

RESOLUTION OF THE  
NAVAJO NATION COUNCIL

Supporting the Findings and Results of the Congressionally  
Mandated Study Conducted by the American Indian Vietnam  
Veterans Project and Urging the Federal Government to Access  
Local Health Care/Benefits Services For Navajo Veterans

## WHEREAS:

1. Pursuant to 2 N.N.C. §102 (A), the Navajo Nation Council is the governing body of the Navajo Nation; and

2. Pursuant to Resolutions CJ-5-40 and AC-56-50 (attached and incorporated herein as Exhibits C and D, respectively), the Navajo Nation Council pledged loyalty to the United States Government and agreed to assist in the defense of the principles of the Constitution of the United States of America, with its manpower and material resources; and

3. The Human Services Committee of the Navajo Nation Council has reviewed and supported the findings and results of the Congressional mandated studies done by American Indian Vietnam Veterans Project (AIVVP), by Resolution HSCAP-25-96, attached and incorporated herein as Exhibit "A"; and

4. In 1983, Congress enacted P.L. 98-160 mandating that a study be done to establish "the prevalence and incidence of Post-Traumatic Stress Disorder (PTSD) and other problems in readjusting to civilian life among Vietnam Veterans. The study concentrated on African-American, Hispanic and Anglo veterans and the studies discovered the rates of PTSD was much higher among African-American and Hispanic veterans and as a result, the Veterans Administration dedicated considerable resources towards their needs; and

5. In 1991, Congress enacted P.L. 101-144 authorizing that a similar study be completed with American Indians, Asian Americans, and Native Hawaiian veterans. The National Center for American Indian and Alaskan Native Mental Health Research (NCAIANMHR) based in Denver, Colorado was asked to complete the American Indian portion of this study, which was called the American Indian Vietnam Veterans Project (AIVVP); and

6. In 1992, the NCAIANMHR, through a Memorandum of Agreement (MOA) with the Navajo Nation, conducted a study among 316 Navajo Vietnam Veterans. The results and findings of this study, attached herein as Exhibit "B", has been reviewed and supported by local veterans organizations and Navajo Nation chapters; and

7. The findings validate and complement previous surveys that have been done, e.g. a Navajo Veterans Health Needs Survey concerning health care problems of veterans and therefore, it is strongly recommended that these problems be seriously addressed by the United States Congress and the U.S. Department of Veterans Affairs; and

8. It must never be forgotten that the solemn debt the United States owes its veterans has been crystal clear in wartime, as in peacetime. As someone said, "we send our equipment into battle and they come back damaged and inoperable and we repair them"; the same goes for veterans, we send them into battle and they come home injured, disabled, etc., and the U.S. Government has the responsibility to care for them through VA benefits and programs.

**NOW THEREFORE BE IT RESOLVED THAT:**

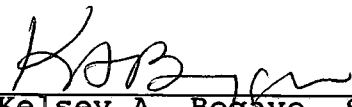
1. The Navajo Nation Council supports the findings and results of the Congressionally mandated study conducted by the American Indian Vietnam Veterans Project and urges the Federal Government to develop local health care/benefits services for Navajo veterans.

2. The Navajo Nation Council requests the Congress of the United States, President Bill Clinton, and the U.S. Department of Veterans Affairs to ensure that the necessary benefits and services are enhanced based on the findings of the project.

3. The Navajo Nation Council further requests the President/Vice-President of the Navajo Nation and the Department of Navajo Veterans Affairs to initiate an Intergovernmental Agreement with the U.S. Department of Veterans Affairs to establish local health care/benefits services and a Readjustment Counseling Services for all Navajo veterans as soon as possible.

**CERTIFICATION**

I hereby certify that the foregoing resolution was duly considered by the Navajo Nation Council at a duly called meeting at Window Rock, Navajo Nation (Arizona), at which a quorum was present and that same was passed by a vote of 50 in favor, 0 opposed and 0 abstained, this 18th day of April 1996.

  
 \_\_\_\_\_  
 Kelsey A. Begaye, Speaker  
 Navajo Nation Council

4-23-96  
 \_\_\_\_\_  
 Date Signed

Motion: Ernest Hubbell  
 Second: Tommy Chavez

# EXHIBIT A

HSCAP-25-96

## RESOLUTION OF THE HUMAN SERVICES COMMITTEE OF THE NAVAJO NATION COUNCIL

### Supporting the Findings and Results of the Congressionally Mandated Study Conducted by the American Indian Vietnam Veterans Project and Urging the Navajo Nation Council to Support Same

#### WHEREAS:

1. Pursuant to 2 N.T.C. Section 601, the Human Services Committee of the Navajo Nation Council is established and continued as a standing committee of the Navajo Nation Council; and
2. Pursuant to 2 N.t.C. Section 604 (b) (1), (3) and (5), the Human Services Committee of the Navajo Nation Council is empowered to promulgate regulations for the enforcement and implementation of the labor laws and laws relating to veterans services; to recommend legislation regarding employment and training and veterans services; and to serve as the oversight authority for the Division of Human Resources; and
3. In 1983, the United States Congress through P.L. 98-160 mandated a study to establish "the prevalence and incidence of Post-Traumatic Stress Disorder (PTSD) and other problems in readjusting to civilian life" among Vietnam veterans. The study was mainly concentrated on Afro-American, Hispanic and Anglo veterans in which it was discovered that the rates of PTSD was much higher among Afro-American and Hispanic veterans and as a result, the Veterans Administration dedicated considerable resources towards their needs; and
4. Consequently, in 1991, Congress Enacted P.L. 101-144 and authorized a similar study be completed with American Indians, Asian Americans, and Native Hawaiian veterans. The National Center for American Indian and Alaska Native Mental Health Research (NCAIANMHR) based in Denver, Colorado was asked to complete the American Indian portion of this project, which was called the American Indian Vietnam Veterans Project (AIVVP); and
5. A Memorandum of Agreement (MOA) attached herein as Exhibit "A" was signed in 1992 between the Navajo Nation and the National Center for American Indian and Alaska Native Mental Health Research (NCAIANMHR) to conduct the study among 316 Navajo Vietnam veteran participants. This study (attached herein as Exhibit "B") has refined the results and findings, which have been disseminated to veterans and veteran organizations who have given their support and request for remedial action to address the health care need; and

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6. The findings have also indicated that Navajo veterans have been exposed to combat at a higher percentage than other ethnic groups, that significantly demands more utilization of traditional healing for emotional health problems and prevalence of PTSD was noted to be at a higher level among Navajo Vietnam Veterans. The study further and strongly indicated a definite need for more services, e.g., educational benefits, employment and training and readjustment counseling.

**NOW THEREFORE BE IT RESOLVED THAT:**

1. The Human Services Committee of the Navajo Nation Council supports the findings and results of the Congressionally mandated Study conducted by the American Indian Vietnam Veterans Project and urges the Navajo Nation Council to support the study and requests the Federal Government to initiate a local access to care for mental/physical health services.

2. The Human Services Committee of the Navajo Nation Council further requests that the results from the studies be utilized effectively and appropriately by Office of the President/Vice President, Department of Navajo Veterans Affairs, and veteran organizations to advocate successfully for the services/benefits needed to enhance the health and well-being of Navajo and other American Indian veterans.

**CERTIFICATION**

I hereby certify that the foregoing resolution was duly considered by the Human Services Committee of the Navajo Nation Council at a duly called meeting at Window Rock, Navajo Nation (Arizona), at which a quorum was present, and the same was passed by a vote of 5 in favor, 0 opposed, and 0 abstained, this 18th day of April, 1996.



Chairperson  
Human Services Committee of the  
Navajo Nation Council

Motion: Ronald Gishey  
Second: Jerry Bodie

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# AMERICAN INDIAN VIETNAM VETERANS PROJECT

## *The Congressional Mandate*

In 1983, the United States Congress mandated that a study be done to establish "the prevalence and incidence of post-traumatic stress disorder (PTSD) and other problems in readjusting to civilian life" among Vietnam veterans. Over the next seven years, researchers at the Research Triangle Institute (RTI) in North Carolina conducted the National Vietnam Veterans Readjustment Study (NVVRS) in which they interviewed 3,016 men and women, most served in the military during the Vietnam era but also included for comparison were civilians who did not serve. Of the 3,016 interviews, approximately 1,200 were male theater veterans, that is, they had served in or around Vietnam. The investigators searched out Black and Hispanic veterans especially so they could compare them to White veterans. However, they did not do the same for American Indians and other minority groups who served in Vietnam.

Finally in 1987, when the RTI investigators analyzed the data, they found that approximately 15% of the Vietnam veterans were suffering from PTSD. They were quite surprised to discover that these rates were different for the two other ethnic groups. Over 27% of the Hispanic veterans had PTSD, so too did nearly 20% of the Black veterans, but only 14% of the White veterans. Coupled with other observations that existing programs often were inaccessible, culturally unacceptable, or generally not responsive to these kinds of problems, the VA dedicated considerable resources to help Hispanic and Black Vietnam veterans. Unfortunately, American Indian and several other groups of ethnic minority Vietnam veterans received little benefit from this additional programming.

Consequently, in 1991, Congress asked that a similar study be completed with American Indians, Asian Americans, and Native Hawaiians. The National Center for American Indian and Alaska Native Mental Health Research (NCAIANMHR) in Denver was asked to complete the American Indian portion of this project, which is called the American Indian Vietnam Veterans Project (AIVVP).

## *Questions to be Answered*

The AIVVP, and the larger project of which it is a part, was designed to answer six questions:

- 1) **PREVALENCE OF PTSD**  
What is the nature and extent of PTSD among two samples (one Northern Plains and one Southwest tribe) of male American Indian Vietnam Theater veterans?
- 2) **ETHNOCULTURAL VARIATIONS OF PTSD**  
Are there important cultural variations in the clinical appearance of PTSD, that is, in its onset, manifestation, course and outcome?
- 3) **SERVICE UTILIZATION**  
To what extent do these veterans, both those with and without PTSD, use existing services? Are others needed? Special attention is given to sources of care, satisfaction, acceptability, accessibility, barriers, and frequency of use.

4) **PREVALENCE OTHER DISORDERS**

To what extent do veterans from these two American Indian communities experience mental health problems other than PTSD (e.g., depression, anxiety, panic), as well as alcoholism and substance abuse?

A second set of questions, less central to the congressional mandate, is also of concern here. They include:

- 5) What appear to be some of the major causes as well as consequences of PTSD among these American Indian Vietnam veterans?
- 6) What do the veterans, themselves, see as the nature, cause(s), and appropriate ways of treating PTSD?

These questions are similar to those addressed by the NVVRS. However, we have placed greater emphasis on trying to understand the important difference that culture may make in each case.

Many difficult decisions had to be made in designing this project—especially about whom to interview. For example, we asked ourselves: “Should we try to interview veterans from many different Indian tribes?” “Include Alaska Natives?” “Should we try to interview both theater and era veterans?” “Men and women?” “Should we restrict ourselves to the reservations or include urban veterans?” Unfortunately, we did not receive the same amount of money from the VA as RTI did in the original study; so resources often dictated these decisions for us. Consulting with Indian veterans, program heads, and tribal leaders, the National Center decided to focus its efforts on Vietnam veterans from a select group of communities. For statistical reasons, we needed to interview at least 300 men in order to make good comparisons to the information generated by the national study (NVVRS). Only three tribes were large enough to meet this condition: a Northern Plains Tribe, a Southeastern Tribe and Southwest Tribe. Although less than half of American Indians live on reservations, they make up a very small percentage of the residents of any city. Thus we decided to start by focusing only on reservation communities. The Southwest and Northern Plains tribes have the largest reservations and offered an opportunity to at least compare the experiences of Vietnam veterans across two very different tribes, allowing us to speak to some of the similarities and differences along these lines. Only a few women served in Vietnam, mostly nurses. Since we needed such large numbers of veterans, we decided not to formally interview the few Southwest or Northern Plains women veterans we could find, but to gather information from them on a more informal basis, letting them tell us their stories in their own way.

### ***Steps Taken in Pursuing the Project***

Four major steps had to be taken in order to complete the AIVVP in a way that is scientifically sound and yet culturally sensitive. These steps were as follows:

- 1) On each of the reservations, we formed discussion groups of Southwest and Northern Plains Vietnam veterans, their relatives, service providers, and elders. These discussion groups were called Focus Groups. The Focus Groups studied the questionnaires used in the National Vietnam Veterans Readjustment Study and gave many suggestions about how to make them more culturally appropriate for use with the Northern Plains and Southwest veterans.

- 2) Working with each tribe, we developed a list of enrolled Northern Plains and Southwest men who were eligible to serve in the U.S. Armed Forces during the Vietnam era. This list was drawn from men born between 1930 and 1958 and included those who actually went to Vietnam, those who served in other places during this period, as well as men who did not serve at all.
- 3) The next step was to identify which men on this list were Vietnam veterans and, among them, who still lived on or near the reservation. These veterans were contacted by Locators (fellow Vietnam veterans) from the same community. If they were interested, the veteran was asked to participate in an interview. Ultimately, 305 Northern Plains and 316 Southwest Vietnam veterans completed the 6-8 hour interview. These interviews were conducted by local tribal members who were trained by National Center staff. The interview asked veterans about any physical or emotional problems stemming from the war, their experiences in the military, and how they have adjusted since the war. We also asked them about the services they have received from Veterans Administration clinics and hospitals, Indian Health Service, traditional healers, and other agencies.
- 4) The final stage of the project involved a follow-up clinical interview, by a highly trained mental health professional (e.g., a psychiatrist or psychologist), of approximately 30% of each of the veterans who had been interviewed previously. The purpose of this interview was to determine how confident we could be in the findings of the lay-interview with respect to PTSD and other alcohol, drug, and mental problems.

AIVVP started data collection in April of 1993 in the Northern Plains and November, 1993 in the Southwest. Location of eligible veterans was an enormous task because, unlike the NVVRS, we did not know anyone's veteran status before contact. Data collection for the lay interview was completed in the Northern Plains in January of 1995, with the Southwest following four months later, that is May, 1995. The clinical reinterviews were finished within two months of the final lay interviews.

One note about the use of the generic terms to describe the tribal groups as Northern Plains and Southwest. In our work with Indian communities, the maintenance of the confidentiality of the tribes is as important as confidentiality of the individual. The Barrow Alaska Study (Foulks, 1989) incorrectly branded an entire community as alcoholic. More recently, the CDC had an agreement with the Navajo Nation not to divulge the location of their work on the hanta virus, yet the communities were explicitly identified in an article in *Science*. Therefore, in these preliminary presentations of the AIVVP results, we prefer to use generic terms, not so much to maintain confidentiality from the current audience, but rather to guard against the casual dissemination of findings with the tribes identified. We hope that as the Indian people, various programs, and tribal government learn of the results of this project, they will want to be identified, for there are many important lessons that are emerging and which may position the tribe to successfully advocate for new resources.

As can be seen in Table 1, the response rates--that is, the number of veterans who agreed to participate in this project--for AIVVP compare very favorably with those of the NVVRS. The samples for the Blacks, Hispanics, Northern Plains Indians, and Southwest Indians are approximately 300 each, allowing sufficient statistical power to make informative comparisons.



**Table 1**  
**AIVVP and NVVRS: Numbers Interviewed and Response Rates**

	Northern Plains	Southwest	NVVRS
Lay interviews completed	305	316	1200
Response rate of those sampled and eligible	86.1%	89.3%	83%
Clinical interviews completed	100	118	344
Response rate	78%	87%	85%

***Important Preliminary Results***

The information collected from the 305 Northern Plains and 316 Southwest veterans have been coded and input. These data have been merged with those from the National Vietnam Veterans Readjustment Study and some initial comparisons made. It is very important to note the preliminary nature of these findings. The Final Report to Congress is due to be completed and presented Summer, 1996. Full copies of the final report will be distributed among relevant tribal programs and offices at that time.

In Table 2 we present some demographic comparisons between the samples. Included are some premilitary and postmilitary data, as well as descriptions of the military experiences of the Indian, White, Black and Hispanic samples. Notable findings include:

- ◆ Both Indian veteran samples were less likely to have been employed before entering the military.
- ◆ Whites were least likely of the 5 samples to have served in the Army.
- ◆ Both Indian veteran groups, but especially those from the Northern Plains, were less likely to have served in the Air Force than the other ethnic/racial groups.
- ◆ American Indian veterans from the Southwest were the least likely to have served in the Navy.
- ◆ Whites were the most likely to be commissioned officers.
- ◆ Whites were also most likely to have received a Purple Heart, although the percentage of Whites reporting having been injured in Vietnam was only slightly higher.

- ♦ Northern Plains veterans were the most likely to have served multiple tours but also the least likely to have received an honorable discharge.
- ♦ Northern Plains veterans were the least likely to be currently married, Whites the most likely.
- ♦ There were no significant differences in lifetime contact with the VA.

**Table 2**  
**AIVP and NVVRS: Descriptive Comparisons**

Variable	Southwest (N=316)	Northern Plains (N=305)	White (N=595)	Black (N=307)	Hispanic (N=280)	p(sig)
Employed before entering military	39.6%	41.6%	62.3%	65.8%	59.3%	<b>.001</b>
Served in Army	60.4%	64.9%	53.7%	64.2%	58.9%	<b>.001</b>
Served in Navy	6.0%	17.7%	20.0%	9.3%	16.0%	<b>.001</b>
Served in Air Force	5.1%	1.9%	15.2%	15.3%	10.4%	<b>.001</b>
Served in Marines	29.1%	16.4%	14.2%	14.7%	17.5%	<b>.006</b>
Commissioned Officer	0.95%	0.98%	8.8%	1.3%	1.8%	<b>.001</b>
Received a Purple Heart	13.2%	17.4%	25.1%	14.5%	15.7%	<b>.001</b>
Wounded or injured in Vietnam	23.9%	28.5%	35.1%	25.5%	29.3%	.098
Honorable discharge	92.7%	81.3%	96.7%	94.2%	97.5%	<b>.001</b>
Served multiple tours of duty	13.4%	23.2%	17.8%	17.5%	14.7%	<b>.021</b>
Currently married?	67.1%	47.1%	76.6%	59.4%	74.0%	<b>.001</b>
Lifetime contact with VA?	88.6%	83.2%	83.6%	86.3%	85.8%	.61

Note: The far right column of this and other tables, labeled **p**, indicates whether or not the numbers, percentages, or averages observed among the different groups of veterans differ statistically from one another. Values  $\leq .05$  are significant and are boldfaced for ease of reference.

Other information that veterans from this community, family members, and local human service programs have typically found interesting include the following:

- 92% of the Southwest Indian veterans have children  
51% of the veterans who have children have 3 or more.
- 58% of the Southwest Indian veterans have at least a high school education, while 40% report having attended at least some college.
- 59% of the Southwest Indian veterans are currently working, 22% are unemployed, and 5% are disabled, the remaining 14% are either working part-time, working off and on, or retired.

Some forms of information allow stronger conclusions where we can test for statistically significant differences between pairs of groups. These comparisons may be found in Table 3 with the superscripts indicating those groups from which the current sample is significantly different. Highlights include:

- On average the Indians and Hispanics samples are younger than the White and Black samples.
- On average the Southwest veterans went to Vietnam later than any of the other groups while the Blacks went earlier than either of the American Indian samples.
- The Southwest veterans returned later than all but the Northern Plains veterans.
- There were few differences in the number of months served in Vietnam, in fact only the Southwest veterans served fewer months on average than did the Black veterans.
- In terms of readjustment problems experienced since the war, both groups of American Indian veterans reported having more problems than did any of the other groups.
- The average Mississippi PTSD scale score (a widely used measure of serious symptoms of PTSD) for the two groups of American Indian veterans were also substantially higher than for any of the other samples.

**Table 3**  
**AIVVP and NVVRS: Mean Comparisons**

Variable	Southwest (N=316)	Northern Plains (N=305)	White (N=595)	Black (N=307)	Hispanic (N=280)
Year of birth	3.88 <sup>W,B</sup>	3.89 <sup>W,B</sup>	3.64	3.52	3.83 <sup>W,B</sup>
Year first went to Vietnam	4.48 <sup>N,W,B,H</sup>	3.96 <sup>S,B</sup>	3.68 <sup>S</sup>	3.49 <sup>S,N</sup>	3.65 <sup>S</sup>
Year left Vietnam	4.57 <sup>W,B,H</sup>	4.3 <sup>B</sup>	3.96 <sup>S</sup>	3.86 <sup>S,N</sup>	3.93 <sup>S</sup>
Months served in Vietnam	2.8 <sup>B</sup>	2.99	2.92	3.12	3.11
Readjustment problems	3.34 <sup>W,B,H</sup>	3.43 <sup>W,B,H</sup>	2.45 <sup>S,N,B,H</sup>	2.80 <sup>S,N,W</sup>	2.76 <sup>S,N,W</sup>
Mississippi PTSD scale	95.3 <sup>W,B,H</sup>	93.3 <sup>W,B,H</sup>	73.6 <sup>S,N,B</sup>	78.9 <sup>S,N,W</sup>	77.7 <sup>S,N</sup>

One section of the interview asked the veterans, in a general way, what problems they had experienced since the war, and whether they considered these problems serious, and if so, were these problems still serious today. Among Southwest Indian veterans,

- 22% have had serious problems **finding jobs**;  
16% continue to have serious difficulty in this area.
- 30% have had problems **getting enough money to live on**;  
22% have serious problems in this area now.
- 21% have had serious problems **holding a job**;  
15.5% have this problem now.
- 6% have had serious **problems with drugs**;  
2% continue to have these problems.
- 43% report having problems with **drinking too much**;  
15% report having such problems now.
- 24% report having had serious **mental or emotional problems**;  
14% report such problems now.
- 28% report having had serious **physical health problems**;  
26% continue to have such problems.
- 12% report having had serious **problems with the law**  
4% report having such problems now.
- 26% report having had serious **problems with their wives or children**;  
11% report having such problems now.

In another section of the interview, we asked the veterans to give us their overall impression of their physical health, as well as to report on specific problems. We ended by asking questions about the degree of impairment caused by physical health problems. Among the Southwest Indian veterans,

- 29% report their health as "very good" or "excellent"  
37% report it as "good"  
28% as "fair"  
7% as "poor"
- When comparing their physical health to others their age:  
  
37% of these veterans report their health as "better" than others their age  
46% as "about the same"  
17% as "worse"
- The prevalence of physical problems in the past year was reported to be:
 

◆ Trouble hearing	48%
◆ Arthritis	35%
◆ Hypertension	35%
◆ Respiratory problems	27%
◆ Skin condition	19%
◆ Diabetes	16%
◆ Urinary tract problem	16%
◆ Heart trouble	11%
◆ Ulcers	11%
◆ Arm or hand stiffness	11%
◆ Back or leg stiffness	10%
◆ Seizures	7%
◆ Cirrhosis of the liver	3%
◆ Cancer	1%
◆ Paralysis	1%
- In terms of impairment, physical health problems have kept these veterans from the following activities for 3 months or more.
 

◆ kept from working	19%
◆ limited other activities	19%
◆ trouble walking	14%
◆ driving a car	7%
◆ needed help in travel	5%
◆ stayed in bed	3%
- 53% report some physical limitation to the type of work they do  
  
53% of these individuals, in turn, report that the limitations are a result of their war experiences.

Clearly a major goal of this effort was to better understand use of health services by American Indian Vietnam Veterans. In order to do this we had to increase the scope of the Service Utilization section drawn from the original NVVRS to include other important service systems for American Indian people; namely IHS and traditional healing resources. In the following tables we present some preliminary findings for service use for PHYSICAL and EMOTIONAL/DRUG/ALCOHOL problems.

We asked the veterans if they had ever received help for physical health problems, and if so, from which service systems. We created two versions of "ever received help": one for biomedical services only (VA, IHS, other Biomedical services), and another which included traditional healers. When comparisons are made by type of providers, one can see that the Northern Plains veterans were more likely to have used VA services while the Southwest veterans were more likely to have sought help from traditional healers.

**Table 4**  
**AIVVP: Service Use for PHYSICAL Health Problems**

	Southwest	Northern Plains	p
EVER GET TREATMENT	76.0	79.7	.265
INCLUDING HEALERS	85.4	81.0	.137
VA	45.4	64.8	.001
IHS	67.4	78.4	.042
OTHER BIOMEDICAL	34.3	28.5	.122
HEALERS	55.9	16.7	.001

When a veteran had used services, we asked about his experiences in that system; when he had not used these services, we asked "why not". The percentages given here are restricted to use of services by Southwest Indian veterans for physical health problems.

**Use of VA services:**

- Of those who had gone to the VA for care of a physical problem:
  - 34% of them had received inpatient care at some time
  - 81% had received outpatient care at some time
  - 51% felt treatment was "good" or "excellent"

- Reasons the other 55% have not used the VA (they were allowed to choose more than one reason) include:

VA too far away	83%
used other health care	77%
wanted to solve problem on your own	52%
problem not serious enough	50%
treatment wouldn't help	32%
VA doesn't offer needed care	26%
not trust the VA	26%
too much red tape	25%
quality of care poor at VA	24%
worried about what others would think	20%
not eligible	15%
worried about racial prejudice	12%

- 28% have applied for VA disability, of these

64% have had their claim allowed  
 21% have been denied their claim  
 15% have a claim pending

- Of the 72% who have not applied for VA disability, 19% believe they do have a service-connected disability.

#### Use of IHS services:

- Of those who had gone to the IHS for care of a physical problem:

45% of these had received inpatient care at some time  
 71% had received outpatient care at some time

55% felt treatment was "good" or "excellent"

- Reasons the other 33% have not used the IHS (allowed more than one reason) include:

too much red tape	63%
problem not serious enough	60%
wanted to solve problem on your own	55%
used other health care	50%
quality of care poor at IHS	39%
IHS doesn't offer needed care	33%
treatment wouldn't help	33%
not trust the IHS	30%
worried about what others would think	22%
IHS too far away	15%
worried about racial prejudice	8%
not eligible	5%

#### Use of traditional healing resources:

Of those who had seen a traditional healer for help with a physical problem, 85% felt that their treatment was "good" or "excellent".

When we move to help for emotional problems, broadly defined, we see a similar pattern. In this case the Northern Plains veterans report heavier use of biomedical services than do the Southwest veterans. However, when traditional healers are included, the Southwest veterans report significantly MORE use for emotional problems than do the Northern Plains vets. Again these differences are caused by greater use of the VA by the Northern Plains veterans and of traditional healers by the Southwest veterans.

**Table 5**  
**AIVP: Service Use for EMOTIONAL Health Problems**

	Southwest	Northern Plains	p
EVER GET TREATMENT	32.3	48.2	.001
INCLUDING HEALERS	66.1	54.8	.004
VA	19.0	42.0	.001
IHS	14.9	12.8	.442
OTHER BIOMEDICAL	10.2	11.3	.654
HEALERS	56.1	12.9	.001

Finally, we wanted to obtain an early look to see if veterans suffering from PTSD are using services more heavily than those without PTSD. Given that the prevalence estimates are still several months away, we decided to use the M-PTSD, but with a very stringent criterion for caseness. Thus, we chose to divide the samples into those with M-PTSD scores of below 107 compared to those with 107 and above. Early work with the M-PTSD indicated that 107 was the best cutoff for identifying "clinical" (i.e., a treatment) population. It is important to note that for both tribal groups of veterans, 30% of the sample reached this stringent criterion. We then compared those above and below this cutoff in their use of services for each tribal group.

As can be seen Table 6, Southwest veterans with clinically significant PTSD symptoms only were more likely to use VA services for physical health problems. The Northern Plains veterans only were more likely to use traditional healing when they had many PTSD symptoms.



**Table 6**  
**AIVVP: Use of Services for PHYSICAL Health Problems by Level of PTSD Symptomatology**

	Southwest		p	Northern Plains		p
	<107	≥107		<107	≥107	
<b>N</b>	223 (70.6%)	93 (29.4%)		212 (69.5%)	93 (30.5%)	
<b>EVER GET TREATMENT</b>	70.0	90.3	.001	77.4	85.0	.13
<b>INCLUDING HEALERS</b>	82.5	92.5	.022	78.3	87.1	.072
<b>VA</b>	38.3	62.4	.001	61.6	72.0	.079
<b>IHS</b>	63.5	75.3	.069	83.0	73.5	.241
<b>OTHER BIOMEDICAL</b>	33.8	35.5	.772	30.2	24.7	.331
<b>HEALERS</b>	60.3	55.4	.805	12.3	26.9	.002

When we look at the same questions but for EMOTIONAL health problems (Table 7), we see that both the Southwest and Northern Plains veterans with clinically significant PTSD symptoms were more likely to seek help from the VA, IHS, and traditional healers than those who do not suffer from clinically significant PTSD symptoms.

Table 7  
**AIVVP: Use of Services for EMOTIONAL Health Problems by Level of PTSD Symptomatology**

	Southwest		p	Northern Plains		p
	<107	≥107		<107	≥107	
<b>N</b>	223 (70.6%)	93 (29.4%)		212 (69.5%)	93 (30.5%)	
<b>EVER GET TREATMENT</b>	23.8	52.7	.001	39.6	67.7	.001
<b>INCLUDING HEALERS</b>	61.9	76.3	.013	45.8	75.3	.001
<b>VA</b>	10.8	38.7	.001	34.0	60.2	.001
<b>IHS</b>	10.8	24.7	.002	10.4	18.3	.057
<b>OTHER BIOMEDICAL</b>	9.2	12.6	.365	10.2	13.8	.379
<b>HEALERS</b>	52.5	64.5	.050	9.6	20.4	.009

Much more is available than can be provided by an overview such as this general briefing on the AIVVP results. Indeed, the final report to Congress will generate an enormous volume of information that will be shared with the participating communities. And, a mechanism has been established whereby the tribes can request additional analyses of the data to help their own planning and advocacy efforts. This report will close with a description of that mechanism and related efforts to inform tribal members and local community organizations of the outcomes.

But before turning to the dissemination effort, it is important to acknowledge that sheer numbers alone do not adequately convey the personal costs and consequences of such combat-related trauma, for the veteran, his family, and community. Thus, we present next a case example drawn from the qualitative research that was done in tandem with the interviews. This example traces the history and circumstances of one Southwest Indian Vietnam veteran's struggle to deal with PTSD and associated problems of living. It describes much more powerfully the challenges faced and some of the victories won 30 years after the initial battle.

***The Wounded Spirit: One Veteran's Struggle with PTSD***

**Personal identification.** J (not a real name) is a 45 year old Indian male, married, the father of 4 sons and 3 daughters, ages 8 to 20. He, his wife, and 5 of their children live in a small, rural community on a large reservation in Arizona. His wife has a part-time job in a tribal human services program and sells craft items which she makes. J. is sporadically employed as a manual laborer. The family maintains some sheep and, during summer months,

relocates to a seasonal camp. J. served as a Marine Corps infantry squad leader in Vietnam during 1968-69. He most recently was seen on an outpatient basis through the Gallup-based VA medical program, where he participates in an all-Indian Posttraumatic Stress Disorder support group.

**History of present illness and treatment.** J. acknowledges alcoholism among two of his four brothers and his father's likely history of PTSD, a World War II combat veteran who served in the Pacific Theatre. The onset of J.'s symptoms occurred in early 1969, while he was in Vietnam. He spent most of his tour in the bush, on patrol, conducting ambushes involving heavy combat. J. reported some racial discrimination, notably being called "Chief," always expected to serve as point on patrols because he is Indian, and several near brushes with death when he was mistaken for the enemy by his fellow infantrymen. He was wounded, suffering serious shrapnel injuries of the chest, right arm, and hand, of which he recovered only partial use.

That year J. experienced intrusive thoughts almost daily, became hypervigilant, and began to exhibit a range of avoidant symptoms. He felt alienated from others and gradually withdrew from extended social contact. J.'s affect became more restricted; he struggled to avoid thinking about traumatic events. The possibility of dying at any time preoccupied him. His sleep was seriously disturbed; J. reported distressing dreams, often awakening drenched in sweat. He became noticeably irritated, often angry. Sudden flashbacks of combat were common and unpredictable.

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

On at least five separate occasions, between 1975 and 1990, J. was treated through tribal outpatient programs for alcohol dependence. In 1990, shortly after the death of his father due to a heart attack, and after his wife threatened to leave him, he entered an Indian-operated residential alcohol treatment program in a distant city. That program linked J. with the local VAMC where he was evaluated extensively, determined to be suffering from PTSD, and, after completing treatment for his alcoholism, transferred to an inpatient unit specializing in the treatment of combat trauma. After attending one month of the 12 week course, J. left the program against medical advice, sober, but still experiencing significant PTSD symptoms. He returned to the reservation. Some months later, through local outreach, J. learned of the Gallup support group, which he attended off and on -- except during summers -- for two years.

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

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

**Family history.** Several male members on both sides of J.'s family have obvious alcohol problems, currently two younger siblings. His father, as noted above, also appeared to suffer from PTSD, plagued by nightmares, displaying unpredictable irritation, and avoiding certain activities. J.'s father, previously alcohol dependent as well, had been sober for the 20 years prior to his death.

**Course and outcome.** Faced with his father's death, possible divorce by his wife, and loss of his children, J. confronted his alcohol dependence and successfully completed residential treatment. This treatment environment enabled him to examine his use of alcohol as it related to his military experience, one of the first times that he reported talking about the latter outside of his circle of "drinking buddies," virtually all of whom were themselves Indian Vietnam combat veterans. J.'s participation in the VA PTSD treatment program occurred soon after. However, being the only Indian in the program, greater intensity of intervention, and protracted absence from family led to his early departure. J. remains open to counseling for his combat-related trauma and, as noted, has attended a local VA support group.

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

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

On his mother's side, J. is a descendant of a family of medicine people, hand-tremblers (diagnosticians) among the women and singers (healers) among the men. Consequently, there have been expectations that he would play a leadership role in the cultural and spiritual life of the community. Boarding school interrupted J.'s participation in some of the important

aspects of local ceremonial life, but his mother's family worked hard to include him in critical events.

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

Except for military service, and treatment-related absences, J. has lived on the reservation all of his life. The boarding school that he attended was located on reservation, but more than a hundred miles from his home community. During childhood, J. was involved in tribal ceremonial life, orchestrated by his mother's family through clan affiliations. He is a member of the Native American Church, as was his father. J. has begun to take an active part in pow-wow's, prompted by his recent joining of a local gourd society -- originally a southern plains phenomenon that has diffused to many other tribes. A gourd society is a men's group comprised of military veterans that serves to honor warriors, provides mutual support, and dances together in public celebrations.

J. is moderately bicultural. Regular interaction with non-Indians has been limited to school, the military, and human service contacts (e.g., the VA and IHS). Though mildly uncomfortable in non-Indian settings, J.'s military experience provided him with important social skills for transitioning to and from majority environments.

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

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

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

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

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

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

**Cultural factors related to psychosocial environment and levels of functioning.** Steady employment opportunities are rare in J.'s community. Thus, he has chosen to attend community college to complete his G.E.D. and prepare for vocational training. This is not easy, but made possible by the shared resources (food, money, transportation) of the large extended family with whom he resides. Work is sporadic for him, but he readily seeks odd jobs.

J. received active encouragement from family and the community as he began to work seriously on sobriety and recovery from war trauma. Introduced through Native American Church contacts, members of a local gourd society sought him out and invited him to join them. He did and participates in their activities with increasing frequency.

As a consequence of this support, J. just entered a physical rehabilitation program at VA center, which has helped him to cope better with the handicap posed by his injured hand. Previously, the mere mention of this disability sent him into a hostile rage, with a lengthy tirade -- not entirely unfounded -- about the poor quality and insensitivity of medical care.

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

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

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

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

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

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

J. has a great deal of work before him. His PTSD symptoms are impairing. He looks hopefully to the tribal ceremonial to assist with the resolution of their cause. Continued work with VA

counselors, the support group, and the gourd society may have long term benefits along these lines as well. Perhaps most difficult is the residual grief over the death of his father. The options within his culture by which to process these feelings are less clear.

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

Many stories like J's surfaced during the AIVVP. Some were less tortured and twisting in the paths followed by the veterans, but most were not. It also is clear that a number of Southwest Indian Vietnam veterans could not be included in the study because they are no longer alive to tell their stories: a sad legacy not only of the war, but of the long delays in recognizing their needs. Hopefully, the work begun by this effort will combine with the programs already available--and those to come--to increase the likelihood that these veterans receive the attention that their service on behalf of the community and nation deserves.

### *Sharing the Results, Realizing the Benefits*

The preliminary results of the study already have been shared to a significant extent within the local community. Over the last 9 months, AIVVP staff, led by Buck Chambers and helped by Nelson Chee, Shirlene Jim, Denise Lee, and Tilda Nez, organized more than 70 presentations about the findings. These included 51 Chapter meetings, 20 meetings of various Veteran groups, and 5 Agency meetings. Three other chapter meetings were canceled due to weather or local conflicts in scheduling. Chapter meetings were felt to be the most successful means of sharing information: 25 or more people typically attended each session. Agency presentations were the least well attended. Considerable interest in and support for the project were expressed at these meetings. Many of those in attendance noted that their personal experiences, as veterans and family members, mirrored the findings described above. Veterans voiced the need for more services, especially those typically available through Veterans Centers (e.g., educational benefits, employment training and assistance, help in applying for service-connected benefits, readjustment counseling), outreach clinics such as the one on Hopi, and more accessible inpatient as well as outpatient treatment for PTSD and problems with alcohol. At almost every meeting questions arose about reimbursement for traditional ceremonies. Six formal resolutions of support--which were *not* requested by project staff during these meetings--for the AIVVP results and requests for



action were submitted by local chapters, agencies, and veteran organizations to the President's Office.

In anticipation of the Congressional hearings, the National Center for American Indian and Alaska Native Mental Health Research funded the establishment of the AIVVP Advisory Group. The purpose of the AIVVP Advisory Group is to review the findings of its work, to assist in their interpretation, to prioritize the sharing of information, and to prepare for the Congressional testimony. This group includes representatives from each of the three Northern Plains tribal communities (4), from the Southwest tribal community (3; Beverly Coho, Thomas Boyd, and Richard Begay), the Department of Veterans Affairs' National Center for PTSD, located in White River Junction, VT, the Center for Minority Affairs, Central Office, Department of Veterans Affairs in Washington, D.C., and the National Center for American Indian and Alaska Native Mental Health Research. Tribal representatives were nominated either by the Tribal Councils or President's Offices of their local communities. The AIVVP Advisory Group held its first meeting in Denver, CO on Tuesday, October 17, 1996. A second meeting is planned for May, 1996. The latter meeting will focus on service priorities suggested by the project's results.

The impact of the AIVVP results are becoming evident even before release of the final report and Congressional hearings. Based in part on information provided from the study, as presented to his staff by American Indian veterans, Senator Daschle's (D-SD) office successfully earmarked new monies to fund 6-8 new Readjustment Counseling Service positions which will be located in the participating communities. Discussions recently were initiated by the DVA regional office in Denver with appropriate tribal representatives about these additional staff resources. In addition, we were just advised that information from the AIVVP was helpful in obtaining the DVA's agreement to reimbursement Southwest veterans for the cost of any of six ceremonials performed on their behalf. Lastly, through the liaison efforts of Syd Flame (Yuma and a Vietnam combat veteran), who previously coordinated community feedback for the National Center, five (5) Southwest participants in the AIVVP have received extensive treatment at the Denver Veterans Administration Medical Center inpatient PTSD unit; several more are being evaluated for possible admission. We believe that these benefits represent only the early ones to be realized by the participating communities. We look forward to continuing our partnership with the Tribe over the years ahead to use the results of the AIVVP and other, related efforts to advocate successfully for the services needed to enhance the health and well-being of American Indian Vietnam veterans, and their counterparts from other eras.

For further information about the AIVVP, please contact:

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Subject Matter: Loyalty Pledge to United States  
 Page: June 1940 Meeting: Res. No. CJ-5-40  
 Passed: June 4, 1940  
 Vote: Passed Unanimously

RESOLUTION NO. CJ-5-40

WHEREAS, the Navajo Tribal Council and the fifth thousand people we represent, cannot fail to recognize the crisis now facing the world in the threat of foreign invasion and the destruction of the great liberties and benefits which we enjoy on our Reservation, and

WHEREAS, there exists no purer concentration of Americanism than among the First Americans, and

WHEREAS, it has become common practice to attempt national destruction through the sowing of seeds of treachery among minority groups such as ours, and

WHEREAS, we may expect such activity among our people,

THEREFORE, we hereby serve notice that any un-American movement among our people will be resented and dealt with severely, and

NOW THEREFORE, we resolve that the Navajo Indians stand ready as they did in 1918 to aid and defend our Government and its institutions against all subversive and armed conflict and pledge our loyalty to the system which recognizes minority rights and a way of life that has placed us among the greatest people of our race.

CERTIFICATION

I hereby certify that the foregoing resolution was considered and duly approved by the Unanimous vote of the members of the Navajo Tribal Council at a regularly called meeting at Window Rock, Arizona, at which a quorum was present, on this 4th day of June, 1940.

WITNESSED:

HOWARD GORMAN (Sgd)  
 Vice-Chairman, Navajo Tribal Council

J. C. MORGAN (Sgd)  
 Chairman, Navajo Tribal Council

Subject Matter - Patriotism - Expression of  
Page October 18-20, 1950 Adv. Comm. Meeting Summary:  
AC 56-50

Discussed - Not Recorded  
Passed - October 19, 1950  
Vote - 5 for - 0 against

EXHIBIT "D"

### RESOLUTION

WHEREAS, We, the Navajo People, have been known throughout our history for the high premium we have traditionally placed upon freedom and justice, and

WHEREAS, We are citizens of the United States of America, and

WHEREAS, In the past wars involving this nation, our people have given ample evidence of our willingness to fight for our country, and

WHEREAS, Our nation today is again preparing itself for defense, not only of itself but of all other free peoples, and

WHEREAS, Certain newspaper reports have unintentionally created in some quarters an opinion that the Navajos might concur with a recent statement coming from the Hopi Tribe requesting exemption from the Selective Service Act;

BE IT THEREFORE RESOLVED, That the Advisory Committee of the Navajo Tribal Council, speaking in behalf of the Navajo Tribe, gives to the Government of our nation and to our fellow citizens everywhere the assurance that we wish to accept our full share of the responsibilities involved, and we place our material resources and our manpower at the disposal of our country as our contribution to national defense and to the effort this nation is making to bring peace and security to people the world over.

AND BE IT FURTHER RESOLVED, That the Navajo Tribe never ceases to protest against discriminations to which Navajo ex-G. I.'s are subject in the enjoyment of veterans' benefits and in receiving equal opportunities as citizens of the United States.

### CERTIFICATION

We hereby certify that the foregoing resolution was considered by the Advisory Committee of the Navajo Tribal Council at a duly called meeting at Window Rock, Arizona, at which a quorum was present, and that the same was approved by a vote of 5 in favor and none opposed on this 19th day of October, 1950.

/s/ Sam Ahkeah

Approved October 20, 1950  
/s/ Allan Harper

Zhealy Tso, (Not present)