HEALING THE WARRIOR: ADMISSION OF TWO AMERICAN INDIAN WAR-VETERAN COHORT GROUPS TO A SPECIALIZED INPATIENT PTSD UNIT

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Abstract: The American Lake VA Post-Traumatic Stress Disorder (PTSD) Treatment Program provides intensive inpatient treatment for war-related PTSD and associated conditions. As part of a substantial outreach effort to American Indians (AI) in the Northwest U.S., the program significantly modified its admission criteria and treatment to be more clinically and culturally relevant. An all-AI cohort, and then a group that was 50% AI, were admitted. Highlighted are lessons learned regarding: treating "traditional" versus more "assimilated" AI veterans; culture-specific additions of building and utilizing a sweatlodge on the hospital grounds, hiring an AI spiritual leader as a clinical advisor, and promoting attendance at weekend Pow-Wows; the relevance of the "regular" treatment components; and the need for regular debriefings about counter-transference dynamics among staff.

The American Lake VA Medical Center Post-Traumatic Stress Treatment Program (PTSTP) is one of 22 specialized inpatient PTSD programs in the Department of Veterans Affairs. In an attempt to be more clinically and culturally relevant to American Indian (AI) combat veterans and to attract more American Indian veterans to utilize the PTSTP, two modified inpatient treatment cycles were implemented. The modifications primarily were in four areas: (a) special advance preparations to sensitize program staff about AI cultural dynamics; (b) recruitment of patients of AI ethnicity to enter together in two consecutive admission groups; (c) facilitating access during the inpatient phase of treatment to sweatlodge and Pow-Wow activities, and to an AI traditional healer hired as a paid VA consultant; and (d) altering regular program offerings and clinical techniques, such as the adoption of a more non-confrontive and non-directive approach.

The Post-Traumatic Stress Treatment Program (PTSTP)

Established in 1985, the American Lake VAMC PTSTP offers inpatient treatment for war-related PTSD and serves war veterans from a large multi-state catchment area in the Northwestern United States. While veterans from all wars are accepted, about 95% of the veterans admitted to the PTSTP are Vietnam veterans. With a 31-bed capacity, the PTSTP offers a bio-psycho-social, multi-disciplinary approach to the treatment of war-related PTSD. At the time of admission of the two AI cohorts, standard treatment consisted of an 11-week program of bio-psycho-social education, process and war-trauma focus groups, and "in-action" therapy. The latter included an adventure based component (five-day Outward Bound wilderness course) and a helicopter-ride therapy activity (Hyer, Scurfield, Smith, Boyd, & Burke, in press; Scurfield, Wong, & Zeerocah, 1992).[1]

In recognition of the special and powerful role that peer group treatment has in war-related PTSD (Scurfield, Johnson, Gongla, & Hough, 1984; Scurfield, 1993), the PTSTP is designed with the admission of cohort groups of ten-to-twelve war-veterans every six weeks, who then proceed together through the 11-week inpatient treatment process. At any one time there are two cohort groups in the program admitted five weeks apart from each other; the more senior group is closer to graduation, and the more junior group is just recently admitted. Each cohort primarily participates in its own treatment schedule; a few activities, such as the weekday morning meetings, patient/staff rules' infraction advisory committee, and graduation ceremony, are attended by members of both cohorts.

Outreach and Planning Efforts in Preparation For Two American Indian Veterans' Cohort Groups

A cohort admission of an all-AI veterans' group was a precedent setting and innovative approach in PTSD treatment. Admission of an all-AI cohort group was the result of several years of outreach work to AI veterans, organizations, health care agencies, and reservations. This outreach involvement began in March 1989, when the PTSTP was approached by an AI Vietnam combat veteran from the Nisqually Reservation in Washington. He was a member of the Portland Indian Health Board, and a graduate of the program. A meeting was planned to prepare a needs assessment which indicated that American Indians are the ethnic minority with the highest percentage of veterans in their population and yet had underutilized VA services. At the same time, the American Lake VA Medical Center Social Work Service and Domiciliary had made several connections to AI health care providers and agencies.

Out of these developments, an outreach and support effort was created that intensified over the next two years. At first, meetings with AI health care providers and community leaders were held at the hospital.

The hospital staff involved in these meetings began to develop a keener insight into the reasons why this population had underutilized Department of Veterans Affairs services for their health care needs. The familiar dynamic of "veteran vs. the system" undoubtedly played a role, but was dramatically intensified by a 300-year history of being betrayed, discriminated and misunderstood as a race. However, the desire of this facility to work more closely with AI veterans was appreciated, albeit cautiously, and welcomed by their representatives. After several such meetings, where motives and intentions were mutually explored, certain key players emerged from various Indian communities, the State Department of Veterans Affairs, Indian Health Services, and the PTSTP. The latter took on the responsibility to carry this effort into practical application.

Sensitization of PTSTP Staff Regarding American Indian Ethnocultural Factors

Staff members from the hospital, primarily from the PTSTP, began to give in-service trainings and presentations to AI veterans, family members, and community agencies. These trainings were provided on reservations and in surrounding rural areas, primarily in Washington, Idaho, and Oregon. It became obvious to the hospital staff involved that there were distinct differences in personal interaction styles between themselves and participating American Indians. For example, a more informal style of presentation that also prompted give-and-take interactions with the audience throughout the presentation, was much more effective than a more typical didactic training approach that would doggedly stick to completion of a pre-arranged agenda, content and closely-adhered-to length of presentation. Indeed, American Indians, like other ethnic minority groups, are sensitive to being "talked down to" and tend to prefer a more egalitarian structure and format (C. Loo, personal communication, August 3, 1994).

Other cultural practices also became better understood. For example, it is considered very impolite not to offer food to visitors or to refuse food when it is offered, regardless of time or circumstance (except during periods of fasting). It is not acceptable to interrupt someone who is talking, particularly an "elder." This is a consideration unfortunately rare in American society, and especially challenging for most Americans since an AI speaker may easily go on for a considerable length of time. Meetings rarely began (or ended) exactly on time; clearly, at least initially, it was as much the establishment of personal relationships, credibility and beginning trust as it was the content of what was presented that were important. It also was quite clear that American Indians were quite used to hearing all kinds of *promises* and commitments from various governmental officials but not a lot of sustained follow-through on the same. Thus, the PTSTP staff were very careful not to promise anything that could not be fully provided.

There was lengthy discussion as to the appropriate terminology to describe these cohort groups. There were arguments in favor of the usage of "American Indian", and others in favor of "Native American." Ultimately, the staff decided to allow the participants to choose; hence the usage of "American Indian."[2]

Initiation Of and Rationale For An American Indian Cohort Group

During this time period one other significant development took place: the founding of NIVA (Northwest Indian Veteran Association). NIVA was established and staffed by AI veterans from the greater Puget Sound area. Representing over 50 tribes, this service organization had proved to be an increasingly powerful political force on behalf of its members. NIVA had helped AI veterans access services for benefits, health, and PTSD problems, partly through following up with various VA and other governmental resources to insure that "good-intentions" did not lapse into non-actions. Further, NIVA had promoted traditional native ways to facilitate healing and a balanced way of life.

Members of NIVA brought the idea of an all-AI cohort to PTSTP staff. It became increasingly clear to PTSTP staff working with NIVA members that an AI cohort could have several advantages: veterans might feel less culturally isolated; veterans might experience more peer support and validation with veterans from their own cultural background; and staff would be forced to be more responsive to issues of ethnicity with a bearing on treatment.

Approval of this project was secured from the (former) Chief of Psychiatry, Steven Risse, M.D., and American Lake VAMC Director, Frank Taylor. However, the idea was not easily accepted by everyone on staff in the PTSTP, the hospital or the community. One of the concerns voiced was doubt of being able to interact in a clinically effective manner with a group comprised entirely of one ethnic minority race. This concern was exacerbated among some staff members who thought the PTSTP was not even doing a good job when *one* such veteran was in a group! Another issue was future implications. Would the PTSTP at a later time have to then bring in an all Hispanic, all African-American or all Asian group, and be able to deal with them appropriately and sensitively? Another argument was that there was not an all-AI unit in Vietnam, so how would such a cohort group fit into the 'reality' of a multi-ethnic war? The fact is, most units in the Vietnam War had ethnic minority compositions significantly above the typical 20% represented in any one cohort group at the PTSTP. Thus, typical group composition at the PTSTP also did not represent "the reality of Vietnam."

The single most asked question about this project was: Why American Indians? Why not African-Americans, Hispanics, or Asian Americans? Rationale for an all-Native American cohort included:

1. There was a very high percentage of veterans among this population, and they represented only 0.1% of the patients at the medical center.

2. The request for an all-Native American group was brought to the PTSTP from AI veterans with NIVA, suggesting readiness and need.

3. Native American veterans (to include American Indians and Native Hawaiians) are among the only ethnic groups in the U.S. who come from a "warrior" society (not all tribes, but many). As such, many tribes have developed specific strategies to prepare warriors for battle, heal them of emotional war wounds, cleanse them from the 'taint' of killing, re-integrate warriors back into society and involve families and community in the process. PTSD treatment providers have much to learn of these ways, as the strategies may apply more generically to treatment of PTSD for all veterans (Ching, 1989; Department of Veterans Affairs, 1984, 1989a, 1989b, 1992; Holmes, 1986; Johnson & LaDue, 1990; Silver & Wilson, 1988; Wilson 1989).

4. AI resources from the community were willing to justify devoting a significant amount of time to support these special treatment cycles in a way they were not able to when only one or two American Indians were in a group.

5. It was the initial assumption of the PTSTP that this was a "one shot" strategy that would significantly enhance staff sensitivity and skills in working with AI veterans, improve networking with various AI and other community resources, and allow the provision of more culturally-relevant knowledge about PTSD and its treatment when other AI veterans were subsequently admitted.

AI veterans contacted during numerous outreach visits to "Indian Country" provided a further rationale for admitting an AI cohort to the PTSTP. They expressed the hope that some of the veterans admitted would be able to gain additional knowledge about PTSD to bring back to their communities in order to help create relevant PTSD programs and continuing care supports *on* the reservations.

Finally, the PTSTP considered the inherent difficulties that face any ethnic minority veteran who is admitted with other patients to a program in which the staff are dominantly Anglo (or not of the same ethnicity and cultural background as minority veterans). The concept of admitting any single ethnic minority veteran to a dominantly Anglo American peer group is not only difficult for the individual veteran, but also unfair. In effect, the program is asking the individual to adjust to the majority of the group and the program ethos, rather than asking the program and staff to adjust to different ethnic diversities. Requiring such adjustments primarily

by the staff hopefully would improve the treatment approach to such groups and increase program abilities to subsequently adjust to other minority groups.

Modifications and Preparations to Adapt Inpatient PTSD Treatment to American Indian Cohort Groups

The plan was to offer the regular 11-week PTSD program, with some modifications. These modifications primarily involved adding spiritual and cultural activities, with the specifics to be left up to the group's discretion and negotiation with the staff. The staff knew that several "outside" (non-VA) AI consultants needed to be involved to provide knowledgeable support and guidance, such as recognized, native spiritual advisors and healers, and other community resources. This overall plan was discussed with several AI resources and their input pointed out three necessities:

1. It was agreed that the staff working with the cohort group would need additional culture-specific training *before* the special cohort groups were admitted in order to be able to deal more effectively and sensibly with this population.
2. It was necessary to facilitate access to a series of traditional AI rituals or ceremonies, either on station or at a site acceptable to the group.
3. It was important to have AI spiritual advisors from the community conduct several sessions on AI-based spiritual concepts, during the residential stay, rather than utilizing the PTST Program staff to present this subject.

It was decided that only PTSTP Program staff interested in working with this cohort group would be included on the clinical team assigned to this cohort group. Also, two AI Vietnam veterans on staff at the Seattle Indian Health Board provided an intensive eight hour training session to the Program staff and other interested hospital workers on cultural sensitivity in working with American Indians; one of these AI veterans also was a respected healer in the Seattle area. In addition, a Korean War veteran Vet Center team leader further helped with staff training and sensitization, and screening of some possible candidates. Finally, six previous AI graduates of the program were contacted for feedback on the appropriateness of the services offered by the PTSTP.

The typical screening process for admission to a cohort group consisted of an assessment of several factors: significant exposure to war-related trauma; presence of comorbid conditions that might contraindicate acceptance into the PTSTP (current abuse of illicit drugs and/or alcohol, active psychosis, severe character pathology); inability or unwillingness to terminate anti-psychotic or benzodiazypine medications; presence of any

medical condition unable to be stabilized during the projected course of inpatient treatment; prior experience in PTSD treatment, preferably to include peer group treatment; and a current counseling relationship. The latter requirements were due to the nature of the PTSTP as a treatment option designed for veterans for whom outpatient treatment had proven insufficient and/or unavailable, and the necessity for the veteran to have a treatment provider to return to following discharge from the PTSTP in order to promote continuity of care and enhancement of any gains made during hospitalization.

The usual admission criterion of prior PTSD treatment, preferably to include peer group treatment, and a current counseling relationship, were not strictly adhered to. This was in recognition of the realities of very limited PTSD resources in many rural areas, and especially in "Indian Country." Also, the selection process for this cohort group proved challenging in that *ethnicity was utilized for the first time as an inclusionary criterion* in addition to our usual clinical criteria. A question frequently asked by referrers was what the (PTSTP) considered an "American Indian" to be? It was a complex question, since in some tribes only persons born on a reservation are considered American Indian; in others, there needs to be a certain percentage of documented heritage. To be enrolled in a tribe turned out to be the initial basic criterion that the PTSTP utilized for a veteran to be considered an "American Indian."

However, the program was somewhat concerned about admitting veterans to this cohort group who had minimal or no documented AI heritage. It was not as clear if veterans were to be considered American Indians when their heritage was 1/8, 1/16, or less AI, *and* they had minimal versus considerable cultural exposure (such as "grew up on the reservation," or "went to an all American Indian school," etc.) In the end the PTSTP agreed to accept a veteran claiming an AI heritage if both the veteran *and* referrer agreed that he would benefit from inclusion in this uniquely AI cohort group rather than in another cohort group that did not have a significant representation of AI veterans.[3] The complexity of what had been initially considered a relatively straight forward criterion foreshadowed the emergence of the issue and dynamics surrounding AI identity later in the treatment process.

Admission of the 100% American Indian Cohort Group

With these preparations in place, 12 AI veterans were admitted to the PTST Program. They represented 10 different tribes from 9 different states. Three of the twelve were former graduates of this program, who were thought to provide a "cultural link" between the PTST Program and the newly admitted cohort group. Eleven group members were of the Vietnam Era, and one was a veteran of the Korean Era. Out of the 12 group members, seven were from reservations and rural areas, the other five from urban settings.

The first few weeks were challenging for staff and veterans. Perhaps for the first time the PTSTP *staff* felt as intimidated by an incoming group as veterans being admitted to the program might typically feel. By design, admission week was less structured than usual to allow patients and staff the time to get to know one another informally. In retrospect, the lack of (typical) structure seemed to exacerbate tendencies among the staff to be somewhat preoccupied with the group as "special" and to feel inhibited about providing the normal amount of classes and groups. Such inhibition continued through most of the treatment cycle of the first AI cohort.

Culture-Specific Additions to the Treatment Program

There were three primary culture-specific additions that were incorporated into the treatment program. Building a traditional sweatlodge on the grounds of the hospital that was easily accessible, hiring a recognized local tribal spiritual leader as a clinical and cultural consultant to be readily available to the veterans during the inpatient treatment, and providing support necessary to facilitate attendance at Pow-Wows on weekends, all were considered to be very important culture-specific components of the modified PTSTP for this AI cohort.

The first decisive development with the cohort group was the unanimous agreement that a sweatlodge needed to be as readily available as necessary for cleansing and purification to interested members of the group. The PTSTP had been made aware of this possibility early during the pre-admission planning stage, and appropriate arrangements had been made prior to admission of the group to receive permission to build and operate a sweatlodge on hospital grounds (Department of Veterans Affairs, 1990; Scurfield, 1990). Some staff members had previous experience with this traditional AI purification ritual. However, it had been agreed that it would be not only more appropriate and respectful, but also a valuable group bonding process if the group members assumed the responsibility to build the lodge by themselves.

Prior to building the sweatlodge it was brought to the attention of the program staff that a traditional ground blessing ceremony was needed. The Korean War veteran of the group, who was also a "pipe carrier" (spiritual leader) from Minnesota, clarified for the staff that the ground blessing ceremony should be conducted by someone native to the Pacific Northwest; e.g., it is not proper for a spiritual person to bless the ground of an area his or her tribal affiliation is not at home on historically. A consultant service was therefore contracted with a respected AI spiritual leader from the nearby Nisqually Reservation. Spiritual advisors were available on a volunteer basis; however, it was agreed to be important, both symbolically and tangibly, to go through the VA contracting process and officially sanction and monetarily reimburse such as "expert consultants." The consultant

performed the ceremony, which was conducted on a Saturday; the sweatlodge was built by the veterans the following day.

There were several logistical considerations required to build the sweatlodge. Group members collected willow sticks at the Nisqually river bank and lava rocks from Ellensburg, WA. The skin (cover) proved more difficult. The logistics branch of McChord Air Force Base was able to help out by providing the PTST Program with two surplus 'GP Mediums' (military tents) that served the purpose very well.

That same weekend the Nisqually spiritual leader consultant made his first therapeutic intervention on behalf of one particular group member. This veteran had become almost overwhelmed by anxiety in this strange place and was isolating from the group and program. Before making a final decision to leave the program, the veteran requested to speak to the spiritual leader and a meeting was arranged that same evening. The veteran met first with the spiritual leader; later, both of them met with the group. A ceremony was conducted and the veteran, even though still extremely anxious, decided to remain in the program.[4]

The sweatlodge was operational several days later after the ground blessing ceremony was performed and adequate supplies of firewood had been cut and stacked. All of these preparations were conducted by the veterans "under supervision" of staff to satisfy hospital liability requirements. Permission was secured from the hospital administration to allow the group members to swim in American Lake after the ceremony. Life saving and fire extinguishing equipment were stored at the site and a staff member with life rescue experience and a portable telephone was to be at the site during all times of operation, again to satisfy liability concerns.

The sweatlodge proved to be the single, most effective and frequently utilized traditional support activity for approximately six of the group members during the 11-week program. The sweatlodge was in use at least four days a week (after regular PTSTP classes and groups ended), and sometimes on weekends. It was primarily used by the veterans to "finish up" following important war - trauma focus group session work, to set painful memories free and to further resolve war - focus and other group issues. The sweatlodge was also utilized on two occasions by three veterans in the group as a preparatory means *before* discussing war - trauma in group sessions. It was extremely beneficial to their healing process that the PTSTP was able to secure permission to have it built on VA grounds; also, it was instrumental to facilitate healing that the location was in a scenic, relatively private, protected, and readily accessible area.

It is important to note that the VA Chaplain's Service was instrumental in facilitating approval for the sweatlodge. There had been considerable concern raised by some VA officials and staff as to whether the PTSTP was "*mandating* a religious component" to the program. To counter this concern the sweatlodge was offered as an entirely optional

activity, and was only accessible *after* regular program hours. Also, the question was raised as to whether having an American Indian spiritual ceremonial area designated on the hospital grounds somehow was inappropriately preferential to one "religion" over others and to one group of patients over others at the hospital. To address these issues, the area where the sweatlodge was constructed was to be available to other VA patients when it was not scheduled for the cohort group. However, it was required for such veterans to be under hospital staff supervision and act in the blessed ground area with proper respect as would be expected in the chapel, for example. Finally, the cohort group agreed to take down the sweatlodge when their group graduated from the PTSTP (for a further discussion of the role that spirituality has in the treatment of war-related PTSD, see Mahedy, 1986; Scurfield, 1994; Wilson, 1989).

The second most utilized traditional activity during this time period was attendance at Pow-Wows at various locations in the Northwest. Pow-Wows are intertribal gatherings which celebrate American Indian culture with traditional song, dance, and drum competitions as well as contests with the participants in colorful traditional clothing and accessories. There are honor ceremonies, traditional foods, and arts and crafts proudly displayed at trader's tables; the items on display are to sell, trade or market. Perhaps most importantly to this discussion, the role of the Warrior is prominent. The Warrior opens the ceremonies, receives tribute and recognition through many of the dances, and usually is involved in closing ceremonies (Department of Veterans Affairs, 1984).

For the three group members who were traditional dancers, continued regular participation at Pow-Wows was extremely important to their overall recovery and well-being. It was therefore agreed by staff that Pow-Wows were to be considered religious holidays for veterans interested in attending. This step was necessary to expand the number of off-station passes usually allowed (e.g., six) during the 11-week stay and to justify the provision of transportation for veterans who otherwise would have been unable to attend. Several of the group members and staff became very involved in weekend Pow-Wow activities and further bonded with each other.

Lessons Learned From the All-American Indian Cohort Group

Overall, the AI cohort group experience appeared to be beneficial for most group members and remarkably educational for the staff. Notably, several of the graduates maintained regular contact with staff after completing the 11-week program. However, two issues emerged that were instructive about cultural and treatment issues related to American Indians: (a) sub-group differences in the perception and use of culture-specific additions to the program; and (b) divisiveness among staff around the extent of involvement in AI activities and attributions associated with the extent of staff participation in culture-specific additions to the program.

Both of these issues reflected the divergence of perspectives within the veteran cohort, and among the staff, about the preferred balance between PTSD treatment and culture-specific activities.

Subgroup Differences in the Cohort

One of the most commonly voiced concerns raised early in the planning stages by several AI providers from the community and by some of the PTSTP staff had been the fear of conflicts between and among group members because of historical tribal animosities or rivalries and differences. Interestingly, quite the opposite occurred. Among the "traditionals" from different tribes, there developed a very close, mutually respectful and very sincere interest to learn more about each other's ways that seemed to be independent of tribal affiliation.

On the other hand, it appeared that some of the most intense interpersonal differences arose (regardless of tribal affiliation) between "traditionals" versus "assimilated" AI veterans. Such differences were attributed at least partly to an incongruity if not clash of values, personalities, and styles of interacting. For example, compared to the more anglo-acculturated, most of the "traditionals" tended to be less confronting in groups, less willing to interrupt each other, less comfortable expressing rage, more comfortable talking in quiet and uninterrupted monologues, and less satisfied with receiving "PTSD only" treatment. They were very appreciative of the psycho-educational classes and groups and equally appreciative of staff support to allow them access to traditional cultural activities. The "traditionals" also tended to express their appreciation in quiet, personal ways and rarely in public. Finally, in retrospect, it may be that other underlying dynamics that the staff did not recognize also were taking place pertaining to the divisions and sub-groupings within this cohort, such as between "bloods" (full bloods of one Indian Nation) versus "breeds" (blood lineage of more than one tribe and/or of non-Indian heritage) (F. Montour, personal communication, August 5, 1994). Unfortunately, program staff were not sufficiently aware of these important distinctions and the roles they were playing in the group process of the AI cohort.

Towards the six week mark in the program, it became apparent that a major split was dividing the cohort, centering around subtle differences in opinion over when and how frequently to use the sweatlodge. This agreement ended in a heated group therapy session during which one of the group members left AMA (against medical advice) from the program. Similar issues arose within the cohort concerning frequency of attendance at Pow-Wows. Closer observation led to the conclusion that the split had occurred between more "traditional" and more "assimilated" group members. Somewhat naturally it turned out that the veterans who regularly attended Pow-Wows were the same members who also regularly attended sweatlodge ceremonies.

Since most of these "traditional" activities in the beginning were designed to be group bonding experiences, the necessary preparations were discussed partly in group therapy and partly in scheduled "vet-run" meetings. Almost all of the program staff were committed to being very responsive to cultural needs and nuances of the AI cohort group. Therefore, lengthy discussion and debate was facilitated and allowed among the group members about such planning or whether or not to attend Pow-Wows and other cultural activities. However, this led to considerable disruption of regular program offerings, including the cancellation of some regularly scheduled classes and groups.

In addition, all group members did not regularly attend traditional AI activities outside of the program; these veterans soon objected to any "PTSD treatment time" that was taken away from the program to discuss "traditional" events. The argument made in their case was short and clear: "We have sweatlodges at home and can go to Pow-Wows anytime we want to. We came here for treatment of PTSD and not awareness of American Indian culture." It was not until such discussions (which tended to be quite lengthy) were made optional and held "after-hours" that the regular day program could be fully provided and appreciated by the group.

The split crept into the group to the point where it was decided by program staff and the group to allow the veterans to divide into two self-selected sub-groups for war-trauma focus sessions; not surprisingly, the focus sub-groups split along the same lines of traditionals and assimilated veterans. The more traditional sub-group members preferred to have their sessions facilitated in a more non-confrontive, non-interrupting style than was characteristic of the usual PTSTP approach to war-focus. But by no means did the subgroup of veterans interested almost only in PTSD treatment appreciate being referred to as "non-traditionals." Every member of the group showed great reverence and respect for the traditional AI way of life. However, some members were committed to these ways as a complete life style, to include it as an integral part of the 11-week PTSTP; others made use of certain aspects of it when they saw the need for them.

Finally, it was agreed that special arrangements for traditional activities would be discussed by those interested veterans in *off*-program hours only. Therefore, no "regular PTSD treatment" time would be lost. This helped to ease the separation within the group somewhat, even though it continued to exist.

Staff Reactions and Divisiveness

A gap also developed between *staff* (and veterans) involved in the more traditional activities versus staff (and veterans) involved with the more assimilated veterans. For example, the staff highly involved in the traditional AI activities were perceived by other staff and the more assimilated veterans as being overextended and over-involved with the "traditional"

veterans. In turn, the staff highly involved in the traditional AI activities felt misunderstood and under-appreciated by other staff and the "assimilated" veterans. Contributing to these dynamics were the location of a number of the culture-specific activities outside of the office-setting, during "off-hours," without normal staff back-up or oversight, the emotionally proactive and spiritually charged nature of the activities, and the relatively frequent number of culture-specific activities that were being scheduled ("at the expense of" a number of regular program activities). The staff, and veterans, struggled to find an acceptable balance between the frequency and emphasis on culture-specific activities, and provision of the regular PTSD treatment program.

The nature, frequency, and locations of the culture-specific activities, combined with the need for staff oversight of such, resulted in those several staff who were highly involved in accompanying the veterans to such activities to become somewhat overextended. In retrospect, the program staff came to the conclusion that they had not been sufficiently aware *at the time* of how overextended several staff were, and the subsequent blurring of some patient - staff boundaries. For example, a staff member (unaccompanied) took an AI veteran home for a social visit; and, a staff member did not come forth to report being physically shoved in a ward bathroom by an AI veteran (a serious violation of the "no violence" rule). Somewhat belatedly, the program staff had learned that due at least in part to the increased, distinctive and intense activities for this population, transference and countertransference dynamics were a powerful influence throughout the treatment cycle. Hence, more rigorous and additional debriefings of veterans and staff would have been beneficial, and should have been proactively and vigorously initiated by the program leadership.

Group Losses, Graduation, and Immediate Aftermath

A total of four group members did not complete the PTST Program inpatient phase. In addition to the one member mentioned earlier who left due to issues over how frequently the sweat lodge was to be utilized, a second member left due to dissatisfaction regarding the medications he was being prescribed and a third left following receipt of a letter from his ex-wife asking for a reconciliation. The fourth group member was discharged one week before graduation due to an infraction of the PTST Program violence policy (he physically shoved a staff member). It is important to note that each time a group member left the program, a sweatlodge ceremony was held in the evening to pray for the ones who left and to send them good thoughts. The Nisqually spiritual leader consultant was called in to perform the proper rituals.

On December 5, 1990, eight of the original twelve veterans (67%) graduated from the program; the graduation ceremony was, by far, the most elaborate and longest in the program's history. Many American

Indians from the community paid tribute to these veterans by serving refreshments and giving presents. A host drum was invited, honor and warrior songs were sung and verbal tributes were given. Many of these presentations were rather impromptu, elaborate, and some came as a surprise to both program staff and graduating veterans.

During the course of the following two weeks, events developed tragically for two group members who had left the program early. One veteran died in a fishing accident. Another who had subsequently gone on to receive additional inpatient and outpatient treatment in California committed suicide. The group and staff came together to mourn and pay respect for these two veterans. In the case of the latter veteran, there also was a review of warning signs regarding possible suicidal intent that may have been overlooked by staff or cohort members (none were so identified). Again, the Nisqually spiritual leader consultant performed the proper rituals and ceremonies to facilitate the necessary recognition and grieving process.

Admission of A 50% American Indian Cohort Group

The PTSTP also had decided to admit a second cohort group immediately following the all-AI group; only, this group consisted of 50% AI and 50% non-AI war-veterans. All of the veterans were given the option in advance of being admitted with this 50% AI veterans' cohort or being admitted to another group; thus, all who came were interested in being part of this unique 50% AI group. (It should be noted that some of the AI veterans had expressed interest in either the 100% or 50% AI cohort. They were placed in the latter cohort once all the slots in the former cohort were filled).

This design for a 50% AI cohort had been decided *prior* to the admission of the all-AI group and was intended to counter some of the issues raised by an "exclusive" AI cohort group. There also was the objective to see if there would be positive aspects of having several AI and several non-Indian veterans interacting in the same group. In addition, some of the "lessons learned" with the all-AI group were proactively applied to this group. The results were a much smoother and seemingly more positive experience for all of the group members:

1. Veterans were provided with the "regular" PTST Program during weekday hours.
2. All discussions, debates, and planning for possible involvement in "traditional" AI activities were set aside for after 4:00 p.m., and were run by the veterans themselves. These meetings were optional for whomever in the cohort group (AI and other veterans alike) wished to attend.

3. Several of the non-AI group members embraced the opportunity to participate in traditional AI healing techniques and integrated these opportunities into their PTSD recovery.

4. While the staff did provide logistical support for sweatlodge ceremonies and Pow-Wows, these type of activities were reduced to a more manageable number (e.g., one about every other weekend in order to decrease the frequency of activities for which staff provided transportation, etc.). In this way, neither staff nor veterans had become "overextended" in such activities to the point where it hurt their focus and benefits from the regular program.

5. Only a few "split" war-focus groups were held (e.g., where the group was divided into two sub-groups with each sub-group simultaneously having a war-focus group session). And, each sub-group was purposefully selected to include both "traditional" and "assimilated" orientations. In this way, the split groups did not accentuate splitting within the group as occurred in the all-AI group.

Staff overall appeared much more comfortable with the 50% AI group. However, it is not possible to determine how much this was due to the PTST Program having become more familiar and hence more at ease with an AI cohort group, and/or how much was due to the dynamic of a 50% vs. a 100% AI cohort group *per se*. In addition, in contrast to a 67% graduation or completion rate that occurred with the all-AI cohort group (versus a typical 80% completion rate for other non-AI cohort groups), there was a 100% completion rate in the 50% AI group. On the other hand, both cohorts had a combination of more "traditional", and more "assimilated", members. It may be that factors other than or in combination with ethnicity were more important than ethnic composition factors alone in influencing the completion rate. For example, the program had gained valuable experience working with the 100% AI group. Also, the clinical treatment team that was with the all-AI group had turnover of several staff during the 11-week cycle; in contrast the treatment team for the 50% AI group was intact throughout the cycle. Overall, the global staff impression of the 50% AI cohort group was so positive that two more 50% AI cohort groups were planned.

In Retrospect: Other Important Lessons Learned

To the author's knowledge, this was the first time that any hospital-based VA specialized PTSD unit admitted and treated an entire cohort group of AI veterans, as well as an additional cohort group purposefully comprised of 50% AI veterans. Thus, there naturally was somewhat of a preoccupation by the PTST Program staff with the dynamics and issues of AI ethnicity and ethnocultural factors. Perhaps due in part to some of the staff's own insecurities, many of us became rather over-sensitive and

over-reactive to some of the concepts that had been taught by AI consultants, e.g., "you can't confront an American Indian directly; when American Indians talk, let them talk until they want to stop; don't look in the eyes or demand eye contact; don't force emotions," etc. Some of the PTST Program staff took these concepts *very* literally. In retrospect, when someone is culturally unfamiliar, there is a tendency to overgeneralize cultural "rules of normative conduct"; one simply does not know the subtleties of its nuances and limits (C. Loo, personal communication, August 3, 1994).

Also, the staff often times did not pay attention to their *own clinical* judgments as to what *each individual* or the group needed. For example, there was a hesitation to set certain limits or confront persons whom the staff might otherwise have confronted. There is a need to find a balance between what may appear to be culturally sensitive and what appears to be clinically appropriate. It is important to note that to be culturally sensitive does not necessarily come *at the expense* of what is clinically appropriate. Rather, it is the blending of the two that becomes the challenge for the staff (C. Loo, personal communication, August 3, 1994). With more experience, this author is confident that the PTSD Program is moving in this direction.

In retrospect, the PTST Program also tended to *minimize* factors that should not have been discounted as much as they were:

1. A tendency to minimize the effectiveness and importance of offering the core PTST Program to these cohort groups.

2. A tendency to overlook the *non*-AI ethnicity composition of many of the group members. Most veterans had both an AI and non-American Indian heritage. There were consequent issues of identity and assimilation of at least two different ethnic backgrounds. Some of the veterans had primarily rejected or avoided dealing with their AI *or* non-AI identity.

3. There was a rather impressive amount of violence and trauma that was present in most of these veteran's lives both before and after the war. This had not been paid adequate attention and must be better incorporated into trauma focus groups (along with war-trauma). For example, one recognized AI leader mentioned on several occasions that he personally knew of many more AI veterans who were killed or died in violent circumstances *since* the war than *during* duty in the war-zone.

In addition, a number of the AI veterans clearly stated, "I came to the PTSTP for the PTSD treatment, not for the cultural stuff; I am already aware of the American Indian ways." The PTST Program had mistakenly assumed that all AI veterans *entering an American Indian cohort group* would be equally interested in incorporating *both* cultural and PTSD knowledge and activities. As previously mentioned, there also was some

role confusion between younger and older veterans in the cohort groups, e.g., older veterans being differentially accorded an "elder" status by some younger group members or being used to that status. In contrast, the typical approach in the PTSTP groups was to operate as peers and treat each other "equally" in terms of confrontation, etc. The staff also became enmeshed in this dynamic by being quite tentative to interrupt, for example, an "elder" veteran even when he seemed to be inappropriately or unproductively "consuming time" in various groups or classes. It would have been much better if differing AI versus PTST Program role expectations, such as this "elder" dynamic, had been openly discussed and strategies agreed to early in the program.

The AI cohort members had differing opinions about the extent to which they wanted various AI resources from the community to become involved in their inpatient treatment. For example, one counselor from another federal agency was willing to be a "guest" facilitator for two group therapy sessions at the PTSTP; however, a number of the AI cohort members felt that to come to participate in just two group therapy sessions would not be very helpful. Conversely, some of the community AI resources clearly were ambivalent about what degree of sanction they wanted to provide to a dominantly Anglo and African American staff who were conducting this untested AI ethnic cohort group concept. Some cohort group members thought that "some outside American Indians were bringing tribal politics to the program," and they "did not desire or need that". However, most were appreciative of the overall level of support offered or provided by various AI resources.

It is important that there was significantly more community involvement in these two groups during their inpatient phase of treatment *than had ever occurred* in the previous five years of the PTSTP. This significant level of community involvement included increased involvement by both veterans and staff in AI cultural activities *outside* of the hospital. In addition, lay-persons were very involved at such activities *and* in activities at the hospital. Such significant community involvement clearly was a major factor in reducing the typical isolation from community that characterizes most inpatient hospital treatment programs.

It is also of significance that the *non*-native veterans in the 50% AI cohort group were very positive in their self-evaluation of the benefits of participating in this unique cohort group. They reported substantial relief from some of their PTSD symptoms through the regular program offerings. In addition, they reported what might be called an enhanced set of rich, positive benefits related to the specialness of this group's ethnic composition and the program's cultural adaptations:

1. A unique appreciation and learning about AI culture through the personal relationships developed in the cohort group bonding process over the 11-week residential stay.

2. Spiritual and therapeutic benefits from participation in sweat lodge rituals.

3. An "insider's perspective" at Pow-Wows through attendance with their AI veteran peers and consequent heightened access to meaningful interactions with Pow-Wow participants through personal introductions.

Also, there was the profound and bittersweet acknowledgment and welcome home receptions that occurred during visits to reservations when there were veterans' recognition ceremonies sponsored by the local tribes. *All* veterans of all eras in attendance, native and non-native, were enthusiastically enjoined to take part in a veterans' procession that was honored by the multi-generational audiences, from small children to elders. Joining and participating in the line of warriors being honored by the very supportive and emotional ceremonies and community members in attendance was a most moving experience. The power of such rituals, anchored in generations of tribal tradition and support for their warriors, is unique in American society. The bittersweet aspect was the recognition by non-native veterans (to include the author) that we never have had or would have this depth of mutual affinity with, let alone such support and recognition from, the communities in which we had been raised.

Conclusions

Admission of two AI cohort groups to the PTST Program was a challenging, invigorating, stressful, and learning experience for us all. The PTSTP became considerably more knowledgeable about specific aspects of AI cultural factors and dynamics. In addition, the program's substantial outreach and networking with various AI resources was a source of invaluable learning and "relationship-building" with AI veterans and resources. It became clear that many AI veterans felt that they have been given the bureaucratic shuffle by various agencies, to include the VA; that many World War II and Korean War veterans and family members had never seen veterans service organization or VA representatives and were quite ill-informed about benefits and services they are entitled to; and that typical VA contact in the past was provided in a "totally white" fashion (e.g., sitting in an office to wait for an AI to come in to ask for help) and so sporadic in frequency that necessary continuity of relationships just did not develop. There was considerable reluctance to accept help that was only offered back at the hospital setting, and considerable distrust when traditional AI knowledge was seemingly ignored or not accorded appropriate respect. Finally, there was a considerable split among AI themselves about whether their traditional ceremonies and rituals were appropriate for utilization *only* by AI; there was an opposing viewpoint that the traditional AI healing ways are for anyone, both AI and non-AI alike, if

approached and conducted properly (see Montour, 1985: Department of Veterans Affairs, 1984, 1989a, 1989b, 1992; Johnson & LaDue, 1990; Wilson, 1989).

The experience of the program staff also, ironically, enhanced appreciation both of traditional culture-specific activities, *and* the staffs own confidence that the "regular" PTST Program could provide very valuable therapeutic impact to AI and other veterans from a wide variety of ethnic, assimilation, geographic, and personality backgrounds - once staff were appropriately attuned and respectful of the values, ethos, and belief systems of each veteran.

The program staff somewhat belatedly recognized and intervened concerning the powerful transference and counter-transference dynamics that arose. Indeed, one might ask whether it was transference and counter transference as much as the nexus of cultural contact and adjustment (C. Loo, personal communication, 1994). Finally, there was yet an increased appreciation of pre-military, war and post-war experiences of AI veterans that was both distinctive from and similar to those of other war-veterans. This latter appreciation reaffirmed the program's emphasis on a "whole-life" perspective and approach, and the need to incorporate more culture-specific inquiry concerning all aspects of pre-military, military, and post-military life.

In closing, the author would be remiss not to mention the AI warriors of various PTSTP groups, to include those in the special 100% and 50% AI cohorts. They taught us all so very much, even as we were not cognizant of when we were the students, and not the teachers.

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Notes

1. Since 1991, there have been significant changes in the PTSTP. For example, the Helicopter Ride collaboration with the Washington State Department of Veterans Affairs was discontinued, and funding provided by the Paralyzed Veterans of America for the Outward Bound project and study was completed. In regards to the latter, the PTSTP now utilizes a rope and height challenge course that is located on the hospital grounds rather than a five-day wilderness course. More recently, there has been a significant

reduction in the number of rehabilitation beds, with other beds converted to a more acute treatment regimen.

2. The need to be sensitive to the meanings of each of these labels is reflected in the advice, given to the author by a reviewer of an earlier draft of this manuscript, to specify in this article how to term "American Indian" (AI) was finally selected (F. Montour, personal communication, August 5, 1994).

3. The senior psychiatrist with the Portland Indian Health Service agreed to endorse the idea of an American Indian cohort group in a cover letter sent to all American Indian Health Service Centers in the greater Northeast. She also agreed to provide clinical consultation or liaison for any specific candidates applying to this cohort group, if desired by PTSTP staff.

4. Because of very prominent anxiety symptoms, it was decided to make an exception to program policy which generally prohibits the use of benzodiazepines. The veteran was temporarily placed on Xanax to decrease his anxiety during this initial phase of hospital adjustment. With the sweatlodge in place and functional, the veteran soon was able to discontinue this medication and continued on a non-habituating anxiolitic (Buspar).