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Healing the American Indian Soul Wound

EDUARDO DURAN, BONNIE DURAN, MARIA YELLOW HORSE BRAVE HEART, and SUSAN YELLOW HORSE-DAVIS

INTRODUCTION

It was almost two decades ago that the authors became aware of the concept of a "soul wound," although knowledge of what is characterized as the "soul wound" had been an integral part of indigenous knowledge ever since Columbus landed in this hemisphere and Cortez arrived in Vera Cruz, Mexico. Native people who were asked about problems in the contemporary Native community explained that present problems had their etiology in the traumatic events known as the "soul wound." Knowledge of the soul wound has been present in Indian country for many generations. Current synonymous terms include historical trauma (Brave Heart, in press a), historical legacy, American Indian holocaust, and intergenerational posttraumatic stress disorder (Brave Heart & De Brun, in press). In addition, there has been academic literature documenting the American Indian holocaust, thus bringing some validation to the feelings of a community that has not had the world acknowledge the systematic genocide perpetrated on it (Brave Heart-Jordan & DeBruyn, 1995; Brown, 1971; Legters, 1988; Stannard, 1992; Thornton, 1987).

> European contact brought decimation of the indigenous population, primarily through waves of disease, annihilation, and military and colonialist expansionist policies. The forced social changes and bleak living conditions of the reservation system also contributed to the disruption of American Indian cultures. This painful legacy includes themes of encroachment based on the *manifest destiny* doctrine and betrayal of earlier agreements and treaties (Limmerick, 1987). Armed conflict and removal of tribes from traditional lands became the norm. Numerous tribes faced "long walks" where many, if not the majority, died of disease, fatigue, and starvation. As the reservation system developed, tribal groups were often forced to live together in restricted areas. When lands were found to be valuable to the government and Whites, . . . more ways were found to take them away and resettle the

EDUARDO DURAN and BONNIE DURAN • First Nations, 4100 Silver SE, Albuquerque, New Mexico 87108.
MARIA YELLOW HORSE BRAVE HEART and SUSAN YELLOW HORSE-DAVIS • Graduate School of Social Work, University of Denver, Denver, Colorado 80208.

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> Native peoples elsewhere (Jacobs, 1972; Pearce, 1988; White, 1983; Brave Heart and DeBruyn, in press).

Historical trauma is more complex than surface exploration would reveal. Historical trauma is trauma that is multignerational and cumulative over time; it extends beyond the life span. Historical trauma response has been identified and is delineated as a constellation of features in reaction to the multigenerational, collective, historical, and cumulative psychic wounding over time, both over the life span and across generations (Brave Heart-Jordan, 1995; Brave Heart, in press a). Mourning that has not been completed and the ensuing depression are absorbed by children from birth on (Shoshan, 1989). Unresolved trauma also has been found to be intergenerationally cumulative, thus compounding the subsequent health problems of the community (Solomon, Kotler, & Mikulincer, 1988; Brave Heart, in press b). Evidence suggests depressive and emotional breakdowns of children who are descendants of Holocaust survivors are always linked to Holocaust experiences (Solomon *et al.,* 1988).

> The survivor's child complex is a constellation of features resulting from the intergenerational transmission of parental traumatic experiences and responses (Bergmann & Jucovy, 1982/1990; Kestenberg, 1990a; Kestenberg & Kestenberg, 1982, 1990a). Bergmann and Jucovy . . . concluded that, despite the possibility of adaptation and sublimation, the mental health of most children of survivors is at risk, and that they are scarred by the psychic reality of the Holocaust. Cardinal themes of parental survival, persecution, and deaths of relatives, at times unconscious, were manifested in the analyses of survivors' children according to Kestenberg and Kestenberg (1990a).
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> Rather than a syndrome, the Kestenbergs describe a "survivor's child complex," which includes the Holocaust's impact upon psychic structure, fantasies, and identification. . . . Post-Holocaust experiences of oppression were regarded . . . as further impacting parental survivorship and quality of transmission to offspring (Brave Heart-Jordan, 1995, pp. 76–77).

Some of the features associated with the complex include depression, suicidal ideation and behavior, guilt and concern about betraying the ancestors for being excluded from the suffering, as well as obligation to share in the ancestral pain, a sense of being obliged to take care of and being responsible for survivor parents, identification with parental suffering and a compulsion to compensate for the genocidal legacy, persecutory and intrusive Holocaust as well as grandiose fantasies, dreams, images, and a perception of the world as dangerous.

The features of the survivor's child complex were congruent with those identified by Macgregor (1946/1975; Erikson, 1950) among the Lakota, including persecutory fantasies and a perception of the world as dangerous; the fantasy of the return of the old way of life, analogous to compensatory fantasies; apprehension, shame, withdrawal, grandiosity in daydreams, and anxiety about aggressive impulses (Brave Heart-Jordan, 1995; Brave Heart & DeBruyn, in press). Dreams of community members were collected over a period of 4 years and their content was analyzed. There were over 800 themes, with the overwhelming message of the dreams being a hostile environment or hostile world.

> It is apparent that the psyche of the community recognized the wounding of the environment, and that this awareness in turn was perceived as a wounding of the psyche. Harmony had become discord and the community's unconscious perception was that the world was unfriendly and hostile. The problems that were manifested and verbalized were merely symptoms of a deeper wound—the soul wound. (Duran & Duran, 1995, p. 195)

Historical trauma is also an ongoing process via pressures brought on by acculturative stress. The concept of acculturative stress refers to one kind of stress in which the stressors

are identified as having their source in the process of acculturation, often resulting in a particular set of stress behaviors that include anxiety, depression, feelings of marginality and alienation, heightened psychosomatic symptoms, and identity confusion. Acculturative stress is thus a phenomenon that may underlie a reduction in the health status of individuals, including physical, psychological, and social health (Williams & Berry, 1991). While historical trauma included acculturative stress, it goes much deeper and encompasses the aftereffects of racism, oppression, and genocide.

HISTORICAL LEGACY

Since the arrival of Europeans on Turtle Island (also known by the colonial name "New World"), the so-called "Indian Problem" has taken on a paternalistic dispassion by dominant policymakers (Yellow Horse-Davis, 1994). In the treaty era, European settlers used treaty-making as a form of protection from "hostiles" whose lands they were invading (Deloria & Lytle, 1983). Instead of using force to seize lands, treaty-making provided an atmosphere of "civility and legitimacy" to the settlers (Deloria & Lytle, 1983, p. 3). Thus, according to Deloria and Lytle, treaty-making was used to establish "legal and political relationships" by the invading forces (1983, p. 3).

When the United States won independence from Great Britain, the first treaty signed was between the government and the Delaware Tribe (Deloria & Lytle, 1983). Over the next century, over "600 treaties and agreements" were made between Indian tribes and colonial interests (Deloria, 1983, p. 4). Many of the treaties were broken by colonists. In addition, most treaties were written in English, and Indians signed (many times by force) by thumbpriniting documents, thus placing Indians at a clear disadvantage (Yellow Horse-Davis, 1994).

The resulting Treaty of Fort Stanwix of 1784 was a fraud. Native leaders were coerced at gunpoint into signing a document conceding large tracts of land. Many of the Native delegates left before the treaty was signed. The inability of the delegates to adequately represent the interests of their tribes led to the disintegration of the original Iroquois Confederacy.

To offer structure to a chaotic and painful set of events, Duran and Duran (1995) delineate a sequence of six phases in historical trauma. (A similar structure has been offered by Brave Heart-Jordan, 1995.) Any trauma to one phase of life resulted in trauma to other aspects, since these life activities were interconnected. These phases are as follows:

First Contact

At this point, there was a total environmental and "lifeworld shock."[1] The lifeworld of the Native people was systematically destroyed through genocidal military actions. Grief and bereavement for losses were not possible due to yet other traumatic events that quickly followed.

Economic Competition

During this phase, Native people suffered the losses of sustenance, both physically and spiritually. It is therefore improper to view these traumas as separate for Native peoples.

[1] *Lifeworld* refers to all aspects of being. These include the physical, spiritual, cultural, and emotional facets of existence.

Invasion War Period

In this era the U.S. government carried out a policy of extermination through military force. Many Native people who were not killed were removed from traditional homelands by force. Native people began to suffer from a refugee syndrome as they were displaced.

Subjugation and Reservation Period

Native peoples were forced to live within the confines of reservations. This imposition of boundaries that kept people from moving from one place to another was yet another event that exacerbated the soul wound.

Boarding School Period

Since Native people still retained Native identity, the U.S. government decided to attack systematically the core of Native identity (i.e., the family system). Removing children from parents and placing them in distant boarding schools became the policy. Within the boarding schools, children were forbidden to speak Native languages, practice Native religion, or to convey anything that might remotely resemble native subjectivity.[2] Children were forced into a colonial lifeworld, where the Native lifeworld was despised and thought of as inferior and evil.

Brave Heart-Jordan's (1995) examination of the historical, traumatic boarding-school experiences among the Lakota is generalizable to other tribes. Boarding schools were operated like prison camps, with Indian children being starved, chained, and beaten (Brave Heart-Jordan, 1995; Tanner, 1982). Furthermore, the poor standards at the boarding schools, the confinement in overcrowded reservation housing, the neglect of Indian health needs, and the deliberate undermining of traditional healers by the federal government resulted in poor health for approximately 80% of the population on some reservations (Tanner, 1982). More than one-third of the Lakota population over one year of age died of tuberculosis between 1936 and 1941 (Brave Heart, in press a; Tanner, 1982).

Forced Relocation and Termination Period

During the 1950s, many Native people were relocated from reservations into large metropolitan areas. The intent was similar to the previous one (i.e., to assimilate Native people and remove them from any connections to the remaining indigenous culture).

> Over 100,000 American Indians were sent to major urban centers throughout the United States (Bars, 1994; Sorkin, 1978). Many . . . returned to their respective reservations within a very short period of time. Others remained in the cities, often developing a lifestyle of going back and forth to the home reservation. . . . This situation created additional stressors on American Indian families economically, socially, and spiritually. As of 1995, over half of all American Indians live in urban settings where they face a concerted lack of economic and health resources (Brave Heart & DeBruyn, in press).

Genocide has taken different forms in the American Indian community. There is "growing attention to a less murderous form of genocide, sometimes labeled 'cultural genocide,' that is taken to cover actions that are threatening to the integrity and continuing viability of peoples and social groups" (Legters, 1988, p. 769, as cited in Brave Heart-Jordan & DeBruyn, in

[2]The term *subjectivity* infers the deeper experience of who a person is and how he or she define him- or herself.

press). Prohibition of religious freedom has been a form of cultural genocide that is ongoing even to this day. It was only in 1994 that Native peoples were allowed to practice some forms of religion without fear of reprisal by state and federal governmental policies.

SURVIVOR SYNDROME/SURVIVOR'S CHILD COMPLEX

Although some caution is urged in the assertion of a "Survivor Syndrome" (Marcus & Rosenberg, 1988; Weinfeld, Sigal, & Eaton, 1981), "the bulk of the literature acknowledges the existence of special features among the clinical population of survivors. The similar dynamics observed among the children of survivors and their descendants have been called a "survivor's child complex" (Kestenberg & Kestenberg, 1990; Brave-Heart & De Bruyn, in press). Addressing criticisms of the Survivor Syndrome, Fogelman (1988) asserts that although more empirical studies are needed, the pain and psychological impairment of survivors are not captured by standardized personality tests.

Brave Heart-Jordan (1995) outlines aspects of Jewish survivors that are relevant for American Indians, such as "the difficulty in mourning a mass grave, the dynamics of collective grief, and the importance of community memorialization" (p. 67). A specific example is the Lakota survivors and descendants of the Wounded Knee Massacre in 1890. Fogleman further "addresses the challenges for Jews in European countries, where [they] 'lived among the perpetrators and murderers of their families'" (p. 94). A comparison may be made to natives who live in a colonized country, suggesting that similar patterns of grief have emerged. Fogelman asserts that

> Jews in Europe have not found . . . effective means of coping, integration, and adaption. Most are in a stage of complete denial and stunted mourning of their losses. . . . They feel a great need to control their emotions, because they fear that if their intense emotions were given free reign, they might go insane. . . . Survivors feared the uncontrollable rage locked within them, they feared they would be devoured by thoughts of avenging the deaths of their loved ones. These repressions result in "psychic numbing." (1988, p. 93)

She also distinguishes the healthier, communal grief process of American Jews from the delayed and impaired grief of European Jews (Brave Heart & De Bruyn, in press; Brave Heart-Jordan, 1995, pp. 67–68).

For American Indians, the United States is the perpetrator of their holocaust. Whereas other oppressed groups have a place to immigrate to escape further genocide, Native people have not had this option (Brave Heart-Jordan, 1995; Brave Heart & DeBruyn, in press). Kehoe (1989) states, "Where was America for American Indians? No other country welcomed them as immigrants, no other country promised them what their native land had denied them" (p. 133).

Native problems brought on by the devastation of their holocaust are further complicated by a lack of validation and no escape route being offered by the world community. These dynamics make it necessary for a repressed psychology to manifest symptoms of the pain suffered. A 15-year-old Pueblo girl, referred for a suicide attempt from an aspirin overdose, manifests a protective attitude toward her parents and a sense of guilt about her own pain. "I just can't talk to my parents. I don't want to burden them with my problems and feelings. They have so much pain of their own. I just can't bring myself to do that, but I felt like I had no one to talk to" (Brave Heart & DeBruyn, in press).

In another case, a young man reported walking in a certain part of his homeland. As he was doing so, he found himself engulfed by horses and cavalry in the middle of a massacre. He

saw old Indian women and children huddled against the river bank, trying to shield themselves from the sabers and the shooting. When he came out of this vision, he shared it with some of the elders of his community. They informed him that on that very spot, a massacre had occurred over 100 years ago (Duran & Duran, 1995).

Such cases are common in clinical settings where American Indians are seen for treatment. The pain is evident in both cases. In the second case, it is remarkable that there was a complete experience of the trauma of the young man's people in what may otherwise appear as a psychological breakdown. A similar phenomenon, *transposition,* has been observed among Jewish Holocaust descendants, where the past is simultaneously experienced with the present reality (Kestenberg, 1990, cited in Brave Heart & DeBruyn, in press, and Brave Heart, in press a). In many cases, there is a complete denial or shutdown of emotions, since the surfacing of these emotions would elicit extreme anger. The anger may be manifested externally or internally. The resulting need for anesthetic self-intervention, such as alcohol, drug abuse, domestic violence, and suicide, makes psychological sense.

CHRONIC AND ACUTE REACTIONS TO COLONIALISM

The title of this section underscores colonialism as the focus of people's reactions. This distinction is important to make since, in most instances, health providers prefer to label these problems with standardized diagnostic names. Labeling and naming are powerful methods of creating subjectivity and lifeworlds. If the authors were to utilize standard diagnosing practices, they would be contributing to the invalidation of the pain and suffering that is directly connected to the centuries of genocide.

In 1984, American Indians died due to alcoholism, alcohol psychosis, and cirrhosis of the liver at a rate of 30 per 100,000, which is 4.8 times the 1984 all-races rate of 6.2 deaths per 100,000 (Indian Health Service, 1987). Loss of life due to alcohol-related problems has affected the community over several generations. Although the problem of alcoholism is very complex, there can be very little argument that the genocidal legacy is a key factor in understanding it.

Alcohol was known by few Indians before colonization. Some tribes used it sparingly for either informal secular gatherings or religious ceremonies. Within this context, alcohol was strictly controlled and did not create social problems. White explorers such as Jacques Cartier and Henry Hudson noticed alcohol being used as a trading commodity in the late 1500s (MacAndrews & Edgerton, 1969). Captain Cook reported that when offered spirituous liquors, they rejected them as something unnatural and disgusting to the taste (MacAndrews & Edgerton, 1969).

Indian attitudes toward alcohol changed in time. They were distrustful of its effects early on but some learned to enjoy them. Explorers began to trade alcohol for furs, and alcoholic beverages became the ideal commodity for the conspicuous consumption that the traders needed to increase their business and profits. By the 1800s, liquor was the basic bartering item on the frontier, as colonists used deceitful tactics to make large profits. There are numerous reports of plying Indians with rum or whiskey as a show of friendship, then trading watered liquor of the most vile nature (often poisonous) for the valuable furs and other items that Indians gave away while intoxicated.

Suicide on some reservations is as high as 70.3 per 100,000, as compared with 11.6 per 100,000 for the general U.S. population (Claymore, 1988). Most of the studies on suicide ne-

glect the effects of historical trauma caused by centuries of colonialism (Brave Heart, in press; Brave Heart & DeBruyn, in press). The Indian Health Service (1995) reports that suicide is a serious problem, particularly among younger age groups. Such deaths occur needlessly and are usually predictable and preventable. The lack of awareness of the historical legacy limits true understanding of American Indian health status and fosters the practice of blaming Indian people for alcohol-related and other health-related morbidity. The relationship between morbidity and trauma is examined in the literature (Brave Heart, in press b). Villanueva (1989) notes:

> The more recent literature shows both the suicidal adult and the suicidal adolescent as holding rapidly eroding tribal tradition; the developmental social structure which for centuries established roles and expectation and guided both through the life span is tottering—for many Native Americans it is no longer applicable, for others it is non-existent. For those pueblos, tribes and individual Native American families in cities for which their traditions are viable and workable, the suicide rates are the lowest. In other words, if the culture would have remained intact, we would not be experiencing the devastating problems that we are facing. The responsibility should be placed in the right place and some honesty shed on the issue and then perhaps we could begin to ameliorate the problem. (p. 30)

Krugman (1987) utilized the concept of intergenerational transfer of posttraumatic stress disorder (PTSD) and unresolved trauma in his clinical work with family violence. "He concluded that untreated family violence victims appeared to suffer from chronic or delayed PTSD, and that trauma appears to be the central organizing factor in these families across generations. The central role of trauma within the family implicitly influences its transfer to subsequent generations" (Brave Heart-Jordan, 1995, p. 89). Incidence of domestic violence is remarkably high in Indian country, although no systematic epidemiological studies have been conducted in this area.

Violence directed at family members or other Indian people can be understood through the internalized oppression model (Freire, 1968). The release of psychic tension is directed either at the self, as in suicide, or projected outward to someone who is close to the person (i.e., a family member). Curry (1972) states that "the explicit and conscious act of killing involves the affirmation of life, which is nourished by that which is killed. . . . Death belongs to life, perhaps not as specifically as the phrase destructive love suggests. But they are nevertheless related. The patient has not actually committed murder; he is, we may quickly conclude, only killing an image of himself" (p. 103). The acts of killing or hurting family members makes sense in light of the many generations of imposed lessons that focused on teaching Indians how unworthy they were of life.

Physical health has also been a historical problem among Indian people since the imposition of the reservation era (Erikson, 1950; Macgregor, 1975; Tanner, 1982). Indian Health Service (1995) statistics reveal high rates of coronary heart disease, hypertension, diabetes, and other life-threatening chronic diseases. Paternalistic views also create suppression and bureaucratic barriers that prevent Indians from receiving quality social and health services. Specifically, the problem is made manifest when the Indian Health Service expects urban Indians to access services through the local public mainstream. On the other hand, the public mainstream has a myth that urban Indians can access health services from the Indian Health Service, thus leaving urban Indians without the help they need (Yellow Horse-Davis, 1994). Considering the extremely numerous health problems and the large numbers of urban Indians, the case for ongoing trauma is obvious.

PRESENT ENVIRONMENTAL RISK FACTORS AND SOCIAL PROBLEMS AND POLICIES AFFECTING NATIVE AMERICANS

A broader understanding of present social problems can only be arrived at through scrutinizing environmental risk factors. Federal government policy has been the source of community instability in addressing the aforementioned problems (Yellow Horse-Davis, 1994). Some Indian policy researchers believe that some of the problems confronting Indian people today may be related to historical oversights by federal policymakers (Report to Congress, 1992).

Another environmental factor is institutional oppression. Literature on institutional oppression and its effect on Indian people is limited. Calling it cultural oppression, Latimer reports that American Indians continue to experience oppression as a result of forced dominant values in institutional settings (Indian Health Service Report, 1991). Paternalistic policymaking is an environmental risk factor that has exacerbated Indian social problems for centuries (Yellow Horse-Davis, 1994). Examples of this paternalistic attitude exist in the language embedded in the Indian Child Welfare Act of 1978, which states, "Congress has plenary power over Indian affairs" (Prucha, 1990, p. 293).

Although some progress has been made in policies toward Indians, there is still an overtone of paternalism in the delivery of health services. While the Indian Health Service is responsible for providing health services to tribal and urban communities, Congress has "inconsistently" provided funds for appropriate levels of functioning (Yellow Horse-Davis, 1994). Policymakers appropriate funds based on their conception of what is good for Indians, without considering needs assessment data. These decisions have a direct impact on the delivery of mental health services, which would address some of the healing of the trauma discussed in this chapter. In 1990, a meager 2% of the Indian Health Service budget was devoted to mental health, while the rest of the money went for upkeep of the bureaucracy and to support the Western medical model of dealing with health issues (Indian Health Service, 1991).

RESTORATION OF THE CIRCLE

> And as I looked and wept, I saw that there stood on the north side of the starving camp a Sacred man who was painted red all over his body, and he held a spear as he walked into the center of his people, and there he layed down and rolled. And when he got up it was a fat bison standing there, and where the bison stood a Sacred herb sprang up right where the tree had been in the center of the nation's hoop. The herb grew and bore four blossoms on a single stem while I was looking—a blue, a white, a scarlet and a yellow—and the bright rays of these flashed to the heavens. (Black Elk, quoted in Neihardt, 1959)

When the young Black Elk saw this vision, he understood it as the restoration of the nations' hoop—the healing of the Indian nations. Black Elk also understood that the healing would take place in seven generations—the youth today.

Contemporary philosophical and scientific advances inform us that theories do not mirror reality and, at best, they are tools. Sociocultural, behavioral, and disease theories are the leading approaches that public and Indian Health Service officials apply to interpret and intervene in some of the problems afflicting Indians.

> These approaches, however useful, are not neutral insights and assessments of native drinking patterns but rather venture to explain and predict behavior based on a very historically

> and culturally specific mode of representation—realism—which erroneously assumes unity between the sensible and intelligible. Embedded within this Eurocentric mode of representation is a biased assessment of non-Western cultures. Behavioral theories decontextualize and individualize social problems and many sociocultural theories continue European representations of native peoples that have origins in the politics of the colonial and early American era. Insofar as these approaches are cultural products—a form of literature— we can say that they are hegemonic. By this we mean that they partake in ideological/cultural domination by the assertion of universality and neutrality and by the disavowal of all other cultural forms or interpretations. (Duran & Duran, 1995)

Hegemonic policy is reflected in the bureaucratic attempts at ameliorating the problems of Indian people. Indian Health Service programs are often forced to hire non-Indian clinicians who work under the belief that they know what's best for Indians (Yellow Horse-Davis, 1994). A roundtable panel reached a consensus that providers working in Indian country must make an effort to "understand and value the resilience of healthy traditions and cultural strengths" (Indian Health Service, 1991, p. 3). Usually, it is found that blame is placed on the patient instead of on a delivery system that is still ladened with 1800s Department of War policy: assimilation and/or termination of Indian people. Western attitudes must be approached with care, since many of these therapies are ways of colonizing the lifeworld, which results in the ongoing cultural hegemony over the Indian client seeking relief for the soul wound. Clinicians working with Indian people must develop cultural competence, which requires therapeutic congruence with the client's culture (Brave Heart-Jordan & DeBruyn, 1995).

Most therapies used in Indian country today are a direct derivative of psychoanalysis: client-centered, behavioral, and other European/Euro-American models. The fact that traditional indigenous therapies are completely disregarded is indicative of ongoing cultural hegemony within the therapeutic arena. As mentioned earlier, the therapeutic arena does not exist in a vacuum and is therefore suspect as a hegemonic tool. Foucault (1967) eloquently describes the mental health field as merely another tool of social control. Until traditional indigenous therapies are implemented and considered legitimate, there will be a struggle, and, sadly, the suffering of a historical legacy and ongoing trauma will continue.

It is interesting that many of the present-day interventions in some arenas within Indian country were recommended by our ancestors for centuries. Early in the 17th century, Handsome Lake had a series of visions in which he prescribed cultural revitalization as a way of counteracting the devastation of colonialism and its effects. The use of alcohol was seen as a prime force causing instability in Indian country (Wallace, 1969). "The second social principle was peace and social unity. This principle was institutionalized in 1801 when Handsome Lake became the moral censor and principal leader of the Six Nations" (Duran & Duran, 1995, p. 65). Tenskwatawa also urged tribal members to give up ideas of private property and to return to communal life and fight the acquisition of land by whites. He taught Indians to move away from white people's food, technology, and manner of dress. Tenskwatawa also cautioned against any close association with colonial Americans.

Interventions have been prescribed by our ancestors for many generations, and through the integrating and reviving of their teachings, some effective therapies have been developed. These therapies have moved from a colonized mind-set into a postcolonial paradigm. By postcolonial we mean "a social criticism that bears witness to those unequal processes of representation by which the historical experience of the once colonized comes to be framed in the west" (Bhabha, 1983, p. 8). Postcolonial therapies will not operate on the logic of equivalence—A:non-A—but rather on a logic of difference—A:B—thus celebrating all diverse ways of life rather than comparing others to what they are not (Duran & Duran, 1995).

Programs that have succeeded are programs that have utilized indigenous epistemology as the root metaphor for theoretical and clinical implementation. Once indigenous knowledge and therapies are in place, it becomes a simple task to integrate the healing with Euro-American models of therapy. This is remarkable, because the opposite is true in most situations where the bureaucracy seeks integrated treatment models. That bureaucratic model continues to place Western medical practitioners in charge, and any indigenous knowledge is therefore the handmaiden of the perceived superior Western model. It is obvious that this merely reifies ongoing colonial paradigms and serves to exacerbate the soul wound.

A protocol has been developed in which the movement of therapy in a postcolonial treatment paradigm can be seen. The program described has staff who are trained in both Western and indigenous treatment and epistemological systems, which allows them to have some understanding of the client's lifeworld. In addition, there are traditional medicine people who also participate in diagnosis, treatment, and other facets of therapy. A typical protocol for a client may be as follows:

1. The client is referred to either the traditional (indigenous therapist) provider or psychologist for intervention (both of these instances will have people who understand both Western and indigenous treatments).
2. The traditional counselor or psychologist makes an assessment of the client and immediately has a conference with the other providers.
3. The client then receives psychotherapy, as well as participates in traditional ceremonies as appropriate. If the client needs help from a medicine person, she or he is referred to one from her or his traditional belief system. The therapy that the client receives is designed to help the client understand the process itself. Many Native American clients have been so acculturated that, many times, the focus of the therapy is merely to reconnect them to a traditional system of belief and make sense of their lifeworld from a traditional perspective.
4. The client is evaluated and recommendations are made for ongoing therapy or participation in traditional ceremonies.

We have attempted to delineate an approach that has had significant success with people from many tribes. It is critical that the reader understand that this is not a technique taught in most counseling programs. The people intervening must themselves practice a lifestyle that reflects some indigenous teachings. If the practitioners do not live a lifestyle that follows some traditional forms, the interventions will be seen as caricatures and offensive by the community.

We must impress on the reader the importance of helping the client get in touch with indigenous identities and ways of being in the world. In so doing, the client's self-esteem and identity will be enhanced. In addition, by becoming aware of historical factors, the client will be able to rid him- or herself of the internalized oppressor. The exorcizing of the internalized oppressor is one of the biggest accomplishments that the client can make in the therapy process. Ridding the client of the oppressor can only be effected through the implementation of the integrated model of therapy. If there is no integrated model of treatment, then the client is once more hearing that only white models are valid, thus facilitating a deeper internalization of the oppressor.

There are approaches being used that address the trauma of a whole community. Brave Heart-Jordan (1995; see also Brave Heart, in press a) details, in her study, an intervention model of culturally syntonic grief resolution and healing from the historical trauma response among the Lakota. She identified and incorporated features congruent with treatment for Holocaust survivors and descendants such as the following: (1) facilitating mourning as the

primary task (Danieli, 1989; Fogelman, 1991); (2) helping the patient tolerate affects that accompany the traumatic memories and the process of working through (Krystal, 1984; van der Kolk, 1987); (3) codifications in self- and object representations as well as world representations (Krystal, 1984); and (4) validation and normalization of the trauma response (Krystal, 1984; Lifton, 1988) and techniques such as visualization and pseudohypnotic suggestibility (Koller, Marmar, & Kansas, 1992). She also uses techniques involving exploration of pre-Holocaust family history (Danieli, 1989, 1993).

Brave Heart-Jordan (1995) describes her treatment as a group treatment model. The restorative factors of this modality incorporate sharing experiences, the provision of hope, collective mourning, and social support. Specifically, short-term group treatment models are also recommended. Advantages of group treatment include bonding through sharing common traumatic experiences and mutual identification. "The transmission of psychopathology is inhibited through developing awareness of the intergenerational transfer processes" (Danieli, 1989; Brave Heart-Jordan, 1995, p. 114).

The Lakota have implemented a communal memorialization through the Tatanka Iyotake and Wokiksuye (Sitting Bull Memorial and Bigfoot) Ride, which traces the path of the Hunkpapa and Miniconju massacred at Wounded Knee. "The Lakota intervention model includes catharsis, abreaction, group sharing, testimony, opportunities for expression of traditional culture and language, and ritual and communal mourning" (Brave Heart, in press a). Wounded Knee and the generational boarding-school trauma cannot be forgotten.

Brave Heart-Jordan (1995) found that

- Education about the historical trauma leads to increased awareness about trauma, its impact, and the grief-related affects.
- The process of sharing these affects with others of similar background and within a traditional Lakota context leads to a cathartic sense of relief.
- A healing and mourning process was initiated, resulting in a reduction of grief affects, an experience of more positive group identity, and an increased commitment to continuing healing work both on an individual and community level.

In the study conducted by Brave Heart-Jordan (1995), 100% found the intervention helped them with their grief resolution and 72.7% found it very helpful. Ninety-seven percent felt they could now make a constructive commitment to the memory of their ancestors; a majority found this to be very true. All respondents felt better about themselves after the intervention, with 75.8% expressing high agreement with this statement. In a qualitative study of a reservation Lakota parenting skills curriculum based on her historical trauma intervention model, Brave Heart (in press c) found that participants experienced improvement in their parenting. The Takini Network, a collective of Lakota historical trauma survivors, is furthering this type of research as well as community healing interventions and prevention curricula.

DISCUSSION

Many years of pain and grieving have gone into the concepts and thoughts presented in this chapter. All of the knowledge discussed has been passed in an oral manner from many elders in our communities. The knowledge imparted by the elders has been translated into a form that will make sense to academicians and other people interested in the topic. It is important to note that explanations of the soul wound are centuries old. This knowledge has been kept out of the mainstream due to the invalidating nature of Western gatekeepers of literature dissemination.

For the most part, the information available to the public in this regard has had to pass through colonial lenses, and by the time it is made available, the story has been distorted.

Intervention strategies that have been useful in dealing with the soul wound have been effective in many ways. People have engaged the healing process and have made use of traditional forms of healing. The fact that they integrate indigenous knowledge into their lives is a step in the creation of counterhegemonic discourse. Most of the people who became clients in our clinics and/or participants at our workshops engaged in this discourse. That made their lives more meaningful and helped to liberate them from the symptoms of ongoing neocolonialism that may have been imposed on them by other health systems that were not aware of the issues discussed in this chapter.

Soul-wound workshops and group interventions on healing from historical trauma and unresolved grief have been developed and given all over Indian country. Every time these workshops are given, many participants make it public that finally they understand why they have been feeling so bad, and why they have been symptomatic. We have seen many tears in the eyes of our elders as they feel the liberating touch of historical truth and the validation of their pain, grief, and anger. Through purification and other ceremonies, the pain can then be transformed into a powerful, life-giving force. As one healer states, "We have already paid the price. It's time to accept the many blessings that the Creator has in store for us. We must honor our people who sacrificed everything through honoring ourselves and healing ourselves. By healing ourselves, we will also heal the wounds of our ancestors and the unborn generations."

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