Clinical Case Study

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THE AMERICAN INDIAN VETERAN AND POSTTRAUMATIC STRESS DISORDER: A TELEHEALTH ASSESSMENT AND FORMULATION

CLINICAL HISTORY

A. Patient identification

V. is a 52-year-old American Indian male, divorced father of two daughters and one son, ages 15–29. He lives by himself in an isolated part of a large rural reservation in the Dakotas. V. currently works in the maintenance department of the Tribal Housing Authority, a job he has held for the past eight years. He served in the Marine Corps from 1967 to 1970, and did two combat tours in Vietnam from 1968 to 1970 with Marine Reconnaissance. V. was recently evaluated and assessed through a Veterans Administration (VA) telehealth clinic that provides outpatient services to his community. This VA telehealth clinic uses live interactive videoconferencing technology to link the Regional Veterans Administration Medical Center (VAMC) to a reservation-based clinic to provide weekly mental health assessments and treatment.

B. History of present illness

V. was referred to the clinic from his work, after several recent incidents during which he lost his temper and had angry outbursts at his coworkers. In the past several weeks V. had felt extremely irritable at work, and found it difficult to be patient with his coworkers. He stated that there were times when he lost his temper with different coworkers for what he perceived to be their poor performance. During these incidents he yelled at them, but within a short period of time his anger dissipated and he experienced remorse and regret for these behaviors. Afterward V. wanted to apologize to his coworkers, but was unsure how to do so. V.'s nephew was killed in a car wreck one and-a-half months previously, and V. identified this as the cause of his recent irritability at work. He complained of feeling "down in the dumps" since his nephew's death and could not understand why he just "can't snap out of it." In the two weeks prior to presentation he also had increasing thoughts and memories of his experiences in Vietnam that were quite bothersome for him.

V. spent his two tours in Vietnam serving in six-man Marine Reconnaissance teams that conducted multiple-day patrols in enemy territory, engaging in reconnaissance and ambushes. During his time in Vietnam V. had several combat

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experiences, and is able to relate numerous incidents that meet Criterion A for posttraumatic stress disorder (PTSD). The most troubling experience for V. was during his second tour of duty when he was on recreational leave and his entire recon team was wiped out in an enemy ambush. V. felt that if he had been on this patrol he would have been able to prevent the tragedy from occurring.

V. described a history of heavy alcohol use beginning in Vietnam, but reported that he quit drinking five years before with the help of a local Alcoholics Anonymous (AA) group. Three weeks prior to assessment he went on a two-day drinking binge, which V. attributed to a reaction to his nephew's death. He denied having used alcohol since that time.

V.'s recent symptoms related to his Vietnam experiences, including trouble with intrusive thoughts, Vietnam-related nightmares two to three times a week, occasional flashbacks, numbing, isolation, avoidance, exaggerated startle response, irritability, and trouble with sleep. In addition he complained of depressed mood and trouble with concentration, but reported no appetite or energy problems. V. denied current suicide ideation, although he described having suicidal thoughts in the past when drinking heavily. He has never attempted suicide. V. has a history of fights when drinking, but denied recent altercations. He also denied homicidal thoughts or intent.

V. stated that he recently heard his deceased nephew's voice calling his name at times, and also reported seeing his ghost sitting on a bridge two weeks previously as V. drove by. For the past several years when going to bed V. reported hearing the voices of his dead Vietnam comrades calling his name.

C. Psychiatric history

V. had not received previous treatment for PTSD, although during a stay in alcohol rehabilitation in the 1980s he recalled treatment providers mentioning that he might have PTSD. His first drink at age 16 was with an older cousin. V. drank several times in high school, but did not report drinking regularly until enlistment in the military. V. began drinking more frequently during his initial military service, and reported heavy drinking binges in Vietnam when off duty. This drinking pattern continued after he returned from Vietnam. He remained sober during the week and drank heavily on weekends, consuming at times up to two to three cases of beer or a liter of hard liquor. On several occasions V. drank to the point of passing out and experienced blackouts. He has a history of DUIs, as well as several arrests for being drunk and disorderly.

In the mid-1980s V. participated in two inpatient alcohol treatment programs at separate Veterans Affairs Medical Centers (VAMCs). After both treatments he was able to maintain his sobriety for several months but eventually returned to previous drinking patterns. In 1996 V. again quit drinking, and joined a local AA group. He has been fairly successful at maintaining his sobriety since 1996, but

has experienced two to three short relapses lasting a couple of days each. Prior to the binge three weeks ago, V. had not had a drink for the past two years.

D. Social and developmental history

Born in an Indian Health Service (IHS) hospital on his reservation, V. had an uncomplicated delivery. He grew up in a small rural reservation community with an older brother, an older sister, and a younger brother who is also a Vietnam combat veteran. Both parents were migrant laborers. V. was partially raised by his paternal grandparents, who were fairly traditional and spoke V.'s native language at home. In addition to his native language, V.'s parents spoke English. He did not become fluent in English until attending boarding school when he was six years old. His mother was Catholic and the children attended church with her. V. also participated in traditional activities while growing up, mainly powwows and sweat lodges. V. does not have a history of childhood abuse.

Beginning in first grade V. was educated at a Catholic boarding school, and spent his summers at home. The boarding school was a relatively strict, structured environment. V. remembers being physically disciplined on occasion at school and his teachers discouraging him from speaking his native language. Upon graduating from high school he joined the Marines and volunteered for Vietnam.

In 1970 V. returned to the reservation from Vietnam and married his high school girlfriend. They had one daughter, currently 29, who lives with her children several hours away. His first wife left him in 1975 and V. remarried in 1982. The second marriage lasted 12 years, producing two children, and ended in divorce in 1994. The son from the second marriage is 20 years old and in the Air Force; the 15-year-old daughter lives with her mother and stepfather on the reservation. V. blamed his drinking and temper for causing the break-up of both marriages. He is on good terms with his ex-wives, and reported that he is close to his children, although he is unable to see them as often as he would like.

Upon returning from Vietnam V. attended a local community college, obtained a degree, and worked as a tribal police officer for ten years. It is unclear whether he quit or was fired from this job, but V. reported that working in law enforcement was extremely stressful for him, and contributed to increased alcohol consumption. During this period V. witnessed several traumatic events, primarily motor vehicle accidents, in the course of his work. After leaving the police force V. engaged in odd jobs, including farm and ranch work, until undertaking his current job, which he has held for the past eight years.

V. lives by himself in a rural area several miles from his nearest neighbors. He likes the feeling of isolation and safety that this provides. V. does not interact with others outside of work, and avoids big gatherings. He is not active in the Catholic Church, and although V. would like to participate in more traditional ceremonies

such as sweats and sundances, he avoids them due to the crowds and claustrophobic conditions.

E. Family history

V.'s father struggled with alcohol problems for several years during V.'s early childhood but has maintained his sobriety since the mid-1960s. V.'s younger brother, also a Vietnam combat veteran, is a heavy user of alcohol, and by V.'s reports also seems to be struggling with the aftermath of his Vietnam experiences.

F. Course and outcome

After receiving an initial assessment and diagnosis, V. began participating in outpatient treatment through the VA telehealth clinic. He is receiving medication management for his PTSD, individual therapy, and is a member of a weekly PTSD support group, all through telehealth. He is currently taking Sertaline (100 milligrams a day) and Trazadone (25–50 milligrams as needed for sleep).

The treatment received through telehealth has allowed V. to gain better mastery of his anger and irritability. Since beginning this treatment he has not had any further incidents or angry outbursts at work. This treatment has also helped to reduce the level and severity of V.'s PTSD symptoms, and he has been able to maintain his sobriety. Through therapy and the support group V. has learned coping mechanisms to help him better tolerate and deal with his multiple PTSD symptoms. His medications seemed to help eliminate the voices that he had heard when drifting off to sleep. V. still struggles with daily intrusive thoughts and memories about his Vietnam experiences and the accompanying arousal that goes with them.

G. Diagnostic formulation

Axis I:	309.81	Posttraumatic Stress Disorder, Chronic
	303.90	Alcohol Dependence, with Physiological Dependence, Sustained Partial Remission
	V62.82	Bereavement
Axis II:	None	
Axis III:	409.1	Hypertension, essential
Axis IV:	Problems with primary support group	
	Problems related to the social environment	
Axis V:	Highest past year:	GAF = 60
	Current:	GAF = 70

CULTURAL FORMULATION

A. Cultural identity

1. Cultural reference group(s). V. is a half-blood (1/2 quantum) enrolled member of a Northern Plains American Indian tribe located in the Dakotas. V. is a combat veteran, and also spent ten years in the law enforcement community. V. is typical of the Tribal veterans in his community who utilize the VA telehealth clinic. Vietnam-era veterans make up the lion's share of clinic patients, the majority of whom are combat veterans diagnosed with PTSD.

2. Language. V. is fluent in English, and currently identifies it as his primary language. V.'s native language was his first, and he spoke it most of the time in early childhood. Once he started school English became his primary language. He currently speaks English at work and at home. His family and children speak English and have very limited knowledge of their native language. V. uses his native language on occasion when speaking with elders in the community and with some of his older peers.

3. Cultural factors in development. During V.'s early childhood he was raised by his grandparents, who imparted knowledge of many of his tribe's traditional concepts and practices to V. He has fond memories of going to powwows with his grandfather and watching the dancers. In his teenage years he participated in sweats and pipe ceremonies, and attended several sun dance ceremonies.

V. also attended the local Catholic Church on Sundays with his mother. The boarding school was administered by the Catholic Church, and V. was required to participate in Catholic services at the school. Forbidden to speak his native tongue in school, V. was caught doing so on several occasions and punished by his teachers.

4. Involvement with culture of origin. V. currently desires to be more involved in traditional activities, such as sweats, powwows, and sun dances. Since returning from Vietnam he has attended very few of these activities. On the rare occasion when V. has attended sweats, he states that the high heat and humidity trigger associations with Vietnam. The complete darkness in the sweat lodges makes him feel claustrophobic and uncomfortable. Prior to Vietnam he did not have these feelings and associations. Following Vietnam V. has also struggled with discomfort in crowded environments. V. does not feel safe in crowds, and when he is in one constantly feels the need to scan the crowd for any potential dangers. The few times after Vietnam he has attended powwows or sun dances, he has felt "on edge" due to the crowds, and made excuses to his family and friends so that he could

leave the events early. Despite these issues V. believes that it is important for him to pursue a more active role in the traditional activities available in his community.

5. Involvement with host culture. In his lifetime, V. has experienced many different cultural environments. His early years were spent heavily immersed in his traditional culture. During his time in boarding school he was exposed to the unique culture of the school—a blend between the values of the Catholic teachers and his Indian peers. His military experience indoctrinated V. into an explicit military culture, as well as providing him entry to the reservation combat veteran community. V. still frequently associates with his fellow combat veterans to seek their shared experiences and perspectives. Ten years in law enforcement socialized V. into the values and beliefs held by those in the law enforcement community. The culture that V. is most heavily involved in at this time is that of his reservation environment. This culture is an eclectic blend of Northern Plains tribal traditions, multiple Christian influences, modern American culture, and economically depressed, small rural communities.

B. Cultural explanation of the individual's illness

1. Predominant idioms of distress and local illness categories. PTSD is not explicitly recognized as a disease or illness in V.'s community, yet members acknowledge that warriors may develop emotional or spiritual difficulties precipitated by battlefield experiences, sometimes with long-term consequences. Traditionally, medicine men tailor specific remedies (herbal treatments, sweat lodges, and ceremonies) to address these problems. Combat-related problems are seen as time-limited and resolvable through these means. Recently some members of V.'s community have been exposed to the medical definition of PTSD. This usually happens through interactions with the health care system in seeking treatment for a traumatic event.

Many community members are also aware that veterans, particularly Vietnam combat veterans, suffer a disproportionate amount of psychological and social difficulties. Community members often puzzle over the duration and intensity of problems that combat veterans exhibit. They observe that these veterans struggle with substance use, employment, and relationship difficulties. These are viewed as likely related to the veterans' combat experiences. At times PTSD-related behaviors (substance use, expressions of anger) cause community members to distance themselves from specific veterans and to develop negative perceptions of them. Many combat veterans from V.'s community struggle with alcohol abuse at some point during the course of their PTSD. Troubles brought on by PTSD often are explained locally in terms of addiction, wherein drinking is seen as the fundamental

problem for these veterans. Others look upon PTSD as a unique set of symptoms brought upon by a character deficit or weakness.

V.'s community adheres to a very structured mourning ritual in situations of grief or bereavement. The ritual prescribes a short but intense period of grieving the death, followed by a year-long observance that ends with a memorial ceremony. Throughout this year the deceased is remembered and honored by relatives through offerings, prayers, sweats, and even restricted social engagement among spouses or siblings. After the prescribed grieving period one is not expected to openly express feelings associated with the loss, for to do so is thought to invite further misfortune among the bereaved.

There is a high degree of variability in the notions and practices of traditional mourning within the community. Many members blend traditional and Western grieving practices and beliefs, driven in part by the high frequency of loss in these communities and the need to reduce the burden of observing otherwise demanding obligations by allowing quicker closure to this process.

2. Meaning and severity of symptoms in relation to cultural norms. The concepts and practices regarding war and combat exposure in V's tribe are fairly typical for Plains American Indians, and are heavily influenced by traditional warrior culture and values. Traditional expectations held that most males would become warriors within the tribe. There was, and still is, much prestige and honor in being a warrior. At modern-day powwows time is set aside to honor those who have served in the military. Being a combat veteran carries additional respect and privilege, especially among other veterans. Like V., many veterans in his community volunteered not only for military service during Vietnam but specifically for combat duty. V. and his peers cite the strong role that the warrior values of their traditional culture played in their seeking military service.

Another value held by many of these modern day warriors is the belief that warriors traditionally did not suffer problems such as PTSD, or were not bothered by the actions committed in combat. Many combat veterans consider it a sign of weakness to have these experiences after combat. V. commented that he feels bad about "feeling sorry for myself" in regard to his combat experiences and that if he where a "real" warrior, he would not have these feelings. V. feels that his PTSD symptoms are due to his own faults and deficits, rather than to the overwhelming character of the trauma that he has experienced. V. holds a set of seemingly conflicting beliefs, combining an understanding from traditional knowledge that warriors can have combat-induced psychological problems with the view that the archetypal warrior should be strong enough not to be affected by combat experiences.

V.'s experience of hearing his nephew's voice and seeing his ghost after his death is considered a normal experience in his community. V.'s family follows

many of the traditional mourning rituals, which can be very effective in helping the community cope with loss. The cultural sanction against expressing grief after the traditional mourning period may make it difficult for V. to process the loss of his nephew with others, particularly if this loss triggers memories of unresolved losses from Vietnam.

3. Perceived causes and explanatory model. V. is caught between multiple explanatory models for his problems: traditional concepts, community beliefs, and the biomedical model. No one model adequately explains the complexity of V.'s distress. These models share the notion that there can be psychological consequences of a veteran's wartime experiences. V. and other community members associate many of V.'s subsequent problems with his Vietnam experiences. The explanations of the nature, duration, and solution of these problems and their accompanying symptoms vary widely among the models.

For example, in the case of V.'s PTSD, traditional concepts hold that combat-related problems are infrequently found, time-limited in nature, and can be remedied through particular traditional treatments. Community beliefs, as previously discussed, vary widely and are influenced by exposure and interaction with combat veterans. These range from acknowledging the impact of war on behaviors to the notion that veterans' traumatic symptoms are caused by individual character deficits. Finally the biomedical model sees these problems as common and as having the potential to cause ongoing, long-term, and often permanent changes in an individual's functioning. This model also provides a label for the psychological consequences of combat, and prescribes specific biomedical treatments for this disorder. V. understands his grief mostly in terms of the traditional model of mourning in the community. This model is limited to grieving and does not account for or explain how the loss of his nephew interacts with V.'s past losses or traumatic experiences.

4. Help-seeking experiences, plans, and reaction to telehealth assessment. Prior to his experience at the VA telehealth clinic, V. had not actively sought help for his PTSD from the medical system. For the past five years V. was able to seek help for his drinking by regularly attending a local AA group. He cited the break-up of his second marriage as the catalyst for examining how alcohol was affecting his life, and the impetus for seeking help. V. stated that he mainly discusses his struggles with alcohol in his AA group. Initially when he brought up his combat experience, the group became uncomfortable and did not know how to handle his stories. V. quickly learned to keep these experiences to himself and focused exclusively on his drinking issues at AA meetings.

There are a number of reasons why V. did not seek help earlier for his PTSD symptoms. Although he was informed during one of his inpatient alcohol

treatments that he might be struggling with PTSD, for a long time V. would not admit to himself that these symptoms were a problem for him. After joining AA he began to consider talking to someone about his Vietnam experiences. He was extremely reluctant to seek care from the local mental health services, fearing that his confidentially might be violated. V. knows many of the employees of the local mental health services; not only was he concerned about sharing his experiences with them, he was also afraid someone might see him walking into the clinic. V. also had problems with seeking care at the local VA, which is a half-day drive away. V. incurs considerable cost in time, money, gas, and lodging each time he goes. V. has also voiced a general distrust of the VA system. He feels betrayed by the government because of his experiences in Vietnam and V.'s perceived mistreatment upon his return, which have made it difficult for him to consider seeking care from the VA.

As described previously, V. had also sought help for his problems by participating in traditional ceremonies. But his PTSD symptoms, specifically discomfort in crowds and claustrophobia, made it difficult for him to participate in the events that were available to him. V. never specifically sought help from a medicine man to address his wartime memories.

Prior to initial assessment V. had little knowledge of telehealth or its use and no direct experience with it. His willingness to participate in a telehealth assessment was largely due to pressure from work to obtain help for his irritability, and the welcome relief from driving all the way to the local VA to receive an assessment. V. was skeptical about the usefulness of participating in a telehealth clinic. On the other hand he realized that his PTSD symptoms greatly impacted his life and that he needed help.

C. Cultural factors related to psychosocial environment and levels of functioning

1. Social stressors. V's biggest social stressor is related to income. Finding a long-term job in the reservation community can be very difficult. He currently functions much better in his workplace since engaging in treatment, but at times the work environment is intense and stressful, due to a high turnover rate in personnel. Work stress potentially aggravates his PTSD symptoms, and he has had to quit jobs (i.e., law enforcement) in the past partially due to his PTSD. V. currently works with the local Veterans Service Officer in applying for disability for his PTSD. This will help to provide financial security for V. if he has to scale back or quit his work due to his PTSD symptoms.

2. Social supports. Although V. reports good relationships with his family, because of his PTSD symptoms he has chosen to physically isolate himself from them and his community. V. often is perceived by himself and his family to over-

react with anger to normal family disagreements and tensions. He has found that being around a lot of activity increases his anxiety. To deal with this he tends to withdraw from others. This decreases his overall level of stimulation and helps to control his PTSD, but it also removes him from an important network of social support. Through group and individual therapy V. has been exploring activities in which he can participate and ways to become more involved with people. In this regard, his weekly telehealth PTSD support group provides him with more social support in a less threatening manner than might otherwise be possible for him.

3. Levels of functioning and disability. With treatment V. has been able to improve his functioning at work. The treatment also helps him explore ways to expand his social networks and consider using other treatment resources available in the community. Overall, treatment has helped to improve his functioning and given V. hope he can master his past traumas and continue to improve.

D. Cultural elements of the clinician–patient relationship and the use of telehealth
The telehealth clinic through which V. receives his care is located in a tribal veterans program located on the reservation. The clinic has a designated telehealth room with live interactive videoconferencing capacity connecting with the regional VA. This clinic operates one day each week providing assessments, medication management, and therapy for tribal veterans with mental health issues. An on-site designated staff member coordinates and administers the clinic. The clinicians are located at the regional VA.

On V.'s first visit to the clinic he expressed doubts about the effectiveness of telehealth assessment. He had no exposure to live interactive videoconferencing and very little experience with computer technology. Before assessment V. was given a brief ten-minute orientation to the use of the telehealth technology. During the first 10–15 minutes of the assessment V. remained extremely guarded and reserved. As the assessment continued V., seemed to become progressively more relaxed and comfortable with the technology and the assessment process. He was able to talk at length about his Vietnam experiences and his current problems. At the end of the interview V. stated that he had shared things during the assessment that he had never been able to discuss with anyone else previously.

Since his initial assessment V. has been very active in receiving care through the telehealth clinic. He has engaged in individual as well as group sessions by real time interactive videoconferencing. V. has expressed great enthusiasm for this treatment modality and has been able to work well with his telehealth providers.

One expressed benefit of telehealth for V. revolves around issues of privacy and confidentiality. The clinicians working with V. are hundreds of miles distant, are not active members of the community, and do not work or live in the local area. This has helped address V.'s concerns about accessing local mental health

resources as a member of a small rural community. V. does not have the same fears that the clinicians he sees via telehealth may interact or share information with his friends or relatives.

Another important aspect of the telehealth component of the clinician–patient relationship is that of space and comfort for the patient. Although some may argue that live interactive videoconferencing introduces additional distance between the clinician and patient, this distance seemed to contribute to V's ability to open up in a meaningful way and feel safe sharing his struggles. Having a clinician in the same room as V., especially during the initial assessment, appears to have created a feeling of intrusiveness that may have made it difficult to share traumatic experiences. Telehealth, by providing space and distance for V., helped to create an environment wherein he felt safe to explore traumatic issues.

The videoconferencing technology has not been a problem for V. He has become very adept at the use of the cameras and volume controls at his teleconference site. Although V. continues periodically to express some distrust and suspicion of the federal government, he has been able to build enough rapport with his VA providers through telehealth to engage in treatment and to seek care.

E. Overall cultural assessment

This American Indian Vietnam combat veteran is dealing with multifaceted mental health issues, including chronic posttraumatic stress disorder, acute bereavement, and long-standing alcohol dependence. There are also several complex cultural issues and interactions pertinent to his assessment and treatment, which are the focus of this cultural formulation. Although almost all of V.'s current problems can be linked to his Vietnam experience, until very recently V. had not sought or received treatment for PTSD. V's drinking, his contradictory views about PTSD, its associated stigma, and limited access to resources presented significant impediments to adequate treatment. When his drinking became better controlled in the 1990s, V.'s contradictory views about his distress still prevented him from seeking appropriate care. On the one hand, he felt these could be pathological sequelae to his traumatic exposures. On the other, he associated these difficulties with personal weakness, which conflicted with his warrior persona. Even aside from these barriers, his comfort level with the local services and distance from specialized care significantly hindered his seeking help to address his PTSD. The telehealth clinic proved important to facilitating V.'s treatment.

V.'s grief over his nephew's death was complicated by his previous losses from Vietnam. The loss of his nephew amplified his symptoms of PTSD, and reminded V. of the loss of his military team. The traditional notions and practices around death that limit grieving in V.'s culture make it more difficult for him to process this loss and the additional losses that this reminded him of. Yet these concepts also serve as a powerful framework for V.'s understanding and engagement in mourning.

The stress of these difficult emotions led V. to briefly return to nonadaptive coping mechanisms, i.e., binge drinking. Luckily V. quickly realized the danger in this behavior and turned to his AA group for support. His current PTSD treatment encourages and supports continued sobriety while enabling V. to deal with his multiple losses.

V. is caught in a dilemma with respect to his desire to increase his involvement in traditional activities. Going to ceremonies and participating in powwows could be a significant benefit in treating his PTSD, by aiding in his spiritual healing and increasing V.'s social support. Unfortunately V.'s PTSD symptoms currently prevent him from taking advantage of these opportunities. Hopefully by engaging in active PTSD treatment V. can increase his coping and find ways to increase his involvement in traditional activities. Through the telehealth clinic V. is exploring ways in which he can become more involved in these activities. The clinic is considering ways to facilitate this, such as by talking with traditional spiritual leaders in the community about V.'s specific concerns and needs.

One of V's most challenging tasks in treatment is integrating the multiple traditional, community, and biomedical models available to him for understanding and addressing his illness. Each model presents its own strengths and weaknesses. V. seeks an understanding for himself that helps to account for his experiences and individual perspective while facilitating his ability to utilize available resources in the healing process.

The telehealth clinic has provided an ideal medium for assessment and engagement in treatment. It has provided V. with feelings of safety and comfort that he was unable to obtain from the local health services. It has also been able to provide access to the VA system, which offers specialized mental health care for veterans suffering from PTSD. Without access to telehealth, VA services would be time-consuming, difficult, and costly. V. would not be able to receive care at the same level of intensity, including weekly support group and individual therapy sessions. V.'s case demonstrates that high-quality cross-cultural assessment and care can be provided through live interactive videoconferencing, and that this modality can be critical in delivering such care to isolated, underserved communities.

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