

American Indian Vietnam Combat Veterans:
How Out-of-home Placement and Having a Veteran Primary Care Giver are
Associated with Features and Symptoms of Trauma

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Dedication

This dissertation is dedicated to all veterans who have served in the armed forces, their families, and all the providers who work to lessen the impact of combat and historical atrocities. I specifically want to thank the American Indian veterans who took the time to complete the surveys and their communities who provided both monetary and environmental support that made it possible for me to complete this project. Besides the veterans who participated, I wish to dedicate this work to the American Indian veterans who in the past enlisted to become United States citizens. These same men, after fighting battles overseas returned home only to find that citizenship was not guaranteed. Also upon their return they encountered additional battles such as the fight to have their children returned to them from government boarding schools and other extra-cultural placements.

I dedicate this study to all American Indians who have suffered the impact of having husbands, fathers and grandfathers return from combat carrying the scars of war; which have had generational impacts without explanation for distant looks, rage, moodiness, nightmares and years of self-medicating. This work is also dedicated to those who are interested in developing an understanding and cultural competency to work effectively with American Indian populations. I wish to include those students who are willing to learn the truths of the American Indian veteran experience who I hope will be in awe to learn about the number of American Indians represented in the armed services. Furthermore, I would like to dedicate this project to all the lay people who wish to risk hearing how many American Indians lost their lives in Vietnam and then be open to

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Abstract

It was the purpose of this study to examine the relationships among American Indian Vietnam combat veterans' childhood experiences: extra-cultural placement and having a veteran primary care giver, and features and symptoms of Post Traumatic Stress Disorder. Participants were 150 American Indian Vietnam combat veterans from the Midwest.

This study examined scores from two dependent measures: Traumatic Attachment Belief Scale (TABS) and the Mississippi Combat PTSD Scale-Short Form (M-PTSD Short Form). The two independent measures were: veterans who experienced extra-cultural placement or those who did not experience extra-cultural placement, and veterans who had a veteran primary care giver as a child or who did not have a veteran primary care giver as a child.

Research findings indicated that veterans who experienced extra-cultural placement were significantly more likely to have experienced incarceration and homelessness. There were no significant differences in alcohol and drug treatment between those who had experienced extra-cultural placement and those who had not. There were no significant differences found if participants had a veteran primary care giver or not in homelessness or treatment for alcohol or drug abuse. Those who had a veteran primary care giver were found to be significantly more likely to experience incarceration than those who did not. Research findings also showed that participants who experienced actual or threatened homelessness were also more likely to experience incarceration and alcohol or drug treatment. The impact of trauma on beliefs about others' safety was significantly greater than the impact of trauma on beliefs about self-

safety, trust of others or of self-esteem toward others or toward self, and of intimacy with self or others. Other differences in these constructs were found. Significant differences were not found in the impact of trauma on features and symptoms of PTSD as a function of the absence of extra-cultural placement or extra-cultural placement or having a non-veteran or veteran primary care giver. Finally, there were significant associations between the impact of trauma on beliefs about self and others, features and symptoms of PTSD, no extra-cultural placement/extra-cultural placement, and having a non veteran or veteran primary care giver.

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Chapter I

Introduction

It is important for providers of psychological services for American Indian veterans to be aware of both current issues facing this population and historical cultural issues. This introduction will provide overviews of some of the therapeutic needs of this group and related obstacles to providing good quality mental health care. To provide culturally competent care, providers must have working knowledge of historical federal policies such as the American Indian Citizen Act; the Removal, Reservation and Assimilation Era; the Indian Child Welfare Act; the Indian Self Determination and Education Acts; and the American Indian Religious Freedom Act. Next, providers should know that there are unique cultural identity and post-combat issues that are specific to this group of veterans.

American Indian Vietnam combat veterans face many challenges. These veterans, who seek counseling for Post Traumatic Stress Disorder (PTSD), often become frustrated with culturally unaware service providers. The Matsunaga study was mandated by Public Law 101-507 and directed by researchers at the National Center for PTSD. The goal was to conduct an epidemiological study of American Indian and Asian Pacific Islander Vietnam veterans. It showed that the lifetime prevalence of PTSD was 45 - 57% for American Indians compared to 20% for their White counterparts (Kulka et al., 1990). This overrepresentation, the confirmation of intergenerational effects of combat trauma being passed from father to son (National Center for Post-Traumatic Stress Disorder, 1996; National Center for American Indian and Alaska Mental Health Research, 1996), and the historical atrocities American Indians have faced (American Indian Development

Corporation, 1990), help us understand why American Indian Vietnam veterans, with cumulative stress and trauma, would be at greater risk for exhibiting symptoms of post-traumatic stress or for being diagnosed with Post Traumatic Stress Disorder. Counselors often do not realize that trauma from combat exposure may be secondary to trauma American Indian veterans experienced as children in boarding schools and in foster care placements (Green, 1983). Addressing combat trauma without acknowledging trauma from out-of-home placements or from family disruptions associated with having a veteran primary care giver may perpetuate emotional fragmentation many veterans experience. The constructs that will be examined in this study seek to capture relationships among childhood experiences and trauma related symptoms and attachment beliefs among American Indian Vietnam combat veterans.

To understand potential sources of these symptoms and beliefs, it is essential to understand the American Indian combat veteran experience. Examination of the demographics of American Indian Vietnam veterans reveals that 90% of the 86,000 American Indians who served, volunteered, giving American Indians the highest record of service per capita of any ethnic group (Thompson, 1990). Over half served in combat during the Vietnam War, and approximately 300 were killed (Thompson, 1990). Upon examining the mental health status of the general population of Vietnam veterans, approximately 700,000 to 800,000 Vietnam veterans have been diagnosed with PTSD or have expressed symptoms of PTSD (Williams, 1980). This represents 20% of veterans in general who served in the war. If this percentage is accurate and the distribution is similar across ethnic groups, then approximately 2,200 American Indian Vietnam veterans could

be diagnosed with PTSD. This is without considering any additional factors that may contribute to a PTSD diagnosis.

Historical Impacts

To provide culturally sensitive services to American Indian Vietnam veterans, it is important to understand the potential impact of the American Indian social and historical experiences. This review will address: historical impacts, traumatic experiences and governmental policies designed to ameliorate some of the challenges that American Indians have experienced from the early 1900's to the present. Although the United States withdrew from participation in the Vietnam War in 1973, the basis for the present review of literature will reflect the continued absence of social and cultural support experienced by Vietnam combat veterans. Ongoing policies post Vietnam may have exacerbated the experience and expression of PTSD symptoms by these veterans. Therefore, the framework for this review will include current as well as historical federal-tribal relationships.

American Indians have been subjected to one of the most systematic attempts at genocide in the history of civilization. At the beginning of the colonization process, there were over 10 million indigenous people living in North America (Thorton, 1986). By the year 1900 there were only 250,000 (ibid.). This 90% reduction stemmed from the systematic destruction of American Indian people supported by federal policies. Policies to address the "Indian problem" included the intentional spread of disease, malnutrition, war, and murder, removal from American Indian traditional lands through relocation policies, extreme poverty, removal of young people to boarding schools, and the

introduction of alcohol and other drugs. Given active attempts to exterminate American Indians the resiliency of many tribes is remarkable.

Phil Tingley (Duran, Guillory, & Tingley, 1993), President of the National Indian Social Workers Association, stated:

American Indians, like some war veterans and survivors of concentration camps and other severe traumas, suffer from post traumatic stress.

American Indians are survivors of from one to five hundred years of the most brutal genocide, ethnocide and forced acculturation the world has ever seen....For the past five generations, we have experienced one cultural and individual trauma after another (p. 16).

Besides the systematic historical genocide of American Indian people, there were cultural ramifications that contributed to the disruption of the family unit. For example, Medicine (1987) highlighted that the loss of language was not limited only to oral expression, but also included the loss of the linguistic symbols of culture, the gain of new male-biased communication patterns (i.e. many traditional societies were matriarchal in comparison to the patriarchal society, which was introduced), and the loss of kinship terms that served to define social and familial relationships.

Cultural Identity

Early attempts at cooperative, blended cohabitation with the dominant culture have been continually shown to be unsuccessful. American Indians initially resisted paternalistic attitudes and policies of the U.S. Government. Results of forced assimilation processes created a dependency among American Indians, individually and collectively,

on the government. This dependency fostered unsuccessful coping styles, including passivity, alcoholism, denial of Indian ancestry, rejection of Indian culture, and inter and intra-tribal strife (Orlandi, 1992). The multiple conflicts experienced caused a split, which resulted in shame and self-medicating (Duran, 1993).

The first personal identifier for American Indian people is usually membership in or affiliation with a specific tribe or tribes. For many, the next most salient identifier is membership in a clan or society within a tribe. It is important to realize that a great concern among many American Indian people is the fear that identification with a non-American Indian culture is equivalent to the loss of one's American Indian culture (Orlandi, 1992).

American Indian Citizen Act (1924)

Many Vietnam veterans' fathers were World War II and Korean veterans (Holm, 1994). World War II had 9,000 American Indian men enlisted. Some enlisted because it enhanced their tribal identity. Others enlisted in order to become United States citizens. Citizenship became a tool used to entice American Indians to enlist in the armed services (Nebraska Department of Education, 2008). However, the 1924 American Indian Citizen Act did not guarantee automatic citizenship to World War II veterans who received an honorable discharge. It only allowed American Indian veterans to apply for citizenship (Nebraska Department of Education, 2008). The 1924 American Indian Citizenship Act stated that all non-citizen American Indians born within the territorial limits of the United States would become citizens of the United States. Although the United States enacted this law in 1924, there were three states which continued to deny citizenship to American Indians. Maine, Arizona and New Mexico did not confer citizenship on American Indians

until the middle of the 20th century (Nebraska Department of Education, 2008). These states did not recognize the citizenship that had already been bestowed on American Indians, and so denied citizenship benefits (e.g. voting privileges, property ownership, right to participate fully in the judicial system) to them until the 1950's.

Prior to the enactment of the American Indian Citizen Act (1924), other more oppressive means had been offered for American Indian people to attain citizenship, such as giving up tribal property rights, or marrying a male United States citizen (Thorton, 1986). This could also be viewed by some as an intentional form of devaluing American Indian men by rewarding American Indian women for marrying outside their own race or tribal affiliation.

The psychological ramifications of devaluing the American Indian male through the manipulation and sterilization of American Indian women (Native American Women, International Treaty Council, 1975), strategic child removal, and systematic genocide have been best described by Eduardo Duran, author of *American Indian Post Colonial Psychology* (1995).

Warriors are supposed to repel the enemy and ensure the safety of the community; when this is not possible, defeat has deep psychological ramifications. These ramifications are even greater if the colonizer imposes a diametrically opposed mythology on the people and also on the land that the warriors are supposed to keep safe and alive within the traditional tribal life world. Add to this the destruction of men's role in the traditional economy and you have men divested of meaningful cultural roles (p. 56).

Removal, Reservation and Assimilation Era (1830-1930)

Earlier public policies impacted all ages within communities. The impact of the removal, reservation and assimilation era (Byers, 2003) conditioned tribal people to feel helpless to defend themselves against future atrocities. The Indian Removal Act of 1830 enabled the President of the United States to negotiate relocation agreements with American Indian tribes. Although this act did not explicitly use the term “forced” it did enable it. Titles to American Indian properties could be arbitrarily extinguished as judged necessary by the President. In exchange, tribes were often relocated to geographic areas with which they were not only unfamiliar but lacked the natural resources on which the American Indian people had become dependent. This also meant being forced to leave the sacred burial sites of ancestors (Thorton, 1986). For several tribes, (Choctaw, Cherokee and Chickasaw) this process occurred more than once, with several forced removals (Byers, 2003).

The areas to which they were removed are still regarded by some American Indian people as “prisoner of war camps” (Yaekel, 1999). Forced ongoing displacement caused disruptions in traditional families and clan systems (American Indian Development Corp., 1990). Today we continue to see the effects of this systematic displacement process, especially when examining the numbers of American Indian families who struggle with attachment and paternal bonding issues (ibid). It is likely these disruptions stem from generations of American Indian children being removed by force to boarding schools and non-American Indian homes (Duran, 1995). According to Coleman (1990, p. 76), “the process of deculturation out of the ‘savage’ ways of life proceeded hand-in-hand with enculturation into an alien world for thousands of American

Indian children.” Coleman (1990) added that there are many today who believe that the negative consequences associated with this period of assimilative education are still being felt by subsequent generations.

The Indian Child Welfare Act (1975)

The Indian Child Welfare Act (ICWA) was created to address the alarmingly high percentage of American Indian children who were being removed from American Indian families and placed in non-American Indian foster or adoptive homes or government boarding schools (US Code: Title 25, 1901.Congressional findings § 1901). This act also acknowledged that American Indian children are the most vital resource for the continued existence and integrity of Indian tribes. Therefore, generations of removal of American Indian children have resulted in effects that impacted not only the individual child and his or her family but also the community, tribe, and American Indian people as a race (Nebraska Department of Education, 2008).

These effects are reflected in the breakdown of the traditional family unit, which included the critical role of the extended family in raising children. In cases of placement in boarding schools, the impact was greater, resulting in generations of un-parented parents and institutionalized children (Yaekel-Black Elk, 2005). Indeed, some American Indian men have commented that both the military and incarceration were easily adjusted to because of the similarities between these types of institutions and the institutionalized life they had lived in boarding schools (Yaekel-Black Elk, 2005). Some of these men also indicated that boot camp was “a piece of cake” compared to the emotional and physical abuse they endured in boarding schools and foster homes, where they were often treated like indentured farm hands (Yaekel-Black Elk, 2005).

In the Yaekel-Black Elk (2005) study, some of the American Indians interviewed stated that their entry into the military was facilitated by military recruiters who visited the boarding schools and talked to eleventh and twelfth grade classes. These recruiters offered delayed entry programs into the military, which could even include enlisting with a buddy. Since many of these adolescents and young adults lived year long in boarding schools, the guaranteed future of the military seemed secure and predictable, compared to the uncertainties of returning to reservation life. This continues to be reflected in frequent transitions of American Indian children who experience out-of-home placement and for American Indian women and men who experience high recidivism rates of incarceration (Yaekel, 1999; Yaekel-Black Elk, 2005).

Ladue (1982) addressed commonalities between American Indians and Vietnam veterans, specifically the disruptions caused by transitions. Ladue states:

The isolation experienced by many Vietnam veterans is physical but often accompanied by an emotional aloneness. This is a feeling that they cannot let anyone be close to them for fear of either being rejected by others or simply of being “different” from people around them. This pattern is frequently seen in young men, particularly, from minority cultures with a familiar example being both veterans and non-veteran American Indians (p.12).

Indian Self-Determination and Education Act (1975)

In the late 1960's and early 1970's President Nixon pushed for Congress to begin acknowledging that the federal domination of both American Indian programs and educational systems serving American Indians were delaying their progress towards self-

sufficiency. Additionally, these systems were hindering American Indian's potential to address their own problems through their own unique insights into the needs of their communities. These new governmental initiatives allowed for increased parental control within families and the reduction of paternalistic control within systems that gave momentum towards American Indian communities' independence. This began the process of change (Cornell Law School, 2007), which continues to be slow and mired in bureaucratic road blocks (Trimble & Hayes, 1984).

The concept of self-determination was a first step but there needed to be additional changes in policies before American Indian communities became self-reliant. For example, although the government passed the Indian Self-Determination and Education Act in 1975, the American Indian Freedom Act was not passed until 1978. As a result, the members of many tribes, even when given the policy support to move forward, felt helpless. Previous traditional practices that assisted American Indian people in daily coping and problem solving were illegal. Therefore tribes would need time to reintroduce old customs and practices that were forbidden to them.

Tribes needed to know how to make the transition to independence. The Bureau of Indian Affairs did realize that true self-determination was dependent on an educational process in producing future leaders in communities (Law School Legal Information Institute, 1979). Having governmental support did not make the previous abrogation of rights disappear. As with any individual or group of people who have been abused, it takes time to move beyond the paralyzing grip of anger associated with being a victim. This is especially true when the perpetrator has not yet acknowledged responsibility for the trauma (Duran, 1995).

The challenge for American Indians was to give meaning to what appeared to most Native Americans as senseless. De Becker addresses this concept in the book *The Gift of Fear* (1997). “The human violence we abhor and fear the most, that which we call ‘random’ and ‘senseless,’ is neither. It always has purpose and meaning to the perpetrator, at least. We may not choose to explore or understand that purpose, but it is there, and as long as we label it ‘senseless’ we’ll not make sense of it” (p.15). Before American Indians can make sense of these traumas there first has to be the acknowledgement that a trauma actually occurred.

In his book *Native American Post Colonial Psychology* (1995), Duran further asserts that this collective experience among American Indians is an obstacle to healing. Most of the literature on the intergenerational transmission of Post Traumatic Stress Disorder (PTSD) has emerged from research done with victims of the Nazi Holocaust (Duran, 1975). Duran specifically mentioned the similarities and differences between the Jewish experience and the American Indian experience. He shared that one of the obstacles to American Indians moving forward to healing from the trauma is that the world has not acknowledged the holocaust of native people in this hemisphere (Duran, 1975).

American Indian Vietnam combat veterans not only must deal with their own combat and childhood trauma, but they also must continue to battle the as yet unacknowledged trauma experienced by their parents and grandparents. For example, the emotional and physical abuse youth experienced who were sent to the Phoenix Indian School. In December 1899, measles reached an epidemic level at the school. There were 325 cases of measles, 60 cases of pneumonia and 9 deaths within a 10 day period

(Kleinfeld, 1977). To make matters worse, parents were often not notified of these deaths until a significant time had passed. Many of these children died due to the overcrowding and poor health conditions of the boarding school domiciles. To be denied the right to care for a sick child was an unbearable loss for many which may have accelerated self-medicating and death (Bureau of Indian Affairs, 1971).

Additional traumas were experienced by American Indians, such as combat trauma. Furthermore, because of the anti-war sentiment in the United States, homecoming for Vietnam veterans was often more traumatic than actual combat experiences. It is the point of this exploration that cumulative traumas result in greater debilitation. This is not to diminish the actual effects that combat has on veterans' emotional reactions to trauma that have been recorded since ancient times (Bentley, 1997). In this century, these reactions have been categorized as "shell shock" for First World War veterans, as Traumatic Neurosis or Gross Stress Syndrome (DSM), or Transient Situational Disturbance (DSM-II) for World War II veterans; as Survivor's Syndrome for Holocaust survivors (DSM-II), and as PTSD (DSM-III) for Vietnam veterans and beyond (Bentley, 1997).

American Indian Religious Freedom Act (1978)

As significant as the loss of culture, language, and identity were for American Indians, a greater loss was religious freedom. Religions and associated ceremonies make transitions and healing possible. These transitional ceremonies help prepare for changes, such as seasonal changes or a stage of life change. They can also be used for less predictable events such as conflicts, to prepare for or return from war, to heal from physical or mental illness, and to help someone who dies to make their after death

journey. Spiritual beliefs and practices are not just specific isolated ceremonies, but a way of life. For some tribal members, spirituality begins from the moment they wake up and greet the sun until they lay down to sleep, and even then the spirit continued to connect the human to a higher power (Bureau of Indian Affairs, 1978). However, until 1978, American Indians were not allowed to practice their religions resulting in a disconnect that destroyed the means to problem solve, cope with traumatic events and even to die with dignity (Bureau of Indian Affairs, 1978). These emotional disruptions created a breeding ground for alternative unhealthy coping techniques.

The American Indian Religious Freedom Act (Public Law 95-341, 1978) was enacted to protect and preserve American Indian's right to believe, express and exercise the traditional religions of the American Indian, Eskimo, Aleut and Native Hawaiians. Tragically, this law, for many individuals and tribes came too late. Some tribes have lost their traditional teachings, many have lost their languages, and for others they have ceased to exist as tribes (Bureau of Indian Affairs, 1978).

It is not uncommon for American Indians to hear comments like "That was a long time ago -- they need to get over it. After all it has been 500 years ago." However, the wars between American Indian people and White settlers actually lasted longer than most of the general public is aware. For example, with the acquisition of the Gadsden Strip in 1853, the U.S. government took control of the lands that currently comprise southern Arizona and New Mexico, although Apaches continued to defend their independence for decades. The struggle ended in the 1880's with the establishment of the Fort Apache reservation, also known as the White Mountain Apache Reserve (Basso, 1970). The last battle which occurred on the White Mountain Reservation occurred in Cibecue where the

tribe's spiritual leader was shot for conducting a ceremony. This incident caused a new uprising which did not end until 1886 (Basso, 1970).

In many respects, the battles are not over, at least not for American Indian people. Even after the 1978 Religious Freedom Act was passed, children were still being forced to attend Christian schools because these were the only schools available in isolated reservations. This experience was not limited to aboriginal people in the United States. According to the Legacy of Hope Foundation:

Between 1892 and 1969, residential schools operated in Canada through arrangements between the Government of Canada and the Roman Catholic, Anglican, Methodist, United and Presbyterian churches.

Although the Government was no longer officially involved after 1969, a few schools and hostels continued to operate into the 1970s and 1980s. Akaitcho Hall in Yellowknife did not close until 1996. One common objective defined this period -- the assimilation of Aboriginal children (2008).

Even after government policies changed, geographic necessities still often dictated child removal for school attendance. To protest sending children to these schools would result in removal of the child from the home for truancy violations. This continues to contribute to the disruption of the traditional American Indian families. The Legacy of Hope Foundation, on its website, discusses generational impacts of the residential experience (2008):

The unresolved trauma of Aboriginal people who experienced or witnessed physical or sexual abuse in the residential school system is

passed on from generation to generation. The ongoing cycle of intergenerational abuse in Aboriginal communities is the legacy of physical and sexual abuse in residential schools. . . .Some children attended these schools for a short time, others, for their entire schooling. Some graduated with useful skills, while many became self-destructive as a result of the physical, sexual and mental abuse that was inflicted upon them.

Besides dismissing experiences as something that happened in the far reaches of history, American Indian experiences are devalued by some as resistance to assimilation (Orlandi, 1992). Often American Indian people are subjected to comments such as “My grandparents came from... and they learned to adapt.” Statements and attitudes such as these typically break down communication and create barriers to healthy intercultural relationships. It is imperative that we understand the dynamics and complexities which differentiate voluntary and involuntary minorities and chosen acculturation versus forced assimilation.

It is not difficult to see the need to address both pre- and post-combat trauma issues in counseling American Indian Vietnam veterans. A counselor, to be competent, cannot ignore historical or cultural issues. By doing so he or she could continue the ongoing fragmentation of a group of people already traumatized by these processes. Often clients will have military experiences addressed with no inquiry as to a possible PTSD diagnosis prior to veteran combat experience. Therefore, a counselor evaluating American Indian Vietnam combat veterans must be aware of the multifaceted aspects of

trauma in order to develop effective treatment plans (Russo, Ward, Geurts, & Scheres, 1999) that incorporate the generational impacts of trauma.

Chapter II

Literature Review

In this Literature Review the experience of being an American Indian veteran will be examined. Unique demographics for this population will be identified, as well as the pre- and post-combat experiences that are shared by many of these men. Significant findings as they relate to post-combat adjustment, incarceration, drug or alcohol treatment and the extent of homelessness, will also be shared. Finally, it is the goal of this review to answer the question: Did historical cultural experiences in indigenous communities increase susceptibility of American Indian Vietnam combat veterans who experienced out-of-home placement or who had a veteran primary care giver to develop unhealthy attachment beliefs or the features and symptoms of post traumatic stress disorder (PTSD)?

Post Traumatic Stress Disorder Defined

Emotional reactions to trauma have been recorded since ancient times. In this century, these reactions have been categorized as Shell Shock (World War I veterans; DSM-I), Traumatic Neurosis (World War II veterans; DSM-I), Gross Stress Syndrome (DSM II), Transient Situational Disturbance (Holocaust Survivors), Survivors Syndrome (general traumatic experiences across populations), and Post-Traumatic Stress Disorder (PTSD; DSM-III, DSM-IV, DSM-IV-TR). A term predominately used to describe intergenerational traumatic stress among American Indians is Post-Traumatic Cultural Disorder (PTCD; Shold, et al., 1991, p. 125). PTCD is defined as a re-experiencing of a previous or present value or cultural conflict leading to stress and conflict that culminates in a probable codependent dysfunctional state. A salient symptom of PTCD is an

emphasis upon loss of identity and permeable boundaries, as well as a sense of the loss of control and relationship difficulties (Shold et al., 1991).

This disorder is similar to PTSD in symptomatic expression, although the etiology is assumed to be continual cultural conflict and assimilation. Post-Traumatic Stress Disorder (PTSD) has been shown to be co-morbid with a variety of diagnoses exhibited by veteran and non-veteran American Indians. Eduardo Duran, psychologist, reported that in his work with American Indians, at least 75% of his clientele could fit into a diagnostic category of PTSD (1995). However, it should be noted that although PTSD is a recognized DSM diagnostic disorder, PTCO has not been included in the DSM diagnostic classification system to date.

For purposes of this review, the DSM-IV-TR features and symptoms of PTSD will be utilized. These include impaired affect modulation, self-destructive and impulsive behavior, dissociative symptoms, somatic complaints, feelings of ineffectiveness, shame, despair, or hopelessness, feeling permanently damaged, a loss of previously sustained beliefs, hostility, social withdrawal, feeling constantly threatened, impaired relationships with others, and/or a change from the individual's previous personality characteristics. The constructs that will be examined in this study are reflected in both American Indian veteran's combat and childhood experience.

Constructivist Self-Development Theory

Constructivist Self-Development Theory (CSDT) was constructed by Laurie Pearlman. This theory regards psychological trauma (the effect on the person) as rising from an interaction between individual personality differences and the traumatic

situation. The theory integrates cognitive theories with Psycho-Analytic Theory and Self Psychology (Pearlman, 2003).

The CSDT approach is composed of two sub-approaches, self-capacity, and cognitive disruptions that affect attachment beliefs such as safety, trust, esteem, intimacy and control. Pearlman (2003) explained that self-capacity helps clients move toward a fuller experience of self by: 1) developing an awareness of what they feel, 2) accepting a full range of feelings (affect tolerance), 3) a sense of themselves as viable beings who deserve to be alive and to be loved (self worth), and 4) a sense that they are cared about by others (connection).

According to CSDT, therapeutic work on cognitive schemas require six strategies: 1) identifying areas of disruption, 2) exploring the sources of disruption, 3) exploring the meanings of the disrupted schemas and of their alternatives, 4) exploring the self-protective value of the disrupted schemas, 5) gently challenging the disrupted schemas, and 6) arranging small life experiments that will challenge and may expand or alter the schemas. This theoretical approach to counseling takes time and requires authenticity from the therapist. According to Pearlman (2003) authenticity is defined as a psychology provider whose behavior is trustworthy, reliable, and genuine.

Applying this theory to American Indian combat veterans, there is a potentially greater level of cognitive disruptions among American Indian Vietnam combat veterans than among other populations. Because of the nature and impact of combat for people who may already be traumatized by childhood experiences and cultural/historical trauma, it could be essential to understand how these disruptions effect American Indian Vietnam

combat veterans in order to be able to construct effective psychological treatments for this group.

American Indian Veteran Demographics

Besides serving in the Vietnam War, American Indians also served in World War I, World War II, Korea, as well as subsequent United States wars. Tom Holm (1992) discussed the demographics in his study of Vietnam veterans and the possible historical effects of World War II on American Indian Vietnam veterans. In this study, 170 American Indian Vietnam veterans across the nations were surveyed. Participants were drawn from lists provided by Vet Centers nationwide and by the Vietnam Era Veterans Inter-Tribal Association. Although the sample was one of convenience it was considered valid because the geographic distribution of the sample closely matched the geographic distribution of American Indians found in U.S. Census (1990).

According to Holm (1992), “Most veterans surveyed were born between 1946 and 1954. Post World War II was a very disruptive time in America for American Indians.” “Both the federal termination policy and the federal relocation programs were implemented with the often expressed intent to assimilate American Indians into mainstream society,” (Holm, 1992). These policies created disruption in American Indian community’s political and cultural structures, which were also compounded by the disruptive effects of World War II. Additionally, disruptive cultural effects evolved from American Indians moving from rural/reservation areas to urban centers. This is because the migration tended to disrupt tribal kinship patterns, and in many cases destroyed family traditions (Opler, 1992). Thus, because most Vietnam veterans were born during this time of relocation (1950), they were most directly affected by this disruption.

Holm (1992) provided useful demographic information in this study, which is imperative for a foundation of knowledge that is needed to counsel with this population and to understand the historical contexts of American Indian veterans. What the study did not address, however, is specific information on how American Indian and non-American Indian veterans were similar or different in pre-combat adjustment or experiences.

Generational Impact

We know that American Indians experienced both physical and cultural disruptions after World War II. However, we also should assume that World War II created disruptions across ethnicities. Thus, recent empirical research has examined potential relationships between being raised in a home where the parent was a World War II veteran, and developing PTSD symptoms or associated features among Vietnam veterans. For example, it was found in the Rosenheck and Fontana (U.S. Department of Veterans Affairs) literature review (1980) that Vietnam veterans experienced emotional effects from being raised in a home where many fathers had been veterans. Having a parent who was a World War II veteran, according to studies reviewed by Rosenheck and Fontana (1998), was found to be a significant factor in the development of PTSD among multicultural samples of Vietnam veterans. In two of the studies, Vietnam veterans, whose fathers served in combat, were shown to have an increased risk of PTSD or other post war adjustment problems when compared to other Vietnam veterans whose fathers had not served in combat. Study one participants were Vietnam veterans seeking treatment for PTSD from the Department of Veterans Affairs (VA). Study two participants were veterans who participated in the National Vietnam Veterans Readjustment Study (NVVRS).

Study one consisted of four hundred thirty-nine male Vietnam combat veterans whose fathers were veterans ($n = 256$, 58%) and who had also been involved in combat ($n = 155$, 39.5%) (Fontana & Rosenheck, 1993). This study utilized these two sets as comparison groups. Veterans in these two groups (father experienced combat or father did not experience combat) were compared on measures of four principle domains: 1) demographic characteristics, 2) pre-military family environment and personal adjustment, 3) conditions of military entry and war zone experiences, and 4) current symptomology and social adjustment.

Study two, the National Vietnam Veterans Readjustment Survey (NVVRS; Kulka, et al., 1988), is probably the most comprehensive study even conducted on Vietnam veterans. This study was designed to examine the possibility of differential rates of PTSD by ethnicity (Kulka et al., 1988). Results from the NVVRS community sample mirrored the results from the VA treatment sample. For example, veterans whose fathers served in combat entered the military at a younger age ($p < .001$). If veterans' fathers had served in combat then their sons exceeded the cut off for a PTSD diagnosis ($p < .012$), were found to have a poorer relationship with their mothers as children ($p < .040$), were perceived to receive less help at homecoming ($p < .001$), had more survivor guilt ($p < 0.004$), and experienced a significant lifetime risk of alcohol abuse ($p < 0.039$).

With the confirmation of intergenerational effects of combat trauma being passed from father to son in the general population, and given the historical atrocities American Indians have faced, it is understandable that American Indian Vietnam veterans would be at greater risk for being diagnosed with PTSD. The limitation of the Rosenheck and

Fontana study is that the absence of cultural influences may have created unaddressed study confounds.

Cultural influences were addressed, however, in the Matsunaga Vietnam Veterans Project (MVVP; National Center for Post-Traumatic Stress Disorder and the National Center for American Indian and Alaska Mental Health Research, 1996). In this study it was shown that there were extremes in PTSD assessment scores, and post-combat adjustment issues, such as addiction, incarceration and homelessness, were represented more highly among American Indians. The NVVRS study was limited by grouping American Indians veterans with White veterans in the sample, without examining ethnic differences. The problem with this grouping was there were distinct differences in the American Indian population of veterans which have been shown to contribute to greater PTSD symptom expression than veterans from other ethnic groups. These differences were the motivating force for the next study to be examined.

Minority Veterans

The MVVP was mandated by Public Law 101-507, which directed researchers at the National Center for PTSD to conduct an epidemiological study of American Indian and Asian Pacific Islander Vietnam veterans because they had not been specifically sampled in the NVVRS. Because MVVP was stipulated to be an “NVVRS-like study” (p. 7), the results from the two studies can be easily compared. This was evident with the inclusion of data from NVVRS in MVVP with regard to race. Changes were made to MVVP for reasons of fiscal limitations, practicality and scientific considerations. These changes limited MVVP participants to only male respondents (NVVRS full study utilized female respondents), and changing items in the survey instruments so that they were

more culturally sensitive and racially inclusive. However, researchers aimed to not change the items so much that the outcomes could not be comparable across studies.

There were two research centers responsible for conducting the MVVP study. One was the American Indian Vietnam Veterans Project (AIVVP), which was overseen by the National Center for American Indian and Alaskan Native Mental Health Research located in the University of Colorado Health Sciences Center. The other was the Hawaii Vietnam Veterans Project (HVVP), which was overseen by the Veterans Affairs Northwest Center for Cooperative Studies in Health Service at the VA Medical Center in Seattle, Washington. Each research center was responsible to survey two specific populations. Researchers from the AIVVP surveyed Southwest (SW) and Northern Plains (NP) American Indians. Participants were drawn from two separate regions so that the normal differences in culture, ideas, and experiences would not be confounded due to geographic overlay. Researchers from the HVVP surveyed Native Hawaiians (NH) and Americans of Japanese Ancestry (AJA).

For the Northern Plains and Southwest American Indians, sample size was 313. For the Native Hawaiians and Americans of Japanese ancestry, sample size was 329. Interviews averaged between four and five hours for the Northern Plains and Southwest American Indians. For the Native Hawaiians and Americans of Japanese ancestry, interviews averaged between three and four hours. Participant recruiters received three days of training and were also Vietnam veterans. Lay interviewers received two weeks of training, which included viewing a training movie on conducting interviews with Vietnam veterans in a culturally sensitive manner. Data collection was expected to take

twelve months but actually took fifteen months due to staff burnout, vast coverage areas and locating veterans.

One of the major findings in the original NVVRS was that ethnic minority status was associated with a higher level of PTSD assessment scores. This factor was probably the greatest motivation for the MVVP study. The prevalence of PTSD among American Indians from the Northern Plains was 31%; among American Indians from the Southwest, the prevalence rate was 26.8%. Among the Native Hawaiians, the prevalence rate was 12%. Among the Americans of Japanese ancestry, the prevalence rate was 2.9%. As can be seen, American Indians from both the Northern Plains and from the Southwest had higher prevalence rates of PTSD than either the Native Hawaiians or the Americans of Japanese ancestry.

In the Matsunaga study it was found that lifetime PTSD prevalence was highest for American Indians (SW 45.3% and NP 57.2%) when compared to the other groups (NH 38.1%, AJA 8.7%, Hispanics 33.7%, Black 35.4% and White 19.9%). American Indians in this sample also had much higher rates of alcohol abuse/dependence than other American ethnic groups. Lifetime rates were over 80% and current were 70%. For all other races, lifetime rates were between 33% and 50% and current rates were between 11% and 32%. Although percentages were not specifically mentioned, MVVP found that American Indians were more likely to report committing a felony. The Northern Plains reported that one-third (33.8%) had been or were currently homeless (SW 19.3%), (NH 11.6%), (AJA 2.9%), (Black 12.2%), (White 10.4%) and (Hispanic 2.9%). When combined, the Northern Plains and Southwest American Indian population made up 54.1% of the homeless population. This rate of post combat homelessness was greater

than homeless rates that had been reported in previous studies (NVVRS; Kulka, 1990) for other ethnic groups. For example, among Black veterans, research has shown that 12.2% have been or are currently homeless. Among White veterans, the homelessness rate was 10.4%. Among Hispanic veterans, the homeless rate was 2.9%.

Since the MVVP study was developed to be compared to the NVVRS study, comparisons across other populations (White, Black and Hispanic) could be compared with American Indians and Native Hawaiians as well. For example, in the MVVP study, American Indians and Native Hawaiians were found to have experienced the greatest demoralization (1990). The MVVP showed that even after the experience of combat was adjusted for demoralization, levels were still high (SW 1.7, adj. 0.95), (NP 1.66, adj. 0.99), (NH 1.18, adj. 0.99), (AJA 0.95, adj. 0.6), (Hispanic 1.15, adj. 0.8), (Black 1.10, adj. 0.68), and (White .92, adj. 0.68). Demoralization was defined as complaints about derogatory comments (i.e.: being called Chief.)

The Matsunaga study (Kulka, 1990) has been the most comprehensive in determining the differential impact of the Vietnam War between ethnicities. It was instrumental in rectifying some of the assumptions made in the NVVRS study, such as there would not be significant differences between ethnic groups. What is not clear is how much the disparity may have changed if the American Indian and the White samples would have been separated for the analyses. If this is the case comparisons used in the Matsunaga study between American Indians and the category “White” probably could be assumed to have yielded conservative estimates of the actual difference since the earlier data are based in grouping together of Whites and American Indians. This could have created the higher mean rates of maladjustment among the White populations as well.

Therefore, if they were later compared, the comparison would have been actually with American Indians in one group and White and American Indians together in the second group.

Another limitation of this study is that Southwest and Northern Plains American Indians were assumed by the researchers to be commensurate in terms of cultural experiences and values. Although there may be some similarities between tribes in different regions it should not be assumed that experiences can be generalized which will be discussed later in another study (Yaekel-Black Elk, 2005).

American Indian Veterans

Studies have found cultural disparities in combat experiences. Beals et al. (2002) examined differential exposure to war-zone stress and its effects. Utilizing data from the NVVRS and AIVVP, researchers examined whether American Indians actually experienced more war zone exposure than soldiers from other ethnic groups tested in the Matsunaga study (SW, NP, NH, AJA, Hispanics, Black and White). They also examined how American Indians' reactions to war zone exposure compared to that of other populations (Kulka et al., 1988). The NVVRS study measured wartime experience by using a factor analysis examining five underlying constructs, exposure to atrocities and violence, combat exposure, deprivation, loss of meaning, and loss of control.

Results from this study showed that American Indian Vietnam veterans had higher rates of lifetime and current PTSD diagnoses because of differential Vietnam war-zone stress exposure. Military indicators were used to support self-reports of greater war-zone stress exposure experienced by the American Indian veterans. They were more likely to have been enlisted in the Army and Marines and to have served in I-Corps (who

served in areas with a great deal of firefight). They also were more likely to have received combat medals and to have been wounded in Vietnam than military personnel from other ethnic groups (National Center for Post-Traumatic Stress Disorder and the National Center for American Indian and Alaskan Mental Health Research, 1996).

Researchers also found that when comparing ethnic groups there were no statistical differences in how veterans reacted to war zone exposure during or after Vietnam. Adjustments were made in these studies by using pre-combat experiences as the covariate. These pre-combat experiences included having a father who was a veteran, and experiences of family violence. The study was limited in that non-responses were coded by researchers as no violence was experienced. Researchers also did not examine whether veterans had actually lived with their parents or not. Therefore, pre-existing variables such as those connected with extra-cultural placement, would not have been considered or adjusted for. Moreover, this may have confounded results because pre-existing childhood trauma experienced by American Indian veterans by legal guardians other than parents may not have been examined.

Post-Combat Adjustment

In a recent study by Yaekel-Black Elk (2005), the relationship between childhood experiences and post-combat adjustment as measured by prevalence rates of incarceration and drug or alcohol treatment, was studied. Childhood experiences and post-combat adjustment were assessed using a structured interview with 100 American Indian Vietnam combat veterans. Interviews were conducted during American Indian community events in South Dakota, Minnesota and Wisconsin.

The tribal affiliations represented by participants in this study were Annishinabe, Lakota, Dakota and other. Members of these tribes were grouped into two categories based on geography and nation. The Annishinabe and other were grouped together because in the breakdown of “other,” all participants were geographically located in the same region as the Annishinabe and were surveyed at traditional Annishinabe events. The Annishinabe and other were defined as the Woodlands American Indians. The Lakota and Dakota were defined as Northern Plains American Indians (These two would have also been identified together under the Matsunaga study under the title Northern Plains due to cultural and geographic commonalities). This grouping of participants was done to allow chi-square analysis.

Preliminary analyses revealed that the Northern Plains American Indians were more likely to have experienced extra-cultural placement as a group -- 16 out of 30, compared to the Woodlands Tribes, 15 out of 55. All of the Northern Plains participants who had experienced extra-cultural placement had been placed in boarding schools as children. The Woodland American Indian veterans who experienced extra-cultural out-of-home placement were placed in both Non-American Indian Foster Care homes and boarding schools.

Results showed that there was no significant relationship between extra-cultural placement and post-combat adjustment when considering all American Indians in the study together. There was a significant difference in post-combat adjustment between the Northern Plains and the Woodland tribal groups when extra-cultural out-of-home placement as defined as experiencing out of home placement in a non American Indian foster home or having resided in a boarding school and post-combat alcohol or drug

treatment were considered. A chi square analysis found that the Northern Plains were significantly more likely to have gone to alcohol and drug treatment ($p = .008$).

The results also did not find a significant relationship between extra-cultural placement and incarceration for all American Indians. There were no differences between Plains and Woodland American Indians in rates of incarceration in this study. However, the results of this study may have been confounded by not sampling currently incarcerated American Indian veterans.

Extra-cultural placement and post combat adjustment as it relates to alcohol/drug treatment was only found to have significant differences between extra-cultural out-of-home placement and alcohol and drug treatment when tribal affiliation was considered. The Northern Plains group had higher rates of alcohol/drug treatment when they experienced extra-cultural placement.

As with the Rosenheck and Fontana study (1998), there were significant differences in rates of alcohol/drug abuse treatment between American Indian veterans who had a veteran primary care giver and those who did not. There was also an overrepresentation of the Northern Plains group that reported having a veteran primary care giver in comparison to the Woodlands American Indian group. Therefore, unequal rates of extra-cultural placement/non extra-cultural placement and having a veteran primary care giver/not have a veteran primary care giver between the two groups may have confounded the results of this study.

Although the Yaekel-Black Elk (2005) study examined differences within general geographic regions, there exists the continued caution expressed earlier in the Matsunaga critique that tribes should not be grouped together. Another limitation of the Yaekel-

Black Elk study is that it was assumed that the findings should not be generalized to American Indian populations who are currently incarcerated, hospitalized, in drug and or alcohol treatment programs and homeless veterans who may not have had access to getting to the community events where surveys were conducted because these groups were not included in the study.

Boarding Schools

Since the early 1970's, there have been studies that examined how out-of-home placement has affected American Indian youth. According to the House of Representatives Report No.95-1386 (1971), at the turn of the century it was found that there were 34,538 children currently living in institutional facilities rather than at home. On the Navajo reservation, in 1972 it was reported that there were about 20,000 children or 90% of the BIA school population in grades K-12 currently living in boarding schools (Indian Child Welfare Act, 1978). Kleinfeld and Bloom (1977) examined the effects of four representative boarding schools on 132 Alaskan Eskimo adolescents during their freshman and sophomore years. They found that 49% of the freshman developed school related social and emotional disturbances, 25% of which were judged to be serious. In this study, emotional disturbance rates were not attributed to high school adjustment difficulties because rates had increased between the freshman and sophomore years. For example, at one boarding school the rate of disturbance jumped from 14% to 84%. Lastly, the authors stated that the greatest limitation was that 43% of the students had dropped out between the two years. The reduction in attrition limits the interpretation and generalizability of these research results.

What may appear to be a limitation of this review is that the above research may seem dated. However, a thorough review of the literature shows that there are comparatively few studies on this topic, and that the research that has been done although not recent is reflective of the population. The topic is also still salient in view of the psychological suffering that is still experienced by American Indian combat veterans, and in light of the continued service of American Indians in combat situations.

Out-of-Home Placement

Nationwide the rates for maltreatment for American Indian children under 14 was 1 in 30 compared to 1 in 58 children of all races in 1995 (Department of Justice, 1999). It is not fair to assume that all traumas to American Indian children are experienced in the home. Trauma, in fact, may be a result of out-of-home placements. Green (1983) reported that in areas with large American Indian populations, such as Minnesota and South Dakota, the rate of foster placement has been 5 to 16 times greater than for the White population. He also noted that 85% of these placements were in non-American Indian homes. Green highlights risks and attitudes associated with extra-cultural placement of American Indian children. For example, there are unique spiritual resources that are available within American Indian communities that may be overlooked once children are in extra-cultural placements. There are also social safeguards in American Indian communities, including a continuity of care that exists within traditional extended family systems, and distinctive cultural norms exist for the regulation of parent-child interactions.

Green wrote, "Often these [out-of-home] placements are short term because of the child's resistance to adaptation; the sad thing about this resistance is that many disruptive

behaviors also accompany the child's return to the reservation" (p. 66). Further, researchers have found that there is considerable psychiatric morbidity associated with extra-familial adoption, foster placement and institutional care across the general population (Simon & Senturia, 1966). Although there is no conclusive evidence that a significant relationship between extra-cultural out-of-home placement and PTSD exists, the Yaekel-Black Elk (2005) study on American Indian Vietnam veterans who experienced extra-cultural out-of-home placement as children were found to be from the same geographic area that had the most cases of diagnosed PTSD in the MVVP study.

In the Warriors Within study, Yaekel (1999) found a significant relationship ($p < 0.001$) between the American Indian men being placed in a foster home or boarding school and being incarcerated. Recidivism rates were also examined in this study, and it was shown that for American Indians in Minnesota these rates are between 52% for short-term placements, and 70% for long-term placements. In contrast, the recidivism rates for Whites are 33%. Due to these study results, the author suggested that the higher recidivism rates found among American Indian men might have been influenced by Post Traumatic Cultural Disorder (i.e., a re-experiencing of a previous or present value or cultural conflict leading to stress and conflict that culminates into a probable codependent dysfunctional state, with a major emphasis upon loss of identity and boundary/control and relational difficulties; Shold, et al., 1991).

There were 100 men interviewed for this research study. The men's ages ranged from 18 to 58. Many of the men reported they had dropped out of school at age 16, the legal age to leave school in Minnesota at that time. The men were categorized into three separate groups: never incarcerated, incarcerated one time, and incarcerated more than

one time. Fifty of these men were incarcerated at the time of the interviews in three correctional facilities in Minnesota. Of the fifty men incarcerated, 23 were unemployed at the time of the offense. Out of 100 American Indian men, 30 had never been incarcerated, 19 had been incarcerated one time and 51 had been incarcerated more than one time. The study showed a significant correlation between incarceration and rates of alcohol/drug treatment. Forty of the 50 men incarcerated were under the influence of alcohol or drugs at the time of the offense and had been through alcohol/drug treatment prior to being incarcerated. The study also showed a significant correlation between incarceration and out-of-home placements in early childhood. Specifically, out of 100 men interviewed, 48 men reported that they had experienced out-of-home placement, and 46 of the 48 said they had also been incarcerated.

The results of this study give us information about the relationship between American Indians, out-of-home placement and incarceration rates. A limitation of this study is that it was only focused on American Indians, and therefore information about how other ethnic groups would react to the experience of out-of-home placement was not obtained. Without this information we can not assume that the effects of out-of-home placement are more significant for American Indians than for people of other ethnicities.

In a second study, Yaekel-Black Elk (2006) examined how problem solving, being under the influence of drugs and/or alcohol at the time of offense, rates of drug/alcohol treatment, and having been placed in foster home or boarding school during childhood, predicted recidivism rates for American Indian and White incarcerated men. A positive significant predictor for American Indian recidivism was being placed in a foster home or boarding school as a child, and self-reported problem solving skills significantly

negatively predicted recidivism rates. For White Americans, results indicated that recidivism was significantly predicted by the number of times in treatment, and negatively predicted by being under the influence of drugs or alcohol at the time of offense, and being placed in a foster home or boarding school. It was also found that American Indian men had significantly greater recidivism rates than White offenders. The author interpreted this finding to mean that there may be different pathways to recidivism between American Indian male recidivists and White male recidivists. The greatest limitation of this study was that small study sample may have yielded less stable results ($N = 50$). However, a strength of this study was that the ethnic distribution of the sample was representative of the jail population in the upper Midwest (60% American Indian and 40% White). This strength enhances study generalizability.

Homelessness

According to the Surgeon General's Report (SAMHSA, 2001), American Indians in general comprise 2% of the population and 8% of the homeless population in the United States. American Indians and veterans are overrepresented in the homeless population within the United States. Homeless in the United States is defined under PL100-77 and is commonly known as the McKinney Act (July 22, 1987). The general definition for being homeless is (1) an individual who lacks a fixed, regular, and adequate nighttime residence; and (2) an individual who has a primary nighttime residence that is: (a) a supervised publicly or privately operated shelter designed to provide temporary living accommodations; (b) an institution that provides a temporary residence for individuals intended to be institutionalized; or (c) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings (National Coalition

for Homeless Veterans (NCHV), 2008). Homelessness has also been related to PTSD. According to the Matsunaga study (1990), homeless people have been found to have higher rates of PTSD (22%) as a group than the general public (8%). For American Indian veterans, PTSD rates have been estimated at between 45% - 57% (Kulka, 1990).

Veterans, according to the NCHV (2001), make up 23% ($n = 529,000-840,000$) of the estimated 2.3 to 3.5 million people who experience homelessness each year.

Demographics of this homeless veteran population are: 33% male, 47% Vietnam era veterans, 17% post-Vietnam War, 15% pre-Vietnam War, 76% alcohol abuse, drug abuse, or mental health problems, 67% three or more years in the military, 89% honorably discharged, and 85% received a high school diploma or GED.

Victimization, Trauma and Self-Medicating

According to Kaspro and Rosenheck (1998), American Indian veterans represent 19% of the homeless veteran population. In a study conducted by these researchers, American Indian veterans reported more current alcohol abuse, more previous hospitalization for alcohol dependence and more recent alcohol intoxication (within the previous six months) than members of other veteran groups by ethnicity. However, study results also showed that American Indians were less drug dependent, had less psychiatric problems, and had less psychiatric-related hospitalizations than veterans from other ethnic groups. Results from this study were consistent with the study conducted by the Matsunaga Vietnam Veterans Project (1996), in which American Indian veterans were found to have had much higher rates of alcohol abuse/dependence, both lifetime and current.

Victimization, trauma and self-medicating are ever present in American Indian communities (Department of Justice, 1999). According to the Bureau of Justice Statistics, (Department of Justice, 1999), the average annual victimization rate for violent crimes for American Indians ages 12 and older is 124 violent crimes per 1000. This is 2 ½ times the national rate of 50 per 1000. American Indians between the ages of 18 and 24 have the highest per capita rate of being victims of interracial violence than any other American racial group (about one in four American Indians have been victimized by interracial violence).

Traumatic childhood experiences like childhood extra-cultural placement may be associated with later alcohol/drug abuse. The National Institute of Justice, Bureau of Justice Statistics (1999) reported about half the convicted American Indian inmates in local jails were under the influence of alcohol at the time of the offense. American Indian victims of family violence reported that they perceived three out of four offenders to have been drinking at the time of commission of the crime compared to only half reported from all other races. The 1997 arrest rates among American Indians for alcohol-related offenses, such as driving under the influence, liquor law violations and public drunkenness, was also reported at being more than double the rates of all races combined. Additionally, approximately 16,000 American Indians were incarcerated in local jails in 1997, a rate of 1,083 per 100,000, the highest of any racial group. American Indian offenders make up approximately 26% of the local jail population compared to the 10% rate of the general population (National Institute Of Justice, Bureau of Justice Statistics, 1997).

According to Office of the Legislature Auditor, State of Minnesota Program Evaluation Division (1997), co-morbidity of trauma and alcohol/drug abuse is from approximately 70% to 90%. These co-morbid conditions can cause impairment of memory and judgment, and can affect the ability to problem-solve. Both emotional and physical trauma can affect neurophysiologic development (Fischer & Rose, 1994).

The brain reaches 90% of its adult size by age five; cognitive development and physical maturation continue throughout childhood and adolescence and into young adulthood. These cognitive changes increase with age and are influenced by various “environmental demands and experiences” (Fischer & Rose, 1994). If a person is exposed to emotional and physical trauma during critical periods of development the limbic system is susceptible to injury (Palmer et al., 1999). In the Yaekel (1999) and Yaekel-Black Elk (2005, 2006) studies, it is during this critical period that participants reported experiencing extra-cultural out-of-home placement. However, out-of-home placement is only one aspect of the historical atrocities which effect American Indian men. Other atrocities have perpetuated generations of un-parented parents thus perpetuating the high rates of child removal and extra-cultural placement. Knowledge of these experiences is crucial to understanding an American Indian client’s history in order to provide more effective counseling services to him or her. It is imperative that in order to improve mental health services to American Indian Veterans that we bridge the past to current issues of adjustment so that mental health service providers may be better informed about the unique issues surrounding this population.

This literature review has examined the statistical overrepresentation of American Indians as it relates to both historical and current experiences of trauma. American Indian

demographics were examined with regard to how they relate to post-combat adjustment, including homelessness, incarceration and drug or alcohol treatment. This review also showed that historical cultural experiences in indigenous communities and childhood experiences may increase susceptibility of American Indian Vietnam combat veterans to develop features and symptoms of post traumatic stress disorder and to develop cognitive disruptions that are related to attachment beliefs. Lastly, this literature review has provided scientific findings which are directly related to the specific purpose of this current study which will now be discussed.

Purpose of the Study

It was the purpose of this study to examine relationships among In-Home or Out-of-Home Placement, having a Non-Veteran or Veteran Primary Care Giver, Features and Symptoms of Post Traumatic Stress Disorder (PTSD), and the impact of trauma on beliefs about self and others among American Indian Vietnam combat veterans. Because the impact of homelessness has shown to be so great among veterans, a separate hypothesis was constructed to examine relationships between homelessness and incarceration and homelessness and receiving alcohol or drug treatment.

Hypotheses

Hypothesis 1: There would be significant differences in rates of no extra-cultural placement/extra-cultural placement and rates of having a non veteran/veteran primary care giver between Woodlands and Northern Plains American Indians.

Hypothesis 2: There would be significant differences between veterans who had no extra-cultural placement or extra-cultural placement on post combat adjustment as measured by: incarceration, alcohol or drug treatment and homelessness.

Hypothesis 3: There would be significant differences between veterans who had a veteran primary caregiver and those who had no veteran primary caregiver on post combat adjustment as measured by: incarceration, alcohol or drug treatment and homelessness.

Hypothesis 4: There would be significant differences between veterans who had experienced homelessness or the threat of homelessness and the post-combat adjustment experiences of incarceration, or having received alcohol or drug treatment.

Hypothesis 5. Among American Indian combat veterans as a group, there would be significant differences in the various types of trauma-impact on attachment beliefs about self and others.

Hypothesis 6. There would be significant differences in the impact of trauma on attachment beliefs about self and others (as measured by the Trauma and Attachment Belief Scale (TABS), as a function of no extra-cultural placement/extra-cultural placement and having a non veteran/veteran primary care giver.

Hypothesis 7. There would be significant differences in the magnitude of features and symptoms of PTSD (as measured by the Mississippi Combat PTSD Scale Short Form (M-PTSD Short Form) as a function of no extra-cultural placement/extra-cultural placement and having a non veteran/veteran primary care giver.

Hypothesis 8. There would be significant associations among the impact of trauma on beliefs about self and others (as measured by TABS), features and symptoms of PTSD (as measured by the M-PTSD Short Form), no extra-cultural placement, extra-cultural placement, non veteran primary caregiver, and veteran primary care giver.

Chapter III

Method

Participants

Participants were 150 American Indian Vietnam combat veterans, born between 1937 and 1957, from South Dakota, North Dakota, Nebraska, Wisconsin and Minnesota. These states were chosen because of the high rate of out-of-home placement experienced among American Indians in the region during the late 1960's and early 1970's (Indian Child Welfare Act, 1978). Participants' time spent in combat varied. Fifty-seven percent ($n = 86$) reported being in combat for 1 - 6 months; 21.3% ($n = 32$) reported 7 - 12 months; 9.3% ($n = 14$) reported 13 - 18 months; 7.3% ($n = 11$) reported 19 - 24 months; and 4.7% ($n = 7$) reported being in combat for 25 or more months. Forty-eight percent ($n = 72$) of the veterans reported not having lived in their home tribal communities prior to their combat experience.

The median age of participants was 59 years (mean 60.33, $SD = 8$). The educational level of the participants was: 18.7% ($n = 28$) of participants did not have a high school diploma, 41.3% ($n = 62$) of the participants did have a high school diploma or the equivalent, and 40% ($n = 60$) of the participants had some post-high school course work. Their educational history included technical school, tribal college or university training. Participants were recruited from Vet Centers (Vet Centers are clinics that provide readjustment counseling and outreach services to all veterans who served in any combat zone), outpatient psychological clinics, tribal, county, and foundation sponsored homeless veteran programs and traditional American Indian gatherings (Pow Wows).

For the purposes of this study, participants were classified into two separate tribal cultural groups, the Northern Plains ($n = 75$) and the Woodland group ($n = 75$). These tribal groupings were based on tribal membership and the geographical location where participants completed the instruments. For example, the Lakota and Dakota tribes (that were categorized as Northern Plains American Indians) identify as the same nation. The Annishinabe and other American Indians were grouped together because all participants were geographically located in the same region as the Annishinabe and were surveyed at traditional Annishinabe events. This grouping was categorized as the Woodland tribal group.

Research Design

This was a quasi-experimental study which evaluated scores from two dependent measures: one designed to identify clinical symptoms of PTSD and the other designed to explore the impact of trauma on beliefs about self and others associated with traumatic childhood events. Two independent measures were used: veterans who experienced or did not experience out-of-home placement as children, and veterans who had or did not have a veteran primary care giver as children.

Procedures

There were two instruments used to measure features and symptoms of trauma and disruptions in attachment beliefs. These instruments were administered at various veteran service agencies and at traditional American Indian gatherings. Participants were also asked to complete a brief demographic questionnaire that included experiences of out-of-home or no out-of-home placement as a child and experiences of having or not having a primary care giver that had been a veteran. All testing was out of direct view of others.

For example, if the activity was at a veteran's Pow Wow, the instruments were administered at a designated space or room made available for the sole purpose of testing. All testing materials were completed in an individual rather than a group format. Surveys took approximately 30 minutes to complete.

Participants were self-selected and voluntary. Participants were recruited through announcements at tribal gatherings, and through fliers that were posted in clinics. Once potential participants had been recruited, they initiated contact with the principal investigator if they chose to participate in the study. Those professionals who assisted with the recruitment process, for example clinic staff, were not subsequently informed if potential participants contacted the principal investigator or if these potential participants had actually participated in the study. Below, is a description of each of the recruitment sites, procedures used, and the process of informed consent.

Recruitment at Tribal Gatherings (i.e., Pow Wows)

There are specific tribal Pow Wows for veterans. Some Pow Wows have as many as 1,200 veterans in attendance. Other veteran Pow Wows may have only one or two hundred in attendance. Because this project was supported by the tribes and Vet Centers in the designated region, interest in participation and support from tribal leaders had been established early in the planning stages of the study (See Appendix A).

Various levels of gatekeepers in American Indian communities were contacted and permission sought to conduct this research. Some of these levels were tribal councils, Pow Wow committees, Vet Centers, administrators at the Veterans Administration and lastly, but most importantly, the veterans themselves.

At the time of the events and gatherings, emcee's introduced this researcher and the purpose of the study. (Pow Wow emcees provide direction for Pow Wow events and keep dancers, vendors and other participants informed about activities occurring in conjunction with the event.) It was announced by the emcees that the research consisted of completing a survey that addressed pre- and post-combat experiences, and the attitudes and beliefs of American Indian Vietnam combat veterans.

The emcee announced that individual results would be kept confidential and that the aggregated results of the study would be made available to tribal and veteran counseling organizations in the hope of improving veteran adjustment services to American Indian veterans. Emcees also informed potential participants that besides being asked to consent to complete the survey they would also be asked to respond to brief questions about specific childhood experiences such as: "Did you experience in home or out-of-home placement as a child?" and "Was your childhood primary care giver a veteran or not?" The emcees that provided this information then stated that there was tribal support for the study.

The emcees included in their announcement that the study was specifically focusing on male Vietnam veterans. Also it was announced that veterans needed to have experienced combat in order to qualify to participate in the study. Potential participants were told where the researcher would be located on the Pow Wow grounds. Veterans were also informed how to contact the researcher for those interested in participating in the study or for those just interested in the topic. An area was selected at each site that was private and not visible to the general public or other clients, and the research surveys and demographic questionnaire was administered at that location (See Appendix B.)

Recruitment from Veterans Centers, Outpatient Clinics, and Homeless Programs

Recruitment from veterans' service agencies was done through service providers. Providers included both physical and mental health staff (therapists, psychologists, social workers, physicians, pharmacists and psychiatric staff.). These providers assisted in recruiting participants by handing out an information sheet about the study with additional information explaining how to contact this principal investigator and when surveys would be conducted (See Appendix C).

The Team Leaders (i.e. coordinators) of Vet Centers (i.e. outpatient walk in veteran counseling centers) were provided with information about the purpose of this study. Instruments were completed at center locations when there was space available. If there was not adequate space available (space availability varied between Vet Centers) a separate location was identified. These locations were identified in cooperation with this researcher and the Vet Center's Team Leader. One site identified was at the local college. Other sites identified were at area tribal centers, tribal mental health clinics and spaces set aside to conduct this research at scheduled veteran gatherings such as Pow Wows.

Outpatient clinics were comprised of on and off reservation tribal health department clinics. On reservation clinics were centrally located on reservations and provided both mental and physical health services for American Indian Vietnam veterans. Off-reservation clinic sites were tribal urban area clinics that were operated primarily by tribal staff and community members. Recruiting from these sites provided access to the population of American Indian veterans who did not reside within their communities. The clinics were ideal locations for completing the instruments because the available office spaces ensured privacy and confidentiality to the veteran participants. A location was

identified in cooperation with the investigator and the clinic administrator. Recruitment was also conducted at outpatient counseling agencies contacted for recruiting purposes that were contracted with the Department of Veteran Affairs (DVA) to provide psychological services to veterans. A flyer was posted with the information listed on how to contact the primary researcher and locations where instruments could be completed. Although specific information was not gathered from participant about how they had heard about the study; some participants mentioned that they had heard about it through the Vet Centers.

There are numerous homeless centers for veterans. Some are operated through the DVA and others are operated independently through organizations such as YMCA, citizen's councils, religious organizations and tribal entities. For example, in Minnesota, the Minnesota Area Council for Veterans has five different sites that provide services for homeless veterans in the state. The primary supervisor for these five sites was contacted for identifying geographic locations and office space to conduct this research. Again, an area was selected at each site that was non-threatening and yet conducive to completing the instruments.

Informed Consent

Veterans who expressed an interest in participating in this research were provided with a copy of the consent form (See Appendix D). Veterans were also given the opportunity to have the consent form read to them. This also provided an opportunity to ask for clarification of any areas on the consent form. Participants were informed both in writing and verbally that they could withdraw from participation at any time. An additional copy of the consent form was given to participants upon completing the

assessments. Participants were notified that the participants' names were not needed for the consent forms or for the instruments they were being asked to complete. Because trauma is a highly sensitive topic, all participants were given a list of resources to contact if they felt they would like to have someone to talk with about issues that may have surfaced from participation during the study. All participants were compensated \$10.00 for their time. These monies had been allocated by tribes requesting that future studies be conducted with this population to improve treatment and care of American Indian veterans (See Appendix E). A sign-up sheet for participants who were interested in receiving the results of the study was offered to them to sign during the informed consent process as well.

During the process of informed consent, potential participants' competence, capacity, comprehension, and voluntariness were assessed. Capacity was assessed by asking a series of questions that anyone with any level of education would know who was not disoriented, suffering from advanced dementia, or otherwise cognitively impaired such as: name, age, length of military service, where were they stationed, and where did they live now. Comprehension was assessed by the researcher asking participants specific questions to see if they understood to what they were consenting. For example, voluntariness was assessed by asking participants if they understood the informed consent process. This procedure was followed up with the open-ended question: "If at any time you become uncomfortable with the research instruments what option do you have?" Lastly, potential participants were asked, "If after completing the research instruments you feel distressed, where are the professional services in your area to which you can go for support?"

Variables

Extra-Cultural Placement/No Extra-Cultural Placement is a two-level independent variable. No Extra-Cultural Placement refers to being reared in one's biological or adoptive family, with an American Indian guardian, or in an American Indian foster home during childhood. The No Extra-Cultural Placement category included placement in an American Indian foster home because participants stated that this type of placement did not cause undue trauma, suffering or oppression because their primary care giver was also a relative.

No Extra-Cultural Placement is defined as being placed in a non-American Indian foster home, boarding school, or orphanage during childhood due to personal or family related circumstances. Included in this category were children who resided at Bureau of Indian Affairs (BIA) government residential schools, Christian private boarding schools, or tribal residential schools that were operated by primarily non-American Indians due to geographic necessities, such as not being able to be transported to and from school by parents. This may have been due to the isolated area that a child resided in and if either public or private transportation was not available. This category does not include brief hospitalizations from 1 to 30 days for the purpose of psychiatric assessments, or voluntary short-term visits with a relative such as a grandparent, aunt, uncle or other extended family members. Extra-Cultural Placement/No Extra-Cultural Placement was scored dichotomously, with Extra-Cultural Placement = 1, and No Extra-Cultural Placement = 0.

Veteran Primary Care Giver/No-Veteran Primary Care Giver is a two-level independent variable. Veteran Primary Care Giver/No Veteran Primary Care Giver is

defined as having a veteran primary care giver who was also a combat veteran. The primary caregiver could be at least one of the parents or one or more custodial guardians. This variable was scored dichotomously, with Veteran Primary Care Giver = 1 and No Veteran Primary Care Giver = 0.

Post Combat Adjustment is comprised of three variables. These variables are previous Incarceration, previous or current Alcohol or Drug Treatment, and Homelessness or the Threat of Homelessness. Each of these variables were measured dichotomously, with previous Incarceration = 1 and no previous Incarceration = 0; previous or current Alcohol or Drug Treatment = 1 and no previous or current Alcohol or Drug Treatment = 0; and, Homelessness or the Threat of Homelessness = 1 and no Homelessness or the Threat of Homelessness = 0.

The Trauma and Attachment Belief Scale (Pearlman, 2003; TABS) is an 84-item paper and pencil instrument that measures the impact of trauma on attachment beliefs (See Appendix F). The instrument is scored on a six-point Likert Scale (1 = Strongly Disagree Strongly to 6 = Strongly Agree). Using the Flesch Read Ease scoring system (Flesch, 1970); items from this instrument have been assessed to be appropriate for anyone who can read at a 3rd grade level (Pearlman, 2003).

The instrument is comprised of 10 subscales: Self Safety, Other Safety, Self Trust, Other Trust, Self Esteem, Other Esteem, Self Intimacy, Other Intimacy, Self Control and Other Control. Self Safety is defined as struggling with issues regarding one's own safety. Other Safety is defined as being concerned about the safety of significant others. Self Trust is defined as struggling with trusting one's own judgments and perceptions. Other Trust is defined as the inability to trust or rely on other people.

Self Esteem is defined as believing what happens to individuals is their fault and they deserved it. Other Esteem is defined as viewing others with disdain and disrespect, Self Intimacy is defined as spending time alone challenging and may avoid spending time alone. Other Intimacy is defined as being disconnected and isolated from others either interpersonally or emotionally. Self-Control is defined as having the fear of losing control over one's emotions or behaviors. Other Control is defined as feeling uncomfortable when they are not in charge. Mean standardized TABS T-scores for men in the general population are Self Safety = 49.7, Other Safety = 53.3, Self Trust = 50.1, Other Trust = 51.6, Self Esteem = 52.0, Other Esteem = 53.0, Self Intimacy = 51.6, Other Intimacy = 52.0, Self Control = 51.4, and Other Control = 52.7.

Examples of, and number of items representing each scale are: Self Safety (SS; 13 items, *I feel threatened by others*), Other Safety (OS; 8 items, *I never think anyone is safe from danger*), Self Trust (ST; 7 items, *I don't trust my instincts*), Other Trust (OT; 8 items, *Trusting people is not smart*), Self Esteem (SE; 9 items, *I don't feel like I deserve much*), Other Esteem (OE; 8 items, *People are no good*), Self Intimacy (SI; 7 items, *I hate to be alone*), Other Intimacy (OI; 8 items, *I feel cut off from people*), Self Control (SC; 9 items, *I have problems with self-control*), and Other Control (OC; 7 items, *I can't do good work unless I am the leader*.) Each of these scales can be scored individually to represent the constructs indicated above. Additionally, a total score for this instrument can be obtained, which reflects the amount of overall cognitive disruptions experienced by the test-taker.

Norms for the TABS are currently available for adults aged 17 and older. In this population, internal consistency and test-retest reliabilities for the TABS total scores are

.96 and .75 respectively. The subscales have also been shown to be reliable with a median internal consistency estimate of .79 (range= .67 to .87) and median test-retest reliability of .72 (range = .60 to .79) among adults (Pearlman, 2003).

The Mississippi Scale for Combat-Related PTSD-Short Form (M-PTSD Short Form) measures PTSD symptoms as defined by the DSM-III-R. This instrument is an eleven-item version of the 35-item longer form. The item stem for each item is: “Do you ever experience...?”. Each item is measured on a five-point Likert Scale (1 = Never to 5 = Always). For this instrument, two items measure traumatic re-experiencing and intrusive thoughts (e.g., *I have nightmares of experiences in the military that really happened*), three items measure avoidance and numbing (e.g., *I have a hard time expressing my feelings, even to the people I care about*), three items measure hyperarousal (e.g., *unexpected noises make me jump*), and three items measure suicidal feelings, substance abuse, and feeling different from other people (e.g., *lately, I have felt like killing myself*) (Stamm, 1996).

The stability coefficient of the M-PTSD Short Form as utilized with combat veterans seeking treatment for PTSD and related disorders has been reported as: 0.83 at intake, 0.85 at four months after intake, and 0.87 at twelve months after intake. A strong correlation has been found between the longer, full scale scores of the M-PTSD and the M-PTSD Short Form among Vietnam combat veterans (Stamm, 1996). Correlation coefficient scores between these two instruments have been shown to remain strong at .95 at intake to .96 one year after intake. The short form has also been shown to be consistent in its predictive validity with clinician’s ratings of client improvement in combat-related PTSD (Fontanna & Rosenheck, 1994; Stamm, 1996).

Data Analysis

In this section, the types of statistical analyses used to test the hypotheses of this dissertation will be presented. All statistical analyses were conducted using SPSS version 15.0 for Windows (2006).

Chi-Square

Chi-Square analysis was used to test between group differences between the dichotomous variables. The Chi-Square statistic requires no assumptions about the shape of a population distribution from which the sample was drawn (Rubin, 2007). Although the Chi-Square can be used to assess both nominal and ordinal data (Rubin, 2007), for the purposes of this study only nominal data (coded 0 or 1) was assessed.

The Chi-Square sampling distribution depends on the degrees of freedom. As the number of degrees of freedom increases the Chi-Square distribution becomes more symmetrical, which is one of its greatest strengths. Limitations of utilizing this statistic are that the Chi-Square test for significance between group differences, but does not provide information about the strength of relationships or their substantive significance (Rubin, 2007). The second limitation is its sensitivity to sample size, with smaller sample sizes more likely to yield unstable results. However, for this study the sample size was 150 participants, which was considered sufficient to conduct these analyses.

Repeated Measures MANOVA

A Repeated Measures Multivariate Analysis of Variance is a special case of MANOVA in which each repeated measure is a separate DV. This analysis has two uses. One is to examine differences in data collected at specific points in time. The other is to examine differences on within-subject factors (i.e., differences in dependent variables). In

this case, linear combinations of responses reflecting a repeated measure effect (for example, the difference of responses on a measure) can be constructed and tested for significance. These differences can also be examined in light of the independent variables using the Repeated Measures MANOVA (using either the Univariate or Multivariate approach to analyzing repeated measures in the general linear model) but in this case, only the within-subject Repeated Measures statistic was used.

To obtain adequate power to detect true population differences, the researcher needs more cases than dependent variables in every cell. Assumptions include homogeneity of variance (Univariate ANOVA & MANOVA), homogeneity of variance-covariance matrices (MANOVA), and homogeneity of covariance, also known as sphericity (Repeated Measures ANOVA). A Repeated Measure MANOVA is typically more powerful than just the MANOVA, but the tradeoff is that there are more assumptions to be concerned about due to the analysis of a number of separate variances. It is robust to assumptions of normality unless non-normal distributions are caused by outliers.

Post-Hoc Analyses

Post-Hoc Analyses can be used to detect differences among variables when an omnibus F is significant. Fisher's Least Significant Difference (LSD) was used to conduct post-hoc analyses for this research. This statistic is preferred due to its superiority over other comparisons in attaining power. It is superior in terms of hypothesis testing because it has a small critical value. It also uses per comparison error rates. The limitation of the LSD is that it does not protect against familywise error rate

when there is not significance in the omnibus F statistic. (Tukey's Honestly Significant Difference Test and Scheffe Test does protect against familywise error.)

Multivariate Analysis of Variance

Multivariate Analyses of Variance (MANOVA's) were used to test hypotheses in which there were two independent variables and one or more dependent variables. The MANOVA allows a researcher to test for both main and interaction effects of the independent variables on the dependant variables. The MANOVA is a preferred statistic to use when multiple comparisons are made in order to decrease the risk of Type I error (Rubin, 2007). Assumptions for the MANOVA are linearity, homogeneity of variance, homogeneity of variance and covariance, normality, and statistical independence. However, MANOVA's are robust to the effects of correlated dependent variables (Rubin, 2007), and to non-normal distributions if the non-normality is caused by Skewness rather than by outliers. To obtain adequate power to detect true population differences, the researcher needs more cases than dependant variables in every cell.

There are several ways to detect if the MANOVA model is significant. Those most commonly used by social scientist researchers are Wilk's Lambda, the Pillai statistic, and Roy's Largest Root. Roy's Largest Root, represents maximum possible between-group differences. Additionally, it is the most sensitive when population centroids differ along a single dimension, but otherwise is least sensitive. Pillai's Trace is the most robust to violations of assumptions concerning homogeneity of the covariance matrix compared to either Roy's Largest Root or Wilk's Lambda. However, it is a very conservative test, and therefore is less powerful than either Wilk's Lambda, or Roy's Largest Root. Wilk's Lambda indicates the proportion of generalized variance in the

dependent variables that is accounted for by the predictors as does Roy's Largest Root or Pillai's Trace. It is the Multivariate equivalent of the F test. This statistic uses all possible comparisons rather than using only the gross comparisons used by Roy's Largest Root. Additionally, it is easier to interpret than the other two tests, and is more often used by social scientist than others. Therefore, in this research, Wilk's Lambda will be used to examine the significance of the multivariate models tested.

Two-Factor ANOVA

In a two factor ANOVA analysis we can examine the relationship between two independent variables and one dependant variable. It is used to study the effects of two independent variables separately (their main effects) and together (their interaction effects) upon the dependent variable. In a two-factor ANOVA, both factors are fixed, the two factors are fully crossed, and the dependent variable is measured at least at the interval level. Assumptions of the two-factor ANOVA are random assignment, independence of observations, normal distribution of the dependent variable, and equality of populations variances. The procedure is robust to violations of random assignment, independence, and normal distribution. Strengths in conducting a two factor ANOVA over a MANOVA are the complexity of the MANOVA, and the additional assumptions in the MANOVA. Lastly, a MANOVA usually has lower power than the two factor ANOVA.

Correlation

The product moment correlation is used to determine if significant relationships are present among independent and/or dependent variables. Using correlations, causation cannot be assumed. The results of correlation can also be useful within other types of

analyses, that is, it is a central measure within the general linear model of statistics. For example, in the MANOVA if independent variables are correlated they may be redundant. Correlation analysis can be used to test independence or dependence of the variables. If the independent and dependent variables correlate significantly than we know we have purposeful relationships between our sample and the test instruments. Point-biserial correlations are used to measure not only the relationship between two variables but it also to measure variables on both interval and ratio scales. Assumptions of correlation are normal distributions of variables, linearity and homoscedasticity.

Chapter IV

Results

In this chapter, each hypothesis will be restated, as well as the statistical analyses used to test each hypothesis. In Chapter 5, the findings in this section will be discussed and stated in light of theory and prior research.

Hypothesis 1

Hypothesis 1 stated that there would be significant differences in rates of no extra-cultural placement/extra-cultural placement and rates of having a non veteran/veteran primary care giver between Woodlands and Northern Plains American Indians. Chi-Square analyses were used to test these differences. Results are shown in Tables 1 through 3. Table 1 shows the results of a frequency analysis for Tribal Affiliation and No Extra-Cultural Placement/Extra-Cultural Placement.

Table 1. Frequencies for Tribal Affiliation and No Extra-Cultural Placement/Extra-Cultural Placement

Tribal Affiliation	<i>n</i>	No Extra-Cultural Placement			Extra-Cultural Placement	
		Nuclear Family	Extended Family	American Indian Foster Care	Non-American Indian Foster Care	Boarding School
Woodlands	75	n = 36 24%	n = 9 6%	n = 2 1.3%	n = 19 12.7%	n = 9 6%
Northern Plains	75	n = 40 26.7%	n = 1 .7%	n = 5 3.3%	n = 4 2.7%	n = 25 16.7%

N = 150.

As shown in Table 2, there were no significant differences between No Extra-Cultural/Extra-Cultural Placement between the two tribal groups (Woodland and Northern Plains), $\chi^2 = .028(1, N = 150) p < .866$. Fifty-seven of the participants (Woodland American Indians = 28 and Northern Plains American Indians = 29) experienced extra-cultural placement and 93 (Woodland American Indians = 47 and Northern Plains American Indians = 46) reported that they experienced no extra-cultural placement.

Table 2. Differences in Extra-Cultural Placement between Tribes

Tribal Affiliation	Extra-Cultural Placement Yes	Extra-Cultural Placement No	<i>n</i>	χ^2	<i>df</i>
Woodland	<i>n</i> = 47 50.5%	<i>n</i> = 28 49.1%	75	.028	1
Northern Plains	<i>n</i> = 46 49.5%	<i>n</i> = 29 50.9%	75		

N = 150; *p* = 1.00.

As shown in Table 3, there were no significant differences between the two tribal groups in having a Veteran Primary Caregiver or not having a Veteran Primary Giver, $2.671(1, N = 150) p < .141$. Seventy-two of the men reported having a veteran primary care giver compared to 78 who did not.

Table 3. Differences in Having a Veteran/Non-Veteran Primary Giver between Tribes

Tribal Affiliation	Veteran Primary Care Giver Yes	Veteran Primary Care Giver No	<i>n</i>	χ^2	<i>df</i>
Woodland	<i>n</i> = 31 43.1%	<i>n</i> = 44 56.4%	75	2.671	1
Northern Plains	<i>n</i> = 41 56.9%	<i>n</i> = 34 43.6%	75		

$N = 150; p = .141$.

Hypothesis 2

Hypothesis 2 stated that there would be significant differences between veterans who had no extra-cultural placement or extra-cultural placement on post combat adjustment as measured by: incarceration, alcohol or drug treatment and homelessness. This hypothesis was tested by Chi-Square analyses. Results are shown in Tables 4 through 6 below. As shown in Table 4, there were significant differences between the participants who experienced extra-cultural placement and those that did not and incarceration, $\chi^2 = 9.15$ (1, $N = 150$) $p < .004$. Thirty-nine (68.4%) of the 57 men who experienced extra-cultural placement reported having been incarcerated.

Table 4. Differences in Previous Incarceration between Veterans Who Experienced Extra-Cultural Placement versus No Extra-Cultural Placement in Childhood

Extra-Cultural Placement	Incarceration Yes	Incarceration No	<i>n</i>	χ^2	<i>df</i>
Yes	<i>n</i> = 39 68.4%	<i>n</i> = 18 31.6%	57	9.15	1
No	<i>n</i> = 40 43.0%	<i>n</i> = 53 57.0%	93		

$N = 150$; $p = .004$.

As shown in Table 5, there were no significant differences between Alcohol or Drug Treatment between veterans who experienced Extra-Cultural Placement and those who did not experience Extra-Cultural Placement, $\chi^2 = 4.06$ (1, $N = 150$) $p < .063$. Thirty-six (63.2%) of the 57 participants who had experienced Extra-Cultural Placement reported that they had previously received or were currently receiving alcohol or drug treatment.

Table 5. Differences in Receiving Alcohol or Drug Treatment between Veterans Who Experienced Extra-Cultural Placement versus No Extra-Cultural Placement in Childhood

Extra-cultural Placement	Alcohol/Drug Treatment Yes	Alcohol/Drug Treatment No	<i>n</i>	χ^2	<i>df</i>
Yes	<i>n</i> = 36 63.2%	<i>n</i> = 21 36.8%	57	4.06	1
No	<i>n</i> = 43 28.7%	<i>n</i> = 50 53.8%	93		

$N = 150$; $p = .063$.

As shown in Table 6 there were significant differences between the experience of actual or threat of Homelessness between veterans who had experienced Extra-Cultural Placement versus No Extra-Cultural Placement, $\chi^2 = 16.76 (1, N = 150) p < .0001$. Forty-four (77.2%) of the 57 men who reported experiencing Extra-Cultural Placement had also experienced actual Homelessness or the threat of Homelessness.

Table 6. Differences in Experiencing Homelessness or Threat of Homelessness between Veterans Who Experienced Extra-Cultural Placement versus No Extra-Cultural Placement in Childhood

Extra Cultural Placement	Experienced Homelessness Yes	Experienced Homelessness No	<i>n</i>	χ^2	<i>df</i>
Yes	<i>n</i> = 44 77.2%	<i>n</i> = 13 22.8%	57	16.76	1
No	<i>n</i> = 40 43%	<i>n</i> = 53 57%	93		

N = 150; *p* < .0001.

Hypothesis 3

Hypothesis 3 stated that there would be significant differences between veterans who had a veteran primary caregiver and those who had no veteran primary caregiver on post combat adjustment as measured by: incarceration, alcohol or drug treatment and homelessness. This hypothesis was tested by Chi-Square analyses. Results are shown in Tables 7 through 9. As shown in Table 7, there were significant differences between veterans who had a Non-Veteran Primary Caregiver and veterans who had a Veteran Primary Caregiver as children on the experience of being Incarcerated prior to this research study, $\chi^2 = 5.37(1, N = 150) p < .023$. Forty five (62.5%) of the 72 participants who had a Veteran Primary Care Giver had also been incarcerated.

Table 7. Differences in being Previously Incarcerated between Veterans Who Had a Veteran Primary Caregiver Versus those Who Did Not Have a Veteran Primary Caregiver

Veteran Primary Care Giver	Incarceration Yes	Incarceration No	<i>n</i>	χ^2	<i>df</i>
Yes	<i>n</i> = 45 62.5%	<i>n</i> = 27 37.5%	72	5.37	1
No	<i>n</i> = 34 43.6%	<i>n</i> = 44 56.4%	78		

N = 150; *p* = .023.

As shown in Table 8, there were no significant differences in receiving alcohol or drug treatment between veterans who had a veteran primary caregiver versus those who did not have a veteran primary caregiver, $\chi^2 = 1.016$ (1, $N = 150$) $p < .331$. Forty-one (56.9%) of the participants out of the 72 who had a veteran primary care giver had received or was currently receiving alcohol or drug treatment.

Table 8. Differences in Receiving Alcohol or Drug Treatment between Veterans Who Had a Veteran Primary Caregiver versus those Who Did Not Have a Veteran Primary Caregiver

Veteran Primary Care Giver	Alcohol/Drug Treatment Yes	Alcohol/Drug Treatment No	<i>n</i>	χ^2	<i>df</i>
Yes	<i>n</i> = 41 56.9%	<i>n</i> = 31 43.1%	72	1.016	1
No	<i>n</i> = 38 48.7%	<i>n</i> = 40 51.3%	78		

$N = 150$; $p = .331$.

As shown in Table 9, there were no significant differences in the experience of actual or threat of homelessness between veterans who had a veteran primary caregiver versus those who did not have a veteran primary caregiver, $\chi^2 = 2.37 (1, N = 150) p < .140$. Forty-five (62.5%) of the 72 participants who had a veteran primary care giver reported experiencing actual or the threat of Homelessness.

Table 9. Differences in Actual or Threat of Homelessness between Veterans Who Had a Veteran Primary Caregiver versus Those Who Did Not have a Veteran Primary Caregiver as Children

Veteran Primary Care Giver	Experienced Homelessness Yes	Experienced Homelessness No	<i>n</i>	χ^2	<i>df</i>
Yes	<i>n</i> = 45 62.5%	<i>n</i> = 27 37.5%	72	2.37	1
No	<i>n</i> = 39 50%	<i>n</i> = 39 50%	78		

N = 150. *p* = .140.

Hypothesis 4

Hypothesis 4 stated that there would be significant differences between veterans who had experienced homelessness or the threat of homelessness and the post-combat adjustment experiences of incarceration, or having received alcohol or drug treatment. This hypothesis was tested by Chi-Square analyses. Results are shown in Tables 10 and 11 below. As shown in Table 10, there were significant differences between participants who had experienced actual or threatened Homelessness and being Incarcerated, $\chi^2 = 12.57(1, N = 150) p < .001$. Fifty-five (65.5%) of the 84 participants who reported that they had experienced homelessness also reported that they had been incarcerated.

Table 10. Differences in Being Incarcerated between Veterans Who Had Experienced Actual Homelessness or the Threat of Homelessness and Those Who Had Not

Experienced Homelessness	Incarceration Yes	Incarceration No	<i>n</i>	χ^2	<i>df</i>
Yes	<i>n</i> = 55 65.5%	<i>n</i> = 29 34.5%	84	12.57	1
No	<i>n</i> = 24 36.4%	<i>n</i> = 42 63.6%	66		

N = 150 *p* < .001.

As shown in Table 11, there were significant differences between participants who had actually been Homeless or who had been threatened with Homelessness on receiving Alcohol or Drug Treatment, $\chi^2 = 23.65$ (1, $N = 150$) $p < .0001$. Fifty-nine (70.2%) of the 84 men who had experienced homelessness also had received or were currently receiving alcohol or drug treatment.

Table 11. Differences in Receiving Alcohol or Drug Treatment between Veterans Who Had Experienced Actual Homelessness or the Threat of Homelessness and Those Who Had Not

Experienced Homelessness	Alcohol or Drug Treatment Yes	Alcohol or Drug Treatment No	<i>n</i>	²	<i>df</i>
Yes	<i>n</i> = 59 70.2%	<i>n</i> = 25 29.8%	84	23.65	1
No	<i>n</i> = 20 30.3%	<i>n</i> = 46 69.7%	66		

$N = 150$; $p < .0001$.

Hypothesis 5

Hypothesis 5 stated that among American Indian combat veterans as a group, there would be significant differences in the various types of trauma-impact on attachment beliefs about self and others. Hypothesis 5 was tested using a within-subject Repeated Measure MANOVA with scores from the 10 TABS subscales as the dependent variables. Table 12 shows the Means and Standard Deviations for each of the subscales for this sample.

Table 12. Descriptive Statistics for the Traumatic Attachments Beliefs Scale for All Veterans in the Sample

TABS Subscale	Mean	Std. Deviation
Self-Safety	57.01	14.19
Other Safety	69.09	12.09
Self-Trust	55.58	12.26
Other Trust	55.79	10.67
Self-Esteem	59.21	10.74
Other Esteem	57.87	13.11
Self-Intimacy	58.33	11.39
Other Intimacy	57.93	12.05
Self-Control	59.96	13.61
Other Control	56.96	11.57

Results of the Repeated Analysis of Variance showed significant differences among the TABS subscales, Wilk's λ $F(9, 151) = 38.90, p < .0001$. As shown in Table 13, pairwise comparison on the TABS subscales scores showed that among Vietnam combat veterans, the impact of trauma Other's Safety was significantly greater than all other variables measured by TABS (mean differences range from 9.133 to 13.51, $p < .001$). The impact of trauma on Self-Esteem was significantly greater than on Self-Safety (mean difference 2.20, $p < .011$), on Self-Trust (mean difference = 3.63, $p < .001$), on Other Trust (mean difference = 3.43, $p < .001$), on Other Intimacy (mean difference = 1.28, $p < .047$), and on Other Control (mean difference = 2.25, $p < .003$). The impact of trauma on Other Esteem was significantly greater than on Self-Trust (mean difference = 2.29, $p < .026$), and on Other Trust (mean difference = 2.09, $p < .015$). The impact of trauma on Self-Intimacy was significantly greater than on Self-Trust (mean difference = 2.75, $p < .010$), and on Other Trust (mean difference = 2.54, $p < .018$). The impact of trauma on Other Intimacy was significantly greater than on Self-Trust (mean difference = 2.35, $p < .016$), and on Other Trust (mean difference = 2.15, $p < .009$). The impact of trauma on Self-Control was significantly greater than on Self-Safety (mean difference = 2.95, $p < .002$), on Self-Trust (mean difference = 4.38, $p < .001$), on Other Trust (mean difference = 4.17, $p < .001$), on Other Esteem (mean difference = 2.09, $p < .019$), on Other Intimacy (mean difference = 2.03, $p < .006$), and on Other Control (mean difference = 3.00, $p < .001$).

Table 13. Pairwise Comparisons of TABS Sub Scale Scores

(I) Factor	(J) Factor	Mean Difference	Significance
1-Self-Safety	2	-12.080	.000
	3	1.433	.145
	4	1.227	.231
	5	-2.200	.010
	6	-.860	.357
	7	-1.313	.165
	8	-.920	.311
	9	-2.947	.001
	10	.053	.955
	2- Other Safety	1	12.080
3		13.513	.000
4		13.307	.000
5		9.880	.000
6		11.220	.000
7		10.767	.000
8		11.160	.000
9		9.133	.000
10		12.133	.000
3- Self-Trust		1	-1.433
	2	-13.513	.000
	4	-.207	.832
	5	-3.633	.000
	6	-2.293	.025
	7	-2.747	.009
	8	-2.353	.015
	9	-4.380	.000
	10	-1.380	.144
	4- Other Trust	1	-1.227
2		-13.307	.000
3		.207	.832
5		-3.427	.000
6		-2.087	.014
7		-2.540	.017
8		-2.147	.008
9		-4.173	.000
10		-1.173	.136
5-Self-Esteem		1	2.200
	2	-9.880	.000

	3	3.633	.000
	4	3.427	.000
	6	1.340	.067
	7	.887	.338
	8	1.280	.046
	9	-.747	.398
	10	2.253	.002
6-Other Esteem	1	.860	.357
	2	-11.220	.000
	3	2.293	.025
	4	2.087	.014
	5	-1.340	.067
	7	-.453	.661
	8	-.060	.933
	9	-2.087	.018
	10	.913	.322
7- Self-Intimacy	1	1.313	.165
	2	-10.767	.000
	3	2.747	.009
	4	2.540	.017
	5	-.887	.338
	6	.453	.661
	8	.393	.679
	9	-1.633	.077
	10	1.367	.174
8- Other Intimacy	1	.920	.311
	2	-11.160	.000
	3	2.353	.015
	4	2.147	.008
	5	-1.280	.046
	6	.060	.933
	7	-.393	.679
	9	-2.027	.005
	10	.973	.204
9- Self-Control	1	2.947	.001
	2	-9.133	.000
	3	4.380	.000
	4	4.173	.000
	5	.747	.398
	6	2.087	.018
	7	1.633	.077
	8	2.027	.005
	10	3.000	.000
10- Other Control	1	-.053	.955
	2	-12.133	.000

	3	1.380	.144
	4	1.173	.136
	5	-2.253	.002
	6	-.913	.322
	7	-1.367	.174
	8	-.973	.204
	9	-3.000	.000

Hypothesis 6

Hypothesis 6 stated that there would be significant differences in the impact of trauma on attachment beliefs about self and others (as measured by the Trauma and Attachment Belief Scale (TABS), as a function of no extra-cultural placement/extra-cultural placement and having a non veteran/veteran primary care giver. This hypothesis was tested using a 2 (No Extra-Cultural/Extra-Cultural Placement and Non Veteran/Veteran Primary Care Giver) by 10 (Self-Safety, Other Safety, Self-Trust, Other Trust, Self-Esteem, Other Esteem, Self-Intimacy, Other Intimacy, Self-Control, Other Control) Multivariate Analysis of Variance. As shown in Table 14, there were no significant difference in the effects of Veteran/Non-Veteran Primary Caregiver, $F(1, 149) = 1.26, p = .259$, or Extra-Cultural/No Extra-Cultural Placement, $F(1, 149) = 1.65, p = .099$, on the dependent variables. Because the main effects showed no significant differences, interaction effects were not examined.

Table 14. MANOVA: TABS and Childhood Experiences.

	Primary Care Provider	Extra-Cultural Placement	Mean	Std. Deviation	<i>n</i>
SELF SAFETY	Non-Veteran	No Extra-Cultural Placement	51.79	16.85	52
		Extra-Cultural Placement	60.96	11.19	26
		Total	54.85	15.73	78
	Veteran	No Extra-Cultural Placement	57.95	12.53	41
		Extra-Cultural Placement	61.23	11.14	31
		Total	59.36	11.98	72
	Total	No Extra-Cultural Placement	54.51	15.33	93
		Extra-Cultural Placement	61.11	11.06	57
		Total	57.01	14.19	150
OTHER SAFETY	Non-Veteran	No Extra-Cultural Placement	65.88	13.65	52
		Extra-Cultural Placement	71.92	12.41	26
		Total	67.90	13.47	78
	Veteran	No Extra-Cultural Placement	69.93	9.80	41
		Extra-Cultural Placement	71.00	11.10	31
		Total	70.39	10.32	72
	Total	No Extra-Cultural Placement	67.67	12.21	93
		Extra-Cultural Placement	71.42	11.62	57
		Total	69.09	12.09	150
SELF TRUST	Non-Veteran	No Extra-Cultural Placement	53.17	13.58	52
		Extra-Cultural Placement	55.04	12.96	26
		Total	53.79	13.32	78
	Veteran	No Extra-Cultural Placement	58.80	10.46	41
		Extra-Cultural Placement	55.81	11.10	31
		Total	57.51	10.77	72
	Total	No Extra-Cultural Placement	55.66	12.56	93
		Extra-Cultural Placement	55.46	11.88	57
		Total	55.58	12.26	150
OTHER TRUST	Non-Veteran	No Extra-Cultural Placement	53.77	11.06	52
		Extra-Cultural Placement	57.08	10.52	26
		Total	54.87	10.93	78
	Veteran	No Extra-Cultural Placement	57.00	11.25	41

		Extra-Cultural Placement	56.48	9.23	31
		Total	56.78	10.36	72
	Total	No Extra-Cultural Placement	55.19	11.20	93
		Extra-Cultural Placement	56.75	9.75	57
		Total	55.79	10.67	150
SELF ESTEEM	Non-Veteran	No Extra-Cultural Placement	56.54	11.30	52
		Extra-Cultural Placement	61.31	10.51	26
		Total	58.13	11.20	78
	Veteran	No Extra-Cultural Placement	59.41	9.26	41
		Extra-Cultural Placement	61.68	11.29	31
		Total	60.39	10.17	72
	Total	No Extra-Cultural Placement	57.81	10.49	93
		Extra-Cultural Placement	61.51	10.85	57
		Total	59.21	10.74	150
OTHER ESTEEM	Non-Veteran	No Extra-Cultural Placement	54.13	14.521	52
		Extra-Cultural Placement	59.73	14.10	26
		Total	56.00	14.53	78
	Veteran	No Extra-Cultural Placement	60.27	11.57	41
		Extra-Cultural Placement	59.42	10.66	31
		Total	59.90	11.12	72
	Total	No Extra-Cultural Placement	56.84	13.58	93
		Extra-Cultural Placement	59.56	12.23	57
		Total	57.87	13.11	150
SELF INTIMACY	Non-Veteran	No Extra-Cultural Placement	55.46	11.93	52
		Extra-Cultural Placement	59.65	8.13	26
		Total	56.86	10.94	78
	Veteran	No Extra-Cultural Placement	58.61	13.52	41
		Extra-Cultural Placement	61.65	8.73	31
		Total	59.92	11.72	72
	Total	No Extra-Cultural Placement	56.85	12.68	93
		Extra-Cultural Placement	60.74	8.45	57
		Total	58.33	11.39	150
OTHER INTIMACY	Non-Veteran	No Extra-Cultural Placement	54.48	13.48	52
		Extra-Cultural Placement	59.77	10.99	26
		Total	56.24	12.88	78
	Veteran	No Extra-Cultural Placement	59.37	10.35	41

		Extra-Cultural Placement	60.29	11.69	31
		Total	59.76	10.87	72
	Total	No Extra-Cultural Placement	56.63	12.38	93
		Extra-Cultural Placement	60.05	11.28	57
		Total	57.93	12.05	150
SELF CONTROL	Non-Veteran	No Extra-Cultural Placement	56.50	14.62	52
		Extra-Cultural Placement	61.88	12.88	26
		Total	58.29	14.21	78
	Veteran	No Extra-Cultural Placement	60.76	13.85	41
		Extra-Cultural Placement	63.10	11.27	31
		Total	61.76	12.77	72
	Total	No Extra-Cultural Placement	58.38	14.37	93
		Extra-Cultural Placement	62.54	11.94	57
		Total	59.96	13.61	150
OTHER CONTROL	Non-Veteran	No Extra-Cultural Placement	52.73	13.65	52
		Extra-Cultural Placement	58.19	9.95	26
		Total	54.55	12.74	78
	Veteran	No Extra-Cultural Placement	59.85	11.01	41
		Extra-Cultural Placement	59.19	7.47	31
		Total	59.57	9.59	72
	Total	No Extra-Cultural Placement	55.87	12.98	93
		Extra-Cultural Placement	58.74	8.62	57
		Total	56.96	11.57	150

Hypothesis 7

Hypothesis 7 stated that there would be significant differences in the magnitude of Features and Symptoms of PTSD (as measured by the Mississippi Combat PTSD Scale Short Form (M-PTSD Short Form) as a function of no extra-cultural placement/extra-cultural placement and having a non-veteran/veteran primary care giver. This hypothesis was tested using a two factor ANOVA with No Extra-Cultural/Extra-Cultural Placement and having a Non-Veteran/Veteran Primary Caregiver as the Independent variables, and the magnitude of Features and Symptoms of PTSD as the dependent variable. As shown in Table 15, no significant differences were found for Non-Veteran/Veteran Primary Care, $F(1, 149) = .191, p = .170$ or for Extra-Cultural/Non-Extra-Cultural Placement, $F(1, 149) = .53, p = .47$. Because the main effects showed no significant differences, interaction effects were not examined.

Table 15. Two-Way ANOVA with Mississippi PTSD-Short Form Score and Childhood Experiences

Extra-Cultural Placement	Primary Care Provider	Mean	Std. Deviation	<i>n</i>
No Extra-Cultural Placement	Non-Veteran	15.92	9.14	52
	Veteran	18.68	7.68	41
	Total	17.14	8.59	93
Extra-Cultural Placement	Non-Veteran	18.15	7.02	26
	Veteran	18.45	7.25	31
	Total	18.32	7.08	57
Total	Non-Veteran	16.67	8.51	78
	Veteran	18.58	7.44	72
	Total	17.59	8.05	150

Hypothesis 8

Hypothesis 8 stated that there would be significant associations among the impact of trauma on beliefs about self and others (as measured by TABS), features and symptoms of PTSD (as measured by the M-PTSD Short Form), no extra-cultural placement, extra-cultural placement, non veteran primary caregiver, and veteran primary care giver. To test this hypothesis, a series of Pearson Product Moment correlations were conducted. All TABS scores and the M-PTSD Short Form scores were significantly correlated. Values for these correlations were $p < .0001$ except for Self-Intimacy with the M-PTSD Short Form scale which was $r = .24, p < .001$. Correlations of the subjects' childhood experiences resulted in significance with the following subscales: Extra-Cultural placement and TABS subscales Self Safety ($r = .23, p < .001$); Self Esteem ($r = .17, p < .05$), Self Intimacy ($r = .17, p < .05$). Only one correlation was significant when contrasted with having a veteran primary caregiver: Other Control ($r = .22, p < .001$).

Table 16. Correlation Matrix of All Independent and Dependent Variables

	<u>ECP</u>	<u>VPCG</u>	<u>PTSD</u>	<u>SS</u>	<u>OS</u>	<u>ST</u>	<u>OT</u>	<u>SE</u>	<u>OE</u>	<u>SI</u>	<u>OI</u>	<u>SC</u>	<u>OC</u>
ECP	–												
VPCG	.10	–											
PTSD	.07	.12	–										
SS	.23**	.16	.40***	–									
OS	.15	.10	.50***	.61***	–								
ST	-.01	.15	.34***	.60***	.41***	–							
OT	.07	.09	.32***	.53***	.55***	.47***	–						
SE	.17*	.11	.39***	.69***	.59***	.67***	.61***	–					
OE	.10	.15	.42***	.66***	.62***	.53***	.65***	.74***	–				
SI	.17*	.14	.24**	.61***	.36***	.43***	.32***	.48***	.48***	–			
OI	.14	.15	.55***	.65***	.60***	.54***	.64***	.77***	.76***	.51***	–		
SC	.15	.13	.43***	.68***	.58***	.45***	.58***	.63***	.68***	.61***	.78***	–	
OC	.12	.22**	.45***	.61***	.66***	.53***	.63***	.70***	.59***	.43***	.69***	.70***	–

Note: * $p < .05$, ** $p < .001$; Extra-Cultural Placement = ECP, Veteran Primary Care Giver = VPCG, Mississippi Post Traumatic Stress Disorder = PTSD, Self Safety = SS, Other Safety = OS, Self Trust = ST, Other Trust = OT, Self Esteem = SE, Other Esteem = OE, Self Intimacy = SI, Other Intimacy = OI, Self Control = SC, and Other Control = O.

Chapter V

Discussion

It was the purpose of this study to examine the relationships among American Indian Vietnam combat veterans and the childhood experiences of extra-cultural placement and having a primary care giver that was also a veteran. Features and Symptoms of Post Traumatic Stress Disorder (PTSD), and the impact of trauma on beliefs about self and others were also examined in this population in relationship to these experiences. Participants were 150 American Indian Vietnam veterans from the Midwest.

The unique characteristics of individual tribes and their geographic regions need to be considered in conducting research and analysis of data. Manson and Trimble (1982) discuss the danger of categorizing the diversity found in 512 federally recognized tribes and an additional 365 state-recognized Indian tribes as one entity. Each of these entities has had a unique set of social, religious, economic and legal-political relationships with other tribes, other ethnic/racial groups, and Euro-American societies (Manson and Trimble, 1982). Therefore, for this study it was essential that we assess the differences between the tribal groups.

In the current study there were no significant differences found between Woodlands and Northern Plains American Indians on rates of extra-cultural placement. However, in the Yaekel-Black Elk (2005) study differences were found, with members of the Northern Plains group significantly more likely to have experienced extra-cultural placement compared to the Woodland tribal group. This could be because careful examination of the sample from the 2005 study showed that there were potential differences in sample characteristics. Also in the 2005 study, it is likely that there were

no homeless included in the Woodlands group. This is because of the differences in data collection procedures. In the previous study, there were homeless veteran domiciles located within the Northern Plains' communities where the data was gathered. Therefore, it would have been easier for this tribal group to get to Pow Wows than the Woodland tribal group whose homeless population resided approximately one to two hours away from their communities. Therefore, it was assumed that these homeless veterans were not included in the 2005 study.

There were also no significant differences found in this study between the two tribal groups in having a veteran primary caregiver or not. This finding parallels the finding of the Yaekel-Black Elk (2005) study. This finding is important because of previous research that has shown that veterans who have a childhood primary caregiver who is also a veteran are more likely to suffer the effects of trauma and to have post-combat adjustment difficulties (Rosenheck et al., 1998).

The current study, did demonstrate significant differences between veterans who experienced extra-cultural placement as children and those who did not experience extra-cultural placement on incarceration, and homelessness, with veterans who had experienced greater extra-cultural placement having significantly greater rates in each of these areas than veterans who had not experienced extra-cultural placement. There were no differences between veterans who had experienced extra-cultural placement and those who had not on alcohol or drug treatment.

There were also significant differences between veterans who had a veteran primary caregiver as children and those who did not have a veteran primary caregiver on incarceration, with those veterans who had a veteran primary caregiver having

significantly greater rates of incarceration. There were no differences between these two groups on homelessness or having been in alcohol or drug treatment. There were significant differences between veterans who had been or were homeless and those who had not been or were not homeless on rates of incarceration and rates of alcohol and drug treatment, with homeless veterans significantly more likely to have been incarcerated or had received alcohol or drug treatment than non-homeless veterans.

There are many theories about why there are so many homeless veterans. Some believe it has to do with housing shortages, not having a formal education, unemployment, family conflicts or previous criminal behavior that does not allow someone to return to the reservation (Yaekel, 1999). Orlandi (1992) hypothesized that dependencies based on forced treaties that required American Indians to rely on the government for their shelter and sustenance could have fostered unsuccessful coping styles, which include passivity, alcoholism, denial of Indian ancestry, rejection of Indian culture, and inter and intra-tribal strife. According to Orlandi (1992), American Indians' survival is dependent on desperate measures of fight or flight. It is possible that American Indians felt flight was their only option.

Another mechanism used to avoid or run away from problems in American Indian communities is self medicating to emotionally run away. The Matsunaga Study (Kulka et al., 1990) and the Yaekel-Black Elk (2005, 2006) studies of American Indian incarcerated participants showed a significant correlation between incarceration and rates of alcohol or drug treatment. In the Yaekel-Black Elk (1996) study, 40 of the 50 men incarcerated were under the influence of alcohol or drugs at the time of the offense and had been through alcohol or drug treatment prior to being incarcerated. American Indian

veterans reported more current alcohol abuse, more previous hospitalization for alcohol dependence and more recent alcohol intoxication than members of other ethnic groups of veterans. The Matsunaga Vietnam Veterans Project (1996) reported that American Indian veterans were found to have had much higher rates of alcohol abuse/dependence, both lifetime and current.

Thomason (1983) also found potential underlying motives for drinking. He found that heavy drinking among American Indians is associated with a variety of factors. These include dependency conflict, genetic predisposition, anxiety, feelings of alienation, helplessness, deprivation, frustration, and powerlessness. He interpreted these findings in light of the economic changes experienced by American Indians who were forced to transition from an economy of hunting and gathering to an economy of subsistence and reliance upon the government. Thomason believed that the economy of hunting and gathering had a low degree of social complexities compared to unmet economic demands. Moreover, because of forced governmental dependencies, American Indians are now entrapped in a culturally disadvantaged position (Thomason, 1983).

Regarding relationships between incarceration and alcohol and drug abuse, it is likely incarceration may be used as a substitute for the treatment of alcohol and drug abuse (U.S. Bureau of Prisons, 1996). Although there are many efforts underway by tribal agencies and the Indian Health Service to provide effective treatment for chemical abuse, these programs reach only a portion of American Indians who need assistance (Yaekel-Black Elk, 1996). Moreover, programming that focuses treatment efforts on American Indians' mental health challenges frequently attempt to operate within inadequate facilities that are understaffed. Thus, many American Indians who have been

arrested have committed no other crime than public drunkenness (U.S. Bureau of Prisons, 1996).

In summary, American Indian veterans who experienced extra-cultural placement were significantly more likely to have experienced incarceration and homelessness. Differences for alcohol and drug treatment were not found to be significant. Between American Indian veterans who had a veteran primary care giver and those who did not there were no differences in rates of alcohol or drug treatment or homelessness. However, veterans who had a veteran primary caregiver were significantly more likely to have been incarcerated. Lastly, there was a significant difference between American Indians who reported experiencing actual homelessness or the threat of being homeless with incarceration and alcohol or drug treatment, with homeless veterans more likely to have experienced incarceration or alcohol or drug treatment.

Results of this study also showed that the impact of trauma on other's safety was significantly greater than on all other beliefs about self and others. The impact of trauma on self-esteem was significantly greater than on self-safety, self-trust, other trust, other intimacy, and on other control. The impact of trauma on other esteem was significantly greater than on self-trust or on other trust. The impact of trauma on self-intimacy was significantly greater than on self-trust or on other trust. The impact of trauma on other intimacy was significantly greater than on self-trust or on other trust. The impact of trauma on self-control was significantly greater than on self-safety, self-trust, other trust, other esteem, other intimacy, or other control.

Many veterans post combat symptomology is similar compared to victims of other types of trauma (Stamm, 1996). One such symptom is hyper-vigilance, which may

be directly related to other safety (which was earlier noted as significantly greater than all attachment beliefs' constructs examined in this study. The nature of combat and how it would relate to concerns regarding others' safety was reflected in the anecdotal stories the veterans in this study shared in regard to always having to protect their comrades. To quote one of the veterans, his buddy died because he did not have his "friend's back". Finally, there were no significant differences between veteran's who had a veteran primary caregiver as a child and those who did not, or veterans who had experienced extra-cultural placements and those who had not on the impact of trauma on their beliefs about self and others, or on the magnitude of features and symptoms of PTSD.

It is important to take the time to listen to the unique experiences of being an American Indian veteran in order to begin to understand how to treat these individuals. Further studies need to be conducted to examine the sensitivity of the M-PTSD Short Form or the TABS with this population.

Lastly, as expected due to measuring similar constructs, there were significant associations among the impact of trauma on beliefs about self and others (as measured by TABS), features and symptoms of PTSD (as measured by the M-PTSD Short Form), no extra-cultural placement, extra-cultural placement, non veteran primary caregiver, and veteran primary care giver. Values for these correlations were weak to moderate. Extra-cultural placement had weak to moderate correlations with self-safety, self-esteem, and self-intimacy. Having a veteran primary caregiver was weakly correlated with other control.

Limitations

One limitation of this study is that the measures were all self-report and may have been influenced by social desirability as well as a desire to influence the effectiveness of services currently being offered. Another limitation is that there could be a restricted range of scores in the sample due to high mortality rates among older veterans, such as Vietnam era veterans. As well, there could be a possible restriction of score range because of high mortality rates among veterans with more severe PTSD symptomology. Restriction in score range is associated with Type II error, thus true differences between the subgroups in this population may not have been found.

Suggestions for Future Research

Future research with this population should include correlational studies between PTSD and alexithymia symptoms (inaccessible and restricted range of emotions) and the impact of trauma on beliefs. Future research should also be conducted on the traumatic effects of war on the entire veteran's family. Additionally, on small American Indian reservations this research should be extended to include the entire community.

Other studies with this population should also focus on the psychological impacts of these childhood experiences and their influences on adult adjustment to other traumatic experiences. This is particularly true in light of the American Indian representation in the current war in the Middle East. Already, Vet Centers are seeing these young men and women returning with emotional scars who are looking for readjustment counseling and a place to heal.

Clinical Considerations

The Racial/Cultural Identification Model (R/CID) proposed in Sue (1999) provides a conceptual framework to aid therapists in understanding their culturally different clients' attitudes and behaviors. These attitudes and behaviors are typically the result of the oppression that people experience as they struggle to understand themselves in terms of their own culture, the dominant culture, and the oppressive relationship between the two cultures. The stages of development are conformity, dissonance, resistance and immersion, introspection, and integrative awareness. There are also four corresponding beliefs that are associated with each stage. These beliefs are an integral part of a minority person's identity and are manifested in how he/she views (a) the self, (b) others of the same minority group, (c) others of another minority group, and (d) majority individuals (Sue, 1999).

These are developmental cultural stages that are seen often in incarcerated individuals (Yaekel-Black Elk, 1999; 2006). Prison officials misread American Indian offenders as beginning to regress when they begin to move through stages of cultural identity when in fact they may actually be moving forward. For example, in this study, there were significant associations between the experience of incarceration and extra-cultural placement. Therefore, for veterans who were incarcerated and had experienced extra-cultural placement, their time in prison might have been the first time they have been able to participate in cultural activities. This could be especially true for American Indians who did not grow up in their own culture because they were placed extra-culturally as children. Being with other American Indians in prison causes them to explore their identity and begin to work through these stages. At this time they may

become angry because they are grieving their opportunities to understand their own identity as children (Yaekel, 1999).

First it is important to have a working definition of culture. Pinderhughes (1989) describes culture as:

...a factor in the interactive processes between individuals, their families, their groups, and their environment; in the assignment of people's opportunities and lifestyles by their place in the social structures; in the cohesiveness and solidarity of groups and their manner of survival; in the structure and process of family dynamics; in the development of personality and ego functioning, including the sense of cohesiveness and the stability of the self; in the coping mechanisms evolved and the identity achieved; in how people view and behave toward culturally different others (p.12).

The most important clinical consideration of this study is to increase the awareness of the complexities of pre-combat childhood experiences of American Indian Vietnam combat veterans. Thus, it is the purpose of increasing this awareness that service providers will then ask the right questions to assess both childhood and adult traumatic experiences in this population. A more inclusive assessment will provide for an appropriate treatment plan which will treat the whole person and decrease the fragmentation experienced by these men with well-intentioned providers. Therefore, a mental health provider must possess a certain level of cultural competency to assist American Indian Vietnam veterans to work through their traumatic experiences.

Summary

In conclusion, it is the intent of this study that the results will be used to decrease the alienation of American Indian veterans by providing increased culturally-competent psychological services. Additionally, this study is intended to promote prevention services among veterans who have not yet developed more severe symptoms of PTSD. Lastly, that this study will encourage psychological service providers to advocate for immediate responses to those who have experienced trauma in order to help prevent the more negative impacts of both primary and secondary PTSD symptoms.

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Appendices A – F

Appendix A. Letters of Support



Akicita Wookiye Tipi

Internal Review Board
University of Minnesota
Minneapolis, MN, 55407

Rosebud Sioux Tribe
Veteran's Affairs Program
Box 720

Rosebud, South Dakota 57570
Phone (605) 747-2593 Fax (605) 747-5418
TOLL FREE: 1-888-275-0935

Orlando B. Morrison Sr.
Billie Jo Two Eagle
Troylynn Peneaux
Ronald Gassman

This is a letter of support for Julie Yaekel-Black Elk, University of Minnesota doctoral candidate in the Counseling Student Personnel Psychology program. We understand that she is requesting IRB approval to conduct research in our communities with American Indian Veterans as part of her doctoral dissertation. Julie has successfully completed numerous research projects since 1999 with both American Indian veterans and incarcerated tribal members with no known adverse effects.

Julie Yaekel-Black Elk has worked in various capacities in our communities for the past 20 years. Because of this experience and her professional reputation we are confident that all participants will be treated with cultural sensitivity and the respect necessary to successfully complete this important area of research.

It is our understanding that Julie will be utilizing: research instruments, asking demographic questions and questions regarding childhood experiences. We understand that the research questions will be asked at community events such as pow wows but not in plain view of other event participants. We also understand that participants will be compensated ten dollars for their participation in the research project.

In closing, we are asking the IRB committee to consider not only this important endeavor but Julie's previous work experience and research on behalf of American Indian veterans and community members.

Sincerely,

Orlando B. Morrison Sr., Director
RST Veterans Affairs Program

7-30-08

Internal Review Board
University of Minnesota
Minneapolis, MN, 55407

This is a letter of support for Julie Yaekel-Black Elk, University of Minnesota doctoral candidate in the Counseling Student Personnel Psychology program. We understand that she is requesting IRB approval to conduct research in our communities with American Indian Veterans as part of her doctoral dissertation. Julie has successfully completed numerous research projects since 1999 with both American Indian veterans and incarcerated tribal members with no known adverse effects.

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In closing, we are asking the IRB committee to consider not only this important endeavor but Julie's previous work experience and research on behalf of American Indian veterans and community members.

Sincerely,

Lena Hart

Lena Hart
Health Tech
PR TR House



THE MILLE LACS BAND OF
OJIBWE INDIANS

*Legislative Branch of Tribal Government
District III Representative*

Internal Review Board
University of Minnesota
Minneapolis, MN, 55407

This is a letter of support for Julie Yaekel-Black Elk, University of Minnesota doctoral candidate in the Counseling Student Personnel Psychology program. We understand that she is requesting IRB approval to conduct research in our communities with American Indian Veterans as part of her doctoral dissertation. Julie has successfully completed numerous research projects since 1999 with both American Indian veterans and incarcerated tribal members with no known adverse effects.

Julie Yaekel-Black Elk has worked in various capacities in our communities for the past 20 years. Because of this experience and her professional reputation we are confident that all participants will be treated with cultural sensitivity and the respect necessary to successfully complete this important area of research.

The Mille Lacs Band of Ojibwe not only supports this project but is willing to compensate 25 participants for their participation. The tribal council has agreed to an individual compensation in the amount of ten dollars for twenty five American Indian Vietnam Veteran who agree to participate in this important area of research.

It is our understanding that Julie will be utilizing: research instruments, asking demographic questions and questions regarding childhood experiences. We understand that the research questions will be asked at community events such as pow wows but not in plain view of other event participants.

In closing, we are asking the IRB committee to consider not only this important endeavor but Julie's previous work experience and research on behalf of American Indian veterans and community members.

Sincerely,

Harry Davis

St. Croix Chippewa Indians of Wisconsin

24663 Angeline Avenue • Webster, WI 54893 • (715) 349-2195 • Fax (715) 349-5768

Internal Review Board
University of Minnesota
Minneapolis, MN, 55407

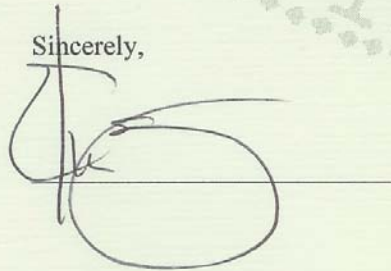
This is a letter of support for Julie Yaekel-Black Elk, University of Minnesota doctoral candidate in the Counseling Student Personnel Psychology program. We understand that she is requesting IRB approval to conduct research in our communities with American Indian Veterans as part of her doctoral dissertation. Julie has successfully completed numerous research projects since 1999 with both American Indian veterans and incarcerated tribal members with no known adverse effects.

Julie Yaekel-Black Elk has worked in various capacities in our communities for the past 20 years. Because of this experience and her professional reputation we are confident that all participants will be treated with cultural sensitivity and the respect necessary to successfully complete this important area of research.

It is our understanding that Julie will be utilizing: research instruments, asking demographic questions and questions regarding childhood experiences. We understand that the research questions will be asked at community events such as pow wows but not in plain view of other event participants. We also understand that participants will be compensated ten dollars for their participation in the research project.

In closing, we are asking the IRB committee to consider not only this important endeavor but Julie's previous work experience and research on behalf of American Indian veterans and community members.

Sincerely,



Hazel Hindsley
Tribal Chairwoman
Maple Plain Community

Gloria E. Benjamin
Tribal Vice-Chairwoman
Danbury Community

Jerald Lowe
Secretary/Treasurer
Round Lake Community

Elmer J. Emery
Representative
Big Sand Lake Community

Michael Decorah
Representative
Big Sand Lake Community

St. Croix Chippewa Indians of Wisconsin

24663 Angeline Avenue • Webster, WI 54893 • (715) 349-2195 • Fax (715) 349-5768

Internal Review Board
University of Minnesota
Minneapolis, MN, 55407

This is a letter of support for Julie Yaekel-Black Elk, University of Minnesota doctoral candidate in the Counseling Student Personnel Psychology program. We understand that she is requesting IRB approval to conduct research in our communities with American Indian Veterans as part of her doctoral dissertation. Julie has successfully completed numerous research projects since 1999 with both American Indian veterans and incarcerated tribal members with no known adverse effects.

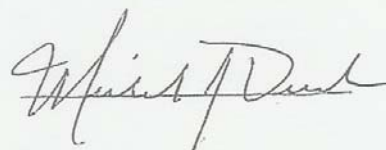
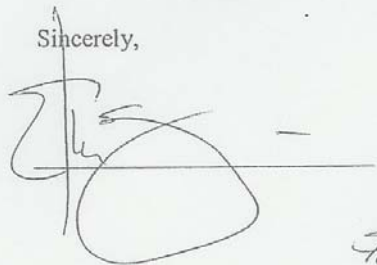
Julie Yaekel-Black Elk has worked in various capacities in our communities for the past 20 years. Because of this experience and her professional reputation we are confident that all participants will be treated with cultural sensitivity and the respect necessary to successfully complete this important area of research.

The St. Croix Chippewa Tribe not only supports this project but is willing to compensate 50 participants for their participation. The tribal council has agreed to an individual compensation in the amount of ten dollars for fifty American Indian Vietnam Veterans who agree to participate in this important area of research.

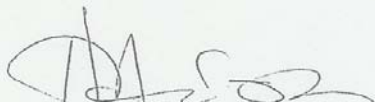
It is our understanding that Julie will be utilizing: research instruments, asking demographic questions and questions regarding childhood experiences. We understand that the research questions will be asked at community events such as pow wows but not in plain view of other event participants.

In closing, we are asking the IRB committee to consider not only this important endeavor but Julie's previous work experience and research on behalf of American Indian veterans and community members.

Sincerely,



\$500 memb. to Julie Y. Black Elk





**LAC COURTE OREILLES
COMMUNITY HEALTH CENTER**
13380 W Trepania Road • Hayward, Wisconsin 54843-2186

Telephone: 715-638-5100

Administration Fax: 715-634-6107

Medical Records Fax: 715-634-2740

Internal Review Board
University of Minnesota
Minneapolis, MN, 55407

This is a letter of support for Julie Yaekel-Black Elk, University of Minnesota doctoral candidate in the Counseling Student Personnel Psychology program. We understand that she is requesting IRB approval to conduct research in our communities with American Indian Veterans as part of her doctoral dissertation. Julie has successfully completed numerous research projects since 1999 with both American Indian veterans and incarcerated tribal members with no known adverse effects.

Julie Yaekel-Black Elk has worked in various capacities in our communities for the past 20 years and is currently working on her Internship at the Lac Courte Oreilles Tribal Health Clinic. Because of this experience and her professional reputation we are confident that all participants will be treated with cultural sensitivity and the respect necessary to successfully complete this important area of research.

It is our understanding that Julie will be utilizing: research instruments, asking demographic questions and questions regarding childhood experiences. We understand that the research questions will be asked at community events such as pow wows but not in plain view of other event participants. We also understand that participants will be compensated ten dollars for their participation in the research project.

In closing, we are asking the IRB committee to consider not only this important endeavor but Julie's previous work experience and research on behalf of American Indian veterans and community members.

Sincerely,

A handwritten signature in black ink, appearing to read "Julie Yaekel-Black Elk", written over a horizontal line.



Pride Of The Ojibwa
13394 W Trepania Road
Hayward • Wisconsin • 54843
PHONE (715) 634-8934 • FAX (715) 634-4797

Internal Review Board
University of Minnesota
Minneapolis, MN, 55407

This is a letter of support for Julie Yaekel-Black Elk, University of Minnesota doctoral candidate in the Counseling Student Personnel Psychology program. We understand that she is requesting IRB approval to conduct research in our communities with American Indian Veterans as part of her doctoral dissertation. Julie has successfully completed numerous research projects since 1999 with both American Indian veterans and incarcerated tribal members with no known adverse effects.

Julie Yaekel-Black Elk has worked in various capacities in our communities for the past 20 years. Because of this experience and her professional reputation we are confident that all participants will be treated with cultural sensitivity and the respect necessary to successfully complete this important area of research.

The Lac Courte Oreilles Tribe not only supports this project but is willing to compensate participants for participation. The tribal council has agreed to an individual compensation in the amount of ten dollars for every American Indian Vietnam Veteran who agrees to participate in this important area of research. Not to exceed \$750.00.

It is our understanding that Julie will be utilizing research instruments, asking demographic questions and questions regarding childhood experiences. We understand that the research questions will be asked at community events such as pow wows but not in plain view of other event participants.

In closing, we are asking the IRB committee to consider not only this important endeavor but Julie's previous work experience and research on behalf of American Indian veterans and community members.

Sincerely,

Post-it™ Fax Note	7671	Date	# of pages ▶
To	<i>JULIE BLACK-ELK</i>	From	<i>NORMA ROSS</i>
Co./Dept.		Co.	<i>LCO</i>
Phone #		Phone #	
Fax #	<i>612 624-8241</i>	Fax #	

3600 S. Glebe Rd.
Unit 621
Arlington, VA 22202

18 July 2008

Internal Review Board
University of Minnesota
Minneapolis, MN, 55407

This is a letter of support for Julie Yackel-Black Elk, University of Minnesota doctoral candidate in the Counseling Student Personnel Psychology program. I understand that she is requesting IRB approval to conduct research with American Indian Veterans as part of her doctoral dissertation.

Julie has provided services within the community for the past twenty years demonstrating commitment, dedication, and professionalism in all of her work. Having observed her interaction with the Veteran and the American Indian Communities, I am confident that all participants will be treated with cultural sensitivity and the respect necessary to successfully complete this important area of research.

I understand that Julie will be using research instruments, asking demographic questions and questions regarding childhood experiences. I understand that the research questions will be asked at community events such as pow wows but not in plain view of other event participants. I also understand that participants will be compensated ten dollars for their participation in the research project.

I am asking the IRB committee consider this important undertaking as well as Julie's previous work experience and research on behalf of American Indian Veterans and community members.

Sincerely,



Mary W. Erickson
COL, SP, USAR
703-681-3273

Appendix B. American Indian Vietnam Combat Veterans Questionnaire

American Indian Vietnam Combat Veterans Questionnaire

- 1) Age: _____
- 2) Tribal Affiliation: _____
- 3) Highest Level of Education Completed: _____
- 4) Pre-Combat Residence (circle one):
ON the Reservation // OFF the Reservation // Other _____
- 5) Was your pre-combat primary care giver a veteran: YES // NO
- 6) Did you experience out-of-home placement as a child? YES//NO
If yes, please circle
- | | |
|---------------------------------|-----------------------------|
| Relative Placement | Boarding School |
| Non-American Indian Foster Care | American Indian Foster Care |
- 7) Were you ever incarcerated before Vietnam? YES // NO
If yes, number of times. _____
- Were you ever incarcerated after Vietnam? YES // NO
If yes, number of times. _____
- 8) Were you ever in a drug/alcohol treatment program before Vietnam? YES // NO
If yes, number of times. _____
- Were you ever in a drug/alcohol treatment program after Vietnam? YES // NO
If yes, number of times. _____
- 9) How much of your enlisted time was spent in combat?
Please rate by months
1-3 4-6 7-9 10-12 13-15 16-18 19-21 22-24 25-above
- 10) Over the past year have you been homeless or experienced the threat of becoming homeless? YES // NO

Appendix C. Flyer

An Investigation of American Indian Vietnam Combat Veterans

You are invited to be in a research study about the lives of American Indian Vietnam veterans.

Eligibility: You are eligible if you are an American Indian combat veteran who served in the Vietnam War.

Background Information: The purpose of this study is to identify whether you were placed in foster care or other out-of-home placement during your childhood, whether you had a veteran care giver as a child, and whether you have experienced any trauma or PTSD symptoms either in the past or currently.

Procedures: If you agree to be in this study, I will ask you to complete two research instruments. These two instruments will take approximately thirty minutes to complete.

Risks and Benefits of Being in the Study: This study includes questions regarding your experiences as an American Indian child and combat veteran. I do not believe that you will suffer greater stress from participating in this study than you would experience during the course of a normal day.

There are no direct benefits of participation other than the monetary compensation that you will be given for your time.

Compensation: You will receive a monetary compensation of ten dollars for your participation. This compensation is yours to keep even if you decide to withdraw from the research.

Confidentiality: The records of this study will be kept private. Although the results will be published, they will not include any information that will make it possible to identify you or any other participant.

Voluntary Nature of the Study: Your decision whether or not to participate is completely voluntary. You have the right to withdraw your participation at any time. Your decision to withdraw will not affect your current or future relations with the University of Minnesota or the College of Education and Human Development.

Contacts and Questions: This study is being conducted by Julie Yaekel-Black Elk, a graduate student in the Counseling Student Personnel Psychology Program in the Department of Educational Psychology at the University of Minnesota

If you are interested in participating in this study please contact Ms. Yaekel-Black Elk at (320) 242-3494 or e-mail her at densite@centurytel.net.

If you have any questions or concerns regarding this study and would like to talk to someone other than Ms. Black Elk, you may call the Research Subjects' Advocate line at the University of Minnesota (612) 625-1650.

Appendix D. Consent Form

Consent Form

An Investigation of American Indian Vietnam Combat Veterans

You are invited to be in a research study about the lives of American Indian Vietnam veterans. You are eligible as a possible participant because you are an American Indian combat veteran who served in the Vietnam War. I will be reading this form to you. I ask that you also read this form and ask any questions you may have before agreeing to be in the study. This study is being conducted by Julie Yaekel-Black Elk, a graduate student in the Counseling Student Personnel Psychology Program in the Department of Educational Psychology at the University of Minnesota, under the supervision of Sherri Turner, Ph.D.

Background Information: The purpose of this study is to identify whether you were placed in foster care or other out-of-home placement during your childhood, whether you had a veteran care giver as a child, and whether you have experienced any trauma or PTSD symptoms either in the past or currently.

Procedures: If you agree to be in this study, I will ask you to complete two research instruments, the Traumatic Attachment and Belief Scale (TABS) and the Mississippi Post Traumatic Stress Disorder-Short Form (M-PTSD Short Form). These two instruments will take approximately thirty minutes to complete. I will also ask you several questions about who you are, what your age is, where and when you served, and where you currently live.

Risks and Benefits of Being in the Study: This study includes questions regarding your experiences both as an American Indian child and combat veteran. Even though I will not pry for details of specific experiences, the research instruments I will be giving you do include questions about your attitudes and beliefs. I do not believe that you will suffer greater stress for participating in this study than you would experience during the course of a normal day. If you do, we can stop and talk about what you are experiencing. You also can stop answering questions at any time, and it will not effect you negatively. There are no direct benefits of participation other than the monetary compensation that you will be given for your time. You will receive this compensation whether you finish participating in this research or not.

Compensation: You will receive a monetary compensation of ten dollars for your participation. This compensation is yours to keep even if you decide to withdraw from

the research. Participation in this study may improve veteran services to American Indian combat veterans.

Confidentiality: The records of this study will be kept private. Although I will be publishing the results of many records together in my dissertation project, I will not include any information that will make it possible to identify you or any other participant. Research records will be kept secure; only my advisor and I will have access to the records.

Voluntary Nature of the Study: Your decision whether or not to participate will not affect your current or future relations with the University of Minnesota or the College of Education and Human Development. If you decide to participate, you are free to withdraw at any time.

Contacts and Questions: The researcher conducting this study is Ms. Julie Yaekel-Black Elk. The research is being supervised by my advisor, Dr. Sherri Turner. You may ask any questions you have now. If you have questions later, you may contact Ms. Yaekel-Black Elk at (320) 242-3494 (e-mail: densite@centurytel.net) or Dr. Turner at (612) 624-1381 (e-mail: turne047@umn.edu). If you have any questions or concerns regarding this study and would like to talk to someone other than myself, you may contact Research Subjects' Advocate line, D528 Mayo, 420 Delaware Street Southeast, Minneapolis, Minnesota 55455; telephone (612) 625-1650.

You will be given a copy of this form to keep for your records.

Statement of Consent:

I have read the above information. I have asked questions and have received answers. By reading this consent form and voluntarily completing the instruments provided I understand that I will be considered a participant of the American Indian Vietnam Combat Veteran Study.

Appendix E. Compensation

Internal Review Board

University of Minnesota
Minneapolis, MN, 55407

Study Number: 0808P43143

Principle Investigator: Julie Yaekel-Black Elk

Title: American Indian Vietnam Combat Veterans: How out-of-home Placement and having a veteran primary care giver are associated with features and symptoms of trauma.

I am faxing copies of agreements from the three tribes that have agreed to donate monies to be used for the compensation for participation in this research study.

The breakdown is as follows:

The Mille Lacs Band of Ojibwe	250.00-25 participants @ 10.00 each
The Lac Courte Oreilles Tribal Governing Board	750.00-75 participants @ 10.00 each
The St. Croix Chippewa Indians of Wisconsin	500.00-50 participants @ 10.00 each

Total Donated: 1,500.00-150 participants @ 10.00 each

Sincerely,

Julie Yaekel-Black Elk

Appendix F. Traumatic Attachment Belief Scale

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November 21, 2008

Julie Yaekel-Black Elk
Doctoral Student
University of Minnesota

Re: Trauma Attachment and Belief Scale

Dear Ms. Yaekel-Black Elk—

This follows up your email today, seeking permission to reprint copyrighted test material in your thesis.

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SDW:se

TABS Subscales and Sample Items

TABS Scale	No. of Items	Sample Item No.	Sample Item
Total	84		
Self-Safety (SS)	13	54	I feel threatened by others.
Other-Safety (OS)	8	6	I never think anyone is safe from danger.
Self-Trust (ST)	7	19	I don't trust my instincts.
Other-Trust (OT)	8	26	Trusting people is not smart.
Self-Esteem (SE)	9	3	I don't feel like I deserve much.
Other-Esteem (OE)	8	39	People are no good.
Self-Intimacy (SI)	7	53	I hate to be alone.
Other-Intimacy (OI)	8	35	I feel cut off from people.
Self-Control (SC)	9	56	I have problems with self-control.
Other-Control (OC)	7	78	I can't do good work unless I am the leader.

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