Wounded Spirits, Ailing Hearts Training Manual

This manual is to help practitioners understand the unique needs present when dealing with a specific ethnocultural group, in this case, Native Americans. This Training Manual was created to accompany the Wounded Spirits Ailing Hearts videos for health care providers and clinicians, but can be used with or without the accompanying videos. Please use below to access the videos.

The online manual provides information on the following topics:

- Knowledge regarding the impact of PTSD specific to the American Indian and Alaska Native Veteran
- Cultural approaches and suggestions for treatment
- A description of Native Americans and Military Service
- A definition of Posttraumatic Stress Disorder, how it is diagnosed, and its impact
- Information on available services and barriers to care
- Traditional healing methods information
- The role of other health and mental health care providers in care

A particular goal of this manual is to help teach practitioners to provide culturally competent care and it takes the user through a cultural formulation of a clinical case of PTSD. These ideas can be adopted for use with members of other ethnocultural groups.

Videos related to the Manual are available on the website for these audiences:

- General Audience
- Native American Veterans and their Families
- Mental Health Care Providers
- Health Care Providers
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1. Native Americans and Military Service

American Indian and Alaska Native Veterans have a proud history of service in the United States military. Unfortunately, the stereotype that American Indians are members of a martial race is at least as old as the U.S. itself. For example, Colonel James Smith, held captive by an unnamed Indian tribe between 1755 and 1759, wrote an account of American Indian modes of warfare that was accurate enough to popularize the idea that Indians were uniquely brave and adept warriors. Later, Secretary of the Interior Ickes furthered these ideas in his writings for a national magazine, saying that, "the rigors of combat hold no terror for American Indians and, better than all else, they have an enthusiasm for fighting." Thus, by the end of World War II, the stereotype of the American Indian as a martial race, with special propensities and desire for warfare, was firmly and pervasively entrenched in the American mind.

From the American Indian perspective, war is viewed as a major disruption of the natural order of life and of the universe. Native American peoples conceptualize no separation between mind, body, spirit, and "religion," while the western society world-view (that of the U.S. majority) embraces a reductionistic/separatist conceptualization of a mind, body, and spirit. Thus, a more holistic paradigm of self, spirit, and nature is embraced by American Indian and Alaska Native peoples. Warriors are viewed as people who are placed not only in physical danger, but also in spiritual danger by their participation in war. All tribes see the warrior as sacrificing self (purposefully exposing oneself to trauma or even death) on behalf of the people; it is a role and an undertaking worthy of the highest respect. Thus, only the most serious reasons legitimize war.
2. Posttraumatic Stress Disorder

The risk of exposure to trauma (e.g., combat or rape) is a risk of the human condition. A possible consequence of trauma is Posttraumatic Stress Disorder (PTSD). Historical accounts and world literature provide us with many illustrations of trauma and its sequelae. One example is Homer's ancient story of the battle between the Greeks and the Trojans. In a more modern-day work, Shakespeare's Henry IV appears to have met many, if not all, of the diagnostic criteria for PTSD.

Yet, as familiar as clinicians and the general public have become with PTSD in general, knowledge about its prevalence, incidence, comorbidities, treatments, and cultural aspects specific to American Indian and Alaska Native peoples remains relatively underinvestigated and undisseminated.

This section contains information about PTSD and various topics:

- Causes, Risk and Prevalence of PTSD
- Making the Diagnosis of PTSD
- Is PTSD Different for Native Veterans?
- Impact of PTSD on Social Readjustment
- Impact on Quality of Life
- Impact on Family, Social and Work Relationships
- Impact on Mental Health
- PTSD, Alcohol Problems and Drug Abuse
- PTSD and Physical Illness
Causes, Risks and Prevalence of PTSD

What Causes PTSD?
The major factor that determines the development of PTSD is the amount of exposure to combat or other life-threatening trauma. Other aspects of a veteran's personal background before and after the war can make him or her vulnerable to PTSD, as discussed below. However, it is traumatic experiences, not any weaknesses or defects in a person, that cause PTSD.

Prevalence
The estimated lifetime prevalence of PTSD among all adult Americans is 7.8%, with women (10.400) twice as likely as men (5%) to meet criteria for PTSD at some point during their lives. This, however, represents a small proportion of those who have experienced a traumatic event (60.7% for men, 51.2% for women).

The findings of the National Vietnam Veterans Readjustment Survey (NVVRS) estimated lifetime prevalence of PTSD among American Vietnam theater Veterans is 30.9% for men and 26.9% for women. An additional 22.5% of men and 21.2% of women have had partial PTSD (some symptoms) at some point in their lives. Thus, more than half of all male Vietnam Veterans and almost half of all female Veterans have experienced clinically significant reactions to traumatic stress.

However, the National Vietnam Veterans Readjustment Survey underrepresented members of certain minorities. Therefore, to more accurately measure the impact of war on Native American, Asian American, and Pacific Islander Veterans, the Matsunaga Vietnam Veterans Project (MVVP) was undertaken.

The MVVP report, like its predecessor, focused primarily on prevalence of PTSD, comorbid psychiatric diagnoses, readjustment problems, and clinical utilization. The MVVP has two components: American Indian and Alaska Natives and Native Hawaiians and Americans of Japanese Ancestry.

Of all segments of Native American Veterans assessed, Northern Plains Indians had the greatest lifetime prevalence of PTSD (57.2%), followed by Southwest American Indians (45.3%). In all population groups, war-zone experience was the best predictor of PTSD prevalence, explaining between 26% and 39% of the variance.

Risk factors
Risk factors that affected the likelihood of developing war-zone-related PTSD included: a family history of substance abuse, physical abuse as a child, a negative relationship with parents, childhood deviant behaviors, lower educational attainment, non-officer status in Vietnam, and heavy combat experience. After the effects of combat trauma were accounted for, American Indian and Alaska Native Veterans were no more likely than any other Vietnam Veterans to develop PTSD.
Making the Diagnosis of PTSD

PTSD is unique in that one cannot make the diagnosis unless the patient has experienced a traumatic stressor. The framers of the initial formulation of PTSD conceptualized traumatic stressors as those that were outside the range of normal human experience (e.g., war, torture, rape, and natural disasters). The dichotomization between traumatic and other stressors was based on the assumption that most individuals have the ability to cope with ordinary stressors (e.g., divorce, major financial losses). It was assumed that the adaptive capacities of almost anyone are likely to become overwhelmed when confronted by a traumatic stressor. When faced with life-threatening stressors such as rape or combat, it is normal to feel terrified or shocked. It also is normal, after exposure to such traumatic events, to experience unwanted memories, to have difficulties with anger, to feel a continuing sense of danger, or to feel emotionally distant and "cut-off" from other people. PTSD occurs when these normal reactions become chronic and fail to improve with time. Symptoms of PTSD may be experienced for many weeks, months, or years.

Current conceptualization of PTSD in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994) recognizes that traumatic stressors are, in fact, common experiences in many societies today. Considering the widespread nature of traumatic stressors, the DSM-IV specifies that four diagnostic requirements be met before a diagnosis of PTSD can be made. First, the individual must have experienced, witnessed, or been confronted with an event or events that involved "actual or threatened death or serious injury, or a threat to the physical integrity of self or others," and the individual's response must have involved "intense fear, helplessness, or horror." Such events include rape, war combat, and childhood abuse. The other three diagnostic criteria address the major types of PTSD symptoms:

- Intrusive reexperiencing of traumatic memories;
- Avoidance; and
- Increased arousal.

Each described further below.

Intrusions/Reexperiencing

Individuals with PTSD often describe repeated, intrusive imagery of their traumatic event(s). These intrusive memories may be sudden and unexpected multi-sensory experiences, such as "flashbacks," during which the individual may feel that the trauma is reoccurring. In addition, intrusive reexperiencing in the form of unwanted memories and feelings from the trauma experience(s) can occur during sleep (i.e.,
nightmares). Thus, the trauma survivor is unable to stop "reliving" the trauma and experiencing associated thoughts and feelings.

"...there's noises that bring on [memories] ... even the summer heat, so, I think it's a situation that stays with me constantly. There's not a single day that goes by without some recurring memory or even feelings that come out of it. [I have] dreams where were running through the jungle. I can actually feel the bark stinging my face, my arms, as we're running through the jungle. I can hear the gunfire behind us. And the talking, sometimes laughter of the VC or NVA or whoever's out there. And they're chasing us and we're running and stumbling."

### Avoidance

In order to try to minimize intrusive reexperiencing, the individual avoids many trauma-based cues--interpersonal situations, people, places, thoughts, and emotions. Unfortunately efforts at avoidance often dominate--and can destroy--a person's life and relationships.

"I always remember that feeling. I'll never forget it. It's the one of helplessness ... It's a feeling that I don't care for very much. And to this day, I avoid situations that would bring that feeling back up again."

### Physical tension and over-arousal

A person with PTSD is physically tense. This hyperarousal may manifest itself in problems with sleep, irritability and anger, concentration, and "hypervigilance." Hypervigilance is the feeling that it is never safe to relax because something terrible is just about to happen. However, it is impossible to stay "on alert" constantly without becoming mentally and physically exhausted, irritable, and unable to concentrate on tasks or activities.

"My household is a miniature base camp. I've got lights everywhere ... locking windows and, even though I know that all of these things are in place, I still tend to--for no reason--I'll stand up and I'll go over and I'll look out and look around. And I'll go to the back door and do the same thing, you know. And then, I'm up and around, you know. I'm moving and I'm looking."

### Is PTSD Different for Native Veterans?

The psychological, physiological, and behavioral manifestations of PTSD are different for each individual trauma survivor and are dependent upon the life experiences and the social world of the trauma survivor. Therefore, to understand how PTSD affects American Indian and Alaska Native Veterans, families, and communities, we must consider each veteran's unique personal, social, and cultural experiences.

The following sections highlight common situations and issues that Native American Veterans experienced during and after military service:
• Prejudice and stigma
• Moral compromise
• No Homecoming

Each is described further below.

**Prejudice and stigma**

The trauma of war may have been worsened by encounters with racial or cultural prejudice during or since the military. Native traditions and history often prepared Veterans for military service as an honor and sacred duty. Many became disillusioned when they encountered prejudice and disrespect in the military. Due to their somewhat similar physical appearance, American Indian and Alaska Native Veterans were, at times, mistaken for the enemy. Such experiences not only made the traumas of war more terrifying, but they were also a betrayal of personal trust.

**Moral compromise**

War often forces or leads soldiers to violate their own ethical rules or spiritual beliefs. For some Native Veterans, past failure to uphold these moral standards feels like a failure that can never be made right. Past killing of civilians--including women, children, and elders--can be a source of terrible shame and guilt for some. In addition, such experiences are reminders of the brutality that many American Indian and Alaska Native peoples experienced in the past.

"When I got back, I was ashamed of what I did, because ... even our own people, as we walked down the hallways ... they'd whisper to us ... "Baby killers", "junkies"... And to this day, I still feel that guilt. And I felt like I did something terrible."

**No homecoming**

Tribal practices and beliefs honor the warrior's path as a courageous and selfless way to serve and protect the entire community. Tribal practices honor and serve the veteran warrior in an equally important way--they welcome the warrior home with cleansing ceremonies to enable him or her to resume a peaceful and dignified role in the community. Some Native Veterans either were not offered or felt they could not accept such healing after Vietnam.

"I got home and oddly enough, ... they didn't really shun me, but [it] seemed like they were always scared or apprehensive to be around me. It made me real uncomfortable. I felt really like I didn't belong there anymore. And yet that was my home. And so, I tried to talk to some of 'em about it, and see why they were treating me that way. And finally, one of the ladies that lived a couple blocks down from me said, "Well, a lot of people think that you're a baby murderer and you murdered civilians."
Impact of PTSD on Social Readjustment

Native Vietnam Veterans report more social readjustment problems than do white Vietnam Veterans. Identified problems include difficulty finishing school, difficulty finding or holding a job, inability to earn a sufficient income, difficulties with a spouse or children, and trouble with the law.

PTSD is often the key to readjustment problems. Native Veterans with PTSD are very likely to isolate themselves not only from their families but also from their co-workers, neighbors, former friends, and society in general. When they do have contact with people, frustration and conflict often arise as a result of feelings of vulnerability, intense anger, alienation, and guilt. Often, Native Veterans with PTSD describe feeling profoundly demoralized - like outcasts who have been banished or exiled forever from a safe home or community.

"It seemed like the life I had before Vietnam, it didn't exist anymore. The harder I tried to find it, the further away it got. When I realized that I could never go back, I got pretty tore up, pretty sad. And ... I didn't know how to deal with who I was. I couldn't go back."

Impact of PTSD on Quality of Life

PTSD profoundly affects the psychological and physical health of American Indian Veterans and their families. In many ways, PTSD interferes not only with enjoying life, but even with "having a life." PTSD can involve an endless struggle with:

- Guilt "Why am I alive if I didn't do enough to save my buddies, and if I am no good to my family?"
- Grief "I can never stop thinking of the men we left behind."
- Distrust "We were lied to and used by the country we were trying to protect, so how can I trust anyone?"

Impact of PTSD on Family, Social, and Work Relationships

A constant sense of facing life-threatening danger can lead Veterans to be emotionally distant, constantly on-edge, and overprotective. Consequently the veteran may be unable to listen attentively or speak calmly, may engage in war-like behaviors in and around the family home (constant "perimeter" checking), and may avoid responsibilities in a number of important areas (such as wage-earning, parenting, or lawful behaviors). Families often feel that they now live in a "war zone."

"I was taking counseling sessions at the vet center ... The counselor asked about [my husband], how long he was in Vietnam.... And I said, 'I went there, too.' He said, 'You were in Vietnam?' So I said, I don't think you understand. I'm in Vietnam sixteen years, every day. I gotta live with it every day."
In some cases family members or friends have been directly traumatized by the veteran's violent rage, or by witnessing violence done to others. In other cases they were not exposed directly to trauma, but have had to alter their entire way of living, feeling, and thinking in order to adjust to the veteran's PTSD. Intimate partners often find themselves living with a cold, withdrawn, or hostile stranger instead of the person they used to love and be loved by.

"[My husband] experienced a lot of ... they're called flashbacks. They were scary.... One night we were sleeping. And all of a sudden, I'm slammed out of sleep, because he grabbed me and threw me down. And I remember looking into his eyes. They were, like, dead. No feeling. I just had a horrible feeling like he was gonna kill me. And then, he kind of snapped out of it."

Symptoms of PTSD often interfere with work and education by disrupting attention and concentration. The irritability and anger problems that result from trauma can create difficulties with co-workers and bosses, attendance, and job performance.

**Impact of PTSD on Mental Health**

At the time of the survey more than twenty years after the war, thirty percent of American Indian and Alaska Native Vietnam Veterans suffered from PTSD. This is twice the rate as that among white Vietnam Veterans. Fully half of the Native Veterans have had PTSD at some time in their lives since Vietnam - again at least twice as high a rate as that for white Vietnam Veterans.

PTSD rarely occurs alone. This complicates the symptom picture and often makes diagnosis and treatment complex tasks. Common comorbidities include depression, panic disorder, and substance abuse. As many as 1 in 10 American Indian and Alaska Native Veterans are seriously depressed - four times the rate for white Veterans. Further, 1 in 12 Native American Veterans have had panic disorder at some time since Vietnam. This is more than four times the rate for white, black, or Hispanic Vietnam Veterans. Again, PTSD is the key factor. Native Veterans without PTSD rarely experience severe panic attacks.

Approximately 90% of those American Indian and Alaska Native Vietnam Veterans with PTSD also suffer from alcohol problems. Among all those seeking treatment for PTSD, up to 80% have at least one additional psychiatric diagnosis in these major categories:

- Alcohol abuse or other chemical dependency [60-80%]
- Affective disorders [26-65%]
- Anxiety disorders [30-60%]
- Personality disorders [40-60%]
PTSD, Alcohol Problems, and Drug Abuse

"My first medication was alcohol ... when I was dead drunk, I would talk about these things. One time, I brought a foot locker home, and I had a North Vietnamese backpack in there, and I had two North Vietnamese pistols ... and a Cambodian flag and Cambodian medals, and some Cambodian pictures. One morning I woke up and I found that trunk all full of holes. And ... everybody was tiptoeing around.... I asked my mother. I said what happened? What happened to my trunk? ... She said 'You were talking all this crazy stuff, and you took a gun and started shooting that trunk up. Then you put holes in my wall and my floor and everything, I had to take that rifle away from you.'"

The combination of PTSD and alcohol abuse is devastating and may lead to loss of control and family or community violence. A vicious cycle may develop, with drinking to relieve tension, frustration, or unhappiness providing temporary relief, at the cost of worsening symptomatology and increasing tension. Native Veterans are vulnerable to excessive alcohol use for several reasons:

- Drinking as a means to "socialize"
- Drinking as a means to share trauma
- Drug abuse

Drinking as a means to "socialize"

Alcohol is readily available in American Indian and Alaska Native communities, and drinking is considered to be one of the few ways available to be sociable. Drinking is also a well-entrenched aspect of military culture.

"... I walked in my aunt's place, and they're all in the basement. There was a party going on. My aunt and uncle, they're all drunk downstairs ... And so my coming home was more or less into the world of alcoholism."

Drinking as a means to share trauma

Alcohol use is often condoned as a socially acceptable way of facilitating emotional release and the sharing of traumatic memories. Yet, intoxication only creates a false sense of numbness that prevents the experience of genuine healing. Alcohol problems also can become a way to hide PTSD from oneself and from the world. Healing does not occur unless the veteran and family deal with the symptoms of PTSD without covering them up with alcohol.

"And I really dreaded the question of talking about it.... Probably the first time I ever said anything about the war--I came home drunk.... that was the only way I could tell my dad anything, tell him about what it was really like over there, when I was drunk... Later on, I felt real ashamed of it, you know... that I had to tell something under the influence of alcohol."
Drug abuse

Although not as common among Native Veterans as alcohol abuse, drug abuse is a serious problem for as many as 1 in 7—more than twice the rate for white Vietnam Veterans. Native Veterans diagnosed with PTSD are much more likely to abuse drugs than are those without PTSD.

PTSD and Physical Illness

PTSD can have a devastating effect on physical integrity and general health. No group of Vietnam Veterans is more susceptible to physical illness than American Indian and Alaska Native Veterans. Native American Veterans surveyed in the MVVP reported an average of two to three chronic illnesses, including heart or lung disease, cancer, high blood pressure, diabetes, and severe skin, eye, or gastrointestinal conditions (twice the rate for all other ethnocultural groups of Vietnam Veterans). Native Veterans who also suffered from PTSD complained of symptoms of even more chronic physical illnesses. They often experienced so many debilitating physical problems that their bodies seemed to be completely breaking down. It is possible that PTSD creates a chronic state of physical and emotional tension and exhaustion, thus setting the stage for physical illness.

A combination of PTSD and chronic health problems is the key factor in leading American Indian and Alaska Native Veterans to seek VA outpatient medical care. This group seeks care approximately five times as often as other Vietnam Veterans.

A combination of PTSD and chronic physical illness also predicts especially high levels of medical disability among American Indian and Alaska Native Veterans. The Native Vietnam Veterans who were considered disabled by the Department of Veterans Affairs at the time of the MVVP study had an overall disability evaluation due to PTSD and physical illness of almost 50%, compared to a 25-30% average level for all other Vietnam Veterans.
3. Care: VA and Indian Health Service Health Care Services

Native Veterans tend to seek medical care from the two largest health care systems available to them: VA medical centers and outpatient clinics, and Indian Health Service (IHS) hospitals and clinics. Analysis of veteran use and satisfaction with VA and IHS services found the following:

More than half of the American Indian and Alaska Native Vietnam Veterans who went to VA or IHS facilities rated the medical care "good or excellent."

Unfortunately more than half were not currently receiving any medical care, despite often having chronic physical health problems.

- Barriers to VA/IHS Care
- PTSD and Mental Health Care
- VA PTSD Programs and Vet Centers
- Traditional Healing
- Roles of Health Care Providers
- The Primary Care Provider’s Role
- Trauma Exposure/PTSD Screening
- The Psychiatrist’s Role
- The Mental Health Provider’s Role
- Toward Culturally Competent Care
Barriers to VA/IHS Care

Numerous barriers have kept American Indian and Alaska Native Veterans from seeking the VA or IHS medical care to which they are entitled. Sometimes hospitals and clinics have been too far away to reach. Sometimes Veterans have lacked trust in the VA and IHS or have considered the quality of care to be poor. Both the VA and IHS health care systems are working to make medical care more accessible, more dependable, and of high quality. Professional staff and patient advocates are aware that every patient is entitled to respectful, quality care.

Other barriers to seeking quality medical care from the VA or the Indian Health Service are the following concerns about needing or benefiting from medical care, which are endorsed by many Veterans and/or their families:

- Want to solve problem on my own
- Believe problem not serious enough
- Believe treatment won't help
- Worry about what others would think

PTSD contributes to negative attitudes toward health care. The desire to avoid trauma reminders may lead the veteran to avoid necessary health care. Hyper-vigilance and anger may lead to excessive distrust of and hostility toward healthcare providers. Social isolation and emotional numbing can prevent asking for help.

"I just didn't understand. I just had no patience. I would get angry. And all these things that I'm supposed to be getting treatment for are those things that are preventing me from getting that, because I didn't want to deal with the system."

PTSD and Mental Health Care

Three quarters of American Indian and Alaska Native Vietnam Veterans have significant mental health problems (including PTSD, alcohol and substance abuse, depression, and panic disorder). The great majority have not received any mental health services. In the MVVP more than 5 in 6 (84%) had not received any mental health care in the past year.

Barriers to participation in mental health care noted in the MVVP included most of those that also prevented use of medical care:

- Hospital/clinic too far away
- Needed care not offered
- Too much red tape at the VA/IHS
- Quality of care poor at the VA/IHS
- Not eligible for VA health care services
• Encountered/feared racial prejudice

But many people reported additional fears and concerns about seeking mental health treatment.

"I was kind of afraid they would just confine me in some facility...they suggested the PTSD treatment center in California. And they said it [treatment] took three months. And I said to myself, you know three months, boy, that's a long time. I wondered is it like a dormitory or a barracks? I kind of pictured a barracks, with bunks lined up on each side of the wall and kind of run like the military...So I said, Oh, I wouldn't like it. But they assured me that it was a good setting. And when I came here to the VA Medical Center it wasn't like [my] picture. So when I got here. I knew I would get help."

Sometimes, Veterans have had bad experiences with VA mental health services in the past. Some are now finding that services have changed for the better.

"I had an incident where I had went into the VA looking for information for a problem, and the person was trying to get me to see a doctor And I said, 'What don't you understand about what I'm asking you?' And they told me, 'Well, where do you come off having an attitude?' And so, it wasn't necessarily that they didn't want to help me. It's that we didn't understand each other.

...[But] now, when you go to the VA...they have an awareness and an understanding of it... They don't always have an answer; but they always have an open hand. They always have a fresh cup of coffee. And they always have an open area. And they'll let you sit there and talk. They’ll support you. They'll do the best they can to explain what they heard from you. And if they can't, they'll find someone in that office that will."

**VA PTSD Programs and Vet Centers**

The VA has set up specialized PTSD treatment programs as well as community clinics (Readjustment Counseling Service "Vet Centers") in more than 200 locations across the United States. Providing Vet Centers is one way VA is making better care more available. Several Vet Centers are located within reservation tribal communities, so Veterans don't have to travel hundreds of miles for counseling and other services. Vet Center staff often seek out Veterans in schools, homeless shelters, addiction rehabilitation programs and support groups, and prisons - where many Veterans struggling with PTSD can be found. Vet Centers are often staffed by counselors who themselves are American Indian or Alaska Native Veterans.

**Traditional Healing**

American Indian and Alaska Native communities enjoy a rich history of traditional forms of healing. For hundreds of years, tribal healers have provided a range of herbal and ritual treatments for physical and spiritual problems. Tribal leaders and
elders serve as spiritual guides and conduct elaborate healing ceremonies that include the entire community in ritual activities such as dance, chanting, meals, fasts, physical challenges, or sweats. In traditional healing encounters, prayer and ceremony tap the strength housed within family, community, and Creator. Recently more American Indian and Alaska Native Veterans are drawing on these resources for help with both physical and mental health problems. Traditional healing options can go hand in hand with conventional western medicine and counseling.

"I needed to take a stand, take a step forward, be able to, be open for these things to have any good things for me. And so, basically, that's what I did. It was one little step at a time. I started doing sweat lodges over the years.... On the behalf of Veterans, we sponsored Native American church meetings for healing. Over the course of the whole thing, I've participated in numerous ceremonies that each have a little cog in it, a little step.... All these things helped me."

Roles of Health Care Providers

Healthcare providers often are the first and only contacts that Native Veterans are willing to make for help in healing. Seeking medical care for a physical illness often is more socially and personally acceptable for Native Veterans (and their families) than seeking psychological treatment for "mental illness" or addiction. During the routine health and medical history, health care professionals must be alert to the symptoms of PTSD, as well as to a variety of problems that are sometimes associated with PTSD and that warrant further inquiry:

- Anger or hostility
- Social isolation
- Grossly disturbed interpersonal relationships (e.g., violence in intimate relationships, inappropriate sexual behaviors)
- A wide variety of somatic complaints
- Smoking
- Poor nutrition
- Poor self-care

Patients vary greatly in degree of impairment. For example, some individuals may exhibit high levels of interpersonal, social, and vocational functioning, whereas others may be totally incapacitated and may appear to have a mental illness such as chronic schizophrenia.

If trauma or PTSD is suspected, a sensitive and careful exploration is extremely important. Obtaining a trauma history is an essential first step in diagnosing PTSD and distinguishing it from other major mental disorders. Although patients most often welcome the opportunity to talk about their trauma, it can often be stressful for them. At first, the discussion will likely be quite brief; and at that point, the patient can be referred to a psychiatrist or psychologist for further evaluation. Initially American Indian and Alaska Native Veterans, like most people, may be
more open to meeting with a "stress management" clinician - one who is also a specialist in PTSD, depression, and alcohol or drug abuse - than to be referred to a mental health practitioner.

A four-question, symptom-related paper-and-pencil screening instrument can be used in primary care and other medical settings (Prins and Kimerling, 2004). This PTSD screening instrument has shown promising psychometric properties for detecting those individuals with more severe trauma-related difficulties. A positive response to the screen does not necessarily indicate a problem with posttraumatic stress. However, it indicates the need for sensitive questioning by a helping professional. We recommend that these questions be embedded in a more comprehensive screen used to assess health behaviors, mental health problems, and perceived health difficulties. Further questioning about trauma and its effects would be warranted if a patient responded "YES" to two or more of the following items (all use yes or no response format):

Have you ever had an experience that was so frightening, horrible, or upsetting that, in the past month you...

- Have had nightmares about it or went out of your way to avoid situations that reminded you of it?
- Tried hard not the think about it or went out of your way to avoid situations that reminded you of it?
- Were constantly on guard, watchful, or easily startled?
- Felt numb or detached from others, activities, or your surroundings?

In discussing traumatic stress symptoms, it is important to inform patients that traumatic events and the distress they create can have important effects on the body and on health as well as on the patient's psychological functioning. The health care provider can explain that he or she is opening this discussion as part of an effort to provide more comprehensive health care. The patient should be made aware that greater understanding and recognition of symptoms of posttraumatic stress and, if appropriate, help from a professional will be of benefit, both physically and psychologically.

The Primary Care Provider's Role

Primary care practitioners play key roles in case identification, patient support, referral, treatment of associated medical problems, delivery of pharmacotherapy and overall patient management. In general, primary care providers should be expected neither to initiate pharmacological treatment nor to assume full responsibility for its management. The patient with PTSD will likely require, at minimum, a medication consult and on-going management by a psychiatrist experienced in PTSD treatment.

There is no question that medications and behavioral interventions can provide some symptomatic relief of anxiety, depression, insomnia, and other symptoms of
PTSD. Timely, brief psychological assistance can prevent or greatly reduce the onset or severity of PTSD and decrease the overall cost of medical care. A working model of patient management might include the following steps:

**First**
Identify a mental health or PTSD specialist (e.g., psychologist, social worker, psychiatric nurse, psychiatrist, community clinic, rape crisis center) that can act as a source of professional consultation, patient assessment, patient education, and psychological or psychiatric treatment.

**Second**
Administer a brief self-report or interview screen to all patients or to patients whose combat history or current signs or symptoms suggest the possible presence of PTSD (see PC-PTSD, or screening for PTSD on this website).

**Third**
For those patients who screen likely for PTSD, establish a plan for referral to the identified specialist or clinic. The medical provider should then ensure that the patient complies with this crucial part of his or her treatment plan.

**Finally**
An equally critical step is to maintain on-going contact with the mental health or PTSD specialist in order to monitor the patient's compliance and responses to mental health intervention.

**Trauma Exposure/PTSD Screening**
Inquiry regarding exposure to trauma and possible symptoms of PTSD can be part of a routine intake protocol. The use of screening interview questions or written questionnaires provides the practitioner with an efficient and comfortable way of introducing the topic of trauma.

If the patient has been given the written screen, the practitioner can say:
"I notice from your answers to our questionnaire that you experience some symptoms of stress. Many people have experienced extremely distressing events at some time in their lives, especially during war, and sometimes those events lead to the kinds of symptoms you have. Have you ever had an experience like that?"

If the screen has not been administered, the following sentence may help to introduce the subject:
"Many Veterans experienced extremely distressing events, such as firefights, during their military service. Did you have any experiences like that?"
For those patients who screen likely for PTSD, a previously identified referral plan, such as to a PTSD specialist or clinic, should be implemented. As previously mentioned, the medical provider should then ensure that the patient complies with this crucial part of his or her treatment plan. In order to monitor the patient's compliance and progress, the medical provider should maintain on-going contact with the mental health or PTSD specialist.

The Psychiatrist's Role

The psychiatrist can play important roles in evaluation, case management, and pharmacotherapy. In addition, the psychiatrist can provide the patient with appropriate additional referrals. The psychiatrist's prescription and management of the patient's medications is often pivotal to overall improvement. A main function of medications is to provide a degree of relief in order to facilitate patients' participation in psychotherapy. In most cases, combined pharmacological and psychotherapeutic treatment for PTSD is more effective than either conducted alone. The following topics are described below:

- Associated Psychophysiological Changes
- Medications
- Comorbidities and Medication Selection

Associated Psychophysiological Changes

Research indicates that PTSD may be associated with stable and enduring neurobiological alterations of both the central and autonomic nervous systems. Neuropharmacologic and neuroendocrine abnormalities have been detected in the noradrenergic, hypothalamic-pituitary-adrenocortical, and endogenous opioid systems - all of which have direct effects on physiology, mental health, and adaptive functioning.

More specifically psychophysiological alterations associated with PTSD include hyperarousal of the sympathetic nervous system, increased sensitivity and augmentation of the acoustic-startle-eyeblink reflex, a reduced pattern of auditory evoked cortical potentials, and sleep abnormalities. PTSD results in vulnerabilities to abnormalities of thyroid functioning and other hormone fluctuations, and increased susceptibility to infections and immunologic disorders. Other associated difficulties include problems with pain perception, pain tolerance, chronic pain, and gastrointestinal disturbance.

Medications

Unfortunately, there is a paucity of published literature on pharmacotherapy for PTSD. Further, the complexity of PTSD makes it difficult to predict which classes of drugs might be expected to improve which clusters of symptoms.
In most, but not all, trials, improvement has been achieved with tricyclic antidepressants such as imipramine, amitriptyline, or possibly nortriptyline or desipramine. Desipramine and nortriptyline generally have less anticholinergic, sedative, or orthostatic hypotension effects and may be useful for the elderly patient. Additionally the monoamine oxidase inhibitors (MAOIs; e.g., phenelzine), the selective serotonin reuptake inhibitors (SSRIs; e.g., fluoxetine), and propanolol have offered improvement.

Choice of medication may be tailored to specific focal symptoms. For example, intrusive and avoidant symptoms may be improved with tricyclics, MAOIs, SSRIs, and possibly valproate. However, these may prove to be more recalcitrant to psychopharmacological treatment than other symptoms. The SSRIs (e.g., fluoxetine, paroxetine, sertraline) are effective for symptoms such as rage, aggression, impulsivity, and suicidal behaviors. However, because of medication side effects such as arousal or insomnia, the SSRIs may be intolerable for some patients.

In general, pharmacological treatment may begin with an SSRI. However, should this prove to be too stimulating, a 5HT2 antagonist (e.g., nefazadone) may be warranted. General dose ranges for the SSRIs are: fluoxetine (20-60mg); sertraline (50-200mg); paroxetine (10-50mg). Titrating the dose upward too fast or stopping too soon are often the reasons for the apparent ineffectiveness of the SSRIs.

Therefore, the SSRI should be increased gradually toward the higher dosage spectrum and should continue at this level for three months. At this point, the patient should be reevaluated for residual PTSD symptoms. To address symptoms not otherwise controlled by SSRIs, other medications may then be added to the regimen. To assist the patient and inform any other health care provider, give the patient a wallet card stating your prescribed medications.

**Comorbidities and Medication Selection**

Adding further complication to the choice of medications is the likely presence of one or more comorbid medical and psychiatric disorders. For example, a careful screening must be made for the presence of a Bipolar disorder. In this case, because of their arousal features, SSRIs as first line medications are contraindicated. Treatment may begin with valproic acid, carbamazepine, gabapentin, venlafaxine, or bupropion. Once the patient is stabilized SSRIs may then be cautiously added to the drug regimen.

When selecting medications, the clinician must try to prescribe a drug that might be expected to improve PTSD symptoms and the comorbid disorder(s) concurrently. Unfortunately little is known about the influence of comorbid disorders on choice of medications because most drug trials have not attempted to balance the various experimental groups with respect to comorbidities. However, taken as a whole, the most common comorbid disorders (depression, panic disorder, obsessive-
compulsive disorder, and chemical abuse or dependency) respond to SSRI treatment.

The complex symptoms of PTSD require careful monitoring and management. For example, the SSRIs (as with many other antidepressant agents) can potentially interact with many other drugs metabolized by the liver. In addition, the effectiveness of any antidepressant may be affected by other drug therapy. Further, drug-drug interactions may pose risks. Therefore, as with any medication, it is necessary to review medication profiles prior to prescribing any agent.

As always, physicians should be alert to the likelihood of dropout from medical care as a result of medication side effects and should, therefore, take prophylactic steps to increase compliance with treatments. A watchful eye can aid in preventing compliance problems, recidivism, dropout, and complications. In particular, adequate dosing and length of trial is necessary. Many American Indian and Alaska Native Veterans who suffer from PTSD also drink heavily and providers should be especially cautious of interactions between alcohol and medications.

The Mental Health Provider's Role: Therapies

Mental health professionals have a variety of assessment tools available to them to appropriately diagnose PTSD. The Clinician Administered PTSD Scale (CAPS) is a structured clinical interview designed to assess adults for the seventeen symptoms of PTSD outlined in DSM-IV along with five associated features (guilt, dissociation, derealization, depersonalization, and reduction in awareness of surroundings). The CAPS has standardized prompts and follow-up questions, and a behaviorally-anchored 5-point rating scale corresponding to the frequency and intensity of each symptom listed.

Mental health professionals can offer expert education, counseling, and psychotherapeutic interventions that have been empirically shown to help recovery from PTSD. Many psychotherapeutic approaches have recognized merit in the treatment of PTSD. A survey of experts in the field of PTSD recognized cognitive therapy, exposure therapy, anxiety management training, and psychoeducation as the psychotherapeutic treatments of choice for adults.

"He came back [from the VA treatment program] and he said, Oh, I feel so good, you know... he talked about how the counselors helped him into getting a lot of this out and talking about all this stuff that was ugly to him, and he never even talked about it to anybody. And there was even a time that he said he missed 'em and that he wished that they could be there."

Below several types of therapy are described:

- Cognitive-behavioral therapy (CBT): Includes cognitive therapy and types of exposure therapy
- Anxiety management training (AMT)
• Psychoeducation

**Cognitive-behavioral therapy (CBT)**

Among psychotherapies, CBT treatments have received the most empirical study. CBT methods, together with psychoeducation, are the most recommended psychotherapy techniques. CBT includes methods such as:

- Cognitive therapy—modification of unrealistic assumptions, beliefs, and automatic thoughts that lead to disturbing emotions and impaired functioning.
- Imaginal exposure—the repeated verbal recounting of the traumatic memories until they no longer evoke high levels of distress.
- In vivo exposure—confrontation with situations that are now safe, but which the person avoids because they have become associated with the trauma and trigger strong fear. Repeated exposures facilitate habituation to the feared situation.

**Anxiety management training (AMT)**

AMT techniques may also be classified as CBT techniques. AMT teaches a set of tools to deal with stress and anxiety.

- Relaxation training—management of fear and anxiety through the systematic relaxation of the major muscle groups or the imagining of relaxing images.
- Breathing retraining—the use of slow abdominal breathing to help the patient relax and/or avoid hyperventilation with its unpleasant and often frightening physical symptoms.
- Assertiveness training—teaches expression of one's wishes, opinions, and emotions appropriately and without alienating others.

**Psychoeducation**

Psychoeducation provides patients (and often families) with information about the symptoms of and the various treatments for PTSD.

Psychotherapy conceptualized and implemented with sensitivity to the cultural context of American Indian and Alaska Native Veterans can provide a powerful healing experience for the patient and a learning experience for the practitioner.

**Toward Culturally Competent Care**

The construct of PTSD has been criticized from the perspective of cross-cultural psychology and medical anthropology because it has usually been diagnosed by clinicians from Western industrialized nations working with patients from a similar background. Major gaps exist in our understanding of the effects of ethnicity and culture on the phenomenology of posttraumatic syndromes. Only recently have
vigoruous ethnocultural strategies been employed to delineate possible differences in
cross-cultural impacts of traumatic exposure and its intrapsychic effects and clinical
manifestations.

It is important that both psychological and pharmacological interventions be
adapted carefully to the cultural and spiritual expectations and realities of American
Indian and Alaska Native Veterans. The DSM-IV provides an outline for the cultural
formulation of a patient’s signs and symptoms within the patient’s cultural context:

- Ascertain the cultural identity of the individual.
- Consider the extent of involvement in both the culture of origin and the
  majority culture. Also note language abilities, use, and preference(s).
- Identify and explain the symptoms within the cultural context.
- Identify the predominant idioms of distress through which symptoms or the
  need for social support are communicated (e.g. "nerves," possessing spirits,
  somatic complaints, inexplicable misfortune).
- Identify the meaning and perceived severity of the individual's symptoms in
  relation to the norms of the cultural reference group.
- Identify any local illness category used by the individual's family and
  community to identify the condition.
- Identify the perceived causes or explanatory models that the individual and
  the reference group use to explain the illness.
- Identify current preferences for and past experiences with mainstream,
  alternative, and traditional sources of care.
- Identify social supports and stressors.

Cultural factors related to the psychosocial environment and levels of functioning
include culturally relevant interpretations of social stressors, available social
supports, and levels of functioning and disability. This would include kinship ties
and the role of religion/spirituality in the patient's life.

Facilitate awareness of cultural differences between the individual and the clinician.
Consider such factors as:

- Difficulty in communicating in the individual's first language.
- Difficulty in eliciting symptoms and understanding their cultural significance.
- Difficulty in negotiating an appropriate relationship or an appropriate level of
  intimacy.
- Difficulty in determining whether a behavior is normative or pathological.

**Some practical factors to keep in mind**

Conceptualize PTSD as a wounding of the spirit. A disturbance has occurred in the
connectedness, reciprocity, balance, and coherence of the veteran's world. Start
with a full measure of patience and aim for basic human understanding.
Let the veteran know you are interested in his or her well being.

Listen with empathy.

Respect silences; allow long latencies in responses. Do not interrupt the speaker. This may be interpreted as "you're not really listening."

Selectively validate feelings.

Do not expect prolonged "eye contact", as the veteran will likely feel more comfortable looking away from you, rather than at you.

Family and clan are very important. Options may need to be discussed with the group prior to a decision being made. Elders are honored.

American Indian and Alaska Native Veterans' culture is based on the sharing of resources.

"Hallucinations" are an important part of the American Indian and Alaska Native spirituality. In American Indian culture, people may "see spirits."

Try to obtain the nature of what the spirit did or said. If the message was bad or evil, then consider pathology.

American Indian and Alaska Native Veterans' cultures share a present orientation; therefore memories of trauma often are not "put in the past" and thus may be "brought up" quickly and with as great an intensity as when they happened.
### Traditional Native American values that may clash with dominate society values

<table>
<thead>
<tr>
<th>Dominant Society Values</th>
<th>Native-American Traditional Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self is the priority (Take care of #1)</td>
<td>Tribe and extended family first, before self</td>
</tr>
<tr>
<td>Prepare for tomorrow</td>
<td>Today (is a good day)</td>
</tr>
<tr>
<td>Time (linear; use every minute)</td>
<td>Time - a right time/a right place/non-linear</td>
</tr>
<tr>
<td>Youth (value rich, young, beautiful)</td>
<td>Age (knowledge, wisdom)</td>
</tr>
<tr>
<td>Compete to &quot;get ahead&quot;</td>
<td>Cooperate</td>
</tr>
<tr>
<td>Be aggressive</td>
<td>Be patient</td>
</tr>
<tr>
<td>Speak up</td>
<td>Listen (and you'll learn)</td>
</tr>
<tr>
<td>Take and save</td>
<td>Give and share</td>
</tr>
<tr>
<td>Conquer nature</td>
<td>Live in harmony (with all things)</td>
</tr>
<tr>
<td>Skepticism and logical thinking are valued</td>
<td>Great mystery - the intuitive honored</td>
</tr>
<tr>
<td>Self is more important than group</td>
<td>Humility</td>
</tr>
<tr>
<td>Religion is a part of life</td>
<td>A spiritual life (religion not &quot;separate&quot;)</td>
</tr>
<tr>
<td>Be a critical thinker</td>
<td>Don't criticize your people</td>
</tr>
<tr>
<td>Live with your mind</td>
<td>Live with your hands - manual activity is sacred</td>
</tr>
<tr>
<td>Orient yourself to a house and job</td>
<td>Orient yourself to the land</td>
</tr>
<tr>
<td>You're in America: speak English!</td>
<td>Cherish your own language and speak it when possible</td>
</tr>
<tr>
<td>Discipline your own children</td>
<td>Children are a gift of the Great Spirit to be shared with others</td>
</tr>
<tr>
<td>Have a rule for every contingency</td>
<td>Few rules are best, loosely written and flexible</td>
</tr>
<tr>
<td>Have instruments judge for you</td>
<td>Judge things for yourself</td>
</tr>
</tbody>
</table>
4. Cultural Formulation of a Clinical Case of PTSD – part 1

A Clinical Case presented by Spero M. Manson
THE WOUNDED SPIRIT: A Cultural Formulation of Posttraumatic Stress Disorder
Clinical History

A. Patient identification

J. is a 45 year old Indian male, married, the father of 4 sons and 3 daughters, ages 8 to 20. He, his wife, and S of their children live in a small, rural community on a large reservation in Arizona. His wife has a part-time job in a tribal human services program and sells craft items which she makes. J. is sporadically employed as a manual laborer. The family maintains some sheep and relocates to a seasonal camp during the summer months. J. served as a Marine Corps infantry squad leader in Vietnam during 1968-69. He most recently was seen on an outpatient basis through the Gallup-based VA medical program, where he participates in an all-Indian posttraumatic stress disorder (PTSD) support group.

B. History of present illness

In 1990, shortly after the death of his father due to a heart attack, and threatened by the possible loss of his wife and children, J. was admitted to the local Veterans Administration Medical Center (VAMC), having been referred by an Indian-operated residential alcohol treatment program in a distant city. He was evaluated extensively and confirmed as alcohol dependent. J.'s daily drinking substantially affected his ability to secure and hold a job, led to frequent fist-fights, and was consistently related to the physical abuse of his wife. His driver's license had been revoked for numerous violations. He reported blacking out and having "the shakes" while incarcerated in the reservation and nearby county jails. J. initially was treated for this condition in the VAMC's residential alcohol program.

J.'s symptoms of alcoholism were discovered to have begun in early 1969, while he was in Vietnam. He spent most of his tour in the bush, on patrol, conducting ambushes involving heavy combat. J. reported some racial discrimination, notably being called "Chief," always expected to serve as point on patrols because he is Indian, and encountering several near brushes with death when he was mistaken for the enemy by his fellow infantrymen. He was wounded, suffering serious shrapnel injuries of the chest, right arm, and hand, of which he recovered only partial use.

During treatment for his alcohol dependence at the VAMC, it became apparent that J. experienced intrusive thoughts almost daily, displayed marked hypervigilance, and exhibited a range of avoidant symptoms. He acknowledged feeling alienated from others and having gradually withdrawn from extended social contact. J.'s
affect was restricted; he struggled to avoid thinking about traumatic events. The possibility of dying at any time preoccupied him. His sleep was seriously disturbed; J. reported distressing dreams, often awakening drenched in sweat. He became noticeably irritated, often angry. Sudden flashbacks of combat were common and unpredictable. J. placed the onset of these symptoms as occurring soon after his wounding, concurrent with the significant alteration in drinking behavior. A provisional diagnosis of posttraumatic stress disorder was made. J. completed treatment for his alcoholism at the VAMC and was transferred to an inpatient unit specializing in the treatment of combat trauma.

C. Psychiatric history and previous treatment

Whereas J. previously had drunk alcohol in binge-like fashion, in 1969 while recovering from his wounds he began to drink heavily on a daily basis. This abated somewhat once he returned home. From 1970 through 1990, his drinking remained highly problematic, characterized by frequent multi-day binges, with intermittent periods of sobriety. J. reported numerous occasions on which he would lose consciousness while drinking. He denied more than experimental use of marijuana and cocaine. From 1970 through 1990 he was arrested repeatedly for assault, public intoxication, and D.U.I.

On at least five separate occasions between 1975 and 1990, J. was treated for alcohol dependence through tribal outpatient programs and the urban Indian residential program that referred him to the VAMC. Previously unsuccessful attempts to treat his alcoholism were due, in part, to a lack of aftercare and enmeshment in dysfunctional peer relationships.

D. Social and developmental history

J. was born in an Indian Health Service (IHS) hospital on his reservation; there were no complications during delivery. He grew up in a small, rural community with his parents and 7 siblings, of which he is the second oldest, living in a housing cluster that included his maternal grandparents and two maternal aunts and their immediate families. J. experimented with alcohol on several occasions during his early teens but reported no serious consequences. He attended boarding school some distance from his home. J. disliked school, describing it as "very difficult" and the teachers as "harsh." Upon further inquiry, he reported frequent and severe beatings by school staff with a belt for being disobedient, like many of the other boys. J. quit mid-way through his junior year in high school to "help out at home." Eighteen months later, like his father and two uncles before him, he enlisted in the Marines. He married in 1971, shortly after his return to the U.S. with an honorable discharge from the military. J. and his wife established a household near her parents, approximately 70 miles from his natal home, where they continue to reside. He recently began taking GED classes at the tribal community college, he works seasonally in construction, and he plans to seek vocational training.
E. Family history

J. acknowledges alcoholism among two of his four brothers and his father's likely history of PTSD, a World War II combat veteran who served in the Pacific Theater. Several male members on both sides of J.'s family have obvious alcohol problems; currently two younger siblings suffer from "liver" problems, presumably cirrhosis, for which they have been hospitalized on past occasions. His father also appeared to suffer from PTSD, plagued by nightmares, displaying unpredictable irritation, and avoiding certain activities. J.'s father, though previously alcohol dependent as well, had been sober for the 20 years prior to his death.

F. Course and outcome

After attending one month of a 12-week course of treatment, during which the provisional diagnosis of PTSD was confirmed, J. left the VAMC's PTSD in-patient unit against medical advice, sober, but still experiencing significant symptoms of trauma. He returned to the reservation. Some months later, through local outreach, J. learned of a Gallup support group, which he has attended off and on - except during summers - for three years.

The VAMC treatment environment had enabled him to examine his use of alcohol as it related to his military experience, one of the first times that he reported talking about the latter outside of his circle of "drinking buddies," virtually all of whom were themselves Indian Vietnam combat Veterans. However, being the only Indian in the PTSD in-patient unit, its greater intensity of intervention, and protracted absence from family led to his early departure from this residential program. J. remains open to counseling for his combat-related trauma and, as noted, attends a local VA support group.

J. has remained sober, but periodically experiences difficulty sleeping, flashbacks, and bursts of anger, albeit less frequently than before. He continues to feel "on guard" and "a little uneasy" around people. J. still dreams of his dead soldier companions who call for him to join them. But he knows that he cannot. He occasionally hears his father's voice "speaking Indian" to him, which is more comforting than fearful, but nonetheless troublesome.

G. Diagnostic formulation

Axis I:

309.81 Posttraumatic Stress Disorder, Chronic 303.90 Alcohol Dependence with Physiological Dependence, Sustained Full Remission

Axis II:

Undetermined
**Axis III:**
959.4 Injury, hand

**Axis IV:**
Current: Marital difficulties, moderate; Residual grief for loss of father, mild
Past: Combat-related trauma, extreme; Marital difficulties, extreme; Unemployment, extreme; Childhood physical abuse, moderate; Poverty, moderate; Racial discrimination, moderate

**Axis V:**
Highest past year: GAF = 75; Current GAF = 80
5. Cultural Formulation of a Clinical Case of PTSD - part 2

A. Cultural identity

Cultural reference group(s)
J. is a full-blood (4/4's quantum) and an enrolled member of a southwestern American Indian tribe residing largely in Arizona; both of his parents are also tribal members, as are his wife and children.

Language
He speaks and understands English moderately well. J. is fluent in his native language, speaking it most of the time in his home setting and among family and friends. The children also are conversant in his native language, but generally more adept than he in English, which is predominant in school and among their peers.

Cultural factors in development
On his mother's side, J. is a descendant of a family of medicine people, hand-tremblers (diagnosticians) among the women and singers (healers) among the men. Consequently there have been expectations that he would play a leadership role in the cultural and spiritual life of the community. Boarding school interrupted J.'s participation in some of the important aspects of local ceremonial life, but his mother's family worked hard to include him in critical events.

J.'s severe and frequent physical punishment at boarding school was related to issues of identity. He was beaten regularly by non-Indian staff for speaking his native language, for wearing his hair long, and for running away on a number of occasions - all home to his family. J., afraid of ridicule and harassment, attributes his reluctance to share the cultural aspects of his personal background with fellow infantrymen to this experience.

B. Cultural explanations of the illness

Predominant idioms of distress and local illness categories
The pattern of symptoms presented by J. is widely acknowledged as a real problem in his community although it has no consistently specific label in local terms. Until recently tribal members had never heard of PTSD, but now they sometimes refer to it as the "wounded spirit." J.'s culture typically employs etiologic rather than descriptive categories to refer to illness. Here, the consequences of being a warrior
and participating in combat have long been recognized. Indeed, a ceremony has evolved to prevent as well as treat the underlying causes of these consequences.

Meaning and severity of symptoms in relation to cultural norms

Cultural dynamics clearly influence J.'s problem drinking and subsequent alcohol dependence. Talking about the traumas that J. experienced poses psychologically and culturally constructed risks for him. Group drinking, most often with other Veterans, is one of the few contexts that frees him from these risks in his community. Recognition of the risks of talking about such traumas and the culturally ascribed role of alcohol in permitting such talk helps to explain, at one level, why J. maintained a lifestyle of heavy drinking for 20 years after his return from Vietnam. The resurrection of the agony, fear, guilt, sorrow, and horror associated with combat is done while being "blanked out," to use the local term. Veterans claim to have no memory of what transpired when they were drinking, what they talked about, whether they wept, or who fought. It is this ability of alcohol - to enable one to disclose intimate details about "Nam," and yet at the same time forget it for even a brief moment - that many Indian Veterans cite as the most important reason for their drinking.

J's hearing his father's voice years following the death is not considered by his tribal community to be out of the ordinary. However, it is uncommon to talk openly about these experiences or to dwell at much length on the death of a loved one, as doing so may pose a serious risk to the individual and to those around him. Thus, J. who was not able to participate in the brief, intense period of ritual mourning at the time of his father's death, but now is capable of doing so, finds few cultural avenues open to him to resolve this enormous sense of loss.

Perceived causes and explanatory models

J.'s tribal community subscribes to a distinct philosophy of life captured in the phrase sb'a naghai bik'e hozhq. The first half of this phrase (sb'a nagai) refers to spirituality, an individual's goal or quest to attain eternal life and physically to live his mortal life to the fullest extent. Sb'a refers to old age and naghai to the attainment of a goal, specifically the process or effort of getting there. Bik’e hozhq, the second part of the phrase, refers to the beauty of this process. These two main parts of the phrase also embody female and male identity, respectively, which must be balanced in order to maintain a positive, harmonious self. It is this balance that underpins one's personal, physical, mental, emotional, and spiritual health. In J.'s view, the Vietnam War and failure to participate in the culturally prescribed grieving process immediately after his father's death have upset this harmony. The consequences - alcoholism and PTSD - kept him from pursuing its restoration.
Help-seeking experiences and plans

As noted earlier, J. attends a VA-sponsored support group comprised of all Indian Vietnam Veterans. This group functions as an important substitute for the circle of "Indian drinking buddies" from whom J. separated as a part of his successful alcohol treatment. The regular summer hiatus in his attendance relates to familial responsibilities, namely sheep-herding at summer camps, and to his pow-wow activities, which bridge his absences from the support group. The same ethnicity composition of the VA support group proved to be important to J. His discomfort with the brief PTSD inpatient experience stemmed from different styles of disclosure, expectations in regard to reflexivity, and therapeutic group membership defined exclusively on the basis of status as a combat veteran.

Until 1991, J. had participated sporadically in the Native American Church. His reimmersion, and now steady involvement, in it provides an understanding of the forces that led to his drinking, ongoing reinforcement of the decision to remain sober, and encouragement to continue positive life changes. The roadman who leads the services that J. regularly attends is himself a Vietnam combat veteran. Thus, much of the symbolism contained in the ritual structure (e.g., an altar shaped as a combat-V; Marine flag upon which the staff, eagle feather fan, and sage are placed) are relevant to this other dimension of J.'s identity.

J. feels that he is ready to benefit from the major tribal ceremonial intended to bless and purify its warriors. His family is busily preparing for that event, which is quite costly and labor intensive.

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

Social stressors

Steady employment opportunities are rare in J.'s community. Thus, he has chosen to attend community college to complete his GED and prepare for vocational training. This is not easy but is made possible by the shared resources (food, money, transportation) of the large extended family with which he resides. Work is sporadic for him, but he readily seeks odd jobs.

Social supports

J. received active encouragement from family and the community as he began to work seriously on sobriety and recovery from war trauma. Introduced through Native American Church contacts, members of a local gourd society sought him out and invited him to join them. He did and participates in their activities with increasing frequency.
Levels of functioning and disability
As a consequence of this support, J. just entered a physical rehabilitation program at the VA center, which has helped him to cope better with the handicap posed by his injured hand. Previously the mere mention of this disability sent him into a hostile rage, with a lengthy tirade - not entirely unfounded - about the poor quality and insensitivity of medical care.

J. has begun to visualize social and economic stability in his future. Although challenges remain, notably the successful resolution of remaining PTSD symptoms, his overall functioning has improved and is expected to continue to do so.

D. Cultural elements of the clinician-patient relationship
Upon presentation at the Gallup VA outpatient medical program, J. already had some experience with majority behavioral health services. The primary providers at the program were non-Indian but experienced in working with Veterans from J.'s tribe. Hence, after reviewing his case, they recommended the all-Indian support group which has worked well. Moreover, his positive experience with these providers increased J.’s respect for their abilities and has led him to seek periodic counseling from them in an adjunctive fashion. This counseling has focused on cognitive-behavioral strategies for managing his anger and on recognizing situations that consistently prove to be problematic for him. Neither they nor he discuss underlying causes in this regard but focus instead on changing the overt behaviors and how J. thinks about them. J. and his providers have talked about his upcoming ceremonial, for which the latter have voiced support.

E. Overall cultural assessment
This is a complex presentation of an American Indian patient with multiple problems: combat-related trauma, alcohol dependence, a history of childhood physical abuse, and bereavement. Accurate assessment and treatment of his long-term PTSD symptoms initially were precluded by the focus on his alcoholism. This was inevitable given the particular array of services available in his community and the lack of awareness of PTSD in general. Once his alcohol abuse was controlled, J. sought appropriate guidance and treatment for his trauma-related symptoms, first from the VA and subsequently from traditional cultural resources. J.’s bi-cultural identity allowed him to be open to different modalities of help, but it also presented challenges for both Indian and non-Indian providers to understand fully his needs and resources. The restricted nature of culturally prescribed mourning practices in his tribe, coupled with severe drinking at the time of his father's death, may have contributed to still unresolved grief.

J.'s residential alcohol treatment proved effective because it separated J. from his "Indian drinking buddies," addressed issues specific to American Indians, and allowed him to acknowledge possible links between his problems with alcohol and
combat trauma. J.'s initial reticence to seek help from local cultural resources may have been compounded by significant insults to his ethnic identity - earlier at boarding school and later in the military - thereby confusing his sense of self. His brief tenure in the PTSD inpatient program underscored the severity of his symptomatology, its relationship to Vietnam, and commonality among combat Veterans. However, the alien nature of that treatment experience also emphasized the need for something different, more familiar, which J. initially found in the Indian Vietnam veteran support group.

J's comfort with this support group enabled him to explore his combat trauma more deeply and in a culturally appropriate fashion, and also awakened him to the physical abuse he suffered in boarding school; something shared with many of these Veterans. A sense of ethnic pride emerged from the bonding that ensued. Moreover, he felt able to seek more narrowly defined help from non-Indian providers at the Gallup VA program. These gains facilitated his joining a local gourd society, which further reinforced feelings of belonging, connection, and dignity as a warrior.

Cultural values surrounding family and a large extended kin network have kept important resources in place for J., even during times when he severely tested those commitments. He now is drawing upon them as he pursues significant self-improvement.

Involvement in the Native American Church has helped J. to struggle effectively with the reasons for his drinking, to continue self-reflection, and to maintain a life plan. That the roadman also is a Vietnam veteran encourages further attention to shared traumatic experiences and the ways in which one may seek to escape their memory.

J. has a great deal of work before him. His PTSD symptoms are impairing. He looks hopefully to the tribal ceremonial to assist with the resolution of their cause. Continued work with VA counselors, the support group, and the gourd society may have long-term benefits along these lines as well. Perhaps most difficult is the residual grief over the death of his father. The options within his culture by which to process these feelings are less clear.

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6. Summary, References, and Resources

This completes the Wounded Spirits Ailing Hearts Training Guide. We hope you have found this information useful. Other videos and information on a variety of ethnocultural groups can be found on the National Center for PTSD’s main website.

References and Resources

Below is a list of some helpful references and resources as well as acknowledgements and information about the development of this program.

• Selected Resources for American Indian/Alaska Natives, including IHS locations
• Selected References
• Dedication and Acknowledgements
• Faculty and Strategic Planning Committee
• Program Development Assistance
Selected Resources - American Indian/Alaska Natives

Indian Health Service (202) 273-5674
Department of the Interior
Bureau of Indian Affairs (202) 208-3711
Ancestry and Benefits: www.doi.gov/benefits
Indian Health Service: www.ihs.gov
American Indian and Alaska Native Mental Health Programs: http://aianp.uchsc.edu/
Department of the Interior - Bureau of Indian Affairs: www.doi.gov/bia

1849 C. Street NW
Washington, DC 20240-0001
office (202) 208-3711
FAX (202) 501-1516
This site provides many links for services for Native Americans (e.g. Indian Health Services, Tribal Leaders, Area Offices, Facilities, and News)

Indian Health Service List Area Offices and Geographic Locations

Aberdeen Area Indian Health Service
Federal Building
115 Fourth Avenue, Southeast
Aberdeen, South Dakota 57401
Telephone: (605) 226-7581
Geographic Region: Iowa, Nebraska, North Dakota, South Dakota

Alaska Area Indian Health Service
4141 Ambassador Drive
Anchorage, AK 99508-5928
Telephone: (907) 729-3686
Geographic Region: Alaska

Albuquerque Area Indian Health Service
5300 Homestead Road, N.E.
Albuquerque, New Mexico 87110
Telephone: (505) 248-4500
Geographic Region: Colorado, New Mexico
Bemidji Area Indian Health Service
522 Minnesota Ave. N.W.
Bemidji, Minnesota 56601
Telephone: (218) 759-3412
Geographic Region: Minnesota, Wisconsin

Billings Area Indian Health Service
P.O. Box 2143
Billings, Montana 59103
Telephone: (406) 247-7107
Geographic Region: Montana, Wyoming

California Area Indian Health Service
Suite 200
1825 Bell Street
Sacramento, California 95825-1097
Telephone: (916) 566-7020
Geographic Region: California

Nashville Area Indian Health Service
711 Stewarts Ferry Pike
Nashville, Tennessee 37214-2634
Telephone: (615) 736-2400
Geographic Region: Alabama, Arkansas, Connecticut, Delaware, Florida, Georgia, Illinois, Kentucky, Indiana, Maine, Maryland, Massachusetts, Mississippi, Missouri, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia

Navajo Area Indian Health Service
P.O. Box 9020
Window Rock, Arizona 86515-9020
Telephone: (520) 871-5811
Geographic Region: Navajo Nation (portions of Arizona, Colorado, New Mexico, Utah)

Oklahoma Area Indian Health Service
Five Corporate Plaza
3625 N.W. 56th Street
Oklahoma City, Oklahoma 73112
Telephone: (405) 951-3768
Geographic Region: Kansas, Oklahoma

Phoenix Area Indian Health Service
Two Renaissance Square, Suite 600
Phoenix, Arizona 85004-4424
Telephone: (602) 364-5039
Geographic Region: Arizona, Nevada, Utah

**Portland Area Indian Health Service**
Room 476
1220 S.W Third Avenue
Portland, Oregon 97204-2892
Telephone: (503) 326-2020
Geographic Region: Idaho, Oregon, Washington

**Tucson Area Indian Health Service**
7900 South "J" Stock Road
Tucson, Arizona 85746-9352
Telephone: (602) 295-2406
Geographic Region: (portions of) Arizona

**Selected References**


Dedication and Acknowledgments

Dedication

This Guide is dedicated to the memory of Angie and Sam Loudhawk. Their triumphs give hope to all who journey along the same path.

Acknowledgments

The Department of Veterans Affairs would like to thank the people of the Indian Nations for their contributions to this program:
Oglala Lakota: Pine Ridge, SD
Rosebud Sioux Tribe: Rosebud, SD
Navajo Nation: Window Rock, AZ and Chinle, AZ
Navajo Nation Film Office: Window Rock, AZ

**Special Thanks To:**
Anthony Milford
Elbert "El" R. Wheeler
Navajo Nation Museum
Chinle Vet Center
Window Rock, AZ
Chinle, Arizona
## Faculty and Strategic Planning Committee

### Faculty* and Strategic Planning Committee

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# Faculty and Strategic Planning Committee

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