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Clinical Assessment of Post-Traumatic Stress Disorder (PTSD) Among American Minorities Who Served in Vietnam

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This paper will review issues in clinical assessment of minority combat veterans who served in Vietnam. We will specify differences and similarities for assessing minorities within the context of evaluating the larger combat veteran population. As a way of introducing a need for specialized diagnosis and treatment, we will present data demonstrating that minorities may be characterized as a distinct group among Vietnam combat veterans; data demonstrating differential rates of PTSD and other psychological disorders; as well as differences in vocational, social, educational, physical and health adjustment along with differential rates of health services utilization. Throughout this paper, we will attempt to give a historical perspective to the role of the minority soldier before, during, and after military service in Vietnam, as well as inter-related civilian events that impacted minority veterans. We will review pertinent theories that explain higher PTSD rates among minority veterans—considering the special nature of the Vietnam War and its impact on young minority soldiers. We will frankly discuss problems we have observed about clinician prejudice that adversely affect clinical assessment and treatment. We emphasize that every combat veteran, regardless of racial background, is a unique individual with his or her own unique story to tell. We are aware, though, that cross-cultural interactions, because of factors internal to both client and clinician, can impede, if not preclude, effective therapeutic encounter. We recognize that providing information about minorities may do relatively little to alter deeply rooted prejudice of an

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unconscious nature. We hope to address the issues of ethnicity in ways that do not stir clinical resistance but rather that enhance clinician sensitivity, curiosity, and confidence.

KEY WORDS: post-traumatic stress; minorities.

INTRODUCTION

The purpose of this paper is to provide guidelines for assessing Post-traumatic Stress Disorder (PTSD) and other psychological conditions among American minorities who served in Vietnam.

The need for such a paper is supported by two circumstances. One, little has been published about problems assessing American minorities who served in Vietnam. Two, only recently has the collective consciousness of conventional clinical wisdom accepted that PTSD and other disorders occur more frequently among minority Vietnam combat veterans.

A simple event represents the extent to which clinical assessment of minority combat veterans has been actively ignored. As recently as 5 years ago, one of us submitted a research plan to the Merit Review Board of the General Medical Research Service of the Veterans Administration (VA) proposing to study the possibilities that PTSD may be higher among minorities seeking treatment in VA facilities for addiction disorders. Literature was reviewed supporting needs for clinical research, citing alarms sounded early by Terry (1972) and Fendrich (1972), presenting confirmatory empirical evidence from *Legacies of Vietnam* (1981), summarizing the clinical studies of Erwin Parson (1984a, b, 1985a, b) and our well-documented research showing black and Hispanic Vietnam combat veterans among the addicted were more maladjusted than their white counterparts (e.g., Penk *et al.*, 1985). VA reviewers rejected the proposal on grounds that they did not believe the results, writing that even if the findings were replicated, they could not possibly be of importance to such an agency funded to provide health care for veterans. Other investigators encountered similar rejections, especially during the early 1980s, when VA research review panels failed to fund research on the fledgling concept of "PTSD."

However, subsequent epidemiological findings, completed 25 years after the Vietnam War started and 14 years after the Vietnam War ended, have confirmed what the prior studies were suggesting. Prevalence rates of current PTSD are running 13.7% for whites, 20.6% for Blacks, and 27.9% for Hispanics. But even this landmark study, the National Vietnam Veterans Readjustment Study (NVVRS, Kulka *et al.*, 1988), remains as yet silent on needs for developing special treatment intervention for American minorities who served in Vietnam. Moreover, the NVVRS, while noting that ethnic minorities achieved higher rates of PTSD, failed to interpret why white and minority groups were similar

in rates of using VA and non-VA treatment services. The NVVRS even limited the term "minority" to Blacks and Hispanics, omitting American Indian, Asian-American, Vietnamese, and Polynesian combat veterans.

These episodes, highly representative of many similar delays in the tragic history of clinical research among Vietnam combat veterans, forewarn the reader that it is most difficult to develop guidelines for assessing ethnic issues in combat-related PTSD. So much valuable time has been lost by ignoring the problem and delaying the research. Notwithstanding research by a few individuals (e.g., Wilson, 1989) and the remarkable record of the VA Readjustment Counseling Service led by Arthur Blank, MD, even now too little is being done too late. Given inconsistency in available information, the reader can only expect that this draft will weave subjective impressions with objective facts. Even though this paper may seen uneven by presenting the subjective alongside the objective, the reader might keep in mind that the subjective presented here is, at least, the subjective of clinicians who have lived through these times and who have served both white and minority Vietnam combat veterans.

WHY DO CLINICIANS NEED TO BE SENSITIZED TO DIFFERENCES AMONG AMERICAN MINORITIES WHO SERVED IN VIETNAM?

We can answer this question in at least two ways. First, we are witnesses to racism in mental health services across the years. We have seen how fellow clinicians have gone along with institutional racism during the Vietnam War (1963-1974) and its aftermath. Secondly, we have conducted clinical research and we have read results identifying differential ethnic responsivity to effects of war. Even though it was clear that American minorities became increasingly conflicted (especially after 1968) about fighting for a segregated country less integrated than the military units in which they served, few have advocated developing programs specifically targeting the unique problems of minorities.

Conflicts between clients and professional employees of treatment centers rarely have an overtly racial quality. Whereas social graces in the present era de-emphasize obvious racial slurs, these have been replaced by more subtle indicators that produce more ambiguity. Racial and ethnic bias, presented in many subtle forms, occur much more than any of us would care to admit. Even mental health treatment settings are not immune from the infection of institutional racism. We have seen prejudice concretized in many forms—from active resistance in hiring minorities, despite affirmative action laws; in expecting higher performance from minorities than from whites; in doing nothing when racially motivated conflicts occurred; in preferences to work with clients and

patients of one's own class and familiarity and avoiding staff and patients from different socioeconomic groups.

The act of preparing this paper has resensitized us to many events in clinical practice about which we ourselves may have become lax or taken for granted. And just as we have become resensitized to unusual behaviors of ourselves and our colleagues in our respective familiar and comfortable clinical settings, so we must communicate in the course of this paper our basic conclusion that prejudice happens frequently and that we must frankly recognize and eliminate it. We have concluded that the major obstacle in the clinical assessment of Vietnam combat veterans is the prejudice of the beholder. *And such prejudices are intensified when the bias is doubled in the case of Vietnam veterans who are also American minorities.* Clinicians do not like to think of themselves as prejudiced. Unfortunately, prejudice is commonplace, as episodes like the 1989 Carol DiMaiti Stuart murder case in Boston remind us (a case where a racially mixed community was "indicted" rather than the husband of the murdered woman who may have been involved).

Pinderhughes (1986) has postulated, from psychoanalytic and psychophysiological research, that prejudice is "hard-wired" in even the normal human psyche. He finds that social relationships are built on "differential bonding"—affiliative-affectionate drives toward in-group people, and differentiative-aggressive drives toward out-group people. This process includes positive projections toward in-group people, and negative projections toward out-group people. The 400-year history of blacks in the United States has been characterized by the attribution of negative traits to blacks by the dominant population and, until recently, this was a deliberate systematic process. The same has been true to a far less extent for every "new" ethnic or racial group that has immigrated. For native Americans, this process provided the rationale for genocidal wars conducted against these populations. These negative traits precluded the use of blacks in large-scale combat roles in the nation's wars prior to Vietnam, even though blacks have in fact served with distinction in all previous wars (cf. "Glory," a 1989 film about soldiers during the Civil War).

Pinderhughes' work suggests that without corrective experiences, or very unusual developmental experiences, most Americans retain significant prejudice toward racial/ethnic minorities. Our experience indicates that these processes are clearly operative in treating minority Vietnam combat veterans. We will discuss in later sections Parson's theory concerning the minority soldiers' unique problems with racism in the military and the nature of the Vietnam War. The nonminority clinician, through the discovery of his/her own innate prejudice, can understand in an enriched way, the special adjustment tasks faced by minority veterans.

EMPIRICAL EVIDENCE DEMONSTRATING ETHNIC DIFFERENCES AMONG VIETNAM COMBAT VETERANS JUSTIFYING DEVELOPMENT OF PARTICULARIZED APPROACHES FOR CLINICAL ASSESSMENT OF MINORITIES

Research has consistently demonstrated that effects of the Vietnam War are more pronounced among the American minorities who served. That is, studies of treatment-seeking and non-treatment-seeking samples concur in showing higher rates of maladjustment among nonwhites than among whites. Such findings do not mean that white combatants have suffered the effects of war any less; rather, readjustment needs of any veteran are complex but those of the American minority veteran are compounded by the traditional ethnic minority problems of other stresses produced by prejudice in a segregated and racist society. Racism adds stresses to traumatic experiences. Most clinicians have by now concluded that fighting in Vietnam (like any extraordinary life-threatening experience) can produce residual stress for many combatants. But many clinicians have not comprehended the additional complications experienced by many American minority Vietnam veterans whose stress reactions are increased by their experiences of not being majority-culture members. Thus, clinicians must develop a strategy that will fully account for what Parson (1985b) has so eloquently conceptualized as the "tripartite adaptational dilemma"—where the American minority Vietnam combat veteran must resolve the triple effects of a bicultural identity, racism, and residual stress from trauma.

ETHNIC DIFFERENCES IN RESEARCH ON NONTREATMENT SAMPLES

The *Legacies of Vietnam* study (Egendorf *et al.*, 1981) documented greater disturbances among minorities but did not call for special forms of treatment intervention. *Legacies* demonstrated that although blacks had come from disadvantaged families (e.g., fathers of blacks had less education than fathers of whites), blacks did not significantly differ in premilitary adjustment. But, profound postmilitary adjustment differences were observed. That is, blacks were found to suffer stress symptom at rates twice as high as whites (e.g., 40% among minorities compared with 20% for whites, based on samples drawn in 1976-1977). Moreover, blacks were more dissatisfied with postmilitary employment, made less money, endured longer periods of unemployment, and held jobs lower in occupational status. Originally, blacks regarded the military as a positive opportunity for them to gain resources needed for building a more successful life, but the objective result was that service for their country inter-

rupted their climb up the career ladder, stalled career opportunities, and produced more undesirable and insecure jobs. Egendorf *et al.* (1981) interpreted the greater incidence of stress symptoms among blacks as produced by lower education, lower income, and poorer employment.

Recommendations from *Legacies*, however, did not touch upon effects of prejudice or minority status. In fact, little was made of the contrast that minorities were equal in premilitary adjustment, but more disturbed in postmilitary adjustment. Not until later were findings interpreted from the standpoint of lingering effects of both war and prejudice [e.g., "Working through any major life experience may be complicated by the added burdens of minority status in this country" (Boulanger and Kadushin, 1986, p. 1)] or as suggesting more discrimination (". . . we have now discovered possible discriminatory practices in the assignment of rank and in the official meting out of punishment," p. 21).

Performing more sophisticated causal analyses with *Legacies* data after the first report, Laufer *et al.*, 1984) established clearer links between abusive violence in combat and differential ethnic responsivity. That is, blacks were distinguished by greater postwar demoralization and guilt than were whites. Laufer *et al.* explain such differences on grounds that ". . . black participants were generally more sympathetic to the Vietnamese, held a less negative conception of them, were less supportive of the war and were less supportive of unrestrained warfare than white participants . . . The capacity of white participants to dehumanize civilians and other noncombatants was not matched among the blacks. Where whites who were involved in abusive violence developed a number of mechanisms for estranging themselves from the immoral character of their acts, blacks found themselves confronted with a basic contradiction between their actions and their sympathy for the victims" (p. 31). Later, Yager *et. al.* (1984) added "Our hypothesis that sympathy for the Vietnamese is a key element in explaining blacks' emotional reactions does not preclude the possibility that some whites may have reacted in a similar fashion" (p. 332).

As the data pool from the *Legacies* study continues to yield important results about effects of war on later civilian adjustment for groups sampled in 1978, the evidence is mounting that (a) blacks are more troubled for longer periods later than are whites; (b) such greater adjustment difficulties in part may be associated with racism in society and its deleterious consequences for American minorities; and (c) maladjustment may be related to war trauma itself, particularly to conflicts that many blacks experienced in fighting against a Third World country consisting of other minorities (cf. Leventman and Camacho, 1980, "The Gook Syndrome: The Vietnam War as Racial Encounter").

The National Vietnam Veterans Readjustment Study (NVVRS) provides the best-documented evidence of greater maladjustment for American minorities

among Vietnam combat veterans. Kulka *et al.* (1988) compared stratified groups of whites, Hispanics, and blacks with samples tested in 1987. Whites were significantly better adjusted across a wider range of measures than either Hispanics or blacks, with Hispanics evidencing more maladjustment than even Black Vietnam combat veterans. Compared with whites, rates of PTSD among Hispanics were over two times higher (i.e., 27% to 12%). Minorities were rated as significantly higher on specific PTSD symptoms (e.g., disturbing memories, nightmares, flashbacks, loss of interest, detachment, irritability, and trouble concentrating). Minorities also achieved significantly lower employment status, more trouble in marriage, more time in jail, more violent acts, more alcohol and drug problems, and more physical health problems.

Although blacks and Hispanics evidenced greater postmilitary disturbance than did whites, nevertheless the NVVRS indicated that rates of physical and mental treatment services were decidedly lower among Hispanics and lower than expected among blacks. A similar disproportionate ethnic representation was also noted in awarding service-connected compensation. That is, looking at the 40% or higher service-connected compensation category, whites averaged 4.5%, blacks, 3.5%, and Hispanics, 0.0%—even though rates of PTSD were nearly double for minorities. These findings raise serious questions about the process of awarding veterans benefits.

It is not clear at the moment whether racial prejudice accounts for a contribution to higher PTSD among black and Hispanic combat veterans. The NVVRS only analyzed one question about prejudice, black Vietnam combat veterans reporting more discrimination than Hispanics or whites. Effects of racism were not tested; the 5-hr battery of the NVVRS remained silent on the contributions of racial prejudice to adjustment after Vietnam.

Speculation need not last long on this issue, since unanalyzed NVVRS data would permit testing hypotheses that more stress and trauma among blacks and Hispanics before and after their military experience is associated with greater maladjustment. Indirect evidence is already available from three other sources, however. First, it has been shown that minorities in general experience greater degrees of civilian trauma and stress than do their white counterparts (e.g., Dohrenwend and Dohrenwend, 1974). Second, it has been demonstrated that higher civilian stress and trauma combined with combat trauma is associated with greater maladjustment than combat trauma combined with lower levels of civilian stress and trauma (see Berk *et al.*, 1989). Third, blacks were disproportionately exposed to heavier combat, particularly those who served in Vietnam before 1968 (see *Legacies*, where degree-of-combat-exposure-by-ethnicity was analyzed in detail).

NVVRS results are similar to white-nonwhite Vietnam combat veteran differences reported from the Vietnam Experience Study conducted by the Center for Disease Control (1988). Although only part of the CDC study has been

published, nevertheless trends are consonant with the NVVRS when it was found that "nonwhite veterans who had been young and had had low general technical test scores at enlistment" were at greatest risk for postwar maladjustment. In contrast, "white veterans who had been older and had had high general technical test scores at enlistment were significantly less likely to be disturbed than blacks" (p. 2704). Such differences run throughout a variety of physical and mental health analyses; typical is the finding that ". . .total defects among offspring of black veterans is 3.3. . .compared to 0.9. . .for offspring of white veterans. . ." (p. 2717).

ETHNIC DIFFERENCES IN RESEARCH FOR TREATMENT-SEEKING SAMPLES

Despite possible limitations on generalizability from treatment- to non-treatment-seeking samples, nevertheless results among clinical groups approximate ethnic differences found in epidemiological surveys (except that addicted blacks are more maladjusted than addicted Hispanics).

Among Vietnam combat veterans classified as meeting criteria for Substance Use Disorder, Penk *et al.* (1985) reported differential maladjustment as a function of ethnicity, with whites reporting more depression (i.e., significantly higher scale 2 scores on the MMPI) and blacks reporting more suspiciousness and agitation (i.e., significantly higher scale 6 and 9 scores). However, the pattern of differences was not simply a matter of blacks scoring significantly higher on one dimension of maladjustment and whites higher on another. For, when comparing groups subdivided into "light" and "heavy" combat exposure, blacks were significantly better adjusted than whites among those lower in combat exposure whereas blacks were significantly more maladjusted than whites among those with high combat exposure (Penk *et al.*, 1988). The above findings were replicated and extended to measures of PTSD. Penk *et al.* (1989) have found that blacks score higher than either whites or Hispanics on a check-list of PTSD symptoms, as well as on MMPI scales *F*, 1 (Hypochondriasis), 3 (Hysteria), 6 (Paranoia), 7 (Psychasthenia), 8 (Schizophrenia), and 9 (Mania). Whereas adjustment of Hispanics was more similar to their white than to their black Vietnam combat veteran counterpart, nevertheless Hispanics reported significantly higher scores on the MMPI than did whites.

The hypothesis that, among Vietnam combat veterans seeking treatment for substance abuse, blacks evidence greater disturbance than do whites was evaluated further by comparing retrospective ratings of family social climates (Penk *et al.* 1988). The purpose of this study was to determine whether premilitary adjustment (as measured by retrospective ratings of family of origin adjustment) might be implicated in postmilitary adjustment. Black and white

groups did not differ appreciably on either ratings of past family-of-origin or current family-of-procreation ratings. Taken together these findings point toward combat exposure (not premilitary *family* adjustment) as the major factor implicated in development of PTSD and other forms of maladjustment among black combatants. Comparable findings have also been reported for measures other than the MMPI. Penk *et al.* (1988) have shown that black Vietnam combat veterans are deficient in coping efficiency: blacks report using more avoidance maneuvers when problem-solving in conflict-laden situations.

Not every study among treatment-seeking clinical groups has found minorities are more disturbed than nonminorities. Iacono and Silver (1984) reported that white psychiatric inpatient Vietnam combat veterans were more disturbed than black psychiatric outpatients. Research is needed to explore interacting effects of type of diagnostic group with ethnicity. Patterns of ethnic differences among treatment-seeking, diagnostic groups probably differ from those found in epidemiological surveys of non-treatment-seeking populations.

AN ASSESSMENT STRATEGY

Both clinical observations and empirical evidence suggest, then, that American minorities among Vietnam combat veterans require specific approaches to clinical assessment of PTSD that take into account not only varying types and degrees of combat exposure, but also civilian stresses and traumas from racism and from residuals of the ghetto, barrio, and reservation. Combat veterans of various ethnic origins are not likely to present themselves to clinicians all that much more differently than will white Vietnam combat veterans—although we have heard some white clinicians consistently say that they have been treated with more deference and politeness than was accorded them by white combat veterans.

Rather, it is the avoidance symptoms that are most apparent among Vietnam combat veterans in general—avoidance symptoms that are even more pronounced among ethnic minorities when beginning to work with a white diagnostician and/or therapist. By avoidance maneuvers, we are not limiting our comments to passivity, lassitude, or nonresponsiveness for conflict-laden material. On the contrary, avoidance behaviors can be quite dramatic where the Vietnam combat veteran maintains emotional and social distance by a bellicose facade or outrageous demands that dampen any enthusiasm for establishing a working alliance—except among the more inexperienced or idealistic clinicians.

Most clinicians conclude, after a while, that Vietnam combat veterans are among the more difficult diagnostic groups with which to work. And some white clinicians may find that minority Vietnam combat veterans are even more

elusive for many different reasons—such as more distrust of the white diagnostician/therapist because of previous difficulties with members of the majority culture; differences in values of what is being sought through treatment and expectations for what might be received; differences in "speaking the same language," etc. There are two ways in which clinicians traditionally deal with difficulties in assessing elusive clients. One is based upon knowledge-driven information about how to accurately interview. The other is based upon psychometrically sound tests.

CLINICAL CONSIDERATIONS IN DEVELOPING INTERVIEWS FOR ASSESSING MINORITIES AMONG COMBAT VETERANS

Excellent discussions of diagnostic and treatment concerns with black veterans (e.g., Parson, 1985a, b) and Hispanic veterans (Pina, 1985) have been provided recently. More investigations concerning Native American veterans would be very welcome, as the National Working Group on American Indian Vietnam Era Veterans (of the VA's Readjustment Counseling Service) has provided in their 1984 report, "Worth of the Warrior" (Silver, 1984). Reports from this project provide a fascinating look at the cultural differences between the various Indian tribal views of war and home-coming (see also Wilson, 1989).

Obviously, there are not enough minority clinicians available to provide all the services needed by minority clients. Therefore, cross-ethnic, cross-racial therapy relationships predominate. But clinical relationships exist in an institutional context. Racial/ethnic diversity of staffing at all levels has a powerful bearing on both the clinician's as well as the client's willingness and capacity to enter into a complex, often ambiguous therapeutic process. An appropriately integrated facility exerts a powerful positive effect on minority veterans, just as the absence of integration exerts a negative effect. What is not generally appreciated is that the same holds true for clinicians. An appropriate racially and ethnically diverse "aware" clinical environment is a necessary precondition for advice, "tips," etc., concerning minorities to have any real meaning. It makes a certain kind of sense that if the American military achieved a high level of integration during the Vietnam Era, then white and minority veterans deserve to be treated in facilities that are at least trying to achieve a reasonable level of ethnic diversity.

We suggest the concept of "projective identification" is relevant for the cross cultural interface (Ogden, 1982; Zinner and Shapiro, 1972). "Projective Identification" refers to an unconscious psychological process in which both parties in a relationship (object and subject) relate to each other in such a way as to "make" the other party confirm the validity of deeply held internal pro-

jections. Both parties, in a sense, act as though they are in collusion to maintain conflict or negative interactions, thereby recapitulating some aspect of each participant's past. We think that this dynamic occurs frequently in cross-racial transactions because racial biases are part of the personality fabric of every American, to varying degrees. For example, in the veteran context, blacks and Hispanics have been labeled by whites as traditionally suspicious of VA personnel, while clinicians have been characterized by blacks and Hispanics as cold and aloof. The effects of these two attitudes may sometimes be an impoverished clinical interface, mistaken diagnosis, ineffective treatment planning, subtle or open conflict, and broken treatment with involvement of many different clinicians. This situation has negative consequences not only for the patient's improvement, but also may have adverse effects on legitimate seeking of compensation.

It is our contention that racial biases exist in most Americans. These stereotypes are variably conscious, and are variably operating in controlling behavior (e.g., Pinderhughes, 1982). There is no reason to exclude mental health clinicians from this unfortunate, if natural, dynamic. In fact, it strikes us that in all likelihood, most black and white Vietnam veterans have had more interpersonal cross-cultural experiences than many treating clinicians. Minority veterans, in their different appearance, language, philosophies, etc. (cf. Parson, 1985a, b), combined with the fact of having borne arms in combat, have a unique capacity to activate racial stereotypes in nonminority clinicians [recalling that there was resistance to blacks bearing arms even in combat, partially based upon fears about what would happen when blacks returned home (Allen 1986)]. Simultaneously, these same veterans may be operating on their own racially biased stereotypes fearing rejection and mistreatment. Such expectations govern behavior toward clinicians. For example, the "black mask" of blunted affect and apparent dullness that some black Americans show toward whites is not merely a static phenomenon; it is also an interactive mechanism that can be altered depending upon circumstances.

Racial bias notwithstanding, it is the clinician's responsibility to become aware of his/her own biases that would interfere with a neutral "objective" understanding of the client. Projective identification provides a conceptual tool by which these intrapsychic and interpersonal phenomena can be understood, tolerated, and applied in the therapeutic setting. The mechanism is not only pertinent in the cross-cultural or cross-racial relationship. The earlier attitude held by some clinicians and VA employees that Vietnam veterans were "losers," unkempt, distrusting, etc., was reflected in the behavior of these personnel towards veterans, and the negative reactions on the part of the young veterans only confirmed the negative opinions about them. Continued resistance to the concept of PTSD (e.g., Kolb, 1987) may have both a genuine scientific basis as well as one rooted in continued genuine prejudice against veterans of this

war. Certainly, we have no doubt, minority veterans are in even greater jeopardy of running afoul of clinician unconscious prejudice. Vietnam combat veterans suffering from PTSD and its variants present in many ways. Minority veterans are no exception. Often though, the association between the presenting symptom/complaint and the war is not easy to establish.

Most experienced clinicians advise the inclusion of military history as an integral part of the complete evaluation. Scurfield and Blank (1985) provide an exhaustive set of questions from which the clinician may choose, depending on the specific clinical circumstances. We stress sensitive, flexible judgment rather than a prescribed "cookbook" approach to gathering military history, in an interracial context. Unconscious psychological defenses may be operative, as well as conscious resistance to associating to war experiences. The timing of directly seeking information about the war is essential with resistant veterans; nonetheless, at some point, some deliberate effort by the clinician to elicit a military or combat history must be made both to rule out as well as to rule in PTSD.

It has been our practice to meet veteran's complaints "head on" and to establish a working rapport that provides the basis for subsequent long-term treatments, including psychotherapy (and medications, in the case of the physician-therapist). Symptoms which are not among the primary features of PTSD are often prominent initial complaints—i.e., job problems, marital discord, alcohol abuse, medical problems. These can be very urgent to the veteran, and these symptoms may be the "testing ground" on which the clinician should demonstrate availability, empathy, and competence. We would caution the clinician to evaluate each veteran as an individual, regardless of any generalizations made about minorities—such as "suspiciousness" among blacks, or "machismo" among Hispanics. As with white veterans, the variation in basic personalities runs the whole gamut of possibilities. Also, the presentation of the veteran may differ once the initial crisis has been resolved.

We have encountered the curious problem of clinicians unable to accept backgrounds of clients because of racial stereotypes. For example, we have heard of middle-class blacks presented as impoverished and ghetto-bred even though their history—indicating otherwise—was available! While there are certain taciturn minority veterans, there are assuredly insight-curious minority veterans quite willing to associate freely—if the clinician conducts that type of interview. The interviewer's capacity to avoid stereotypical, unconsciously-determined, biased responses to the minority client will determine not only resolution of initial crisis, but also quality of the subsequent working relationship.

But what may work against achieving stability in forming a working alliance is that many veterans often do not see the same therapist over time. It is not clear from our reviews of treatment records whether the veterans's counterdependency or avoidance is the major cause producing a change of therapist,

or whether the determining factors are within the therapists involved. In our experience, veterans may avoid treatment for varying lengths of time; many clinics or therapists do not allow the flexibility for the same therapist to resume working with the veteran when he or she returns, even if both parties choose. Clinician indifference to continuity of care may also be central and clearly offers the resistant veteran an "out" from ever confronting latent PTSD.

It has been suggested that blacks tend to somaticize emotional/psychological complaints. It is our experience that many veterans complain of various physical symptoms, especially gastrointestinal symptoms, such as nausea, abdominal pain, etc. NVVRS results (Kulka *et al.*, 1988) show that a significant number of combat veterans, especially blacks, complain of feeling "unwell" many years after the war. Utilizing medical referrals appropriately, i.e., taking these complaints seriously, is essential for reestablishing rapport. Listening to complaints and taking heed of the veteran's associations both "to" as well as "from" the physical complaint is challenging and necessary in order to obtain valuable information about psychological underpinnings of complaints, even at times when affective blunting is present or the patient tends to be nonverbal. The therapist's clinical curiosity may indeed have to fill a relative void, but this can be done using the veteran's associations. Clinicians must keep in mind that premature efforts toward insight will threaten the veteran and the therapeutic relationship, especially if cultural factors are not well understood. It is our opinion that such problems as alcohol abuse, physical symptoms, dangerous behavior problems, and severe relationship problems must be addressed first; the therapist's restraint and patience are even more important when working with PTSD suffers, given the intrapsychic depth of the psychological wound.

We can't stress enough that content pertinent to the minority veteran's experience as a minority, whether in civilian or in military life, must inevitably be explored. We have found that many untoward reactions emerge from nonminority clinicians, a common one being, "Do you think he (or she) is just using racial problems as an excuse?" This attitude is remarkable, given the fact that psychotherapy with patients of any racial or ethnic background in any clinical context deals at times with the client's "excuses" for their difficulties. We find that many nonminority clinicians are simply uncomfortable hearing about minority patients' suffering from this aspect of American life. The association of civilian racism with combat trauma makes nonminority clinicians anxious, particularly when the black or Hispanic veteran begins to express appropriate anger. We think that this anxiety can be eased, for example, by establishing integrated clinical settings and giving cross-cultural and cross-racial staff training to alleviate discomfort about the realities of racism. Dissemination of information about minorities before, during, and after military service in Vietnam is essential.

Also relevant is the importance of the mental status examination both in recent evaluation and during treatment. In cross-cultural treatment situations in which projective processes may inordinately threaten clinician as well as client, the clinician must be able to review formally such factors as the client's associations, content, level of agitation, eye contact, etc. It is likely that minority veterans, as well as combat veterans suffering from PTSD generally, may experience withdrawal and discomfort from the clinician at the very time that they start to really "get into it."

No one really wants to hear about combat atrocities, gross officer misconduct, leadership breakdown, fragging, wracking guilt, etc. However, working through all of the physical complaints, substance abuse problems, and other related difficulties leads, at least for some combat veterans, to core PTSD issues from which the clinician should not withdraw since that has been the goal of any therapy since the initial complaints. The therapist must be able to distinguish between appropriate expressions of long-repressed affect and psychotic transference, regression, etc. Medications are often inappropriately introduced, giving a disturbing message to the veteran who is just "opening up." The mental status examination, whether done formally or not, is essential for the clinician to think about, especially in the cross-cultural or cross-racial setting. Adebimpe (1981) has reviewed the problems American blacks have experienced with lack of diagnostic accuracy in mental health settings, pointing out tendencies to over-diagnose thought disorder and to under-diagnose mood disorders.

PSYCHOMETRIC CONSIDERATIONS IN ASSESSING MINORITIES AMONG VIETNAM COMBAT VETERANS

Orienting Remarks Preparatory to Administering Psychometric Instruments for Minorities

One way of gathering information for purposes of breaking down stereotypes is based upon psychometrically standardized tests that have been designed to eliminate personal bias in evaluating people (after all, the psychometric tradition arose in part to overcome stereotypes and to eliminate bias). However, recently, psychological tests have been accused of contributing to, not breaking down, stereotypes. Debates rage in many domains of psychological measurement (i.e., intelligence, personality) about the possibilities that ethnic bias in tests may distort results [for an excellent review, see Dahlstrom *et al.* (1986); also see special monograph in the *Journal of Consulting and Clinical Psychology* on ethnicity and psychological test performance (e.g., Greene, 1987; Harre and Secord, 1972; Jones and Thorne, 1987; Sue and Sue, 1987)]. These reviews about psychometrics and ethnicity, metaphorically speaking, are like the month

of March; that is, they all begin with lions' roars loudly proclaiming that psychological tests are biased against ethnics, and they usually end more anticlimactically like frolicking lambs saying that it is not possible to specify how tests are biased but, since tests are so widely used, we had better make sure that they are not biased.

Thus, in orienting the clinician to developing a strategy for testing minorities among Vietnam combat veterans, we have concluded, in reviewing the literature, that there is very little evidence to support the accusation that all personality tests are ethnically biased. [To illustrate, Greene (1987) decides, after exhaustively reviewing the MMPI ethnicity literature, that ". . .the failure to find a consistent pattern of scale differences between any two ethnic groups in any population suggests that it is very premature to begin to develop new norms for ethnic groups. . ." (p. 509).] This recent conclusion coincides nicely with what Penk and Robinowitz pointed out in 1974 when they demonstrated, with the supposedly racially biased MMPI, that black heroin addicts were comparatively better adjusted than white heroin addicts. (If the MMPI was negatively biased against minorities, then blacks could not have been seen as better adjusted.)

What is biased is people, that is, how clinicians go about using tests—e.g., asking inappropriate questions of the test; not understanding individual ways, for example, some Asian-Americans deferentially approach such authority figures as physicians and psychometricians; misunderstanding that within-group ethnic differences are sometimes larger than between-group differences. Although Gnostics by the end of the Third Century effectively countered the argument that evil lives in things, modern-day psychologists have had a hard time giving up the notion that bias resides in tests—in favor of the more practical consideration that most prejudice is contained in how clinicians use tests.

Consequently, in reviewing psychometrics for purposes of developing a general assessment strategy for evaluating ethnic minorities among Vietnam combat veterans, we conclude that clinical assessment of PTSD of American minorities risks less by acts of commission (i.e., less by bias contained in tests) but risks bias more by acts of omission (i.e., by what test-makers leave out when constructing tests and by what test users leave out when using tests). Psychometrically based tests of PTSD, by-and-large, are fairly accurate, because test-makers usually included blacks and Hispanics when tests were normed and scales developed. [Perhaps one exception is the NIMH's Diagnostic Interview Schedule, or DIS, which has been challenged on the basis of low rates of DIS-clinician agreements when classifying schizophrenia among blacks. See Hendricks *et al.* (1983).] However, examination of test items reveals that all currently available tests of PTSD omit culturally specific aspects of stress. PTSD tests and interviews do not review stresses and traumas of being a minority civilian. Most of us forgot that minority veterans went from a segregated society to a partially integrated Vietnam military

service, and then returned to a less integrated society still in racial turmoil. Interviews that assess these complicated civilian-soldier transitions are the Scurfield-Blank (1985) military history, the Hough-Gongla (1983) Brentwood VA Interview for Hispanics, and the Barse-Ladue-Holm (1984) PTSD Interview for American Indians.

Currently available PTSD clinical assessment methods may accurately evaluate those aspects of PTSD that are culturally general, but no instrument is available that taps into culturally specific aspects of PTSD. So, in clinically assessing black, Hispanic, American Indian, and Asian-American combat veterans, clinicians may have to go beyond what some cross-cultural psychologists refer to as *etic* PTSD measures (i.e., those that are generally applicable or nomothetic in type) to *emic* PTSD measures (i.e., adding clinical inquiry about facts that are culturally specific or idiographic in nature).

Psychometric tests recommended for PTSD assessment usually are paper-and-pencil tests. Some clinicians favor psychophysiological measures as well (e.g., Keane *et al.*, 1987). Whereas we agree wholeheartedly with the multi-modal assessment strategy for measuring PTSD, two cautionary remarks must be sounded. First, psychometric measures of PTSD have been found to achieve acceptable levels of diagnostic accuracy, sensitivity, and specificity – above results using psychophysiological or endocrinological measures (see Gerardi *et al.*, 1989, for a review comparing relative efficiency of several types of PTSD measures). Second, ethnic differences have not been assessed for comparative efficiency of diagnostic accuracy using either physiological or endocrinological measures. It is untested whether visual or auditory stimuli traditionally included in physiological studies of PTSD are subject to culturally-specific biases. (The authors endorse conducting psychophysiological studies measuring heart rate and skin conductance using culturally specific or personal-vignettes, or personal stimuli – e.g., race riots, martyred black leaders such as Martin Luther King, etc.)

It might also be noted that comparing white, black, and Hispanic Vietnam combat veterans may not be, strictly speaking, acts of cross-cultural research. Conceivably, majority and minority groups in the United States share many cultural experiences simultaneously as they experience unique culture-specific differences. So, clinical assessments with such groups are more a matter of evaluating cultural differences among ethnic groups living in the same region; assessing ethnic minorities among Vietnam combat veterans differs from that form of cross-cultural clinical assessment that evaluates cultures living in different geographical places. So, given these characteristics (i.e., tests of PTSD omitting culturally specific reactions, complications of different cultures living in the same region, generational changes in segregation and integration, etc.), we recommend that emic measures of specific cultural experiences be added to existing etic measures when clinically assessing American minorities among Vietnam combat veterans.

But, practically, how does one do this? Pathways to improving assessment have been charted brilliantly in the writings of Erwin Parson (1984a, b; 1985a and 1985b; see also the Report of the Working Group on Black Vietnam Veterans, chaired by Parson). For purposes of general assessment, the compendium edited by R. L. Jones (1988) may prove helpful. For specific purposes, the reader can implement the "accounts method" (Harre and Secord, 1972) that is based upon structuring a free-flowing clinical interview that elicits a person's first-hand, narrative account through the use of directed probes on culture-specific topics. To develop effectively such a technique, clinicians need (a) to be acquainted with the process of constructing critical incidents about social interactions between ethnic groups (see also Triandis, 1976; Triandis and Draguns, 1980); (b) to know some history about the Vietnam War as well as life in the United States during this era (e.g., Karnow, 1983); and (c) to know and to be sensitive about minorities in America and in the Armed Forces before, during, and after military service [see Andrews (1987) for critical incidents about premilitary adjustment, military induction process, military training process, basic training, military role in Vietnam, return from Vietnam and from military, etc.]

If a working alliance (going well beyond merely establishing rapport) can be effected with a minority client, then we recommend that a structured clinical interview might explore emotional reactions from the emic, culturally specific perspective on a number of topics. Scurfield and Blank (1985) have listed specific questions that might be asked from the minority perspective. Examples are: minority views of entering the military, of boot camp events, military role models (whether minority or majority groups members), proportion of minorities in units, the unit of service, perceptions and emotional reactions to one's role in Vietnam and feelings about Vietnamese, experiences about death and dying (perhaps about abusive violence or atrocities), areas served, types and extent of combat experiences, interactions with other minorities as well as the majority in the field and at the rear, evidence of a "Gook" identification, perceptions of sociopolitical changes during the war years, personal experiences with racism both as a soldier and as a civilian, self-identification changes that occurred during the process of shifting from civilian identity to soldier identity to civilian identity, feelings about homecoming, feelings about shifting from comparatively more integration in the military to comparatively less integration at home, feelings about educational achievement, income, employment history, differences in stress levels in everyday civilian life, feelings about the effects of military service on personal life, and civilian stresses and traumas.

The reader is forewarned that each of these topics may be emotionally charged. We are not advocating exploration of these topics by the unskilled, the merely curious, or the obsessive clinician. These subjects must be approached with care and empathy only by a skilled and understanding clinician

who has developed expertise in the history of minorities as civilians and as soldiers.

In dealing with such topics, Parson recommends focusing upon: "1. How veterans view their symptoms; 2. What they define as a symptom; 3. The veterans' experiences of their own stress-related problems vis-á-vis the Vietnam experience; 4. Their attitudes about sharing their problems with therapists and other helpers; 5. Their personal experience of pain; 6. The expected type of treatment they believe will meet their needs; and 7. How they understand the causes of their difficulties . . ." [Parson, 1985b, p. 373; compare also Jones and Thorne (1987), who emphasize shifting assessment of American minorities away from "empiricist methods of psychological inquiry" to ". . . gaining access to subjective experience by obtaining introspective, narrative accounts . . ." p. 488].

But what distinguishes the traditional clinical assessment from the more nontraditional activity of assessing PTSD among American minorities who served in Vietnam is the emphasis that clinicians must give to evaluating "ethnicity" as ethnicity relates to PTSD. Degree of ethnic identification may provide subjective and objective cues about PTSD—subjective in appreciating acculturation strains before, during, and after Vietnam (e.g., Parson, 1984a, b) and objective in the sense of understanding the interaction of social class and mental disorders (e.g., Dohrenwend and Dohrenwend, 1969).

Measures of ethnic identity and acculturation are better developed for Hispanics than for other ethnic groups (e.g., Olmedo and Padilla, 1978; Olmedo, 1979; Montgomery and Orozco, 1985). Parson suggests, to determine degree of ethnicity, that these eight points be covered: ". . . 1. the language spoken in the home; 2. how well English is spoken; 3. stresses of migration and length of time in the United States; 4. community of residence and opportunities for linking with fellow countrymen; 5. the educational attainment and socioeconomic status; 6. the degree of religious faith; 7. the nature of political affiliation, and 8. the presence of intermarriage" (1985b, pp. 324-325).

Evaluating degrees of acculturation has many purposes. One is to understand the language by which emotions are expressed and emotional conflicts are relieved and resolved. Another is to know and to sense the degree of cultural stress and strain that might be occurring in the immediate clinician-client relationship. Still another is to understand how stressful it was growing up into adolescence; shifting from civilian to combatant status in boot camp; serving as a combatant; shifting from combatant to civilian; and understanding the adjustment process as a veteran, who, over the last 15 to 20 years, may have had contact with a variety of agencies—from resuming training and education to being treated for physical and/or mental problems.

As in assessing PTSD, determining the degrees of acculturation and ethnic identity should be made by charting the waxing and waning of adjustment across time. PTSD and acculturation should be assessed *phasically*. Phasicality

in PTSD symptomatology and in ethnic identity implies that intensification of either may be an interactive process, changing over time with variations in civilian stresses and traumas. Over the years, we have seen some black and Hispanic combat veterans, who, after intensive contact with the white majority, have either markedly increased or decreased their symptoms and their assimilation with the majority. But what does not change is the following: "Ethnicity is an irreducible entity, central to how persons organize experience, and to an understanding of the unique 'cultural prism' they use in perception and evaluation of reality. Ethnicity is thus central to how the patient or client seeks assistance (help-seeking behavior), what he or she defines as a 'problem,' what he or she understands as the causes of psychological difficulties, and the unique subjective experience of traumatic stress symptoms. Ethnicity also shapes how the client views his or her symptoms, and the degree of hopefulness or pessimism toward recovery. Ethnic identification, additionally, determines the patient's attitudes about sharing troublesome emotional problems with therapists, attitudes toward his or her pain, expectations of the treatment, and what the client perceives as the best method of addressing the presenting difficulties" (Parson, 1985b, p. 315).

PSYCHOMETRIC MEASURES OF VIETNAM COMBAT-RELATED PTSD

In this section, we review psychometric measures of Vietnam combat-related PTSD. We begin with prototypes for developing tests (i.e., interviews), preparatory for identifying items that may eventually be used in formal tests. The section on standardized interviews is then followed by formal tests.

PTSD evaluations are hampered by at least two deficits. First, although there are several good PTSD measures currently under development, there does not exist a "gold standard" for diagnosing PTSD. And, second, whereas blacks (but not Hispanics or other ethnic groups) have been adequately represented in standardization and norming of PTSD measures, studies have not been completed that will settle issues about the contributions of ethnic factors to measuring PTSD.

The topic of reliability and validity in measuring PTSD, generally considered, is a topic of continuing investigation [see summary by Keane *et al.* (1987)]. Moreover, efforts are underway about how to research the ethnic influence in PTSD comparison studies and scale construction. Hopefully, the NVVRS results showing more PTSD among minority Vietnam combat veterans should inspire efforts to improve methods of diagnosis and treatment among American minorities.

Noting no gold standard for measuring PTSD, combined with too little attention given to interactions of ethnic factors, care must be taken in making concrete recommendations for the practicing clinician. To assess PTSD, in general, we encourage readers to begin by mastering the recommendations developed by Arthur Arnold in his excellent chapter, "Diagnosis of Post-traumatic stress disorder in Viet Nam veterans" (Sonnenberg *et al.*, 1985, pp. 99-123). To assess PTSD among minorities in particular, we endorse the thoughtful chapter in the same volume by Raymond Scurfield and Arthur Blank, "A guide to obtaining a military history from Viet Nam veterans" (1985, pp. 263-291), one of the few to consider the role of minorities in Vietnam.

Basically, clinicians should use several different methods for diagnosing PTSD. For Vietnam combat-related PTSD, a typical test battery might include the Structured Clinical Interview for DSM-III-Revised (or SCID) with the supplemental section for Vietnam combat veterans (Spitzer and Williams, 1986). The SCID features a standardized approach meeting acceptable levels of reliability and validity. As yet, no systematic ethnic bias has been identified. The SCID yields presence/absence classifications for all Axis I diagnoses (and a form for classifying Axis II disorders currently is being field-tested). The SCID is recommended as an introductory task for classifying PTSD because (a) the instrument is comprehensive in scope; (b) training guidelines are well-developed; and (c) the structured clinical interview usually facilitates rapport. Beginning with a personal, face-to-face interview permits the clinician to be sensitive to possible misunderstandings and biases that might arise as the clinical assessment shifts from individual interview to reading paper-and-pencil tests or reading items at a terminal. The SCID does contain a "cookbook" format, and we recommend that clinicians master the presentation of the structured interview so the awkwardness of following an outline does not intrude upon the challenging demands of the assessment situation where the white clinician already has enough trouble trying to establish rapport with nonwhite clients.

The Jackson PTSD Structured Interview (Keane *et al.*, 1984a) is an excellent second task to administer for specifics about combat-related PTSD, following general information about psychopathology from the SCID. The Jackson Interview yields information about combat exposure and postmilitary adjustment (particularly in terms of PTSD). The Jackson Interview asks for background information about experiences and feelings that may not have been elicited by the more general SCID questions (Keane *et al.*, 1984a). Cautionary comments must be echoed from warnings sounded by developers of both the SCID and the Jackson. Namely, good rapport must be established. Further, independent, objective information about the veteran's military service in Vietnam must be obtained [e.g., from military separation papers, DD-Form-214, VA and or military service records, etc.: see Keane *et al.*, (1984a, p. 268)].

Currently, the best available psychometric measure of combat-related PTSD is the recently published Mississippi Scale for Combat-related PTSD (Keane *et al.*, 1988). This set of scales has not as yet been demonstrated to be racially biased—perhaps because, again, a representative sampling of blacks was included in scale development. The Mississippi instrument yields subscores for specific PTSD dimensions—e.g., intrusive memories and depressive symptomatology, interpersonal adjustment problems, lability of affect, memory problems, ruminative features, and personal difficulties. The instrument as yet has not been evaluated for whether or not any items are sensitive to ethnic-related differences or for whether or not subscales could be yielded for ethnic-specific dimensions of PTSD

For a general psychometric measure, the revised Minnesota Multiphasic Personality Inventory (or MMPI-2, Butcher *et al.*, 1989) is recommended, although clinicians may have developed other personal favorites. The MMPI yields a score from a recently developed PTSD subscale [as devised by Keane *et al.* (1984b); see review in Denny *et al.* (1987)]. This PTSD MMPI subscale has not as yet been empirically demonstrated as being racially-biased—perhaps because a representative proportion of blacks and Hispanics was included in validation and cross-validation. Further research is needed, however, to rule out any possible ethnic bias; moreover, the scale may not detect ethnically specific aspects of PTSD. The Keane *et al.* (1984a) PTSD MMPI scale probably attains greater sensitivity and specificity when PTSD is to be detected among psychiatric patients and when base rates of the disorder are around 50% prevalence. Further, the PTSD MMPI scale has been cross-validated in a recent nation-wide sample and both sensitivity and specificity were demonstrated at levels of accuracy acceptable for diagnostic use (Kulka *et al.*, 1988). Moreover, the MMPI-2 now contains a PTSD scale to be used with nontreatment-seeking samples—the Schlenger-Kulka PTSD Scale (Butcher *et al.*, 1989). Derived from the NVVRS epidemiological survey, this addition to psychometric scales awaits field testing.

Of all the measures of PTSD, the MMPI stands alone as the one instrument that yields reliable and valid measures of response sets. Even though the clinician may not be certain whether an ethnic client is registering culturally-unique aspects of PTSD, the one thing the clinician can be certain about is whether or not the test-taker is down-playing or exaggerating symptoms. The validity scales of the MMPI-2 alone recommend its routine inclusion in any test of PTSD for any client. No other test or structured interview of PTSD contains this essential feature of measuring response set: anyone who undertakes an evaluation of PTSD without assessing response set simply courts disaster.

Diagnostic accuracy of PTSD measures was recently summarized in a paper by Gerardi *et al.* (1989). These authors conclude that the first stage of developing descriptive PTSD criteria now is coming to an end and that the next round of research will focus upon comparing the variety of measurement

techniques that have been developed. The preferred design will be testing comparative efficiency of self-report, psychometric, endocrinological, and psychophysiological measures of PTSD for relative degrees of sensitivity and specificity among populations varying in prevalence and incidence rates. Given notable differences in PTSD by ethnic groups (e.g., Penk *et al.*, 1988, 1989), studies about diagnostic accuracy of various instruments should examine the question of whether diagnostic accuracy varies by ethnic group. Such data simply are not available at the present time and clinicians must rely upon personal diagnostic skills to enhance instruments limited to measuring mainstream PTSD symptoms when working with American minorities.

CONCLUDING REMARKS

In summary, the history of diagnosing and treating Vietnam combat veterans has been conducted with as much ambivalence as the Vietnam War was conducted by the public at large. There have been many splits. And such splits are magnified in our failure to develop appropriate diagnostic and treatment programs for minority Vietnam combat veterans.

However, the *eternal task* of the behavioral sciences is to break down stereotypes. Behavioral sciences began their ascendancy to public consciousness by efforts to break down stereotypes about intelligence. One of the earliest areas in which psychologists played a public role in this pluralistic society was to ensure that millions of immigrants from many diverse ethnic and cultural groups would be accurately assessed. Now another important challenge is that of developing accurate assessments of ethnic and cultural differences among Vietnam combat veterans. The *eternal task* of a psychologist is to confront and to master one's own genetic predilections for classifying others into in-groups and out-groups. And then, once learning the skills to rise above one's own genetics, the next task is to teach others how to achieve tolerance for, and understanding of, other peoples.

Prejudice within our profession confronts us everyday. It appears in many forms so subtle that most of us remain unaware until we notice that someone else is doing it. It appears in how we go about affiliating with some colleagues but not with others. It manifests itself in how we decide what is good and what is bad clinical research. It shows itself in the kinds of patients we elect to treat and who we choose to refer to colleagues. We feel it and see it when confronted with situations demanding decisions about policy and planning and in how we go about deciding whom to side with in group interactions. We have lived through times when we have seen the destructive power of prejudice when it was institutionalized in the very laws by which we related to minorities and to women.

But it is the abiding task of mental health practioners to go beyond prejudices that subtly infect our treatment environments and our own behaviors. Prejudice arising from our ambivalence about the Vietnam War continues to be expressed in the slowness with which we developed treatment programs for Vietnam combat veterans in general and for minority Vietnam combat veterans in particular.

The major findings of the NVVRS are the minority differences. The issue confronting us now is how shall we respond. Having accurately established PTSD prevalence rates among Vietnam combat veterans, the next most important contribution of the NVVRS was the clear demonstration that PTSD is higher among minority veterans. The legacy of Vietnam will now be shown in how behavioral scientists proceed to diagnose and to test minority Vietnam combat veterans.

But the legacies of Vietnam War may present us with other inheritances by giving the impetus for behavioral sciences to grow in other ways. One direction for growth is to expand our awareness of what is meant by "minority"; hopefully, we can soon learn that "minority" refers not just to how the dominant culture treats the less dominant in the culture but also refers to how the disadvantaged have been treated. (It is likely that many American middle-class whites are just as prejudiced toward lower-class whites as they are prejudiced toward members of different cultures.)

And, finally, another direction for growth is to expand our awareness of the lingering effects of civilian trauma. This chapter has centered on long-standing neglect of Vietnam combat trauma among American minorities. One of our next major goals as clinicians is to improve diagnostic and treatment methods for those civilians who have endured civilian trauma, especially for minorities where the prevalence of stress and trauma is so much higher.

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