A PHENOMENOLOGICAL STUDY ADDRESSING CLINICIANS' UNDERSTANDING OF THE EFFECTIVENESS OF EVIDENCE-BASED TRAUMA TREATMENT FOR BLACK MALE VETERANS DIAGNOSED WITH PTSD

by

Kelvin Tyler Jr.

Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirement for the Degree

Doctor of Education

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ABSTRACT

This qualitative, phenomenological study sought to address clinicians understanding of the effectiveness of individual and group trauma therapy for Black male veterans. The investigation sought to expand previous research by conducting a more in-depth study on the efficacy of evidence-based trauma therapy practices for Black male veterans. The participants included in this study were nine clinicians that utilized evidence-based trauma therapy when treating Black male veterans that are students in Liberty University's Behavioral Health Doctoral Programs. The current research reveals that various treatment options are found to help treat Black male veterans with PTSD. The stress that is linked to PTSD impacts the multiple domains of an individual's life as well as their daily functioning. These domains of life include their capacity to manage their mood and health practices, behavior norms in the community, ability to problem solve and cope with distressing situations, and control of substance use. Evidence-based trauma therapy seeks to support individuals as they pursue optimal health, including the reduction of PTSD symptoms and maintenance of these domains of life. This study was guided by the emotional processing theory (EPT) developed by Foa and Kozak (1986). Identifying the effectiveness of the therapeutic modalities of trauma-focused cognitive behavior therapy (TF-CBT), prolonged exposure (PE), and cognitive processing therapy (CPT) is highly imperative for the overall progress of Black male veterans. Thematic analysis was used to identify, examine, and interpret emerging patterns and themes. The results of this study reveal the importance of tailoring clinical strategies and interventions to the unique needs of Black male veterans. As a result of this research, the researcher aims to develop a workbook that will include strategies to help new clinicians as they provide evidence-based trauma therapy to Black male veterans. This will serve as a contribution to the counseling field.

Keywords: Post-traumatic stress disorder, evidence-based psychotherapy, Black male veteran, emotional processing theory, trauma-focused cognitive behavior therapy, prolonged exposure therapy, cognitive processing therapy

Dedication

To my parents, Drs. Kelvin Sr. and Cynthia Tyler, and my siblings, Monique and Sherresse, thank you for your continued support, unwavering love, and consistent encouragement throughout all of my life. Thank you for all that you have done and the influence you have on my life. To my friends and other family members, I truly appreciate you all as well.

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List of Abbreviations

American Counseling Code of Ethics (ACA)

American Psychiatric Association (APA)

Cognitive Processing Theory (CPT)

Department of Defense (DOD)

Diagnostic Statistical Manual of Mental Disorders (DSM-5)

Emotional Processing Theory (EPT)

National Association of Social Workers (NASW)

Prolonged-Exposure Therapy (PE)

Post-Traumatic Stress Disorder (PTSD)

Subjective Units of Distress (SUD)

Trauma-Focused Cognitive Behavior Therapy (TF-CBT)

Substance Abuse and Mental Health Services Administration (SAMHSA)

Veteran's Affairs (VA)

CHAPTER ONE: INTRODUCTION

Overview

This phenomenological study addressed clinicians' understanding of the effectiveness of evidence-based therapy for Black male veterans diagnosed with Post-Traumatic Stress Disorder. A need exists for more information about the effectiveness of individual and group trauma therapy for symptom reduction and overall progress in daily functioning for Black male veterans. This chapter outlines the background information, the study's purpose, situation to self, purpose statement, the significance of the study, research questions and descriptions. Finally, the chapter concludes with a definition of terms and a summary.

Background

Post-traumatic stress disorder (PTSD) is a severe and persistent mental health disorder impacting the general public and is prevalent among veterans (Kozel et al., 2018; Resick et al., 2017). Studies reveal the importance of evidence-based trauma therapy for Black male veterans diagnosed with PTSD because of the need for culturally competent treatment that helps support the symptom reduction and improvement of their daily functioning (ACA, 2014; Dolev et al., 2018; Steenkamp et al., 2020). Traditional evidenced-based practices are not well studied within minority populations; thus, there is a need to know how effective these evidence-based trauma modalities are for the unique population of Black male veterans who have been diagnosed with PTSD (Coleman et al., 2019; Hundt et al., 2020; Spoont et al., 2021). The purpose of this study is to gain insight into clinicians' understanding of the effectiveness of individual and group trauma therapy for Black male veterans.

According to the ACA (2014), through professional competence, clinicians support the development, growth, and welfare of clients. The ACA (2014) conveys the importance of

clinicians being culturally sensitive when working with clients. Cultural sensitivity is paramount because one's culture influences how their problems are defined and experienced and should be considered when a mental disorder is diagnosed (ACA, 2014, Section E.5.b). The ACA (2014) stated, "multicultural counseling competency is required across all counseling specialties, counselors gain knowledge, personal awareness, sensitivity, dispositions, and skills pertinent to being a culturally competent counselor in working with a diverse client population" (Section C.2.a). There are historical and social prejudices in the diagnosis of pathology (ACA, 2014, Section E.5.c). To challenge these prejudices, clinicians should be aware and address such biases in themselves or others. The ACA (2014) also pointed out that clinicians should be cognizant of multicultural issues and diversity within the frameworks of the assessment techniques utilized as well as the process of administration and interpretation (Section E.8).

Military service members and veterans are at an increased risk of being diagnosed with trauma-related disorders due to working and living in high-stress environments (Highfill-McRoy et al., 2022). War, violence, accidents, and loss are some of the many categories of adverse experiences that may result in military service members' and veterans experiencing trauma symptoms that can negatively impact an individual's well-being and quality of life (Agarwal et al., 2020). These adverse experiences cause stressful reactions such as avoidance, re-experiencing of the trauma, and hyperarousal, and negative changes in cognitions (Miao et al., 2018). Military service members who have experienced these events and are present with these stressful reactions may be diagnosed with trauma-related disorders. Decades of research have been conducted to highlight the causes, mechanisms, and treatment for trauma-related disorders (Bryant, 2019). According to Watkins et al. (2018), trauma therapy focuses on memories or thoughts and feelings linked to traumatic events.

Several studies have been completed throughout the years to highlight the need and effectiveness of trauma therapy for veterans (Kehle et al., 2011; Schnurr et al., 2022; Steenkamp et al., 2020). However, there is still a gap in the literature regarding the specific efficacy of trauma therapy for Black male veterans (Coleman et al., 2019; Spoont et al., 2021). According to Stecker et al. (2016), Black veterans were more likely to initiate treatment but attended fewer sessions than White veterans. The White veterans reported higher symptom severity, and the researchers believe this is why they attended more sessions. Castro et al. (2015) reported potential reasons Black veterans engage in therapy less frequently than other racial groups. The researchers included reasons such as the influence of one's culture, the counseling interventions that are employed, the overall perspective of mental health treatment encounters with the clinician, or a possible mixture of these factors.

Veterans have had access to care in the community for many years (Marques et al., 2016). Recent federal legislation has increased veteran's access to care within the private and civilian sectors (Tanielian et al., 2014). Furthermore, there is an expansion for veteran eligibility to receive care outside of the Veteran's Affairs Hospital and in the community (Boscarino et al., 2015; Tanielian et al., 2014). Examples of facilities in the community include behavioral health centers, primary care practices, hospital trauma centers, and substance-abuse treatment facilities (Reisman, 2016). An array of evidence-based trauma therapies is being utilized and promoted by The U.S. Department of the VA (Thompson-Hollands et al., 2021) and in community-based settings (Reisman, 2016). Research indicates that many veterans and their families seek care outside the VA (Finley et al., 2018). The study also indicated that community-based providers must receive education and training for addressing the needs of veterans (Reisman, 2016). The VA supports community-based professionals and has developed the PTSD Consultation Program

for community providers. This program provides free information, education, training, consultation, and other resources to the clinicians who treat veterans, even if they are not employed by the VA (Reisman, 2016). The Center of Deployment Psychology provides training to behavioral health clinicians (Reisman, 2016). Still, there is a need to understand the effectiveness of evidence-based trauma treatment for Black male veterans.

Dondanville et al. (2022) conducted a study of 280 health clinicians' who serve the veteran population in community settings. The clinicians participated in a national training program to help develop competency in learning and adopting cognitive processing therapy and prolonged exposure. As a result of the education, these clinicians educated more than 2,200 clients about evidenced based therapy for PTSD and provided the EBT for more than 1,000 clients diagnosed with PTSD (Dondanville et al., 2022). Treatment providers at the community level must consider "the diversity of community-based mental health options (e.g., grant-funded agencies, community mental health centers, private practice clinicians)" (p. 2). Dondanville et al. (2022) noted that this will help to increase the understanding of community-based clinicians' clinical competence and skill in delivering EBTs for PTSD (p. 2).

Evidence-based therapies are being employed through individual and group therapy formats and include trauma-focused cognitive behavior therapy (TF-CBT), prolonged exposure therapy (PE), and cognitive processing theory (CPT). Spoont et al. (2021) indicated that it is beneficial to Black male veterans to highlight the effectiveness of the trauma therapy approach, including strategies and techniques that help support their overall recovery from trauma-related disorders. Coleman et al. (2018) identified group therapy as a practical treatment approach for PTSD; however, the literature is mixed and limited regarding treatment outcomes for racial minorities. This research study will help advance the counseling profession and support

clinicians treating Black male veterans by addressing clinicians' understanding of the effectiveness of evidence-based trauma therapy for Black male veterans. Thus, providing direction to clinicians on what evidence-based practices are most effective for Black male veterans.

Situation to Self

I am a Black male Licensed Professional Counselor in South Carolina. I am a clinical mental health therapist within a Community Mental Health Center. I treat severe and persistent mental health disorders that impact all age groups. Among these are trauma-related disorders such as PTSD. The Community Mental Health Center services are available to all community members, including veterans of all racial backgrounds and ethnicities. The mental health center utilizes evidence-based therapeutic practices that align with the professional standard of treatment. Examples of the therapeutic approaches provided within the center include TF-CBT, PE, and CPT, which are included in this study.

I consistently see the apprehension toward mental health therapy for many veterans, particularly Black male veterans. The question remains: How effective are these evidence-based practices for the symptom reduction and enhancement of daily functioning for Black male veterans (Highfill-McRoy et al., 2022; Johnson & Possemato, 2019)? Improved therapeutic services for Black male veterans can be accomplished by obtaining this greater understanding from clinicians. Ultimately, I intend to develop an inventory to prepare clinicians to determine how each therapeutic modality affects Black male veterans.

In addition to highlighting the motivation behind conducting this study, it is also important to note that my worldview is anchored in ontological assumptions philosophically. This assumption allows the individual to pinpoint their interpretation and meaning toward a

particular phenomenon and infers that no one reality exists (Bradshaw et al., 2017). Exploring clinicians understanding of the effectiveness of trauma therapy for Black male veterans helps to gain ontological insight that may lead to greater awareness of symptom reduction and enhancement of daily functioning. Furthermore, the constructivist paradigm guides this study. According to Heppner and Heppner (2021), constructivism posits that reality is defined as the meaning linked to the event instead of solely the event itself. This means that reality is not limited to one particular view, which prompts the gathering of participants views by the researcher (Teherani et al., 2015). Focusing on the clinicians' understanding fulfills the constructivist aspect of the research. The phenomenological study intends to provide a voice for clinicians in their natural environment to discuss their understanding of the effectiveness of evidence-based therapy for Black male veterans. This study strives to fill this gap to help clinicians provide the best PTSD treatments to Black male veterans.

Problem Statement

Research has reported a need to understand the effectiveness of trauma therapy for Black male veterans (Coleman et al., 2019; Hundt et al., 2020; Spoont et al., 2021). There is a need to know how TF-CBT, PE, and CPT affect the various domains of life for Black male veterans and how the therapeutic strategies contribute to their welfare and betterment (Coleman et al., 2019; McClendon et al., 2020; Spoont et al., 2021). Clinicians utilize these treatment modalities to help support healthy functioning in all domains of activity for veterans. Currier et al. (2014) said, moving forward, clinicians should be cognizant of the needed treatment approaches to implement when working with veterans. These needed approaches include evidence-based treatment for the reduction of PTSD symptoms and other strategies for supporting the enhancement of veterans' health in their spiritual, physical, and social domains of functioning.

They proposed that a holistic approach may be needed to address symptom reduction and domains of daily functioning.

Furthermore, veterans diagnosed with PTSD experience impairments in their activities of daily functioning, including their capacity to manage their mood and health practices, behavior norms in the community, problem-solving and coping with distressing situations, and addressing substance use (Duan-Porter et al., 2021; Johnson & Possemato, 2019; Jones & Drummond, 2021). Hence, it is necessary to know how effective these evidence-based trauma treatments are for Black male veterans in reducing their PTSD symptoms and affecting their domains of life.

Statistics reveal that 13.5% of deployed and nondeployed veterans of the Iraq and Afghanistan wars were diagnosed with PTSD (Reisman, 2016). The current literature indicates that the diagnosis of PTSD has become prevalent in the veteran population (Finley et al., 2015). Although some scars are visible, it is essential to recognize that many veterans have invisible scars that negatively impact the domains of their daily functioning including interpersonal relationships, self-care, productivity, and community connectedness (Koven, 2018; Sayer et al., 2010). We also know that the VA Hospital promotes EBP's and provides training to clinicians to provide effective treatment to veterans (Castro et al., 2015). Still, the therapeutic needs of veterans are supported outside of the VA hospital in community-based settings (Reisman, 2016; Sayer et al., 2015). As these evidence-based treatments continue to be utilized, we do not know how effective they are for Black male veterans (McClendon et al., 2020).

Research indicates that the risk of exposure to PTSD increases for veterans when they do not seek and complete trauma therapy (Zhou et al., 2021). Black veterans often enter counseling for mental health services but do not always complete treatment (Hundt et al., 2020). Research shows significant dropout rates and lower treatment engagement among Black Americans than

White Americans (Castro et al., 2015). Providing quality care to Black male veterans is essential, considering their background, cultural needs, and heritage (Onoye et al., 2017; Ward et al., 2021). McClendon et al. (2020) reported the limited research exploring racial and ethnic differences in the effectiveness of trauma-focused treatments for reducing symptoms of PTSD. All domains of an individual's life are connected to these elements and should be considered when providing adequate care.

According to Castro et al. (2015), limited literature exists on the association between race and attitudes toward treatment and treatment outcomes. On a similar note, McClendon et al. (2020) said that to deliver equitably adequate and culturally relevant PTSD treatment, clarifying to which level race and ethnicity influence outcomes is needed. No qualitative studies depict the result of trauma treatment for Black male veterans and the clinicians' understanding of effective trauma treatment for Black male veterans, which motivates this study (Steenkamp et al., 2015).

The United States Substance Abuse and Mental Health Services Administration's (SAMHSA; 2012) working definition of recovery from mental health disorders as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (p. 3). The problem is limited research regarding the efficacy of evidence-based trauma therapy for Black male veterans (Steenkamp et al., 2015). Clinicians would benefit from increased awareness of the specific strategies and interventions to employ for therapeutic progress to be accomplished (Castro et al., 2015). Identifying the effectiveness of trauma therapy for Black male veterans will enhance the effectiveness of treatment by providing clinicians with the interventions and strategies to be culturally competent and support recovery (Onoye et al., 2017). The study's implications will support the need to adapt treatment for Black

male veterans that will help enhance their therapeutic experience and engagement and increase overall progress (Maguen et al., 2014).

Nine clinicians, who are students at Liberty University in the Behavioral Health Doctoral Programs are the participants in this study. The study's gained insights and implications will yield a valuable contribution to the counseling field. Furthermore, this study yields a greater understanding and direction of how mental health clinicians can assist and support Black male veterans diagnosed with PTSD (Koo et al., 2016; Maguen et al., 2014).

Purpose Statement

The purpose of this qualitative phenomenological study is to address clinicians' understanding of the effectiveness of individual and group evidence-based trauma therapy for Black male veterans. At this stage in the research, trauma therapy modalities will be generally defined through the lens of evidence-based therapies, including TF-CBT, PE, and CPT. This study is guided by Foa and Kozak's (1986) Emotional Processing Theory to understand trauma therapy's effectiveness for PTSD symptom reduction and its impact on Black male veteran's daily functioning.

To ensure ethical standards of care are being delivered, Blease et al. (2016) indicated, the best evidence related to treatment modalities must be implemented in training and practice. Research evidenced and clinical expertise are the basis for EBP's (Castro et al., 2015; Stewart et al., 2018). Blease et al. (2016) reported that the APA necessitates clinicians to be trained in EBP's for the following reasons: (a) clinicians are able to evaluate the effectiveness of different treatment modalities, (b) identify the strengths and limitations of clinician intuition, (c) be cognizant of client preferences, and (d) values provide appropriate care within the socio-cultural context of the client (Blease et al., 2016). Clients need to know about the efficacy and

effectiveness of specific treatment interventions. EBP's are deemed cost-effective and efficacious for treating psychiatric conditions while promoting client choices for their treatment (Cook et al., 2017). The focus of EBP's on clients is beneficial for veterans seeking therapeutic services because they respect their autonomy (Blease et al., 2016). Many veterans have completed their time in the armed forces and are diagnosed with PTSD (Bryant, 2019; Highfill-McRoy et al., 2022). Experiencing PTSD symptoms causes impairments in daily functioning, including daily living activities such as managing mood and health practices, behavior norms in the community, problem-solving, and coping with distressing situations, and managing substance use (Sayer et al., 2015). Health is defined as the ability one has to function well socially, physically, spiritually, and mentally while maximizing their potential within their environment (Svalastog et al., 2017). Health practices stem from factors such as age, education, gender, income, cultural background, social support, and physical environment (MacLean et al., 2004). These practices include exercise, eating practices, weight control, substance use, and use of medication and alternative therapies (MacLean et al., 2004). The interviews for this study will elicit insights into the specific strategies and interventions utilized through these evidence-based trauma therapies to help Black male veterans. Obtaining greater understanding from clinicians will help to increase support for symptom reduction and enhancement of daily functioning.

Significance of the Study

There was a need to explore clinicians' understanding of the effectiveness of evidence-based trauma therapy for Black male veterans (Coleman et al., 2019; Hundt et al., 2020; Spoont et al., 2021). The significance of this study is essential to the field of counseling and veterans because it contributes to the existing literature that supports the phenomenon of therapeutic services being delivered to Black male veterans diagnosed with PTSD. A review of the literature

indicated a gap in the effectiveness of evidence-based trauma therapy for Black male veterans (Steenkamp et al., 2015). Insights obtained from the study will benefit Black male veterans as they seek therapeutic support for symptom reduction and enhancement in daily functioning (Ali et al., 2018; McClendon et al., 2020; Spoont et al., 2021). Clinicians provide evidence-based therapeutic services; however, it is essential to recognize how these evidence-based treatment modalities are helping. These insights will help the counseling field to provide appropriate care to Black male veterans since PTSD is prevalent among the veteran population (Finley et al., 2015; Highfill-McRoy et al., 2022). This research is warranted through a qualitative approach encompassing the clinicians' understanding of the effectiveness of TF-CBT, CPT, PE for treating Black male veterans.

Comparing the prevalence of PTSD among different racial and ethnic groups, Alegría et al. (2013) found that lifetime PTSD is more prevalent among Black people and that these differences are poorly understood. Due to the prevalence of PTSD diagnosis among the veteran population, it is beneficial to understand the best methods for trauma therapy (Browne et al., 2021; Pearce et al., 2018; Stecker et al., 2016). The literature does not reveal the effectiveness of trauma therapy for Black male veterans as it pertains to their maintenance of daily functioning, including daily living domains (Highfill-McRoy et al., 2022). Since the number of Black male veterans is projected to increase by 2030 (Office of Health Equity, 2022), it is crucial to understand the effectiveness of trauma therapies through individual and group therapy formats (Coleman et al., 2018).

There are different forms of PTSD treatment (Watkins et al., 2018). These treatments target the memories, feelings, and thoughts related to the trauma. Among these differing forms are TF-CBT, PE, and CPT (Kozel et al., 2018; Watkins et al., 2018). McClendon et al. (2020)

reported that further research is needed to create adapted treatments that distinguish the improved outcomes of these treatments compared to traditional treatments. Kozel et al. (2018) said to enrich treatment outcomes for PE and CPT, there is a need to discover new treatment approaches or approaches that strengthen the benefits of PE and CPT. Similarly, Galovski et al. (2016) recommended adjusting interventions within current evidence-based protocols to help enhance treatment outcomes. Identifying effective strategies, methods used to make decisions, and delivery method explorations will help to highlight efficient outcomes and improve services (Schnurr et al., 2022). The limited research regarding the effectiveness of specific evidence-based therapies and racial differences serves as the gap of this study (Castro et al., 2015; Williams et al., 2019). Furthermore, as it pertains to the treatment modalities, CPT, PE, and TF-CBT, Watkins et al. (2018) stated, "outcomes from these treatments can be improved." They recommend the further exploring of effectiveness in treatment for specific populations, including the military (Watkins et al., 2018). Therefore, this study will explore the effectiveness of individual and group therapy of different treatment modalities for Black male veterans, which will shed light on ways to improve treatment outcomes (Watkins et al., 2018).

Research Questions

The purpose of this qualitative phenomenological study was to address clinicians' understanding of the effectiveness of individual and group evidence-based trauma therapy for Black male veterans. The following research questions were intended to serve as a guide for depicting the effectiveness of individual and group trauma treatment.

RQ1. How do clinicians understand trauma therapy's effectiveness for PTSD symptom reduction and its impact on Black male veterans' daily functioning?

Research question one is based on the comprehensive review of the literature that indicates that veterans who are diagnosed with PTSD have access to trauma therapy through the VA and community resources (Hundt et al., 2020). The research also indicated that Black male veterans attend individual and group therapy (Coleman et al., 2021; Spoont et al., 2021; Stecker et al., 2016); however, there was little literature about the specific strategies and interventions of evidenced-based trauma therapies used by clinicians that support symptom reduction and promote progress in daily functioning for Black male veterans (McClendon et al., 2020).

RQ2. How do clinicians describe the barriers that Black male veterans experience in individual and group trauma therapy?

Research question two, addresses cultural, economic, environmental, and geographical barriers that impeded on the ability to attend and be consistent with services for Black male veterans (Motley & Banks, 2018; Pearce et al., 2018; Watkins et al., 2017). This question elicits further understanding from participants on the specific barriers they notice and how these have been mitigated.

RQ3. How do clinicians understand the impact of their clinical expertise on the nature of treatment and evidence-based practices?

The third question explores the extent to which clinicians recognize the influence of their professional competence, awareness of multicultural differences, and clinical expertise when using EBPs (ACA, 2014; Blease et al., 2016; Stewart et al., 2018). There are a variety of EBPs that support the reduction of PTSD symptoms and enhancement of daily functioning (Watkins et al., 2018). Participants discussed the training and experience they have in providing EPPs. The researcher asked about specific strategies and interventions used when treating Black male veterans.

Definitions

Anticipated stigma - the thought that due to one's mental health challenges they may be discriminated against (Docksey et al., 2022).

Black - an ethnically heterogeneous socially constructed racial group or identity (Motley et al., 2017).

Behavioral activation- implementing pleasant and rewarding activities (Burkhardt et al., 2021).

Clinical videoconferencing (CVT) - telehealth format that allows a clinician and client to meet synchronously through video-sharing technology (Morland, Wells, Glassman, et al., 2020).

Culturally competent - the ability to effectively work with individuals from different cultural backgrounds (Stubbe, 2020).

Diagnostic Statistical Manual of Mental Disorders (DSM-5) - a handbook that helps clinicians make accurate diagnosis and supports client outcomes (Vahia, 2013).

Emotional processing - challenging the expression of trauma related emotions and cognitions and implementing new information into trauma-related fear structures (Foa et al., 2008).

Epigenetics - the changes in organisms as a result of alterations in the expression of genes instead of changes in the genetic code. (Howie et al., 2019).

Evidence-based practices - care rooted in the best available research linked with clinical expertise (Stewart et al., 2018).

Homebound - living life confined to the home (Schirghuber & Schrems, 2021).

Imaginal exposure - repeatedly facing trauma memories that are related to emotions and cognitions (Sripada et al., 2022).

In vivo exposure - repeatedly facing feared and safe situations, people, objects, and places, in real life (Sripada et al., 2022).

Marginalization - categorizing people as insignificant based on their environment, experiences identity, and associations (Hall et al., 1994).

Masculinity - a set of beliefs and attitudes regarding the meaning of the male gender role as established by society (Plys et al., 2020).

Post-traumatic stress disorder (PTSD) - a mental disorder that occurs after an individual has been exposed to horrific events (Bisson et al., 2015).

Quality of life - a multi-factorial phenomenon influenced objectively and subjectively. These 10 domains include relationships, work, money, health, and leisure, mindfulness, self-esteem, resolution of past life events, mental style, and life management skills (Jones & Drummond, 2021).

Racism - an organized social system, that results in the disempowering, degrading, and misallocating resources to groups that are deemed as inferior (Williams et al., 2019).

Self-stigma - the thoughts people have about themselves in the event they have a mental health challenge (Docksey et al., 2022).

Social connectedness - the opposite of social isolation that involves the presence of social networks and support (Wickramaratne et al., 2022).

Veterans Affairs Hospital - the system that provides comprehensive healthcare services to eligible U.S. military veterans (Anhang Price et al., 2018).

Summary

The diagnosis of PTSD has become prevalent in the veteran population (Finley et al., 2015; Highfill-McRoy et al., 2022). Research indicates evidence-based trauma treatment

supports the recovery of veterans, including symptom reduction and enhancement of their daily functioning (Coleman et al., 2018; Sloan et al., 2018). The literature is limited on the efficacy of individual and group trauma therapy provided to Black male veterans in reducing symptoms of PTSD and the enhancement of daily functioning (Ali et al., 2018; McClendon et al., 2020; Spoont et al., 2021). This study addresses the clinicians understanding of the effectiveness of EBP's for the reduction of PTSD symptoms and enhancement of daily functioning (Watkins et al., 2018). In this study, this is completed by interviewing clinicians' perceptions on the effectiveness of the treatment modalities.

This study seeks to fill the gap in the literature and narrow the lack of understanding of the efficacy of trauma treatment for Black male veterans provided by mental health clinicians. Results of the study will build upon the current literature by providing therapeutic implications concerning future trauma treatment of Black male veterans. Chapter Two will consist of the background to the problem and the theoretical foundation that helps guide the proposed study. A review of the literature, including the areas from the literature regarding trauma and trauma therapy that are relevant to the proposed study, is also incorporated in Chapter Two. The conclusion of Chapter Two will include a chapter summary.

CHAPTER TWO: LITERATURE REVIEW

Overview

This chapter presents a review of literature relevant to the effectiveness of trauma therapy and veterans. Previously, researchers have addressed similar topics related to different evidenced-based trauma treatments and veterans. However, there is minimal research on the effectiveness for Black male veterans. This review discusses important PTSD impacts, including symptomology, different trauma-evidenced-based practices, environmental impacts, delivery methods of evidence-based practices, and the influence of trauma on the domains of the daily functioning of Black male veterans. The gap in the literature underscores the need for further interventions and support for this demographic, highlighting a practical need for this research study. This chapter presents an overview of the theoretical framework, related literature, and a summary.

According to Watkins et al. (2018), further research on particular PTSD treatments are needed. Research finds that 20% to 30% of individuals in the military who seek treatment fully recover from PTSD (Pearce et al., 2018). Hence, the development of effective treatment interventions that support minority populations has become a public health concern. Discovering further effectiveness in providing treatment for PTSD will assist in adding to the existing literature and enhance the professional competency of the clinician (Watkins et al., 2018). Mental health services are provided by a variety of community-based clinicians' including those that work in the hospital, community mental health centers, and private practice. Professional competency is imperative as the clinician utilizes evidence-based practices when working with Black male veterans. Watkins et al. (2018) said the direction for the future is linking therapy to the particular individual. This creates the need for research to explore the ways evidenced-based

trauma treatment helps in reducing PTSD symptoms and enhancing the domains of daily functioning.

Clinicians implement a variety of evidence-based practices when treating traumatized clients. This study connects the existing literature with the identifiable effectiveness of trauma treatment for Black male veterans. Addressing the clinicians' understanding of the best methods for Black male veterans who receive individual and group therapy trauma treatment, ensures that appropriate therapeutic care is being delivered (Castro et al., 2015; Coleman et al., 2019; Sagar-Ouriaghli et al., 2019; Sheehan & Hayward, 2019; Ward et al., 2021; Watkins et al., 2018). Creswell and Poth (2018) described various philosophical assumptions, such as methodological assumptions, to examine procedures. The researchers' methodological viewpoint is to explore the prevalence of PTSD among minority populations and highlight the effectiveness of treatment (Dixon et al., 2016).

Wiltsey Stirman et al. (2017) reported a need for further research that explores various treatment strategies to ensure treatment interventions are sustained. Peterson et al. (2022) say future studies should explore how the blending of various evidence-based practices supports the improvement of treatment outcomes. Pearce et al. (2018) point out that targeting specific barriers to recovery is the key to enhanced PTSD treatment effectiveness. Similarly, Motley and Banks (2018) say that future research should explore cultural perceptions of barriers and the delivery of mental health services for Black males. These research findings will assist the clinicians' in their proficiency and competence when supporting this population of veterans. These research topics helped to serve as the foundation of this study.

The current literature informs that an individual becomes susceptible to several comorbid disorders when PTSD has not been treated (Back et al., 2022; Wisco et al., 2014). Among these

disorders include substance use disorders and other psychiatric disorders, medical problems, challenges in one's social and family domains, employment issues, and suicidality. Ahern et al. (2015) reported that for veterans, the constant intrusions in connecting with family during their time serving in the military can be traumatic. There is a need for further research regarding the comorbidity between PTSD and mood and anxiety because of the impacts on daily function (Knowles et al., 2019; Smith et al., 2016). Researchers believe that in comparing interventions, there is a need to identify what treatment is more or less effective for various groups of people (Sayers et al., 2015; Watkins et al., 2018). Several existing sources point to the evidence-based practices utilized for veterans. Knowles et al. (2019) postulated that examining these comorbidities in veterans assists in treatment planning, including identifying when to therapeutically focus on the primary disorder or the comorbidities along with the primary disorder. These understanding will ultimately support treatment outcomes for Black male veterans.

Theoretical Framework

Emotional Processing Theory

This study was guided by Foa and Kozak's (1986) emotional processing theory (EPT). EPT postulates that after a person experiences a traumatic event, they develop unhealthy fear structures (Stojek et al., 2018). The current research finds that some people develop another emotional structure outside of just fear. Within these emotional structures include representations of the stimulus, response, and meaning elements that are related to the traumatic event. However, these are not real representations of threat and danger outside the framework of that particular trauma (Asnaani et al., 2016; Held et al., 2020; Stojek et al., 2018). Through the lens of EPT, the focus is on how psychopathology relates to anxiety and traumatic stress that is represented by a

pathological network of stimuli and response elements (e.g., cognitive, emotional, behavioral, physiological, etc.), and their meaning (Alpert et al., 2021; Wisco et al., 2016). This helps to identify why exposure therapy is effective.

Foa and Kozak (1986) expanded on Lang's model and bio-informational theory of emotion because EPT focuses on the meaning of the feared stimulus and response. The bio-informational model posits that cognitive structures are influenced by pathological fear involving inaccurate information about the meanings of stimuli and responses (Wisco et al., 2016). When completing exposure work, alterations in cognition lead to reductions in fear (Wisco et al., 2016). The goal of exposure therapy is to reduce the symptoms of PTSD and related problems (Foa et al., 2013). Therefore, EPT is a common practical framework to study how therapeutic change occurs in PE and other trauma treatments.

According to Held et al. (2020), EPT is not limited to the emotion of fear, but can also be applied to emotions such as shame, disgust, and guilt. Held et al. (2020) provided an example of the effectiveness of EPT. They say, imagine a veteran that shot a child and had an adrenaline rush while in the combat situation and ultimately developed PTSD. In the future, whenever they have an adrenaline rush or are around a child they would experience feelings of guilt and shame that are connected to the memory structures, 'I am a monster.' As a result of these painful emotions, they would avoid children or experiences that lead to an adrenaline rush including activities that were once enjoyable. This experience inhibits the veteran from recognizing their authentic self as being compassionate with children and causes them to believe that experiencing excitement makes them a dangerous person.

Foa and Kozak (1986) asserted that the fear structure must be activated, and conflicting pathological information should be integrated. The therapeutic process includes pinpointing

information that promotes fear activation and changes the fear structure. Memories exemplify fear as a cognitive structure for escaping danger. Whenever there is a real threat, the normal fear response will model effective action (Foa et al., 2008). As an example, to this point, an individual encountering a bear (feared stimuli) would experience an accelerated heart rate (feared response), then realize that the bear is dangerous (meaning associated with the feared stimuli), and recognize that when the heart rate speeds up, the individual is afraid (responses).

Foa and Kozak (1986) indicated that the purpose of their research is to explain how exposure work reduces anxiety. Their research expands from the behavioral viewpoint that associates stimuli with responses but does not identify how fear is acquired and maintained. Foa and Kozak (1986) believed that fear is represented in memory structures linked to fear behavior. EPT assists the person in understanding and processing how fear is processed and helps to modify the fear response. A feared structure can become uncontrolled causing inaccuracies of the representations of the world are not in line with associations among stimulus elements. Another reason is that a feared structure can become pathological occurs when harmless stimuli activate escape/avoidance responses. When interference between easily triggered response elements and adaptive behavior takes place, and when response elements that do not pose harm are wrongfully correlated with the meaning of the threat.

Anxiety disorder treatments are of paramount importance because they reduce pathological elements in the fear structure that underlie anxiety disorder symptoms. These pathological modifications are the essence of emotional processing theory and the foundation for exposure therapy. Foa and Kozak (1986) stated that the fear structure must be activated so that it is available for modifications, and new information that is incompatible with the erroneous

information embedded in the fear structure must be available and incorporated into the fear structure.

According to Korstjens and Moser (2017), theoretical theory provides a lens to examine the phenomenon of the study. It is posited that the theoretical lens helps the researcher look into specific aspects of the data and gives a framework for analyzing the data (Korstjens & Moser., 2017). Researchers have encouraged the implementation of EPT when discussing trauma treatment because it is geared toward the enhancement of PTSD symptoms by focusing on processing traumatic memories (Foa et al., 2008; Rupp et al., 2017).

Interestingly, EPT serves as a model exploring how exposure treatment for anxiety disorders works. According to EPT, emotional processing is the recovery mechanism and is associated with the presence of PTSD (Asnaani et al., 2016). EPT provides a framework for evidence-based exposure and cognitive therapy, including PE (Asnaani et al., 2016; Foa et al., 2008). Exposure therapy has many benefits such as promoting emotional processing by supporting individuals as they repeatedly confront safe but feared thoughts, sensations, situations, and activities (Sripada et al., 2022). According to Foa et al. (2006), three factors are linked to the natural recovery of trauma and PTSD symptom reduction through exposure therapy. These factors include emotional engagement with the trauma memory, changes in trauma-related cognitions, and the level of organization of trauma narratives encompasses. Success in emotional processing results in decreased negative cognitions. The increased organization of the trauma narrative typically occurs throughout trauma treatment (Foa et al., 2006). Furthermore, it has been noted that exposure leads to a long-term decline in anxiety. Hence, Foa and Kozak (1986) emphasized emotional processing through behavioral treatment.

Furthermore, EPT combines learning standards of classical conditioning and cognitive theories and accounts for PTSD treatment response (Stojek et al., 2018; Wisco et al., 2016). Foa considers the impacts of cognitive and behavioral resistance correlated with the success or lack thereof concerning exposure therapy (Markowitz & Fanselow, 2020). Fortunately, EPT uses a multimodal approach, including trauma-related cognitions, emotions, behaviors, and physiological responses (Alpert et al., 2021). This expands from other trauma treatments focusing only on one domain of functioning (Alpert et al., 2021). As Asnaani et al. (2016) put it, this theory helps to explain how CBT reduces the symptoms of PTSD. EPT also highlights the emotion of anger as an element of avoidance to fear and emotional pain (Galovski et al., 2014). EPT was relevant to this study because it supported examining how trauma impacts Black male veterans regarding symptom reduction and enhancement of daily functioning.

Related Literature

The purpose of this qualitative phenomenological study was to explore the clinicians understanding of the effectiveness of individual and group trauma therapy for Black male veterans diagnosed with PTSD. The problem was that the research is limited regarding the effectiveness of evidence-based trauma therapy on the various domains of life for Black male veterans and how the therapeutic strategies contribute to their welfare and betterment. The three research questions driving this study are the following:

RQ1. How do clinicians' understand trauma therapy's effectiveness for PTSD symptom reduction and its impact on Black male veterans' daily functioning?

RQ2. How do clinicians' describe the barriers that Black male veterans experience in individual and group trauma therapy?

RQ3. How do clinicians' understand the impact of their clinical expertise on the nature of treatment and evidence-based practices?

This literature review provided a foundation for the study by exploring how clinicians have utilized evidence-based practices to treat Black male veterans. The review addressed topics such as PTSD, the role and purpose of the DSM, PTSD within the veteran population, trauma treatment and Black veterans, trauma treatment needs of veterans, barriers that Black male veterans experience, and cultural factors.

History of the Trauma Diagnosis and the DSM

The word trauma is derived from the Greek word, "wound" or "hurt" (Feriante & Sharma, 2023). Hebrew, Greek, and Roman literature all talk about the impacts of trauma on the human brain (Gettings et al., 2022). Carvajal (2018) reported throughout history, the reference name of trauma has been modified several times. The concept of traumatic neurosis was promoted toward the end of the 19th century. This concept was inferred from the field of psychoanalytic thought, and it postulated that posttraumatic symptoms were triggered by stress, which leads to a psychic conflict. This diagnosis was applied to the civilian population, particularly survivors of railroad accidents. To categorize the symptoms that many soldiers experienced after World War I, the diagnostic term Shell Shock was implemented. This referred to traumatic hysteria which involved dissociative and amnesiac components. Many soldiers discharged from the hospital were given this diagnosis and some experienced prolonged hospitalizations.

This led to a distance of American psychiatry from the field of medicine (Surís et al., 2016). Borsboom (2017) reported that psychiatry focuses on problems and identifying effective solutions. The U.S. Census Bureau worked towards approximating the prevalence of mental

disorders for the 1920 census (Surís et al., 2016). This ultimately led to the development of standardized diagnostic criteria. This manual was named the Statistical Manual for the Use of Institutions for the Insane (SMUII)—the manual outlined 21 disorders and 19 psychotic disorders and was ignored by American psychiatrists. The American Psychiatric Association (APA) launched the first two diagnostic manuals in 1952 and 1968, which included diagnostic criteria for psychiatric disorders (Surís et al., 2016). Understanding the research and efficacy is useful when exploring the effectiveness of treatment for particular groups of people.

The first edition of the Diagnostic Statistical Manual was released in 1952 and contained a diagnosis named Gross Stress Reaction, which included an overwhelming fear response that impacted an individual's personality. In 1970, the updated diagnostic term, Post-Vietnam Syndrome was implemented into the DSM (Carvajal, 2018). Vietnam War soldiers were given this diagnosis after being decommissioned from the war. The second edition of the DSM does not incorporate this specific diagnosis.

However, PTSD was introduced in the third edition of the DSM in 1980 (Pai et al., 2017). Besel van der Kolk, in his book *The Body Keeps the Score* (2014), points out that psychoanalysts Chaim Shatan and Robert J. Lifton along Vietnam veterans lobbied the APA to develop a new diagnosis for trauma. He reported that their efforts were successful and this led to the creation of the diagnosis, PTSD, and caused a burst of research interests and attempts at finding effective treatments (van der Kolk, 2014). PTSD shifted from being named among anxiety disorders to the group named trauma-and- stressor-related disorders (Carvajal, 2018). The diagnosis name of PTSD remains the same today. According to Pai et al. (2017), it took several years to establish the current criteria of PTSD in the DSM-5. The process began with planning for 7 years, group activity for 6 years, and review of the materials for 1 year to eventually submit for publication

and approval from the APA Board of Trustees (Pai et al., 2017). There were several steps that supported the revision process for the diagnostic criteria for PTSD. These steps involved reviews regarding the intended criteria from professionals and the public, discussions with nosologists and trauma experts, further evaluations, and exploration of the literature (Pai et al., 2017).

In March 2022, the DSM-5-Text Revision (TR) was released. The aim of the DSM-5-TR is to revise the descriptive content of the DSM disorder with information found in the literature since the previous version (First et al., 2022). The DSM-5-TR contains new diagnostic criteria and specifiers as well as updated names and symptoms. The process to begin the text revision of the DSM-5 began in 2019 and involved over 200 experts.

History and Importance of Evidence-based Therapy

Evidence-based therapy has been implemented into practice for many years. According to Cook et al. (2017), evidence-based medicine goes back many centuries, and Dr. David Sackett formally coined the term evidence-based therapy in 1996. Lilienfeld (2019) asserted that evidence-based treatment is held on a three-legged stool. The first leg encompasses evidence associated with efficacy and evidence, and the second and third legs refer to clinician expertise and the client's preferences and values.

Providing care through the lens of evidence-based therapy is connected with professional competence. Professional competence refers to accurately and efficiently assessing the problem, diagnosing the disorder, recommending appropriate treatment, and completing that treatment (Blease et al., 2016). As Duff et al. (2020) indicated evidence-based therapy is the appropriate model that has become the prospect of those that fund the healthcare system, the clients being treated, and the agencies that provide the regulations. Since most clients initially utilize services through the community sector, it is crucial to understand what prompts the utilization of

evidence-based therapeutic practices by community clinicians' (Thomas et al., 2023). The clinical practice guideline encourages for the management of PTSD that trauma-focused therapy be individualized and manualized with a foremost focus on exposure and/or cognitive restructuring elements, including PE and CPT (Galovski et al., 2016; Sloan et al., 2018). Along with this approach, narrative therapy is promoted as it has been found to support the delivery of exposure therapy for PTSD (Sloan et al., 2018).

Williams and Beidas (2019) stated that many in the community do not receive evidence-based treatment interventions. Since PTSD has physical and psychological impacts, the current research recommends that effective treatments be developed (Foa et al., 2018). Similarly, Thomas et al. (2023) said evidence-based practices for PTSD are underutilized in community settings, including "private practice settings, community hospitals, and outpatient mental health clinics" (p. 137). It becomes a notable public concern when clients with PTSD are not treated through evidence-based practices (Wiltsey Stirman et al., 2017). Some of these concerns impact domains of functioning such as family relationships, impairments in productivity, including work presence, over-utilization of healthcare, and increased risk of suicide (Wiltsey Stirman et al., 2017). Blease et al. (2016) pointed out that the client has a right to be well-informed about the efficacy and effectiveness of specific techniques in therapy. This is essential information for the current study because it points to the value of evidence-based treatment.

Psychological treatments have been developed for various mental health disorders (Frank et al., 2020). Still, many clinicians still need to be trained in evidence-based therapy (Frank et al., 2020). Clinicians in community settings do not always have access to the resources, consultations, and training their colleagues at institutions may have, which impacts the quality of care provided (Finley et al., 2019; Thomas et al., 2023). This research found that the dropout

rates for outpatient evidence-based treatment for PTSD range from 30-62% (Ragsdale et al., 2020). Promoting and facilitating effective treatments is essential (Kitchiner et al., 2019; Tiley & Kyriakopoulos, 2018). To challenge this deficit this, Tiley and Kyriakopoulos (2018) stated it may occur through training local researchers and supporting institutions.

Furthermore, Marques et al. (2019) said that identifying the modifications and fidelity regarding evidence-based practices helps promote sustainable programs in settings that provide care. Treatment fidelity refers to the provider's intentional adherence to treatment interventions, competence in delivering treatment interventions, and distinguishing from other treatments (Marques et al., 2019). At the end of Marques et al. (2019) study, the researchers promoted future studies examine the fidelity-consistent evidence-based treatment adaptations result in clinical and implementation improvements.

Chu and Leino (2017) stated that subtle adjustments to therapy practice protocols are sometimes necessary because this helps enhance the delivery of the treatment to clients. They also say the current research does not reveal whether these treatment adaptations benefit treatment (Chu & Leino, 2017). This is important for the proposed study because promoting effective treatment for Black male veterans requires clinicians with experience implementing evidence-based therapy. According to Castro et al. (2015), it is vital to understand the effectiveness of evidence-based therapy interventions on treatment engagement. Some barriers to using evidence-based trauma treatments include the extensive trauma histories and multiple traumas that some clients have experienced (Marques et al., 2016). This leads many community mental health clinicians to believe they must modify treatment protocols to address the complexity (Marques et al., 2019). Similarly, Thomas et al. (2023) sought to identify how community clinicians' decide when to begin engaging in trauma treatment. This proposed study

explores how community-based clinicians and clinicians in all settings identify the effectiveness of trauma treatment and highlight the influences behind their decisions to begin trauma treatment with Black male veterans.

Post-Traumatic Stress Disorder

In 1980, PTSD was introduced in the 3rd edition of the Diagnostic and Statistical Manual (DSM; Miao et al., 2018). PTSD is categorized under the category of trauma-and-stressor-related-disorder (Miao et al., 2018; Pai et al., 2017). The criteria for PTSD include:

> Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: (1) Directly experiencing the traumatic event(s); (2) witnessing, in person, the event(s) as it occurred to others; (3) learning that the traumatic event(s) occurred to a close family member or close friend – in cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental; (4) experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to 30 details of child abuse). (5th ed.; DSM-5; American Psychiatric Association, 2013)

At least one traumatic event is the requirement to meet the criteria for PTSD (Karam et al., 2014). Noticeable impairments in functioning that persist for one month, as per the DSM criteria, lead to a diagnosis of PTSD (Bisson et al., 2015). According to the National Comorbidity Survey, 64% of the U.S. population has experienced at least two traumatic events, and 20% of males and 11% of females have faced three or more traumatic events (Karam et al., 2014).

Borsboom (2017) provided a differentiation between a "disease" and a "disorder." He asserted that a "disease" has symptoms that originate from a particular pathogenic pathway. On

the other hand, a "disorder" is referred to as a collection of congregated symptoms, with no clear reason. PTSD is a mental disorder that occurs after an individual has been exposed to horrific events (Bisson et al., 2015, Lancaster et al., 2016; Miao et al., 2018; Schrader & Ross, 2021). Trauma has the potential to impact the daily lives of individuals including the behavioral, somatic, affect, and cognitive domains of their functioning (Miao et al., 2018; Paiva et al., 2021). The World Health Organization (WHO; 2021) International Classification of Disease (ICD)- 11 version, includes three clusters of symptoms: "constant re-experiencing of the traumatic event, avoidance of traumatic reminders and a sense of threat." To be diagnosed with PTSD, the individual must present with at least one symptom from each cluster with a duration lasting several weeks following exposure to a chronic stress (Miao et al., 2018). The emphasis on experiencing a traumatic experience and duration of time differentiates PTSD from other mental health disorders such as personality disorders, adjustment disorder, obsessive-compulsive disorder, and anxiety.

Miao et al. (2018) reported that although several revisions have been made to the DSM, we do not know how much stress a person must experience before ultimately causing symptoms of PTSD. Some factors that were found to contribute to the activating of PTSD symptoms for military personnel include combat injury, and shame and guilt related to moral injury. Liddell and Jobson (2016) reported that culture influences cognitive and emotional processes. Research is needed to explore whether there are cultural similarities involved with the development, maintenance, and treatment of PTSD across different backgrounds.

According to Liddell and Jobson (2016), regarding the spectrum of PTSD psychopathology, affective and cognitive functions are disrupted in PTSD (e.g., disruptive mechanisms include fear dysregulation) and are impacted by culture. This area involves fear

responses occurring as a result of fear dysregulation. When hyperactivity occurs in the fear-processing networks, including the amygdala, insula, hippocampus, and lessened regulatory activity occurs within medial prefrontal cortical (MPFC) regions and cognitive control centers, this decreases the ability to control fear responses. These disruptions impact parts of the brain that lead to hypervigilance, fear learning, intense stress sensitivity, emotional dysregulation and extinction processes that have been compromised. These are some of the symptoms experienced by Black male veterans who have been diagnosed with PTSD.

Post-Traumatic Stress Disorder and Veterans

Research shows that the longest and most extensive war that the United States has fought since the Vietnam War include, Operation Enduring Freedom (OFE), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND; Sayer et al., 2015). These wars have utilized all branches of the U.S. military. According to Lee et al. (2014), there are about 22 million veterans in the United States. They find that about nine million of these U.S. veterans receive care at the VA hospital. It is important to provide quality care to all veterans whether they receive services at the VA or through alternative services in the community. Research indicates that it is very important to provide quality healthcare to the robust number of veterans that have served in Iraq and Afghanistan (Ross et al., 2015; Sayer et al., 2015).

Veterans that have been exposed to trauma and have PTSD are more likely to experience mood changes, loneliness, reckless behaviors, sleep challenges, and substance use (Kinztle et al., 2018; Markowitz et al., 2023). These factors often impair their ability to re-enter civilian life effectively (Kintzle et al., 2018). When veterans are exposed to combat, there is an increased likelihood that they experienced symptoms of PTSD. Compared to White veterans, Ethno-racial minority veterans reported that in the war zone, they experienced more perceived threats and

family-related challenges and stressors (Muralidharan et al., 2016). These experiences negatively influence PTSD symptoms and the daily functioning of veterans. Furthermore, these findings reveal the importance of recognizing PTSD treatment effectiveness.

Research finds that documenting the psychological costs of war helps to point out the global necessity of improving treatment for veterans and civilians (McFarlane, 2015). One study conducted for veterans with PTSD explored the impacts of PTSD symptomology on their daily functioning. These daily functions included sleep, social roles, relationships, and the ability to perform tasks such as working, recreation, and education (Dillahunt-Aspillaga et al., 2019). They found that these daily functioning domains were significantly impacted by PTSD symptoms and their ability to seek and obtain employment. It is postulated that those who work with veterans with PTSD would benefit from further education and training on how PTSD impacts the daily functioning of veterans. The findings noted by Dillahunt-Aspillaga et al. (2019) relate to the study because it explores the impacts on the daily functioning of veterans diagnosed with PTSD. This highlights the importance for clinicians to be aware of the symptoms of PTSD and its effects on daily functioning.

Wisco et al. (2014) identified factors associated with decreased risk for PTSD that include protective psychosocial characteristics and social connectedness, which involve a sense of resilience, community integration, and secure attachment styles. Social connectedness refers to the opposite of social isolation that involves the presence of social networks and support (Wickramaratne et al., 2022). Thus, these factors must be addressed in prevention and treatment efforts. This research intended to explore the effectiveness of evidence-based therapy for the various domains, as highlighted by Steenkamp et al. (2015). This will provide clarity for clinicians who treat Black male veterans that have been diagnosed with PTSD.

There are several factors to consider when exploring trauma treatment barriers for veterans. Sloan et al. (2018) recommended that future studies research should identify the impacts of written accounts in implementing CPT to highlight if this influences treatment dropout. Permitting client choice and engagement for veterans would be beneficial and challenge the stigma (Yasinski & Rauch, 2018) associated with mental health care and other treatment barriers related to military culture (Vance, 2017). This is related to my second research question: What barriers do you recognize for Black male veterans who utilize individual and group trauma therapy?

Trauma Treatment for the Veteran Population

According to the existing literature, current PTSD therapies need to be improved (Kozel et al., 2018; Steenkamp et al., 2015). Vance (2017) postulated that first-line medications and psychotherapies should be available for veterans and civilians. Similarly, Castro et al. (2015) reported that therapists should continue to provide evidence-based practices to enhance treatment engagement and that the client's goals and different therapy styles and types should be incorporated.

According to Watkins et al. (2018), the goal of trauma treatment is to focus on memories, thoughts, and feelings related to traumatic experiences There are trauma-focused treatment and non-trauma-focused treatment modalities. The current research does not indicate whether either of these treatments are more effective than the other (Watkins et al., 2018). Examples of trauma-focused treatment include CPT and PE. On the other hand, interpersonal therapy, relaxation, and stress-inoculation are examples of non-trauma-focused therapy.

PTSD treatment guidelines were developed by the VA/DOD and APA in 2017 (Watkins et al., 2018). These recommendations provide an evidence-based framework for clinicians to use.

Among these guidelines, there is a strong recommendation for clinicians to utilize CPT, PE, and TF-CBT as a first option when providing PTSD treatment. The clinician must be competent in these treatment modalities and be cognizant of the client's preferences. Current research reveals that clients prefer CPT, PE, and TF-CBT. Furthermore, research also shows that in comparison to medication, there was a greater preference for the use of PE and CBT. As it pertains to the trauma-focused treatment, Watkins et al. (2018) stated that the research shows there are no associations to increased adverse effects. Still, they reported that there is a need for greater understanding of how effective these treatments are for the military population. They also recommend further research that explores how effective trauma treatment interventions are for different populations of people.

The VA is known to be a first-line opportunity for veterans and is believed to be an ideal place to observe the implementation clinical best practices (Cook et al., 2015). Eligible U.S. military veterans can receive all-inclusive healthcare services from the VA hospital (Anhang Price et al., 2018). The VA hospital is the most all-encompassing healthcare system in the United States. According to Dedert et al. (2021), there is not a lot of veterans that begin and complete CPT and PE treatment within the VA or VA specialty clinics. They reported that sufficient attendance to treatment increases the likelihood of experiencing progress in addressing symptoms and quality of life (Dedert et al., 2021).

The current literature identifies several factors that contribute to the utilization and compliance of veterans in therapy. In other words, it is important to explore what serves as a barrier to treatment for veterans. Thompson-Hollands et al. (2021) reported that people who have PTSD may have a difficult time developing a strong therapeutic alliance between the counselor and the client. This can serve as a barrier to treatment because it serves as a foundation for

progress. Research finds that 22% of soldiers who have been diagnosed with PTSD attend only one mental health visit (Peterson et al., 2022). Lane et al. (2021) highlighted mental health stigma as a big barrier to assessment and treatment among the military.

There are many factors that are barriers to treatment for veterans that results in them being homebound. The term homebound refers to the concept of living life confined to the home (Schirghuber & Schrems, 2021). These homebound factors include, injuries and illnesses, limited transportation options, family life responsibilities, and an unwillingness to go to certain treatment facilities because of challenges related to scheduling, work, and stigma (Peterson et al., 2022). Identifying barriers to treatment is useful to clinicians when understanding the effectiveness of trauma treatment. The study by Koven (2018) highlighted that many treatment studies focused on reducing PTSD symptoms and put little attention on improving impairments. Another barrier to treatment is that many veterans live in medically underserved regions (Ohl et al., 2018). This points to the need for increased clinicians that provide therapy services in rural areas. Furthermore, there is a need to see the relationship between access to care and clinical outcomes for those who seek treatment (Kehle et al., 2011). This will help to provide treatment that supports the betterment of Black male veterans.

Sagar-Ouriaghli et al. (2019) identified the methods that help to encourage men to seek treatment including assisting Black male veterans in acknowledging their masculinity, providing psychoeducation, identifying symptoms skill building, promoting behavior change, implementing problem-solving, having role models, and providing direction on how to find support helps a great deal. They reported that further research is warranted because all men are not the same and effective treatment must be customized to meet their specific needs, including the influence of culture and diagnoses.

Compared to other mental health conditions that veterans experience, PTSD causes the greatest financial burden on society (Murphy et al., 2019) which necessitates further research on treatment options for veterans (Koven, 2018). According to Davis et al. (2022), the economic burden of PTSD for military populations was $42.7 billion for 2018. The direct and indirect expenditures related to the loss of productivity, unemployment, disability, PTSD-related care giving, and homelessness contribute to the financial burden of PTSD on society. Thus, it is important to gain an understanding of the effectiveness of trauma treatment.

It is reported that there are decades worth of research and clinical trials that find PE and CPT effective for the adult population in various therapy settings (Dondanville et al., 2022; Steenkamp et al., 2015). Matching a particular trauma treatment to the needs of the client is important (Cook et al., 2014). Clinicians need a better understanding of the functional challenges veterans' experiences to develop interventions and techniques that support their productivity in civilian life (Sayer et al., 2015).

The National Survey of Veterans found that minority veterans are more likely to serve in the Army, which is why there are differences in outcomes for research (Ward et al., 2021). Research highlights differences in treatment outcomes and initiation for therapy for Black veterans and White veterans. The current literature indicates Black veterans, compared to White Americans, do not seek psychotherapy as much, typically end treatment early, and attend sessions less frequently (Castro et al., 2015). Similarly, Coleman et al. (2019) found that Black veterans scored higher on the re-experiencing symptom cluster when compared to White veterans. Furthermore, higher socioeconomic status for black veterans is linked to a reduction in mortality risk compared to Black non-veterans (Castro et al., 2015). There are socioeconomic advantages promoted by Black veterans that have benefited their longevity, at least compared to

their peers who never served (Sheehan & Hayward, 2019). When individuals could not solve their problems independently, they sought mental health treatment.

Trauma and Black Males. Although the present study focused on the impacts of evidence-based trauma therapy on the daily functioning of Black male veterans, it is essential to look into the influence of trauma and PTSD on Black males overall (Motley & Banks, 2018). According to the current research, men are less likely to seek help for mental health issues (Sagar-Ouriaghli et al., 2019). McClendon et al. (2020) reported that there is a need for further research specifically geared toward identifying differences in race and ethnicity as related to trauma treatment outcomes and various treatment modalities.

Compared to other groups in the United States, research reveals that Black men's overall health is the poorest (Gilbert et al., 2016). To address this, interventions to help must comprehensive because Black men are not a homogenous group. Addressing the spheres of public health, education, urban planning, labor, criminal justice, and medicine will help to minimize poor health outcomes in men. However, the current research indicates that when Black males attend therapy, oftentimes the clinician does not address their trauma experiences, but instead focuses on other presenting problems. It is believed that this is due to the clinicians' lack of competency in treating trauma (Motley & Banks, 2018). With this in mind, argue that further research is needed to explore the relationship between trauma and the utilization of mental health services for Black men.

A daily reality for Black males is that they may be faced with exposure to trauma (Motley & Banks, 2018). As a result of PTSD, Black males face various negative health behaviors that impact their psychological well-being. PTSD is linked with a higher risk of diabetes, hypertension, heart disease, and stroke for Black Americans (Jones et al., 2022). There is also

comorbidity between PTSD and other psychiatric disorders, such as major depressive disorder and substance use disorders (Jones et al., 2022; Williams et al., 2014).

Jones et al. (2022) studied the impacts of PTSD on different age groups in the Black community. Jones et al. (2022) examined the severity, persistence, and prevalence of PTSD. Jones et al. (2022) found that prolonged stress on individuals in their middle age causes impairments to various domains of their functioning, including significant their employment, money, and health. Jones et al. (2022) also indicated that there are associations between Black men with PTSD, and lower education, unemployment, stress, and poverty. Motley and Banks (2018) reported that a lack of education and reduced financial resources decreases the options Black men have for obtaining mental health treatment.

Interventions in mental health should consider the barriers such as race/ethnicity, age, gender, and environmental impacts such as socioeconomic status to mental health services (Bauer et al., 2022; Valentine et al., 2019; Watkins et al., 2017). Motley and Banks (2018) expressed that to effectively challenge barriers to mental health services and to promote support systems for Black male trauma survivors, there is a need for collaboration between policymakers, mental and behavioral health organizations, researchers, and clinicians. In the study by Bauer et al. (2022), it was indicated that young Black men found it very important to have someone with whom they could discuss their mental health and identify interpersonal relationships. This encouraged them to pursue treatment for mental health challenges. The researchers found it very important that mental health care be provided in all communities in an effort to implement interventions that support young black men who have experienced trauma. Reyes et al. (2022) noted that social support is highly valued among Black young adults and is associated with a decrease of substance misuse as related to PTSD symptoms. Motley and Banks

(2018) reported that clinicians should be aware of the value of social support for Black males, such as their friends, peers, and significant other.

The foundation of mistreatment for Black Americans and how one views their experience in the world from a group perspective is demonstrated through the idea of race. Scott-Jones and Kamara (2020) defined race as "beliefs, attitudes, institutional arrangements, and acts that tend to denigrate individuals or groups because of phenotypic characteristics or ethnic group affiliation" (p. 1). Williams (2018) said linking race and mental health can become difficult. It is difficult because compared to other races, overall psychological well-being, levels of psychological impairments, intensity of psychological episodes, are different in Black Americans.

Black Americans continue to be impacted by the influence of racism on their daily functioning (Boynton, 2020; Scott-Jones & Kamara, 2020). Racial trauma is pervasive in the lives of those who are racialized (Cénat, 2023). Racial trauma harms the mental health of Black Americans and may negatively impact their White counterparts (Boynton, 2020). While not addressing this directly, the DSM-5 does mention that culture may influence the experiences of trauma (5th ed.; DSM-5; American Psychiatric Association, 2013). Boynton (2020) indicated that due to experiences in history, Black Americans may be hesitant about clinical treatment practices. To effectively reach the Black-American population, it is recommended that clinicians understand institutionalized racism, ethno-violence, and microaggressions (Boynton, 2020). Enriched functioning for the affected individual is the key to recovery.

Historical Trauma and Discrimination. Ford et al. (2015) asserted that historical trauma refers to the racial and ethnocultural trauma experienced by multiple generations. Beginning in the 17th century, Black people were captured from Africa and forced to live in America and labor as slaves. Black people suffered psychological, biological, sexual, and

emotional abuse and trauma. During this time, Black people were "burned, beaten, lynched, raped, experimented upon, and feared… portrayed as unworthy, unfit, and less deserving of fundamental equality" (McCrary, 2019, p. 33). Although the Declaration of Independence and the Constitution were established, Black slaves did not have any civil rights (Hahn et al., 2018). Black slaves endured harsh conditions that impacted all domains of functioning. The Civil War initiated a turnaround of inequality and disparity (Hahn et al., 2018). The Civil Rights Act of 1866, states, "An Act to protect all Persons in the United States in their Civil Rights and furnish the Means of their Vindication." The U.S. 14th Amendment states,

> All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the state wherein they reside. No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

The denial of civil rights for Black people in the United States, is linked to poor health outcomes (Hahn et al., 2018). Being aware of the reality of having civil rights is not sufficient; they must be applied. There is continual work that needs to be done to ensure that civil rights are implemented within the sphere of healthcare.

The abuse that Black people have experienced has had continual traumatic impacts that resulted in health, social, and economic challenges within Black communities (Baharian et al., 2016; Walsemann et al., 2022). Black Americans are at greater risk for PTSD compared to non-Hispanic White Americans (Bird et al., 2021). Marginalization continues to negatively oppress the welfare of Black Americans and is recognized in various systems and institutions across

America today. Racial discrimination is a contributing factor to the increased risk of PTSD among Black Americans. Compared to Black women and men with different ethnic and cultural backgrounds, Black men are at greater risk for discrimination because of negative stereotypes (Gilbert et al., 2016). Vines et al. (2017) defined racial discrimination as "the unfair treatment that members of marginalized racial and ethnic groups experience because of their phenotypical or linguistic characteristics and cultural practices" (p. 2). Stepanikova and Oates (2017) indicated that racial discrimination is the perception of unfair treatment due to an individual's race. Perceived discrimination is also associated with poor health outcomes, including mental health (Chapman et al., 2014). The long history of inequality faced by Black men makes it difficult for them to implement effective behavior change such as reasonable employment and healthy living choices (Gilbert et al., 2016). This is important for this current study because perceived discrimination can be a barrier to treatment that clinicians must be aware of.

Sibrava et al. (2019) stated that there is limited research on perceived discrimination among minority groups and the development of PTSD. Understanding the role of discrimination is paramount, especially when providing trauma treatment. Williams et al. (2014) expressed that racial microaggressions that Black people have experienced throughout their life are oftentimes associated with maladaptive cognitions. Self-reported experiences of discrimination continue to serve as an example of psychosocial stress that impacts the mental and physical health of racial and ethnic groups (Lewis et al., 2015; Williams, 2018). Biologically speaking, the sympathetic nervous system (SNS) and the hypothalamic-pituitary- adrenal (HPA) axis comprise the stress response systems in humans (Walsemann et al., 2022). Disruptions in these systems negatively impacts homeostasis and effective functioning leading to chronic stress. Cardiovascular,

immunological, hormonal, and metabolic systems become exacerbated by reoccurring psychological and physical threats.

Marques et al. (2016) reported that discussions about experiences related to general discrimination and trauma are critical when providing treatment in a diverse community mental health setting. To help mitigate the impacts of discrimination towards Black Americans, Williams et al. (2014) highlighted the need for "culturally informed adaptations to PE" (p. 103). The objective of their study was to explore the necessary changes for implementing PE to Black Americans. These treatment modifications must attend to the traumas' unique to Black Americans. The Black culture is not homogeneous, thus, assessments that explore cultural factors is necessary. Their research indicated the need for clinicians to maintain cultural sensitivity when working with different populations of people. This is consistent with ethical standards of treatment. The ACA (2014) stated, clinicians must consider the role of culture when administering a test and for interpretation (Section E.8). According to the Ethical Principles and Code of Conduct for Psychologists, when interpreting assessment results, they must be mindful of the role of culture (Standard 9.06). Furthermore, the NASW Code of ethics (2021), report the importance that social workers "demonstrate cultural awareness and humility" (1.05 c). Adhering to these recommendations and codes of ethics helps to ensure that the clinician is providing culturally competent treatment.

In their research study, Williams et al. (2014) encouraged that clinicians should have cultural knowledge and sensitivity when providing treatment to various groups of people. Before providing PE treatment it is recommended that a formal assessment of trauma symptoms be administered. Furthermore, administering a cultural assessment helps to understand the client's cultural influences. After this has been completed, provide psychoeducation and assessment

while addressing how racism may be linked to the development of PTSD. The steps in PE treatment involves, in-vivo exposure, imaginal exposure, and emotional processing. In vivo exposure entails repeatedly facing safe situations, people, objects, and places that were previously avoided (Sripada et al., 2022). Imaginal exposure involves repeatedly facing trauma memories that are related to emotions and cognitions (Wells et al., 2020). Emotional processing includes challenging the expression of trauma related emotions and cognitions to implement new information into trauma-related fear structures (Foa et al., 2008). Throughout treatment, Williams et al. (2014) shared that emphasizing Afrocentric perspectives such as family support, resilience, faith, optimism is important. When concluding the study, it was reported that there is a need to gain better understanding of the "phenomenology of PTSD" specific to Black people. To complete this, they recommend further research that helps to refine the assessment and diagnostic tools utilized when treating Black people.

Transgenerational Trauma

Researchers have sought to understand how trauma affects the different domains of an individual's life and the long-term impacts. The current research posits that the occurrence of trauma may influence several generations (Klengel et al., 2016; Reyes et al., 2022; Youssef et al., 2018). The term transgenerational trauma refers to the transmission of traumatic effects people experience after being exposed to a horrific event, to their offspring (Yehuda & Lehrner, 2018). According to the literature, it is possible that the effects of parental trauma may impact offspring even if the exposure occurred prior to their conception and birth. This results in heightened offspring vulnerability to psychological distress and psychopathology, particularly, challenges in stress response functioning (Lacal & Ventura, 2018). The effects influence the

sociological, psychological, and biological domains of life (Afifah Ridhuan et al., 2021). The transmission of deleterious trauma effects is often done without awareness (O'Neill et al., 2016).

The thoughts, emotions, and behaviors of the traumatized parent are the elements that are typically transmitted to the children (Dashorst et al., 2019). Epigenetics helps to clarify the association of genetics and environmental exposure to trauma (Howie et al., 2019). Epigenetics refer to the changes in the organism as a result of alterations in the expression of genes rather than the changes in the genetic code. Recent studies find that it is a result of direct changes of DNA regulation and without alterations to the genetic code or original sequence of DNA. Researchers report that the transfer of parental trauma can be passed down through prearranged epigenetic marks on DNA and transmitted through the germ line, the egg or the sperm (Kaufman et al., 2023; Yehuda et al., 2018). Genetic and epigenetic factors represent about 70% of the development of PTSD in individuals.

The three forms of epigenetic alterations involved in transgenerational inheritance are DNA Methylation, histones, and non-coding of RNA molecules (Beck et al., 2021). Histones reels DNA because they are proteins, however, chemical changes to histones influence the regulation of genes. RNA molecules influence the process of coding proteins, but non-coding RNA are another form of epigenetic changes because they influence the regulation of genes as well.

There is robust evidence supporting the influence of transgenerational trauma on many different communities based on horrific experiences. These cultures and groups of people include Holocaust survivors, African Americans, Australian aboriginal people, and First Nation and native Americans (Hankerson et al., 2022). The notion that trauma can be transmitted from parents to children was indicated when researchers recognized this phenomenon in Holocaust

survivors (Yehuda et al., 2008). The research exploring this phenomenon in offspring of Holocaust survivors found that the traumatic distress experienced in parents were passed down to their children. The research indicated that the existence of maternal PTSD increased the likelihood of PTSD in the offspring of Holocaust survivors.

This research highlights the generational consequences of trauma and adversity including, racism (Lugo-Candelas et al., 2021). To develop and maintain effective intervention and prevention for the influence of racism, it is recommended that a transgenerational framework be employed. This is useful because it expands the framework from the individual to family and society (Mooren et al., 2023). It also helps in identifying the presence of resilience and exploring effective clinical interventions. Through further research, clinical interventions can be developed that support the diminishing of transgenerational trauma.

Military Culture

The stigma surrounding mental health is a significant barrier among the military (McGuffin et al., 2021; Sharp et al., 2015). Research asserts that there are different types of stigmas, including self-stigma and public stigma (Lin & Tsang, 2020). Self-stigma refers to the thoughts people have about themselves in the event they have a mental health challenge (Docksey et al., 2022). Anticipated stigma is the belief that an individual may be discriminated against due to their mental health challenges. This is also referred to as perceived public stigma.

Many veterans decide to seek mental health treatment when they feel they have the support of their military leaders (McGuffin et al., 2021). Sharp et al. (2015) found that the stigma around seeking mental health treatment was highest among military personnel who were apprehensive about military leadership treating them differently because of their mental health needs. This is an example of anticipated stigma. Sharp et al. (2015) indicated that military

personnel often have concerns about being prescribed mental health medication because it could result in being medically downgraded and their weapon handling authorization revoked. This serves as another barrier to treatment that often influences their decision to seek treatment. Furthermore, there is a greater level of stigma related to having a psychological health disorder compared to a physical health disorder.

Sharp et al. (2015) reported that the current literature does not measure the links between stigma and the utilization of mental health treatment. In other words, the current studies only explore the stigma around seeking mental health treatment. Furthermore, they assert that self-reports are not an effective way to identify mental health utilization because some may not share that they use mental health services due to stigmatizing beliefs. It is for these reasons that this current study addressed the clinicians understanding of the effectiveness of evidence-based trauma treatment.

Sharp et al. (2015) encouraged future research to further explore the delays in utilizing mental health treatment that is related to stigma. Policies that foster early mental health treatment services could help to reduce the economic and social costs that are incurred when individuals seek treatment due to being in a crisis. Other barriers to explore include the awareness one has that they need mental health treatment, the beliefs one has about mental health treatment, and self-stigma.

Cultural identity influences an individual's self-perception and interactions with others (Joseph et al., 2023). There are differing domains of culture that veterans occupy including race/ethnicity, religion, sexual orientation, socioeconomic status, and military culture (Ross et al., 2015). Research indicates that there are several benefits to understanding the influence of military culture for veterans, including improvements in treatment planning, improved health

outcomes, and contextualizing symptomology (Ross et al., 2015). Military culture posits that many veterans view the military as a family that develops a unique set of expectations for them and provides support to each other (Ahern et al., 2015).

The American veteran population is multifaceted and has unique needs (Olenick et al., 2015). Clinicians need to be aware of the unique needs of veterans in order to provide quality treatment (Lee et al., 2014). It is important to be prepared to provide trauma treatment that is culturally tailored to veterans as they return to civilian life (Treichler et al., 2023). Shifting from military life to civilian life involves a change in daily living, roles and responsibilities, expression of the self, laws, attire, structure, culture, affiliation, and identity (Joseph et al., 2023). Miao et al. (2018) stated that between 44% and 72% of veterans returning to civilian life, experience chronic stress. Among the challenges faced by veterans returning to civilian life, include, emotional dysregulation, which negatively impacts emotional intelligence and self-control and expression (Miao et al., 2018). Emotional dysregulation and PTSD symptom severity could result in domestic violence and impaired family relationships for veterans.

Ahern et al. (2015) asserted that improved interventions can be employed to help veterans readapt when there is an increased understanding of the negative impacts of transitioning from the military to the civilian environment. They recommend that future research explore the effectiveness of such interventions. Sayer et al. (2015) found that some veterans did not show difficulty with reintegrating back into civilian life until 6 years after they were discharged from the military. Some veterans do not overcome the challenge of reintegration without effective interventions. Romaniuk et al. (2020) recommended that clinicians gain a better understanding of the timing and diversity of interventions employed when working with veterans that are reintegrating into civilian life.

There is an emphasis on competent and efficient care that supports the various facets of the veterans daily functioning (Lee et al., 2014). Among the tenets of military culture include maintaining and demonstrating the notion of being strong. This belief is often infused into the consideration of seeking mental health challenges which results in many veterans believing they do not need mental health assistance (Hom et al., 2017). Dismantling this belief will help veterans feel secure in seeking assistance for their mental health challenges. It is recommended that clinicians who lack military experience participate in trainings that teach them about the influence of military culture on seeking mental health services for veterans (Treichler et al., 2023). This will help the clinician provide competent treatment to veterans that supports their daily functioning and reduces their PTSD symptoms.

An individual's self-concept is often molded by military culture (Joseph et al., 2023). Other functions of military culture include aggression, self-less service, toughness, respect, accountability, and courage (Joseph et al., 2023; Plys et al., 2020). These functions vary from civilian culture, hence, increasing one's awareness of these functions will help the clinician to provide effective trauma treatment. Another aspect of identity instilled into service members is that of a warrior. Separating from the military and transitioning and adjusting back to civilian life could be difficult for military personnel and lead to increased risk of psychological disorders including PTSD (Amick et al., 2018; Joseph et al., 2023; Lippa et al., 2015; Romaniuk et al., 2020). As veterans leave the military, they often view themselves as separating from the warrior identity that they occupied while serving. This causes difficulty for veterans in accepting themselves and worrying about the ways they are perceived by others (Joseph et al., 2023). In a similar study, Sharp et al. (2015) indicated that military personnel often believe they will be seen as weak if they seek treatment. Sharp et al. (2015) reported that this stigmatizing belief is linked

with the masculine culture in the military. These stigmatizing beliefs are often maintained because military personnel that are returning back to civilian life typically hold to the military culture and ways of thinking.

Researchers assert that providing quality care to veterans involves understanding the influence of masculinity in military culture (Plys et al., 2020). Masculinity is a set of beliefs and attitudes regarding the meaning of the male gender role as established by society (Plys et al., 2020). Kivari et al. (2018) conducted a study with military veterans that participated in the Veterans Transition Program (VTP). This is a 10-day residential group that involves developing autobiographies, goal setting, group building, and processing traumatic events. One of the goals of their study was to explore the effectiveness of male counseling in a group format because this represents a social microcosm. The results of the study revealed that at the completion of the group-based therapy program, the veterans usually experienced reduced stigma regarding mental health challenges and engaged with others more often.

There were several findings that emerged from their study that indicate the effectiveness of this counseling intervention. One finding includes the importance of creating an environment where there was no advice giving and judging others. The second finding that helped the veterans was when there was freedom for self-disclosure with the goal of taking care of their own health. The third finding involved having competent and proficient leadership. The men recognized they did not have to ignore or prove their masculine beliefs. Through these findings, the researchers noted that the early part of treatment is important for men because it is the period they make their decisions.

The researchers identified several factors that were not clearly delineated in the study. First, the results do not distinctively report whether the emphasize of implementing action

activities into the program was linked to increased engagement. Secondly, therapy-like language such as the term "depression" and "therapy" were not used. Other phrasing such as "completing course" and "picking up tools" were utilized instead. The research findings reveal that there is little evidence of how effective this approach was and if it actually helped. The researchers recommend further qualitative studies to explore the factors associated with treatment engagement for men.

Among the challenges experienced by veterans as they re-enter civilian life includes the loss of social connectedness (Kintzle et al., 2018). Social connectedness influences the dynamics of one's social network including their memberships, interpersonal relationships, social behavior, and peer affiliation. Social connectedness is particularly important for protecting against the development of PTSD. Furthermore, the identity of the veteran is negatively impacted by the loss of social connectedness and could ultimately lead to isolation.

Trauma Treatment Modalities

Trauma-Focused - Cognitive Behavior Therapy (TF-CBT). TF-CBT is an evidenced-based therapy approach found to help treat trauma and was developed by Anthony Mannarino, Judith Cohen, and Esther Deblinger (de Arellano et al., 2014). It can be provided through individual and group therapy formats. EPT is a useful framework for identifying how change takes place in TF-CBT (Alpert et al., 2021). The trauma narration and processing have been found to be components of TF-CBT that are founded upon EPT. Watkins et al. (2018) asserted that as research continues to transition to using DSM-5 criteria, it will be essential to update the guidelines informed by the new criteria. This new conceptualization could impact the measurement and efficacy of these treatments.

Cognitive behavior therapy is an accepted treatment modality for PTSD (Bryant, 2019; Reisman, 2016). Behavioral techniques that encompass TF-CBT, include exposure and cognitive processes such as cognitive restructuring (Watkins et al., 2018). These mental and behavioral models are built upon CBT theories such as PE and CPT. The goals of TF-CBT are to adjust negative appraisals, change autobiographical memory, and remove problematic behavioral and cognitive strategies and focuses on awareness and management of emotions (Farnia et al., 2018; Watkins et al., 2018)

It is important to note that trauma-focused treatment necessitates learning new skills and between-session practice (Beck et al., 2021). For group CBT, higher outcome expectancies were linked to significant amounts of change in negative cognitions/mood symptoms. Research finds that exposure and cognitive restructuring were more effective in reducing PTSD symptoms than relaxation (Watkins et al., 2018). With this information, it will be interesting to highlight the protocols each participant utilizes when treating Black male veterans.

In one study by Stecker et al. (2016), Black and White veterans were compared regarding treatment utilization in a CBT group. The research study found that Black veterans completed fewer PTSD treatment sessions throughout the 6-month study, compared to White veterans. However, it was also found that Black veterans were more likely to initiate therapy. The Black veterans had more significant social connections and family involvement and presented with a desire for help to maintain these relationships. It was noted that White veterans reported higher symptom severity, which the researchers believe is connected to why they participated in more sessions. Notably, both Black and White veterans experienced significant reductions in PTSD symptoms. Thus, it was found that PTSD treatment was effective for Black veterans.

The researchers encourage the understanding of interventions that are cognizant of diversity among the veteran population. Watkins et al. (2018) said that there needs to be further exploration of the various treatments that are "recommended" rather than "strongly recommended," as well as the factors involved in keeping individuals engaged in treatment (i.e., reducing dropout), and determining individual factors predicting response/nonresponse. The findings of the study completed by Stecker et al. (2016) are essential to this study because they encourage research that provides a greater understanding of the interventions beneficial for diverse veterans.

Alpert et al. (2021) conveyed the various phases of treatment for TF-CBT. The first phase includes stabilization and skill building which focuses on providing psychoeducation and coping skills. The coping skills include relaxation and emotion regulation skills. The emphasis of the next phase is on trauma narration and processing. Clinicians support clients in emotionally processing their experiences and challenge maladaptive beliefs about the trauma as they create and discuss their narratives. This helps the client recognize both the meaning and consequences. The last phase is the integration and consolidation phase. This phase involves in vivo mastery activities when needed and the development of personal safety skills. In vivo exposure is important and involves repeatedly facing safe situations, people, objects, and places that due to previous trauma are avoided (Sripada et al., 2022).

Prolonged Exposure (PE). Foa et al. (2008) at the University of Pennsylvania developed PE. This treatment modality was developed in a multicultural city comprised of various ethnicities such as Asians, African Americans, Caucasians, and Latinos (Schnyder et al., 2016). The American Psychological Association, International Society of Traumatic Stress Studies, Veterans Health Administration and Department of Defense, recommend PE as a front-line

trauma therapy protocol found to be effective for veterans and civilians (APA, 2017; Foa et al., 2018; ISTSS, 2020; VA, DoD, 2018). PE is a manualized, flexible individualized treatment approach that focuses on three areas, including emotional processing, imaginal exposure, and in-vivo exposure (Fina et al., 2021; Foa et al., 2018; Sripada et al., 2022; Stojek et al., 2018). The theoretical foundation for PE is EPT and stems from exposure therapy for anxiety disorders (Foa et al., 2008; Held et al., 2020; Wells et al., 2020). PE involves prompting clients to confront safe anxiety-evoking situations to challenge disproportionate fear and anxiety (Foa et al., 2008). Through emotional processing, clients are able to address their traumatic perceptions and experiences and change their behaviors to increase pleasant activities and challenge avoidance (Fina et al., 2021). According to Foa et al. (2008), PE targets avoidance and distorted beliefs about the world, self, and others. The PTSD criteria of avoidance and distorted beliefs are considered to prolong the symptoms of PTSD. According to Held et al. (2020), the purpose of PE is to reduce the intensity and frequency of PTSD symptoms.

Research continues to find PE to be an effective exposure therapy (Foa et al., 2008). According to the literature, the response rate for PE is 65% to 80% (Back et al., 2022; McLean & Foa, 2011). PE is provided over eight- to 15-sessions, lasting about 90 minutes each (Beidel et al., 2019; Held et al., 2020; Sripada et al., 2022). Regarding treatment delivery, PE is effective through telehealth services in an office, home, and via telehealth (Morland, Mackintosh, Glassman, et al., 2020; Peterson et al., 2022).

The research finds many benefits to utilizing PE for veterans. According to EPT, there is an increased likelihood of cohesive trauma narratives when prolonged exposure therapy is implemented (Gandelman et al., 2022). PE focuses on integrating and organizing trauma memory into conceptualizations of fear. Watkins et al. (2018) indicated that EPT suggests

memory represents fear as a cognitive structure that includes representations of the feared stimuli, the fear responses, and the meaning associated with the triggers and reactions.

PE is delivered in a variety of settings. However, PE is not provided in the community settings as much as in other settings because of the training, supervision, and consultation the clinician needs (Sripada et al., 2022). Kehle-Forbes et al. (2022) highlighted the impacts on physical health and functioning upon completing PE/CPT and said there is limited research on why so few veterans initiate and complete PE/CPT and those that utilize PE/CPT-initiated treatment. Their findings indicate that only about one-half completed the treatment of PE/CPT and for those that did, about one-third dropped out before completing treatment. In terms of dropout rates, Kehle-Forbes et al. (2022) found that therapy type was a predictor. Veterans who received PE were more likely to be late dropouts than those who received CPT. Research by Schrader and Ross (2021) found dropout rates for PE higher than other cognitive-focused therapies such as CPT. One study noted that PE served as a treatment alternative to CPT for individuals who experienced cognitive impairments (Cook et al., 2014). Similarly, Bryant (2019) reported that PE is a treatment variant of TF-CBT.

Schnurr et al. (2022) compared the effectiveness of PE and CPT and found that PE was more effective than CPT. They noted that the PE sessions were 90 minutes compared to CPT sessions, which were 60 minutes. It is believed that this is one determining factor because the veterans had more time for therapy per session. Still, the researchers do not believe this provides a substantial explanation for their findings. Another consideration includes the administrative error that potentially thwarted the outcome measures associated with diagnosis, remission, and response to treatment. Due to this, the researchers advise interpreting the data with caution. It is important to note that treatment differences were not in relation to the veterans' symptoms, their

functioning, or the experience of quality of life. Overall, significant improvements were made by veterans who received PE and CPT.

PE Treatment Protocol. Fina et al. (2021) expressed that clinicians should collaboratively discuss the treatment of PE with the client. The treatment encompasses four components: education about reactions to trauma and PTSD, breathing retraining, exposure to trauma-related situations (in vivo exposure), and imaginal exposure, which includes exposure to trauma memories (Fina et al., 2021; Wisco et al., 2016). In-vivo exposures are important in PE treatment (Back et al., 2022; Wells et al., 2020). These exposures involve approaching safe stimuli that has been avoided such as crowds and driving. The stimuli typically increase PTSD symptoms and reminds the veteran of the trauma. Thus, these exposures help veterans implement new knowledge and behaviors into their environments (Fina et al., 2021).

The first session of PE includes providing the treatment rationale and an interview with the client to identify the impacts of trauma on their daily functioning. During the first session, clients are introduced to breathing retraining techniques. In the second session, clients receive psychoeducation and support for creating the in-vivo hierarchy. For homework, they are assigned an in vivo exposure exercise. In the third session, imaginal exposure and emotional processing of the traumatic event are introduced. During treatment, this therapeutic protocol repeats several times. At the last session, the progress of the client is explored, relapse prevention plans are reinforced, and needed improvements are discussed (Fina et al., 2021).

Clinicians and clients collaborate together when deciding to address the items on the hierarchy (Fina et al., 2021). It is important that the hierarchy developed, be consistent with the client's treatment needs. The SUD scales (Subjective Units of Distress) are implemented to help clients rate the level of intensity for each item on their hierarchy. Clients began with items that

they rate with moderate intensity and stay in the exposure until their level of distress has waned to about 50%. Clinicians support clients as they progressively move up the hierarchy. Through imaginal exposure, the client is able to process the emotions, anxiety, and meaning of the traumatic event and traumatic memory. In between sessions and as homework, it is common for clients to listen to the audio recordings of the imaginal exposures (Fina et al., 2021; Foa et al., 2018). Including behavioral activation in the in vivo hierarchy is pivotal because there is a high likelihood that pleasant activities have been avoided.

CPT. According to the literature, CPT is another first-line trauma therapy protocol utilizing cognitive and exposure factors to help reduce PTSD symptoms (Kozel et al., 2018; Sloan et al., 2018; Thomas et al., 2023). CPT was developed by Patricia Resick and other psychologists to treat PTSD. According to the research, CPT and PE are variants of TF-CBT and decades of clinical trials find PE and CPT effective for adults in various settings (Bryant, 2019; Dondanville et al., 2022). The CPT treatment modality has been modified to support combat veterans but was initially utilized to treat individuals who are victims of sexual assault (Kozel et al., 2018). According to the literature, the therapy has a significant evidence base and is effective across various client populations (Watkins et al., 2018). CPT has been employed in at least eight countries and continues to be utilized in mental health systems worldwide (Wiltsey Stirman et al., 2017).

CPT is a structured, time-limited, evidence-based practice (Resick et al., 2016; Thomas et al., 2023). CPT is a cognitive-behavioral treatment for PTSD that can be delivered through individual and group formats (Zalta et al., 2018). Thomas et al. (2023) stated, when clinicians have a healthy perspective regarding CPT, this increases the likelihood that the therapeutic modality will be implemented. However, there is a gap in the research that assesses the

effectiveness of CPT for racially and ethnically diverse populations (Marques et al., 2016). This study sought to fill this gap in literature.

Trauma-focused treatments directly address memories of traumatic events or thoughts and feelings related to the event (Watkins et al., 2018). On the other hand, non-trauma-focused treatments aim to reduce PTSD symptoms, but not by directly targeting thoughts, memories, and feelings related to the traumatic event. The rationale for CPT involves targeting memories of traumatic events and addressing the beliefs attached to those memories. CPT also addresses the individual's affect as linked to their trauma and supports them in developing a different perception of the trauma and altering beliefs and thoughts that impact them (Kozel et al., 2018).

Lord et al. (2020) completed a study on the relationship between PTSD and social functioning during CPT and found that there is a strong association. They found that social functioning plays a pivotal role in symptom reduction during CPT for PTSD for military personnel. Social functioning is a domain of overall functioning that this current study explored. Understanding social environments is important for understanding PTSD treatment drop out (Meis et al., 2019). Social functioning is the interaction people have and their capacity to bear out their role in their environment (Bosc, 2000 as cited by Lord et al., 2020). For clients with military status, they found that throughout their treatment, there are reductions in PTSD symptoms and higher social role functioning in areas such as family, intimate partner relationships, parenting, work, school, and home (Lord et al., 2020). For future research, Lord et al. (2020) encouraged further exploration of separate domains of social functioning because certain relationships are more meaningful in relation to the symptom reduction of PTSD. Furthermore, researchers should examine the temporal relationships between social role functioning, self-efficacy, and PTSD symptoms. It is important to explore this because it pertains

to the therapeutic approach most useful for veterans. This helps to enhance the professional competency of the clinician as they treat the veteran. This study examined several domains of social functioning and its relation to PTSD symptom reduction.

CPT can be delivered in a variety of settings. However, the research says, delivering CPT in a community setting can be challenging (Marques et al., 2016). Research conducted by Finley et al. (2015) found that CPT was not being utilized as often in the community setting because of limits in staffing and the lack of a coherent team. In the study by Dondanville et al. (2022), clinicians say the challenges they faced in implementing CPT included issues with client referrals, clients who were not interested in the treatment, and the need for increased confidence in delivering CPT as a clinician. Regarding the clinician, Thomas et al. (2023) found that the motivation for some clinicians to initiate CPT revolved around their personal attributes as a clinician, their training background, and sense of self-efficacy. Furthermore, another challenge to implementing CPT in the community setting includes insurance coverage. Thomas et al. (2023) said insurance should permit billing for the necessary CPT sessions.

The study completed by Marques et al. (2016) found that when the clinicians' and clients have difficulty pinpointing clear stuck points, this can become a barrier to employing CPT in a community setting. This is important to note because the overall goal of CPT involves identifying and challenging stuck points. Facilitating discussions about the client's values and negative experiences related to marginalization and discrimination by the clinician is essential in clinical settings, particularly in community mental health settings.

CPT Treatment Protocol. The protocol for CPT is delivered over 12 therapy sessions lasting about 60 minutes each (Resick et al., 2017; Thomas et al., 2023). There is a structured protocol for implementing CPT (Held et al., 2020). Treatment typically begins with

psychoeducation and providing the treatment rationale (Marques et al., 2016). This treatment orientation typically occurs over the first three sessions (Held et al., 2020). It involves techniques such as cognitive restructuring and emotional processing of memories and beliefs related to trauma (Resick et al., 2016; Thomas et al., 2023).

Education is provided regarding cognitive theory and identifying stuck points (Resick et al., 2017). As addressed in CPT, stuck points are dysfunctional thoughts and problematic beliefs (Pearce et al., 2018; Resick et al., 2017). These beliefs typically lead to feelings of guilt, shame, and self-blame, and cause the individual to stagnate in their trauma recovery. The goal of CPT is to identify and challenge these cognitions because they are associated with traumatic events and current beliefs about themselves, others, and the world (Resick et al., 2017). Strategies used in CPT include cognitive restructuring and behavioral exercise (Pearce et al., 2017). Socratic questioning is utilized to help explore facts about the trauma (Resick et al., 2017). These strategies help alter the ways the individual thinks about the trauma. CPT intends to address these stuck points so individuals can process their emotions, effectively categorize, and assimilate the experience in a healthy way (Pearce et al., 2018).

Resick et al. (2016) stated, stuck points begin to be challenged as early as session two. The next set of sessions are sessions four through seven, focusing on cognitive restructuring. Worksheets and homework are utilized to assist clients in learning how to challenge their stuck points. Sessions eight through 12 emphasize safety, trust, power/control, esteem, and intimacy. Held et al. (2020) said these areas are recognized as affected by the experience of trauma.

Thomas et al. (2023) found that deciding with the client about the particular evidence-based practice used in the session was beneficial. Their study noted that clinicians' informed clients of different trauma treatments they were aware of, even if they were not trained in that

specific evidence-based practice. If the client becomes interested in a trauma treatment the provider did not have skills in, they begin the referral process for the client. During this process, the clinicians' highlighted that some clients selected CPT and others did not because they recognized another treatment modality as more appropriate. This helped to promote care that is client-centered and recovery-oriented. Instances where CPT was delayed but utilized involved situations where psychosocial barriers impeded, such as challenges with housing. Through the sample from the study, it was noted that psychosocial challenges may delay the utilization of CPT in community settings because the client may need to be referred elsewhere for that service.

For future studies, Thomas et al. (2023) recommended exploring the decision-making processes within different settings, such as hospitals and private practice. With this in mind, examining what influences clinicians' decisions to utilize CPT, such as associations with insurance clinicians' and the number of sessions they can provide CPT, is recommended. Furthermore, it is recommended that clinicians working in community settings who are not offered training for CPT, have the opportunity to be a part of a study to be interviewed regarding CPT decision-making. Another recommendation for the effectiveness of CPT was made by Held et al. (2020) who encouraged increased rigorous trials to test the treatment delivery format for CPT.

Group Trauma Therapy

There are gaps in the literature regarding trauma treatment provided through group formats (Resick et al., 2017; Sloan et al., 2018). It is for this reason that this current study is needed to provide insight into the effectiveness of group trauma treatment for Black male veterans. Individuals with PTSD are benefitted in a distinctive way when they participate in group therapy compared to individual therapy (Coleman et al., 2018). The American Group

Psychotherapy Association (AGPA) is a multidisciplinary professional and educational organization. The association includes psychiatrists, psychologists, clinical mental health counselors, marriage and family therapists, art therapists, nurses, social workers, and pastoral counselors. There is a code of ethics established by the AGPA. The AGPA and the International Board for Certification of Group Psychotherapists (IBCGP) maintains guidelines for ethical practice. Among the ethics is stated,

> The group psychotherapist shall not practice or condone any form of discrimination that includes, but is not limited to nationality, ethnicity, race, gender, gender identity, sexual orientation, size, disability, age, religion, socioeconomic status or cultural background, except that this guideline shall not prohibit group therapy practice with population specific or problem specific groups. (American Group Psychotherapy Association & International Board for Certification of Group Psychotherapists, 1.3)

Thompson-Hollands et al. (2021) conducted research on group therapy alliance among veterans with PTSD. They sought to examine the patterns and changes of group therapy alliance. Their findings indicated that the group alliance was not negatively impacted by interpersonal trauma. They reported that the type of group treatment plays a key role in how therapeutic alliances are established. Groups that put an emphasis on skill building may not be as effective as a group that puts an emphasize on creating and maintaining social supports.

To enhance engagement in evidence-based PTSD treatments, it is essential to understand the perspectives of clinicians who treat veterans as it pertains to their choices not to initiate, regularly attend, or complete trauma-focused psychotherapies (Browne et al., 2021). Furthermore, it is crucial to understand whether these choices differ from other forms of individual and group psychotherapy offered to veterans. Notably, the study conducted by Sloan

et al. (2018) found that individual CPT was more effective than group CPT. Sloan et al. (2018) concluded that building parameters of efficacy and effectiveness for group treatments is essential. This served as a foundation for the current study.

Coleman et al. (2018) explored the effectiveness of group therapy in reducing the symptoms of PTSD for non-Hispanic Black American and non-Hispanic White male veterans with PTSD. This cognitive-behavioral-based group therapy was implemented for 10 weeks and included over 90-minute sessions. The study found that race composition was not associated with the degree of PTSD symptom reduction for any racial group. This infers that the group was influential for all racial groups. The researchers reported that there was a high percentage of Black American veterans included in the study.

Sloan et al. (2018) led group cognitive behavior therapy. This group was led by two trained clinicians over 14 sessions of 16 weeks. Each group lasted for 2 hours and implemented in-between-session tasks. The group sought to promote group cohesion and introduce cognitive behavioral interventions. The group members introduced themselves in the first session and were provided with the treatment guidelines, discussion about confidentiality, and the CBT format. In session two, education about PTSD was delivered, and a trauma hierarchy was constructed to be used during in vivo exposure. Session three involved reviewing the hierarchy, and members began exposure homework. Then for session four, group members completed their written exposure exercise. Researchers indicated that this was derived from the CPT treatment modality.

At the end of the session, group members were led through a group progressive muscle relaxation exercise to help reduce distress. Session five was similar to session four because members re-wrote their trauma descriptions and practiced progressive muscle relaxation. In session six, cognitive therapy for PTSD is introduced and discussed further in sessions seven and

eight. The focus of sessions nine, 10, and 11 were on anger and depression. Emphasis is added to pleasant activities in session 12, and the risk of relapse was discussed in session 13. In the last session, a review was completed. This study includes 196 males and is currently being completed (Sloan et al., 2018). The researchers of this study agree that the current literature regarding the benefits of group therapy is limited. They believe this study will help to contribute to moving the field of counseling forward. This is relevant to this study that sought to understand the effectiveness of such group therapy for Black male veterans. The researcher believes this will expand the current literature by contributing to counseling and supporting the welfare and betterment of Black male veterans.

Delivery Methods of Trauma Treatment

Virtual and In-Home Therapy Options. There are several options for therapy outside of the traditional in-person face-face encounter. There is a need for more convenient, cost-effective, and person-centered therapeutic options for veterans to choose from (Fortier et al., 2022). Veterans may prefer telehealth services because it involves reduced travel time and more flexibility in scheduling. Wells et al. (2020) asserted that with the increase in telehealth options, there can be an expansion of PTSD treatments. An important factor is that telehealth services be provided through platforms that are HIPPAA compliant such as Doxy.me, and Webex (Ho & Serper, 2022). There are also paid versions of other platforms that are HIPPAA compliant such as Zoom for Healthcare and TheraNest.

Fortier et al. (2022) studied the impacts of group therapy delivered through telehealth and found that it was successful and reasonably safe for veterans. The researchers indicated that symptoms of PTSD can be triggered when veterans are sitting together in small spaces during group therapy. However, this risk is reduced when providing treatment through telehealth.

Fortier et al. (2022) asserted that it is important for veterans to be able to see other group members and the leader, concurrently; whereas this is not always possible through telehealth platforms. This interaction helps to develop group cohesion, an important component of group therapy.

Many individuals are only able to attend therapy services in their homes; providing home services helps increase access to care (Peterson et al., 2022). This is particularly important to recognize for veterans. Therapy in an individual's home effectively increases the likelihood that military members and veterans will avoid traumatic cues and engage in avoidance behaviors (Jones et al., 2020). One study utilized three treatment delivery options for CPT: In-office, in-home, and telehealth (Peterson et al., 2022). The study explored whether in-office CPT or telehealth CPT "would result in increased acceptability, fewer dropouts, and better outcomes than routine in-office treatment" (Peterson et al., 2022, p. 1). The study included active-duty service members diagnosed with PTSD with 12 sessions that were 60 minutes each and delivered twice a week for 6 weeks. In-office CPT was conducted traditionally at university offices. Clinicians traveled to the client's home to complete the in-home CPT and telehealth CPT was delivered through a computer-based video link.

The study found that the lowest dropout rates were for in-home CPT. It was noted that due to the patient's being the least acceptable modality and double the time for the therapist, this modality should be utilized for homebound clients or extreme travel barriers, only. Still, there was strong support for using telehealth for PTSD as it was noted to be cost-effective, with reports of symptom improvements, treatment acceptability, and treatment retention. This study was vital to the current study because it revealed the different modalities for CPT that are effective for symptom reduction and enhance daily functioning.

Ho and Serper (2022) indicated that implementing CPT through telehealth for individuals who experience economic, emotional, societal and impacts of PTSD is an effective option. Wells et al. (2020) reported that PE can be delivered via telehealth. Appropriate safety planning addresses the needs of clients with low, moderate, and high risk for suicide. Wells et al. (2020) recommended that when clinicians utilize virtual options for therapy, they assess the relevant client's physical health conditions and medical history when initiating treatment to ensure therapy is being applied safely.

Summary

The purpose of this qualitative phenomenological study was to address clinicians' understanding of the effectiveness of individual and group trauma therapy for Black male veterans. Several studies have been completed to explore the need for treatment to address the symptoms of PTSD (Watkins et al., 2018) and the daily functioning of veterans (Dillahunt-Aspillaga et al., 2019). There is also a solid foundation on emotional processing theory developed by Foa and Kozak (1986) and how emotional processing theory applies to evidence-based trauma treatment (Rupp et al., 2017). Emotional processing theory helps researchers to understand the activation of trauma-related content among biological, cognitive, and behavioral domains (Alpert et al., 2021).

There was a gap in the literature regarding the clinicians' understanding of the effectiveness of trauma therapy for Black male veterans. Most studies explored the phenomenon through a quantitative research lens and did not explore the interventions and strategies most useful for Black male veterans. Researchers agree that there is a need for increased awareness of the various interventions utilized and the availability of services to all populations (Kehle et al., 2011; Vance, 2017; Wisco et al., 2014). Trauma treatment is being provided to veterans in many

community-based settings. This study sought to fill the gaps within the existing literature as it will help clinicians and the overall community with the interventions, strategies, and resources that are available and most appropriate for Black male veterans.

Although the definition of trauma continues to change over time, its history and impact remain the same. This literature review highlighted the various treatment modalities for treating PTSD in veterans. The gap identified in this phenomenological study points to the clinicians' understanding of the effectiveness of these treatment modalities for Black male veterans. The body of literature pinpoints the various trauma-related factors, and it is essential to highlight the significance of individual and group therapy to further the helping relationship and advance the counseling field.

The existing literature reveals the different treatment modalities used to treat veterans with PTSD (Beck et al., 2021; Coventry et al., 2020; Farnia et al., 2018; Gainer et al., 2020; Hurely et al., 2021; Jones et al., 2020; Valiente-Gómez et al., 2017). Still, the existing literature does not highlight the specifics of the effectiveness of these evidence-based treatment modalities for Black veterans (Castro et al., 2015; Coleman et al., 2019; Sagar-Ouriaghli et al., 2019; Sheehan & Hayward, 2019; Ward et al., 2021; Watkins et al., 2018). Addressing these questions is of paramount importance.

Due to the prevalence of PTSD diagnosis among the veteran population, it is beneficial to understand the best methods for trauma therapy (Browne et al., 2021; Stecker et al., 2016). Stecker et al. (2016) found that Black Americans were likelier to initiate therapy and reported significant PTSD symptom reductions. Still, the researchers encourage the understanding of interventions that are cognizant of diversity among the veteran population. Although it was found that White Americans attended therapy more often than Black Americans, their initiation

for therapy, including group therapy and symptom reduction, speaks to the need for further exploration into this phenomenon.

The research questions of this proposed study explored clinicians understanding regarding the effectiveness of various trauma therapies as applied to Black male Veterans; what barriers you recognize for Black male veterans that utilize individual and group trauma therapy; how clinicians understand the impact of their clinical expertise on the nature of treatment and evidence-based practices. The study aimed to expand the literature on improving mental health services for Black male veterans diagnosed with PTSD by addressing clinicians' understanding of trauma therapy's effectiveness for PTSD symptom reduction and its impact on Black male veterans' daily functioning. Furthermore, the study will contribute to the knowledge in counseling. Chapter Three provides an overview of the study's research methodology and data analysis.

CHAPTER THREE: METHODS

Overview

The purpose of this qualitative phenomenological study was to address clinicians understanding of the effectiveness of individual and group evidence-based trauma therapy for Black male veterans. Chapter Three encompasses the phenomenological research design and methodology used in this study. This chapter also explores the research questions that guide the study, setting and participants, procedures for the study, the researcher's role, and data collection. A discussion on data analysis, trustworthiness, ethical considerations, and a summation of Chapter Three are included.

Design

Qualitative research is scientific research that collects and analyses non-numerical data (Creswell & Poth, 2018). This data are then interpreted to identify the meaning to assist in understanding social situations or a particular phenomenon for a targeted population or location. Qualitative research focuses on phenomena linked to the natural setting and builds on post-positivist or constructivist beliefs (Teherani et al., 2015). The goal of qualitative research is to create a meaningful picture while identifying the richness and dimensionality of patterns among words, typically proposed through subjectivity (Leung, 2015).

Creswell and Poth (2018) reported that qualitative methods help change the world by involving interpretive practices. Examining the real-life factors involved with addressing clinicians understanding of the effectiveness of evidence-based trauma therapy for Black male veterans diagnosed with PTSD was beneficial through interviews. A qualitative study allowed for reports of the efficacy of treatment approaches within individual and group therapy formats.

The qualitative study also enabled clinicians to highlight the racial and ethnic differences in effective trauma individual and group therapy evidence-based therapy.

A phenomenological study explores the significance related to the lived experiences of several individuals (Creswell & Poth, 2018). Korstjens and Moser (2018) indicated that phenomenology is based on psychology and philosophy. Phenomenology emphasizes the what and how of human experience (Neubauer et al., 2019). Creswell and Poth (2018) reported that phenomenology links the experiences of several individuals that have the same phenomenon. The methodology of this study is qualitative, using phenomenological design. Phenomenology was appropriate for this study because it highlighted the therapy phenomenon and its effectiveness for Black male veterans from the clinicians' understanding. Applying a qualitative phenomenological study design enabled the researcher to explore themes that best described the clinicians understanding of the effectiveness of evidenced-based trauma treatment for Black male veterans.

Research Questions

The following questions directed this qualitative phenomenological study:

RQ1. How do clinicians understand trauma therapy's effectiveness for PTSD symptom reduction and its impact on Black male veterans' daily functioning?

RQ2. How do clinicians describe the barriers that Black male veterans experience in individual and group trauma therapy?

RQ3. How do clinicians understand the impact of their clinical expertise on the nature of treatment and evidence-based practices?

Setting

The setting for this study was Liberty University's Behavioral Health Doctoral Programs. The researcher emailed the Dean of the Behavioral Health Sciences Doctoral Programs for permission to enlist participants. In the email to the dean, the researcher described the study and identified desired participants. The participants for this study consisted of Liberty University students in the following Behavioral Health Doctoral Programs:

- Community Care and Counseling
- Counselor Education and Supervision
- Doctor of Psychology in Clinical Psychology.

The students were master's level clinicians that provide trauma therapy to veterans. Behavioral Health Doctoral Programs were chosen because these programs include diverse clinicians that are working in the counseling field and provide treatment services to several populations while employing various evidence-based trauma treatments.

Each participant received a recruitment email and was asked to respond if they were interested in participating in the study. The email provided the purpose of the research and the expectations of what the study entailed. Purposeful sampling was utilized as this helped to lead the collection of data and was the initial data analysis that the researcher used (Chun Tie et al., 2019).

Participants

The participants in the study were master's level clinicians and have experience providing evidence-based trauma therapy to Black male veterans. It was essential that these clinicians' have similar experiences related to the phenomenon being studied (Renjith et al., 2021). A total of nine participants were recruited to participate in this study. All nine participants

were recruited from Liberty University Behavioral Health Doctoral Programs. With nine participants included in this study, sufficient data was collected to highlight the various perspectives of this phenomenon. Each participant was scheduled individually for one semi-structured interview that was held through audio-and-videoconferencing and between roughly 30 - 45 minutes. There was also one focus group. Informing the participants of the time frame before the day of the interview helped the participant and researcher to plan appropriately. A non-random purposeful sample of clinicians were selected for interviews because of their experience and knowledge regarding trauma treatment modalities. Convenience sampling was utilized for the focus group (Stewart & Shamdasani, 2014).

Procedures

The researcher obtained permission from the Dean of the School of Behavioral Sciences (Appendix L) to recruit students to participate in this study. After receiving Liberty University Institutional Review Board (IRB) approval (Appendix A), the Participant Recruitment Letter (Appendix C) was sent to the Director of Operations to send to students in the Behavioral Health Sciences Doctoral Programs. The email included the participant's rights and the study's description and purpose.

Once interested participants reached out to the researcher, the informed consent was sent as an attachment in an email. The web-based demographic questionnaire (Appendix G) and the screening questionnaire (Appendix F) were sent via Google Forms. After receipt of the completed consent form, interviews with participants were scheduled. This web-based questionnaire ensured that the participant's completed information about themselves, including age, gender, ethnicity, degree of education, highest level of education, treatment specialties/training/ certification, and years employed as a clinician.

The screening questionnaire asked about the doctoral program and each clinicians' license type and briefly inquired about their clinical experience. The researcher was notified via email that the participant had completed the consent form. The researcher was notified via Google Forms that the participant had completed the demographic questionnaire and screening questionnaire.

Once participants returned the consent form, the researcher scheduled individual interviews at the most convenient time for the participant. Each interview was scheduled to last approximately 30-45 minutes and was recorded on Zoom. The researcher informed each participant about the transcribing and recording of interviews and focus group to ensure trustworthiness. The semi-structured interviews and focus group were recorded to permit the researcher to complete the transcription of the data collection methods. Renjith et al. (2021) said documents and observations help collect data, but the most considered are individual interviews. The clinicians scheduled a time for the semi-structured interview, which was held electronically through audio-and-videoconferencing. During the initial interview, the researcher verbally reviewed the informed consent. This was also a time for participants to ask questions and to be reminded that the study is voluntary, confidential, and would be audio-and- video-recorded.

The focus group was scheduled after the interviews were completed. Upon completing the interviews, they were transcribed. Each participant was sent a copy of their transcript via email and asked to participate in a member checking review for accuracy. This helped to ensure accuracy and guarantee that participants' comments and opinions were correctly recorded (Busetto et al., 2020).

The Researcher's Role

The researcher's role in qualitative research requires empathy and distance (Korstjens & Moser, 2017). In terms of empathy, the researcher puts themselves into the participant's situation, which helps to build trust. Regarding distance, the researcher must be cognizant of their values and remain non-judgmental and non-directive to avoid influencing the data collection. According to Creswell and Creswell (2017), the role of the researcher is to be the primary data collection instrument and to identify personal values, assumptions, and biases at the beginning of the study. This helps to safeguard the study.

The researcher recorded the interview with the participant's consent, and all responses were transcribed. This important step is a preventative measure against bias in research. Furthermore, open-ended questions were used during the semi-structured interviews and focus group. As the researcher in this study, I was motivated to hear about the effectiveness of individual and group trauma therapy for Black male veterans. I am a Black male Licensed Professional Counselor with experience working with all age populations, including veterans. I provide therapeutic services to people that are challenged with severe and persistent mental health disorders. I attained my master's in professional counseling at Liberty University in 2020. I obtained my Professional Counseling License in May 2023 and am a student in the Community Care and Counseling Doctoral Program. Furthermore, I am a Clinic Based Mental Health Counselor at the Community Mental Health Center in South Carolina, providing individual, family, and group therapy. I use evidence-based practices when treating clients.

Data Collection

The researcher emailed the dean of the School of Behavioral Sciences to inform of the proposed study and to seek permission to recruit students to participate in the study. The data

collection method for this study included web-based questionnaires, semi-structured interviews, and a focus group. Data collection encompasses compiling large amounts of data (Sutton & Austin, 2015). This section includes informed consent, data collection, and data management. The acquired data for the proposed study are actively and rigorously evaluated (Holloway & Galvin, 2017).

The purpose of the informed consent form in Appendix B is to obtain the participant's consent to participate in the study and to outline the study's rationale, expectations, confidentiality procedures, and purpose of the study. The informed consent form also ensured that each participant understood the risks and benefits of the study, their responsibility within the study, and that they could withdraw at any time without providing a reason. Pseudo-names were used to conceal the names of the participants. By signing the Consent Form, the participants gave their consent to participate in the study. They also gave consent for the researcher to use the information they provide in this current study. It was made known that the interviews would be audio-and-video recorded and transcribed.

A web-based questionnaire was used to obtain participant demographic information. The web-based questionnaire was generated through Google Forms, which helped to determine whether the participants met the research criteria. There are seven questions included in the questionnaire, and there is no requirement for participants to share personally identifiable information. The questionnaire responses were directly emailed to the researcher at xxxxxxxxx@gmail.com. A password-protected computer protected each questionnaire. Codes were given to each eligible participant to protect their identity.

Questionnaire Questions

1. What is your age range?

18-20 21-29 30-39 40-49 50-59 60 or older

2. What is your gender?

   Male Female I chose not to disclose

3. What is your ethnicity?

   White/Caucasian/European American

   African/African American

   Spanish/Latino

   Asian/Pacific Islander

   Native American

   Middle Eastern

   Multiracial

4. What is your degree of Education?
5. What type of license do you hold?
6. What are your Treatment Specialties/Training/ Certification?
7. How many years have you been employed as a clinician?

Semi-structured Interviews

Semi-structured interviews are helpful because they allow the researcher to gather the participants' perspectives on the research topic (McIntosh & Morse, 2015). This study addressed the clinicians understanding of evidence-based therapy's effectiveness for Black male veterans. The open-ended interview questions were structured around the evidence-based therapeutic modalities and prompted the participants to delve into their clinical experience and expertise when treating Black male veterans. The interviews took place over Zoom and the researcher discussed with each participant the day and time of availability to complete the interview. At the

beginning of the interview, the researcher reviewed the informed consent, the purpose of the study, and expectations during the interview. The interview was set to last between 30 and 45 minutes.

Each participant was interviewed individually through audio- and- video conferencing. Semi-structured interviews allow the participants to respond to open-ended questions as they would like to and enable the researcher to probe their responses (McIntosh & Morse, 2015). Interviews were conducted with privacy to ensure that confidentiality was upheld. The audio-and -video recordings and transcriptions from the study will be stored on a hard drive and destroyed after their use in the study.

Interview Questions

The following open-ended questions serve as a guide during the interview:

Opening Questions

1. Please introduce yourself to me as if we had just met one another.
2. Please walk me through your therapeutic approach and style when working with veterans.

Questions Related to Therapeutic Experience

3. In your experience, what does participation look like for Black male veterans attending both individual and group therapy sessions?
    a. Frequency in attendance.
    b. Duration in therapy services.
    c. Participation in session work and homework.
4. Through your perception, which trauma treatment interventions and strategies have you found most beneficial for Black male veterans?

   a. How do you identify the appropriateness of each modality for your Black male clients?
   b. When do you begin the treatment protocols?

5. In as much detail as possible, describe the outcome measures you utilize to measure progress in therapy for Black male veterans and how often they are used.
   a. How often is each measurement tool utilized?
6. Which factors are involved regarding the consistency with individual and group therapy sessions for Black male veterans?
7. From your experience, what barriers do you see impact Black male veterans as they participate in individual and group therapy? (i.e., Cultural, Economic).
8. Through your perception, what impact has treatment had on the cognitions, behaviors, and feelings related to the trauma for Black male veterans?
9. From your experience, how effective are treatment strategies such as exposure?
   a. Imaginal exposure
   b. In vivo exposure
10. From your experience, how do Black male veterans respond to narrative therapy?
11. In as much detail as you can, describe what impact treatment has had on the daily functioning of Black male veterans, including:

    A. Their capacity to manage their mood and health practices.
    B. Behavior norms in the community.
    C. Ability to problem solve.
    D. Ability to cope with distressing situations.
    E. Managing substance use.

Question one was designed to gather background information about the Licensed clinician. Question two was designed to understand the therapeutic approach and style the licensed clinician is comfortable employing in session. Question three sought to understand the compliance of Black male veterans with therapy services and to identify their consistency. Question four aimed to understand how Licensed clinicians observe the effectiveness of evidence-based trauma treatment in reducing PTSD symptoms. This question is open-ended, which supports varying answers.

Question five explored the outcome measures utilized by the clinician in the proposed study. Question six was designed to observe what licensed clinicians observe as motivators for consistent engagement in therapy services for Black male veterans. Question seven identified what specific barriers often impede on the consistency and progress of Black male veterans that may impact their treatment. Question eight was designed to elicit information on the effectiveness of the treatment strategies and interventions utilized in TF-CBT for Black male veterans. Question nine directly explored the effectiveness of exposure work completed in PE and CPT. The goal of question 10 was to identify the effectiveness of Narrative Therapy for Black male Veterans. Question 11 was designed to understand the effectiveness of trauma therapy on daily functioning, including various domains of the Black male veteran's life.

Focus Groups

The third data collection method included one focus group. Focus groups are helpful because "researchers collect data by speaking with a group of research subjects about their experiences" (Doria et al., 2018). Through the focus group, the researcher can denote participant's comments and reactions and highlight similarities and differences in viewpoints (Paradis et al., 2016). Each participant was asked to participate in an online focus group via

Zoom. The Zoom session was arranged after participants scheduled a day and time with the researcher. Like individual semi-structured interviews, the focus group was recorded and transcribed. The role of the researcher during the focus group is as the facilitator and moderator to ensure each participant can share with the group (Creswell & Poth, 2018). Confidentiality cannot be guaranteed in the focus group setting. Each participant was encouraged to keep all information shared in the focus group confidential. Still, the researcher discussed the importance of confidentiality with the group participants and confirmed their understanding.

The researcher managed the recruitment of participants for the focus group based on the availability of the clinicians whom had previously been interviewed. The focus group encompassed previously questioned participants. Excessive recruitment helped to guarantee sufficient participants in the group if someone drops out (Stewart & Shamdasani, 2014). The results of the focus group were interpreted and reported once the focus group was completed. A summary and transcription of notes were sent for member checking. The focus group lasted approximately 30-45 minutes with the participants who participated in the semi-structured interviews. The focus group covered the research questions:

RQ1. How do clinicians understand trauma therapy's effectiveness for PTSD symptom reduction and its impact on Black male veterans' daily functioning?

RQ2. How do clinicians describe the barriers that Black male veterans experience in individual and group trauma therapy?

RQ3. How do clinicians understand the impact of their clinical expertise on the nature of treatment and evidence-based practices?

Focus Group Questions

The following open-ended questions serve as a guide during the focus group:

1. Tell us a little bit about yourself.
2. What have you found most helpful when treating Black male veterans?
3. What are some of the most valuable clinical skills you have learned for treating PTSD?
4. Describe how you are using your clinical skills when treating Black male veterans with a diagnosis of PTSD.

Data Analysis

This qualitative descriptive study's data analysis sheds light on the clinicians' effectiveness of individual and group evidence-based trauma therapy for Black male veterans. Descriptive phenomenology emphasizes the nature of experiences and is suitable in situations that need to communicate the lived phenomenon (Renjith et al., 2021). Since the study sought to address the clinicians' understanding of the effectiveness of individual and group trauma therapy, qualitative interviews were needed to collect this data. Past researchers have sought either quantitative data that identifies the impacts of trauma therapy or specific experiences from veterans. These researchers have encouraged further studies to explore gender and race's role in service utilization (Koo et al., 2016).

Furthermore, McClendon et al. (2020) shared that there is limited research highlighting the effectiveness of trauma therapy for reducing symptoms of PTSD that considers racial differences. To address the gaps in the literature, this study sought to thematically analyze the data by using the six steps of thematic analysis outlined by Braun and Clarke (2006). These questions were formulated before the interview time. These six steps were implemented to help guide the data analysis.

Thematic Analysis

Each interview was recorded for further review. After the interviews had been completed and the transcriptions were returned from the participants, the collected data was analyzed. Braun and Clarke's (2006) six-step thematic analysis model was utilized to analyze data. Thematic content analysis identified reoccurring themes (Crowe et al., 2015). According to Sundler et al. (2019), thematic investigation is focused on understanding the complexity of meanings and organizing patterns into themes, and the analysis must be guided by openness. The six steps of thematic analysis, as outlined in Braun and Clarke (2006), include (a) familiarizing yourself with the data, (b) generating initial codes, (c) searching for themes, (d) reviewing themes, (e) defining and naming themes, and (f) producing the report.

Familiarization with the Data

During the first step of analysis, the researcher became familiar with the data. Through open-minded reading, the researcher read the data several times (Sundler et al., 2019). The researcher transcribed the data, read the data, and took notes from the data. During this process, the researcher explored themes and patterns present in the data while taking notes. The goal of this step is for the researcher to immerse oneself in the data to be cognizant of all aspects of the data as conveyed by the participants (Braun & Clarke, 2006). The researcher read through all the interview transcripts individually while listening to the recorded interview before beginning to code any data.

Generating Initial Codes

After the researcher became familiar with the analysis, he began to identify the initial codes. Saldaña (2021) reported that a code is a word or concise phrase that gives a comprehensive feature to a portion of data. This process involves searching through all facets of

the data and coding it. Notes are made on the data as the researcher begins to code. The researcher also developed a codebook that included ideas in the data that stand out to the researcher. A codebook is used in qualitative research to help analyze data sets (Roberts et al., 2019). The researcher used a highlighter on the notes and wrote the codes that developed while reading the transcribed data.

Searching for Themes

During the next phase, the researcher began searching for themes. The researcher reviewed the codes and grouped them into themes. Braun and Clarke (2006) reported that tables and graphs are visual aids that help to sort themes. The researcher used a spreadsheet to group themes and identified keywords related to the themes. An indication that searching for themes is complete occurs when codes unrelated to the study emerge.

Reviewing Themes

The researcher's thematic process becomes more solidified in the fourth phase. During this phase, the researcher identified the emergence of sub-themes developed from the initial themes and connects them to the data (Braun & Clarke, 2006). This also involved combining themes related to the data. This process produces a comprehensive understanding of the themes and the meaning they portray about the data.

Defining and Naming Themes. According to Braun and Clarke (2006), this analysis phase involves naming the themes, which includes identifying a distinction for the names. Hence, through a narrow focus, themes are specified and given a name. To keep things manageable, subthemes may be provided to themes. Hemming et al. (2021) said themes should have a concise title to help readers recognize the theme. This phase aims to enhance understanding of each theme (Braun & Clarke, 2006).

Producing the Report

The last phase involves delivering a concise report of what the data is about (Hemming et al., 2021). This includes reviewing the themes and the data and writing the report. According to Braun and Clarke (2006), quotes help to support the data as they clearly describe the concept expressed in each theme. This step helps to create a clear and concise report for the reader to understand and increases the validity of the research.

Trustworthiness

In qualitative research, trustworthiness involves four elements: Credibility, Dependability, Confirmability, and Transferability. I established procedures to ensure the trustworthiness of the study was maintained. Creswell and Poth (2018) indicated that research must be trustworthy for researchers to remain ethical. According to Lincoln and Guba (1985), the focus of trustworthiness is on whether the study's findings can be trusted.

Credibility

According to Lincoln and Guba (1985), credibility focuses on the truth value of the study. Credibility helps to ensure the research findings are consistent with participants' original data and views (Korstjens & Moser, 2018). The researcher utilized member checking and peer review to ensure credibility.

Member Checks. Member checks were utilized in this study to help strengthen the study's trustworthiness. Creswell and Poth (2018) reported that member checking is an example of rigor that involves the technique of validation. Through member checking, each participant had the opportunity to verify accuracy by correcting and challenging any interpretations they perceived as wrong (Korstjens & Moser, 2018). This process increased the reliability of the study because it helped to enhance confidence in the interpretations.

Peer Review. The researcher worked with the dissertation chair and committee, who are familiar with the topics of trauma and working with the veteran population. The researcher enlisted a peer group that included assistance from three colleagues to evaluate the interview questions. The three colleagues have master's and doctoral degrees in counseling and understand each trauma therapeutic modality involved in the proposed study. The researcher sent a request email to the peer group (Appendix I).

Dependability and Confirmability

Dependability focuses on consistency (Lincoln & Guba, 1985). Forero et al. (2018) indicated that dependability ensures that the study findings can be repeated. Conformability ensures that the findings do not stem from the researcher's imagination but are received from the data (Korstjens & Moser, 2018). To ensure dependability, the researcher followed the following process: (a) interviewing, (b) transcribing, and (c) hand-writing themes. The researcher repeated those steps for the remainder of the participants.

Transferability

Transferability refers to the results of the qualitative study being transferred to another context (Korstjens & Moser, 2018). This helps future researchers as they apply the results of the study. Exploring detailed descriptions and identifying themes helps apply the current findings for future research designs. For example, the study on the effectiveness of trauma therapy for Black male veterans can be applied to other minority communities. Rich and thick descriptions help the research determine transferability (Johnson et al., 2020).

Ethical Considerations

Maintaining participant confidentiality is a primary ethical concern. Data was collected using codes, and interviews were conducted with privacy to ensure confidentiality. The

recordings and transcriptions from the study will be stored on a hard drive and destroyed after their use in the study. This study sought to understand the effectiveness of evidence-based individual and group trauma therapy for Black male veterans.

Each participant's name was changed, and codes were given to protect the participants' privacy. Each interview was conducted via Zoom to ensure privacy. Randomly generated Zoom IDs protect participants' privacy while using Zoom. The researcher sent each participant a unique link to the meeting instead of using personal meeting IDs to host the meetings. The waiting room was also enabled, and the researcher personally admitted each participant into the Zoom meeting room.

Summary

This study was a phenomenological study to address clinicians understanding of the effectiveness of evidence-based trauma therapy for Black male veterans diagnosed with PTSD. Presented here is the detailed description of what the research study consisted of. There are increased amounts of veterans diagnosed with PTSD. The qualitative method addressed clinicians' understanding of the effectiveness of individual and group trauma therapy for Black male veterans diagnosed with PTSD. The participants who work with this population were able to highlight the various strategies and interventions TF-CBT, PE, and CPT and discuss the effectiveness they have seen among Black male veterans. As promoted through qualitative design, the study includes a demographic survey (Mozersky et al., 2020), focus group, and semi-structured interviews (Sutton & Austin, 2015).

The study was guided by three research questions that help to facilitate an understanding of the effectiveness of evidence-based trauma therapy for Black male veterans diagnosed with PTSD. This section also included the setting and participants of the proposed study while

discussing procedures. The study consisted of nine clinicians that are students at Liberty University. Each participant had experience utilizing evidence-based therapy to support Black male veterans diagnosed with PTSD. Informed consent and confidentiality of data are also incorporated into this chapter. Codes were used to protect the privacy of each participant and the setting. Thematic data analysis was implemented, including identifying themes from each interview were collected. This study is essential to the field of counseling and veterans because it contributes to the existing literature that supports the phenomenon of therapeutic services being delivered to Black male veterans diagnosed with PTSD. Chapter Four focuses on the study's findings.

CHAPTER FOUR: FINDINGS

Overview

The purpose of this qualitative phenomenological study was to address clinicians' understanding of the effectiveness of individual and group evidence-based trauma therapy for Black male veterans. This study sought to illuminate the gap in the effectiveness of evidence-based trauma therapy for Black male veterans. The interviews held with the clinicians sought to answer the following specific research questions:

1. How do clinicians understand trauma therapy's effectiveness for PTSD symptom reduction and its impact on Black male veterans' daily functioning?
2. How do clinicians describe the barriers that Black male veterans experience in individual and group trauma therapy?
3. How do clinicians understand the impact of their clinical expertise on the nature of treatment and evidence-based practices?

This chapter begins with a description of each of the participants as well as a brief narrative of their experiences as shared by each master's level clinician in their interviews. After transcription, data from these interviews were analyzed and organized into themes that provided insight into how clinicians understand the effectiveness of evidence-based trauma therapy for Black male veterans. Findings from the interviews and focus group were analyzed using the development of the themes. The chapter includes responses to the research questions and concludes with a summary of findings.

Participants

This section outlines the participants in the study. Each participant in the study was identified by an appropriate pseudonym to provide enough detail without revealing their true

identity. To qualify for the study, participants had to be 18 years of age or older, a doctoral student in one of Liberty University's Behavioral Health Doctoral Programs including (a) Community Care and Counseling, (b) Counselor Education and Supervision, and (c) Doctor of Psychology in Clinical Psychology. The participants had to have a master's in social work, psychology, and or clinical mental health counseling. Each clinician had at minimum, a master's degree and experience working with at least one Black male veteran.

Table 1

Participants Demographic Data

Participants	Age	Sex	Ethnicity	Education	Years of Practice	Treatment Specialty
Clinician 1	30+	F	White/ Caucasian/ European American	Masters	9	TF-CBT
Clinician 2	30+	F	African American	Masters	3.5	TF-CBT
Clinician 3	40+	F	African American	Masters	10	CBT, PE, CPT
Clinician 4	30+	F	White/ Caucasian/ European American	Masters	4	TF-CBT, PE

Participants	Age	Sex	Ethnicity	Education	Years of Practice	Treatment Specialty
Clinician 5	50+	F	White/ Caucasian/ European American	Masters	5	TF-CBT, PE, CPT
Clinician 6	40+	F	Multiracial	Masters	17	TF-CBT
Clinician 7	30+	F	African/African American	Masters	6	TF-CBT
Clinician 8	40+	M	Asian/Pacific Islander	Masters	3	TF-CBT, CPT
Clinician 9	40+	M	African American	Masters	12	TF-CBT, CPT

Clinician 1

Clinician 1 is a 30+ year old White/ Caucasian/ European American, female. She is a doctoral student in the Community Care and Counseling doctoral program specializing in Traumatology. Clinician 1 identified herself as a Licensed Mental Health Counselor and a Licensed Professional Counselor. She reported that she has been a mental health therapist for nine years and fully licensed for 6 years. She reports having experience providing therapeutic treatment to Black male veterans using the TF-CBT treatment modality. She has a private practice and works full-time as an onsite mental health therapist at a major company in her area. She expressed that she conducts therapy, virtually.

Clinician 2

Clinician 2 is a 30+ year old African/African American, female. She identified herself as an LPC-A and MFT-A. She reported that she is in the Community Care and Counseling doctoral program specializing in Marriage and Family Therapy. She reported that she has experience working with Black male veterans and uses the TF-CBT treatment modality. She has a private practice and has been employed as a clinician for 3.5 years. She shared that her clinical approach stems from a systemic background.

Clinician 3

Clinician 3 is 40+ year old African/African American, female. She is a doctoral student in the Community Care and Counseling doctoral program. She reports to have 10 years of clinical experience. She is licensed in several states and works across several states. She expressed having several jobs, but her primary work is with veterans in a therapeutic setting. This includes working at the VA and supervising clinicians as well having a private practice. Clinician 3 reported that she uses an eclectic treatment approach and maintains a biblical perspective. She finds exposure to be very effective when she works with veterans. Among the treatment modalities she utilizes, she reports to be using uses CBT, PE, and CPT.

Clinician 4

Clinician 4 is a 30+ year old White/Caucasian/European American, female. She is a doctoral student in the Counselor Education and Supervision doctoral program. She is a licensed clinical mental health counselor and expressed that she has 4 years of clinical experience. Clinician 4 is also an internationally credentialed counselor. She works with service members and their families as well as veterans. She reports utilizing several trauma treatment modalities including TF-CBT and PE.

Clinician 5

Clinician 5 is a 50+ year old White/Caucasian/European American, female. She is a student in the Community Care and Counseling program, specializing in traumatology. Clinician 5 said that she is a veteran. She reports to be an LPC and Licensed Mental Health Counselor and has 5 years of clinical experience. She is a mental health counselor and reported that she has an eclectic treatment approach. She has experience working with combat veterans and expressed that she utilizes TF-CBT, PE, and CPT.

Clinician 6

Clinician 6 is a 40+ year old multiracial, female. She is a student in the Community Care and Counseling doctoral program, specializing in Pastoral Care. She reports to have over 17 years of clinical experience and uses the TF-CBT treatment modality. She has experience treating black male veterans in private practice, community settings, and telehealth.

Clinician 7

Clinician 7 is a 30+ year old African/African American, female. She is a Licensed Clinical Social Worker with 6 years of clinical experience. She reported that she works in the inpatient psychiatric unit at a local hospital. She has experience providing treatment to Black male veterans and uses the TF-CBT modality.

Clinician 8

Clinician 8 is a 40+ year old Asian/Pacific Islander, male. He is a Clinical Mental Health Counselor. He reported having experience in community-based care, outpatient mental health, and VA Hospital. Clinician 8 has retired from the military after 28 years of service. He expressed having 3 years of clinical experience and has been licensed for 6 months. He has experience providing individual and group therapy using the TF-CBT and CPT treatment modalities.

Clinician 9

Clinician 9 is 40+ year old Black, male. He is a Licensed Professional Counselor Supervisor. He is a student in the Community Care and Counseling program. He has experience working for a community mental health center and in Private Practice for about 12 years. He also indicated that he is a veteran. He reported that he uses TF-CBT and CPT. He conducts individual therapy and is considering facilitating group therapy.

Results

This study explored the clinicians understanding of the effectiveness of evidence-based trauma treatment for Black male veterans. The themes of this study were derived from the six-step thematic analysis devised by Braun and Clarke (2006). The themes include:

1. Measuring Treatment Effectiveness
2. Barriers to Treatment Effectiveness
3. Effective Treatment Strategies
4. Influence on Treatment Effectiveness
5. Clinical Expertise and Treatment Effectiveness which were supported by all of the participants.

Furthermore, the summary provides an overview of the methodology, themes, and data used throughout the section.

Theme Development

Thematic analysis, a six-phased qualitative research method for exploring themes and patterns, was employed to identify distinct themes from the study. The web-based questionnaire and transcriptions from the semi-structured interviews and focus group provided rich qualitative data. The results of this study are presented thematically. The six phases of thematic analysis

include: familiarizing yourself with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and finally producing the report. These phases were utilized as a framework to construct the report. This approach allowed the researcher to create a synopsis of the key features of the data and develop and structured report (Nowell et al., 2017).

Themes

Five themes were developed using Thematic Analysis

1. Measuring Treatment Effectiveness
2. Barriers to Treatment Effectiveness
3. Effective Treatment Strategies
4. Influence on Treatment Effectiveness
5. Clinical Expertise and Treatment Effectiveness

Measuring Treatment Effectiveness. All of the participants perceived that measuring effectiveness of trauma treatment is crucial for Black male veterans. There are a variety of assessment and screening tools utilized by clinicians. The participants also discussed how frequently and consistent they administer the measurements. Monitoring client progress on a routine basis is vital for the execution of evidence-based practices (Jensen-Doss et al., 2018).

Table 2

Measuring Treatment Effectiveness

Participants	Responses
Clinician 1	Just because some of them are very quick to administer. So, they're not going through something that's very long and it's going to take them an

Participants	Responses
	hour to just, and it helps them recognize, okay, yeah, maybe in the past few weeks I have been feeling this way.
Clinician 2	I'll use a scale like, on a scale of like 1 to 10 tell me where you are with your anxiety. So, like a Likert scale, okay. And I'll ask, you know, how is this working for you, do we need to try something different? Do we need to try something new? And also, I measure it by, okay, you know, the frequency of how often they need to see me.
Clinician 3	I can only use them every six months, like, so anything outside of that will be almost like unofficially checking to see where they are on the scale, or like officially it's every six months.
Clinician 4	The PCL 5 or, which I use a lot, or just even the, I like to use short assessments, I'm a short assessment gal, so I'll do the, the GAD 7 or the PHQ 9.
Clinician 5	Ones that, these that, that measured PTSD symptoms and dissociative symptoms of PTSD were probably my go to's.
Clinician 6	I put them on an emotional thermometer as well as a distorted thought and behavior thermometer.
Clinician 7	Roughly about halfway through, I'll ask them, how do you feel? It's always good to hear what they think. And then, I'll give them another kind of like symptom checklist.

Participants	Responses
Clinician 8	We basically reassess, do those, inventories again, just make sure they're in the same place or measure where they're at, you know, those are pretty standard.
Clinician 9	So that's like my rule of thumb, you know, to make sure I get at least three different measures to see exactly, what needs to happen and good question, because what it also does for me is it gives me an opportunity to reevaluate my own effectiveness to see whether or not, whether or not, what I am doing is helpful.

Clinician 1 shared:

> Quarterly every couple of months, like it's always going to be in different seasons. So, then you can also see, okay, in winter months, are they experiencing more depressive symptoms, anything like that? It's, it's interesting for me because I live in Florida, so I don't really have seasons. So, it's like everything's pretty consistent all the time. But I, I would like to see like, especially in like the very colder states. Like what is trauma looking like in the winter? Are people having, like are they feeling less supported? Are they feeling like more, like more, like heavier symptomology or just like experiencing it more?

Clinician 2 shared:

> When they do the standardized, they do it just the one time for the initial, and then after that, I'm just using like a Likert scale. I'm just following up on like, how's this working for you? Looking at their frequency and if any behavior changes, you know, that they report to me about what's working and what's not working.

Clinician 3 shared:

> If there's change talk, they've made a change because sometimes we get so caught up in, oh, you have to have achieved this, but no, am I seeing change talk? Am I seeing, and I make note of that. And I even express it to them like, you know, when I bring up this topic, this is typically your reaction. Have you noticed lately, this is how you respond to the same thing, or you even told me how you respond to somebody else and it's like, that is change that is progress.

Clinician 4 shared:

> I always assess physical and then I'm like, okay, so are, how would you say you're feeling, like, hypervigilance wise? How would you say, are you allowing the memories to occur? Are you still avoiding, like, are you still having intrusive memories and thoughts? Are you avoiding them when they happen? Are you learning to accept them? You know, how are you integrating that into your daily life rather than avoiding it?

Clinician 5 shared:

> Outcome measures are always going to be like a reduction in PTSD symptoms. I think it's probably one of the, one of the kind of first places that I would go. You know, are, are your nightmares re, reducing? Are you, you know, is your, your startle reflex?

Clinician 5 continued:

> Has your startle response reduced? You know, when you hear a car backfire, are you, you know, still having physiological responses? So, that for sure is when you're looking at outcomes of, of therapy in general. It is if you see that reduction and, and trauma response. But, you know, also to like, because I think what two or three of them have the in vivo, activities. So, you know, kind of comparing the first time we even talked about

this. How did you feel about having to do that? How did you respond? Did you feel nauseated? Were you shaking? Did you think of, no, ma'am, I'm not gonna do that compared to now after we've done a series of, you know, of activities.

Clinician 6 shared:

They see like the strengths and the weaknesses. I do like a SWOT, not not even a, a SWOT. I do a SNAP, like a strengths, needs, abilities and like preferences type thing. Right, and when they see that compared to what they may have written, let's say at month. At the beginning. So, let's say, the third month, because I'll do one at the beginning, then I'll do one at a month, and then I'll do one, like, the next two months, and we continue to do it, two months after that. Until they feel like, at the eight, eight months to nine-month mark.

Clinician 7 shared:

I might even ask them, well, what does family think since you started the session? Have you talked with them? You know, what do they, what have they said? Sometimes we may call family in or call them on the phone. Hey, I just have an open, you know, question. What does, what are your thoughts on, you know, how Joe has been doing, since he's been working with me? So, again, I like to use multiple realms, you know, when I'm doing these assessments and stuff, because again, my interpretation would be completely different. Or the person may not recognize how much progress they have actually made. So again, I have it black and white here. When we first started, you were ranking, you know, all tens. Now you've been with me a couple weeks, you're at like a six. You know, what do you feel about, you know, going down that?

Clinician 8 shared:

> Typically, when I create a treatment plan with someone, we'll use all three of those measurements, and then about every six months, we go through it, and we'll do it again. Typically, it lines up with creation of a treatment plan and then the reassessment to make sure we're in line with the goals and we're making progress and we're still moving in the direction they want, that could change if somebody drops out and comes back for whatever reason. I'll reassess when we reengage just to make sure they're at the same level. But if we stay continuously engaged, then it's going to be like every six months. So, it could, it could be longer if they drop out for, for whatever reason. And I had a few, a few veterans that, you know pretty consistent for about four months dropped out for reasons unrelated to what we were working on.

Clinician 9 shared:

> Self-inventory, the CAPS 5, well, that's the clinician's inventory. I'll use that by going back and asking, you know, clarification questions. You know, does this still fit? You know, I asked the question, but I'll say, hey, look, this is where you said, does this still fit?

Barriers to Treatment Effectiveness. Participants in the study indicated that treatment barriers were something that impacted the effectiveness of evidence-based trauma therapy for Black male veterans. Personally, as a clinician, when there are barriers for the clients, the goal is to effectively mitigate them. This helps to ensure that quality care is available for all populations. The professional and ethical standards of care prompt clinicians to ensure that treatment barriers are addressed. Common barriers to treatment include an individual's attitude about treatment and the low acknowledged need for therapy (Coêlho et al., 2021).

Table 3

Barriers to Treatment Effectiveness

Participant	Response
Clinician 1	I would say, definitely finances, but because I take TRICARE, that's really kind of eliminated a lot of financial barriers for black male veterans.
Clinician 2	As an African American, some, not everyone believes in therapy. There is a big trust issue, but the support of the family and the help of boundaries so that codependency coming from the family is not, you know, perpetuated is, is going to be a big, factor in how they can help with that treatment.
Clinician 3	There's for some a level of guilt that comes to therapy because it's not necessarily accepted by the church or by the community.
Clinician 4	I would say definitely stigma. But it's, it's specific to, like, I would say to the, the black community of service members and veterans. It's, you know, there's still stigma with my, with my white vets for sure, but it's different.
Clinician 5	Trust is definitely a barrier, and yeah, you pointing it out. Cost can be a barrier. Location, locale, I guess, look how like rural urban, not having access to the internet, you know, other barriers, sometimes I don't know why I didn't think this other barriers or addiction and you know, those that can be, become the priority rather than counseling.
Clinician 6	That's very important because, as we know, minorities are still on the lower end of the totem pole when it comes to services.
Clinician 7	Typically, it's combat. Typically, it's combat. I think that when they experience, especially when it comes to abuse at a younger age, I think that

Participant	Response
	that is where we have that cultural aspect come into place as a barrier, as a black male, let alone, you know, if they're veteran or not veteran, active duty, not active duty.
Clinician 8	I've had some that were really great at participating during session and opening up and practicing the different skill sets that we go through where others that are kind of stuck, they're just stuck in just really stuck in the trauma and can't get past struggling and just want it to be fixed but aren't ready to do the work to try to change it. So yeah, it's been like 50 50.
Clinician 9	Well, there is it that make it difficult or prevent them from wanting to participate is still holding on to that belief that mental health isn't something that we have a problem with. I've had individuals tell me some of the things that I used to hear back when I was younger that we keep our problems in house, or we take them to the church. You know, we don't share our business with people.

Clinician 1 shared:

> If they're not able to come into a physical session, that could be a barrier, but with the improvements with telehealth, that's kind of been reduced. I noticed too a lot of veterans, they can't find someone who takes their insurance or they're struggling with the VA. Like, oh, you know, it's, it's going to be two months before you can even get into be seen. So that's a common issue.

Clinician 2 shared:

> I've had it happen to where I was, you know, I had a black male, you know, former military person that I don't know if he was active or a veteran, but he, his HSA account ran out and. I didn't hear from him after that. So, we run into those types of problems where, you know, they may be ready. And I think I saw him for about like a month or a month and a half. And so, he was ready. We were doing really good work. And to him, I had homework. I would send questions, you know, for him to think about, and I would send a video for him to look at about like self-esteem or something. And when the money ran out. So, did our time and I haven't heard from him since. Yeah, so yeah, you run into those types of issues.

Clinician 3 shared:

> Yeah, because it's not cheap. To pay out of pocket. And they will go to people that are for lack of a better word, subpar because that's who accepts their insurance. Right, and unfortunately, that's just the so then you have to kind of be creative and creating sliding scale type fee system for people and things like that. But there's only so much of that you can do either.

Clinician 4 shared:

> Mental health is important. And you know, there's been that shift the last several years of like mental health now taking new, you know, it's okay, and people are normalizing it more than they used to, but I'm not noticing that same shift. And with my black male veterans, for sure, there's still very much like a shameful, I just want, I don't want to just take a pill and get over it. But at the same time, like, I don't. I don't want to be here. I don't want to be in therapy to address this therapy is just kind of like where you go to, you know, this is like a last-ditch effort type of perspective. So, I'd say stigma is a big

part of that. And there's not the same support from loved ones and family and friends to seek help and to acknowledge change, right?

Clinician 5 shared:

From like my point of view, I feel like, just that that cultural barrier of of mental health in general, maybe even the stigma. I think the stigma may be going away a little bit, but I'm not sure it's going away enough, but there's still that stigma, and in spite of having someone who looks more like you than I do, you still don't want to share because it just doesn't feel right. It's not my family, it's you know, it's not what we talk about outside of the family.

Clinician 6 shared:

This is another reason why black males do not go into therapy because it's such a stigma and when you do go into therapy, it's like, are you really going to help? Are you going to see me? Are you going to see my skin? What are you going to see?

Clinician 7 shared:

I'll speak specific to one patient that I had. I think that that is a huge barrier because or at least I feel in working with this particular individual, I felt that he did not, and it took a little bit of time. He, trying to figure out how to word it. He had difficulties processing all of those layers. So, he was very much fixated on like the here and now. But couldn't connect how his prior kind of shaped him to get to that point and then added that layer of additional trauma on which you know led him to his now. He struggled with a lot of internal conflict with that that we really had to take some time to work through to see because he blamed himself, a lot of self-guilt. Again, that we had to break down, but I

> definitely think that It's a struggle to peel back those, those layers, especially when it happens at a young age.

Clinician 8 shared:

> What I've experienced is that there's a little, there's a lot more trust that has to be built, probably because, you know, I don't necessarily understand their upbringing and so the distrust is a little bit, I think being a veteran helps open up that, but there's some cultural differences. You know, so participation wise, once the trust is built, they're typically open just like any other veteran, because really, they, they all just want help with their trauma, you know, a lot of just trying to get past the way they react to PTSD and find a new way to live. And for, for the black male veterans, it's been kind of mixed.

Clinician 9 shared:

> In the area where I practice, I am one of two black males that provide therapy services, and I am the only black male that provides therapy services for trauma and depression and anxiety. A lot of African American males, when they see in, say, Psychology Today or any other, advertisement, when they go through the search engine, they don't see people that look like us. You know, they don't see people that look like us. The area where I practice at is predominantly Hispanic and low income. So, I have to be very clever with how I advertise so that my picture will pop up in certain areas that, they wouldn't normally pop-up in. So, I would say, you know, that, yeah, not seeing people that look like us is a pretty big barrier.

Effective Treatment Strategies. The participants acknowledged the importance of maintaining an eclectic approach. They mentioned the importance of individualizing treatment by exploring the most effective strategies to address the needs of Black male veterans. Researchers indicated that over time clinicians typically develop an eclectic and integrative

approach to therapy (Behan, 2022). The participants also talked about treatment modalities that are utilized most often and find to help reduce PTSD symptoms and promote enhancement of daily functioning.

Table 4

Effective Treatment Strategies

Participant	Response
Clinician 1	(In terms of TF-CBT) I think it's honestly been very effective. I like the structure and I like I like if the structure is too much I just like pulling parts of it. So, like using some sections so that's, I feel like it's been a really helpful and really beneficial overall, and it usually is.
Clinician 2	TFCBT, just working on the cognitive and behavioral aspects of it because it seems like for black male veterans, there's a lot. There are a lot more layers to work through. And their cognition is definitely, it seems to be more altered, in after their trauma from being in the military on top of whatever trauma was before the military.
Clinician 3	So, I like to use the term eclectic in a sense of I meet people where they are.
Clinician 4	Prolonged exposure, I would say really helps with when you actually have those memories, those intrusive thoughts about what you went through. It will, it decreases those intrusive thoughts. You know, PE works really great at decreasing PTSD symptomology.
Clinician 5	Different aspects of all of them, rather than one specific one, but I'm sure that there are people that are trained and like expert in each of them that

Participant	Response
	would, be inclined to argue on that modality's behalf. But, there are definitely aspects in all of them that without a doubt, can help heal trauma, help others. Work through stuff that just doesn't make sense.
Clinician 6	Cognitive restructuring, it's basically, you know looking at what the thought pattern is and where the person may have gotten stuck in that thought pattern. And, you know, ask the magical question like, you know, what would the world look like to you? Or, what would your life be like if you weren't stuck at that moment.
Clinician 7	I like to do the trauma-focused CBT because it kind of encompasses everything. So, you have the psychoeducation and you have where you're assisting them acknowledge the symptoms. You have, I like to incorporate mindfulness in it. So, helping them cope with the symptoms or at least identifying. Plan out what they can do specifically in relation whatever it is that they like. So, I I like that one. Sometimes I will tailor it, sometimes I'll switch a hundred percent over to mindfulness, but relatively those are the two that I like to use.
Clinician 8	Sometimes you're like, oh man, I was way off. When that happens, I rely back on the basic skills of counseling and just, I'm present and listening, you know, you reflect and hear what they're trying to tell you.
Clinician 9	(In terms of CPT) Stuck points. You know, stuck points is probably the most effective part of the process when we're teaching them how to get

Participant	Response
	past those stuck points, teaching them how to identify when they are actually stuck is something that I've noticed is most experienced.

Several participants discussed the importance of utilizing different trauma treatment modalities to incorporate an integrative and individualized approach. Clinician one stated,

> But, I do pull from different modalities, different things that I feel like the client would be interested in. If they are of a religious background, they want to integrate religion into treatment. I'm completely fine with that. So, I just kind of tailor it to each client's individual needs.

Similarly, Clinician two stated, "I think, also widening the scope of, you know, you know, Not just looking at it from a linear view." Participant 9 stated, I use imaginal exposure. I can't really speak to in vivo exposure much. It helps to create those body sensations that I'm trying to get them to be aware of that are part of that negative thought loop that keeps them connected to, keeps them connected to the image in a negative way.

Clinician 1 shared:

> (Narrative therapy) Some of them have really done well with it. They, some, some do better with prompts. Like, I noticed with some of them, when we would work through workbooks that really kind of helped them just because it was guided and they would have, it wasn't just like, oh, write about your life story. It was, you know, what has happened that has gotten you to this point? What issues have you had in life? What do you feel like you can change, can't change? So, I noticed for some of them, they really, thrive when they were kind of more guided and had like some prompts.

Clinician 1 continued to share:

> I think in general, therapy is so helpful to reduce the trauma symptoms that someone is having. It really gives them a chance to kind of process, of what they've been through and become empowered from it because unfortunately, a lot of people when they've experienced trauma, they feel like, oh, I'm weak, you know, I'm weak because I'm crying or because I'm upset or because I have triggers, but letting them know, okay, you, you went through something awful, but you're working toward, you know, getting back on track, taking over your life again. You know, just enjoying life. So, I've noticed that it, that's definitely helpful. It also helps people to recognize how strong they were. Yes, they went through a traumatic event, but they're still able to succeed at their job to be a good parent, things like that.

Clinician 2 shared:

> It is effective when you are able to. Maybe use the right analogy or, you know, something for them in the work clicks. And so, the reason why I like TFCBT is because you can explain something like, the, the cognitive behavioral cycle. And they can put that together because they can start tracking their thoughts and their feelings. And once they become competent in their feelings vocabulary and then tracking their behaviors that come after those feelings. And so, I think that, you know, depending on what they need and it being broken down and explained to them in like a clinical matter, but also it pertains to their situation. I think that that's when it can be very effective.

Clinician 3 shared:

> I find that exposure therapy is one of the ones that has really been very effective for me working with veterans because many of them, there is this. Just underlying fear of dealing with some things. And then when they get to walk through those processes, they realize

> it's not as difficult sometimes, as challenging because sometimes I think we build the, build-up of the problem in our mind is bigger than it really is

Clinician 4 shared:

> P. E. also does a great job of recognizing or helping the person recognize where typically they would feel. I mean a great example is like going to see fireworks on Fourth of July. Almost every service member hates that, but anybody who's actually been through something combat related, I should say, typically hates that. So, actually working like prolonged exposure helps in that. You are able to recognize and even maybe sit with it in the moment. I had a black male that actually talked through this. He went to a range and it was like, I was able to actually think about what happened to me in Afghanistan while I was at the range and like, sit with it and it was okay. And I felt safe, I was like, Okay. And that was after PE. So, yeah, just actually bringing that, like, I can sit with my feelings.

Clinician 5 shared:

> Allowing yourself to be mindful of how you're responding when you're thinking of this trauma or how you're responding when you're thinking of, of, you know, this, this stuck point of this, this emotion, how are you feeling it?

Clinician 6 shared:

> The exposure pieces to treatment are quite effective. Again, it's all about, the practicality of what you're doing, what you have been doing in treatment and what you want to work on. Practice makes permanent, and the more you're exposed to, what, has been traumatizing for you the more you're exposed to it. Is it really that that you're traumatized about? Is it really that that is affecting your day-to-day life? Is it the act or is it the

person? Is it the shame? Is it the guilt? What is it, you know? And with exposure, all of that comes to the forefront. And then you can pinpoint, okay, this is first, this is second, this is third, which one is most important to you? Simple. End of story.

Clinician 7 shared:

I do like to start off with some psychoeducation, so, again, informing them of kind of, the more structured term of trauma. Typically, I will have, the definition printed out for them from the DSM. Kind of gives them an understanding as to everything that trauma can involve, from abuse to sudden losses, things of that nature.

Clinician 7 continued:

And then I will also present a list of symptoms, typically ranging from the four categories. I'll give that to them and I'll take a second to let them look over and kind of ask them what they think about it. Sometimes I may have the individual circle, the symptoms that they really feel. They are experiencing, or something and again, just start, start there, just letting them know that this is normal reaction to trauma. And let them share openly what they feel comfortable with in, in that moment. And then as the sessions go on again, pulling a little bit more from them.

Clinician 7 shared:

In my last session with a gentleman, he was career military, had recently retired, I want to say a couple of years ago. So, I asked him what it was like with everything being so new. So, a full transition what he experienced while he was in the military, up until the point of discharge, how it feels now. And what that means to him as a black male. Cause he was open with sharing with me that this was a first experience for him. He had been speaking with family and things of that nature. So, I kind of blended it, give or take, the person.

Clinician 8 shared:

> Yeah, that's probably that's a great one, especially when they start to maybe lose control or the physical response starts to overwhelm them. Those different mindfulness and relaxation exercise, even the simple deep breathing exercise, I would say that has been the most effective either to get them out of that spiraling, you know, because then it just gives them a chance to pause, open up their mind and think rationally. Instead of just chasing that emotion and that anger.

Clinician 8 continued:

> Yeah, that, that's usually the first skill set that we really dig into. And I think the challenge with that is it's so simple that a lot of people are like, yeah, that's not going to work. And, but it's amazing. Like, you know, something simple is you got to get sleep. Are you okay? You, you want to function in society?

Clinician 9 shared:

> But what I've noticed is the significant decrease in excuses made for being hypervigilant. The excuses, you know, it's almost like, well, not almost, it's exactly like it's something to be ashamed of because not many civilian people, walk into a place and start scanning for where the exits are and start scanning for what's the best possible seat so I can have, you know, a good view of the door, you know, and if someone wants to bring it up, you know, it kind of creates this feeling of shame that the veteran feels. So, because they decrease in the amount of excuses, it's no longer as debilitating of an issue anymore. It's not like they're being called paranoid anymore.

Influences on Treatment Effectiveness. This theme highlights the importance of recognizing the various influences on trauma treatment for Black male veterans. Addressing

religious factors, the role of family, and attachments influence the effectiveness of trauma treatment. The participants also discussed the childhood traumatic experiences that negatively impact Black male veterans. The participants emphasized the importance of identifying these influences when providing treatment. Research indicates that one way to address diverse needs include incorporating culturally tailored interventions (Jimenez et al., 2022).

Table 5

Influences on Treatment Effectiveness

Participants	Responses
Clinician 1	They talk about how, you know, I pray every day, I pray to God, you know, I, I read my Bible, I, you know, go to church. So, a lot of them like that is something it's like it's not negotiable. I go to church. That's what I do. So, a lot of it like that's a really, really helps them to just think to process different emotions and feel connected with their communities.
Clinician 2	I think that it's important to look at their attachment style. A lot of men in general will have avoided attachment style. So, it makes it harder for them to sometimes process their trauma, because it's harder for them to acknowledge it externally and because they suppress their emotions so much they may not be able to have the emotional language to be able to process it.
Clinician 3	They always want a level of connection where they can go, oh, she relates to me. You know what I mean? Like, excuse me, she relates to me. She knows where I'm coming from.

Participants	Responses
Clinician 4	My black male clients that are not vets are more than happy to, to book in weekly, fortnightly, you know, whatever works best in their schedule. There is that, there's something about the intersectional identity there, like, of being African American and a veteran that like, it does stick differently that I've noticed and talking about it with, with clients, there's not necessarily, anything I can pinpoint except most of my black male clients indicate like, you know, you're not, I'm not meant to show my feeling.
Clinician 5	You know, when it's a very apparent thing like that, there is, some hesitancy. To come to counseling, I, I don't really know what I want to share with you. Can I trust you to share that I've, you know, had this traumatic experience in combat and that I am feeling this way about it and I'm, I'm not inclined to tell people about it? And now you're telling me I have to.
Clinician 6	And a lot of the misconception is that, you know, when veterans come back from war, a lot of the misconception is that their trauma is mostly from whatever war or whatever they've experienced, in war, but they did have a childhood. So, you know, a lot of them have mixed trauma, and it's like peeling away at an onion.
Clinician 7	As a black male, do I feel open enough to speak about how somebody harmed me in a particular way, especially when it comes to sexual abuse? That's pretty, pretty much has been a strong one.

Participants	Responses
	They're much more willing to talk about the combat experience. I saw, you know, my friend get gunned down, or, you know, myself, I was significantly injured, those type of things.
Clinician 8	I've had some that were really great at participating during session and opening up and practicing the different skill sets that we go through where others that are kind of stuck, they're just stuck in just really stuck in the trauma and can't get past struggling and just want it to be fixed, but aren't ready to do the work to try to change it.
Clinician 9	They're actually more comfortable talking about the combat trauma. And my assessment, because I actually did do some, some research myself with a few clients because I was wondering why that was so, why it appears though they were so much more comfortable.

The participants discussed the influence of support and effective treatment outcomes. They also conveyed the differences they see in treatment outcomes for Black males and Black male veterans. Clinician 9 stated,

> And one of the things that I recognize that for black male veterans versus black males that have not served is how cohesiveness being a part of a team better helps them to begin the healing process or trusting process. A lot sooner if they have a support network of some sort, or even if they've had one, like being a part of a unit. I noticed that they were able to begin the healing process much sooner.

Similarly, Clinician 6 stated, "You have black males who aren't veterans, and then you have black males who are veterans who've just seen a totally different world. It's just a totally different world. And they have a totally different mindset."

Clinician 1 shared:

> I think like a lot of the ones that I have worked with, they, they have a such a strong sense of family. So being either being around family, calling family, just being connected with family, that's one of the main coping skills. Like a lot of them, they'll say like, oh, my mom or my grandma, or, you know, someone in my life is really. You know, this person is my go-to if I'm feeling upset. So, I've noticed that like a lot of them had those very strong family relationships. A lot of the men I've seen too, like especially with like black males and black male veterans that they like church religion, that has been a very big coping skill for them. A lot of them, like they, if they felt like, oh, at one point I was kind of moving away from my religion when they were in combat, they really got reconnected with God.

Clinician 2 shared:

> I think it has to do with the generation. So, for those of us that are millennials we are used to having more options and the more options, the better, and, you know, it's something that they can have control over. When you are in the military, you are told what to do, you are given orders. And so now, to be in a, in a space where you can choose how you want your treatment, some people our age, or in the millennial, or, you know, are going to opt for that. Versus some older people, you know, in the, you know, in their 60s or and so on may stay safe and feel like you, you tell me what to do. You direct me in this. You're the professional in doing this.

Clinician 3 shared:

> I feel like I don't represent every black person, you know, but I also let them know I understand where they're coming from. And outside of even all the therapeutic, to be honest, putting that aside is I often tell people, my staff that I can't teach you how to be human. I can't teach you the basics. And I think sometimes we get caught up in therapeutic styles. We forget to just first be human.

Clinician 4 shared:

> So, you see your friend, you know, in an explosion and he doesn't make it. And you realize that like, it's all my fault, right? Well, okay. I wonder when else it was all your fault in life. And typically, you can trace it back to when I was five and I hurt my brother. And from then on, everything is all my fault. But actually, getting you know, veterans to that point is very challenging, recognizing that part.

Clinician 5 shared:

> Generations that we were raised differently. You know, we have you know, I think to that Gen X kind of mentality of the in between the ones that are not really 40 and not really 60 are the I can do this on my own. I did everything else on my own. And maybe not necessarily being as receptive to those specific traumas focus kind of modalities. And then, yeah, the, the older ones I feel like. We, we do kind of get to a certain age and it's like, this has worked all of this time. Why don't I try something new? So, introducing a new modality to a much older generation they might be less receptive.

Clinician 6 shared:

> But, some of them repress these things because it's not something that is spoken about. You know, it's taboo. So, it's not spoken about. So, when they come into therapy, and you

> start to hear that stuff and you start to unpack, like, childhood things and they start to remember things. And it's like, you know, you're in a safe space, like, you've gone through this horrible thing. It's okay to talk about it. And sometimes you wonder too, is it more so the trauma of being sexually abused that they're there for in therapy as opposed to being a veteran and having PTSD. So, then the PTSD becomes secondary and the sexual abuse becomes primary because the sexual abuse, the remembrance of that sexual abuse and possibly what they've experienced in the military is the underlying facts to the PTSD. So, it's, you have to listen because these things will come out in therapy and you're like, Hmm. So, what do you really have? You have to ask the question. I mean, what are your nightmares like? Can you describe your nightmares? What's going on? What's that? What's an ongoing nightmare? You know, can you draw it? Can you put it into words? Do you want to act it out? You gotta ask them these things, like, how, how, how would you be comfortable describing it?

Clinician 7 shared:

> I think that as I think about the individuals that I've worked with, I would say it's relatively, relatively the same. I will say I have had more success with homework and I think because it's intimate because normally I will give them something to take home. So, they're in their private space where they can isolate from family or whomever, complete it and then bring it back to me. And then we discuss rather than saying, okay, here's something I want you to put on this now with me. Where they have to kind of be open in that moment or very intimate in that moment with me. In that, I don't see, I know I mentioned age earlier. I don't see age as a fact with that. Again, I think it's just a male thing. With again, being open, learning how to verbalize their feelings or let alone

identify said feelings and then talk about them with somebody. And I hate to be so generalized saying that it's a male thing.

Clinician 8 shared:

I had a few individuals when I worked community care, it took like seven or eight sessions before they trusted me, with the veteran population we have a lot of similar experiences. They, you know, we, especially during the introduction, we, I give them an opportunity to ask questions and you know, they know that I'm prior military and combat veteran also. So, I think that opens the door quicker with the veteran population because then they know like, all right, I don't have to be here. I'm here to actually help people so the trust is easier to be build.

Clinician 9 shared:

I don't know if that's the right word, but they were much more comfortable with discussing the events that took place in combat that has triggered their, you know, their symptoms, rather than talk about the abuse and neglect and the reason why that is so is because the abuse pretty much revolved around sexual abuse and from my understanding and experience, that is one of those topics for us that is so difficult to have a conversation about because it, you know, it almost is, not almost. It made them feel as though they were less than like they, especially those that were Marines, Marines, super macho, I'm a Marine so I'm talking about my brothers and I'm speaking about them because I recognize that the culture of combat Marines and combat soldiers for that matter as well, made it difficult for them to speak about anything that made them appear as though they were weak. And that was one of the biggest hurdles to overcome because they felt like the experience that they had in combat definitely was an experience that they were, they

were questioning their, their bravery. They were questioning their, you know, how, how they were there or not there for, for their brother.

Clinical Expertise and Treatment Effectiveness. This theme explores how participants in the study emphasized the significance of clinical training, knowledge, and understanding. Participants described appropriate use of evidence-based practices, implementing accurate terminology, and developing a therapeutic alliance. Participants also described the impact of being nonjudgmental, and making connections with the veterans, and showing empathy. One of the most important aspects of therapy is the relationship between the therapist and client (Scarvaglieri, 2020).

Table 6

Clinical Expertise and Treatment Effectiveness

Participant	Response
Clinician 1	If you're using TFCBT, knowing how to appropriately use it, if doing the worksheets, actually making sure that exercises are part of what you're doing.
Clinician 2	And so, because being black is not enough. So, me being a black female therapist is not enough. I have to engage and be interested and learn terms and understand what happens and what they're up against in the military.
Clinician 3	So, what I do is, and sometimes I don't mind a little bit of self-disclosure where I let them understand that. I myself, I have a level of chronic complex, some people call it PTSD, but it's not necessarily war based

Participant	Response
	like theirs, but I also have it as well. And oftentimes that helps them go, okay, she's coming from a place.
Clinician 4	So, your body is going to respond viscerally to a memory of it. It would be weird if it didn't, right? So, like, learning to kind of talk them into it a little bit, but those types of the physical, I would say, like, learning to bridge the gap of mental and physical are really helpful.
Clinician 5	I think they recognize that I have answers without judgment and yeah, sometimes they do recognize that I don't understand the whole plight of where they're at, but they know I do my research and I will find out what I can find out to, to help.
Clinician 6	I think it's because I'm, I don't beat around the bush with them. Really, I'm just straightforward with them. They don't, you don't want, you don't want to walk on eggshells around veterans. Choose your words carefully and your things, but you don't, you also don't want to beat around the bush with them because they can smell that.
Clinician 7	I'm a person who uses a lot of analogies when I do therapy, so I like to apply that and I have them give me, you know, a similar analogy. I like to utilize military experience for them. Can you think of a situation where one thing happened and how it trails?
Clinician 8	It's really a lot of common-sense stuff, just being present, listening, showing empathy. You know, and you can't lie to these guys cause you might get away with it one or two times, but they'll see through you.

Participant	Response
Clinician 9	You can develop an alliance quite quickly, you know, if they recognize that, hey, this person is really going to help me.

Several participants conveyed the value of developing rapport with Black male veterans. Clinician four stated, "I try to utilize humor and making things a little more palatable, for my service members, but especially for my, my, my black male servicemembers." Similarly, Clinician 8 stated,

> Yeah, I really just try to keep it focused on really trying to connect with them. I would say I probably spend most of my time just trying to build the rapport so they trust me enough to try some of the things I might suggest or, you know, things we might try to work on.

Clinician 1 shared:

> The therapeutic relationship and actually building rapport in a way that's really authentic, I think is really important. Being yourself, acknowledging the differences, that do exist, obviously clinician and a, and a black male service member. Or a veteran, and, and being able to really attend to, and I, I think remembering what's going on for your clients goes a long way. So, actually like tracking with them and showing all those basic therapeutic skills.

Clinician 1 also shared:

> I do think a knowledge of the military really does help. And that's not necessarily a therapeutic intervention, but having competence and in that area. And of course the whatever you're using, actually knowing how to use it.

Clinician 2 shared:

> And it helped. And definitely making sure to get sleep, because we know that with PTSD, there could be night terrors, there could be nightmares, there can be, you know, very intrusive thoughts. Impacts of PTSD. So then, things like helping them to write or journal, things out. And just looking at the things that they're writing, like the repetitive things that they're writing out in their journals and things like that.

Clinician 3 shared:

> I'll say training, training, training, outside of that, also exposing myself and putting myself in positions. I require clients to be, I've had to sit on the other side of the couch plenty of time over the years just to work on, you know, self-growth and stuff like that. I've had to do that. So, I, and something I learned a long time ago is I can't keep requiring something of them. I'm not willing to do so. The more I go into therapeutic systems and almost like requesting that and see how it works from someone that's more skilled in it, helped me know what that feels like for me as a client.

Clinician 4 shared:

> I understand what they've been through. And, sympathetically, like I, I, I have never gone through what you've gone through, but what C T F CBT can do is really establish my, my understanding and my knowledge as a clinician and I, and I utilize, some pronouns, I ensure that we talk through, like, the neurobiology of trauma, how that works. I walk through the Siegel brain model and really talk through, kind of, what's going on for you when you're experiencing your symptoms, right? So, explaining that how the, how the brain has not necessarily changed. Like, and to a point where it's no longer, you can't change it back or, you know, I really talked through the ability of learning how to cope with things and that there is, you know, there are ways that we can work through this

> together and really empower, my client. And that's, that's how I would say I utilize TFCBT the most would be in that beginning of the therapeutic relationship.

Clinician 4 continued:

> If they don't want to go ahead and like, dive into things, we really just talk through, some already existing material and just walk through what, what it is that you're actually experiencing, your symptoms, where this looks like it's probably occurring in the brain, what happened to you, like your physical symptoms to your sleeping, your hypervigilance, are you, you know, the, the typical, like, okay, you feel like you're being followed, or are you okay, sitting with your back at the window at a restaurant, all of those types of things, and even learning to say, okay, like, I want to.
>
> I can cognitively see the issue. I can cognitively see my symptom. So, I'm going to behaviorally choose maybe a different response and just experiment with that, that would be, I guess, how I would say I mostly utilize TFCBT.

Clinician 5 shared:

> Yeah. So, for me, two important things, are cultural competence. Number one, as a black person. Number two, military culture is its own thing. So, making sure that they know that we're, understanding of, so I'm, I'm a veteran. So I do have that experience of understanding the military culture, but obviously I'm not a black male, so I make sure that they know that I, I do understand that there are differences in what I, what I do understand what I don't understand, but making sure that they, that they know that I do have an understanding of the need of, of cultural competence and in both of those areas. And so, I think mine also trauma focused cognitive behavioral therapy like and then prolonged exposure were my two.

Clinician 6 shared:

> So, where do you find your resilience? Where do you find your faith? Where do you find your backbone? Where do you find your strength? Now, if they cannot identify those things, that's part of my job, to help them identify those things. And surprisingly enough, as they talk, man, you can pinpoint so many strengths that they have, and you just, you use reflective listening, and you use motivational interviewing skills and all of that, and you start telling them, well, what I'm hearing is that you're very good with words.

Clinician 7 shared:

> So, it helps them stay on schedule, helps them stay on track. I find that, for the veterans, they don't feel like disorganized or they don't have something to talk about, you know, they're just not coming in blind per se when they're coming to the session. So, it's like, okay, during the next session, the next session, we will discuss such and such and I'll follow that line according to, you know, TFCBT and they're okay with that. They actually prefer that because it, again, it keeps them in that structured mode.

Clinician 8 shared:

> Okay. I do kind of a combination of things really depends on where the veterans at. Some of them aren't ready to really dig into the coping skill focused interventions. So, then it's just more a supportive role until they build some trust.

Clinician 8 continued:

> Yeah, I really just try to keep it focused on really trying to connect with them. I would say I probably spend most of my time just trying to build the rapport so they trust me enough to try some of the things I might suggest or, you know, things we might try to work on.

Clinician 9 shared:

> Before I would start doing any trauma work, it would probably take about 4 to 5 weeks. Establishing the therapeutic alliance is like huge, it really is. You know, I have some that come in and they immediately want to, hey, look, let's just get right to work. And it's like, hey, you know, there are some things that we have to establish first so that as I'm taking them through the protocol, they would be less likely to question, you know, why are we doing this or why are we doing that?

Summary

This chapter presented an overview of the clinicians understanding of the effectiveness of evidence-based trauma treatment for Black male veterans. The participants in the study shared their clinical experience and provided detailed information on the effectiveness of trauma treatment for the enhancement of daily functioning and PTSD symptom reduction for Black male veterans. Thematic analysis was used to identify five themes: Measuring Treatment Effectiveness, Barriers to Treatment Effectiveness, Effective Treatment Strategies, Influence on Treatment Effectiveness, and Clinical Expertise and Treatment Effectiveness. Their responses were also used to answer the research questions. Research question one was answered by three themes: Measuring Treatment Effectiveness, Effective Trauma Treatment Strategies, Influence on Treatment Effectiveness, and Clinical Expertise and Treatment Effectiveness. Research question two was answered through Barriers to Trauma Treatment Effectiveness. Research question three was answered through Clinical Expertise and Treatment Effectiveness and Effective Trauma Treatment Strategies.

CHAPTER FIVE: CONCLUSION

Overview

The purpose of this qualitative phenomenological study is to address clinicians' understanding of the effectiveness of individual and group evidence-based trauma therapy for Black male veterans. This study provides valuable insights to current and prospective clinicians about effective evidence-based practices for the symptom reduction and enhancement of daily functioning for Black male veterans. This chapter provides a summary of the findings and then a discussion of the findings. The implications are included along with the delimitations and limitations of the study. The last section includes future recommendations for research.

The following research questions guided this study:

RQ1. How do clinicians understand trauma therapy's effectiveness for PTSD symptom reduction and its impact on Black male veterans' daily functioning?

RQ2. How do clinicians describe the barriers that Black male veterans experience in individual and group trauma therapy?

RQ3. How do clinicians understand the impact of their clinical expertise on the nature of treatment and evidence-based practices?

Summary of Findings

This study explored the clinicians' understanding of effective evidence-based trauma treatment for Black male veterans. Five themes emerged from the key findings of this study. All the participants reported their understanding that the evidence-based therapies of TF-CBT, PE, and CPT are effective for PTSD symptom reduction and positively impacts the daily functioning of Black male veterans. All the participants shared the common theme that measuring treatment effectiveness is crucial for Black male veterans. They understood the importance of utilizing

assessment and screening tools to measure the progress Black male veterans make in therapy. The participants highlighted the importance of the Black male veterans recognizing their progress in therapy for themselves. Hence, the utilization of assessment instruments and tools helps in that process.

Participants shared that there are several treatment barriers that impact the effectiveness of evidence-based trauma therapy for Black male veterans. Barriers such as stigma, service cost and insurance availability, and location have been found to impede upon treatment effectiveness among Black male veterans. These participants noted that as clinicians, they had to be creative when addressing these barriers so that the Black male veterans could obtain quality care. Participants understood the effects of treatment barriers that impact the attendance, frequency, and consistency in therapeutic services for Black male veterans.

Participants highlighted the importance of recognizing effective treatment strategies that help to reduce PTSD symptoms and enhance daily functioning. Each participant identified the treatment modalities they find most effective when treating Black male veterans. The participants shared that their goals were to promote client autonomy and collaboration to help Black male veterans reach their therapeutic goals. The participants conveyed that the strategies used from TF-CBT, PE, and CPT enable Black male veterans to learn about the impacts of PTSD, process traumatic memories and the emotions that are linked, and learn coping skills to successfully reintegrate back into civilian life. Thus, these evidence-based treatment modalities are effective for reducing PTSD symptoms and supporting the enhancement of their daily functioning. Still, the participants noted that this requires a unique therapeutic approach that is tailored to the needs of Black male veterans. The participants noted that even within the population of Black male veterans, they should be considered through an individualized lens.

Participants continued to highlight the need to be aware of the influences on the effectiveness of trauma treatment for Black male veterans. Without this understanding clinicians may ignore the role of cultural influences including Black culture which has often involved the effects of marginalization and even military culture. The participants stated that it is important to be aware of the cultural and generational influences that impact Black male veterans because these may be different for Black males. They discussed the strengths that stem from support Black male veterans receive from their own family, friends, and other service members. The roles these people play in their lives most often influence their decision to seek and continue through with the completion of treatment.

The participants reflected on the value of professional competence and development and discussed their clinical expertise. They recognized their role as a clinician is to do no harm to the client and instill hope. The participants conveyed that their intention is to provide quality care and find that their clinical expertise enhances the overall effectiveness of trauma treatment. The participants indicated that training in evidence-based practices and cultural differences are invaluable experiences for them. This helps to boost their confidence by sharpening their clinical skills. They reported that the treatments they are trained in, are often the determining factor for which modalities they utilize when treating Black male veterans.

Discussion

Relationship of Findings to Theoretical Literature

Emotional processing theory (EPT) postulates that trauma impacts an individual's memories and emotions. As a result of the detrimental effects of trauma on an individual, the participants noted the effective PTSD treatment is geared towards reducing PTSD symptoms and enhancing the daily functioning. The goal of exposure therapy is to reduce the symptoms of

PTSD and related problems (Foa et al., 2008). My study findings were consistent with this theory. The study extends beyond EPT by drawing upon the clinicians understanding of the effectiveness of these evidence-based trauma treatment for Black male veterans. This requires clinical expertise and knowledge in implementing treatment strategies. Therefore, the treatment modalities reviewed in this study were found to be effective but require attention and acknowledgment to the differences in background and circumstances of Black male veterans.

Relationship of Findings to Empirical Literature

The structured interviews and focus group provided valuable insights into how clinicians find evidence-based therapy to be effective for PTSD symptom reduction and enhancement of daily functioning for Black male veterans. The participants in this study have similar experiences with other clinicians in the helping professions. Clinicians who work with veterans find that having a unique approach tailored to the individual's needs increases the likelihood that the therapeutic modalities utilized will be effective. It is imperative that clinicians be aware of the traumatic experiences that many veterans experience before they enter the military. These occurrences typically come up in therapy and must be addressed. Furthermore, the experiences of Black male veterans are unique to their counterparts in the military and other Black males that have not been in the military.

The research validates the various influences of culture, race, and identity and the need for the clinician to be aware of these when treating Black male veterans. Treatment recommendations are offered for clinicians to utilize that have been found to be effective. CPT, PE, and TF-CBT are among the first treatment modalities recommended for treating PTSD for veterans (Watkins et al., 2018). Learning and applying the tenets of these modalities help support PTSD symptom reduction and enhancement of daily functioning.

The participants recognized the value of utilizing an eclectic and integrative approach to trauma treatment for Black male veterans. Still, they were able to highlight what they find most effective from each treatment modality. In terms of TF-CBT, several participants noted that this is often their go-to treatment modality because they find benefits in it being structured, focusing on the cognitive and behavioral impairments due to PTSD, and the implementation of psychoeducation and mindfulness. The study revealed that for CPT, veterans are supported in experiencing a reduction of PTSD symptoms and enhancement of daily functioning as they can target their stuck points. Through emotional processing clients are able to move forward from their stuck points. Several participants prefer PE because of the focus on addressing intrusive thoughts and helping the Black male veterans acknowledge and gain an understanding of their feelings. The narrative and exposure components have also been highlighted by the participants and reported to be found effective. It has been indicated that for narrative therapy, guiding the veteran through this process and implementing strategies that are consistent with what is more appealing to them, such as journaling, is more effective. Furthermore, the exposure component helps the veteran target the fear structures they once experienced which ultimately helps to reduce their fear and anxiety. Overall, many of the participants discussed the need to always remember basic counseling skills as a foundation when working with Black male veterans.

The participants also recognized the differences between treating trauma in Black males and Black male veterans. While many experienced traumatic experiences and are negatively influenced by stressful environmental conditions, this study revealed that Black male veterans experience a different kind of stigma and are found to be more likely to resist therapy. However, the participants reported that when Black male veterans have a greater intrinsic value for attending therapy they typically engage at a deeper level.

During the study, the participants highlighted that building rapport with the Black male veterans is valuable. They reported that they did not rush the process of building rapport. The participants indicated that this was often before they initiated the trauma work in session. They find that this helps Black male veterans to open and develop trust and a connection with their therapist. Therefore, strengthening the therapeutic alliance helps to enrich treatment effectiveness.

Implications

Theoretical Implications

From a theoretical perspective, trauma impacts people on an individual basis. While there are specific criteria that confirm a PTSD diagnosis, the symptoms may be unique to the individual (Agarwal et al., 2020). Many veterans have completed their time in the armed forces and are diagnosed with PTSD (Bryant, 2019; Highfill-McRoy et al., 2022). Therefore, the theoretical implications for this study add further support to the theory of emotional processing as one of the foundational trauma theories related to the veteran's reduction of symptoms and enhancement in daily functioning (Foa & Kozak, 1986). Several participants discussed the value of facilitating the exposure component of therapy. Hence, it is important for prospective clinicians to be adequately trained in emotional processing theory, to gain an understanding and recognize the symptoms of PTSD. Clinicians should also be competent in delivering effective trauma treatment strategies.

Empirical Implications

Many studies have been completed on the topic of trauma treatment. However, research on the effectiveness of trauma treatment for Black male veterans has been limited. This study highlighted effective evidence-based treatment strategies that clinicians utilize when treating

Black male veterans that include TF-CBT, PE, and CPT. Specific findings of this study confirm that tailoring strategies to the unique needs of Black male veterans when providing psychoeducation, processing traumatic memories and emotions that are linked, and facilitating exposures, extends the empirical literature that an individualized treatment approach is a necessity. This provides opportunities to for creating further strategies that ensure the unique needs of Black male veterans are being met. This is consistent with the current research that clinicians must be aware of the needed treatment adaptations including "culturally informed adaptations" (Williams et al., 2019, p. 103) when working veterans (Currier et al., 2014).

The findings of this study also reveal that although there are evidence-based practices utilized to support PTSD symptom reduction and enhancement of daily functioning for Black male veterans, there are barriers and influences that are limiting. As consistent with Pearce et al. (2018), this study finds that targeting specific barriers to recovery is the key to enhanced PTSD treatment effectiveness. Stigma and cost of services as well as influences of race and military culture ensue limitations. Sharp et al. (2015) reported that the current literature does not measure the links between stigma and the utilization of mental health treatment. This study extends the current literature by exploring ways stigma is connected to the implementation of mental health treatment.

Regarding the theme that employing assessments and screenings is important for highlighting the effectiveness of treatment supports the extant literature. This helps to measure progress and effectiveness of treatment modalities. Williams et al. (2014) indicated that there is a need for further exploration that helps to refine the assessment and diagnostic tools utilized when treating Black people.

Practical Implications

The key findings of this study all have practical implications for clinicians that provide evidence-based trauma treatment to Black male veterans. Multiple findings of this study indicated Black male veterans want to ensure that their clinician cares about them, are willing to see and learn about their uniqueness as individuals and are open to knowing about their traumatic experiences inside and outside of the military. Clinicians must be cognizant that Black male veterans value trust and connection. The participants stated that this is important as clinicians seek to build rapport and the therapeutic alliance with Black male veterans. When these areas are addressed for Black male veterans, the participants noted there is an increased likelihood that there will be positive outcomes in treatment for them. Graduate programs must go beyond merely providing education about basic counseling theory and skills such as summarizing, paraphrasing, and silence. It is important to provide teaching and training on adapting basic counseling skills that acknowledge cultural differences. They must also discuss the significance of developing and maintaining a multicultural orientation and humility to support those that they treat. Furthermore, this can occur as the clinician continues to pursue enhancing their clinical expertise through further professional development and competence. Continuing education programs can play a crucial role in providing training, workshops, and seminars for clinicians to develop culturally informed skills that acknowledges cultural values and beliefs.

The findings of the study reveal that increased mental health awareness and improvements in technology help to diminish treatment barriers such as stigma, location of services, and costs of services. These findings help the clinician to better understand and recognize treatment challenges for Black male veterans, while also highlighting their role in being prepared to deconstruct these barriers. Policymakers can also work towards increasing

availability of services so that Black male veterans have more options for obtaining the services that they need.

Delimitations and Limitations

Delimitations

The purpose of this study was to gain the clinicians understanding of the effectiveness of trauma therapy for Black male veterans. There is a lack of extant literature on the effectiveness of evidence-based trauma treatment specific to Black male veterans. There were several delimitations incorporated in the study. The participants had to have at least a Master's degree and experience in providing evidence-based trauma treatment to Black male veterans. The participants of my study were students in the doctoral programs at Liberty University. This is pertinent to my study because these students have experience providing evidence-based trauma treatment to Black male veterans.

Limitations

The sample size was demographically adequate for the purpose of this study. The sample size of this study was limited to nine participants. There were states where clinicians provide trauma therapy that were not included in this study. Therefore, the sample size may have presented a limited overall view of all clinicians that provide trauma therapy in the nation. Despite these limitations, the findings of this study offer valuable insights to the counseling field as well as current and prospective clinicians that provide evidence-based trauma treatment to Black male veterans.

Recommendations for Future Research

In the future, there is value in further research that explores how effective other mental health programs, resources and strategies are for Black male veterans who have been diagnosed

with PTSD. Crisis intervention, peer support and career/vocational training are vital for supporting veterans as they reintegrate back into civilian life. Understanding the effectiveness of these services would help in providing an array of support geared towards promoting the recovery of PTSD symptoms for Black male veterans. It will also be beneficial to examine the effects of vicarious trauma that clinicians experience when providing evidence-based trauma treatment to Black male veterans. Clinicians may experience burnout and stress because of the processing of the traumatic experience veterans have had. It is important that necessary boundaries and self-care practices be in place to ensure that the clinician is not susceptible to any deficiencies. Daily boundaries and self-care practices such as assertiveness, balanced eating, physical exercise, sleep hygiene, and mindfulness helps to improve the overall well-being of the clinician. This enhances their ability to problem-solve, maintain a positive outlook, and take decisive actions. Furthermore, future research should explore the effectiveness of evidence-based trauma therapy among other minority communities. These understandings will be valuable for clinicians and educators, overall.

Summary

The purpose of this qualitative phenomenological study was to address clinicians understanding of the effectiveness of individual and group evidence-based trauma therapy for Black male veterans. The research questions focused on gaining insight on the effectiveness of trauma treatment for the enhancement of daily functioning and PTSD symptom reduction for Black male veterans. Participants discussed their understanding while highlighting the contributing factors such as measuring treatment effectiveness, barriers to treatment effectiveness, effective treatment strategies, influence on treatment effectiveness, and clinical expertise and treatment effectiveness.

Many studies exist that explore the impacts of traumatic experiences. Fewer studies exist about the relationship between treatment effectiveness and Black male veterans. The participants examined the impact of using evidence-based practice while tailoring the treatment strategies to the individual needs of Black male veterans. This chapter included connections between the findings of the current study and previous research. This confirms the need to be aware of influences on treatment and the importance of developing clinical expertise that supports the provision of quality care. The study's theoretical, empirical, and practical implications were outlined. This chapter also explored the delimitations and limitations of the study. Furthermore, the chapter ended by discussing a focus for future research.

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APPENDIX A: Institutional Review Board Approval Letter

September 22, 2023

Kelvin Tyler
William Townsend

Re: IRB Exemption - IRB-FY23-24-188 A Phenomenological study addressing clinician's understanding of the effectiveness of evidence-based Trauma treatment for Black male Veterans diagnosed with PTSD.

Dear Kelvin Tyler, William Townsend,

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data safeguarding methods mentioned in your approved application, and no further IRB oversight is required.

Your study falls under the following exemption category, which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46:104(d):

Category 2. (iii). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:
The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7).

For a PDF of your exemption letter, click on your study number in the My Studies card on your Cayuse dashboard. Next, click the Submissions bar beside the Study Details bar on the Study details page. Finally, click Initial under Submission Type and choose the Letters tab toward the bottom of the Submission Details page. Your information sheet and final versions of your study documents can also be found on the same page under the Attachments tab.

Please note that this exemption only applies to your current research application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued exemption status. You may report these changes by completing a modification submission through your Cayuse IRB account.

If you have any questions about this exemption or need assistance in determining whether possible modifications to your protocol would change your exemption status, please email us at irb@liberty.edu.

Sincerely,

G. Michele Baker, PhD, CIP
Administrative Chair
Research Ethics Office

APPENDIX B: Consent Form

Consent

Title of the Project: A Phenomenological study addressing clinician's understanding of the effectiveness of evidence-based Trauma treatment for Black male Veterans diagnosed with PTSD.

Principal Investigator: Kelvin Tyler Jr., Doctoral Student, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. Student in Liberty University's Behavioral Health Doctoral Programs. Mental Health Clinician with a Master's Degree: Social Workers and Professional Counselors. Experience utilizing evidence-based trauma therapy such as Trauma-Focused Cognitive Behavior Therapy, Prolonged Exposure, and Cognitive Processing Therapy. Experience providing individual and/or group therapy with at least one Black male Veteran throughout their professional career.

Please take time to read this entire form and ask questions before deciding whether to take part in this research.

What is the study about and why is it being done?

The purpose of the study is to understand the effectiveness of evidence-based trauma therapy for Black male Veterans.

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following things:

1. Complete a web-based questionnaire (2 min)
2. Complete a Clinician Inventory (2 min)
3. Participate in a semi-structured interview: The interview is estimated to last thirty to forty-five minutes and will be audio-and-video recorded via Zoom.
4. Participate in a focus group consisting of 5 participants that are estimated to last thirty to forty-five minutes and be audio-and-video recorded via Zoom.
5. Check your completed interview transcript for accuracy. You will be allowed seven days to review the transcript and return it to me.

How could you or others benefit from this study?

Participants should not expect to receive direct benefit from taking part in this study.

Benefits to society include increased understanding and knowledge of the effectiveness of evidence based-trauma therapy for Black male veterans diagnosed with PTSD by clinicians. veterans.

What risks might you experience from being in this study?

The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records. Data collected from you may be shared for use in future research studies or with other researchers. If data collected from you is shared, any information that could identify you, if applicable, will be removed before the data is shared.

- However, confidentiality cannot be guaranteed in focus group settings. While discouraged, other focus group members may share what was discussed with persons outside the group.
- Participant responses will be kept confidential through the use of pseudonyms.
- Interviews and focus groups will be conducted in a location where others will not easily overhear the conversation.
- Data will be stored on a password-locked computer and may be used in future presentations. After three years, all electronic records will be deleted.
- Interviews will be recorded and transcribed. Recordings will be stored on a password-locked computer for three years and then erased. Only the researcher will have access to these recordings.
- Recordings will be stored on a password locked computer for seven years and then deleted. The researcher and members of his doctoral committee will have access to these recordings.

How will you be compensated for being part of the study?

At the end of the study, each participant will receive a complimentary workbook that will include strategies to help new clinicians as they provide evidence-based trauma treatment to Black male Veterans.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please contact the researcher at the email address/phone number included in the next paragraph. Should you choose to withdraw, data collected from you, will be destroyed immediately and will not be included in this study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study Kelvin Tyler Jr. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact him at xxxxxxxxx@liberty.edu. You

may also contact the researcher's faculty sponsor, Dr. William Townsend at xxxxxxxx@liberty.edu.

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu. *Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.*

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to audio and video-recorded me as part of my participation in this study.

_____
Printed Subject Name

_____
Signature & Date

APPENDIX C: Participant Recruitment Email

Dear (Potential Participant):

As a student in the School of Behavioral Sciences at Liberty University, I am conducting research as part of the requirements for a Doctor of Education degree in Community Care and Counseling: Pastoral Counseling. The purpose of my research is to address clinician's understanding of the effectiveness of evidence-based trauma therapy for Black male Veterans, which will help to improve treatment. I am writing to invite eligible participants to join my study. I am currently looking for participants who meet the following criteria:

- Student in Liberty University's Behavioral Health Doctoral Programs.
- Mental Health Clinician with a Master's Degree: Social Workers and Professional Counselors.
- Experience utilizing evidence-based trauma therapy such as Trauma-Focused Cognitive Behavior Therapy, Prolonged Exposure, and Cognitive Processing Theory.
- Experience providing individual and/or group therapy with at least one Black male Veteran throughout their professional career.

Participants, if willing, will be asked to:

- Complete a web-based questionnaire (2 min).
- Complete a Clinician Inventory (2 min)
- Participate in a semi-structured interview: The interview is estimated to last thirty to forty-five minutes and will be audio-and-video recorded via Zoom.
- Participate in a focus group consisting of five participants that are estimated to last 30 to 45 minutes and be audio-and-video recorded for accuracy. You will be allowed 7 days to review the transcript and return it to me.

A consent document will be emailed to you after you have contacted me to express interest. The consent document contains additional information about my research. If you choose to participate, you must sign the consent document and email it to me before any procedures can occur.

At the end of the study, each participant will receive a complimentary workbook that will include strategies to help new clinicians as they provide evidence-based trauma therapy to Black male Veterans.

Sincerely,
Kelvin Tyler Jr.
Tel #: xxx-xxx-xxxx
Email: xxxxx@liberty.edu

APPENDIX D: Recruitment Follow-up Email to Participants

Dear (Potential Participant):

As a student in the School of Behavioral Sciences at Liberty University, I am conducting research as part of the requirements for a Doctor of Education degree in Community Care and Counseling: Pastoral Counseling. The purpose of my research is to address clinician's understanding of the effectiveness of evidence-based trauma therapy for Black male Veterans, which will help to improve treatment. I am writing to invite eligible participants to join my study. I am currently looking for participants who meet the following criteria:

- Student in Liberty University's Behavioral Health Doctoral Programs.
- Mental Health Clinician with a Master's Degree: Social Workers and Professional Counselors.
- Experience utilizing evidence-based trauma therapy such as Trauma-Focused Cognitive Behavior Therapy, Prolonged Exposure, and Cognitive Processing Theory.
- Experience providing individual and/or group therapy with at least one Black male Veteran throughout their professional career.

Participants, if willing, will be asked to:

- Complete a web-based questionnaire (2 min).
- Complete a Clinician Inventory (2 min)
- Participate in a semi-structured interview: The interview is estimated to last 30 to 45 minutes and will be audio-and-video recorded via Zoom.
- Participate in a focus group consisting of five participants that are estimated to last 30 to 45 minutes and be audio-and-video recorded for accuracy. You will be allowed 7 days to review the transcript and return it to me.

A consent document will be emailed to you after you have contacted me to express interest. The consent document contains additional information about my research. If you choose to participate, you must sign the consent document and email it to me before any procedures can occur.

At the end of the study, each participant will receive a complimentary workbook that will include strategies to help new clinicians as they provide evidence-based trauma therapy to Black male Veterans.

Sincerely,
Kelvin Tyler Jr.
Tel #: xxx-xxx-xxxx
Email: xxxxxx@liberty.edu

APPENDIX E: Transcript Review Email

Dear [Recipient]:

Thank you for participating in this study on clinician's understanding of the effectiveness of evidence-based trauma therapy for Black male Veterans.

Please find the attached interview transcript that was conducted on (date) over Zoom for review. Let me know if there are any minor adjustments you find need to be made. You will have seven (7) days from receipt of this email to provide me with those revisions. However, if you do not require any changes, kindly respond to this email with the following statement: "I (insert name) confirm that this recorded transcript is sufficient for submission." Furthermore, a non-response within seven (7) days will be taken as a confirmation of satisfaction with the original transcript.

If you have any inquiries, I can be reached at xxx-xxx-xxxx or xxxxx@liberty.edu.

Sincerely,
Kelvin Tyler Jr.
Tel #: xxx-xxx-xxxx
Email: xxxxxx@liberty.edu

APPENDIX F: Screening Questionnaire

1. Are you 18 years or older?

Yes
No

2. Are you a doctoral student in one of Liberty University's Behavioral Health Doctoral Programs?

Yes
No

3. Which Doctoral Program are you a student in?

Community Care and Counseling
Counselor Education and Supervision
Doctor of Psychology in Clinical Psychology.

4. Do you have a Master's in Social Work, Psychology, and/or Clinical Mental Health Counseling?

Yes
No

5. Please highlight your present or previous job title in the Mental Health field.
    - Social Worker (MSW, LISW, LMSW, LCSW, LICSW, LISW-CP)
    - Psychologist Intern
    - Clinical Mental Health Counselor/Professional Counselor (including LPC, LPCS, LPC-Associate, and LPC-Interns, CMHC)
    - Other:

6. Do you have experience providing trauma treatment to at least one Black male Veteran through individual and or group therapy formats?

Yes
No

7. Which of the following evidence-based trauma treatments do you have clinical experience in utilizing? Highlight all that apply.

- Trauma-focused Cognitive Behavior Therapy (TF-CBT) (i.e., Psycho-education, Relaxation training, Cognitive coping, Trauma narration, in vivo mastery).
- Cognitive Processing Therapy (CPT) (i.e., Psychoeducation, In vivo exposure, Socratic Questioning)

- Prolonged Exposure (PE) (i.e., Imaginal exposure and In vivo exposure)

8. Do you have clinical experience utilizing any of the following PTSD assessment instruments? Highlight all that apply.
    - Post-traumatic Checklist for DSM-5 (PCL-5)
    - Short PTSD Rating Interview (SPRINT)
    - PTSD Symptom Scale Interview (PSS-I-5)
    - Structured Clinical Interview; PTSD Module (SCID PTSD Module)

APPENDIX G: Web-Based Demographic Questionnaire

Name:

Phone number:

Email:

1. What is your age range?

   18-20 21-29 30-39 40-49 50-59 60 or older

2. What is your gender?

   Male Female I chose not to disclose

3. What is your ethnicity?

   White/Caucasian/European American

   African/African American

   Spanish/Latino

   Asian/Pacific Islander

   Native American

   Middle Eastern

   Multiracial

4. What is your degree of Education?
5. List your highest level of Education?
6. What are your Treatment Specialties/Training/ Certification?
7. How many years have you been employed as a clinician?

APPENDIX H: Interview Questions

These interview questions will be piloted by several trauma experts in the field of counseling.

The following open-ended questions serve as a guide during the interview:

1. Please introduce yourself to me as if we had just met one another.
2. Please walk me through your therapeutic approach and style when working with Veterans.
3. In your experience, what does participation look like for Black Male Veterans attending both individual and group therapy sessions?
    d. Frequency in attendance.
    e. Duration in therapy services.
    f. Participation in session work and homework.
4. Through your perception, which trauma treatment interventions and strategies have you found most beneficial for Black male veterans?
    a. How do you identify the appropriateness of each modality for your Black male clients?
    b. When do you begin the treatment protocols?
5. In as much detail as possible, describe the outcome measures you utilize to measure progress in therapy for Black male veterans and how often they are used.
    a. How often is each measurement tool utilized?
6. Which factors are involved regarding the consistency with individual and group therapy sessions for Black male veterans?

7. From your experience, what barriers do you see impact Black male veterans as they participate in individual and group therapy? (i.e., Cultural, Economic).
8. Through your perception, what impact has treatment had on the cognitions, behaviors, and feelings related to the trauma for Black male veterans?
9. From your experience, how effective are treatment strategies such as Exposure?
    a. Imaginal exposure
    b. In vivo exposure
10. From your experience, how do Black male veterans respond to narrative therapy?
11. In as much detail as you can, describe what impact treatment has had on the daily functioning of Black male veterans, including:

F. Their capacity to manage their mood and health practices.

G. Behavior norms in the community.

H. Ability to problem solve.

I. Ability to cope with distressing situations.

J. Managing substance use.

APPENDIX I: Peer Group Email Request

Dear (Pseudonym),

As a student in the School of Behavioral Sciences at Liberty University, I am conducting research as part of the requirements for a Doctor of Education degree in Community Care and Counseling: Pastoral Counseling. The purpose of my research is to address clinicians understanding of the effectiveness of evidence-based trauma therapy for Black male veterans which will help to improve treatment. I have compiled a series of interview questions to be utilized in the study. I am writing to you to inquire if you are willing to review the interview questions and provide feedback on their clarity. Your expertise on this subject is requested. Please respond to this email if you are willing to assist.

Thank you.

Sincerely,

Kelvin Tyler Jr.

Cell #: xxx-xxx-xxxx

Email: xxxxxx@liberty.edu

APPENDIX J: Focus Groups

1. Tell us a little bit about yourself.
2. What have you found most helpful when treating Black male veterans?
3. What are some of the most valuable clinical skills you have learned for treating PTSD?
4. Describe how you are using your clinical skills when treating Black male veterans with a diagnosis of PTSD.

APPENDIX K: Email to the Dean

To the Dean of Behavioral Health Doctoral Programs,

I am a Doctoral Student in the Community Care and Counseling Doctoral Program. My dissertation is entitled, *A Phenomenological study addressing clinician's Understanding of the Effectiveness of Evidence-based Trauma treatment for Black Male Veterans diagnosed with PTSD.* The purpose of my research is to address clinician's understanding of the effectiveness of evidence-based trauma therapy for Black male Veterans, which will help to improve treatment. I am seeking permission from you to conduct my dissertation research with clinicians that are students in the Behavioral Health Doctoral Programs at Liberty University.

The doctoral programs I intend to enlist clinicians from include the following:

- Community Care and Counseling.
- Counselor Education and Supervision.
- Doctor of Psychology in Clinical Psychology.

Their participation will include a web-based questionnaire, screening questionnaire, a 30-45 minutes semi-structured interview that will be audio-and- video recorded, and a focus group that will be 30-45 minutes and will be audio-and- video recorded. All information will be held in the strictest confidence, and all names and identifying factors will be changed (pseudonyms used) to maintain confidentiality for all participants. Participants may withdraw from the study at any time without penalty. My chairman for the study is Dr. William Townsend, and his email is xxxxxxxx@liberty.edu. I look forward to hearing from you soon.

I look forward to hearing from you soon,

Kelvin Tyler Jr.
Liberty University
xxxxx@liberty.edu

APPENDIX L: Dean Approval Letter

Dear Mr. Tyler,

It is approved for you to conduct research with School of Behavioral Sciences students, assuming you will obtain IRB approval also prior to beginning any research. I wish you the best with your work, and hope that it helps many veterans! Thanks.

Kenyon Knapp, Ph.D., LPC
Dean
School of Behavioral Sciences
Health Professions
(xxx) xxx-xxxx