ADDRESSING CHALLENGING CLINICAL ISSUES WITH AFRICAN AMERICAN SERVICE MEMBERS, VETERANS, AND MILITARY FAMILIES

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Importance

- Calls for increased collaboration between community, mental health providers, VA, and clergy (Straits-Troster et al., 2011; Weaver, Koenig, & Ochberg, 1996)
  - Vets more likely to present to primary care, faith-based, MHP in own community than DoD or VA

African Americans in Military

- Representation in active duty US military population
  - 17% of active duty Army (Maxfield, 2010)
- Military segregation preceded desegregation in rest of country
  - Officially ended in 1948 in Korean War
- History of discrimination stateside and while deployed
  - Contrast in segregation between integration in Army and segregation stateside
  - Segregated units often more assigned to services jobs
  - German prisoners allowed in Officer club
  - Could not arrest White Soldiers, even if MP
- Race-related trauma
  - Similarity to enemy, relating to enemy, race/related assaults, racial/ethnic dissociation

Effects of Combat on African Americans

- National Vietnam veterans readjustment study (NVVRS; Kulka et al., 1990)
  - Found racial differences in African Americans
    - Higher PTSD prevalence
      - Mixed findings about whether differences in rates of PTSD and symptom expression exist (Breslau, Aguilar-Gaxiola, Kendler, Su, Williams, & Kessler, 2006)
    - Marital relationships
    - Violent behavior
    - Happiness
    - Life satisfaction
    - Demographic: education, criminal involvement, unemployment
  - When adjusted, difference decreased by 10%
    - SES, previous exposure to trauma, & higher levels of combat (37% African American vs. 23% White)
      - Perception within AA community (Harris & Jones, 2007)
    - African Americans: less likely to be married, less likely to receive compensation, reported more substance use, less likely to commit suicide
      - Currently 60% of African Americans married (Maxfield, 2010, less likely to be divorced (Army Demographics, 2010)

African Americans & Mental Health Treatment

- African Americans (Kulka et al., 1990)
  - More likely to seek help for inpatient substance problems
  - Greater need for basic resources, finances, employment, legal assistance
    - Less likely to seek help in outpatient psychiatric services and psychotropic meds
  - Racial/ethnic differences in usage of non-VA services
    - Consistent with civilian literature (Snowden & Cheung, 1990)
      - Barriers: stigma, resources, cultural mistrust
  - Significantly shorter duration of involvement and fewer individual sessions
      - More likely to terminate within 2 months
    - Clinician observations: less committed to therapy, reported less consistent attendance, less time on insight-oriented therapy, deconditioning negative affects, and discussing war trauma, more time on substance abuse
      - *Partially* explained by less time in treatment
      - Substance use associated with 1 month less in treatment

African Americans & Mental Health Treatment

- Differences in service use and outcome may reflect receptiveness
  - Zayfert (2008): differences may not be great in PTSD symptomatology but greater engagement needed for people of color
  - Lester et al. (2010) found higher drop out for Af. Am. in CPT but appeared to be associated with more efficient use of treatment
- Homogeneity of psychology as field (APA, 2005)
  - APA
    - White -70.9%
    - Ethnic/racial minority -5.8%
    - Other/unknown – 23.3%

Barriers to Help-Seeking

- Stigma
  - General
    - Koenen et al. (2003)
      - Beliefs
        - 28.7% said can handle on own
        - 18% afraid of what people think
        - 13% afraid to take meds
        - 9% don't think have disorder
        - 6% treatment won't help
      - Resources(insurance, can't afford, access)
        - 40% of those with PTSD did not know where to get help
  - Military
    - Downsizing
  - Gender
  - Racial/ethnic
- Cultural mistrust (Terrell & Terrell, 1981)
  - Racial socialization
  - Distrust of therapists (Whaley, 1998)

Presentation Aims

- Identify strategies for risk management with military service members, veterans, or families.
- Identify strategies for overcoming resistance with military service members, veterans, or families.
- Identify strategies for overcoming logical barriers with military service members, veterans, or families.

Collected from Department of Defense Suicide Event Report (DoDSER): 2014

Veteran Military Suicide Attempts

- In 2014, an average of 20 Veterans died from suicide each day; 6 of the 20 were users of VA services.
- In 2014, Veterans accounted for 18% of all deaths from suicide among U.S. adults, while Veterans constituted 8.5% of the US population.
- In 2014, approximately 65% of all Veterans who died from suicide were aged **50 years** or older.
- Risk for suicide was 21% higher among Veterans when compared to U.S. civilian adults.
- Risk for suicide was 18% higher among male Veterans when compared to U.S. civilian adult males.
- Risk for suicide was 2.4 times higher among female Veterans when compared to U.S. civilian adult females.

Active Duty Military Suicide Attempts

- The military saw an increase in active-duty suicides in 2014, while the suicide rate among National Guard and reserve members saw a significant decrease from the previous year.
- In 2014, 269 active-duty troops and 169 reserve and National Guard members were found to have killed themselves, according to the 2014 Defense Department Suicide Event Report
- The Army had the highest suicide rate among the active components, at 23.8 per 100,000 soldiers. The lowest rate, 16.3, was in the Navy.

Most common demographics:

Gender: Male

Race: White/Caucasian

Ethnicity: Non-Hispanic

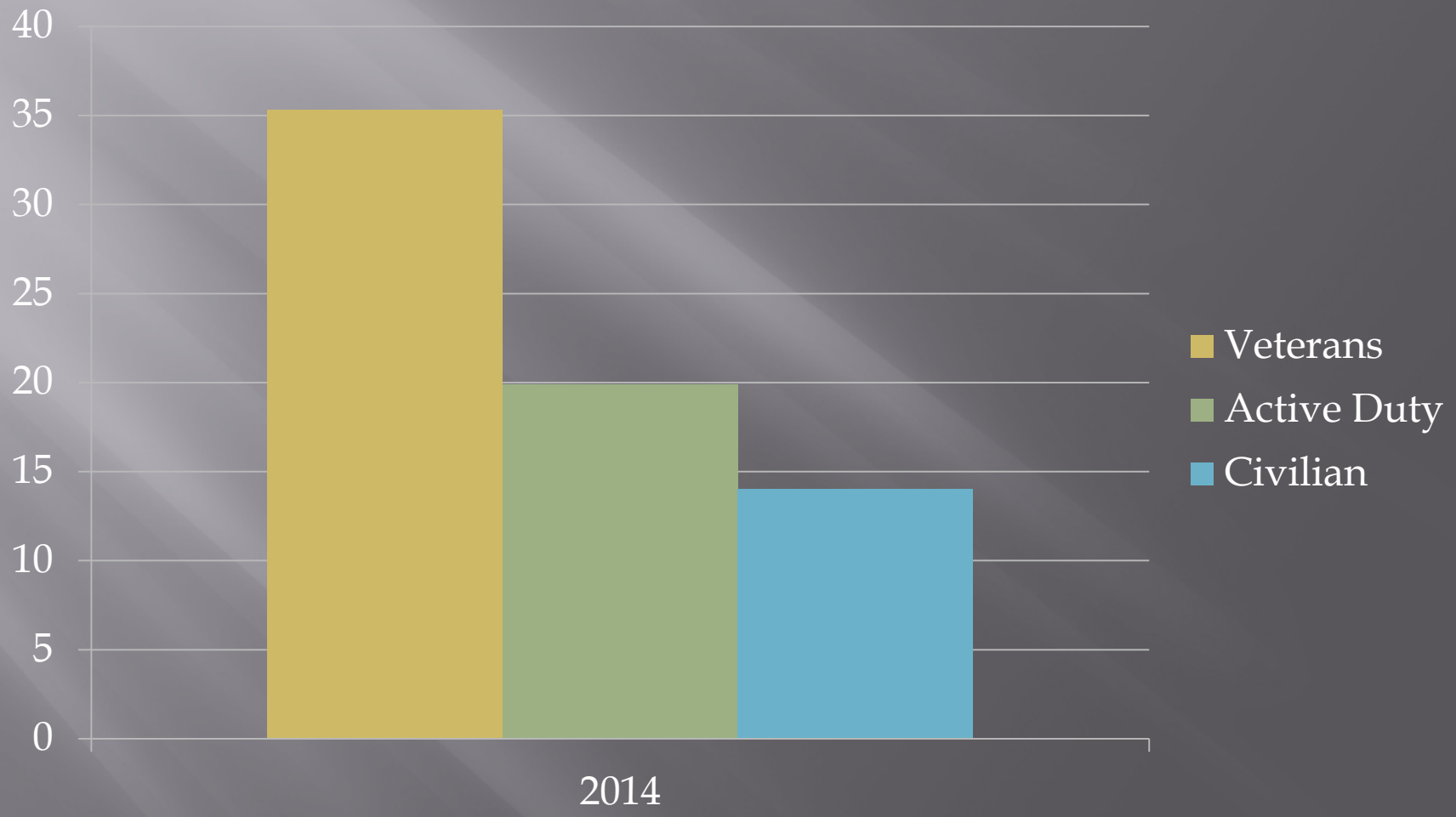
Age: Under 30 years of age

Military Grade: Enlisted (E1- E4)

Education: High school graduate or below

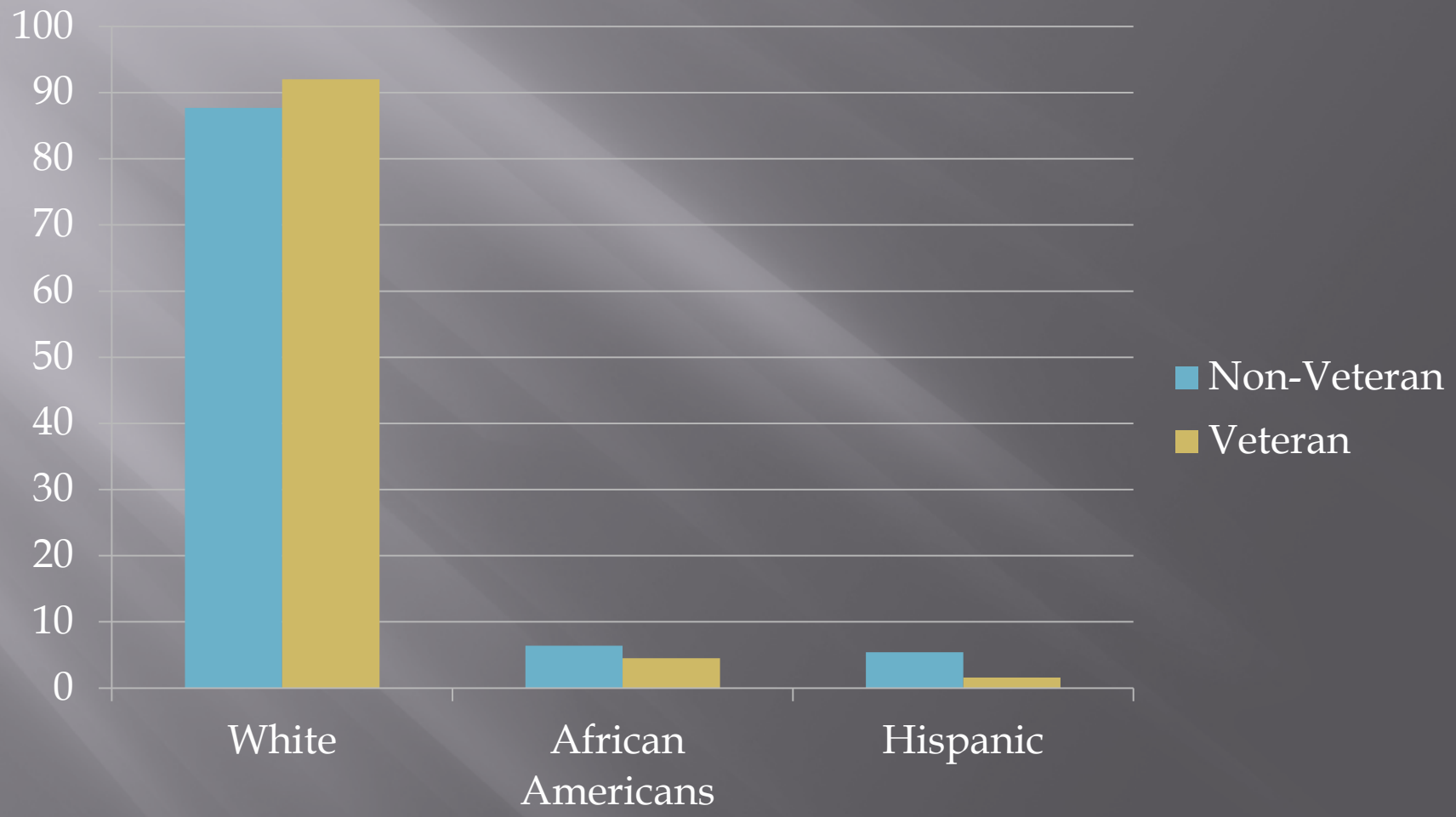
Collected from Department of Defense Suicide Event Report (DoDSER): 2014

U.S. Suicide Rates, 2014



Collected from Department of Defense Suicide Event Report (DoDSER): 2014

Suicide Rates by Race



Kemp & Bossarte, 2012

Suicide Risk Factors

- Research indicates that many of the suicide risk factors identified in nonmilitary populations are applicable to the military (Bryan et al., 2016)
- For example, psychiatric disorders that serve as risk factors include
  - depression and posttraumatic stress disorder (Ursano et al., 2015),
  - life stressors such as relationship problems (Bryan and Rudd, 2012)
  - trauma exposure (Bryan et al., 2015)
  - prior history of suicidal thoughts and behaviors (Bryan et al., 2014)

Fluid Vulnerability Theory (FVT)

- FVT posits that some individuals are more sensitized or "vulnerable" to suicidal behaviors, and this vulnerability persists overtime independent of the individual's specific psychiatric symptom profile.
- Suicide-specific thought processes should be measured independent of psychiatric symptoms and disorders may improve assessment, treatment, and clinical decision-making.
  - For example, the role of hopelessness (Brown et al., 2000; Bryan & Rudd, 2006) and perceived burdensomeness (e.g., "People would be better off without me") over psychiatric symptoms (Joiner et al., 2009).

FVT Assumptions

- Baseline risk can vary
- Baseline risk is determined by static /historical factors (e.g., trauma history)
  - Baseline risk is higher and endures longer for multiple attempters (defined as 2+ attempts)
- Risk is elevated by aggravating factors (e.g., interpersonal issues)
- Severity of risk is dependent on baseline level and severity of aggravating factors

(Rudd, 2015)

Safety Planning

- Safety Planning
  - Means Restriction
    - Best to remove from the house
    - Get spouse involved
    - Language and Collaboration are important (Motivational Interviewing Skills)
  - A hierarchical and prioritized list of coping strategies and sources of support to be used during or preceding a suicidal crisis
    - VA suicide hotline number/911/VA ER number
    - Numbers for family member or friend
    - What do you have to live for

Suicide Risk Assessment

- Current Suicidal Ideation
  - Nature, frequency, intensity, extent of ideation?
- Current Suicide Plan
  - Presence or absence of a plan/method?
  - Any steps taken to enact or prepare plan?
  - What circumstances might lead to enacting plan?
- Current Suicide Intent
  - Intent to act on plan? Lethality of plan? Access to means?

Cultural Considerations

- Perceived racism and discrimination are associated with depression, increased substance use, and hopelessness among African Americans (Gibbons, Gerard, Cleveland, Wills, & Brody, 2004; Nyborg & Curry, 2003).
- Barriers to success such as discrimination and institutional racism may increase frustration, distress, and greater risk for suicide (Joe, 2006)
- Anxiety, stress, or anger due to conflicts over pressures to adopt the values of White individuals while simultaneously trying to hold on to their cultural identity and cultural experiences (Willis, Coombs, Cockerham, & Frison, 2002).
- Self-directed religious coping (Molock, Puri, Matlin, & Barksdale, 2006) vs. a collaborative religious coping style (Molock et al., 2006).
- Victim-precipitated suicide

Overcoming Resistance to Treatment

Signs of Therapeutic Resistance

- Frequent tardiness or rescheduling
- Incomplete assignments
- Hostility
- Difficulty focusing on presenting problem

Resistance to Treatment

- Resistance can be puzzling and frustrating for therapists
  - If clients want help, why are they not following through with recommendations?
  - Clients may give verbal agreement, but behaviors indicate otherwise.
- For clients, resistance may indicate
  - Ambivalence
  - Lack of motivation
  - Fear
  - Self-doubt

Sources of Resistance for Military Personnel

- Mismatch of therapist & client goals
- Stigma
  - "Fit Force" mentality
- Stoicism
- Cultural mistrust
- Avoidance
  - Hallmark of many disorders, e.g. PTSD
  - Behavioral
  - Emotional
  - Cognitive

Overcoming Resistance

- Purpose for seeking help
  - Getting very specific about how client will change
    - Behaviorally
    - Emotionally
    - Functionally
  - Miracle question
- Motivational Interviewing (Miller & Rollnick, 2013)
  - Rolling with resistance
  - Scaling
    - Importance of change
    - Confidence of ability to change

Overcoming Barriers

- Countering cultural mistrust
  - Strive for cultural competence
- Countering stigma
  - Providing psychoeducation
  - Biopsychosocial models
    - Medical analogy

Resistance to Therapeutic Techniques

- Exposure
  - Reviewing rationale
  - Titration
  - Meeting client where he/she is
- Emotional expression
  - Exploring cultural values
  - Role models that demonstrate qualities of empathy and connection with other people
- Behavioral Activation
  - Behavioral experiments
  - Challenging therapy-interfering cognitions

Overcoming Logistical Barriers

Logistical Barriers

- Even when clients are willing, may face daunting logistical barriers to treatment
  - Inability to commit to treatment for 2 or 3 months
  - Inability to come to traditional office hours
  - Difficulty in coordinating schedules among family members
  - Military duty/work conflicts
  - Lack of knowledge about where to seek help

Overcoming Logistical Barriers During Treatment

- Networking/partnering with community & clergy
  - Education about when to seek professional help
  - Can provide services in more accessible locations (e.g. community centers, churches)
- During treatment
  - Obtaining command support
    - Preservation of confidentiality
  - Flexing office hours

Innovative Therapeutic Approaches

- Massed or intensive treatment
  - 2-3 weeks versus. 2-3 months
- Incorporation of social support
  - Address enabling behavior
  - Consultation with valued authority (e.g. clergy)
  - Cognitive Behavioral Conjoint Therapy (Monson & Fredman, 2012)
    - For couples/dyads
    - Accelerated, Multi-Couple Group
- Web – based therapy
- In-home Therapy

Resources

- Risk Management
  - 22 KILL
    - https://www.22kill.com/
  - Veteran Crisis Line
    - 1-800-273-8255
  - Stop Soldier Suicide
    - http://stopsoldiersuicide.org/

Resources

- Prevention/Resilience
  - Military transition programs (e.g. ACAP: Army Career & Alumni program)
  - Strong Families, Strong Forces
    - https://www.facebook.com/strongfamiliesstrongforces/
- Military Culture
  - Center for Deployment Psychology
    - http://deploymentpsych.org/
- Mental Health
  - On-post behavioral health clinics
  - Off-post providers that accept TriCare