

# **American Indian Women Warriors: Historical Trauma and Cultural Perspectives**

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# Overview

- Historical Trauma & Historical Unresolved Grief
- Impact on Traditional Cultural Roles for both Native Women and Men
- Doing “double duty” – parenting/nurturing and protecting
- Tribal Cultural Diversity – in magnitude of collective historical trauma, how recent (e.g. 1890 is not that long ago in history), and ways of processing that trauma
- Modern Women Warriors - Military Service and Veterans
- The HT-informed intervention strategies

# Background

- Contemporary American Indian women and men face generations of historical trauma, changing gender roles, erosion of traditional gender identity development opportunities
- Helpful to examine current psychosocial issues within the framework of the historical context and collective massive group trauma across generations
- Collective responses to historical trauma
- Diverse, idiosyncratic (individual or unique) responses

# Background

- **Although American Indians are the smallest ethnic group in the United States, they rank highest in health disparities compared to any ethnic or racial group AND have the highest rate of enlistment in the military.**
- **Many American Indian communities face multiple traumatic deaths with great frequency due to elevated morbidity and mortality rates, lowered life expectancy, and high accidental death rates.**
- **Both Northern Plains and Southwest tribal groups have greater degrees of trauma exposure compared with the general population, increasing PTSD risk (see literature by Manson, Beals, and others, 2005).**
- **Traditional mourning practices and cultural protective factors were impaired.**

# Background

- Impairment of traditional gender roles and relationships; in many tribes, women and children are sacred and were never the property of men
- Women held special sacredness and spiritual powers (women's societies as well as men's) and political power and influence
- Men lost traditional roles as warriors and protectors to varying degrees – disarmament, massacres, disruption of hunting cultures, etc.
- Although there have been “warrior” women traditionally in some tribes, it was not the norm; however, women always had strength and protected the family
- Both lost traditional parenting roles under the early boarding school system

# Background

- Both Native male and female veterans have frequent signs of PTSD and PTS; although Native men have greater combat exposure, Native women have higher rates of victimization and sexual trauma in military; sexual trauma in the military exists among both genders
- Both Native men and women need outreach and support; victims of such trauma tend to blame themselves and feel shame often keeping them from seeking help

# Background

- **Backdrop of intergenerational trauma – modern, lifespan trauma, combat trauma, military trauma is superimposed upon the collective historical trauma**
- **Complex, often ambivalent relationships with the military (e.g. the 7<sup>th</sup> Cavalry – Custer’s regiment)**
- **Challenge of translating traditional responsibilities into modern times**
- **Military service often seen as only viable option**
- **Socioeconomic factors also come into play for other communities of color and impoverished communities**
- **“Ambivalent transference” – age of recruits developmentally**

# Historical Trauma and Unresolved Grief

- ***Historical trauma*** is cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma (1985-88)
- ***Historical unresolved grief*** accompanies that trauma
- The ***historical trauma response*** (HTR) is a constellation of features in reaction to massive group trauma

(Brave Heart, 1998, 1999, 2000)



# Historical Trauma Healing Efforts

The *Takini* (Survivor) Network formed in 1992 as a collective to address healing from historical trauma and historical unresolved grief among the Lakota as well as other Native people through therapeutic work, prevention, research, publication and community education. Now known as the Takini Institute

# Takini Historical Trauma Healing Efforts

- We are descendants of traditional warriors and survivors of the Wounded Knee Massacre; we are children of World War II Marine, Army, and Navy veterans; Takini includes Vietnam veterans and involving Korean War, OEF/OIF veterans
- We are survivors, descendants, of boarding school trauma, alcoholism in our families, and other trauma
- We are committed to healing and to our traditional ways

# Historical Trauma Response Features

- **Survivor guilt**
- **Depression**
- **Sometimes PTSD symptoms**
- **Psychic numbing**
- **Fixation to trauma**
- **Somatic (physical) symptoms**
- **Low self-esteem**
- **Victim Identity**
- **Anger**
- **Self-destructive behavior including substance abuse**
- **Suicidal ideation**
- **Hypervigilance**
- **Intense fear**
- **Dissociation**
- **Compensatory fantasies**
- **Poor affect (emotion) tolerance**

# Historical Trauma Response Features

- Death identity – fantasies of reunification with the deceased; cheated death
- Preoccupation with trauma, with death
- Dreams of massacres, historical trauma content
- **Loyalty to ancestral suffering & the deceased**
- **Internalization of ancestral suffering**
- **Vitality in own life seen as a betrayal to ancestors who suffered so much**

# One Historical Trauma Response

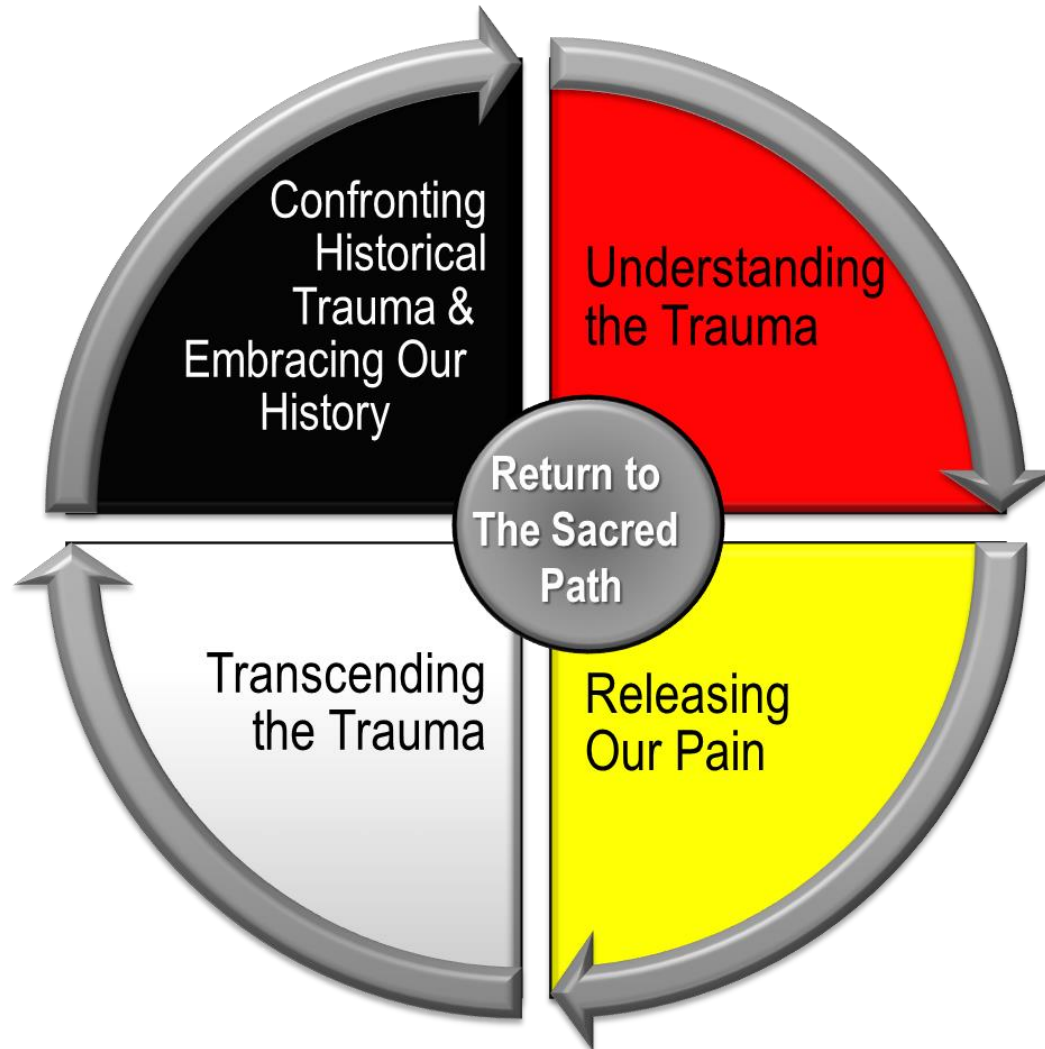
## Example: Abusive Boarding School Descendant & Veteran

Self-destructive, suicidal thoughts, fixation to trauma/trauma exposure

**“I went there [Vietnam] prepared to die, looking to die, so being in combat, war, and shooting guns and being shot at was not traumatic to me. That was my purpose and my reason for being there. What was traumatic for me was that it brought on a lot of rage when seeing other people, the same color as me, being abused by the war. That was the hardest thing while I was there .... I was having a battle with the army I was in.”** (Brave Heart, et al., 2012 , *AJPH*, 102, (S2) S177-S183)

# Historical Trauma & Unresolved Grief Tribal Best Practice :

*Northern Plains*  
*Example*



# Historical Trauma Intervention Research & Evaluation (1992 - 2003)

- Reduction in sense of feeling responsible to undo painful historical past
- Less shame, stigma, anger, sadness
- Decrease in guilt
- Increase in joy
- Improved valuation of true self and of tribe
- Increased sense of personal power

Table 11: Gender Differences for Affects Experienced Often Before, During and After the Intervention

	<b>Before</b>		<b>During</b>		<b>After</b>	
	<b>Female/Male</b>		<b>Female/Male</b>		<b>Female/Male</b>	
<b>Anger</b>	70.6%	73.3%	41.2%	66.7%	11.8%	26.7%
<b>Sadness</b>	70.6%	66.7%	100.0%	80.0%	5.9%	33.3%
<b>Guilt</b>	70.6%	53.3%	29.4%	33.3%	0.0%	13.3%
<b>Shame</b>	64.7%	60.0%	5.9%	40.0%	0.0%	13.3%
<b>Joy</b>	58.8%	33.3%	64.7%	66.7%	70.6%	86.7%



# HT Interventions for Native Veterans

- **Traditional societies for both Native men and women helpful in reclaiming sense of self and sacredness**
- **Importance of purification for those returning from war for reintegration into society and to release the traumatic exposure, combat stress; attend to spiritual beliefs about sacredness of life, death and war (Black Elk – painting faces black to hide from the Creator)**
- **Releasing the historical trauma through healing and reclaiming traditional protective values and practices**
- **Can combine HTUG key components with culturally adapted evidence based practices or empirically supported treatments**
- **HTUG reduces stigma and empowers American Indian/Alaska Native and First Nations communities through acknowledging the collective trauma across generations**

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# HT-Informed Interventions

- Acknowledge the “cultural dissonance” and ambivalence re: what it means to serve in the military that may still discriminate and conflict with traditional values
- Explore the traditional tribal cultural roles of women and how each individual woman views this and her current/past military service experience
- Explore degree of social support within her family and tribal community for her role as a military member or veteran
- Use of the DSM IV Cultural Formulation would be helpful (Lewis-Fernandez & Diaz, 2002), expanded to include exploration of boarding school trauma, tribal relocations, migration, trauma in tribal community of origin, language
- Look at multiple layers of culture – tribal, gender, military (specific to branch, role, years/era of service), etc.
- Explore development of coping resources to fill in gaps when lack of social support
  - © Maria Yellow Horse Brave Heart, PhD; 5/10/13

# Culturally Sensitive Diagnosis: the DSM IV Cultural Formulation

## Overall cultural assessment for diagnosis and care

- Discussion of how cultural considerations specifically influence comprehensive diagnosis and care

## Reference:

Lewis-Fernandez, R. and Diaz, N. The Cultural Formulation: A method for assessing cultural factors affecting the clinical encounter. *Psychiatric Quarterly*, 2002, 73(4): 271-295. (Table 1, p. 275)

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***Examples for Native clients:*** skin color issues, risk for trauma exposure, traditional mourning practices, racism, unemployment rates, housing availability

# HT-Informed Interventions

- Consider HT response features, particularly related to survivor guilt and compensatory fantasies of undoing or making up for the past, fixation to trauma (repeated trauma exposure), etc.
- Acknowledge risks for and presence of sexual trauma; acknowledge gender discrimination and “microaggressions”
- Perceived discrimination (see Whitbeck) and its relationship to depression is important; tendency of women in general to internalize, to blame the self
- Consider tribal diversity in ways of processing trauma, traditional prescriptions for mourning and addressing trauma, traditional purifications; some tribes have longer periods for mourning, some openly talk about loss; cultural congruence is needed and respecting both tribal cultural differences and individual preferences

# Application of Western Evidence-Based Treatments for PTSD in Women Veterans

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# Overview

- PTSD
- Evidence-based treatments for PTSD
  - Exposure & Cognitive Therapies
  - ▶ Clinic Data
    - ▶ WSDTT Program Model—clinical application of treatments
    - ▶ DoD Study Results

# Post-traumatic Stress Disorder— PTSD

- Trauma
- Three symptom categories (17 Total Symptoms):
  - Reexperiencing Symptoms (min. 1)
  - Avoidance/Numbing Symptoms (min. 3)
  - Hyperarousal Symptoms (min. 2)
- Duration >1 mo.

# Trauma

- Life threatening event
- Experienced personally
- Witnessed
- Emotions = horror, helplessness, fear
- Examples:
  - Rape, childhood/adult; MST
  - Combat: Iraq, Afghanistan, Vietnam
  - Natural Disasters, e.g., hurricane Katrina
  - Severe Auto Accidents



# Reexperiencing (min. 1)

- Intrusive recollections
- Nightmares
- Flashbacks
- Psychological Disturbance
- Physiological Arousal

# Avoidance/Numbing (min. 3)

- Avoid thoughts, feelings, conversations
- Avoid reminders
- Psychogenic amnesia
- Reduction in social activities
- Detachment
- Restriction of emotions
- Foreshortened future

# Hyperarousal (min. 2)

- Sleep difficulties
- Irritability/anger outbursts
- Poor concentration
- Hypervigilance
- Exaggerated startle response

# Evidence-Based Therapies for PTSD

## Two Overview Studies:

- 1) 2008 Institute of Medicine—only exposure therapy
- 2) Cahill, et.al., (2009). Cognitive-Behavioral Therapy for Adults. In *Effective Treatments for PTSD* by (2<sup>nd</sup> Ed.) Foa, Keane, Friedman, & Cohen

# Effective Treatments for PTSD

- ▶ Largest Effect Sizes for:
- ▶ Exposure Therapy
  - Prolonged Exposure (PE)—Foa, Keane
- ▶ Cognitive Therapy
  - Cognitive Processing Therapy (Resick)

# Other Effective Treatments for PTSD

Protocol treatments with smaller effect sizes:

- SIT
- Assertiveness training
- Biofeedback/relaxation training
- EMDR

Cahill, et.al., (2009). In *Effective Treatments for PTSD* by (2<sup>nd</sup> Ed.) Foa, Keane, Friedman, & Cohen

# VACO Dissemination Trainings

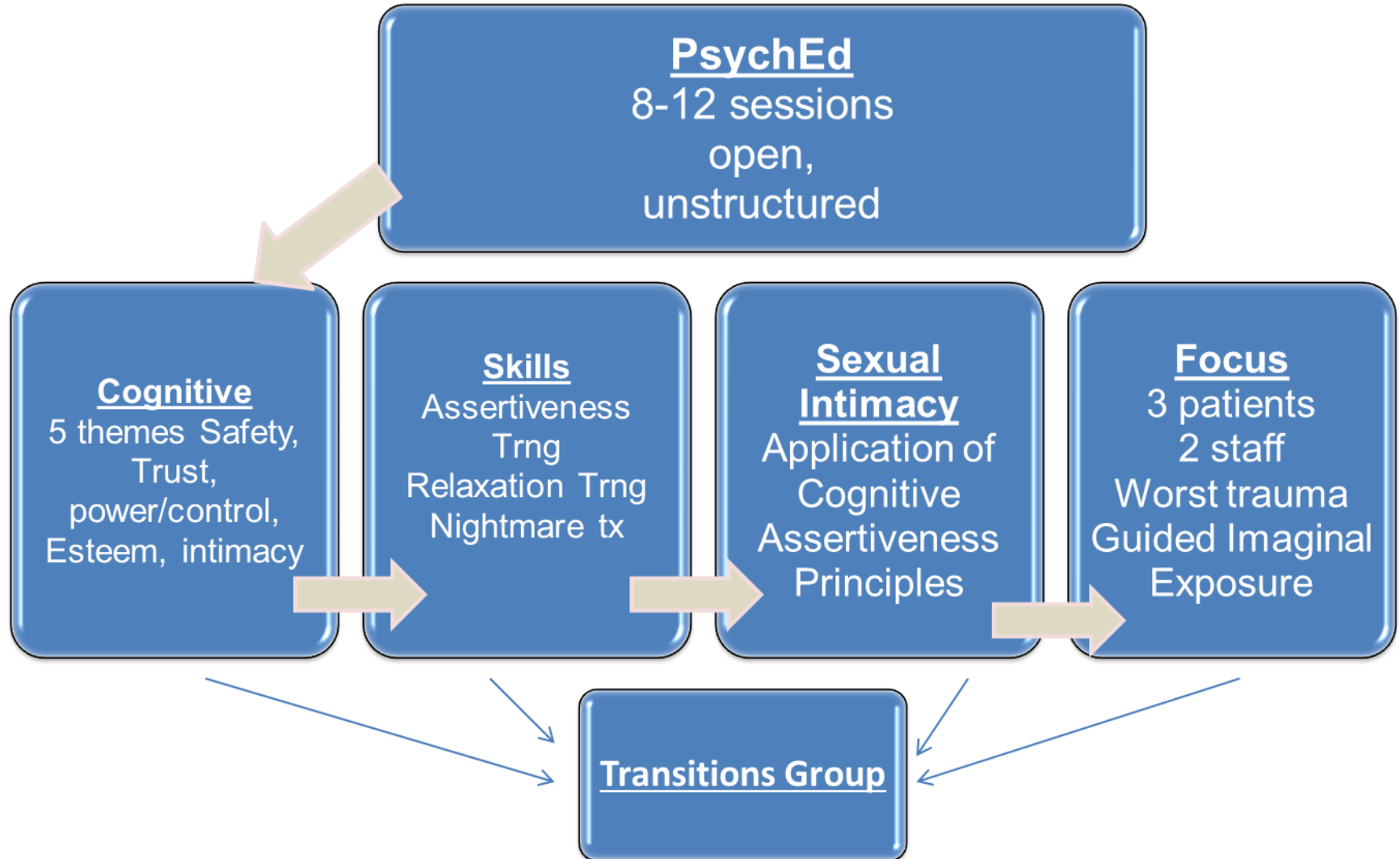
- All PTSD staff trained in:
- Prolonged Exposure (PE)—10 session protocol
- Cognitive Processing Therapy (CPT)—12 session protocol
- Recommended 1<sup>st</sup> Line treatment for PTSD by VA/DoD and ISTSS

# PTSD Services in WSDTT

- Extensive Assessment:
  - Psychological Testing (MMPI2, MCMI3, BDI2, BDHI)
  - Clinician Administered PTSD Scale (CAPS)
- Evidence-Based Treatments:
  - Prolonged Exposure (PE)
  - Cognitive Processing Therapy (CPT)
  - Behavioral (assertiveness, relaxation, nightmare therapy)
  - Sexual Functioning Issues (re: sexual trauma)
- Modalities:
  - Group
  - Individual
  - TMH
- Research—Clinic data (entry, PCL), RCT



# WSDTT Group Treatment Program



# Clinic: Demographics\*

- Mean Age=42.4, SD=10.8
- 37% Army, 26% AF, 18% Navy, 5% MC
- 88% > one trauma
- 17% childhood trauma, 33% adult, 50% both
- 56% sexual trauma, 3% combat, 5% other, 36% combo
- 14% OEF/OIF
- 64% diagnosed with PTSD + other diagnosis

\*N=401

# Cognitive Processing Therapy

## (CPT-C—10 sess)

- Didactics on cognitive restructuring [past=SORC model (Kanfer), types of cognitive distortions, homework: 1 page on beliefs 1<sup>st</sup> of 5 themes—**safety**
- Read aloud writings, challenges irrational/distorted beliefs on board, homework—writing 1 page on **different theme each week**
  - Common distortions=dualistic (life/death) thinking addressed with continuum
  - Same homework each week
- ▶ Each session writing/challenging beliefs on 5 themes: **safety, trust, power/control, esteem/intimacy**

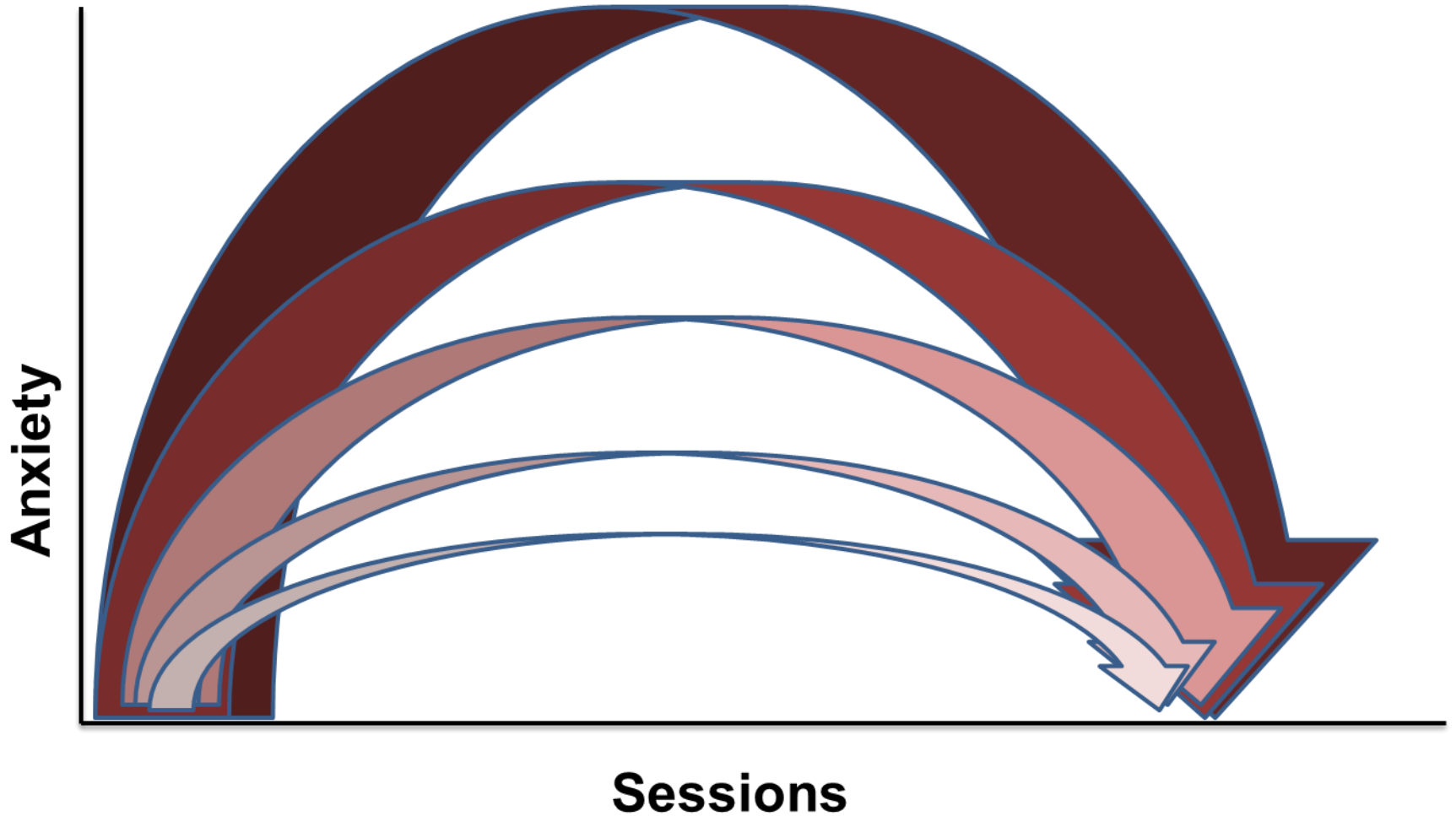
# Skills Group (8 sess)

- Didactics
  - SORC model emphasis on assertiveness training (define passive, assertive, aggressive)
  - Relaxation training--teach/practice (4) in last ½ hr of session
  - Homework: observe self/other's behaviors, practice relaxation daily, & rate SUDs (1-100)
- Practice
  - Videotaped role-play: practice/review in session
    - Passive, aggressive, assertive (fabricated situations)
    - Assertive only to personal situations (formula)
  - Homework: observe self/other's behaviors, practice relaxation daily, & rate SUDs (1-100)
- ▶ Relaxation training sessions 2-6:
  - Teach/practice (breathing, thought-stopping, sensory focusing, progressive deep muscle) in last ½ hr of session

# Exposure Group (6 sess)

- Description, Rationale, id safety nets, SUDs, id worst trauma, breathing relaxation exercise, homework (write trauma narrative)
- In-Session Exposure
  - Patients read trauma, guided imaginal exposure (30 min/pt)
  - Present tense, eyes closed, elicit sensory experiences, thoughts, and feelings, slow pt at worst points
  - Homework: Instructed to re-write same trauma, feedback on what details to include
  - After 3<sup>rd</sup> in-session exposure, patient reads completed narrative daily (2 weeks)

# Habituation to Trauma Memory



# Imaginal Exposure

- Repeated imaginal exposure to memory of trauma in **SAFE** environment
  - Allows experience of emotions
  - Allows processing of emotions and habituation
  - Allows corrective information
- Gets to the heart of the problem--Trauma--in order to heal

# Clinic: Outcome Data with PCL

- Cognitive: Sig. improvement on overall PTSD, large effect size ( $p=.005$ )
- Skills: Sig. improvement on overall PTSD, small effect size ( $p=.04$ )
- Sexual Intimacy: No sig. PTSD improvement
- Exposure: Sig. improvement on overall PTSD, large effect size ( $p=.02$ )





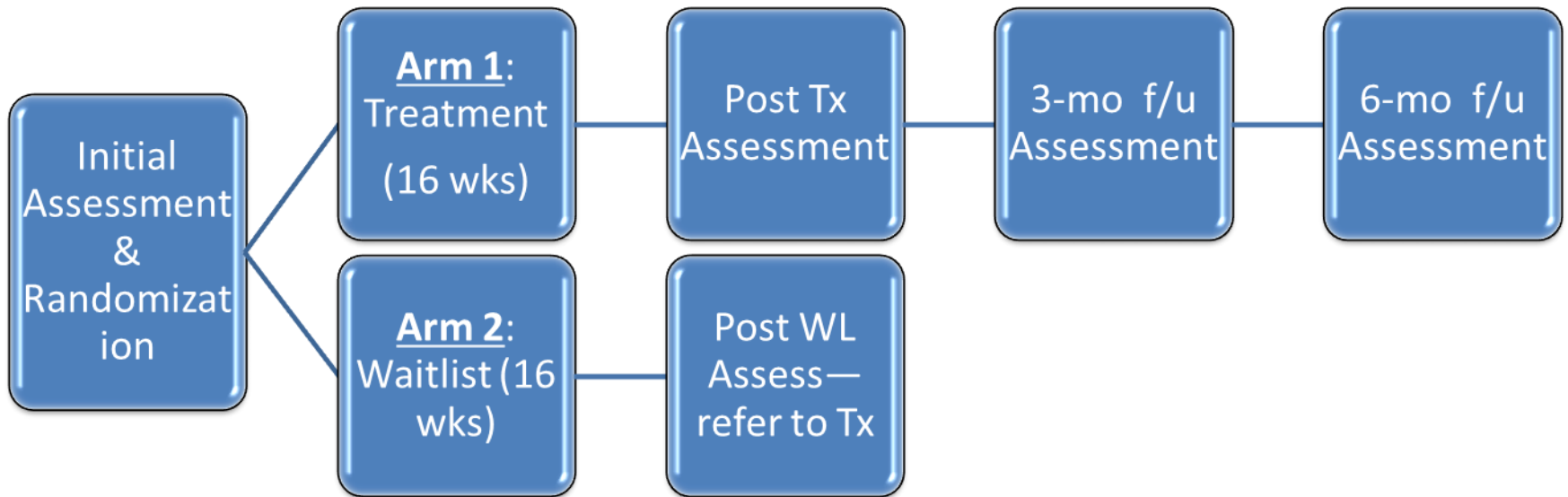
# DoD Study

- Aims:
  - Examine efficacy of 16-week group with 3 blocks of treatment—cognitive, exposure, skills
- Hypotheses:
  - Group Tx > minimal attention wait-list (PTSD—CAPS)
  - Exposure & Cognitive > Skills (PCL)

# DOD Study—Design of RCT

- Participants = 72 OEF/OIF female veterans with PTSD
- Assessment:
  - Descriptive: Demographics, LEC, MSEQ, SCID I/II
  - Outcome: CAPS, QOLI, SF-36:
    - pre, post, 3-mo, & 6-mo. f/u
  - Additional: PCL (between tx blocks) Health Care Utilization (+During active study treatment), Medication use
- Randomized ( $n = 36/\text{arm}$ ):
  - 16-week tx group (3 Tx Blocks, 3 Ss/group)
  - 16-wait-list (minimal attention)

# DOD Treatment Study



# Treatment Blocks

Session 1 and 16—Orientation/Wrap Up



# Results

# Demographics ( $n=86$ )

Age	$M=36$	Axis I = 78%	
Education (Years)	$M=14.6$	Axis II = 22%	
Race/Ethnicity	31% NH White	40% Hisp	17% Nat Am
Employment	57% empl	43% unempl	
Education	11% HS/GED	55% some coll	23% coll grad
Marital Status	30% marr/rel	28% single	20% div
Service Conn Status	54% SC Any	17% SC PTSD	

# Life Event Checklist (LEC--Happened)

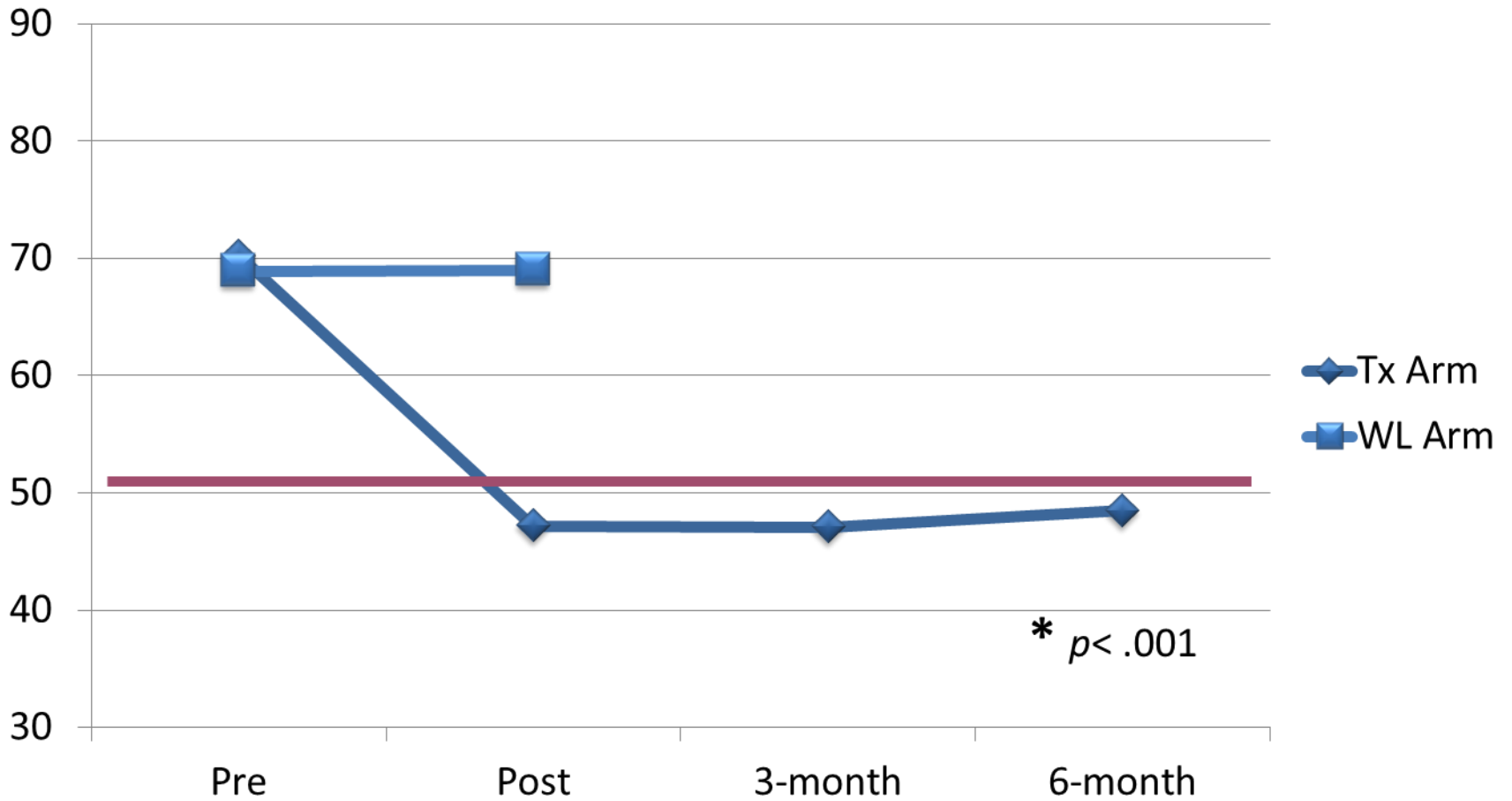
<b>Total Number of Trauma Types</b>	
3%	1-3
27%	4-7
49%	8-12
21%	13-17
<b>Number of Trauma Incidents</b>	
8%	1-10x
26%	11-24x
20%	25-50x
46%	51+x



# Military Stress Exposure Questionnaire (MSEQ)

Trauma	Experienced (min. 1x)
Threat of death, in danger (e.g., bombs)	72%
Knew someone or close to someone who was KIA, MIA, or wounded in action	63%
Witnessed stream casualties	57%
Evacuated the dead	30%
Assigned to combat patrol or dangerous duty	56%
Under enemy fire	58%
Fired at enemy	19%
Killed enemy troops	9%
Killed prisoners or civilians	2%
Verbal sexual harassment	90%
Physical sexual harassment	63%
Sexual assault	47%

# CAPS



**Tx Arm = 33; WL Arm = 35**

# Dr. Christine Chee

- Study Coordinator, DoD Study, 4 years
- WSDTT Clinic Psychologist, 1 year

# Impact of Structured Treatments on Native American Women Veterans

- Native Cultural Values
  - Views of Trauma
  - Traditional Healing from trauma
  - Consistencies/Conflicts with Western treatments
- Observations of Native Women in Western treatments
  - How do NA females respond to:
  - Prolonged Exposure Therapy?
  - Cognitive Processing Therapy?
  - Unique features

# Conclusions

- Two highly effective treatments—CPT & PE
- Treatments are offered in VA for Veterans
- Research ongoing and showing:
  - Young, educated, ethnic, highly traumatized sample of female OEF/OIF Veterans
  - Preliminary results demonstrate a 16-week manualized group treatment protocol for PTSD improves PTSD, results of which are sustained 6 after months
- Hope