

Gender Differences in the Historical Trauma Response Among the Lakota

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SUMMARY. The historical trauma response is a constellation of characteristics associated with massive cumulative group trauma across generations, similar to those found among Jewish Holocaust survivors and descendants. Trauma response features include elevated mortality rates and health problems emanating from heart disease, hypertension, alcohol abuse, and suicidal behavior. This article explores gender differences in the historical trauma response among the Lakota (Teton Sioux) and the correlation with health and mental health statistics.

The theory of a Lakota historical trauma response is first explained. Traditional gender roles are described in combination with modifications engendered by traumatic Lakota history. Then, data from a study on Lakota historical trauma are presented, including gender differences in response to an experimental intervention aimed at facilitating a trauma resolution process.

The data revealed significant gender differences. The sample of women presented initially with a greater degree of conscious affective experience of historical trauma. In contrast, the men reported more lifespan trauma associated with boarding school attendance and appeared to be at an earlier stage of grief. However, at the end of the intervention, women's experience of survivor guilt—a significant trauma response feature—decreased while men's consciousness of historical trauma and unresolved grief increased. Degree of traditional presentation-of-self, including phenotype, appeared to interact with gender to place male participants at greater risk for being traumatized over the lifespan and perhaps subsequently utilizing more rigid defenses against the con-

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scious experience of the trauma with the exception of survivor guilt. The article concludes with a discussion of health and mental health implications for prevention and treatment of the trauma response which could positively impact the health status of the Lakota. Recommendations for future research are suggested. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: getinfo@haworthpressinc.com]

The Lakota (Teton Sioux) *historical trauma response* is a constellation of characteristics associated with massive cumulative group trauma across generations, at least since the 1890 Wounded Knee Massacre, and is similar to traits identified for Jewish Holocaust descendants (Fogelman, 1988; Kestenberg, 1982/1990). Trauma response features include elevated mortality rates and health problems emanating from heart disease, hypertension, alcohol abuse, depression, and suicidal behavior. This article explores gender differences in the historical trauma response among the Lakota and the correlation with health and mental health statistics.

The article begins with a description of historical trauma theory in which traditional gender roles as well as the modifications engendered by traumatic Lakota history are briefly examined. Literature on health and mental health problems and their association with trauma are explored, including available data on gender differences, and other risk factors associated with trauma for American Indians are examined. Then, gender is explored in data from a small quantitative study on Lakota historical trauma including an examination of an intervening variable, degree of traditional presentation-of-self. The article concludes with a discussion of prevention, early identification, and intervention of the trauma response which could positively impact the health status of the Lakota. Recommendations for future research are suggested.

THE LAKOTA HISTORICAL TRAUMA RESPONSE

Lakota historical trauma is defined as cumulative and collective emotional and psychological injury both over the life span and across generations, resulting from a cataclysmic history of genocide. It is analogous to other massive generational group trauma features and is grounded in the trauma literature (van der Kolk, 1987, 1996). The

constellation of features that appear in reaction to this traumatic history is called the Lakota historical trauma response (Brave Heart, 1998). The attending *historical unresolved grief* that results from the cumulative trauma is the impaired or delayed mourning that is part of the experience of massive loss.

Need for a Lakota Historical Trauma Response Theory

Standard Post-traumatic Stress Disorder (PTSD) nomenclature (American Psychiatric Association, 1994) fails to adequately represent American Indian trauma (Robin, Chester, & Goldman, 1996). Despite the extent of trauma reported in several studies of American Indian youth with close to two thirds affirming the experience of trauma and the respondents' perception of being seriously impacted by that trauma, many American Indian youth do not meet all of the diagnostic criteria for PTSD (Jones, Dauphinais, Sack, & Somervell, 1997; Manson, Beals, O'Neil, Piasecki, Bechtold, Keane, & Jones, 1996). Manson et al. (1996) raise questions about (a) cultural bias in the PTSD criteria and assessment instruments, (b) the possibility of a higher threshold for clinical response due to the pervasiveness and frequency of trauma among American Indians, and (c) culture influencing symptom presentation or the determination of what is pathological. Robin et al. (1996) identify the need for a way to examine the impact of a single trauma within the context of multigenerational and community trauma. The concepts of a historical trauma response and historical unresolved grief are intended to be inclusive of massive, genocidal trauma across generations upon which life span trauma is superimposed. Further, the concept of historical unresolved grief may shed light upon the prevalence of major depression among American Indians and is congruent with the concept of a traumatic depression (Davidson & Fairbank, 1993; Robin et al., 1996). Rather than utilizing proposed concepts such as complex PTSD (Herman, 1993), the Lakota historical trauma response incorporates traumatic group experiences such as the Wounded Knee Massacre and cultural constructs around indigenous grief.

Lakota Historical Trauma Response Features

Trauma response features may be manifested psychologically in symptoms such as depression, suicide, and substance abuse, as well as

somatically through heart disease and hypertension. Characteristics of the Lakota historical trauma response are congruent with those identified in the Jewish Holocaust survivor syndrome (Niederland, 1988) and survivor's child complex (Kestenberg, 1990) and include: (a) anxiety, (b) intrusive trauma imagery, (c) depression, (d) survivor guilt, (e) elevated mortality rates from cardiovascular diseases as well as suicide and other forms of violent death (Eitinger & Strom, 1973; Keehn, 1980; Nefzger, 1970; Sigal & Weinfeld, 1989), (f) identification with ancestral pain and deceased ancestors, (g) psychic numbing and poor affect tolerance, and (h) unresolved grief. These features have been identified among the Lakota in early personality studies (Erikson, 1963; Macgregor, 1946/1975; Nurge, 1970) and more recent studies (Brave Heart-Jordan, 1995; Brave Heart, 1998, 1999, in press-d).

TRADITIONAL GENDER ROLES AND RELATIONSHIPS

Traditionally, Lakota women have been esteemed in contrast to the presentation in much of the ethnographic literature (Allen, 1986; Brave Heart-Jordan, & DeBruyn, 1995). Sex roles were complementary and neither women nor children were viewed as property. Domestic violence and child abuse were not tolerated. Men were the protectors of the society. The Sacred Pipe and Lakota spiritual mores were brought by *Pte Sa Win*, the White Buffalo Calf Woman (Black Elk & Brown, 1953/1971). According to Powers (1986), oral history reveals that *Pte Sa Win* asked men (a) to share in the women's sorrow as women experience grief more deeply and carry the grief for the Nation and (b) to help women with caring for the children. Legend reveals a complementary view of traditional indigenous gender roles and relationships.

In an examination of current health-risk behaviors among the Lakota, Han, Hagel, Welty, Ross, Leonardson, and Keckler (1994) found that healthier women were more traditional—defined as having a greater degree of Lakota life style, blood, and language fluency—than less traditional women. In contrast, more acculturated males were healthier than more traditional men. The study concluded that acculturation was more stressful for women. In a study of well-educated working urban Indian women, Napholz (1995) found less depression among women who showed both masculine and feminine

traits. Traditionally Lakota women are valued for being industrious and having fortitude which may be seen, in the European American paradigm, as masculine traits.

COMORBIDITY OF THE TRAUMA RESPONSE WITH OTHER DISORDERS

Psychiatric Disorders

Cumulative trauma and PTSD may influence high rates of other psychiatric disorders among American Indians who have an elevated incidence of childhood sexual abuse; this abuse is a significant risk factor for the development of substance abuse, depression, and/or anxiety disorders (Robin et al., 1996). Excessive rates of trauma among American Indian adults as well as youth have been confirmed by more recent research (Manson et al., 1996) as well as a prevalence of depression and substance abuse which are correlated with PTSD (Robin et al., 1996).

Depression and suicide: Comorbidity and gender. Depression is the most common co-morbid condition with PTSD (Ursano, Grieger, & McCarroll, 1996). Survivors of massive trauma often develop an identification with the dead in their unresolved grief, sometimes manifested in suicidal behavior (Bergmann & Jucovy, 1982/1990; Lifton, 1968, 1988). A study among the Oglala Lakota (May, 1973) reflected that those who attempted suicide exhibited a high incidence of loss over the life span. Van Winkle and May (1993) found that completed suicides are more prevalent among young Indian males while more attempters are female (Zitzow & Desjarlait, 1994). Chronic and complicated depression appeared to be more prevalent among Northern Plains Indians (Shore, Manson, Bloom, Keepers, & Neligh, 1987) which includes the Lakota.

The suicide rate is 27.9 per 100,000 for the Aberdeen Area Indian Health Service (IHS), which includes primarily Lakota and Dakota reservations, more than twice the rate of 11.4 for the United States' general population (IHS, 1995a). The suicide attempt rate on an unspecified Lakota reservation was almost seven times that of the United States' average (Claymore, 1988). The elevated suicide rates among the Lakota are a manifestation of unresolved grief and pathological

identification with the dead (Brave Heart-Jordan, 1995; Brave Heart, 1998). In addition to unresolved grief from traumatic loss, suicide attempts and self-mutilation had high correlations with sexual abuse especially early in life (Herman & van der Kolk, 1987; Bachman, 1992).

Alcohol and/or other drug abuse. Among American Indians, substance abuse is associated with suicide (Bachman, 1992; Claymore, 1988) and childhood trauma (Robin et al., 1996). The alcoholism death rate is 89.3 per 100,000 for Indians in the Aberdeen Area compared with 6.8 for the United States (IHS, 1995). Robin et al. (1996) noted that the alcohol-related mortality rates for Indian women are three to five times higher than for women in the general United States population. Major depression was more prevalent among alcohol free Indian women than abstinent Indian men (Robin et al., 1996). However, liver disease and accident mortality, which are typically alcohol-related, are higher for men than for women (IHS, 1995b). American Indian females in residential treatment for substance abuse manifested a greater degree of family dysfunction including emotional, physical, and sexual abuse (Gutierrez, Russo, & Urbanski, 1994). The possibility of abuses experienced outside of the family, i.e., in boarding schools, was unclear.

Medical and Psychosomatic Conditions

Premenstrual related disorders have been observed among American Indian women with life span trauma, particularly abusive boarding school experiences (Brave Heart, in press-c). Physical health has been a historical problem among the Lakota since the inception of Lakota reservations in 1871 (Tanner, 1982). Indian Health Service (1995a) revealed high rates of coronary heart disease as well as hypertension and accidental deaths, particularly among the Lakota. Untreated major depression and anxiety disorders (which are elevated among Native people) have a negative effect upon health status, with major depression having the greatest impact while PTSD is next (Schonfeld, Verboncoeur, Fifer, Lipschutz, Lubeck, & Buesching, 1997). There is an association between PTSD and somatization (Pribor, Yutzy, Dean, & Wetzal, 1993; Saxe, Chinman, Berkowitz, Hall, Lieberg, Schwartz, & van der Kolk, 1994). Additionally, somatic features and depression are highly correlated on the Center for Epidemiologic Studies–Depression Scale administered to American

Indian boarding school adolescents (Dick, Beals, Keane, & Manson, 1994) which suggests an association between these two. Psychic numbing and poor affect tolerance, common with PTSD, often result in the expression of feelings somatically.

Heart and cerebrovascular diseases. Among the Lakota, the leading cause of death for both genders is heart disease (IHS, 1995b). There is a higher prevalence of heart disease among men. However, women with diabetes had higher rates of coronary heart disease (Howard, Lee, Cowan, Fabsitz, Howard, Oopik, Robbins, Savage, Yeh, & Welty, 1995). The Aberdeen Area age-adjusted mortality rate from heart disease is 237.5 per 100,000, the highest of all Indian groups and almost twice the rate of the general United States population. Lakota have higher rates of morbidity and mortality from myocardial infarctions than the general population (Hrabovsky, Welty, & Coulehan, 1989), particularly among 25-44 year olds who have higher death rates than the United States population (Welty & Coulehan, 1993). Studies within the general population reveal a co-occurrence of heart disease and psychiatric diagnoses, especially depression and anxiety, both elevated among American Indians, as well as PTSD. Psychological factors influence the development and the medical course as well as prognosis of heart disease (Hamner, 1994; Shapiro, 1996).

Cerebrovascular diseases are higher for Indian women (IHS, 1995b). The cerebrovascular mortality rate is 47.4 for the Aberdeen Area, again the highest of all Indian Health Service regions; this is almost double the United States rate of 26.8 (IHS, 1995a).

Tuberculosis. The Aberdeen Area tuberculosis death rate of 5.6 is more than five times the United States rate (IHS, 1995a). While tuberculosis itself has not been associated with PTSD, the elevated mortality rates for the Lakota place this population at risk for additional health related trauma. Further, there is a historical legacy of massive tuberculosis deaths associated with the inception of boarding schools and the reservation system (Brave Heart-Jordan, 1995; Tanner, 1982). Gender differences were not reported.

GENDER DIFFERENCES IN TRAUMA RESPONSE RISK FACTORS

Risk factors are defined here as those conditions which may predispose someone to experiencing trauma. These factors include lower life

expectancy and lower socioeconomic status, racism and oppression, and a history of generational as well as life span trauma such as boarding school attendance. Gender may interact with these risk factors and influence the presentation of symptoms. Interestingly, for another historically oppressed group, African American men showed the highest level of stress in response to trauma (Allen, 1996; Norris, 1992). This is congruent with findings that (a) men with PTSD were more likely to be substance dependent than women with PTSD (Manson et al., 1996) and (b) men have elevated suicide mortality despite women's higher attempt rates and greater incidence of major depression.

Life Expectancy and Socioeconomic Status

Premature death rates for American Indians are higher than the general population and African Americans; 31% of deaths occurred before age 45 compared with 23% for African Americans and 9% for Caucasian Americans (IHS, 1995b). This places American Indians at higher risk for traumatic grief from early losses.

Almost 50% (49.6%) of Indians in the Aberdeen Area live below the poverty level (IHS, 1995a). Unemployment is higher among Lakota males at 26.5% in the Aberdeen Area than for females at 19.4% (IHS, 1995a). On some Lakota reservations, the unemployment rate has been as high as 80% (Bureau of Indian Affairs, 1990), a substantial risk factor particularly for Lakota men. Albers (1983) identified the negative impact of European colonization upon the political status of Indian women under federal domination, gender differences in employment, and the economic balance of power between genders among the Dakotas.

Degree of Traditional Presentation-of-Self

For the purposes of this study, the degree of *traditional presentation-of-self* is utilized to include phenotype (skin color and features) as well as level of traditional identification or orientation, including fluency in Lakota. Traditional presentation-of-self may place one at more risk for racism and discrimination. Racism and oppression have been identified as conditions, coupled with traumatic group history, which may exacerbate PTSD among American Indians (Holm, 1994;

Manson et al., 1996; Silver & Wilson, 1988) and increase the frequency and affliction of PTSD among African Americans who also have elevated rates of hypertension and heart disease (Allen, 1996).

Hughes and Hertel (1990) found that darker skin color negatively impacted the socioeconomic status of African Americans, those with lighter skin having higher status; lighter skin color is still preferred within the African American community (Hall, 1992). Research is needed on the role of skin color psychosocially and biologically in hypertension among African Americans (Thomas, 1984). Montalvo (1987) emphasizes the need for more research on the impact of skin color among Latinos. Indian identity, an aspect of the presentation-of-self, was an issue for Viet Nam veterans, many with PTSD. Indian soldiers identified with the Vietnamese, more phenotypically similar than the European American soldiers who represented the historical enemy—the cavalry (Holm, 1994; Manson et al., 1996; Silver & Wilson, 1988). More research on American Indian identity is needed (Weaver, 1996), including the examination of phenotype as an important construct.

HISTORICAL TRAUMA INTERVENTION AND METHODOLOGY

The historical trauma intervention was delivered to a group of 45 Lakota men and women service providers and community leaders, focusing on the cumulative trauma response through a brief intensive psychoeducational group experience (Brave Heart-Jordan, 1995; Brave Heart, 1998). Goals included imparting a sense of mastery and control (van der Kolk, McFarlane, & van der Hart, 1996), in spite of our oppression and cumulative historical traumatization, within a safe haven—our sacred *Paha Sapa* (Black Hills). Participants were exposed to historical traumatic memories as well as opportunities for cognitive integration, necessary for effective treatment (Resick & Schnicke, 1992). Small and large group process provided opportunities for verbalization of traumatic experiences which has been found to decrease psychosomatic symptoms (Harber & Pennebaker, 1992) as well as reduce psychic numbing and increase affect tolerance. Traditional Lakota culture and ceremonies were integrated throughout the intervention which have a curative effect on PTSD (Silver & Wilson, 1988).

Responses to the intervention were examined. Self-report measures were taken at three intervals. Data collection instruments included a demographic and trauma history questionnaire prior to the intervention (T1), a Lakota Grief Experience Questionnaire (LGEQ), adapted from Barrett and Scott (1989), at T1 and at the end of the intervention (T2), and the semantic differential (Osgood, Suci, & Tannenbaum, 1957/1978) T1 and T2. The semantic differential contained concepts or stimuli followed by bipolar word pairs and a rating scale to measure meaning in three dimensions: evaluation, potency, and activity. An evaluation form at T2 and a six week follow-up measure (T3) were also collected.

The data were analyzed for each instrument using measures of central tendency, frequency, and descriptive statistics. The semantic differential was examined using paired t-tests and t-tests for independent samples.

FINDINGS

Gender Differences in Trauma History and Response

The mean age of the reservation-based study population was 43 years; 59.1% were female. There was a 97.8% completion rate. More men attended boarding school (82.4%) than women (65.4%). Although women were placed in boarding schools at a higher mean distance (139.06 miles) than men (103.64 miles), men visited home less often with 57.1% visiting three or more times per year compared with 64.7% of the women. Other gender differences are illuminated in Table 1 and include the quality of boarding school experiences with men reporting more harsh treatment overall including being hit more often (85.7%) and being sexually abused more often (28.6%) than women (17.7%).

On the Lakota Grief Experience Questionnaire (LGEQ) at T1, women (75.0%) felt more responsible to undo the pain of the historical past than men (66.6%), but men experienced more guilt at having survived trauma (56.3%) than women (44.0%). Women experienced greater pain upon remembering traumatic history (92.0%) than men (85.7%). However, women avoided discussing boarding school trauma (37.5%) less than men (56.3%), yet more men (55.6%) perceived

TABLE 1. Gender Differences on Boarding School Experiences

	<u>% Male</u>	<u>% Female</u>
Attended boarding school	82.4%	65.4%
Hit at boarding school	85.7%	35.3%
Punished for speaking Indian language	57.1%	20.0%
Experienced racism in boarding school	85.7%	58.8%
Sexually abused at boarding school	28.6%	17.7%

themselves as talking openly about sad feelings than women (46.2%). Half of the sample of both men and women (50%) had experienced a death within the past year and 100% within the past two years.

Lakota historical trauma was experienced with significantly more potency by men at T1 on the semantic differential ($P = .001, p. < 01$). In contrast, anger was significantly more potent for women at T1 ($P = .046, p. < 05$).

Health problems included hypertension for 50% of all respondents. A family history of heart disease was reported by 27.9% of respondents but only 2.3%, all men, admitted this for themselves. A history of alcohol abuse was affirmed by a larger number of men (94.4%) than women (73.1%).

Gender Differences in Traditional Presentation-of-Self

I observed more fullblood men than women in the sample and more men (47.1%) reported fluency in Lakota than women (28.0%); parental Lakota fluency for men was 94.1% compared with women at 76.9%, further suggesting a greater number of fullblood men in the sample. The majority of Indian men perceived themselves as looking mostly Indian (67%). When asked if they saw themselves as looking purely Indian, despite the higher number of fullblood men than women, their response was low (1.1%) compared with women (28.0%). When the two categories were combined, more Indian men (68.1%) than women (28.0%) in the sample perceived themselves as having an Indian phenotype. However, more women practiced traditional spirituality (see Table 2).

TABLE 2. Gender Differences in Traditional Presentation-of-Self

	<u>% Male</u>	<u>% Female</u>
Looking purely or mostly Indian	61.1%	28.0%
Speak Indian	47.1%	28.0%
Parents spoke Indian	94.1%	76.9%
Actively participate in pow wows	61.1%	46.2%
Listen to Indian music often/frequently	44.4%	53.8%
Eat Indian food frequently	16.7%	23.1%
Wear Indian clothing/jewelry frequently	38.9%	32.0%
Practice Indian spirituality frequently	27.8%	53.8%

Gender Differences at T2

At the end of the intervention, all respondents (100%) felt the intervention was helpful in their historical trauma and unresolved grief resolution, with 78.8% indicating high agreement. All trauma related affects reduced by a rate of 50-100% after the intervention for the group as a whole including sadness, grief, anger, hopelessness, shame, helplessness, and guilt; positive affects such as joy and pride increased by more than 50% (Brave Heart-Jordan, 1995; Brave Heart, 1998). However, gender differences were apparent on the T2 evaluation, which had a 75% valid response rate. At T2, women's anger reduced more than men's. Women were less sad, felt less overall guilt (as opposed to survivor guilt), and shame at T2 than the men who felt more sadness, guilt, and shame. Joy increased for women but showed less of an increase over time than men who felt less joy at T1 but greater joy at T2 (see Table 3).

Although the group score on the LGEQ decreased, the overall grief score reduction did not meet significance, due to the diversity in response by gender. The women decreased in their overall grief score from 2.99 to 2.64 while men's grief score increased from 2.88 to 2.94. However, there were seven items that reduced over time with significance. Of the significant items on the LGEQ, there were observable gender differences for feeling responsible to undo the pain of the people's past. At T2 women felt less responsible (57.2%) while men felt more responsible (77.0%). Men experienced more survivor guilt at

TABLE 3. Group Totals and Gender Differences for Affects Experienced Often Before and After Intervention

<u>Group</u>				
	<u>Before</u>		<u>After</u>	
Sadness	66.7%		18.2%	
Grief	54.5		27.3	
Pride	51.5		81.8	
Anger	69.7		18.2	
Hopelessness	45.5		0.0	
Shame	60.6		6.1	
Helplessness	54.5		0.0	
Joy	45.5		75.8	
Guilt*	60.6		6.1	
<u>Gender</u>				
	Female		Male	
	<u>Before</u>		<u>After</u>	
Anger	70.6%	73.3%	11.8%	26.7%
Sadness	70.6	66.7	5.9	33.3
Guilt*	70.6	53.3	0.0	13.3
Shame	64.7	60.0	0.0	13.3
Joy	58.8	33.3	70.6	86.7

*general, not specifically survivor guilt

both T1 (56.3%) and T2 (84.7%) than women whose survivor guilt decreased over time from 44.0% (T1) to 28.5% (T2) while men’s increased. Additionally, there were contrasting directional changes for pain upon remembering tribal history with women decreasing from 92.0% (T1) to 85.7% (T2) while men’s pain increased from 85.7% (T1) to 100% (T2). Further, although there was no change for women in their avoidance of discussing boarding school trauma—37.5% at T1 and T2—men’s avoidance increased from 56.3% (T1) to 84.7% (T2).

At T2, there was a significant gender difference on one of the three semantic differential scales. T-tests for independent samples revealed a statistically significant gender difference at T2 on the evaluation scale for the concept *Wasicu* (White Man); women had a more positive score (M = 3.78) than men (M = 4.59) despite their more negative evaluation of this concept at T1. This gender difference was signifi-

cant ($P = .037, p < .05$). Gender difference was also significant on the concept My True Self which changed on the potency ($P = .004, p < .01$) and evaluation ($P = .035, p < .05$) scales in a positive direction.

At T3, the follow-up evaluation return rate was 62.2%. A majority (89.3%) found the intervention had been very helpful in the resolution of historical unresolved grief and the remainder found it at least somewhat helpful. Gender differences were not assessed at T3.

DISCUSSION

Men—more fullblood Lakota in appearance and language—experienced greater trauma in boarding schools including more physical and sexual abuse and experienced greater sadness, survivor guilt, and shame as well as joy at T2. Hair length may have influenced men's limited self-appraisal of looking purely Indian; some fullblood men with short hair rated themselves as looking mostly Indian. Other explanations related to the complexity of Indian identity have been suggested to explain inaccurate self-image (Weaver & Brave Heart, 1999). With a greater degree of phenotypical Indian congruence than the women, men may have been placed at greater risk for compounding traumatic effects of racism. Further, men's historical inability to enact their traditional roles as protectors during the Wounded Knee Massacre, for example, may have heightened initial (T1) defensive denial of shame and general guilt (as opposed to survivor guilt) and lessened conscious awareness of the Lakota historical trauma and its impact. At the end of the intervention, men reported an increase in survivor guilt and shame as well as joy, suggesting an increase in affect tolerance and a decrease in psychic numbing as well as greater consciousness of trauma response features. The intervention may have served to move men from denial and trauma fixation to a later stage of resolution and imparted more tolerance and awareness of their survivor guilt.

In contrast, women's higher grief scores and sense of responsibility and general guilt at the outset of the intervention suggests a greater degree of awareness and perhaps less fixated grief, in keeping with *Pte Sa Win's* observation that the women would carry the grief for the Lakota. The intervention permitted women to relinquish some of their guilt (reduced by almost 100%) as well as grief. Perhaps the men also heeded the request of *Pte Sa Win* to help the women carry the grief,

facilitated by the intervention's spiritual focus and emphasis on traditional Lakota mores.

Interestingly, the men's avoidance of discussing boarding school trauma increased after the intervention. One possible explanation for this response among the men in this sample is the stigma and shame associated with their more prevalent sexual abuse victimization, particularly for Lakota *wicasa* (men) who come from a legacy of warriors. Their shame is compounded by their failure, through no fault of their own, to be the protectors of the *Oyate* (Lakota Nation) and the intervention may have heightened their awareness of their traditional role and their impotence as well as their own victimization at Wounded Knee. Further, Lakota male reaction to trauma may mirror that of African American men who manifested a higher degree of stress in their trauma response (Allen, 1996; Norris, 1992) and hence, more avoidance. In contrast, the women entered the intervention with a greater level of participation in traditional spirituality which probably facilitated greater coping skills (deVries, 1996; Silver & Wilson, 1988).

It is unclear how much gender interacted with phenotype to influence the life span trauma and the response. Research on trauma risk factors including American Indian phenotype and its correlation with life span as well as generational trauma may elucidate features of gender differences in the trauma response. The role of gender is an important consideration in designing effective interventions for both women and men. Comorbidity of the Lakota historical trauma response with psychiatric and somatic conditions, which was not examined in the current study, also needs further exploration.

CONCLUSION

The theory of a Lakota historical trauma response must include examination of the differential effects of gender and traditional presentation-of-self, particularly phenotype, as well as investigation of the relationship with serious health problems among the Lakota. Increased affect tolerance from mastery of trauma may reduce somatization, thereby limiting the risk associated with coronary heart disease and hypertension. Further, trauma mastery can serve as a protective factor against physiological illness as well as depression and other psychiatric disorders. The integration of traditional spirituality and

culture enhance protective factors against the development or exacerbation of PTSD (deVries, 1996; Silver & Wilson, 1988), facilitating prevention and treatment.

One challenge for healing the Lakota historical trauma response is the subjugation and distortion of historical facts about our genocide and the lack of awareness and sensitivity in the general population. As validation of the trauma and giving testimony are germane to the healing process, the lack of acknowledgment of our trauma is a barrier to our liberation from the effects of our historical legacy and the trauma response. This prohibition of the open expression of our traumatic affect and the lack of sufficient validation may increase health risk factors and predispose us to coronary heart disease, hypertension, suicide, and alcohol-related deaths. Theories of oppression which can lead to our self-destruction (Brave Heart & DeBruyn, in press) call for community education about and acknowledgment of our genocide to facilitate a healing process.

The *Takini* (Survivor) Network, a collective of Lakota traditional spiritual leaders and service providers, formed in *Paha Sapa* in 1992 to address healing from our historical trauma. With encouragement from the Jewish Holocaust survivor community, the Takini Network is conducting research, community education, and community healing aimed at validating our historical trauma and providing forums for Native people to begin to confront our traumatic past. It is imperative that we continue and expand this work as our people are in danger of increased trauma and elevated mortality rates in a cycle of risk. We must limit risk factors and develop protective factors through research, prevention, and intervention with historical trauma, for the Lakota Nation and other indigenous nations, *hecel lena oyate kin nipi kte*—so that the people may live!

REFERENCES

- Albers, P. (1983). Sioux women in transition: A study of their changing status in a domestic and capitalist sector of production. In P. Albers & B. Medicine (Eds.), *The hidden half: Studies of Plains Indian women* (pp. 267-277). Lanham, MD & London: University Press of America.
- Allen, I.M. (1996). PTSD among African Americans. In Marsella, A.J., Friedman, M.J., Gerrity, E.T., & Scurfield, R.M. (Eds.), *Ethnocultural aspects of post-traumatic stress disorder: Issues, research, and clinical applications*. Washington, DC: American Psychological Association, 209-238.

- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC.
- Bachman, R. (1992). *Death and violence on the reservation: Homicide, family violence, and suicide in American Indian populations*. New York: Auburn House.
- Barrett, T.W. & Scott, T.B. (1989). Development of the grief experience questionnaire. *Suicide and Life Threatening Behavior*, 19(2), 201-215.
- Bergmann, M.S. & Jucovy, M.E. (Eds.) (1990). *Generations of the Holocaust*. New York: Columbia University Press. (original work published 1982).
- Black Elk & Brown, J.E. (1971). *The Sacred Pipe*. Baltimore: Penguin Books. (original work published 1953).
- Brave Heart-Jordan, M.Y.H. (1995). The return to the sacred path: Healing from historical trauma and historical unresolved grief among the Lakota. Doctoral dissertation, Smith College School for Social Work, 1995.*
- Brave Heart-Jordan, M. & DeBruyn, L. M. (1995). So she may walk in balance: Integrating the impact of historical trauma in the treatment of Native American Indian women. In J. Adleman & G. Enguidanos (Eds.), *Racism in the lives of women: Testimony, theory, and guides to anti-racist practice* (pp. 345-368). New York: The Haworth Press, Inc.
- Brave Heart, M.Y.H. (1998). The return to the sacred path: Healing the historical trauma and historical unresolved grief response among the Lakota. *Smith College Studies*. 68(3), 287-305
- Brave Heart, M.Y.H. (1999). *Oyate Ptayela*: Rebuilding the Lakota Nation through addressing historical trauma among Lakota parents. *Journal of Human Behavior in the Social Environment*. 2(1/2), 109-126
- Brave Heart, M.Y.H. (in press-c). Premenstrual dysphoric disorder among American Indian women: A preliminary exploration. *Rural Community Mental Health*.
- Brave Heart, M.Y.H. (in press-d). *Wakiksuyapi*: Carrying the historical trauma of the Lakota. *Tulane Studies in Social Welfare*.
- Brave Heart, M.Y.H. & DeBruyn, L.M. (1998). The American Indian Holocaust: Healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research* 8(2), 56-78.
- Bureau of Indian Affairs Labor Force Report (1990). Aberdeen, SD: Bureau of Indian Affairs.
- Claymore, B. (1988). A public health approach to suicide attempts on a Sioux reservation. *American Indian and Alaska Native Mental Health Research*, 1(3), 19-24.
- Davidson, R.T. & Fairbank, J.A. (1993). The epidemiology of post-traumatic stress disorder. In Davidson, R.T. & Foa, E.B. (Eds.), *Post-traumatic stress disorder: DSM IV and beyond* (pp. 147-169). Washington, DC: American Psychiatric Press.
- deVries, M.W. (1996). Trauma in cultural perspective. In van der Kolk, B.A., McFarlane, A.C., & Weisaeth, L. (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society*. New York: Guilford Press, pp. 398-413.

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- Dick, R.W., Beals, J., Keane, E.M., & Manson, S.M. (1994). Factorial structure of the CES-D among American Indian adolescents. *Journal of Adolescence, 17*(1), 73-79.
- Eitinger, L. & Strom, A. (1973). *Mortality and morbidity after excessive stress: A follow-up investigation of Norwegian concentration camp survivors*. New York: Humanities Press.
- Erikson, E. H. (1963). *Childhood and Society* (Rev. ed.). New York: W.W. Norton.
- Fogelman, E. (1988). Therapeutic alternatives for Holocaust survivors and the second generation. In R. L. Brahm (Ed.), *The psychological perspectives of the Holocaust and of its aftermath* (pp. 79-108). New York: Columbia University Press.
- Gutierrez, S.E., Russo, N.F., & Urbanski, L. (1994). Sociocultural and psychological factors in American Indian drug use: Implications for treatment. *International Journal of Addictions, 29*(14), 1761-1786.
- Hall, R.E. (1992). Bias among African Americans regarding skin color: Implications for social work practice. *Research on Social Work Practice, 2*(4), 479-486.
- Hamner, M.B. (1994). Exacerbation of Post-traumatic Stress Disorder symptoms with medical illness. *General Hospital Psychiatry, 16*(2), 135-137.
- Han, P.K., Hagel, J., Welty, T.K., Ross, R., Leonardson, G., & Keckler, A. (1994). Cultural factors associated with health-risk behavior among the Cheyenne River Sioux. *American Indian and Alaska Native Mental Health Research, 5*(3), 15-29.
- Harber, K.D. & Pennebaker, J.W. (1992). Overcoming traumatic memories. In S.A. Christianson (Ed.), *The handbook of emotion and memory: Research and theory* (pp. 359-386). Hillsdale, NJ: Erlbaum.
- Herman, J.L. (1993). Sequelae of prolonged and repeated trauma: Evidence for a complex post-traumatic syndrome (DESNOS). In Davidson, R.T. & Foa, E.B. (Eds.), *Post-traumatic stress disorder: DSM IV and beyond* (pp. 213-228). Washington, DC: American Psychiatric Press.
- Herman, J.L. & van der Kolk, B.A. (1987). Traumatic origins of borderline personality disorder. In B.A. van der Kolk (Ed.), *Psychological trauma*. Washington, DC: American Psychiatric Press.
- Holm, T. (1994). The national survey of Indian Vietnam Veterans. *American Indian and Alaska Native Mental Health Research, 6*(3), pp. 18-28.
- Howard, B.V., Lee, E.T., Cowan, L.D., Fabsitz, R.R., Howard, W.J., Oopik, A.J., Robbins, D.C., Savage, P.J., Yeh, J.L., & Welty, T.K. (1995). Coronary heart disease prevalence and its relation to risk factors in American Indians: The Strong Heart study. *American Journal of Epidemiology, 142*(3), 254-268.
- Hrabovsky, S.L., Welty, T.K., & Coulehan, J.L. (1989). Acute myocardial infarction and sudden death in Sioux Indians. *Western Journal of Medicine, 150*(4), 420-422.
- Hughes, M. & Hertel, B.R. (1990). The significance of color remains: A study of life chances, mate selection, and ethnic consciousness among Black Americans. *Social Forces, 68*(4), 1105-1120.
- Indian Health Service (1995a). *Regional differences in Indian health*. Washington, DC: U.S. Department of Health and Human Services.

- Indian Health Service (1995b). *Trends in Indian health*. Washington, DC: U.S. Department of Health and Human Services.
- Jones, M.C., Dauphinais, P., Sacl, W.H., & Somervell, P.D. (1997). Trauma-related symptomatology among American Indian adolescents. *Journal of Traumatic Stress, 10*(2), 163-167.
- Keehn, R.J. (1980). Follow-up studies of World War II and Korean conflict prisoners: Mortality to January 1, 1976. *American Journal of Epidemiology, III*, 194-202.
- Kestenber, J.S. (1990). A metapsychological assessment based on an analysis of a survivor's child. In M.S. Bergmann & M.E. Jucovy (Eds.), *Generations of the Holocaust* (pp. 137-158). New York: Columbia University Press. (original work published 1982).
- Lifton, R.J. (1988). Understanding the traumatized self: Imagery, symbolization, and transformation. In J.P. Wilson, Z. Harel, & B. Kahana (Eds.), *Human adaptation to extreme stress: From the Holocaust to Vietnam* (pp. 7-31). New York: Plenum Press.
- Lifton, R.J. (1968). *Death in life: Survivors of Hiroshima*. New York: Random House.
- Macgregor, G.U. (1975). *Warriors without weapons: A study of the society and personality development of the Pine Ridge Sioux*. Chicago: University of Chicago Press (original work published 1946).
- 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 Marsella, A.J., Friedman, M.J., Gerrity, E.T., & Scurfield, R.M. (Eds), *Ethnocultural aspects of Post-traumatic Stress Disorder*. Washington, DC: American Psychological Association, pp. 255-283.
- May, P. (1973). *Suicide and suicide attempts on the Pine Ridge Reservation*. Pine Ridge, SD: PHS Community Mental Health Program.
- May, P. (1987). Suicide and self-destruction among American Indian youth. *American Indian and Alaska Native Mental Health Research, 1*(1), 52-69.
- Montalvo, F.F. (1987). *Skin color and Latinos: The origins and contemporary patterns of ethnoracial ambiguity among Mexican Americans and Puerto Ricans*. San Antonio, TX: Institute for Intercultural Studies and Worden School of Social Work, Our Lady of the Lake University.
- Napholz, L. (1995). Mental health and American Indian Women's Multiple Roles. *American Indian and Alaska Native Mental Health Research, 6*(2), 57-75.
- Nefzger, M.D. (1970). Follow-up studies of World War II and Korean War prisoners: Study plan and mortality findings. *American Journal of Epidemiology, 91*(2), 123-138.
- Niederland, W.G. (1988). The clinical aftereffects of the Holocaust in survivors and their offspring. In R.L. Braham (Ed.), *The psychological perspectives of the Holocaust and of its aftermath* (pp. 45-52). New York: Columbia University Press.
- Norris, F.H. (1992). Epidemiology of trauma: Frequency and impact of different potentially traumatic events on different demographic groups. *Journal of Consulting and Clinical Psychology, 60*, 409-418.

- Nurges, E. (Ed.). *The modern Sioux: Social systems and reservation culture*. Lincoln, NE: University of Nebraska Press.
- Osgood, C.E., Suci, G.J., & Tannenbaum, P.H. (1978). *The measurement of meaning*. Urbana & Chicago: University of Illinois Press. (original work published 1957).
- Powers, M. (1986). *Oglala women*. Chicago: University of Chicago Press.
- Pribor, E.F., Yutzy, S.H., Dean, T., & Wetzel, R.D. (1993). Briquet's syndrome, dissociation, and abuse. *American Journal of Psychiatry*, *150*, 1507-1511.
- Resick, P.A. & Schnicke, M.K. (1992). Cognitive processing therapy for sexual assault victims. *Journal of Consulting and Clinical Psychology*, *60*(5), 748-756.
- Robin, R.W., Chester, B., & Goldman, D. (1996). Cumulative trauma and PTSD in American Indian communities. 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 Association, pp. 239-253.
- Saxe, G.N., Chinman, G., Berkowitz, R., Hall, K., Lieberg, G., Schwartz, J., & van der Kolk, B.A. (1994). Somatization in patients with dissociative disorders. *American Journal of Psychiatry*, *151*, 1329-1335.
- Schonfeld, W.H., Verboncoeur, C.J., Fifer, S.K., Lipschutz, R.C., Lubeck, D.P., & Buesching, D.P. (1997). The functioning and well-being of patients with unrecognized anxiety disorders and major depressive disorder. *Journal of Affective Disorders*, *43*(2), 105-119.
- Shapiro, P.A. (1996). Psychiatric aspects of cardiovascular disease. *Psychiatric Clinics of North America*, *19*(3), 613-629.
- Shore, J. H., Manson, S. M., Bloom, J.D., Keepers, G., & Neligh, G. (1987). A pilot study of depression among American Indian patients with research diagnostic criteria. *American Indian and Alaska Native Mental Health Research*, *1*(2), 4-15.
- Sigal, J. & Weinfeld, M. (1989). *Trauma and rebirth: Intergenerational effects of the Holocaust*. New York: Praeger.
- Silver, S. M. & Wilson, J. P. (1988). Native American healing and purification rituals for war stress. In John P. Wilson, Zev Harele, & Boaz Hahana (Eds.) *Human adaptation to extreme stress: From the Holocaust to Viet Nam* (pp. 337-355). New York: Plenum Press.
- Tanner, H. (1982). *A history of all the dealings of the United States government with the Sioux*. Unpublished manuscript. Prepared for the Black Hills Land Claim by order of the United States Supreme Court, on file at the D'Arcy McNickle Center for the History of the American Indian, Newberry Library, Chicago.
- Thomas, J.A. (1984). Race, color, and essential hypertension: A proposal for an international symposium. *Journal of the National Medical Association*, *76*(4), 393-399.
- Ursano, R.J., Grieger, T.A., & McCarroll, J.E. (1996). Prevention of post-traumatic stress: Consultation, training, and early treatment. In van der Kolk, B.A., McFarlane, A.C., & Weisaeth, L. (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society*. New York: Guilford Press, pp. 441-462.
- van der Kolk, B.A. (1996). The body keeps the score: Approaches to the psychobiology of Post-traumatic Stress Disorder. In van der Kolk, B.A., McFarlane, A.C., & Weisaeth, L. (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society*. New York: Guilford Press, pp. 214-241.

- van der Kolk, B.A., McFarlane, A.C., & van der Hart, O. (1996). A general approach to treatment of Post-traumatic Stress Disorder. In van der Kolk, B.A., McFarlane, A.C., & Weisaeth, L. (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society*. New York: Guilford Press, pp. 417-440.
- van der Kolk, B.A., Roth, S., Pelcovitz, D. & Mandel, F. (1993). *Complex PTSD: Results of the PTSD field trials for DSM-IV*. Washington, DC: American Psychiatric Association.
- van der Kolk, B.A. (1987). *Psychological trauma*. Washington, DC: American Psychiatric Press.
- Van Winkle, N.W. & May, P.A. (1993). An update on American Indian suicide in New Mexico, 1980-1987. *Human Organization*, 52(3), 304-315.
- Weaver, H.N. (1996). Social work with American Indian youth using the orthogonal model of cultural identification. *Families in Society: The Journal of Contemporary Human Services*, 77(2), 98-107.
- Weaver, H.N. & Brave Heart, M.Y.H. (1999). Examining two facets of American Indian identity: Exposure to other cultures and the influence of historical trauma. *Journal of Human Behavior in the Social Environment* 2(1/2), 19-33.
- Welty, T.K. & Coulehan, J.L. (1993). Cardiovascular disease among American Indians and Alaska Natives. *Diabetes Care*, 16(1), 277-283.
- Zitzow, D. & Desjarlait, F. (1994). A study of suicide attempts comparing adolescents to adults on a Northern Plains American Indian reservation. *American Indian and Alaska Native Mental Health Research*, 4(Mono), 35-69.

