation and less improvement on some measures.

5. Clinical improvement from PTSD treatment is observed among both blacks and whites.

A one-year outcome study of over 400 VA outpatients treated for PTSD showed significant clinical improvement in many clinical domains. Blacks showed greater improvement than whites in employment and legal problems, and whites showed greater improvement in psychological symptoms. In this detailed outcome study, there were no significant differences between blacks and whites in the services they received or in their satisfaction with services. Blacks were somewhat more likely to attempt suicide during treatment than whites. This difference appeared to be related to higher levels of survival guilt among blacks, in this sample, before they entered treatment.

6. Risk of Homelessness is higher for black than white veterans.

In a series of studies, Vietnam era veterans have been shown to be at no greater risk for homelessness than non-veterans of similar age and race, although post-Vietnam veterans do appear to be at substantially greater risk for homelessness than non-veterans. Black veterans are at greater risk for homelessness than white veterans, but this differential risk is lower among veterans than among non-

veterans. Among homeless veterans, blacks are younger and have more substance abuse problems than white veterans.

7. There are no substantial differences in participation or improvement rates of black and white veterans in VA programs for homeless veterans, and both groups show marked improvement in virtually all adjustment domains. Monitoring data on over 70,000 homeless veterans and a follow-up study of over 400 of them showed no substantial differences between black and white veterans in services received or clinical improvement.

Conclusions

The findings reported here, although preliminary in some respects, demonstrate: 1) that the National Center together with VA's Mental Health and Behavioral Sciences service is vigilantly and effectively monitoring medical center treatment of Vietnam veterans treated in Congressionally funded programs; 2) that black veterans appear to choose VA over non-VA programs for mental health treatment and derive substantial benefit from these programs; and 3) that blacks receive less intensive treatment than whites in some programs, but that this difference disappears when treatment is provided by black clinicians.

TESTIMONY TO HOUSE VETERANS' AFFAIRS SUBCOMMITTEE
ON OVERSIGHT AND INVESTIGATIONS

by

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SUBJECT: African-American Veterans and Community: Post-Traumatic Stress Disorder and Related Issues

Sigmund Freud predicted that human beings were destined to repeat an endless cycle of identifying and forgetting the effects of "traumatic stress" on human life. He proposed this cycle would occur because of our narcissistic need to pretend we are in control of our existence. Surely, it is painful for us to recognize that we have no control over our environmental circumstances, which like "traumatic stress", could cause significant alterations in one's mental life. True to Freud's prediction, human beings have repeatedly identified "traumatic stress" as a major factor in human life, only to disregard it later.

The problem of "traumatic stress" was first clearly identified in World War I as "shell shock"; also known as "traumatic neurosis". In World War II and the Korean War it was re-identified as "combat fatigue". Following the Viet Nam War, we have rediscovered "traumatic stress" in the form of Post-Traumatic Stress Disorder (PTSD).

Despite rediscovering "traumatic stress" in the form of PTSD, we still have not proven psychologically mature enough to appropriately address this important dynamic in human life. Post-Traumatic Stress Disorder continues to be a second class diagnosis. For example, mental health centers in Illinois can not bill the Medicaid Clinic Option for services rendered to a patient so diagnosed. Further, the diagnosis continues to be unidentified in various populations (military and civilian), misdiagnosed, and underestimated regarding its significant impact on individual daily life. Even its existence as a legitimate psychiatric disorder has been questioned.

Society needs to be greatly concerned with this issue. But that concern needs to extend further than the military populations that we know are at high risk to being exposed to a "traumatic stressor". The American Psychiatric Association's Diagnostic and Statistical Manual (Third Edition - Revised) defined a "traumatic stressor" as a "psychologically distressing event that is outside the range of usual human experience", and as a stressor which would "be markedly distressing to almost anyone, and is usually experienced with intense fear, terror, and helplessness". There are many people within the United States that are exposed to "traumatic stressors" of a magnitude that could cause them to have "Post-Traumatic Stress Disorder". Similar to the problems veterans experience, these populations' needs are going unaddressed by the society.

The traumatic stress of witnessing violence or being the victim of violence has caused a population of African-American children to suffer PTSD. Concern regarding these children spurred research at the Community Mental Health Council. Ten years ago we were aware of the levels of violence within the African-American community and were cognizant that African-American children were often exposed to violence reflected in national statistics. As a result of our concern we began researching issues concerning African-American children

exposed to violence. The article "Community Violence and Children on Chicago's Southside" (in *Psychiatry* 56: p 46-54, February 1993) provides a detailed summary of our original research, but, for the purpose of the Congressional Record, I will highlight our findings in our early work.

Our first survey, completed in 1984, explored children and violence via a survey of 536 elementary school children in the 2nd, 4th, 6th, and 8th grades at three inner-city grade schools. One in four children witnessed a shooting, and 30% had seen someone get stabbed. A retreat using a smaller subgroup of the original sample of children was conducted in order to explore intervention methods for the children's trauma and discover prevention methods to avoid future violence. Different methods of teaching children conflict resolution skills and ways to avoid violence were successful, but it was important to first "debrief" the child who was exposed to violence. Only then did it become possible to talk to them about issues related to the prevention of violence. Family violence was the factor that encouraged these children's propensity towards violence; not their exposure to violence on TV nor whether their peers encouraged them to be violent.

Dr. Robert Pynoos at UCLA coined the term "dose exposure" which refers to a child's amount of direct exposure to violence. The "dose exposure" is a major determining factor in the sequelae of that exposure. Dr. Pynoos studied the impact of a playground shooting at a Los Angeles grammar school. Children were exposed on three levels, children on the playground being shot and shot at; children in the school who heard the shots; and children who were away from school that day but heard about the shooting. Children directly exposed to the violence suffered the greatest impact of the stress and some developed PTSD. Children who heard the shots from their classrooms but were not directly exposed became upset and concerned but their distress did not qualify as PTSD. Children who heard about the shooting reacted similarly to children in the classroom who were not directly exposed.

There were exceptions to these general findings. First, some directly exposed children used the experience as a major motivating factor and obtained more control of their lives. They found the distress of being in a helpless situation untenable and instead of collapsing, they gained skills to prepare for the future. Some children firmly decided to pursue careers as physicians in order to treat victims if they were ever again in an attack situation.

Major distress symptoms were also seen in children not directly exposed to the violence in the playground (i.e. they either only heard the shots or heard about the shooting). These children had previously directly experienced significant violence and the school ground incident caused their old traumatic memories and fears to resurface. Finally, children not directly exposed but who were good friends of the children shot and/or killed were at risk for having severe grief reactions. Thus, Pynoos' studies confirm our observations that direct exposure to family violence has the potential to produce a negative coping response to violence (e.g. to become violent as "the best defense is a good offense" or the development of PTSD).

While TV violence or peer support of violence are probable factors encouraging violence, society and government must deal with a child's direct exposure to be successful in an intervention. Pynoos' work explored "inoculating" factors which cause some children exposed to significant stressors not to succumb, and other factors which cause other children not directly exposed to significant stressors to still have

unhealthy coping responses.

In 1990, the Community Mental Health Council screened 1035 students (from four high schools and two elementary schools) who participated in violence prevention workshops sponsored by the Council's Victims' Services Program. (An article on the program entitled "Advocacy, Research, and Service to Prevent Violence and Treat Victims", Hospital and Community Psychiatry, 43 (11): p 1134 - 1136, 1992 is attached). Nearly half of the students had been personally victimized (which included being threatened with a weapon), with 11% reporting they had been shot at, 3% having been shot, and 4% having been stabbed. Threats of attack with a gun (17%) or a knife (23%) were the most frequent types of victimization. Further, nearly one in four of these children reported they had personally witnessed a murder. In addition, one third of the students reported that they had carried a weapon, usually a knife; with 12% indicating they had injured someone with a knife or gun. An examination of factors related to exposure to violence found the strongest predictor of witnessing, victimization, and perpetration was carrying a weapon. Thus, we again discovered evidence that exposure to violence and perpetration of violence may be related, and addressing one without addressing the other is shortsighted.

The Community Mental Health Council has also screened psychiatric and medical outpatients regarding personal experiences of physical and sexual assault. Twenty-three percent of mentally ill youth and 12% of medical clinic youths knew of someone who had been raped, and 19% of the medical patients and 14% of the psychiatric outpatients knew of someone who had been murdered. Six percent and two percent of the psychiatric and medical outpatient youth (respectively) reported being victims of sexual assault, and 37% and 18% reported being victims of physical assault.

In summary, our early work surveying children and adolescents on the southside of Chicago revealed that some of these children have considerable exposure to violence either as victims or as witnesses and "survivors" (having close others victimized).

Most recently in 1992, my colleague Dr. Esther Jenkins, Ph.D. (Professor of Psychology at Chicago State University) and I have completed research on a sample of 203 African-American students from a public high school on Chicago's southside. This study, which will be published in Anxiety Disorders in African-Americans edited by S. Friedman, New York: Springer Publishing Company, found that almost two-thirds of the students indicated that they witnessed a shooting and 45% reported they had seen someone killed; further one-quarter reported witnessing a shooting, stabbing, and a killing. Our theory of why these percentages have increased from our earlier studies is that during our most recent study violence in Chicago was reaching record levels, while previous studies were being done while violence was waning.

This last study clearly indicated that boys and girls respond differently to exposure. Girls report significantly higher levels of distress while boys were significantly more likely to report that they carried a gun and were prepared to fight in self-defense. We found significant relationships between psychological distress and all four types of violence exposure.

The bottom line of the research is that the severity of the exposure to violence that some African-American children experience is great enough to be classified as a "traumatic stressor" capable of inducing PTSD. Contrary to popular

belief, children do not become immune to exposure to violence. Rather, they are at greater risk for other sequelae ranging from engaging in high risk-taking behaviors, having a foreshortened sense of their future, using drugs, having school performance problems, getting depressed, etc.

Currently, efforts are being made to address this problem nationwide. Because of advocacy of African-American physicians, the issue of responding to violence in the nation has taken a different turn. In the late 1970's African-American physicians involved in public health began to examine the issue of violence from a public health perspective to determine if such an approach could assist in the prevention of certain forms of violence. Clearly, the criminal justice system approach is to intervene after the violence has occurred, while a public health approach would seek to prevent certain forms of violence. Thus, based on a firm understanding of the circumstances of violence, African-American physicians have been suggesting that "predatory violence (i.e. violence in which the perpetrator consciously initiates behaviors that can result in violence, e.g. take a gun out of the house with the intent to rob someone) be handled by the criminal justice system as its motivation is criminal in nature; while "interpersonal altercation" violence (i.e. violence that begins as a harmless argument which escalates into physical violence and possibly homicide and in which neither party to the violence had any prior intent to do violence, e.g. a husband and wife argument that ends up in a homicide) be addressed through various public health prevention strategies. The nation has been slow in adopting this perspective, but there is now some movement towards this approach.

The National Institute of Health has issued several grants to sites around the country in order to develop curriculum designed to address students' risk-taking behaviors such as inappropriate sexual behavior, drug use, and violence. One of the issues being explored is children's exposure to stressors that may promote their increased likelihood of taking dangerous risks. National institutions and private foundations have placed violence on research agendas and are interested in providing resources to address the problem. The National Medical Association understands the need to address this problem and in 1986 began to design public policy to build an infrastructure in a myriad of institutions. More recently, the American Medical Association addressed the physicians' responsibilities in identifying and addressing family violence.

I want the House Veterans' Affairs Subcommittee to understand that some children in America suffer from PTSD due to exposure to family and community violence. The PTSD experienced by the children and post war veteran's is similar. When the Subcommittee addresses PTSD in African-American veterans, they should seek the opportunity to address the same issue of PTSD African-American children. Studies have shown that African-American veterans who developed PTSD did so in the context of being previously exposed to violence either as victims or witness to violence as children. The Subcommittee can prevent further PTSD development in future American veterans by addressing the issue of early exposure to violence and other "traumatic stressors" in African-American children. Of course the same logic applies to other ethnic groups in society, but public health logic dictates you first place the most resources where they would do the most good. There is evidence that non-white veterans suffered more PTSD than did white veterans due to previous exposure to violence or other "traumatic stressors". Combining resources devoted to addressing PTSD in African-American veterans with funds designated for other residents of the community would be more

efficient and economically effective. Finally, the summarizations of the research completed by the Community Mental Health Council on "traumatic stressors" demonstrates the usefulness of our findings in relation to resolving the issues of PTSD in veterans. But, unless the Subcommittee links the issues of "traumatic stressors" impacting veterans with the issues of "traumatic stressors" impacting the community two sources of research information useful to both sides may never meet and the opportunity for synergy will be lost.

Thank you for the opportunity to provide testimony on the issue of "traumatic stressors" as I feel facing this issue early on gives us the one clear opportunity to prevent damaging consequences later. Certainly our experience in dealing with "traumatic stressors" on the front lines of war has shown the rapid and direct approach to be a valid one.

Gold Award

Advocacy, Research, and Service to Prevent Violence and Treat Victims

Victims' Services Program Community Mental Health Council, Inc., Chicago

The Victims' Services Program at the Community Mental Health Council, Inc., a comprehensive mental health center serving Chicago's South Side, integrates research, advocacy, community education, and direct service to address the effects of violence and victimization among mentally ill patients and nonpatients in the center's predominantly African American catchment area. The victims served by the program include not only those who have directly experienced sexual or interpersonal assault, but others, particularly children, who have witnessed extreme acts of violence against family members or friends.

The Victims' Services Program is one of two 1992 winners of the Gold Achievement Award from the Hospital and Community Psychiatry Service of the American Psychiatric Association. The award is presented annually to recognize outstanding programs for mentally ill and developmentally disabled persons. It includes a \$10,000 prize, made possible by a grant from Roerig, a division of Pfizer Pharmaceuticals, that will be shared by the two 1992 winners. The Victims' Services Program, along with Step Up on Second Street, of Santa Monica, California, received the award October 24 at the opening session of the 44th Institute on Hospital and Community Psychiatry in Toronto, Ontario.

In the area of direct services, the focus of the Victims' Services Program is Chicago's South Side, but its research and advocacy activities have had a national impact. Program staff have used epidemiological data to define the nature of violence and victimization in the African American

community and clarify the circumstances in which violent assaults take place. In 1988 this research and advocacy by program staff were instrumental in maintaining prevention of violence as one of the U.S. Public Health Service's national health objectives for the year 2000.

Staff of the Victims' Services Program have testified before the House of Representatives Select Committee on Children, Youth, and Families and brought the issue of victimization into the public forum through numerous contacts with the media. The program has been the subject of dozens of articles in the lay press, numerous radio talk show discussions, and extensive national level television coverage.

Direct services

Direct services to victims are centered at the Community Mental Health Council, Inc., in Chicago's South Side. Governed by a community board, the center has a staff of 140 who provide a range of services, including emergency services, day treatment, consultation and education, residential care, and outpatient services, for children, adults, and elderly people. The center contracts with a general hospital to provide inpatient care. The mental health center's motto is "We dare to care."

The Victims' Services Program began in 1984. Administrative oversight is provided by Carl C. Bell, M.D., a board-certified psychiatrist. He is joined by two other psychiatrists, Karen T. Crawford, M.D., and E. Evelina Powers, M.D., in providing clinical leadership. Direct service staff include four part-time master's-level therapists (a total of two full-

time-equivalent positions), a full-time clinical coordinator who is a master's-level social worker, and four full-time bachelor's-level staff, including a case manager, a court advocate, a victim's assistant specialist, and a counselor for assault victims who also recruits and trains volunteers.

Direct intervention with victims of sexual assault has been a particularly strong aspect of the program. Currently the program serves about 46 percent of all victims of sexual assaults reported in the police district in which the mental health center is located. Program staff have effectively engaged clients through outreach and service provision at crisis centers, jails, schools, churches, day camps, police stations, and other social service agencies. The program also receives referrals from a victimization network and hospital- and community-based sexual assault programs.

The basic service package for victims consists of eight sessions of crisis intervention, which may include group or individual therapy and counseling for families and couples. The program also offers court advocacy. Staff members work with the victim to choose the most helpful services. The center also operates a 24-hour crisis line; Victims' Services Program staff carry electronic pagers and can respond to calls involving victimization at any hour.

The service program is funded by grants from the Illinois Coalition Against Sexual Assault, the Illinois Attorney General's Office, and the State Department of Child and Family Services. Coordination of the

broad range of funding sources has been a major challenge. However, funding from these sources falls short of expenses, and the Community Mental Health Council also supports the program from nonrestricted revenues.

In 1991 staff in the program's seven and a half full-time positions provided a total of 1,576 hours of direct counseling services to 388 victims and 117 of their significant others and provided referral services to another 181 victims. The staff had 229 contacts with other local institutions to advocate for victims' services. For example, staff met regularly with the Chicago Sexual Assault Services Network, a coalition of court advocates who work with law enforcement, criminal justice, and medical institutions to promote more sensitive handling of victims' issues.

Direct services are intensively monitored with quality assurance and outcome measures, including client satisfaction surveys, reviews by two different oversight boards, peer review, individual case review, and systematic quality assurance using a threshold criteria indicator model.

Research

Despite initial lack of funding for research, Victims' Services Program staff members were willing to begin gathering basic empirical data soon after the program started. Since 1991, partial funding for the program's research has been provided by United Way of Chicago. Over the past eight years, under the leadership of Dr. Bell and Esther J. Jenkins, Ph.D., a social psychologist, program staff, along with visiting psychiatric residents and medical students rotating through the program on training placements, have investigated several aspects of the problem of violence, including the epidemiology of homicide, the extent of victimization in the history of mentally ill patients, and the extent of exposure to violence among children.

For example, a series of studies conducted by Dr. Jenkins and her colleagues have provided insights about children's exposure to violence as witnesses and the types of incidents that are witnessed. In a 1986

survey of 536 African American school children, about 26 percent of the sample reported that they had seen a person get shot and 29 percent indicated that they had seen a stabbing. A subsequent screening done by Victims' Services Program staff of more than 1,000 middle and high school students from a relatively high crime area of Chicago's south side found that 35 percent had witnessed a stabbing, 39 percent had seen a shooting, and 24 percent had seen someone get killed. In the majority of cases, the students reported that they knew the victims. In addition, 46 percent of the sample reported that they had personally been the victim of at least one of eight violent crimes, ranging from having a weapon pulled on them to being robbed, raped, shot, or stabbed.

Clinical experience reveals that children who are exposed to violence may show symptoms of posttraumatic stress disorder, including reexperiencing the event in play, dreams, or intrusive images; psychic numbing characterized by subdued behavior and inactivity; and sleep disorders. Their cognitive performance and achievement in school may be affected due to intrusive thoughts of the trauma, development of a cognitive style of deliberate memory lapses, or simple fatigue from loss of sleep. The findings highlight the need for screening children with learning and behavioral difficulties to determine if exposure to violence plays a role in their problems.

In other research, program staff examined hospitals in Cook County, Illinois, to determine the kinds of procedures and policies in place in emergency rooms to address the needs of victims of family violence, domestic violence, and interpersonal assault. This work will enable the staff to build a theoretical model of service delivery in emergency rooms.

Consultation and community education

Staff of the Victims' Services Program have provided consultation to public service departments in several states and more than 30 cities and to many professional organizations and individuals in models of violence prevention and intervention, screen-

ing clients for victimization, and alternative methods of conflict resolution.

The model of violence prevention developed by the program is based on the three levels of intervention—primary, secondary, and tertiary—used to address public health problems. Primary prevention strategies, intended to stop the problem from occurring, include instruction in conflict-resolution skills, community-based interventions to improve family systems and provide productive outlets for youth, and efforts to reduce head injury and alcohol abuse, which have been linked to violent behavior.

The structured conflict resolution training advocated by the Victims' Services Program teaches individuals how to negotiate difficult situations and identify and implement solutions that are acceptable to all parties. The approach also draws on less structured techniques, such as use of humor to defuse potentially dangerous situations. The Victims' Services Program recommends placement of such training in the curricula in primary and secondary schools.

Secondary prevention involves intervening in the violence process before it results in death by identifying and treating victims and perpetrators of nonlethal violence, such as spouse abuse. To improve the chances of finding these persons, the Victims' Services Program works with staff of emergency rooms and other health care facilities to develop procedures for screening patients. The program also works with churches and other community groups to increase awareness of the problem of victimization and to open avenues for referral for treatment.

Tertiary prevention—interventions that occur after violence has taken place—are aimed at reducing the psychiatric morbidity associated with exposure to violence as a victim, witness, or, in case of homicide, a family member or friend of the victim. The Victims' Services Program advocates that community mental health centers be attentive to victimization issues for both patients

and nonpatients in their catchment areas. The Community Mental Health Council screens every patient for issues of victimization. This routine procedure has produced a much broader focus on these issues in many patients' treatment plans.

In 1991, Victims' Services Program staff delivered 137 community educational presentations on violence and victimization to a total of 7,559 participants. Workshops on prevention of violence were presented at preschools, elementary schools, and high schools; churches; and community health centers. Staff also conducted a day-long workshop on violence that had 60 participants from all over the city. The program co-sponsors peer violence prevention workshops in city schools with the Fraternal Order of Police and has helped the Illinois State Police develop their school security program, which teaches principals and administrators how to handle violence in schools in a nonviolent manner.

In the area of professional training, in 1991 Victims' Services Program staff provided 43 programs on how to counsel victims for a total of

444 participants. Training to help volunteers aid victims during their stressful post-victimization phase is also provided.

Plans for the future

In 1992, the Victims' Services Program began a demonstration service delivery project in the Cook County Juvenile Court detention facility. The project is aimed toward both improving the safety of the environment within the facility and addressing violence in lives of the juveniles who are detained there. There are plans to ensure that the facility's correctional officers and health care personnel receive training in the non-violent management of violence within the facility. Further plans call for program staff to screen for victimization among the juveniles to identify those at risk for academic, behavioral, and psychiatric problems and counsel these children to relieve their trauma. In addition, high-risk juveniles are being taught non-violent conflict resolution skills.

To address the Victims' Services Program's current funding shortfall, program staff plan to seek additional

funding sources. The additional funds will be used to support expansion of needed services, which will focus particularly on victims of physical assault and witnesses of homicides.

The Victims' Services Program combines service, research, advocacy, and community education to address the problem of violence and victimization at several levels—by helping victims through direct counseling, by providing consultation in service delivery and program development to health care facilities and other agencies, and by helping local communities and national policymakers increase their awareness of the mental health consequences of violence and victimization. The program's multifaceted approach is one that recognizes the magnitude and complexity of the problem and that provides useful strategies for change.

For more information, contact Carl C. Bell, M.D., Executive Director, Victims' Services Program, Community Mental Health Council, Inc., 8704 South Constance Street, Chicago, Illinois 60617; telephone, 312-734-4033, ext. 204.

WRITTEN TESTIMONY
for
September 15, 1993
House Veterans' Subcommittee
on
Oversight and Investigations

Submitted by:
Carmen W. Wilson II

I would like to start by thanking Congressman Lane Evans for this opportunity. It is indeed an honor and privilege that far exceeds my wildest dreams. For me it's the ultimate opportunity to discuss a subject near and dear to my heart. Thus, I hope to provide some insight by discussion.

Today I bring to you some good news and disturbing facts. My topics include various ways that Post Traumatic Stress Disorder has effected African American Veterans and other related community issues.

During 1968 -1969, I served in Vietnam. My initial experience in service delivery was as a Veteran's Counselor. Subsequently, I served Director and Deputy Director of Veterans' Affairs for the State Of Indiana, That combination of experiences, has caused me to develop a unique perspective regarding the status of African American Veterans.

Over the last 20 years, I have observed changes in the federal Department of Veterans Affairs. These changes have provided some veterans access to the best medical care available. At the same time, other veterans are denied medical care that the federal Governmen.

Countless experts have concluded as a result of scientific research and other observations, that many young men and women who went from high-schools, factories, colleges and street corners to Vietnam Jungles within twelve months were psychologically scarred.

An interesting editorial was written by Cristine Russell in the February 19th, 1991 edition of the Washington Post Health Magazine. Ms. Russell reported on a study ordered by Congress and conducted by the Research Triangle Institute. The report found that 15% of those who served were still suffering from the Post Traumatic Stress Disorder. The length of the war, stress from exposure to a life threatening situation, emotional instability and the war's unpopularity were factors contributing to the disorder.

A quick calculation reveals that 15% of the approximately 3.5 million service men and women leaves 450,000 veterans suffering from

Post Traumatic Stress Disorder. However, the Department of Veterans Affairs is paying compensation for PTSD to only 40,456 veterans. Of that number, 603 veterans have less than a 10% disability rating. Clearly, the greatest percentage of Veterans suffering from Post Traumatic Stress Disorder are not being compensated for their disability.

Many of those still suffering from PTSD yet manifest symptoms. These include difficulty in holding jobs, inability to maintain relationships and various forms of anti-social behavior. The sad fact is that the aforementioned symptoms are frequently considered by society to be normal behavior for Vietnam Veterans.

The effects of Post Traumatic Stress Disorder have been devastating to America. Most of the expenses caused by this human suffering has resulted in a psychological and financial burden to local governments. A substantial proportion of indigent patients receiving care at locally funded medical facilities are eligible for treatment at Veterans facilities. A lack of training in the diagnosis of Post Traumatic Stress Disorders by personnel at community medical facilities, allows the illness to go untreated.

Making matters worse, many families have been torn apart and destroyed because this illness has remained untreated. In fact, large percentages of criminal behavior and substance abuse are nothing more than manifestations of untreated cases of Post Traumatic Stress Disorder. Further research may reveal a relationship between the increase of violent activity among teens and the effects of P.T.S.D. on families.

Although the veteran's Community has started to heal, recent events often exacerbate the sense of frustration and resentment many former G.I.'s have. The following are examples of incidents and situations that prevent healing.

Many veterans felt betrayed when the United States granted asylum to Vietnam refugees. They were entitled to welfare, food stamps and

important to overcome society's previous rejection of them. Society's rejection destroyed the self-esteem of Vietnam Veteran's at a time when they needed it most.

Although those Veteran's cannot change the past, they can and are doing some things to improve the negative perception that society has of Vietnam veterans.

The previously rejected veterans are finding out that they can be especially useful in areas of prevention, education and reintegration of incarcerated youths between the ages of 8-13 years of age. Helping at-risk youths is extremely important to the healing process. According to the Justice Department, an average of 960,000 children between the ages of 12 and 19 were the victims of 1.9 million violent crimes each year between 1986 and 1988. Between 1987 and 1991, the numbers of juvenile arrests for violent crimes increased 50%. Arrests of juveniles for murder increased 85% during 1987 and 1991. At the "Safeguarding Our Youth: Violence Prevention for Our Nation's Children" Conference, Secretary of Health and Human Services Donna Shalala, labeled the spread of youth violence " a major public health crisis."

The National Association of Black Veterans, N.A.A.C.P., and Tuskegee Airmen are examples of African-American veterans organizations that have been actively involved in providing services to at-risk youths in Indianapolis, Indiana. In Wisconsin, the National Association of Black Veterans have implemented several programs that bring veterans and at-risk youth together. Another example of an organizational approach is the Indianapolis Chapter of the Tuskegee Airmen, who adopted a grade school last year.

Currently, in Indianapolis, Indiana, I serve as Executive Director of Project COURAGE. Project COURAGE represents the Marion County Prosecutor's effort to reduce incidences of illegal-gang activity and violence. It coordinates the operations of law enforcement, social-service agencies, community-based and grass-roots organizations and dedicated individuals.

Vietnam was a difficult war for America. One of the ways this difficulty manifested itself was in a higher incidence of P.T.S.D. among Vietnam Vets. Not withholding this phenomenon, the citizens who served in Vietnam gained valuable experience that can be shared with society's youth. With the continued support of government many Vietnam veterans can begin to recover and heal.

I thank you.

**STATEMENT OF MICHAEL KOCHER
DIRECTOR, AMERASIAN RESETTLEMENT PROGRAM
INTERACTION**

**BEFORE THE HOUSE VETERANS' AFFAIRS SUBCOMMITTEE
ON OVERSIGHT AND INVESTIGATIONS**

SEPTEMBER 15, 1993

Chairman Evans, members of the subcommittee, my name is Michael Kocher and I am the Director of the Amerasian Resettlement Program for InterAction. I want to thank you for the opportunity to testify here today on the topic of Vietnamese Afro-Amerasians and issues involving African-American Veterans and community.

InterAction exists to help promote and enhance the effectiveness of private humanitarian efforts. Our membership includes 154 US-based private voluntary organizations engaged in relief, development, refugee assistance, public policy and global education. Included in our membership are those agencies responsible for resettling refugees into the United States. For the past four years, InterAction has been partner to a cooperative agreement with the Office of Refugee Resettlement/US Department of Health and Human Services for the purpose of supporting local community efforts to enhance the services provided to Vietnamese Amerasians and their families. Vietnamese Amerasians represent a new group of young adults in this country, and included in this group are thousands of Afro-Amerasians.

Vietnamese Amerasians, Mr. Chairman, are the offspring of Vietnamese women and U.S. military and civilian personnel stationed in Vietnam during the war. When the U.S. left Vietnam in 1975, thousands of Amerasian children were left behind. While some men tried and succeeded in bringing their children to this country, the overwhelming majority of these children remained in Vietnam. While many were raised by their mothers or relatives, others were abandoned and forced to live in orphanages, foster homes or in the streets. Historically, Vietnam is a racially homogenous society and, for a variety of cultural and political reasons, Amerasians are often severely discriminated against and made to live on the poorest margins of that society. Interviews in Vietnam and resettlement experience in this country suggest that Afro-Amerasians generally receive the harshest treatment in Vietnam. When faced with the racial realities of their new home, this group may be especially "at risk" as young adults in the United States (see attached 11/13/92 *New York Times* article).

In 1982, Mr. Chairman, the U.S. began accepting small numbers of Amerasians under the Orderly Departure Program (ODP). In 1984, Secretary of State George Schultz announced that the U.S. would accept all Vietnamese Amerasian children and their qualifying family members. In September, 1987, the U.S. and Vietnam reached agreement under a bilateral program allowing increased resettlement of Amerasians. In December, 1987, Congress passed the Amerasian Homecoming Act allowing Amerasians and families admission to the U.S. as immigrants eligible for refugee benefits. The legislation took effect in March, 1988 with the expectation that 25,000 - 30,000 individuals would resettle here under its provisions. To date, approximately 80,000 individuals have come to the U.S. under this legislation with an additional 3,500 expected in FY 1994. This total includes approximately 20,000 Amerasian young adults of which approximately 5,000 are Afro-Amerasian. Once here, these young people who now average twenty-one years

of age resettle in numerous "cluster site" communities throughout the country where they are met by and receive services from the voluntary resettlement agencies. In my role with InterAction, Mr. Chairman, I work closely with these resettlement agencies and communities as they welcome and serve this population.

All immigrants and refugees, regardless of ethnicity and country of origin, must endure severe changes and make significant adjustments when they move to the U.S. Amerasians, however, and due to their unique circumstances, especially Afro-Amerasians, have several additional issues which can cause even greater strain to themselves and those around them. These issues include:

1. Low self-esteem and identity confusion - As noted, Amerasians grew-up markedly different in homogenous Vietnamese society, which is made more extreme for Afro-Amerasians. Marginalized, generally poor and lacking any social group to confer a positive identity, Afro-Amerasians especially may have low self-esteem and a confused sense of self. This may result in self-hatred and an attempt to deny their African-American heritage. This may be heightened upon arrival in the U.S. with realization that cultural and language barriers keep them isolated from African-American communities and that U.S. society possesses racial problems of its own.
2. Low education levels and few transferable job skills - While not officially denied access to schooling in Vietnam, relatively few Amerasians enter the U.S. with a high school education. In fact, most Amerasians had little formal schooling in Vietnam and, given their ages, most do not attend America high school. Illiteracy in both Vietnamese and English is common, with local service providers reporting that illiteracy is of special concern regarding Afro-Amerasians. Similarly, most arrive in the U.S. without appropriate job skills. While the local agencies do provide employment counseling and report most Amerasians go to work soon after arrival, vocational training opportunities in this country are few and Amerasians may face the prospect of minimum wage work as their only long-term option.
3. Sometimes unrealistic expectations of reunion with their father - Amerasians grew-up without a father in a strict patrilineal society which confers identity from the father's family and ancestors. Many hold long-harbored dreams of finding their fathers upon arrival in the US. While most have insufficient information to do so, smaller numbers do have information and choose to initiate a father search. This is an extremely complex emotional area involving agency caseworkers and local Red Cross staff trained to counsel as well as carry out the actual tracing. To date, roughly 3% of the Amerasian population have located their father (it should be noted that the Red Cross workers provide

Amerasians with a located father's address or phone number only with the father's consent). Obviously, whether ultimately successful or not, the father search issue is a difficult one for all involved. The Amerasian may have to deal with unfulfilled dreams, or tensions with his/her biological mother and half-siblings. Similarly, a father who has been located may have unresolved feelings about his experience in Vietnam, as well as his own family which may or may not welcome the knowledge that he left a child behind in Vietnam. I believe the father search issues will increase in importance, as local agency staff report most Amerasians express an interest in finding their fathers. Some Amerasians resettled 3-4 years ago are only recently letting it be known that they do have information about their fathers and now wish to try to find them.

Without question, Mr. Chairman, Vietnamese Amerasians and especially Afro-Amerasians face tremendous obstacles here in the U.S. Similarly, African-American Veterans and their communities face difficulties in welcoming these young people to their new home. But there have been many successes, and initiatives exist which are working. Mentor programs, for example, matching African-Americans and African-American Veterans with Afro-Amerasians can be very beneficial. Local resettlement experience shows that these matches, when carefully screened and monitored by professional staff, can have a positive effect on both individuals involved. For it is only through exposure and positive reinforcement that the young Afro-Amerasian is able to grow comfortable with their identity and embrace both halves of their heritage. Additionally, African-American Veterans now serving as volunteers have told me that they value highly their mentor relationships with these young people. Some have stated that the mentor relationship has aided not only the young person but themselves as well as they have been better able to come to terms with their time in Vietnam as a result.

Parallels between Amerasian young adults and other disadvantaged minority youth in this country suggest that Amerasians and Afro-Amerasians specifically are excellent candidates for inclusion in federal, state and local minority youth initiatives. As noted above, literacy and employment as well as mentoring are critical areas of concern. In conclusion, Mr. Chairman, I urge you and your colleagues to remember the Vietnamese Amerasians as a whole and Afro-Amerasians specifically as the subcommittee continues to address broader issues involving African-American Veterans and community.

Thank you again, Mr. Chairman, for the opportunity to testify here today. I will be very happy to respond to your questions.

NY Times 11/13/92

For Afro-Amerasians, Tangled Emotions

Physically Black, Culturally Vietnamese and Living a Life 'in the Middle'

By DAVID GONZALEZ

When Luong Hung looks in the mirror, he says, shame ripples through his body. His sad-eyed visage, his tightly curled dark hair, are daily reminders of the relationship between his Vietnamese mother, a waitress in Saigon during the war, and his father, a cargo pilot he knows only as John.

"I feel ashamed that my mother was with a black man, and now I have to carry that," said the slender 26-year-old refugee, his knees almost touching his chest as he perched atop a child-sized plastic chair in his Bronx apartment. "I wish I were a white Amerasian."

Luong Hung is an extreme example of the tangled emotions twisting inside these children of the Vietnam War, now young adults in the land of the fathers they do not usually know. Black or white, they have experienced the same discrimination and hardship in Vietnam where they were derided as "the dust of life."

Ridiculed and Beaten

But for those whose fathers were the black foot soldiers, sailors and airmen of that turbulent era, their upbringing in Vietnam's ethnically homogeneous and pariah society was doubly hard — disenfranchised for having no father at home and scorned because that absent parent, black, they recall childhoods spent hidden by their parents, ridiculed or shunned by neighbors and beaten by other children.

Many of them live in places like the Bronx — one of 55 resettlement communities nationwide — where they receive



"I feel ashamed that my mother was with a black man, and now I have to carry that," said Luong Hung, whose mother is Vietnamese and whose father was a cargo pilot during the Vietnam War. "I wish I were a white Amerasian." Henry Jones/The New York Times

Continued on Page B2



Photographs by Nancy Sorell/The New York Times

Linda, right, a black Amerasian, walking with her mother, Thanh, left, and her grandmother, Florence Hendricks, in Chinatown. Linda's father, a former serviceman, is remarried and lives in the Virgin Islands, where Linda and her brother, Lee, visit him in the summer.

For Afro-Amerasians, a Life of Tangled Emotions

Continued From Page B1

education, jobs and counseling help as they try to shake loose the memories of years of a hardcrabble existence. For the first time in their lives, many say they feel they have a chance to succeed or fail on their own merits, blending into racially mixed communities.

At the same time, refugee workers who are guiding their transition to American life fear that these young people are still suffering the after-effects of racism they endured in their early lives. Tugged among three worlds, they say, the black or Afro-Amerasians exhibit more anger, anxiety and depression, if not self-hatred, than their white cousins.

Culturally Vietnamese, politically American and physically black, they do not easily fit into any one category. "We almost saw these kids as interracial but in a sense disenfranchised in every domain," said Mark Johnson, a clinical psychologist and the co-author of a study on the mental health of Afro-Amerasians. "It's difficult to find a space or cultural home for these kids."

Taunted by Children

Dai Thatch, 31, knows that confusion. The Afro-Amerasian who came to the United States this year said he was always perplexed by the taunts of neighborhood children in Vietnam who told him he should "go to your country" because he was black. "I didn't know my country," he said.



Many black Amerasians live in places like the Bronx — one of 35 resettlement communities nationwide — where they receive education, jobs and counseling

help. Hang Thach, Dai Thatch and and Hong Le attended English classes at St. Rita's Asian Center last week on Andrews Avenue.

Some 85,000 Amerasian refugees and their relatives have arrived in the United States since Congress passed the Amerasian Homecoming Act in 1980. The Amerasians themselves accounted for a quarter of the refugee total, with some 4,000 of them being Afro-Amerasian, said Michael Kocher, director of the Amerasian Resettlement Program at InterAction, a Washington-based coalition of resettlement and relief agencies.

Speaking in general terms, Mr. Kocher said the sons of infantrymen who once walked point in the jungle were left behind to bring up the rear of a social order that shunted them to the margins of Vietnamese life.

"It is such a homogenous society, ethnically pure, that it's difficult for anyone with mixed blood," he said. "For whatever cultural reasons, they tended to be even more marginalized."

Lee, a 21-year-old Afro-Amerasian who arrived in the United States two years ago, spoke on the condition that his family's name not be used. He speaks haltingly of his childhood in Saigon, one whose themes resonate in the stories of his fellow refugees.

His mother, who had married a black serviceman, hid Lee and his sister, Linda, in the closet for months after the fall of Saigon. Later, when she sent him to school, he said, he was teased relentlessly and often arrested by the police, who he said tried to coerce confessions from him for crimes he did not commit.

The ultimate indignity came in the fifth grade, when his classmates

pounced on him, pummeling him until half his face was swollen. When his mother confronted the school's principal, he told her to stop sending her son to school because he could do nothing to prevent the beatings.

Feeling Some Kinship

Lee and his family came to the United States in 1980, settling into an apartment in the Kingsbridge Heights section of the Bronx. He attends Martin Luther King High School in Manhattan, where he said his black classmates have welcomed him. He said he did not know much about black culture, although he said he intended to read more about it once his command of English improved. Nonetheless, he feels some kinship to his classmates.

"At the beginning I was surprised to see so many people with the same color skin as me," he said. "That makes me feel surprised and comfortable. I belong to this society."

His mother says, perhaps only partly in jest, that he now wants to forget the part of him that is Vietnamese. He listens grim-faced, slumped in a chair.

"Forget," he said, slowly shaking his head. "I don't want to remember."

The relief many feel for no longer being humbled because of their skin color can be supplanted by urgent economic concerns. Several refugee experts said the Afro-Amerasians were often denied access to education because of their color, arriving in this country with only a few years of formal schooling. If any. Now, many worry about catching up, enrolling in high school at an age when other teenagers have graduated.

Others fret about finding work with little English and few marketable skills at a time when jobs are scarce for many in their neighborhoods.

Needing Federal Help

"When I first got here my face was always angry," said Minh Nguyen, 21, who arrived in the Bronx last year and now is studying English and other subjects at St. Rita's Asian Center. "The language was difficult and this is a big country. I didn't know where to look for work. I don't know what is out there in the future."

There is a sense that time is limited, a sentiment shared by refugee workers who said that because the Amerasians were older, they should be eligible for more assistance from

Government social-service programs. They said it was more critical for the Afro-Amerasians, given their frequent lack of education.

While some of the youths have black friends, their tightest bonds often seem to be with other Amerasians. They refer to living life "in the middle," identifying themselves as Amerasian.

Their blackness, the focal point of their abuse in Vietnam, is something that is either played down or avoided here. Mr. Hung said all he knew about

In Vietnam, children of black soldiers sat in the back of society.

black Americans came from a movie about the antebellum South he saw in his youth.

"I heard in Vietnam that black people were slaves," he said. "I didn't want to be a slave."

He still may be hostage to his decidedly derogatory view of black Americans, fearfully associating them with crime and homelessness. When asked if his time here has helped persuade him otherwise, he nodded affirmatively.

"Of course it changed," he said. "In the United States there is freedom. I don't have to live in the black community."

Although Mr. Hung said he felt more comfortable in New York, not all of his countrymen have been accepting. "Vietnamese here, especially the higher-educated Vietnamese, do not allow their children to make friends with black Amerasians like me," he said.

Psychologists and others who have looked into the experiences of Amerasian refugees said the lasting effects of the young people's difficult years in their homeland were unclear.

A continuing study that has tracked Amerasian refugees along their journey from Vietnam, through Philippine refugee camps and in the United States, found the Afro-Amerasians to be slightly more anxious and depressed than their white counterparts, but the difference was not sta-

tistically significant.

Dr. Robert McKevey, the study's co-author and the head of the department of child psychiatry at Baylor College of Medicine in Houston, said his impression remains that the Afro-Amerasians were having a harder time in the United States.

In terms of their self-image, Dr. McKevey found that many of these young people consider themselves more Vietnamese than their appearance would suggest. But American society, whose own issues of color have never been resolved, views them through its own racial prism, said Carolyn Tisdale, the director of refugee resettlement programs for Catholic Charities in Memphis.

"I see them as black," said Ms. Tisdale, who herself is black. "I know that's what everyone else is going to see. Realistically, that is what they are going to have to deal with."

Unfortunately, she said, the Afro-Amerasians she has encountered in her work arrived in this country with negative racial stereotypes about blacks. "You get a lot of self-hatred," she said.

Some groups have tried to help the Afro-Amerasians better understand their black heritage by incorporating lessons or literature about black history into the school curricula. Sister Jean Marshall of St. Rita's Asian Center said her group hoped to enlist the aid of black military veterans and others to serve as mentors, to help bolster their fragile self-confidence.

"Their self-esteem is so low," she said. "Getting them to realize they can make it is very hard."

Ms. Tisdale and several others in refugee work said they thought that not enough black Americans have reached out to the Afro-Amerasian youths. Part of the problem, some said, was that the resettlement agencies themselves had not done a good enough job of reaching out to blacks.

A little more than two years after arriving here, Lee and his sister, Linda, 20, seem to be adjusting well. He is in 10th grade and talks about going to college. Linda, unschooled in Vietnam, is enrolled in English as a Second Language class at St. Rita's. She says she wants to be a model.

Part of the reason for their relatively smooth adjustment lies in the efforts of their mother, who hired a tutor for her children after Lee was beaten in school in Saigon.

STATEMENT BY JAMES W. WOODARD

TO

THE HOUSE VETERANS AFFAIRS SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS

SEPTEMBER 15, 1993

THE ROLE OF THE MILITARY IN US FOREIGN POLICY

Mr. Chairman,

Members of the Committee. I appreciate this opportunity to share my views on the role of the military in U.S. Foreign Policy.

My brief statement will address three areas of concern:

1. The Role of African Americans and other minorities in helping to formulate foreign policy;
2. The use of military force in the conduct of foreign policy;
3. A change in the focus of foreign policy considerations.

My remarks, as an African-American Vietnam veteran, are tempered by my knowledge of the scornful attitudes that governmental policy makers have historically exhibited toward Black Americans who express opinions about US Foreign Policy.

From my studies, I remember the treatment of W.E. B. DuBois and Paul Robeson. I witnessed first-hand what happened to Malcolm Shabazz when he sought to internationalize the unjust plight of African-Americans and I was traumatized by the assassination of Dr. Martin Luther King, Jr. after he began criticizing American involvement in Vietnam. I vividly remember sitting and staring at the South China Sea wondering what was I doing in Vietnam supposedly making the world safe for democracy while my own country, which sent me there, was unsafe for the apostle of peace.

President Jimmy Carter set a precedent by choosing Congressman Andrew Young for the highly visible (and under Young, controversial) position of U.S. Ambassador to the United Nations. His tenure, however was short lived for doing publicly (talking to the Palestine Liberation Organization) what recent events confirm Israel was doing in private all of these years while they and the United States government refused to recognize the legitimacy of the PLO.

It seems conceivable that had Ambassador Young been allowed to continue his efforts, he may have followed in the footsteps of a seldom discussed African American foreign policy virtuoso. Dr. Ralph Johnson Bunche, who while Under-Secretary of the United Nations, was awarded the Nobel Peace Prize for mediating the first Arab-Israeli conflict. It was his example that influenced me to attend the Fletcher School of Law and Diplomacy as a Martin Luther King Fellow.

Secrecy in Diplomacy is essential for trust among nations. However, as often as is plausible, our government should operate in the sunshine.

There needs to be a continuing substantive role for African-Americans and other minorities in the conduct of foreign policy. I implore you to use your positions to facilitate that participation.

I am aware that foreign policy is primarily the domain of the Executive Branch and that the Senate is the deliberative legislative body in such matters through its advise and consent role. However, just ask Defense Secretary Les Aspin whether or not presidents and cabinet secretaries listen to recommendations from House members as well. Rather than just fighting and dying in wars that others ordain, give us a seat at the table where decisions are made about whether to go to war or exhaust diplomatic initiatives.

The exalted positions of General Colin Powell and Secretary Jesse Brown are commendable. However, they are anomalies. Where are the under secretaries and assistant secretaries? Where are the lesser generals? Where are the ambassadors and national security advisers?

American foreign policy based upon the use of military force to protect and promote American big business interests needs to be re-evaluated. Our foreign policy should, instead, promote what we espouse; that is, democracy around the world, human rights for individual citizens of all countries and a sense of community among nations. The demise of the Soviet Union should have removed our 46 year obsession with preventing the spread of communism.

For almost one hundred years, U.S. foreign policy has been based on "Dollar Diplomacy," a term coined by Philander C. Knox, President William Howard Taft's Secretary of State. John Booth described dollar diplomacy as "...using U.S. businessmen as agents of foreign policy and ...using the Department of State to promote U.S. business interests." (Booth, '82)

More than just businesspersons and members of the State Department promoted dollar diplomacy, however. Marine Major General Smedley D. Butler stated in Common Sense in 1935 that, "I spent thirty-three years and four months in active service as a member of our country's most agile military service--the Marine Corps...And during that period I spent most of my time being a highclass muscleman for Big Business, for Wall Street, and for the bankers. In short, I was a racketeer for capitalism..." He continued, "...I helped to make Mexico...safe for American oil interests in 1914. I helped to make Haiti and Cuba a decent place for the National City Bank to collect revenues in...I helped purify Nicaragua for the International banking house of Brown Brothers in 1909-1912. I brought light to the Dominican Republic for American sugar interests in 1916. I helped make Honduras 'right' for American fruit companies in 1903." (Woddis, 1967).

After serving as legal counsel for the United Fruit Company, John Foster Dulles became President Dwight Eisenhower's Secretary of State (President's Eisenhower's speech denouncing the military/industrial complex is worth reading). George Shultz left the presidency of the Bechtel Corporation to become President Ronald Reagan's Secretary of State. Yet, he remained a director of the foremost national and international construction company.

Despite our claims that we are not colonialists in the sense that European countries were (We were observers, by the way, at the Treaty of Berlin in 1885 when Europe carved up Africa), we have treated and continue to treat Latin America as our plantation. And we are considered by most of the world's countries to be the quintessential imperialistic nation. After all, we inhabit eight percent of the earth's surface; we have eight percent of the world's population; yet, we use one third of the earth's resources.

I am proud of my military service but I am ambivalent about my Vietnam experience. I know that the United States, England and France conspired to insure a return of French control over Indochina after Vietnamese freedom fighters had supported allied efforts during World War II. The ARVN captain who was my vietnamese counterpart told me that despite fighting alongside we Americans, he considered Ho Chi Minh to be the father of his country.

Soldiers who fought in Granada, Panama, Iraq/Kuwait and those now in Somalia have and will have questions about the legitimacy of the causes for which they were sent into combat.

The United States is the sole remaining military superpower. We can use our military might for good. I think we should. However, when questions are raised but not answered satisfactorily about whether the Iraq/Kuwait war just an oil war to protect the interests of big American oil companies, President Bush's cabinet members and national security advisors as well as despots in Kuwait and Saudi Arabia, then the problem of government's credibility becomes serious.

In Duties Beyond Borders, Professor Stanley Hoffman quotes from Thucydides, The Peloponnesian War in which "The Athenians tell the Melians that in international affairs the strong do what they can and the weak do what they must...The Melians insists on talking about right and justice. The Athenians reply 'that expediency goes with security, while justice and honor cannot be followed without danger' and they conquer and kill the Melians." (Hoffman, 81)

In Hoffman's and Thucydides' examples, then, the United States may very well be the Athenians while the smaller countries of Vietnam, Granada, Panama and Iraq are the Melians. If such is true, we are the villains.

Academics who know our history and the reasons for our behavior and public officials who formulate policy have an obligation to educate the average citizen to the contradictions between our espoused theory of behavior (what we say) and the actual implementation of our policy (what we do).

If the general public were more informed and if public officials were more vigilant, soldiers, such as LTC Oliver North could not violate the constitution with impunity and insult Congress as he did during the Iran/Contra scandal and still seriously expect to be elected to the United States Senate from Virginia.

The Jingoism which our leaders encourage to foster nationalism during times of crises is too often misplaced. "My country, right or wrong" is not necessarily in the best national security interests of the United States. Why Not, "Our country, let's make it right."

STATEMENT OF
DAVID LAW, M.D.
ACTING ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR
FOR CLINICAL PROGRAMS
VETERANS HEALTH ADMINISTRATION
BEFORE THE
OVERSIGHT AND INVESTIGATIONS SUBCOMMITTEE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

SEPTEMBER 15, 1993

Mr. Chairman,

It is a pleasure to appear before the Subcommittee to review the incidence of Post-Traumatic Stress Disorder (PTSD) in African-American veterans and the Department of Veterans Affairs efforts to respond to the needs of these veterans.

VA has created a full range of programs for the care of veterans suffering from PTSD, including African-Americans, and has led the nation and the world in developing the understanding and treatment of this disorder. We recognize that there are unique factors affecting African-American veterans with PTSD, and we are committed to providing necessary and appropriate treatment for them. Several types of specialized programs are tailored for the treatment of veterans suffering from PTSD. These programs are designed to provide a continuum of care ranging from intensive long-term inpatient treatment to specialized outpatient care in VA medical centers, clinics, and Vet Centers. VA is expanding these programs with special funding from our FY 1993 Appropriation and has requested additional expansion resources from Congress for FY 1994.

VA's National Center for PTSD carries out a broad range of multidisciplinary activities in research, education and training. The National Center, established in 1989, is a consortium that currently is comprised of six sites. Also, since 1984, VA's PTSD programs and VA's ability to provide PTSD care has been monitored by the Chief Medical Director's Special Committee for PTSD. The Special Committee is made up of a multidisciplinary group of VA clinician experts on PTSD.

The National Vietnam Veterans Readjustment Study (NVVRS) completed in 1988 found that diagnosable PTSD in male Vietnam veterans was 15.2 percent or approximately 480,000 current cases and that an additional 11 percent, or

341,000 veterans, had 3-5 symptoms of PTSD. In addition, 50 percent of Vietnam theatre veterans with PTSD had other psychiatric disorders such as depression, substance abuse or anxiety disorders. This study showed that 20.6 percent of African-American, Vietnam theatre veterans were suffering with PTSD.

VA is currently tracking the mental health status of Persian Gulf veterans with a series of surveys at five VAMCs. These studies show a lower rate of PTSD among Persian Gulf veterans; however, African-American veterans are experiencing a slightly higher rate of PTSD than the overall Persian Gulf veteran population.

VA is tracking African-American veterans' utilization of special PTSD and Readjustment Counseling Programs. The Chief Medical Director's Special Committee on PTSD conducted a survey of inpatient PTSD units in the spring of 1993 which showed that approximately 19.8 percent of inpatients were African-American. Previous surveys have shown that 17 percent of veterans seen in special outpatient PTSD programs are African-American and about 24 percent of Vietnam theatre veterans seen in Vet Centers are African-American. These findings are consistent with VA-wide experience. African-American veterans account for approximately 20 percent of the patients treated in all VA medical centers. This is noteworthy given the fact that 8.6 percent of all veterans are African-Americans and African-Americans as a whole account for 12 percent of the U.S. population. A study by VA's Northeast Program Evaluation Center led by Dr. Robert Rosenheck, which included World War II and Korean era veterans, found that African-American veterans are more likely to use VA health care services even after influences of income, receipt of VA benefits, and health status have been taken into consideration.

We intend to continue studying the needs of African-American veterans with PTSD to determine how those needs can best be met. The National Center for PTSD is developing a proposal to apply the methodologies developed in the epidemiologic study of PTSD in Native American, Native Hawaiian and Asian Pacific Islander Vietnam veterans to achieve a better understanding of PTSD in African-American and Hispanic veterans. The goal of this new study is to design more ethnically sensitive and, therefore, better assessment tools, diagnostic strategies, and treatment approaches.

VA has also paid special attention to the large numbers of homeless African-American veterans, in designing its special programs for homeless veterans. African-Americans make up 40 percent of the more than 70,000 homeless veterans treated in the VA's special homeless veterans programs. The problems faced by African-American homeless veterans are quite similar to those faced by other homeless veterans although African-Americans are generally younger and more likely to have problems with drug abuse, but less likely to have severe psychiatric problems.

Since the early 1980s, the Readjustment Counseling Service (RCS) has had in place eight special population working groups, each composed of several Vet Center staff representatives. Several factors prompted formation of the working groups, including the need to improve recruitment and retention of staff from special populations and the need to assure adequate outreach and counseling services to these identified groups. The RCS African-American Veterans Working Group, has been in existence since 1983. The Working Group provides educational workshops to other Vet Center staff, develops recruitment strategies, and serves as consultants regarding outreach and counseling methods specific to the needs of African-American veterans. A meeting of the Working Group is scheduled this week to facilitate the Working Group's participation in the agenda of the Congressional Black Caucus. In addition to the direct contribution of the Working Group, many articles by Vet Center staff on African-American veterans have been featured in the Vet Center publication, the VOICE, over the years. Regarding recruitment, RCS field staff maintain a booth at the national annual conferences of African-American social workers and psychologists to network with professionals, attend educational sessions, and to provide programmatic and career related information.

The Readjustment Counseling Service is currently carrying out, in collaboration with VA's National Center for PTSD, a prospective study on a sample of new Persian Gulf veteran cases being seen at 82 Vet Centers. This study will produce valuable data for assessing, in the years ahead, the impact of wartime duty on readjustment and other aspects of psychological functioning. This is the first prospective study on war veterans' readjustment ever carried out by VA.

In the initial phase (from October 15, 1991, to April 15, 1992), the Persian Gulf veteran survey was disseminated through 82 Vet Centers nationwide, to include Hawaii, Alaska, and Puerto Rico. The overall PTSD prevalence for this initial sample was 11.5 percent. Seventeen percent of the veterans represented in the initial sample were African-American. Upon completion of all three phases of the study, data to be reported will contain useful information regarding PTSD in African-American, Persian Gulf veterans.

Since May 1990, RCS has operated a Vet Center outstation in Harlem administratively connected to the Manhattan Vet Center. This outstation facility has become overloaded with increasing demands for services from a predominately minority veteran population previously underserved by existing VA facilities. As a result, VHA has authorized a full four-person Vet Center to be located in Harlem. It is anticipated that this Vet Center will be fully staffed and moved to a new community-based site during the first half of FY 94.

Mr. Chairman, we are proud of the accomplishments of our Vet Center and special PTSD treatment programs in treating veterans suffering with PTSD. The data shows that African-American veterans utilize these programs in proportionally greater numbers than white veterans. There have been ongoing efforts for many years to recruit minority professional staff to work in these programs and to train all staff to recognize the importance of cultural differences when treating minority veterans. Dr. Rosenheck has outlined several initiatives that the National Center for PTSD is undertaking to further study the influence of cultural differences with the goal of improving treatment approaches to African-American veterans.

This concludes my testimony. My colleagues and I will be pleased to respond to the Committee's questions.

**THE EPIDEMIOLOGY OF POST-TRAUMATIC STRESS DISORDER
AMONG MALE AFRICAN-AMERICAN VETERANS
OF THE VIETNAM WAR**

Submitted to the U.S. House of Representatives
Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations
as Testimony for a Public Hearing on
African-American Veterans and Community:
Post-Traumatic Stress Disorder and Related Issues

John A. Fairbank, Ph.D.
William E. Schlenger, Ph.D.

Research Triangle Institute
Research Triangle Park, N.C.

September 15, 1993

A. Purpose

This written statement was prepared in response to Representative Lane Evans' letter of August 16, 1993, inviting the preparation of a statement for the record for a public hearing on African-American Veterans and Community: Post-Traumatic Stress Disorder (PTSD) and Related Issues to be held by the House Veterans' Affairs Subcommittee on Oversight and Investigations. As agreed in conversations with Committee staff, this written testimony will focus on summarizing findings from the National Vietnam Veterans Readjustment Study concerning the prevalence of and risk factors for PTSD among African-American male veterans of the Vietnam war. The NVVRS is a nationally-representative, community-based study of Vietnam veterans that was conducted in response to a Congressional mandate in Public Law 98-160.

B. Background

In 1983, Congress mandated in Public Law 98-160 that a nationwide study be conducted to establish "the prevalence and incidence of post-traumatic stress disorder (PTSD) and other psychological problems in readjusting to civilian life" among Vietnam veterans. In September, 1984, based on a peer-reviewed, competitive bid process, the Veterans Administration awarded a contract to conduct the mandated study to the Research Triangle Institute. The resulting study, which became known as the National Vietnam Veterans Readjustment Study (NVVRS), was designed and conducted by a multidisciplinary research team in collaboration with a large number of external collaborators, consultants, and colleagues. Four years later, in November 1988, the contractual report of findings from the NVVRS was submitted to Congress.

Two important aspects of the design of the NVVRS were: (1) that the sample of persons interviewed and assessed for PTSD be nationally representative of the population of Vietnam veterans, and (2) that the study sample contain a sufficient number of African-American Vietnam veterans to support estimates of PTSD and contrasts with other groups of interest (e.g., African-American civilians and veterans who did not serve in the Vietnam theater, veterans of other races and ethnicities). To date, the NVVRS provides the most comprehensive data base for examining the epidemiology of PTSD and other psychosocial problems and disorders among those who served in the Vietnam war, including African-American men. The NVVRS is the first large nationally-representative study of post-war adjustment among African-American men who served in the military during the Vietnam-era.

Another key distinguishing feature of the NVVRS is that it is the first national study of African-American male Vietnam veterans to use a comprehensive multimethod approach to assessing PTSD. PTSD prevalence estimates among Vietnam veterans were determined using an assessment battery consisting of state-of-the-art survey interview, psychometric, and clinical interview measures.

C. Statement

Of the 3.14 million men who served in Vietnam, Cambodia, or Laos during the Vietnam war, nearly 340,000 (10.8%) are African-American. In the NVVRS, we found that 20.6 percent of African-American male Vietnam veterans met diagnostic criteria for PTSD. By comparison, NVVRS findings indicate that the prevalence of current PTSD among white/other Vietnam veterans was 13.7 percent.

These findings mean that about one in five African-American men who served in Vietnam met the full criteria for current PTSD as described in the third edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. Thus in 1988--the year the NVVRS findings were reported to Congress, and 15 or more years after completing their service in the Vietnam war zone--an estimated 70,000 male African-American veterans of the Vietnam

war were found to be suffering from the symptoms of this disorder, as well as the adverse effects that having PTSD imposes on daily living. In addition, the prevalence of PTSD was significantly higher among African-American men than among white/others.

To illustrate how PTSD prevalence rates translate into individual human terms, the following case example was drawn from the sample of Vietnam theater veterans who participated in the NVVRS. Identifying characteristics (including initials) have been modified to protect the veteran's identity.

At the time of his participation in the interview, T.L. was a 38-year-old African-American male living in a primarily blue-collar, working-class suburb of a major city. He had worked for a municipal airport for nearly 15 years and he had been married to his second wife for more than 10 years. T.L.'s parents separated when he was 12 years old, and he and three siblings were raised by his mother in an inner-city neighborhood that he described as "rather poor." He indicated that his relationship with his mother was "good" and that there was no known history of mental illness in his family of origin. Soon after graduating from high school in 1967, he enlisted in the U.S. Marine Corps.

From early 1968 to early 1969, T.L. served with the Marine Corps in the Republic of Vietnam, primarily in the vicinity of the demilitarized zone (DMZ) between North and South Vietnam. He reported heavy combat exposure ("daily encounters with booby traps, a lot of fire fights"). At one point in the interview, T.L. described his experience in Vietnam in the following way. "It seemed like every time I turned around, someone was getting shot, or had a limb blown off, or their guts hanging out. There was nothing that you could do for them." He described one of many specific traumatic incidents in these words: "One time on a mission, a land mine exploded. Three guys were killed...blown up...guys on the ground, screaming." T.L.'s voice faded to a barely audible whisper as he described this event to the NVVRS interviewer.

T.L. reported that severe and persistent problems in daily functioning began within a few months of his return from Vietnam to the United States. From 1970 to the time of the NVVRS interview, he had experienced chronic severe symptoms of post-traumatic stress disorder, the impact of which he has attempted to mollify through alcohol use. He painfully acknowledged the continuing presence of distressing, intrusive memories of death and dying in the combat zone ("Sometimes my thoughts take me right back to what happened to guys there. I wish I could have helped them"). In a voice choked with emotion, he said that he currently attempts to avoid thoughts and reminders of Vietnam, but with little success. "I try (to avoid), but it's hard. In my job I deal with the public and it seems like someone or something is always bringing it up." He also clearly described several discrete episodes during which specific, intrusive traumatic memories of Vietnam overwhelmed his capacity to cope, precipitating what he described as "nervous breakdowns." These episodes were characterized by overwhelming pangs of guilt, shame, and despair related to traumatic war memories, persistent agitation and sleep disturbance, and desperate attempts to escape and avoid these memories through social withdrawal and alcohol use. During at least one of these periods of debilitating PTSD symptomatology, T.L. consulted his family physician, asking for medication for his unspecified nervous problem. At the time of the NVVRS interviews T.L. had not been under a physician's care for almost two years. Moreover, although at the time of the NVVRS interview T.L. was found to meet diagnostic criteria for severe combat-related PTSD, he had never sought help for PTSD and associated symptoms of distress from any mental health service provider or from the Department of Veterans Affairs.

In addition to describing the debilitating nature of PTSD per se, this clinical case example illustrates several other key findings from the NVVRS regarding the post-war adjustment of veterans with PTSD. One major finding was that veterans with a current diagnosis of PTSD have many other problems as well. In T.L.'s case this was illustrated most clearly by his concurrent heavy use of alcohol. In fact, the NVVRS found that co-occurring alcohol abuse was extremely prevalent among Vietnam veterans with PTSD. Nearly a quarter of the men with current PTSD also met DSM-III-R diagnostic criteria for current alcohol abuse or dependence. In comparison, among male Vietnam veterans without PTSD, fewer than 10% met criteria for current alcohol abuse or dependence. Thus, male Vietnam veterans with a current diagnosis of PTSD were more

than twice as likely to meet criteria for current alcohol abuse or dependence as their counterparts without PTSD. More broadly, however, NVVRS findings indicate the Vietnam veterans with PTSD are much more likely than those without to suffer from a broad spectrum of psychosocial and interpersonal deficits.

Thus the NVVRS findings demonstrate clearly that Vietnam veterans with PTSD have a broad range of treatment and service needs. Among male Vietnam veterans with PTSD, however, only about 62 percent reported that they have ever sought some form of post-military treatment for a mental health problem. When NVVRS data were analyzed in terms of whether male Vietnam veterans with PTSD were receiving current help, the results raised additional concerns about unmet need. Three quarters of those with current PTSD had not received any mental health care during the 12-month period prior to the interview. T.L.'s experience therefore appears to be somewhat typical in this respect. Although he received pharmacologic treatment for post-war emotional difficulties from his primary care physician nearly two years prior to the NVVRS interview, his current PTSD symptomatology was not being treated by a mental health professional or other provider.

The NVVRS is also an empirical source of information about the etiology of and risk factors for PTSD among African-American men who served in Vietnam. Our research team examined the contributions of a comprehensive set of pre-Vietnam exposure characteristics, and characteristics of the war experience, to the prevalence of PTSD among African-American, Hispanic, and white/other males who served in Vietnam. Findings of multivariate analyses with a set of over 80 preexposure characteristics that might have rendered a person more vulnerable to the development of PTSD indicated a relatively small but nonetheless statistically significant role for such characteristics, particularly those related to the person's socioeconomic status while growing up, the existence of psychiatric symptoms prior to exposure to war stress, and reported abuse during childhood. Additional analyses indicated a much larger role for the characteristics of the Vietnam war experience--that is, for what happened to the person while he was in Vietnam.

As noted above, NVVRS estimates indicate that 20.6 percent of African-American males who served in Vietnam met current diagnostic criteria for PTSD. Additionally, 27.9 percent of Hispanic Vietnam veterans and 13.7 percent of white/others were found to be current cases of PTSD. In an attempt to understand these differences, we conducted a series of multivariate analyses in which differences in PTSD prevalence rates for African-Americans, Hispanics, and white/others were adjusted for potential predisposing/risk factors and for extent of exposure to war zone stress. First, we adjusted for potential pre-military risk factors and found that this adjustment reduced substantially the current PTSD prevalence difference between African-American, Hispanic, and white/other Vietnam veterans. Next, we adjusted for potential predisposing factors and for exposure to war stress, and the difference in current PTSD prevalence between African-American and white/other Vietnam veterans became essentially insignificant. These findings lend strong support to the belief that higher PTSD prevalence rates among African-American male veterans (compared to whites/others) are to a large extent accounted for by higher levels of exposure to war stress in Vietnam, rather than by characteristics that the veterans brought with them to the war.

As helpful as these NVVRS findings are with respect to describing and explaining the prevalence of PTSD among African-American male Vietnam veterans, they provide but a narrow, incomplete glimpse at the overall picture. Though NVVRS findings are consistent with the conceptualization of PTSD as a chronic disorder, additional studies are needed to establish more clearly the course of combat-related PTSD. Also, NVVRS findings concerning treatment utilization indicate a need for additional studies to identify the factors that influence treatment-seeking among those with PTSD, and of treatment capacity and utilization within the DVA medical center and vet center systems. Such information is critical for decisions about treatment supply (i.e., are there enough treatment slots, the design of outreach programs (i.e., how can Vietnam veterans with PTSD be effectively encouraged to seek help), and the tailoring of those programs to the special needs of African-Americans.

LAWRENCE E. CURRIE, Ph.D., S.C.

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September 7, 1993

Lane Evans, Member of Congress
 Chairman, Subcommittee on Oversight
 and Investigations
 U.S. House of Representatives
 Committee On Veterans' Affairs
 335 Cannon House Office Building
 Washington, D.C. 20515

Dear Congressman Evans:

I regret that I will not be able to attend and prepare testimony for the House Veterans' Affairs Subcommittee on Oversight and Investigations public hearing scheduled for September 15, 1993. My current patient load and family responsibilities has found me pressed for available time to prepare and travel to and from Washington. I most certainly appreciate the invitation.

I would like to take this opportunity to share some feelings about the issue of "African-American Veterans and Community: Post Traumatic Stress Disorder and Related Issues" since nearly 50% of my patient load is comprised of combat veterans who served in Korea, Vietnam, and Desert Storm as psychologist consultant to the National Association for Black Veterans (NABVETS). Recently I was asked as a private practitioner who works with veterans to pose questions related Vet Center programming and the African American veteran in our communities. I framed these questions as follows:

1. In a proactive spirit, from what military and civilian databases can the Vet Center program draw upon to better plan services for African Americans returning from military service?
2. Are there military recruitment, service and discharge data collected in a reasonable form predictive particular civilian lifestyle difficulties of African American veterans available to the Vet Center program?
3. Are Vet Centers across the nation prepared to formulate specific programs of service to African American veteran men and women referencing health, mental health, educational/vocational, and community living (including safety and housing) issues?
4. In what form should the various Vet Centers make linkages to existing health, mental health, educational/vocational, and community living (including safety and housing) resources in their respective communities already dedicated to serving these particular needs of African Americans?
5. Can a format be developed for the Vet Center program to share its resources with the skills of African American health, mental health, educational/vocational, and community living (including safety and housing) professionals in various communities across the nation to more effectively address these particular needs of African American men and women veterans?
6. Would such linkages include database and professional resource sharing with state departments of veterans' affairs, the National Medical Association, the Association of Black Psychologist, the NAACP, and the Urban League (etc.) in a Vet Centers local community?

If I could testify, these questions would certainly be on my mind. In

bc

Congressman Evans

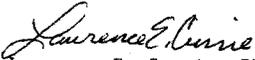
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addition, I believe the issue of Post-traumatic Stress Disorder(PTSD) and the African American veteran in the community has to major enveloping issues: (1)effective treatment programming for African American veteran men and women diagnosed with PTSD and (2) increasing evidence of PTSD as an outcome of violence in communities where many African American veteran men and women live. The questions I posed earlier are antecedents to the complex at-risk life of many African American veterans.

I hope that you find this communication helpful in some way as you conduct the public hearing on September 15, 1993.

Thank you for your consideration.

Sincerely,



Lawrence E. Currie, Ph.D.
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U. S. House of Representatives
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September 3, 1993

This statement is a summary of some of the issues I see pertaining to African American Veterans and Community: Post Traumatic Stress Disorder and Related Issues. I regret that I am unable to give a personal testimony at the hearing on Wednesday, September 15, 1993. However, I am very interested in issues concerning African American veterans and I have advocated for special outreach efforts to African American Veterans.

I am submitting a copy of my paper, "Clinical issues in a black veterans group" as my written testimony. This paper will demonstrate my intensive outreach effort to black veterans at the Veterans Outreach Center in Richmond, Virginia. The presence of a black veteran group has been a significant outreach effort to the black veteran population. This group has been very successful and effective as a way to connect with the African American population. The black veteran group has been an ongoing treatment option for approximately five years. Hence, the black veteran group has served as both an outreach method and treatment option for African American veterans. The presence of the black veteran group has helped the staff and other veterans to become more sensitive and aware of issues related to the African American veterans. The success of the group has promoted more positive feelings in the African American community about the Veterans Outreach Center's genuine interest in providing services to African American veterans.



GLORIA REID, L.C.S.W.
Licensed Clinical Social Worker

Clinical issues in a black veterans group

Here's an article detailing one Vet Center's history working with black combat veterans, including the resulting treatment perspective

by Gloria Reid

STATEMENT FROM THE TEAM LEADER

I encourage all Vet Center staff members to seriously consider the information in the following article. I strongly support a proactive look at your center's environment from a multicultural perspective. Our center made many efforts to counter retention problems with black veterans. Our efforts did not work until we, as a team, looked at and struggled with issues related to our own cultural diversity. I take great pride in our team's dedication to improving our center by improving ourselves as a team. The bottom line: retention of black veterans in treatment has nearly tripled since we began this journey.

—Daniel Doyle, Ph.D.

This article will focus on my clinical experience and feelings as a black, female, non-veteran counselor in a black veterans combat group in a predominantly white agency in a southern, conservative city. In spite of some of the obstacles in such a setting, I have found it exciting and challenging to work with this special group—black veterans. However, I will attempt to give both historical and treatment perspectives about issues leading to the establishment of a black veterans counseling group.

I would like to note that this article describes a working process in a Vet Center over a period of four years. The article is not a criticism of any Vet Center or

Readjustment Counseling Service. This is the experience of the staff and veterans of one Vet Center which had problems communicating and understanding racial issues. This Vet Center chose to confront this sensitive issue as a staff and then to convey what they learned to veterans. This process involved a stable staff which has been employed with the Vet Center from six to ten years. A black veterans group and a multicultural veterans group have evolved from four years of effort to establish a multicultural environment.

Staff at the Richmond, Virginia, Vet Center is comprised of a white Ph.D. psychologist who is a former combat soldier and officer; a white, Vietnam, noncombat veteran; a black non-veteran female counselor; a black office manager; and social work and psychology interns. The Vet Center client population was predominantly white and blue-collar before beginning this program.

This Vet Center acknowledged the need for more aggressive outreach to black veterans. However, the catalyst that moved the agency toward review of its approach to black veterans was a complaint from a black veteran client in January 1987. The client voiced his concerns to the Vet Center, local chapter of the NAACP and our regional manager. Specifically the veteran who wrote the letter had concerns about displaying posters and banners that, to him, glorified war and symbolized racism, further amplifying his perception of an inappropriate atmosphere in the Vet Center. This veteran also had support from another veteran who had a negative experience with the Vet Center. The two veterans and the author also ques-

tioned the validity of using the term "gook" in the center as a way to process Vietnam issues since it indicated racial insensitivity. The two veterans demanded the Vet Center increase its effort to change its treatment approach with black veterans and to encourage more sensitivity toward the issues of African American veterans.

Here is a summary of the Richmond Vet Center's experience with black veterans and staff. Prior to complaints from veterans, the staff had made the following observations: 1) the intake for black veterans was low, 2) black veterans did not remain as long in individual/group therapy, 3) the racial composition of the counseling group usually shifted whenever black veterans brought up the issue of racism—white veterans would leave the group feeling uncomfortable with discussion of racism and tending to deny racism in Vietnam. Black veterans would become alienated, experiencing the discomfort of white veterans when the black veterans wanted to process the impact of racism experienced in Vietnam. As a result, the group's composition would become either predominantly white or all black, 4) black and white veterans did not have a friendly relationship and black veterans did not participate regularly in agency activities (picnics, open houses) and, 5) staff members struggled with personal racial issues.

Early response to black veterans' complaints took the following form: 1) several attempts were made to establish a multicultural group, 2) staff members debated on how to engage black veterans in the group counseling process, 3) staff members realized they had to deal with their own racial issues before making any attempt to establish a multicultural or black combat group, 4) Vet Center staff saw a need to process racial issues in a predominantly white group before black and white veterans could participate in a multicultural group, 5) the author recommended a black combat group after several clinical meetings about the most appropriate way to outreach black veterans. This recommendation was based on the observation that too many unresolved racial issues existed between black and white veterans. As a result of the recommendation to establish a black veterans combat group, some white veterans in the agency opposed the idea, feeling that black veterans were receiving special attention. Also, the team leader was experiencing some anxiety and pressure from white veterans. He did not want to jeopardize his professional relationship as a therapist and leader. Hence, I was experiencing some conflict in terms of my role as therapist, an advocate for clients and an employee for the agency, 6) staff recognized the need for intervention by regional management and consultants who specialized in multicultural issues.

Three events took place: 1) a consultant was hired temporarily to give direct service to clients and staff, 2) a community advisory panel consisting of staff,

consultants and black veterans was established by the Vet Center and, 3) consultants and regional managers met with our staff and black veterans to discuss black veterans' issues and help staff identify racial issues while developing a plan of action to rectify deficiencies.

By summer 1987 a multicultural group met on a trial basis for one cycle, facilitated by a white and a black therapist. Meanwhile, attempts were being made to increase black veterans' participation in the predominantly white group. The group already had two black veterans and several white veterans. However, it was difficult to recruit other black veterans for this core group. The Vet Center was unable to establish another multicultural group. Co-facilitators of the last multicultural group were not available for another cycle. Also, there were still some racial issues that seemed to be a hindrance to conducting another multicultural group. Hence, it was the Vet Center's decision to start a black veterans psychotherapy group and to increase outreach efforts to black veterans.

WHY A BLACK VETERANS COMBAT GROUP?

When we look at the meaning of the group experience and the significance of a veterans combat group, we find group experience provides people who share similar issues with an opportunity to look at maladaptive behavior, developing ways to restore functioning to an optimal level. This experience gives people the opportunity to express feelings in interaction with others. Group members may improve and develop interpersonal skills needed for daily living.

According to J. Michael Jelinck, "The Vietnam veteran's therapy group is a peer group. It is a supportive therapeutic milieu where the individual can present, explore, test and resolve the emotional and cognitive after effects that stem from traumatic warlike experience."¹

Vietnam veterans look at conflicts from the perspective of their experience which may impair functioning at all levels. A group experience helps them deal with guilt and shame.²

WHAT'S DIFFERENT ABOUT BLACK VIETNAM VETERANS?

Black Vietnam veterans have the same conflicts about traumatic experiences as their peers. However, black veterans also have racism which is an element white veterans didn't have to contend with in Vietnam or at home. According to Erwin Parson, "The readjustment problems of black Vietnam veterans is a tripartite adaptation dilemma."³

Further, Parson stated that the readjustment struggle of black veterans can be assessed by mental health professionals in three areas which compose the tripartite adaptation dilemma.

continues

Parson listed the following areas: "1) surviving the potential fragmenting 'lug of war' of an acquired dual identity; being both African by heritage and white American by sociopsychologic conditioning (the bicultural identity or bicultural/cultural ego factor), 2) surviving as a member of a kinship of men and women who are despised and discriminated against by American society for being descendants of African American slaves—the racialism/racism factor and, 3) surviving Vietnam combat trauma and reacting to it—the residual stress factor."⁴

In support of the "Triple Survivor Theory," Parson has indicated if the therapist is not black he or she must acquire knowledge of black culture in order to be effective. Non-veterans must have some understanding of Vietnam trauma. Parson suggests the therapist must have "transracial competency and transexperiential competency" in working with black veterans.

The therapist also must have an understanding of other readjustment problems such as psychic, social, vocational and academic functioning.⁵

THE BLACK GROUP

The structure of our black veterans group followed Yalom's model as much as possible.⁶ The purpose of the combat group was to help black veterans deal with Vietnam trauma issues, racism and factors affecting social, psychological and vocational functioning. The presence of this group refuted the myth that black veterans could not benefit from group therapy. Black veterans had the opportunity to develop trust in the group process and talk about feelings related to anger, shame, rejection and disappointment.

The core group consisted of clients who were in individual psychotherapy. Some had short-term involvement in the predominantly white group. A few men had a long history with the agency but were not involved actively in psychotherapy. The core group consisted of seven men with an array of problems.

The group initially was co-led by myself—a non-veteran black female—and a black Vietnam era veteran and social worker from the spinal cord unit at the local Department of Veterans Affairs medical center. The group accepted my non-veteran status; most group members had some knowledge of my experience with veterans as well as my role as an advocate for the black veteran group.

Also, I had several group members as individual

The presence of this group refuted the myth that black veterans could not benefit from group therapy

clients and often had been a co-group leader in the predominantly white groups which occasionally included black veterans.

The sessions started as an open group with a nine week cycle. Group rules forbade verbal or physical abuse and required adherence to confidentiality, a significant issue for black veterans.

Initially, it was difficult to develop group cohesiveness because of sporadic attendance. Even though some of the men knew each other informally through the agency, group members seemed to need

an enormous amount of time before they could disclose information about themselves, developing trust and confronting one another.⁷

Contrary to what one might expect, I was not discouraged by a slow response from veterans because most of these men never established close relationship or bonded with other men in their lives. Instead, they experienced isolation and fear of sharing feelings, developing major interpersonal problems. Also, I anticipated some therapeutic testing by clients because they perceived rejection by the system. As a full-time staff member, I often extended myself by making contact with group members via telephone and written correspondence expressing sincere interest in their whereabouts when they were absent from the group. From the beginning it was clear that the group must have an open door policy. It would be anti-therapeutic to have closed group policy with black veterans for several reasons. Primarily these veterans were expecting the agency to use rigid group rules to keep them out of the process. Therefore, group leaders had to be flexible about group membership. The group jelled after four months.

During the first cycle the group members' focus centered around pent up emotions related to racism in Vietnam, in the workplace and other areas. The group appeared to be more comfortable talking about non-threatening issues which avoided discussing feelings. However, it was significant that black veterans had a safe place in the Vet Center to talk about racial issues. Gradually the group focused on other themes such as frustration with jobs, inability to control anger, substance abuse, losses in Vietnam, problems with intimacy, and lack of support for posttraumatic stress disorder disability claims. An increased comfort level could be observed in terms of interaction among group members as they developed a greater level of trust in confronting one another, occasionally challenging

group leaders' ability to relate to their issues (for example, my being female and a non-veteran).

Meanwhile there was tension building in the Vet Center about the presence of a black veterans group. I seemed to be serving as an advocate for the black veterans group rather than an advocate for the staff. White veterans began to raise questions about whether black veterans were receiving special treatment. I wondered why white veterans didn't suddenly question the absence of black veterans in the all-white group. White veterans wanted to know why so much attention was given to black veterans who were receiving the same services. This issue caused the surfacing of some tension among staff. As I advocated strongly for the black group, there was some parallel discussion by the team leader about integrating the groups.

The issue was brought to a head by a racist outburst instigated by an intoxicated white veteran on the evening scheduled for all regular group therapy meetings. The white veteran was displacing anger on the agency because of an incident with a black female clerk at the VA medical center. He uttered racial slurs about black women and blacks in general. He also was inappropriate in his interaction with a white female psychology intern and harassed the only black veteran in his treatment group which resulted in the black veteran leaving to join the black group.

The team leader's intervention resulted in some violent acting out, with the drunk white veteran throwing several chairs and manhandling the team leader. With the support of staff, the team leader decided the white veteran would be asked to complete an alcohol treatment program before he would be allowed to rejoin the group. He also was asked to make an apology to staff, veterans and volunteers. The team leader sent an official written response to all veteran clients regarding his actions. The letter stated two major requirements, an apology from the veteran and alcohol treatment within a specified timeframe. The team leader's action divided white veterans.

A core group of white veterans, who had been clients for years, left the Vet Center in protest. They decided to establish their own informal group at a Gold Star Mother's home.

Black veterans were satisfied with the action implemented by the Vet Center regarding the racial incident. Their stance was that they wouldn't tolerate any physical confrontation, and the group focused attention on racism in the system. For example, they wondered how the Vet Center would manage an acting-out black veteran in a similar situation. Would a black veteran be given the same chance for treatment and be allowed to return for services? Black veterans didn't perceive the team leader's response to this incident any different than what happens in society. Society has always had two sets of rules, reiterating a feeling of inequality in the

system. It seemed to them that the system was justifying a white veteran's behavior.

Group leaders worked hard with group members to work through clients' anger. During subsequent meetings, group cohesiveness increased and black veterans seemed determined to establish their place in the Vet Center. One could sense a protective bond was forming among the black veterans. Black veterans participated for the first time in a Vet Center activity (picnic) a month after the incident. This event was significant since black veterans did not usually participate in open house programs, picnics or other Vet Center functions.

As the group moved to the second group cycle, I still had to make telephone contacts and send correspondence to remind black veterans to return to group. A white psychology intern was interviewed as a possible co-facilitator and group membership was growing gradually. The possible introduction of a white co-leader meant I had to contend with counter-transference issues. I had some anxiety about this major change because the veterans group was my "baby." I had struggled so hard to keep these men together—it had been only two or three months since the racial incident—I didn't want to risk disrupting the group process. The introduction of a white intern to replace the departing black co-leader was proposed by the team leader. This generated some suspicion: Was the white psychology intern going to be there to report on group activities for the Vet Center?; Was this a subtle way to sabotage the group?; Could the intern deal with the intensity of the group and the discussion of racism?; Would the group have to control what it said in the presence of the white intern?

The staff processed these issues together and took the proposed changes to the group. We decided to empower the group to make some decisions about the group's direction. Black veterans decided the white intern would be given a trial run as a co-group leader. However, they did not want to feel inhibited by the presence of the new co-leader. They wanted continuation of openness, no violation of confidentiality, and sensitivity to their cultural differences. Hence, the black veterans group had a white co-leader for the first time. The black male co-leader left the group a few months later and the group seemed to make a good adjustment to all major changes.

However, shortly after the white psychology intern became co-leader, and about three weeks prior to ending the group cycle, the team leader approached the group again about starting a multicultural group. He suggested the transfer of some of the older group members to the predominantly white group. Group members experienced some anxiety about this proposed change. Another major change occurred when the black male co-leader made his announcement about leaving the group. Although the team leader stressed that a

see GROUP, p

**GROUP,
from p. 9**

**The black
veterans
combat
group has
been an
integral part
of the
Vet Center
for four
years**

black veterans group would continue to be part of the Vet Center program, this did not alleviate the tension that was building in the black veterans group. The group had accepted a new co-leader but was feeling unsettled about members being transferred to a multicultural group at the end of the cycle.

Following the Christmas break, it became evident that the group was having difficulty starting its new cycle. Several members were experiencing family and substance abuse problems, and it was almost the middle of the cycle before the veterans were able to start working again as a group. By this time I had observed closely my role in the group process. I had expended a great deal of energy to reach out to veterans, holding their interest and, for the first time, I confronted group members about unstable attendance patterns and individuals' inability to follow through with commitment to the group. It occurred to me that the group experience was feeling like a parent-child relationship. After exploring how members related to significant others in their personal relationships, I informed the group that they would be given responsibility for contacting absentee members. I further stated that I would relinquish my role as "Mother," giving them responsibility for maintaining the group.

CONCLUSION

The black veterans combat group has been an integral part of the Vet Center for four years after dealing with many changes including confrontation of the above issues. It has been my continuous observation that this group has the strong ability to adapt to changes, any one of which might have meant the destruction of the group in my prior experience. The membership of the black combat group changed after four years. Some of the core members chose to participate in a multicultural group. The team leader started a multicultural group after observing more positive interaction among all veterans. However, the black combat group has continued to be a significant part of our Vet Center as a way to outreach black veterans and to engage them more readily in therapy. I continue to be proud of the significant growth made by group members in spite of obstacles.

Finally, it has been encouraging to witness the openness of the team leader and Vet Center staff to my confrontation of Vet Center cultural issues. Being the only black professional on staff made this a struggle at times, but the growth and strength of the black veterans group have made it a worthwhile struggle.

RECOMMENDATIONS

Based on my work with our black combat veterans group, I recommend that mental health professionals be sensitive to the following issues: 1) black veterans work best with an open door policy—a closed group seems too rigid and can be viewed by this client population as rejection, 2) therapists must use more energy for outreach to these clients than is typical with other popu-

lations, 3) more effort seems necessary to help black veterans use the group as a support system, 4) therapists need to learn the veterans' language and not assume that being of the same culture will enable them to be effective, 5) group leaders must understand the significance of members dropping in and out of group as a control issue among black veterans, 6) group leaders must empower black veterans to deal with issues and assign them responsibility for change in the group process, 7) along with the last suggestion, it is important that group leaders know when it is safe to make black veterans accountable in the group process (e.g., group leaders must establish client boundaries and be aware of leaders' roles in the group process) and, 8) seek support from the team leader, other team members and RCS regional management for open communication among staff regarding racial/cultural issues. ■

Gloria Reid, L.C.S.W., is a counselor at the Vet Center in Richmond, Virginia.

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- ⁵*Ibid.*, pp. 361-369.
- ⁶Irvin Yalom, *The Theory and Practice of Group Psychotherapy*, Basic Books, Inc., New York, N.Y.
- ⁷*Ibid.*

Voice

Our 13th year, 1979-1992

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November 27, 1992

Congressman Lane Evans
1121 Longworth House Office Bldg
Washington, D.C. 20515-1317

Dear Congressman Evans:

As Chairman of the House Veterans Affairs subcommittee on Oversight and Investigations, you, along with Representatives John Bryant and Pete Geren were scheduled to conduct hearings in Dallas a few years ago regarding the activities and operations of the Dallas VA Medical Center. Unfortunately, the outbreak of Desert Sword/Storm precluded your attendance, and thus the conduct of the official hearing.

Now, perhaps more than ever, an investigation of the negligence, malpractice, medical incompetence, chicanery, and gross insensitivity that pervades the Dallas VA Medical Center demands justice and redress by your subcommittee.

Notwithstanding at least three other cases involving other veterans and the Dallas VA Medical Center, who are prepared to testify, I beg to share with you hereon my personal experience. As a committee chair (appointed) of the Black Congressional Caucus Veteran Brain Trust, I had just returned from California following my testimony before Maxine Waters at the Western Regional Mid Conference Black Caucus. On March 19, 1992 I entered the Dallas VA Hospital for my weekly PTSD counseling session with my Psychologist of six years, Dr. Jack Fudge.

I explained to Dr. Fudge that I was going to the emergency room for the removal of a very painful boil that I had arisen on my butt. I have had these boils before, but had never before sought treatment at the VA for this minor procedure. Congressman Evans, it is worth mentioning to you, that up to this time, my relationship and rapport with the Dallas VA Medical Center and its staff had been positive and amicable, although many of my veteran friends were experiencing serious problems.

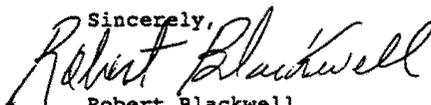
Little did I know or realize, that the lancing of a boil by the Dallas VA would nearly be fatal, put me in a coma, cause permanent damage to my lung, and inflict incalculable

mental anguish upon me, my wife and my mother. Since suffering at the hands of these medical incompetents, the Dallas VA has lied, deceived, covered up, falsified records and signatures, and removed many of my medical records in an effort to obstruct justice. These matters I, of course, will seek to remedy under the law in a federal court.

Congressman Evans, for the sake of other veterans who have been, and are continuing to be killed, injured, and mentally damaged by a broken and dangerous health system for veterans, I implore you and the Texas members of the House Veteran Affairs Committee to conduct an investigation and hearings with regard to the Dallas VA Medical Center. You would do well to include the Houston and San Antonio Medical Centers as well, as the horror stories emerging from these cities are no less compelling than those in the Dallas - Ft. Worth area.

I am enclosing some of my medical records and the names of some fellow veterans who are willing to provide their stories. As the POW-MIA Committee Chair of the Congressional Black Caucus Veteran Brain Trust and a member of several organizations including the DAV, VFW, VVA and the American Legion I urge you and your subcommittee to act on this matter of utmost importance.

Sincerely,



Robert Blackwell
P.O. Box 4403
Tyler, Texas 75712
Phone: (903) 852-3818

cc: Representative Maxine Waters
Representative Eddie Bernice Johnson
Representative Frank Tejeda
Representative Pete Geren
Representative Martin Frost

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

QUESTIONS SUBMITTED BY
HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS

AFRICAN-AMERICAN VETERANS AND COMMUNITY:
POST-TRAUMATIC STRESS DISORDER AND RELATED ISSUES

SEPTEMBER 15, 1993

QUESTIONS FOR DR. DAVID LAW
ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR
FOR CLINICAL PROGRAMS
DEPARTMENT OF VETERANS AFFAIRS

- Question 1: What percent of African-American Vietnam veterans with PTSD have not sought treatment for a mental health problem from VA?
- Answer: The National Vietnam Veterans Readjustment Study (NVVRS) did not break out mental health services by race specifically for veterans with PTSD. However, for veterans with high war zone exposure, 82 percent of African-Americans had not sought mental health treatment from VA at the time of the survey.
- Question 1a: What factors are believed to be most responsible for African-American veterans with PTSD not seeking treatment for a mental health problem from VA?
- Answer: The predominant reason offered in the NVVRS by African-American veterans for not seeking mental health treatment for an emotional problem was that the veteran felt that he could handle the problem on his own. Current program evaluation studies show that African-American veterans do use VA health care services, including mental health services; in fact, they use these services proportionately more than their white counterparts.
- Question 1b: How can African-American Vietnam veterans with PTSD who have not sought treatment for a mental health problem from VA be encouraged to seek this treatment from VA or another provider?
- Answer: Public information and education regarding the availability of specialized services for PTSD and clinical outreach by VA staff are two possible actions, both of which are currently in use by VA. Another method used by VA is location of clinical programs in areas with significant populations of African-American veterans to enhance access to PTSD services. While 16 percent of veterans seen in VA's specialized outpatient PTSD Clinical Teams (PCTs) nationally are African-American, several PCTs located in areas with high African-American populations have a significantly higher African-American patient population. Chicago (West Side) has 65 percent African-American patients; New Orleans 47 percent; Hampton 46 percent, and Philadelphia 45 percent.

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HONORABLE LANE EVANS

Question 2: According to the statement submitted by Dr. Law, "We recognize that there are unique factors affecting African-American veterans with PTSD, and we are committed to providing necessary and appropriate treatment to them.

Please identify the "unique factors" affecting African-American veterans with PTSD.

Answer: Each racial, ethnic and cultural group has a different set of life experiences. Minorities in general experience higher rates of poverty, lower education, and ethnic discrimination. Experiences such as racial discrimination can be experienced by all minority groups and this was certainly a feature of the military environment faced by African-Americans during the Vietnam War. Among the factors significant to African-Americans with PTSD identified by our evaluation of PTSD programs is the fact that they are less well off than other groups of veterans in many respects. They were the least likely of all groups to be married, had the lowest incomes and the highest rates of alcohol and drug abuse. They reported a greater need for help with financial support, employment, and alcohol and other substance abuse. These are issues that represent either clinical complications of PTSD (e.g. substance abuse) or other factors (e.g. lack of financial support) that make the successful adjustment of the veteran with PTSD more difficult. The impetus for the anticipated National Center for PTSD's study of clinical needs of African-American veterans with PTSD stems from the desire to further clarify factors affecting African-American veterans with this disorder.

Question 2a: Discuss the effect of these unique factors on the treatment provided by VA.

Answer: The primary effect is the impetus to match treatment with the needs of the individual patient. Our program evaluation shows that African-American veterans make greater use of the substance abuse treatment offered in our PTSD programs. Similarly, the evaluation showed greater use of vocational counseling services by African-American veterans. These statistics show that VA is offering services to our African-American veterans with PTSD that are most relevant to their self-identified needs, and that the veterans are using these services.

Question 3: Identify VA PTSD treatment programs which have been tailored to be responsive to the special needs of African-American veterans and explain how these programs have been tailored to be responsive to the special needs of African-American veterans.

Answer: Some of the specialized PTSD programs have developed groups or modules for African-American veterans. These groups/modules deal specifically with the veterans' own experiences of racial discrimination in American society as a whole and with racial tensions within the specialized program itself. The PTSD programs at VA Medical Centers Jackson and Hampton have specific

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HONORABLE LANE EVANS

program tracks for African-American veteran issues, and the San Diego program is developing such a track. The North Chicago program is working on a manual for addressing racial tensions in the course of clinical work with veterans. The PTSD programs at Boston, Honolulu and San Francisco also regularly address these issues.

Question 3a: Has VA established a specialized PTSD unit to treat African-American veterans? Please identify the expected benefits of establishing such a unit.

Answer: There is no specialized unit for treatment of African-American veterans with PTSD, nor are there any plans to establish one. While it might appear that a program uniquely for African-American veterans would be particularly attuned to the needs and issues of African-American veterans, we believe that racially segregated treatment programs would be counter-productive. The military which our veterans have served, and the society in which they live have all races, living together, and our treatment settings should reflect that. It is preferable to develop the racial sensitivities of our staff and to recognize the significance of racial and ethnic diversity as it effects treatment across all of our programs.

It should be noted that siting treatment programs in areas with a high African-American population density, as VA does, results in a higher population of African-American patients being served in certain facilities. This is very different from creating an "African-Americans only" program, that would probably require a significant proportion of the patients treated to travel away from their home communities for care.

Question 3b: What additional actions could VA take to tailor PTSD treatment programs to the special needs of African-American veterans?

Answer: Additional actions could include promoting and expanding the availability of treatment groups and modules such as those noted in response to Question 3 (above) at other specialized programs, and fostering the education of clinicians regarding issues of racial significance as they arise in mental health programs. Also, as the National Center study is carried out, diagnostic and treatment approaches particularly useful for African-American patients will be identified and implemented.

Question 4: In testimony before the Subcommittee earlier this year, Dr. Jonathan Shay reported, "that most combat veterans with 'bad paper' committed infractions as a result of psychological injuries incurred in their combat service."

Please explain why you agree or disagree with this statement.

Answer: Many clinicians have reported impressions similar to those expressed by Dr. Shay. We know of no empirical data; however, that substantiates these impressions. We are also aware that Vet Centers have often assisted veterans to upgrade their "bad paper" discharges.

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HONORABLE LANE EVANS

Question 5: What actions could be taken to make VA facilities and service providers more sensitive to cultural diversity among veterans?

Answer: The following actions could be taken to make VA facilities and service providers more sensitive to cultural diversity among veterans:

- Continue pro-active measures to broaden the cultural, racial, ethnic, and gender diversity of the Agency's workforce to ensure it reflects the composition of the veteran population, and recognizes and supports the varying needs of these individuals.
- Provide periodic free health screening to target conditions that are prevalent within the African-American veteran population, i.e., hypertension, sickle cell anemia, and cancer.
- Provide information that promotes preventive health care and wellness for African-American and other ethnic group veterans
- Provide an atmosphere where veterans can feel comfortable and respected within the hospital setting.
- Train facility personnel and providers to value diversity and group norms and also to appreciate cultural differences.

**HONORABLE TOM RIDGE
QUESTIONS SUBMITTED FOR RECORD
DR. DAVID LAW, ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR
FOR CLINICAL PROGRAMS
DEPARTMENT OF VETERANS AFFAIRS
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS**

**AFRICAN-AMERICAN VETERANS AND COMMUNITY:
POST-TRAUMATIC STRESS DISORDER AND RELATED ISSUES**

SEPTEMBER 15, 1993

- Question 1: You mention in your testimony that there are unique factors affecting African-American veterans with PTSD. What are these factors and how do they affect the treatment of African-American veterans?
- Answer: Each racial, ethnic and cultural group has a different set of life experiences. Minorities in general experience higher rates of poverty, lower education, and ethnic discrimination. Experiences such as racial discrimination can be experienced by all minority groups and this was certainly a feature of the military environment faced by African-Americans during the Vietnam War. Among the factors significant to African-Americans with PTSD identified by our evaluation of PTSD programs is the fact that they are less well off than other groups of veterans in many respects. They were the least likely of all groups to be married, had the lowest incomes and the highest rates of alcohol and drug abuse. They reported a greater need for help with financial support, employment, and alcohol and other substance abuse. These are issues that represent either clinical complications of PTSD (e.g. substance abuse) or other factors (e.g. lack of financial support) that make the successful adjustment of the veteran with PTSD more difficult. The impetus for the anticipated National Center for PTSD's study of clinical needs of African-American veterans with PTSD stems from the desire to further clarify factors affecting African-American veterans with this disorder.
- Question 2: What percent of current VA health care funding is dedicated to treatment of PTSD? Has VA received increases in its PTSD funding over the last five years? What has been the effect of such increases? Please be specific regarding the increases in the number of veterans treated, increase in the encumber of specialized treatment units, etc.
- Answer: As of FY 1992, VA Mental Health and Behavioral Sciences Services has \$39,980,352 (roughly 2 percent of the \$2 billion mental health budget) specifically allocated for PTSD services. It should be noted that PTSD care is also provided in general psychiatry inpatient and outpatient programs in addition to the units funded by these appropriations. Other services related to veterans with PTSD include Readjustment Counseling Service and aspects of Veterans Benefits Service. These, along with mental health's budget, are part of the overall VA budget of \$120 billion.

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Most of the mental health PTSD budget has been received since FY 1989. These funds have been used to establish a network of inpatient and outpatient units designed to provide a continuum of care for PTSD. With the inclusion of funds from FY 1993 and those anticipated in FY 1994, the PTSD programs will include 24 Specialized Inpatient PTSD Units; 14 Evaluation and Brief Treatment PTSD Units; 12 PTSD Residential Rehabilitation Programs and 74 PTSD Clinical Teams (outpatient programs). In FY 1992 there were 18,973 discharges from inpatient services with a primary diagnosis of PTSD. This represents approximately 12,650 individuals treated, and was an increase from 17,751 discharges in FY 1991. In FY 1984 there were only 5,377 individuals with a primary diagnosis treated in VA inpatient services. Outpatient treatment has only been monitored for PTSD by diagnosis in the last several years. In FY 1992, there were 156,934 visits for PTSD to PTSD Clinical Teams (PCTs), and 130,463 visits to non-PCT outpatient care. These figures represent an increase from FY 1991 when the PCT visits for PTSD were 100,264 and the non-PCT visits were 92,306.

Question 3: Your testimony identifies a special population working group known as the Readjustment Counseling Service African-American Veterans. What have been the recommendations of this group in the past and what, if any, of their recommendations have yet to be implemented by the Department?

Answer: The attached fact sheet includes a list of all the recommendations submitted by the Readjustment Counseling Service (RCS) Working Group on African-American Veterans. Each recommendation also includes VA's response regarding action taken and current status. With particular reference to RCS, these recommendations have been long-implemented and represent permanent policy and standard practice subject to ongoing clinical and administrative review by management.

ATTACHMENT TO QUESTION #3
(HONORABLE TOM RIDGE)

DEPARTMENT OF VETERANS AFFAIRS
VETERANS HEALTH ADMINISTRATION

Recommendations Submitted by the
Readjustment Counseling Service
Working Group
on African-American Veterans

ISSUE: Veterans Health Administration (VHA) responses to the recommendations submitted by the referenced Working Group in its 1983 report. This information is requested by Congressman Tom Ridge in follow-up to a hearing conducted on September 15, 1993 by the House Committee on Veterans' Affairs in conjunction with the meeting of the Congressional Black Caucus.

DISCUSSION: The statements below pertain to specific issues related to VHA implementation of these recommendations.

RECOMMENDATION NO. 1: Conduct active recruitment of qualified African-Americans for all Vet Center staff (i.e., Team Leaders, Counselors, and Office Managers as openings occur). This is important, especially in areas where there is a high density of African-American Vietnam veterans.

RESPONSE: Done; permanent and ongoing. Recruitment of qualified African-American candidates for all levels of the Readjustment Counseling Service (RCS) staffing is an ongoing and permanent policy of the RCS. Ethnic minority veteran representation on Vet Center teams is specifically referenced in the Department of Veterans Affairs, Veterans Health Administration Manual, M-12, "Readjustment Counseling Service Vet Centers", Part 1, "Administrative Operations," Chapter 2.

In addition to the ongoing efforts of Vet Center team leaders and RCS managers, the members of the RCS African-American Veterans Working Group also provide assistance in locating and recruiting qualified African-American staff. In addition, RCS field staff engage in numerous recruiting activities to include maintaining booths at national annual conferences of African-American social workers and psychologists to network with fellow professionals, attend educational sessions and to provide programmatic and career related information to interested attendees.

RECOMMENDATION NO. 2: Promote and retain current African-American Vet Center staff by systematic provisions for special educational scholarship programs that lead toward professional development in the fields of social work, rehabilitation counseling, nursing, psychology, psychiatry, health care planning and hospital administration.

RESPONSE: The issue of scholarships for professional training of staff are predominately a matter for Congressional action and determination. It is possible, however, for VA to request programs and funds of Congress through the annual legislative initiative process for this purpose. To date, no such requests have been initiated for RCS field staff due to other competing budget priorities. Nonetheless, RCS has supported and promoted staff development for many staff through flexible work schedules, etc., to pursue their own graduate

education in professional Social Work and related fields. Also relevant is the fact that staff retention is not a problem for RCS. Having an annual turnover rate of approximately 9 percent, retention of staff in RCS compares favorably to VHA generally.

RECOMMENDATION NO. 3: Ensure access to readjustment counseling by systematic outstationing of culturally sensitive Vet Center staff in communities of high African-American density.

RESPONSE: Implemented. Vet Center's outstation staff, for the delivery of services at a distance from an existing Vet Center usually in locally donated space, to the extent feasible given current resources and other competing logistical and clinical demands of the Vet Center's catchment area. Vet Center team leaders and RCS regional managers remain open to input from various community and Congressional elements, and its own staff and Working Group members as to where additional outstationing may be needed. The use of Vet Center outstations is an ongoing RCS policy for strategic siting of service delivery personnel in areas where veterans' needs for the services have remained to some degree unmet due to distance from existing Vet Centers. In some cases, due to increasing demands for workload, Vet Center outstations have been converted into permanent sites. Of significance in this vein, regarding services to African-American veterans, is VHA's authorization this year to convert the Vet Center outstation in Harlem, New York City into a full four person Vet Center.

RECOMMENDATION NO. 4: Ensure that staffing patterns at Vet Centers reflect the racial breakdown of the community, with particular attention to Vet Center sites in predominantly African-American locations.

RESPONSE: Implemented, recurrent and ongoing. As specified in the response to Recommendation No. 1 above, ethnic minority veteran representation on Vet Center teams is ongoing RCS policy. The RCS policy regarding Vet Center team composition specifies that, to the fullest extent feasible, Vet Center teams be tailored to the needs of the particular veteran community which is being served. Teams are planned and selected to ensure familiarity with the Vietnam and other eligible veterans' wartime experience, and understanding of the special needs of ethnic minority, disabled and women veterans, etc. Selecting officials strive to recruit in such a fashion that Vietnam and post-Vietnam era veterans, and ethnic minorities and women are well represented in candidates. The Vet Centers have long recognized the important role played by ethnic minority service providers with particular reference to outreach and counseling of minority veterans, and to enhanced family counseling and other community services. The Vet Centers system-wide maintain approximately 23 percent African-American staff in Vet Centers. Currently African-American staff members equal 17 percent of team leaders, 24 percent of counselors and 30 percent of office managers for an overall total of approximately 23 percent of Vet Center staff. These staff levels are significantly above the percentage of African-Americans in the Vietnam era and Vietnam theater veteran populations (11 percent and 11.5 percent respectively).

RECOMMENDATION NO. 5: Ensure consideration, by VHA for locating some post-traumatic stress disorder (PTSD) inpatient units in areas of high African-American veteran concentration.

RESPONSE: Mental Health and Behavioral Sciences Service is the operational office responsible for VA medical center PTSD programs. The siting of PTSD programs in areas with a high African-American population is and will continue to be a VA priority. A Spring 1993 survey of inpatient specialized PTSD units by the Chief Medical Director's Special Committee on PTSD showed that 19.8 percent of patients in treatment at that time were African-American. This number is equivalent to the percentage of African-American staff in these programs and is comparable to the percentage of African-American Vietnam veterans with PTSD as reported by the National Vietnam Veterans Readjustment Study.

VA has also sited other clinical programs in areas with significant populations of African-American veterans to enhance access to PTSD services. While 16 percent of veterans seen in VA's specialized outpatient PTSD Clinical Teams (PCTs) are African-American, several PCTs have significantly higher African-American patient populations. Chicago (West Side) has 65 percent African-American patients; New Orleans 47 percent; Hampton 46 percent, and Philadelphia 45 percent.

In addition, some of the specialized PTSD programs have developed groups or modules for African-American veterans. These groups deal specifically with the veterans' own experiences of racial discrimination in American society as a whole and with racial tensions within the specialized program itself.

RECOMMENDATION NO. 6: Ensure active recruitment of African-American personnel of demonstrated clinical competence and knowledge in the treatment of PTSD, for staff in special inpatient PTSD units.

RESPONSE: See the response to Recommendation No. 5 above.

RECOMMENDATION NO. 7: Develop a systematic method of locating and reaching African-American Vietnam veterans, which may include the usage of Public Service Announcements (PSA's), pertinent program literature and other printed materials geared specifically to African-American veterans.

RESPONSE: Implemented. Since their inception in 1979, the Vet Centers have, as a matter of policy, paid particular attention to culture, socio-economic and gender differences among various veteran populations in tailoring the mix of outreach and counseling services in relation to local need. Many Vet Centers located in proximity to African-American populations maintain outreach and counseling initiatives specifically attuned to serve these veterans and their families. Community outreach has been an essential component of the mix of Vet Center services since their beginning in 1979. Since that time operating policies have been developed system-wide to ensure an active and viable Vet Center outreach effort. As part of established quality management criteria, each Vet Center is required to maintain a written outreach plan specific to the unique features (social, economic, demographic and geographic) of their catchment area. The productivity for each Vet Center is monitored monthly via several indices, one of which is a measure of community outreach and educational activities. In addition, all Readjustment Counseling Service regional training exercises are required to have a three hour training module

on outreach objectives and techniques which is responsive to the needs and community circumstances of different veteran consumer groups. National policy guidance regarding Vet Center outreach and counseling services is contained in the Department of Veterans Affairs, Veterans Health Administration Manual M-12, "Readjustment Counseling Service Vet Centers," Part II, "Direct Service Operations," chapter 3. With specific reference to the issue of PSAs and other culturally specific outreach tools, RCS relies on the African-American Veteran Working Group for the development of such materials. RCS management implements these materials recurrently to the extent resources permit.

RECOMMENDATION NO. 8: Ensure Vet Center outreach efforts to increase involvement from the African-American community in understanding and meeting the readjustment needs of African-American Vietnam veterans. Promotion of greater sensitivity and awareness of the needs of African-American veterans, by Vet Center staff.

RESPONSE: Implemented. Community education and other social interventions to promote the general awareness of the post-war readjustment needs of veterans and to enhance community assistance on behalf of veterans is an integral feature of the Vet Center mission. See the response to Recommendation No. 7 above for national guidance regarding Vet Center community outreach and mix of services.

RECOMMENDATION NO. 9: Ensure clinical training of VA service providers in a wide-ranging variety of cognitive-behavioral procedures, integrating social therapy, case management, dynamic-oriented procedures, and adeptness in cross-cultural treatment modalities.

RESPONSE: Implemented. Ongoing clinical training is a permanent programmatic commitment and an integral feature of the RCS quality management program (reference M-12, Part I, Chapter 5). The required curriculum for RCS annual training conferences covers all major Vet Center service components: outreach, counseling and psychotherapy for PTSD (individual, group and family), clinical military histories, clinical case conferences, and training on minority veteran issues. Regarding the latter, the current requirement is for four hours of content on ethnic minority veterans' counseling issues and four hours of clinical content by an ethnic minority faculty.

RECOMMENDATION NO. 10: Enhance the therapist's awareness about conscious and unconscious stereotypic fears about African-Americans and Vietnam, so that as the therapist encourages the African-American veteran to adjust to reality, he does not unwittingly distort the reality of the clients and their needs.

RESPONSE: Implemented. The therapist's awareness of his/her own attitudes and management of same during the course of the counseling process is a key component of ongoing clinical education which is addressed by Vet Center counseling staff through in-service training, clinical consultation and supervision. Also see the response to Recommendation No. 9 above.

RECOMMENDATION NO. 11: Provide mandatory training to all RCS staff concerning the special readjustment needs of African-American Vietnam veterans and their families, to include counseling methods for how to intervene effectively with this population.

RESPONSE: This is done, ongoing, and recurrent. See response to Recommendation No. 9 above.

RECOMMENDATION NO. 12: Develop methods on how to retain African-American veteran client's involvement in counseling until specific mutually agreed-upon treatment goals have been reached.

RESPONSE: Therapeutic contracting and goal setting are essential ingredients to sound clinical case management and the therapist's forming and maintaining an effective therapeutic of working alliance with the client. As such, these features are covered in Vet Center clinical training, supervision and quality review. Also see the response to Recommendation No. 9 above.

Clinical oversight of the Vet Centers indicates that client retention is not a problem. However, as implied above, this requires continuous quality monitoring. RCS has a workload and clinical data system which enables greater information about services provided and analysis of client needs. Specifically, workload reports regarding ethnic minority and women veteran utilization, as well as types of services provided will be available early in fiscal year 1994.

RECOMMENDATION NO. 13: Identify/upgrade and/or recruit more qualified African-American clinicians.

RESPONSE: See the responses to Recommendations No. 1 and 4 above.

RECOMMENDATION NO. 14: Increase the sensitivity of all staff members to enable them to provide cross-cultural counseling.

RESPONSE: Implemented. The Vet Center service mission of outreach and readjustment counseling was originally designed to provide its menu of services in such a manner as to facilitate overcoming barriers to access for veteran consumers. In this case such barriers include geographical, economic, social, cultural and psychological factors which may hinder the veteran's ability to use the available services. Cultural sensitivity to the various veteran populations in the Vet Center's catchment area is a permanent and ongoing policy. Also, see the response to Recommendation No. 9 above.

RECOMMENDATION NO. 15: Enhance education about African-American culture through subscriptions to relevant magazines, newspapers, and purchase of books on this subject.

RESPONSE: Individual Vet Center budgets have no discretionary funds for purchase of magazine, newspaper or journal subscriptions. However, it would be useful for the RCS African-American Veterans Working Group to identify and recommend a list of relevant publications from which a Vet Center may select for purchase if feasible. Also, the Working Group could identify relevant

literature which could possibly be extended to Vet Centers free as a public service initiative extended to a federal agency. In addition, many articles written by Vet Center staff on African-American veterans have been featured in the Vet Center VOICE over the years, which publication is provided to all Vet Centers four to six times a year.

Professional books are a separate matter from subscriptions. RCS maintains an approved list of core clinical references and texts which are purchased by Vet Centers on the basis that the VA medical facility may not be readily accessible for library purposes. Approved books consist of widely accepted, standard texts pertinent to Vet Center services. Material relevant to serving minority veterans is contained in some of the books on the list. Also, we are considering additional texts on African-American veterans' issues for inclusion on the RCS core reference list.

RECOMMENDATION NO. 16: Vet Center staff to seek supervision from competent and knowledgeable supervisors with experience in working with African-American veterans.

RESPONSE: Implemented, continuous. This recommendation is apparently directed at Vet Center teams to be pursued on the basis of an individual initiative. Such an initiative is fully supported by RCS management and is complementary to the Vet Center's close professional interaction and networking within the community on behalf of local veterans. Vet Centers system-wide make wide and effective use of local consultants and volunteers as auxiliary staff on an as needed basis.

RECOMMENDATION NO. 17: Ensure that Vet Center staff work closely with community resources that have a history of sensitivity to the needs of African-American Vietnam veterans and help other agencies to understand the post-war readjustment needs of Vietnam veterans.

RESPONSE: Implemented. This is standard practice at all Vet Centers subject to continuous monitoring during periodic quality management on-site reviews. RCS regional management staff make over 600 such site visits system-wide on an annual basis.

RECOMMENDATION NO. 18: Networking and referrals should be done with utmost cultural sensitivity; therefore, the Working Group recommends three basic steps in referring the African-American veteran to community agencies:

- a. Give a complete explanation of the referral process in concrete understandable terms.
- b. Give the veterans an opportunity to express their feelings and thoughts about the referral.
- c. Give the veteran the specifics--the person to see, the time, place, and date of the appointment, whenever possible.

RESPONSE: Implemented. Supportive social services and brokering of services on behalf of veterans are part of the mix of services at every Vet Center. All Vet Centers maintain active networks with other community service providers for referral purposes. Also, see the responses to Recommendations No. 7 and 17 above.

RECOMMENDATION NO. 19: For Vet Centers where the office manager may be the only African-American staff member, action should be taken to ensure that he/she is not placed in a position of being the sole "service provider" to African-American veterans.

RESPONSE: Implemented. This is standard practice at all Vet Centers and subject to periodic monitoring during RCS quality management reviews of Vet Center operations.

RECOMMENDATION NO. 20: At least one African-American woman should become a permanent member of the RCS Women Veterans Working Group. African-American female concerns should be addressed by the Working Group.

RESPONSE: Implemented. The RCS Women Veterans Working Group has consistently maintained at least one African-American member. Currently there are 3 (or 43 percent) African-American women staff on the Working Group. This like many other long-implemented recommendations bears frequent re-statement and periodic monitoring.

RECOMMENDATION NO. 21: Ensure an ongoing systematic approach to identify and recruit qualified African-American women for meaningful involvement at all levels of RCS.

RESPONSE: Implemented. This is permanent and ongoing RCS policy. Also, see the responses to Recommendations No. 1 and 4 above.

RECOMMENDATION NO. 22: Seminars and conferences at the Vet Centers for African-American female veterans should be coordinated annually.

RESPONSE: Conferences and seminars per se for specified groups of veteran consumers are provided when dollars are available and staff service providers take such initiatives. Every Vet Center maintains information specific to the needs and experiences of ethnic minority and women veterans which is readily available to veteran consumers.

RECOMMENDATION NO. 23: Direct outreach activities to women's organizations in an effort to enhance contact of African-American women veterans.

RESPONSE: Implemented. This is standard practice for Vet Centers system-wide. See the response to Recommendation No. 7 above.

RECOMMENDATION NO. 24: Presentations covering African-American female veterans concerns should be initiated by the Vet Center staff.

RESPONSE: This is a permanent and ongoing feature of Vet Center services as part of the local outreach and education mission to enhance local community response and assistance on behalf of local veterans.

RECOMMENDATION NO. 25: Vet Centers should obtain a listing of African-American female veterans employed at the VA support facility so that they can be informed about the availability of readjustment counseling services.

RESPONSE: We cannot determine that VA medical facilities maintain lists of personnel specifically denoting ethnicity or gender. Nonetheless, all Vet Centers, as specified in the response to Recommendation No. 7 above, maintain active outreach and education programs which include the staff and patients of the VA support facility as intended targets.

RECOMMENDATION NO. 26: Conduct follow-up in a concerned manner, so as to avoid the development of a strong dependency on Vet Center members by African-American veterans.

RESPONSE: Implemented. Systematic case follow-up is standard practice for all Vet Centers and is a key component of professional clinical case management and therapeutic termination of the counseling relationship. RCS policy and guidance regarding case follow-up as a quality management criteria for continuous monitoring is referenced in M-12, Part I, Chapter 5.

RECOMMENDATION NO. 27: Develop a system of monitoring client satisfaction.

RESPONSE: Clinical follow-up often involves a review of services and accomplishments with veteran consumers. Also, the Vet Centers' high level of community involvement and visibility ensures ample opportunity for Vet Center staff to obtain feedback regarding client satisfaction. A generally high level of veteran satisfaction is evident in the number of referrals from former clients, high regard for the Vet Centers in the community and the absence of negative media coverage. Also, see the response to Recommendation No. 26 above.

RECOMMENDATION NO. 28: Conduct follow-up and aftercare in a flexible and adaptable manner dictated by the needs of the client.

RESPONSE: See the responses to Recommendations No. 26 and 27 above.

RECOMMENDATION NO. 29: Increase the proposed annual funding for the Job Training Act with a specific dollar amount earmarked for training African-American Vietnam veterans.

RESPONSE: This recommendation is a matter for Congressional action.

RECOMMENDATION NO. 30: In addition to the monitoring of these programs which give monetary incentives to employers who hire veterans, it is recommended that those employers who benefit from large government contracts be approached regarding being more responsive to hiring and training Vietnam Veterans.

RESPONSE: This recommendation also pertains to a legislative provision to be built into the federal employment law referenced above. However, to the extent that it refers to advocacy and mediation on behalf of veterans' employment, it is a component of Vet Center community outreach, education and local job finding which is standard practice for all Vet Centers.

RECOMMENDATION NO. 31: Establish a special program fund for severely needy and homeless veterans; namely, those in need of shelter, clothing, transportation (to and from the job site) to "get them on their feet". This service could be authorized for thirty to forty-five days and could be incorporated under VBA/Vet Center sponsorship via vocational rehabilitation.

RESPONSE: Implemented. All elements of this recommendation are covered by programs in VA's spectrum of services for homeless veterans which includes the Vet Centers, VAROs, domiciliaries, and VAMC based programs. VA's assistance to homeless veterans addresses the full range of needs to include income maintenance, shelter, vocational assistance, readjustment counseling and medical and psychiatric care.

RECOMMENDATION NO. 32: Explore and create outreaching mechanisms to incarcerated Vietnam veterans.

RESPONSE: Implemented. VA's expertise concerning PTSD and other post-war readjustment problems is now being utilized rather widely on behalf of veterans in prison. These services are now available, to the extent feasible under current resources, through the Readjustment Counseling Service Vet Centers. Currently Vet Centers system-wide provide services directly and indirectly to many incarcerated Vietnam era veterans. Such services include outreach, case-consultation to prison mental health staff, clinical education for prison health care professionals, and the direct provision to veterans of readjustment counseling on a pre-release basis, when the veteran is due to be released in the reasonably near future. These Vet Center outreach, consultation, education, and counseling services are locally planned according to the priorities specific for each Vet Centers's catchment area. It is estimated that approximately one-third of all Vet Centers system-wide provide assistance at penal institutions (local, State or Federal) at some time during the year. The only limiting factor is resources. In addition, Federal and State parole programs have been linked with Vet Center services in many communities as a local outreach and referral initiative.

RECOMMENDATION NO. 33: Establishing a close working relationship with judges, attorneys and others in the criminal justice system to create sensitivity for Vietnam veterans, especially those first time non-violent offenders who may benefit by treatment as opposed to incarceration.

RESPONSE: Implemented. As an ongoing feature of community outreach, this recommendation is standard practice for Vet Centers system-wide to the extent feasible given available resources and the overall needs of the local veteran community.

RECOMMENDATION NO. 34: Develop a mechanism to work with the local prison systems to offer pre-release readjustment counseling, group counseling experience, as appropriate, and educational and trade/skill programs.

RESPONSE: See the response to Recommendation No. 32 above.

RECOMMENDATION NO. 35: Review the current alcohol and drug treatment approaches, especially within VA, in working with African-American Vietnam veterans.

RESPONSE: This recommendation falls within the operational purview of Mental Health and Behavioral Sciences Service, as the primary site for VA substance abuse treatment is the medical center. VA understands that substance use is frequently found as a secondary diagnosis to war-related PTSD, especially when the latter has gone without clinical intervention and become chronic. The National Vietnam Veterans Readjustment Study reported that African-American Vietnam veterans have been higher rates of PTSD and that 50 percent of all veterans currently having PTSD also had another psychiatric diagnosis, of which substance use (primarily alcohol) was one of the most frequent. VA also understands that treatment for PTSD and substance use must be clinically integrated. VA has developed a number of substance use and PTSD treatment units at VA medical centers to address the clinical needs of veterans with dual diagnosis. The role of the Vet Centers in providing substance use referral and aftercare counseling is also in full appreciation of this clinical need.

RECOMMENDATION NO. 36: Conduct research in areas of alcohol and drug abuse among African-American veterans.

RESPONSE: Research related to PTSD and/or substance abuse is an issue for consideration by Mental Health and Behavioral Science Services. See the responses to Recommendations No. 35 above, and No. 42 below.

RECOMMENDATION NO. 37: Ensure adequate VA programmatic response to the need for effective readjustment/rehabilitation services for substance use, which address possible underlying stress symptomology/disorder related to war-trauma.

RESPONSE: See the response to Recommendation No. 35 above.

RECOMMENDATION NO. 38: Identify local attorneys who are sensitive to the needs of Vietnam veterans, and who are willing to provide concrete legal services at minimal cost.

RESPONSE: Implemented. As an ongoing feature of Vet Center outreach, education and brokering of services within the community, this is standard practice for Vet Centers. All Vet Centers maintain active referral networks among community service providers for services not directly provided by Vet Centers, but needed by veterans in relation to their post-war readjustment.

RECOMMENDATION NO. 39: Organize seminars or community forums at Vet Centers which will allow veterans to interface with local attorneys.

RESPONSE: Implemented. See the response to Recommendation No. 38 above.

RECOMMENDATION NO. 40: Develop a mechanism whereby Vet Center staff can work closely with the VA General Counsel's Office in legal matters pertaining to Vietnam veteran clients.

RESPONSE: Vet Centers seek consultation from local VA District Counsel Offices regarding the legal aspects of client service delivery.

RECOMMENDATION NO. 41: Designate specific funds for Vet Center staff to attend professional workshops pertinent to readjustment problems of Vietnam veterans in general and of African-American Vietnam veterans in particular.

RESPONSE: Implemented. Annually each Vet Center has a limited amount of funds available which are earmarked for staff development purposes. Vet Center team leaders can use available funds for seminars and conferences as specified by this recommendation.

RECOMMENDATION NO. 42: Provide research funds to authorize African-Americans to conduct, participate in and promote the development of ongoing research that is specific to the unique psychosocial readjustment needs of African-American Vietnam veterans.

RESPONSE: The National Vietnam Veterans Readjustment Study (NVVRS) conducted by the Research Triangle Institute (RTI), on contract with VA has produced scientific data indicating that the current prevalence rate of diagnosable post-traumatic stress disorder (PTSD) in Vietnam veterans is 15.2 percent or approximately 480,000 current cases; an additional 11 percent, or 341,000 veterans, have some symptoms of PTSD but not the full amount required for diagnosis. Broken out by ethnic groups the prevalence of PTSD is 20.6 percent for African-American, 27.9 percent for Hispanic and 13.7 percent for white Vietnam theater veterans. Rates of various social and economic problems are also correspondingly high. In addition, 50 percent of all Vietnam theater veterans with PTSD were diagnosed to have other psychiatric disorders such as depression, substance abuse or anxiety disorders.

In addition Readjustment Counseling Service is currently carrying out, in collaboration with VA's National Center for PTSD, a prospective study on a sample of Persian Gulf veteran new cases being seen at 82 Vet Centers. This study will produce valuable data for assessing, in the years ahead, the impact of wartime duty on readjustment and other aspects of psychological functioning. This is the first prospective study on war veterans' readjustment carried out by VA in its history.

In the initial phase (from October 15, 1991 to April 15, 1992), the Persian Gulf veteran survey was disseminated through 82 Vet Centers nationwide, from Hawaii to Alaska to Puerto Rico. The overall PTSD prevalence for this sample was 11.5 percent. The PTSD prevalence in a sub-group seeking specifically help for psychological distress was 37.1 percent. The six-month follow-up study was carried out from April 15 to October 15, 1992. The

overall prevalence of PTSD for the six month follow-up group was 14 percent. However, with particular reference to the group of veterans specifically seeking help for psychological distress, the level of PTSD at the six month interval was markedly reduced (9.4 percent compared to 37.1 percent). An 18 month and final follow-up survey commenced in June 1993.

Seventeen percent of the veterans represented in the initial sample and nine percent of those in the follow-up were African-American. Data to be reported upon completion of all three phases of the study will contain useful information regarding PTSD in African-American Persian Gulf veterans.

Other proposals for research regarding PTSD and other war-related readjustment problems in specific veteran eras and/or populations can be submitted to VA's National Center for PTSD for consideration.

RECOMMENDATION NO. 43: Compile historical and contemporary literature and develop a clearinghouse specific to the military and post-military experiences of African-American Vietnam veterans and African-American veterans of other wars.

RESPONSE: Vet Centers system-wide compile repositories of graphic, visual and written information regarding the military and post-military experiences of eligible veterans, tailored to the veteran populations specific to their catchment areas veterans routinely have materials available for Vet Center staff and veteran consumers regarding the culture, history and military experience of African-American veterans. Such activities are a standard feature of the Vet Centers as community resource centers for understanding veterans' military experiences and post-war readjustment needs.

RECOMMENDATION NO. 44: Conduct research beyond the Legacies of The Vietnam Study to clarify the specific needs of African-American veterans, such as the National Vietnam Veterans Readjustment study currently being planned.

RESPONSE: See the response to Recommendation No. 42 above.

RECOMMENDATION NO. 45: Vet Center national workload data should be retrievable and broken down demographically to account for African-American clients who utilize the Vet Centers.

RESPONSE: Implemented. As indicated above in Recommendation No. 12, the new RCS workload system will provide excellent data for the purposes of tracking ethnic minority veteran use of Vet Center services. In fiscal year 1993 the RCS initiated its new workload and clinical data system to enable greater information about services and analysis of client needs. Specifically, monthly workload reports regarding ethnic minority and women veteran utilization as well as types of services provided will be available early in 1994.

RESPONSE BY JAMES W. WOODARD

TO

QUESTION FROM HONORABLE LANE EVANS
CHAIRMAN OF SUBCOMMITTEE ON OVERSIGHT &
INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS

Q U E S T I O N

1. What criteria should be used to determine if U.S. military force is being used for "good" purposes?

United States military force would be used for "good" purposes if its use provided a positive response to the following questions with consideration given to the succeeding caveats:

- a. Does it protect the legitimate national security interests of the United States?
- b. Has it been debated in the United States Congress and received majority support?
- c. Does it have the support of the community of nations; that is, has it been debated and sanctioned by the United Nations?
- d. Does it prevent the slaughter of innocent civilians by a tyrant or military junta?

a/a Too often the U.S. government has equated our national security interests synonymously with the economic interests of American big business or multinational corporations. Granted, domestic economic stability may be construed as a national security concern. External occurrences which negatively impact our gross national product, gross domestic product or net national product are legitimate concerns. However, when those who make foreign policy and determine when we go to war, are themselves the economic beneficiaries of such combat, then their objectivity is compromised and their actions suspect.

Our history is replete with examples of private sector big businessmen becoming major government decision-makers who are/were in positions to benefit financially from the use of military force. After serving as legal counsel for the United Fruit Company in Latin America, John Foster Dulles became President Dwight Eisenhower's Secretary of State. George Shultz left the presidency of the Bechtel Corporation to become President Ronald Reagan's Secretary of State; he remained a director of that foremost national and international construction company (Its profits were probably monumental after rebuilding Kuwait following the Persian Gulf war). Caspar Weinburger, President Reagan's Secretary of Defense, was a vice-president of the Bechtel Corporation. President Bush's Secretary of State, James Baker, possesses enormous oil wealth leading many to question his and other high level decision makers' motives in promoting U.S. military use in the Gulf.

These comments are not meant to indict these obviously dedicated public servant but to point out that their roles support the historical association between U.S. foreign policy and American big business interests.

b/b While recognizing the constitutional role of the U.S. Congress to declare war, circumstances occur which demand that the President, as commander-in-chief, act precipitously with military force if the U.S. national security is jeopardized. Too often, U.S. presidents have acted to protect big business (with dubious national security relevance) or divert domestic public interests from unpopular political issues. Recent examples have included:

Was the Reagan invasion of Grenada used to divert domestic outrage that 350 marines were killed by a terrorist truck bomb in Lebanon rather than because the U.S. was afraid of a communist government in such an insignificant little island country.

Did President Bush invade Panama in search of General Noreiga (himself a head of state who had formerly worked for Bush as director of the CIA) or was the use of military force a diversion from the U.S. media barrage detailing the president's son, Neil Bush's misconduct in the S & L scandal. A critical thinker would assume that General Noreiga could have been deleted with less fanfare and loss of life.

c/c President Bush's acumen in mobilizing United Nations support for the Persian Gulf war represents the ideal methodology for the future use of U.S. military force. Eventhough the reasoning was less clear than one might have hoped (How legitimate was Iraq's claim to Kuwait [what were the pre-colonial boundaries before British and French conquests?]; Was Kuwait stealing Iraqi oil through subterfuge; what was the relationship of the major American oil companies to ARAMCO), the United Nations decided that a member nation had invaded another member nation and the world community should intervene. Hence, U.S. action was not unilateral and officious.

d/d History teaches us that military force remains the final arbiter in compelling tyrants to change their behavior. Thus, while U.S. national security is the first and most profound priority for the use of military force, the United States has a responsibility to use its military strength to protect the powerless.

The United States was correct to use military force in Somalia. It should consider the use of military force in Haiti and should have used military force in Liberia as well. Some have argued that our use of force in Somalia had geopolitical significance because of its strategic location at the entrance to the Gulf of Aden and at the bottom of the Red Sea. Liberia's special relationship with the United States should have compelled us to stop the slaughter which destroyed that country and Haiti has been our client state since its independence from France.

History will judge us poorly if we do not do more to end the carnage in the former Yugoslavia.

The United States need not accept the axiom promoted by some philosophers that the world is a jungle where only the strong survive in a Darwinian sense; that compassion and magnanimity have no merit in relations among nations. Historically, powerful countries have been selfish and brutal when dealing with less powerful countries. When their power began to diminish, other countries, remembering their behavior, treated them harshly.

The United States is in a peculiarly unique position, as the sole remaining superpower, it can lead the way to a new world order by introducing compassion and fairness along with strength in the conduct of its foreign policy.

**Responses to Questions Submitted by Subcommittee on
Oversight and Investigations, Committee on Veterans' Affairs
Responses by Irving M. Allen, Cambridge, Ma. 10/20/93**

Question 1

I do not know if the NDURS Study confirms this, but it is my impression that African-American and Hispanic-American veterans have been less likely to submit claims for service-connected PTSD. The seeking of service-connection can be a prolonged, arduous, and unfortunately, legalistic process. As a clinician who began working in the VA in 1969, it quickly became my impression that a veteran almost needed to be free of mental illness in order to be able effectively to pursue service-connection. I should point out that many veterans leave the military with service-connection for physical and/or mental illnesses already established so that they never have to struggle for service-connection. Others must establish it after leaving the military, often seeking the connection only after they or a clinician discover the condition. For PTSD, this is obviously problematic since the diagnosis was only accepted in 1980, long after the war ended. Also as a long-time clinician in the VA system, I can say that we as psychiatrists were never, ever, instructed or advised to seek out veterans and to be advocates for their pursuit of claims. If anything, the prevailing attitude was that was not our task, that such advice would be regressive and therefore counter to most veterans' best interests, and was an administrative matter for which the examining psychiatrists were best suited. Gradually, over the years, I and probably others began to involve myself in that process and integrated direct advising about the pursuit of claims into the treatment process.

I advised all veterans in this way, regardless of ethnicity, but it was my impression that African-Americans (I had very few Hispanic-American patients), had particular problems receiving effective advocacy in the claims processing. During the early 1970's, any veteran faced potential "hassle" getting through even the initial opening of a claim. Simply getting started could

be difficult, especially for veterans of color. Also, the DAV and other service organizations in my experience have to be involved to assist veterans through this, along with the claims representatives within the VA system. Advocacy was and probably still is critical at all of these levels to make a claim receive appropriate attention, which involves also the veterans' producing records and documents, submitting to examinations, undergoing medical tests, etc. African-Americans and Hispanic-Americans were not, at least in the Boston area, represented in any significant numbers either within the VA or as DAV representatives. Those that were could be extremely effective, but they could obviously not meet the needs of all veterans of color.

Also included in this process are the doctors who both examine the applicants directly and those who sit on the committees which make the final determinations. Physicians of color certainly were not represented at either of those levels to my knowledge in any significant numbers.

I have tried to point here that seeking a service-connected claim is a complicated process, one which an emotionally disturbed person is not well-suited by definition to follow through on. When racial factors become thought to be complicating factors, the process is even more difficult to engage in by African-American veterans. Clinically, I cannot begin to emphasize enough that the delay between the end of the war and the acceptance of PTSD as a diagnosis complicated the rewarding of claims. The VA advertises that the claims process is non-legalistic and that the veterans' interests will take precedence when doubt exists; that has not been my experience in several cases involving claims for several African-American veterans, most of whom had even been seen for nervous problems while on active duty. One such case just ended within the past few months and I had to conclude reluctantly that race was the only factor that had inexcusably delayed the rewarding of this claim for almost 2 decades.

I should also say that once a claim is granted, it may not be permanent. Therefore, the veteran can expect to be called for periodic reviews or examinations, often with relatively little notice and certainly no real instructions about the process. This is often a time of great turmoil for these veterans, especially

those who are extremely dependent on this compensation for their survival. It is experienced as a process over which they have little control, and it is therefore inherently regressive. Whether African-Americans or Hispanics fare worse in these periodic reviews is probably something that can be studied.

Correct diagnosis of African-Americans is problematic, a fact that has been known since Adebimpe published his findings about this in 1981. PTSD can be a complicated diagnosis, especially when the major symptoms are obscured by substance abuse, behavioral problems, or life-style disturbances which obscure the symptoms like autonomic hyperactivity, reliving the experience and preoccupations, and avoidances. Also, incredibly, one can still find physicians and psychiatrists who don't believe in PTSD. I regret to point out that through my years as a psychiatrist in the system (ending in 1984), many VA psychiatrists were astonishingly removed and detached from the unique aspects of the veterans' population. It could be that some study, even now, of physicians' attitudes could be useful on that subject. In all fairness, it should be observed that making the PTSD diagnosis can be difficult because many of those who suffer the most are treatment-avoidant, and may be difficult to see in a continuous way. Another factor is that many veterans with PTSD have medical problems and are seen for a myriad of conditions in the medical services. At least at Court Street, Boston, where I worked for 12 years, there was minimal formal contact between psychiatry and medicine, so probably many cases were undiagnosed that were actually in the clinic. This was true for WW11 and Korean War veterans also.

I do not know if veterans of color receive lower compensation for their claims than other veterans, but this makes intuitive sense to me. The NUURS and Dr. Rosenheck may have specific data on this. It has been my impression that my African-American patients have had significantly more difficulty seeking approval of claims for the reasons mentioned above.

Question 2.

I am a firm believer in the notion that information can be disseminated in such a way so as to reach those who may still

suffer from PTSD and who have heretofore not sought services, or those who may have sought services but got "turned off" in the process. The original intent of the Outreach Centers was to literally go into the streets, the bars, and the prisons seeking veterans who had this condition. Moreover, there have been over the years TV and radio efforts to reach the undiagnosed veterans' population, but those were short-lived campaigns as I recall. Maybe a group of concerned people might collaborate to revitalize the outreach effort to the African-American/ Hispanic veteran community. Some of the information disseminated will have to be sophisticated--we must assume that there are still large numbers of veterans who do not know what PTSD and have accepted their particular symptoms as "part of their lives." Also, a commitment to a sustained effort over a period of months and years should be made.

Question 3a.

I did not hear Dr. Shay's testimony, but I think that Myra MacPherson's book, "Long Time Passing" graphically speaks to a massive problem with bad paper discharges. I would therefore tend to agree with that opinion.

b. If by blanket upgrade, he means that each and every case of a bad paper discharge is reviewed by a responsible, well-integrated group of people involved in veterans' affairs who have an established track record as veterans' advocates, I would agree. Also, if this group or committee were monitored for its adhering to the mandate to make determinations in the veterans' favor whenever a "close call" exists, I would be in favor. I am not in favor of simply an administrative fiat in removing all bad paper discharges. As a veteran myself, I recall well that the military is a complicated institution with all the complexities of civilian life. There were, to be sure, infractions of military law that had nothing to do with Vietnam service and PTSD. Surely we have the capacity to review each veterans' case now in a responsible manner. This too should include active outreach and case finding of these people, and provision for them of adequate counsel. If for some reason, it was deemed too costly to do a case-by-case review of bad paper discharges, then I'm in favor of his recommendation.

4. Dr. Rosenheck's testimony provides some objective evidence that treatment can be effective for PTSD sufferers. The benefits range from a subjective sense of "quality of life" improvement to a more documentable sense that relationships and worklife improve. These benefits, if multiplied by the thousands of veterans who potentially are in need of treatment, have vast implications for the broader community. I should point out too that if it can be factually demonstrated that veterans of color have been underrewarded service-connection and the actual monetary benefits, this too has obvious implications for the broader community which has both lost the effective functioning of these veterans and also receives inadequate compensation for this loss. In consideration of this, the finding that "the best and brightest" African-Americans served in the Vietnam Era military is especially alarming.

The benefits of African-American veterans receiving treatment from African-American clinicians are considerable. One is that the veteran himself is probably more likely initially to "open up" with an African-American clinician, and reciprocally, an African-American clinician may be more sensitive to the ways to help facilitate that process. African-American clinicians are more likely to identify with and be aware of of the special trials and tribulations of being black in America during all stages of life. An African-American clinician is more likely to truly believe that external trauma can in fact "break down" a person's coping capacities, the essence of the PTSD concept. An African-American is less likely to be afraid of an African-American veteran, and more likely able to strike a balance between empathy, objectivity, and limit-setting. An African-American clinician is more likely to be able to speak with An African-American veteran in a "common language." Also, an African-American clinician is more likely to be appropriately interactive with the client. Lastly, the African-American clinician is more likely to be comfortable with an advocacy role as well as a therapeutic role with a client, i.e., to see no conflict between these two functions and in fact, to see them as mutually reinforcing.

I do not know what the percent of African-American veterans being treated for PTSD receive treatment from an African-American clinician. I am fairly certain that it is a

disproportionately low percentage. My experience since leaving the VA is that I am sought out in my private practice by veterans of color who become disenchanted with psychiatric treatment within the VA and see the problem as at least partially caused by racial insensitivity.

This action often results in some improvement in their care, but it does come at a greater cost for the veteran (or for me, in terms of unpaid bills) and it does represent disillusionment in a system from which they are entitled to receive benefits. There are many actions which could be taken to make VA facilities more sensitive to cultural diversity. At least in this area, I suspect that so little is being done in the way of formal training that anything will be an improvement. Training for staff and professionals at all levels could be undertaken. The most important factor though is integration of all VA facilities at all levels. This would involve active recruitment starting with medical schools, social work schools, nursing schools, and psychology training programs which will provide future clinicians. Recruitment of administrators and other personnel should be undertaken utilizing community-based organizations. It could be that the VA itself should set up some in-house training to African-American and Hispanic people to provide skills which are necessary to be effective employees, skills which may be provided in the local public schools because of the usual problems of underfunding and under staffing these schools face. It seems to me that programs like the Benefits Clearinghouse here in Boston have considerable insight about how to make these facilities more culturally sensitive, given their frequent interface with them as advocates for veterans.

Another possibility is that it is a "lost cause" that these facilities, or at least some of them, have any will or capacity to become more culturally sensitive. Maybe in some locations, innovative programs should be carefully considered which enable veterans of color to receive definitive treatment, even for service-related conditions, outside the VA, in local facilities which are adequately staffed and culturally-sensitive. I realize that this may seem to be a major step, but one that should be considered.

Before the VA can tailor make PTSD programs which meet the needs of veterans of color, there needs to be a consensus that there are deficits in service provision for this population. With that recognition, a process could be established by which such programs could be planned. Such a program, given today's racial climate by which so many European-Americans feel that African-Americans and others are receiving unfair advantages, would have to be considered carefully. The fact is that the Vietnam military experienced a degree of integration probably unparalleled in this society, and splitting the veterans' population along racial lines by ill-considered programs would be unfortunate.

