

Integrating Trauma Informed and Historical Trauma Informed Care in Behavioral Health Interventions with American Indians and Alaska Natives: Part 1

Developed May 31, 2017

Maria Yellow Horse Brave Heart, PhD
Associate Professor of Psychiatry & Behavioral Sciences
Director, Native American & Disparities Research
Division of Community Behavioral Health
Department of Psychiatry and Behavioral Sciences
University of New Mexico Health Sciences Center
The Takini Institute

Learning Objectives and Overview

- a. Summarize historical and cultural considerations in behavioral health treatment with American Indians and Alaska Natives
- b. Appraise cultural barriers to treatment engagement
- c. Illustrate the use of self-awareness and use of self in trauma informed practices

Overview:

- Review definitions of historical trauma, the historical trauma response, and relevance for behavioral health assessment and treatment
- Introduce concepts such as use of self, transference, therapeutic alliance

What Is Trauma?

“trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual’s functioning and physical, social, emotional, or spiritual well-being”

Overview Continued

- Historical Trauma, Historical Unresolved Grief, and Historical Trauma Response
- Incorporating historical trauma with the DSM IV and DSM 5 Cultural Formulation in assessment and treatment planning
- *Is it PTSD or Personality Disorder?* Diagnostic assessment considerations
- Acknowledging resilience pitfalls: silencing and stigmatizing those who don't feel resilient

Historical Trauma and Unresolved Grief Defined

It is our way to mourn for one year when one of our relations enters the Spirit World. Tradition is to wear black while mourning our lost one, tradition is not to be happy, not to sing and dance and enjoy life's beauty during mourning time. Tradition is to suffer with the remembering of our lost one, and to give away much of what we own and to cut our hair short....Chief Sitting Bull was more than a relation....He represented an entire people: our freedom, our way of life -- all that we were. And for one hundred years we as a people have mourned our great leader.

Historical Trauma and Unresolved Grief Defined

We have followed tradition in our mourning. We have not been happy, have not enjoyed life's beauty, have not danced or sung as a proud nation. We have suffered remembering our great Chief and have given away much of what was ours.... blackness has been around us for a hundred years. During this time the heartbeat of our people has been weak, and our life style has deteriorated to a devastating degree. Our people now suffer from the highest rates of unemployment, poverty, alcoholism, and suicide in the country.

Traditional Hunkpapa Lakota Elders Council (Blackcloud, 1990)

Intergenerational Parental Trauma

I never bonded with any parental figures in my home. At seven years old, I could be gone for days at a time and no one would look for me....I've never been to a boarding school....all of the abuse we've talked about happened in my home. If it had happened by strangers, it wouldn't have been so bad- the sexual abuse, the neglect. Then, I could blame it all on another race....And, yes, they [my parents] went to boarding school.

A Lakota Parent in Recovery
(Brave Heart, 2000, pp. 254-255)

Multiple Losses and Trauma Exposure

- Death of five family members killed in a collision by a drunk driver on a reservation road
- One month earlier, death of a diabetic relative
- Following month, adolescent cousin's suicide and the death of another relative from a heart attack
- Surviving family members include individuals who are descendants of massacre survivors & abuse in boarding schools
- Many community members comment that they feel they are always in a state of mourning and constantly attending funerals.

Definitions

- ***Historical trauma*** - Cumulative emotional and psychological wounding from massive group trauma across generations, including lifespan
- ***Historical trauma response*** (HTR) is a constellation of features in reaction to massive group trauma, includes ***historical unresolved grief*** (similar to Child of Survivors Complex re: Jewish Holocaust survivors and descendants, Japanese American internment camp survivors and descendants)

(Brave Heart, 1998, 1999, 2000)

Historical Trauma and Unresolved Grief Intervention Development



Tunkasila Tatanka Iyotake, Mother Her
Holy Door, Daughter, and Grandchild

Historical Trauma Intervention Development

- Motivated by desire to reduce the suffering of AIs; developed HT concept for AIs (1985-88)
- By 1992 first Native historical trauma intervention; founded the Takini Network* to address healing among the Lakota and other Native people (doctoral dissertation)
- 1996 – 2004 - Designed the first Lakota parenting curriculum incorporating HTUG components; number of SAMHSA grants
- 2001-2004 *Models for Healing Indigenous Survivors of HT* Conferences (SAMSHA CMHS and CSAT support)
- 2009 – HTUG selected as Tribal Best Practice by First Nations Behavioral Health Association and SAMHSA
- 2013 - Current NIMH funded study of HTUG combined with Group Interpersonal Psychotherapy (IPT)

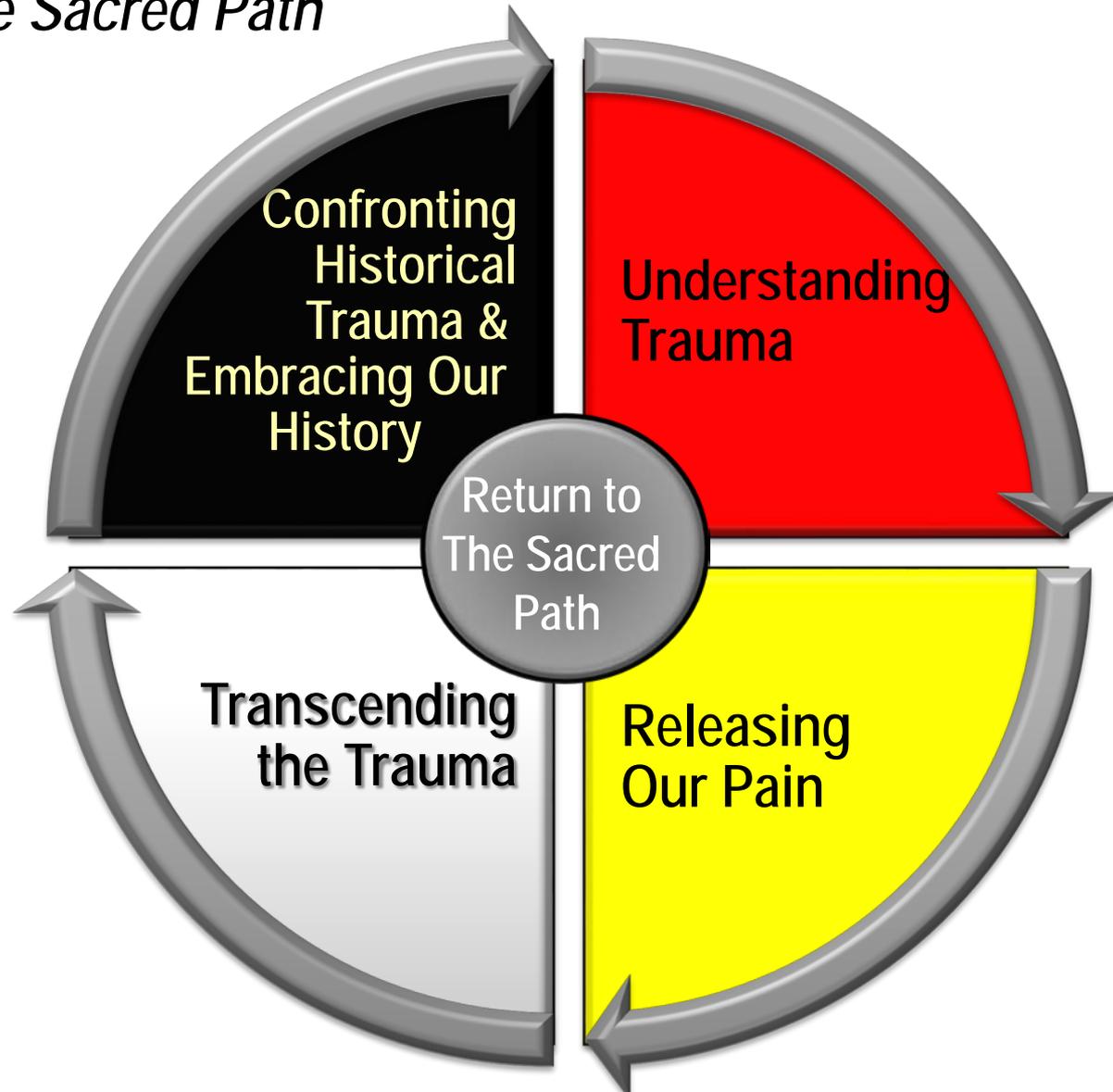
***Takini** - Lakota word meaning survivor, to come back to life, to be reborn

Prolonged/Complicated Grief Risks and Historical and Cultural Features

- **Federal prohibition against practice of traditional Native spirituality limited bereavement**
- **Dominant societal view of Natives as “savage” and unfeeling – dehumanizing, invalidating grief**
- **Modern cumulative traumatic loss superimposed upon collective generational trauma**
- **Active relationship with ancestor spirits**
- **Native attachment, loss of close relative experienced as loss of part of self, may be exhibited by cutting the hair**

Historical Trauma & Unresolved Grief Tribal Best Practice (HTUG):

Return to the Sacred Path



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
- Similarities with the Child of Survivors Complex (Holocaust) and Japanese American internment camp survivors and descendants
- ***Loyalty to ancestral suffering & the deceased***
- **Internalization of ancestral suffering**
- ***Vitality in own life seen as a betrayal to ancestors who suffered so much***

HT, Depression, PTSD, Prolonged Grief

- High rates of PTSD associated with trauma exposure, frequent deaths, military trauma (Manson, et al., 2005; Brave Heart, Lewis-Fernandez, Beals, et al., 2016).
- CG/PG: sadness, separation distress, strong yearnings, longing for & preoccupation with thoughts of deceased, intrusive images, psychic numbness, guilt, extreme difficulty moving on with life, and a sense of the part of the self having died (Boelen & Prigerson, 2007; Shear et al., 2005). May co-occur with PTSD (20-50%).
- Historical unresolved grief includes these but also yearning, pining, preoccupation with thoughts of ancestors lost in massacres, loyalty to ancestors with a focus on their suffering, as if to not suffer is to not honor them, to forget them

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**

Themes from Qualitative Evaluation of Parental Responses (1996-1998)

- * **Increased sense of parental competence**
- * **Increase in use of traditional language**
- * **Increased communication with own parents and grandparents about HT**
- * **Improved relationships with children, parents, grandparents, and extended kinship network**
- * **Increased pride in being Lakota and valuing own culture, i.e. Seven Laws**

Current Research

Randomized assignment of AIs 18 and over to Group Interpersonal Psychotherapy (IPT) combined with the *Historical Trauma and Unresolved Grief Intervention* (HTUG) vs IPT Only in outpatient behavioral health clinics

Classical Psychosocial Assessment: Can Include Appraisal of Cultural Barriers to Treatment

- Identifying and Referral Information
- Presenting Problem – Patient/Client perception
- Presenting Problem – Your perception
- History of the Problem & Precipitating Factors
- Social, Educational, Work, Family, & Medical History including Mental Health, Substance Abuse, & Domestic Violence History; Sexual History
- Psychodynamic Formulation – Use of Induced Feelings
- Mental Status Exam
- Diagnosis & Recommendations

Social History Exploration

- Social, Educational, Work, Family, & Medical/Behavioral Health History – integrate HT, collective group trauma experiences as part of that history
- Early separations from children - a source of incredible traumatic grief for parents
- Early separations from parents, grandparents, and extended family traumatic for children – source of grief
- Perceived abandonment

Mental Status Exam

- Affect – both emotional state and facial expression [attend to cultural styles]
- Full-range, appropriate
- Labile [watch for cultural styles]
- Inappropriate, e.g. grimacing, laughing when it does not match the content of verbalizations (need to distinguish from “nervous laughter” – will feel different)
- Agitated, shaking

Mental Status Exam

- Psychomotor retardation, slowed down
- Clinically depressed affect, sighing
- Thought – concrete thinking – “our time is up” – psychotic process
- Clues – verbalizations make you “scratch your head” seem odd
- Tangential, circumstantial thinking, speech
- Perseveration, repetitive, obsessional
- Pressured speech

Mental Status Exam

- Attend to Appearance, Behavior, Mood, Speech, Thought, Ideation (suicidal, homicidal, paranoid content), Interpersonal Relationship with the clinician and staff
- Attend to Perception – Visual, Auditory, or Olfactory Hallucinations [watch for cultural norms]
- Paranoid thinking, ideas of reference [may be mistaken for coping among oppressed populations]

Mental Status Exam

- Persecutory thoughts
- Delusions
- Government is sending them messages through their television, bizarre thinking
- Ideas of having special powers (narcissistic defense) [consider cultural perspectives]
- Grandiosity, Narcissistic thinking

Mental Status Exam

- Command hallucinations – RED FLAG
- Where do the voices come from – inside or outside their head? Can others hear their thoughts?
- Mental status exam includes questions re: orientation to person, place, time – who they are, who you are, where you both are, and what time is it, what day is it [cultural, age considerations]
- Cognition and memory – specific questions [culturally appropriate]

Mental Status Exam

- Overall intellectual ability, fund of knowledge, and consciousness; sensorium and cognition
- Is the client alert or catatonic? Is the person confused?
- Can the person concentrate on some basic math questions, e.g. simple subtraction, multiplication, counting backwards from 100?
- Do they have a basic fund of knowledge, e.g. who is the President of the United States or the Tribal President/Chairperson/Governor?
- All of these can have cultural differences!

Mental Status Exam

- How is their attention span? Are they distractible?
- How is their memory – both long-term and short-term? Can ask them historical questions, when, where they were born.
- Can ask them to remember a phrase, a set of numbers, three or four unrelated words, and then ask them again 5 minutes later.

Psychodynamic Formulation

- Defense mechanisms – unconscious, intended to protect the ego
- Underlying repression
- Classic defenses – projection, reaction formation, undoing, sublimation (more extensive list in the DSM)
- Defenses are clues to psychopathology and character structure
- Highest level defenses (healthy) – sublimation and altruism

Psychodynamic Formulation

- Ability to delay gratification
- Impulse control
- Other ego strengths, e.g. judgment, ability to operate under the reality principle rather than the pleasure principle (giving into id, to impulses); understanding consequences of their behavior
- Quality of superego – weak, rigid
- Ego mediates between the id and the superego

Psychodynamic Formulation & Traditional Native Cultural Examples

- Ability to delay gratification and impulse control **fasting, tolerating physical discomfort, preparation for ceremony for a year**
- Other ego strengths, e.g. ability to operate under the reality principle; understanding consequences of their behavior **imbedded in traditional cultures**
- Quality of superego – **traditional laws include altruistic values, healthy defense mechanisms and values like compassion, generosity, integrity, self-discipline**

Culturally Sensitive Diagnosis

DSM IV (5) Cultural Formulation

Cultural Identity

- Ethnic or cultural reference group(s)
- Degree of involvement w/culture of origin & host culture
- Language abilities, use, & preference

Cultural Explanations of Illness

- Meaning & perceived severity of symptoms in relation to reference group/s norms
- Perceived causes & explanatory models that the pt. & reference group(s) use to explain the illness
- Preferences for sources of care

Culturally Sensitive Diagnosis: the DSM IV

Cultural Formulation

Cultural factors related to psychosocial environment & levels of functioning

- Culturally relevant interpretations of social stressors, available supports, levels of functioning & disability
- Stresses in the local social environment
- Role of religion & kin networks in providing emotional, instrumental, & informational support

Cultural elements of the relationship between the individual and the clinician

- Individual differences in culture & social status between the individual & clinician
- Problems these differences may cause

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)

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

Cultural Formulation (con't)

- Indirect styles of communication, values of non-interference and non-intrusiveness, & polite reserve may delay help-seeking and true presenting problem
- Variation in eye contact; cultural differences in personal space & cross-gender interaction
- **Listening for the meaning in the metaphor**
- **Client use of narratives, stories; talking in the displacement**
- **Beginning phase may be longer**

Culturally & Historically Responsive Assessment

- Explore generational boarding school history, tribal traumatic events, and investigate how these were/are processed in the family
- Explore degree of involvement in traditional Indigenous culture; complexity of cultural responsiveness
- Use adaptation of the DSM IV Cultural Formulation (Lewis-Fernandez & Diaz, 2002), expanded to include exploration of boarding school trauma, tribal relocations, migration, trauma in tribal community of origin, language

Importance of Culturally Congruent Assessment and Interventions: Case Examples

- Woman diagnosed with schizophrenia, sent from IHS reservation hospital to state hospital; placed on anti-psychotic medication. She continued to hallucinate and have paranoid ideation. Her relatives decided to have a ceremony for her. In the ceremony she was given a spiritual explanation for her symptoms and then healed in the ceremony. Pt never had any psychotic symptoms again and remains free of meds.
- Man accurately diagnosed as schizophrenic with psychotic symptoms and refusing medication, able to function through working with a traditional healer and going to frequent purification lodges and ceremonies. Pt not a danger to self or others – no command hallucinations and did continue therapy.

Importance of Trauma Informed Assessment and Interventions: Case Example

- A male combat veteran initially manifests signs of a personality disorder – somewhat grandiose, appearing narcissistic, not allowing therapist to say much, unable to accept any feedback or interpretation, critical of staff, and resistant to sharing history. Patient highly intelligent. Therapist works on building rapport, following the patient's lead. Although the veteran initially avoided talking about his trauma, with therapist mentioning that these were his sessions and he did not have to talk if he was not ready, the patient began to share his trauma and comes to weekly sessions and reports improvement in symptoms.

Importance of Culturally Congruent Assessment and Interventions: Case Examples

- it became clear that the patient's need for control was related to the PTSD and that the patient would share trauma history but on his terms and when he was ready. Pt also manifested an observing ego – able to see when he avoided, observed how difficult he could be with others, and had insight to his need to control as he felt so out of control in combat situations and controlling the sessions alleviated some anxiety. The therapeutic stance of “these are your sessions” was very helpful in providing a safe space for the patient to share symptoms and accept help; this was a trauma informed approach and also the diagnosis was PTSD rather than borderline or narcissistic PD.

Indigenous Peoples Survey (NIMH study ***R34MH097834 (Brave Heart, PI)***)

- Inventory of Complicated Grief
- Trauma History Inventory/Harvard Trauma Questionnaire
- PTSD Checklist-Civilian Version & Military Version
- Historical Loss Scale (Whitbeck)
- Center for Epidemiologic Studies Depression Scale
- Duke-UNC Functional Social Support Questionnaire
- Items from the Lakota Grief Experience Questionnaire (Experimental) and the *Return to the Sacred Path* Study; items on experiences of racism and discrimination; identity

Use of Self, Transference and Countertransference

- The theory you embrace informs your assessment and intervention
- Psychoanalysts and psychoanalytic or psychodynamic therapists (including clinical social workers, psychologists, psychiatrists) work with concepts like transference, countertransference, bolstering ego strengths, impulse control and judgement, delayed gratification, superego and ego ideals, sense of self, and object relationships
- Some research indicates the power of the therapeutic relationships and success with varying models – not one size fits all.
- Countertransference reactions can be induced – learning to work with observing your own reactions in a session can be very helpful in the therapy.

Trauma Informed Use of Self, Transference and Countertransference

- Trauma narratives of patients will be triggering particularly if therapist has own trauma history.
- Developing comfort with one's own reactions and working on healing from one's own trauma is essential.
- Awareness of trauma is helpful rather than harmful (avoidance is worse as one can “act out” by not listening to the patient, shutting down emotionally, becoming judgmental, and interfering with the patient's healing)
- Trauma informed care includes addressing providers own needs and healing.

Trauma Informed Use of Self, Transference and Countertransference: Unconscious Communication

- Example of unconscious communication: *Pizza in the Microwave* – therapist suddenly starts craving pizza as a patient began sharing that he had an argument with his wife. Therapist was not even hungry and never craved pizza. With the hovering attention she was trained in and “listening with the third ear” the therapist just observed her feeling while simultaneously listening to the patient. The patient starts sharing the circumstances surrounding the argument with his wife and reveals that the argument was about microwaving pizza. The therapist was picking up on unconscious communication as the pizza craving occurred prior to the patient sharing any details about the argument and had made no mention of pizza.

Vicarious or Secondary Trauma

- Experienced by healthcare providers
 - Patients ill and dying
 - Hearing stories of medical trauma
 - Experiencing historical trauma themselves
 - Experiencing trauma themselves
- Experienced by behavioral health providers
 - Hearing stories of trauma from their clients
 - Experiencing historical trauma themselves
 - Experiencing trauma themselves

The System(s) We Work in Can be Traumatizing/Re-traumatizing for Us

- We are all affected by systemic stressors
- We are trained to ignore our own emotions, thoughts, and needs
- We are trained to focus on the patient and their needs
- Many of us have experienced our own trauma in ourselves, our families, our communities
- This can lead to compassion fatigue and burn out

Compassion Fatigue

- The emotional residue or strain of exposure to working with those suffering from the consequences of traumatic events.
- It differs from burn-out, but can co-exist.
- Can occur due to exposure on one case or can be due to a “cumulative” level of trauma.

Signs and Symptoms of Compassion Fatigue

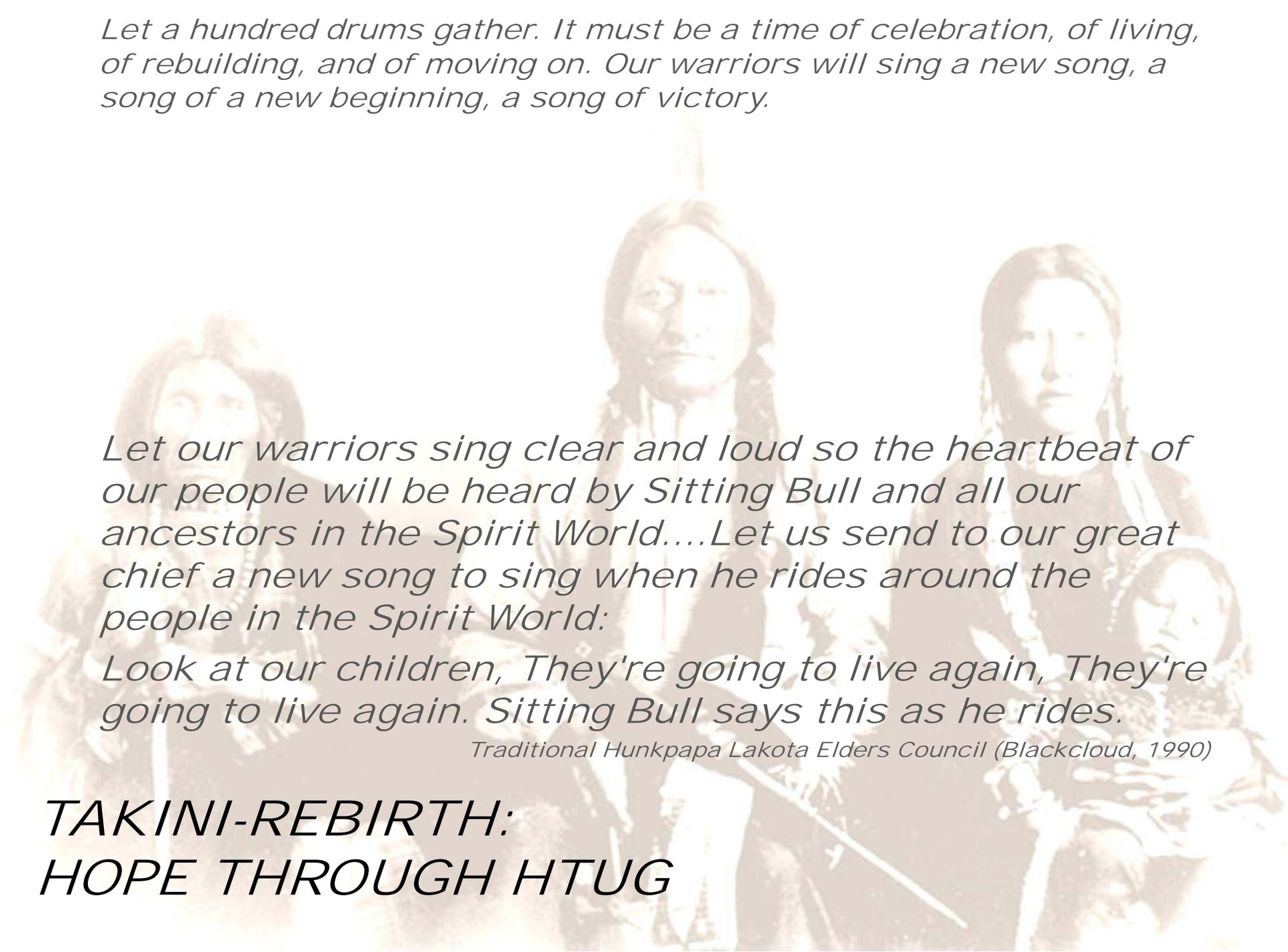
- Exhaustion
- Reduced ability to feel sympathy and empathy
- Anger and irritability
- Increased use of alcohol and drugs
- Dread of working with certain clients/patients
- Diminished sense of enjoyment of career
- Disruption to world view, Heightened anxiety or irrational fears
- Intrusive imagery or dissociation
- Hypersensitivity or Insensitivity to emotional material
- Difficulty separating work life from personal life
- Absenteeism – missing work, taking many sick days
- Impaired ability to make decisions and care for clients/patients
- Problems with intimacy and in personal relationships

Burn Out

- “A syndrome of emotional exhaustion, depersonalization and lack of feelings of personal accomplishment” (Lee & Ashforth)
- Cumulative process marked by emotional exhaustion and withdrawal associated with increased workload and institutional stress, NOT trauma-related. (American Institute of Stress)
- A concept in organizational psychology—occurs when a person’s work environment is so toxic or stressful they don’t see value in their work

Final Point: What is Trauma Informed Care?

- Trauma Informed Care is an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma.
- Trauma Informed Care also emphasizes physical, psychological and emotional safety for both consumers and providers, and helps survivors rebuild a sense of control and empowerment.
- Historical Trauma Informed Care includes integration of recognition of tribal culture and history and the impact up to the present. Both must be incorporated in assessment and treatment approaches.



Let a hundred drums gather. It must be a time of celebration, of living, of rebuilding, and of moving on. Our warriors will sing a new song, a song of a new beginning, a song of victory.

Let our warriors sing clear and loud so the heartbeat of our people will be heard by Sitting Bull and all our ancestors in the Spirit World....Let us send to our great chief a new song to sing when he rides around the people in the Spirit World:

Look at our children, They're going to live again, They're going to live again. Sitting Bull says this as he rides.

Traditional Hunkpapa Lakota Elders Council (Blackcloud, 1990)

***TAKINI-REBIRTH:
HOPE THROUGH HTUG***

Celebration of Survival



Celebration of Survival



Celebration of Survival



Relevant Recent HT Publications

- Brave Heart, M.Y.H., Elkins, J., Tafoya, G., Bird, D., & Salvador (2012). *Wicasa Was'aka: Restoring the traditional strength of American Indian males. American Journal of Public Health, 102 (S2), 177-183.*
- Brave Heart, M.Y.H., Chase, J., Elkins, J., & Altschul, D.B. (2011). Historical trauma among Indigenous Peoples of the Americas: Concepts, research, and clinical considerations. *Journal of Psychoactive Drugs, 43 (4), 282-290.*
- Brave Heart, M.Y.H. & Deschenie, T. (2006). Resource guide: Historical trauma and post-colonial stress in American Indian populations. *Tribal College Journal of American Indian Higher Education, 17 (3), 24-27.*
- Brave Heart, M.Y.H. (2003). The historical trauma response among Natives and its relationship with substance abuse: A Lakota illustration. *Journal of Psychoactive Drugs, 35(1), 7-13.*

Relevant Recent HT Publications

- Brave Heart, M.Y.H., Elkins, J., Tafoya, G., Bird, D., & Salvador (2012). *Wicasa Was'aka: Restoring the traditional strength of American Indian males. American Journal of Public Health, 102 (S2), 177-183.*
- Brave Heart, M.Y.H., Chase, J., Elkins, J., & Altschul, D.B. (2011). Historical trauma among Indigenous Peoples of the Americas: Concepts, research, and clinical considerations. *Journal of Psychoactive Drugs, 43 (4), 282-290.*
- Brave Heart, M.Y.H. (2003). The historical trauma response among Natives and its relationship with substance abuse: A Lakota illustration. *Journal of Psychoactive Drugs, 35(1), 7-13.*
- Evans-Campbell T, Lindhorst T, Huang B, Walters KL (2006) Interpersonal violence in the lives of urban American Indian and Alaska Native women: implications for health, mental health, and help-seeking. *Am J Public Health 96(8):1416–1422.*
doi:[10.2105/ AJPH.2004.054213](https://doi.org/10.2105/AJPH.2004.054213)

References-Brave Heart

- **Brave Heart**, M.Y.H., Lewis-Fernández, R, Beals, J, Hasin, D, Sugaya, L, Wang, S, Grant, BF., Blanco, C. (2016). Psychiatric Disorders and Mental Health Treatment in American Indians and Alaska Natives: Results of the National Epidemiologic Survey on Alcohol and Related Conditions. *Social Psychiatry and Psychiatric Epidemiology*, 51 (7), 1033-1046.
- **Brave Heart**, M.Y.H., Chase, J., Elkins, J., Nanez, J., Martin, J., & Mootz, J. (2016). Women finding the way: American Indian women leading intervention research in Native communities. *American Indian and Alaska Native Mental Health Research Journal* 23 (3), 24-47.
- **Brave Heart**, M.Y.H., Bird, D.M., Altschul, D., & Crisanti, A. (2014). Wiping the tears of American Indian and Alaska Native youth: Suicide risk and prevention. In J.I. Ross (Ed.), *Handbook: American Indians at Risk* (pp. 495-515). Santa Barbara, CA: ABC- CLIO Greenwood.

References-Brave Heart-continued

- Brave Heart, M.Y.H. (1999) *Oyate Ptayela: Rebuilding the Lakota Nation through addressing historical trauma among Lakota parents. Journal of Human Behavior and the Social Environment, 2(1/2), 109-126.*
- Brave Heart, M.Y.H. (2000) *Wakiksuyapi: Carrying the historical trauma of the Lakota. Tulane Studies in Social Welfare, 21-22, 245-266.*
- Brave Heart, M.Y.H. (2001) Clinical assessment with American Indians. In R.Fong & S. Furuto (Eds), *Cultural competent social work practice: Practice skills, interventions, and evaluation* (pp. 163-177). Reading, MA: Longman Publishers.
- Brave Heart, M.Y.H. (2001) Clinical interventions with American Indians. In R. Fong & S. Furuto (Eds). *Cultural competent social work practice: Practice skills, interventions, and evaluation* (pp. 285-298). Reading, MA: Longman Publishers.

References-Brave Heart continued

- Beals, J., Manson, S., Whitesell, N. Spicer, P., Novins, D. & Mitchell, C. (2005). Prevalence of DSM-IV disorders and attendant help-seeking in 2 American Indian reservation populations. *Archives of General Psychiatry*, 162, 99-108.
- Beals J, Belcourt-Ditloff A, Garrouette EM, Croy C, Jervis LL, Whitesell NR, Mitchell CM, Manson SM, Team AI-SUPERPPF (2013) Trauma and conditional risk of posttraumatic stress disorder in two American Indian reservation communities. *Soc Psych Psych Epid* 48(6):895–905. doi:[10.1007/s00127-012-0615- 5](https://doi.org/10.1007/s00127-012-0615-5)
- Beals J, Manson SM, Croy C, Klein SA, Whitesell NR, Mitchell CM, AI-SUPERPPF Team (2013) Lifetime prevalence of post- traumatic stress disorder in two American Indian reservation populations. *J Trauma Stress* 26(4):512–520. doi:[10.1002/jts. 21835](https://doi.org/10.1002/jts. 21835)
- Brave Heart MYH (1998) The return to the sacred path: healing the historical trauma response among the Lakota. *Smith Coll Stud Soc* 68(3):287–305. doi:[10.1080/00377319809517532](https://doi.org/10.1080/00377319809517532)

References-Brave Heart continued

- Legters, L.H. (1988). The American genocide. *Policy Studies Journal*, 16 (4), 768-777.
- Lewis-Fernandez, R. & Diaz, N. (2002). The cultural formulation: A method for assessing cultural factors affecting the clinical encounter. *Psychiatric Quarterly*, 73(4), 271-295.
- Manson, S., Beals, J., O'Neil, T., Piasecki, J., Bechtold, D., Keane, E., & Jones, M. (1996). Wounded spirits, ailing hearts: PTSD and related disorders among American Indians. In A. Marsella, M. Friedman, E. Gerrity, & R. Scurfield (Eds), *Ethnocultural aspects of Posttraumatic Stress Disorder* (pp. 255-283). Washington DC: American Psychological Association.
- Robin, R.W., Chester, B., & Goldman, D. (1996). Cumulative trauma and PTSD in American Indian communities (pp. 239-253). In Marsella, A.J., Friedman, M.J., Gerrity, E.T., & Scurfield, R.M. (Eds), *Ethnocultural aspects of Post-traumatic Stress Disorder*. Washington, DC: American Psychological Press

References-Brave Heart continued

- Robin, R., Chester, B., Rasmussen, J., Jaranson, J. & Goldman, D. (1997). Prevalence and characteristics of trauma and posttraumatic stress disorder in a southwestern American Indian community. *American Journal of Psychiatry*, 154(11), 1582–1588.
- Shear, K., Frank, E., Houck, P.R., and Reynolds, C.F. Treatment of complicated grief: A randomized controlled trial, 2005, *JAMA*, 293 (21), 2601-2608.
- US Senate Miscellaneous Document, #1, 40th Congress, 2nd Session, 1868, [1319]