Historical Trauma, Microaggressions, and Identity: A Framework for Culturally-Based Practice

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Oklahoma Choctaws
The ten states with the largest American Indian populations in 2000

Indigenous Health Overview

- Pervasive pattern of health disparities, unequal burden of chronic illnesses, disproportionate levels of mortality and morbidity for behavioral health conditions (e.g., HIV, CVD)

- Escalating rates of chronic disease states, respiratory and reproductive health problems, and premature mortality related to chronic disease

- Disproportionate exposure to structural inequalities, environmental toxins, high levels of poverty and socioeconomic deprivation, exposure to chronic and persistent discrimination, and poor access to health care services

- Remarkably similar legacies of colonialism and suppression of cultural practices which are empirically linked to poor health and risk behaviors
Status of Urban American Indians and Alaska Natives

- 70% live off reservation or tribal lands with nearly 65% living in cities
- Highest rates of most communicable diseases of any ethnic group. Nearly 27% lack health coverage (2nd highest rate)
- Poverty rate is 3x that of other ethnic/racial groups and is one of the leading co-factors in the advance of the health-related morbidity and mortality
- Relative to rural Indians, urban Indians have higher infant mortality rates, higher mortality rates due to alcohol and injury, and higher rates of low-birth weight newborns
- Economic vulnerability and ill health make Natives more vulnerable to poor health, diet, weakening immune systems, and the hastening of mortality for chronic disease conditions.
Interpreting the Data

Interpreting epidemiological data such as these devoid of a “Fourth World” context leads to problematic interpretations of Native health statistics.

Failure to account for the socio-environmental context can lead to pathologized perceptions of Natives, reinforce power inequities, and perpetuate paternalism and dependency in health care.

Many of behavioral health problems (e.g. HIV risk) are directly connected to colonized status and associated environmental, institutional, and interpersonal discrimination.

Indigenist Research Models: Pathways to Health Outcomes

We present an indigenist stress-coping model for AIANs that incorporates the impact of historical trauma as well as protective functions of cultural practices on wellness outcomes.

The model delineates the pathways between social experiences and health behaviors, thus providing a coherent means of integrating historical, social, psychological, and cultural reasoning about discrimination and other forms of trauma as determinants of risk behaviors and outcomes.

Pathways from intergenerational pain to embodiment of pain.
HISTORICAL TRAUMA AND TERMINOLOGY
Historical Trauma

Collective and cumulative emotional wounding across generations that results from massive cataclysmic events – Historically Traumatic Events (HTE)*

The trauma is held personally and transmitted over generations. Thus, even family members who have not directly experienced the trauma can feel the effects of the event generations later

Intergenerational transmission of trauma is a relatively recent focus of mental health. First observed in 1966 by clinicians alarmed by the number of children of survivors of the Nazi Holocaust seeking treatment

The multigenerational aspects of trauma continue to be treated as secondary and, consequently, the behavior of many children of survivors of massive trauma is misunderstood and not treated appropriately

Brave Heart (1995); Evans-Campbell & Walters (2000)

Historically Traumatic Events

Events include planned phenomenon by government and government-sponsored institutions (e.g., boarding school, massacres)

Environmental trauma (e.g., radioactive dumping into rivers)

Spiritual trauma (prohibition or imprisonment for practicing traditions)
The multigenerational aspects of trauma continue to be treated as secondary and, consequently, the behavior of many children of survivors of massive trauma are misunderstood and not treated appropriately.

Intergenerational transmission of trauma is a relatively recent focus of mental health. It was first observed in 1966 by clinicians alarmed by the number of children of survivors of the Nazi Holocaust seeking treatment in clinics in Canada.

Practitioners and scholars working with other groups began to incorporate the concept of HT into their own work.

Intergenerational Transmission of HT: Research Findings

No clinically significant difference between children of holocaust survivors and Jewish non-survivor controls in terms of PTSD; however, when the survivor children were exposed to stressful events, they were significantly more likely to develop PTSD or sub-threshold PTSD symptoms than controls (Danieli, 1998)

Similar multigenerational effects have been documented among Japanese internment survivors and offspring

For AIAN offspring, increased sensitivity or hyperarousal to stressful events, in particular to events that act as reminders of their colonized status may predispose AIANs to trauma responses and corresponding symptoms
Some living with historical trauma will develop a historical trauma response which includes symptoms such as...

- Obsessive rumination about the deceased
- Transposition or living concurrently in the past and present
- Intrusive thoughts or dreams/nightmares of the event
- Fantasies about projecting oneself into the past
- Withdrawal, numbing, anxiety, depression, cardiovascular problems
- Worry over parenting skills or lack of confidence in parenting
- Guilt over not “living” the experience/ survivor guilt
- Collective sense of loss/grief dynamics and unresolved mourning

In my dream I had been going back into another life. I saw tipis and Indians camping...and then, suddenly, I saw white soldiers riding into camp, killing people, raping, cutting throats. It was so real...sights I did not want to see, but had to see against my will; the screaming of children that I did not want to hear...and the only thing I could do was cry...

For a long time after that dream, I felt depressed, as if all life had been drained from me. I was still going to school, too young to bear such dreams. And I grieved because we had to live a life we were not put on this earth for.
SURVIVOR GUILT

- I don’t talk much to my family about my problems because I don’t want to give them more burdens.
- I feel guilty over having advantages over other Native people.
- If I feel too good, it’s like a betrayal to my family members who died.

UNRESOLVED GRIEF AND MOURNING

- It is hard to mourn for my ancestors since I don’t know where they are buried
- I feel like I must take on some of the pain in my community
- Sometimes I think if we would just find the right medicine, we would be healed
GENDER AND HT

- Women tend to carry more trauma and feel more of a burden to heal the pain of others.
- Feminist theory on development suggests that girls’ sense of self develops via bonds of empathy and projective identification with the mother. While little boys differentiate from their mothers, little girls sense of identity comes from their ability to connect and feel alike.
- The daughter who is constructed in her family as the “emotional” one may, in fact, be carrying the burden of expressing the presence of trauma in the family that is being denied and disowned.
- While it is becoming more common for clinicians to look into a person’s own trauma history, it is still not the norm to ask about the traumatic experiences of their parents and ancestors.

CHARACTERISTICS THAT IMPACT DEGREE OF HT

[Danieli, 1999]

- Some hypothesized that the degree of ancestor trauma would make a difference.
- Studies show this is not the case in general expect for two specific types of trauma – losing a spouse or child in a traumatic event. These circumstances are highly related to poor MH outcomes for descendents including: anger, problems in intimacy, and problems with dependency.
- In a study of Jewish Holocaust survivors and their descendents, length of time spent in the camps did not make a difference nor did the number of relatives lost (Mendel, 1988).
Age at which the traumatization occurred does not appear to change impact.

Having two traumatized parents does make a huge difference on the impact for descendents. As did the gender of the traumatized parents. Children whose mothers had been traumatized fared significantly less well than others.

Type of communication used by parents to discuss the HT also influences degree of HT. Guilt-inducing communication, experiential non-verbal communication, and non-direct communication were significantly related to poor mental health outcomes including paranoia, hypochondrias, anxiety, and low ego strength.

COMMUNICATION ABOUT HT

Silence may create a sense of dread and secrecy about events. The more profound the silence, the more pervasive the inner impact of events (Laub and Auerhahn, 1984). The absence of information heightens curiosity about events and increases the sense of ancestor trauma.

Without the freedom to inquire about histories, children may be left with a sense of profound dread. The missing knowledge takes on toxic meanings.

Children may feel real anger at their parents’ unwillingness to talk. They may feel that their parents don’t recognize their need for knowledge.
SOCIETAL REACTIONS AND THEIR IMPACT

The reactions of society at large to survivors of massive trauma have a significant impact on their health and wellness and their ability to integrate their traumatic experiences.

Many people experiencing HT today encounter a pervasive societal reaction that includes: indifference, disbelief, avoidance, repression, and denial of their community’s historical experiences.

MEMORIAL CANDLES

Wardi (1990/1992) has used the term “memorial candle” to describe how intergenerational trauma manifests itself in children of Jewish Holocaust survivors.

“Memorial candles” are children of survivors who:
- Carry the burden of internalized ancestral trauma and grief
- Possess a core identification with deceased ancestors and a sense of self as being dead
- Manifest chronic mourning or depression
- Assume a family role focused on emotional healing and Holocaust testimony
- Have heightened cultural sensitivity compared to others
WAKIKSUAPI

Brave Heart (1999) uses an equivalent concept for Native people – Wakiksuyapi or “memorial people”

Brave Heart’s conceptualization of the role of a memorial person in the family expands to include entire family groups or bands that shoulder this responsibility

She also argues that some Native communities may have a strong proclivity for being memorial people due to an inherent cultural emphasis on ancestor spirits and the impairment of traditional bereavement in some communities

Native spatial versus temporal worldviews may also connect to notion of a memorial people

WORLD VIEWS CONTRIBUTING TO THE TENDENCY TO BECOME MEMORIAL PEOPLE

Non-Western temporal approaches to the world

Western thought conceptualizes history in a linear sequence where time and events have a beginning and end. On the other hand, many cultures view history in a spatial fashion. In this way, events are thought of as a function of space or “where” an event occurred.

Tendency toward viewing self in a holistic way

In much of Western experience, it is common to compartmentalize the mind, body, and spirit. Not usually true in Native experiences.
HT Issues in Research

- **HT as an etiological factor or causal agent**
  - E.g., Historically traumatic events

- **HT as an outcome**
  - E.g., Historical trauma response (or CTR)

- **HT as a mechanism or pathway**
  - E.g., storytelling in families/ memorial candles

- **HT related factors that interact with proximal stressors**
  - E.g., historical trauma loss (prevalence and immediacy of thoughts pertaining to historical loss)

**Historically Traumatic Events:** Themes From Focus Groups
Three Measures Developed- TINWP Study

**Historical Trauma Index**
- 13 traumatic events (yes/no) that are specific to Native experience across tribal Nations

**Colonial Trauma Response (alpha = .88)**
- 47-item Likert-type measure of vicarious/secondary trauma, soul wounding/psychic numbing, collective grief and loss, trauma mastery, and survivor guilt

**Microaggressions Scale (alpha = .96)**
- 34-item scale measuring level of distress associated with daily hassles, discrimination and other AI-specific prejudice related stressors
- Adapted from the SRE scale by Landrine & Klonoff (1996)

Focus Group Themes: Genocide
“...But the more we can kill this year, the less will have to be killed the next war. For the more I see of these Indians the more convinced am I that they have all to be killed, or be maintained as a species of paupers.”

--- General William Tecumseh Sherman
Sept. 23, 1868
Relocation, Allotments and Reservations
"In 1942, my wife and our four children were whipped away from our home... all our possessions were left... for mother nature to destroy.... I tried to pretend it was really a dream and this could not happen to me and my dear family."

-Bill Tcheripanoff, Sr., of Akutan

Interior of Funter Bay cannery barracks. Conditions at the camps were shocking. The water supply was inadequate and unavailable in the winter. There was no sewer system, no laundry or bathing facilities. Most buildings had no electricity, heat, windows, or doors. There were holes in the roof and the floors were rotten. Food was so scarce that many had only one meal a day.
Environmental and Spiritual Traumas
Marshall Islands

Post WWII, U.S. exploded bomb that was 1,300 times more destructive than bombs on Hiroshima and Nagasaki. This was the first of 66 nuclear tests

Fallout included jellyfish babies (no bones), despite residents being told no serious radiation until 1982 US found Island Rongelap too dangerous to live on

Between 1954-1958 1 out of 3 births ended in deaths

Cancer rates are outstanding as are birth defects
Boarding School Period 1879-1935 +

- Pratt modeled Carlisle and off-reservation boarding schools on school he developed at Fort Marion Prison in Florida from 1872-1875 where Native prisoners of war were held.

- 1879 first off-reservation boarding school Carlisle “Kill the Indian, Save the Man” Policy
  - Proposed forced removal at early age with no return until young adults.

- By 1909, 25 off-reservation boarding schools
  - More than 100,000 Native children forced to attend these schools.

- Attendance mandatory or parents would be imprisoned.
  - In 1895, 19 Hopi men were imprisoned at Alcatraz for refusing to send their children to these schools.
500 years of conversion practices to eradicate Native religious practices and ceremonies

In 1883 the Court of Indian Offenses prohibited ceremonial practices and enforced Christianity on Indian populations

By 1892 this policy was expanded to include prohibition of dances, use of traditional medicines, ceremonies, healing practices, and funerary rites

Violations were met with withholding of food rations and imprisonment for up to 6 months
Health Services-Related Trauma

**History of Medical Impropriety**

- In 1976, U.S. government conceded that its Indian Health Service, then a subpart of the BIA, was not in compliance with providing informed consent for sterilizations of Native women.

- Trachoma eye surgical experimentation leaving 1000s blind or eye damaged.

- TB hospitals in the Northwest.
Hiawatha" Insane Asylum" (1902-1934) for Indians was not staffed by nurses, doctors or psychiatrists for at least a year while patients were chained in deplorable conditions. Administrators refused electricity or plumbing and provided "shows" for the public to see "crazy Indians."

In an 1926 investigation, it was determined that the majority sent there were not mentally ill.
Microaggressions: Discrimination Distress

Microaggressions are the chronic, everyday injustices that Natives endure—the interpersonal and environmental messages that are denigrating, demeaning or invalidating. These verbal and non-verbal encounters place the burden of addressing them on the recipient of the encounter—creating stress (Derald Wing Sue, 2007)

Three types:

1. **Microinsults**
   Behaviors that convey rudeness, insensitivity, or reflect unfair treatment or demean identity or heritage (e.g., eye-rolling)

2. **Microinvalidations**
   Communications that that nullify the experiential reality or identity of Native persons (e.g., are you a “real Indian?”)

3. **Microassaults**
   Characterized by explicit racial derogatory attacks or purposeful discriminatory actions—intentionality more clear (e.g., “don’t go and do a war whoop now”)
BUT I'M HONORING YOU, DUDE!
Contemporary Violence

Trauma in Indian Country

Injury

- Takes the life of one Native American child or teen daily¹
- Injuries are the leading cause of death for Native Americans ages 1 to 44 and the third leading cause of death overall²
  - Kills more Native American children than all other causes combined¹
- Injuries and violence account for 75% of all deaths among Native Americans ages 1 to 19
- The risk of injury-related death is about twice that of all children and youth in the country
- Rates 1.5 to 8 times greater than national injury rates depending on region, cause, and age¹

Violence and Native Women

- Natives are victims of violent crimes at 2.5 times the national average (124 per 1,000)

- Native women are 2.5 times more likely to be raped or sexually assaulted than all other women (5 per 1,000 vs. 2 per 1,000)

- 34.1 per cent, or more than one in three Native women will be raped during their lifetime; whereas for women as whole it is less than one in five

- Native women are more likely to experience more physical brutality and sustain greater physical injury during rapes and sexual assaults compared to all other U.S. women (50% vs. 30% all women)

Sources: Amnesty International, (2007), Maze of injustice: The failure to protect indigenous women from violence in the USA.
Preliminary Findings

HT Events and Mental Health

HT exposure was associated with PTSD (.14**) and attendance of boarding school (M= 3.4 vs. 1.2**) 

Number of HT events over generations were associated with depressive symptoms (.17)*

HT events were associated with lifetime and current depression

* = <.05; **<.01; ***<.001
Prohibition of cultural expression was associated with depressive symptoms (.46)* and anxiety (.44)* (n=28)

Forced relocation was associated with depression (.60)* and anxiety (.71)** (n=22)

Summary:
- HT events associated with depression and anxiety

Historically traumatic events were associated with...
- Contemporary distress associated with microaggressions
- Vicarious trauma, unresolved grief and loss, and loss of hope and mastery (colonial trauma response reactions)
- Drug use (crack, crank, inhalants, opiates, & XTC)
- Alcohol Use (binge, quantity, mood management, drinking injury)
- Risky sexual behavior (inconsistent condom use)
- Poor mental health (PTSD)
- Self-report living with HIV
- Inpatient treatment and seeking a traditional healer

Turtle Island Native Wellness Study (N = 209):
Interpersonal Violence & Trauma: Native Women (TINWP Study)

- 65% had at least one form of interpersonal violence
  - 48% had reported a history of rape in their lifetime
  - 42% had stated they’d been touched against will
  - 40% had experienced assault from partner as adult
  - 28% had history of childhood physical assault

- 41% reported having at least two types of violence

"Colonizers have long tried to crush the spirit of the Indian peoples and blunt their will to resist colonization. One of the most devastating weapons of conquest has been sexual violence."

– Andrea Smith

(www.incitenational.org/involve/colonialism.html)
Fisher and colleagues (2000) found that White men who had sex with both White and Alaska Native women were significantly less likely to use condoms with Alaska Native women.

**Violence and Sexual Risk**

- Women who had experienced any type of violence had dramatically high rates of engaging in HIV sexual risk behaviors (94-97%) compared to women with no history of violence (72%).

- Sexual assault (OR = 28.4) and multiple victimization (OR = 10.00) was associated with HIV sexual risk behaviors.

- Women who had never experienced physical abuse, sexual assault, or domestic violence were significantly less likely to engage in sexual risk behaviors compared to those who had experienced at least one assault.

- Ever been victimized, being multiply victimized, and sexual assault were all associated with an increase in sexual risk behaviors.

Evans-Campbell et al., 2006 AJPH
Colonial Trauma Response

Four factors (18 items) were consistent with theoretical development of items. Overall alpha for the 18 item scale = .83

- Vicarious & secondary traumatization
- Collective loss/unresolved grief/Post colonial stress
- Survivor guilt/pain
- Avoidance & Psychic numbing

Factor loadings ranged from .42-.80

$X^2 = 206.95$ (df=129), CFI=.92 and TLI=.91, RMSEA=.06 (.04, .07)

Hypothesized Relationships

$X^2 = .464$, df=2, CFI=1.0, TLI=1.08, RMSEA = .0(0.0, .09)
## HT and Identity

<table>
<thead>
<tr>
<th></th>
<th>Internalization</th>
<th>Marginalization</th>
<th>Externalization</th>
<th>Actualization</th>
</tr>
</thead>
<tbody>
<tr>
<td>HT Generations</td>
<td>NS</td>
<td>NS</td>
<td>.31***</td>
<td>-.17*</td>
</tr>
<tr>
<td>Micro Last Year</td>
<td>-.28***</td>
<td>NS</td>
<td>.35***</td>
<td>.30***</td>
</tr>
<tr>
<td>Micro Life</td>
<td>-.33***</td>
<td>NS</td>
<td>.28***</td>
<td>.33***</td>
</tr>
<tr>
<td>Trauma Life</td>
<td>NS</td>
<td>NS</td>
<td>.19***</td>
<td>NS</td>
</tr>
<tr>
<td>Trauma Year</td>
<td>NS</td>
<td>.21***</td>
<td>NS</td>
<td>NS</td>
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</tbody>
</table>

†p<.10, *p<.05, **p<.01, ***p<.005

## Traumatic Assault Experiences

<table>
<thead>
<tr>
<th>Trauma Indicator</th>
<th>2 Spirits</th>
<th>Hets</th>
<th>Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child physical abuse</td>
<td>40%</td>
<td>20%</td>
<td>χ²(1) 4.6*</td>
</tr>
<tr>
<td>Child sexual abuse</td>
<td>40%</td>
<td>26%</td>
<td>2.14</td>
</tr>
<tr>
<td>Lifetime sexual assault</td>
<td>48%</td>
<td>35%</td>
<td>1.53</td>
</tr>
<tr>
<td>Lifetime phys abuse by partner</td>
<td>29%</td>
<td>29%</td>
<td>0.00</td>
</tr>
<tr>
<td>Lifetime phys assault by other</td>
<td>28%</td>
<td>24%</td>
<td>0.20</td>
</tr>
<tr>
<td>Lifetime robbed, mugged, attack</td>
<td>60%</td>
<td>48%</td>
<td>1.17</td>
</tr>
</tbody>
</table>

No. of historical trauma events experienced by:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>1.71</td>
<td>1.45</td>
</tr>
<tr>
<td>Parent</td>
<td>2.00</td>
<td>1.17</td>
</tr>
<tr>
<td>Grandparent</td>
<td>2.88</td>
<td>0.49</td>
</tr>
<tr>
<td>Great Grandparent</td>
<td>2.92</td>
<td>1.44</td>
</tr>
<tr>
<td>Great-Great Grandparent</td>
<td>2.79</td>
<td>1.29</td>
</tr>
</tbody>
</table>

†p<.10; *p<.05

As cited in Cultural Diversity and Ethnic Minority Psychology, Vol. 10 (3), 287-301
The Honor Project: Two-Spirit Health Study

- Funded by the NIMH
- 6 sites:
  - Seattle/Tacoma
  - San Francisco/Oakland
  - Los Angeles
  - Minneapolis/St. Paul
  - Tulsa/Oklahoma City
  - New York City
- 65 qualitative interviews
- 4 measurement groups
- 452 survey interviews

Denver* limited participation – unofficial site
Honor Project: Methods

Respondent Driven Sampling (RDS)
- Identified 6-8 Seeds in each site (gender balanced)
- Obtained Social Networks (with basic demography)
- Over-sampled for specific groups (weakly identified LGB & AI/AN, transgender)
- Randomly selected nominees & tracked recruitment coupons
- Exception: Seattle (Census site-6 seeds + volunteer)

Volunteer recruitment
- eg. posters & palm cards in bars, cafes, Gay Pride booths, community centers, etc.

Figure 2 – Seattle Site
Started with six seeds (colored red)
Figure 3 --
and over 200 volunteers (colored blue)

Figure 4 --
everyone else we found out about through their networks/nominations
(shown as yellow arrows)
Figure 5 –
and of all these people we managed to survey about a third of them (shown in black)

Demographics (N = 447)

Where born?
- 43% urban born
- 25% rez/tribal

Age = 39.8

Education
- 18% less than high school
- 29% high school grad
- 53% more than high school

Gender assignment and id
- 51% males (n=227)
- 41% females (n=185)
- 7% trans (n=35)

73% enrolled in tribe

76% more than ½- full-bloods

Income
- 75% < $18,000
- 12% > $30,001

Employment
- 59% unemployed
- 19% part time
- 22% full time
### Adoption, Foster Care, Boarding School (Total Sample)

<table>
<thead>
<tr>
<th>Type</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foster care</td>
<td>113</td>
<td>25%</td>
</tr>
<tr>
<td>Adopted</td>
<td>64</td>
<td>14%</td>
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</table>

<table>
<thead>
<tr>
<th>Boarding School</th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Family member (attended)</td>
<td>176</td>
<td>39%</td>
</tr>
<tr>
<td>Physically harmed</td>
<td>28</td>
<td>34%</td>
</tr>
<tr>
<td>Sexually harmed</td>
<td>23</td>
<td>28%</td>
</tr>
<tr>
<td>Experience very bad/bad</td>
<td>27</td>
<td>33%</td>
</tr>
<tr>
<td>Spent 1-2 years in BS</td>
<td>46</td>
<td>56%</td>
</tr>
</tbody>
</table>

### Childhood Trauma: Percent of Sample Scored “Extreme”

<table>
<thead>
<tr>
<th>Type</th>
<th>Total Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical neglect</td>
<td>18.1%</td>
</tr>
<tr>
<td>Emotional neglect</td>
<td>26.4</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>39.8</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>28.6</td>
</tr>
<tr>
<td>Emotional abuse</td>
<td>41.2</td>
</tr>
</tbody>
</table>

Seattle reported percentage (13.3%) of “extreme physical abuse” than total sample
Childhood Trauma: Two Spirit Women (N = 152)

- 85% (n=128) sexual assault
  - 74% by a family member or acquaintance
  - 63% by a stranger; 53% by both

- 78% (n = 118) physical assault
  - 70% by family member or acquaintance
  - 67% by a stranger; 59% by both

- 38% had experienced both physical and sexual assault by both strangers and family members or acquaintances

Historical Loss Cohort and Minnesota

<table>
<thead>
<tr>
<th>Loss</th>
<th>Cohort</th>
<th>Minn</th>
</tr>
</thead>
<tbody>
<tr>
<td>Losses from the effects of alcoholism on our people</td>
<td>74%</td>
<td>86%</td>
</tr>
<tr>
<td>Loss of respect by our children and grandchildren for elders</td>
<td>69%</td>
<td>83%</td>
</tr>
<tr>
<td>Loss of our people through early death</td>
<td>63%</td>
<td>80%</td>
</tr>
<tr>
<td>Losing our culture</td>
<td>69%</td>
<td>78%</td>
</tr>
<tr>
<td>Loss of respect by our children for traditional ways</td>
<td>65%</td>
<td>76%</td>
</tr>
<tr>
<td>Losing traditional spiritual ways</td>
<td>66%</td>
<td>71%</td>
</tr>
<tr>
<td>Loss of self respect from poor treatment by gov. officials</td>
<td>59%</td>
<td>67%</td>
</tr>
<tr>
<td>Loss of language</td>
<td>59%</td>
<td>63%</td>
</tr>
<tr>
<td>Loss of trust in whites from broken treaties</td>
<td>57%</td>
<td>58%</td>
</tr>
<tr>
<td>Loss of land</td>
<td>54%</td>
<td>46%</td>
</tr>
<tr>
<td>Loss of families from the rez to relocation</td>
<td>43%</td>
<td>43%</td>
</tr>
<tr>
<td>Loss of our family ties due to boarding schools</td>
<td>40%</td>
<td>42%</td>
</tr>
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### Historical Trauma Events by Generation

<table>
<thead>
<tr>
<th>Event</th>
<th>Current</th>
<th>Parents</th>
<th>Grandparents</th>
<th>G grandparents</th>
<th>G-G grandparents</th>
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</thead>
<tbody>
<tr>
<td>1. Boarding school</td>
<td>13%</td>
<td>28%</td>
<td>32%</td>
<td>37%</td>
<td>6%</td>
</tr>
<tr>
<td>2. Adoption/foster care</td>
<td>19%</td>
<td>13%</td>
<td>11%</td>
<td>57%</td>
<td>6%</td>
</tr>
<tr>
<td>3. Prevention of cultural expression</td>
<td>14%</td>
<td>26%</td>
<td>37%</td>
<td>39%</td>
<td>6%</td>
</tr>
<tr>
<td>4. Exploitation of homeland</td>
<td>13%</td>
<td>16%</td>
<td>26%</td>
<td>59%</td>
<td>6%</td>
</tr>
<tr>
<td>5. BIA relocation program</td>
<td>10%</td>
<td>17%</td>
<td>22%</td>
<td>56%</td>
<td>6%</td>
</tr>
<tr>
<td>6. Community massacre</td>
<td>3%</td>
<td>3%</td>
<td>25%</td>
<td>64%</td>
<td>6%</td>
</tr>
<tr>
<td>7. Land allotments stolen</td>
<td>9%</td>
<td>14%</td>
<td>38%</td>
<td>50%</td>
<td>5%</td>
</tr>
<tr>
<td>8. Medical procedures w/o consent</td>
<td>6%</td>
<td>6%</td>
<td>14%</td>
<td>73%</td>
<td>6%</td>
</tr>
<tr>
<td>9. Forcible Relocation</td>
<td>6%</td>
<td>4%</td>
<td>32%</td>
<td>55%</td>
<td>7%</td>
</tr>
<tr>
<td>10. Held hostage or experienced combat</td>
<td>5%</td>
<td>5%</td>
<td>17%</td>
<td>70%</td>
<td>7%</td>
</tr>
<tr>
<td>11. Prevention of traditional healing</td>
<td>8%</td>
<td>15%</td>
<td>39%</td>
<td>49%</td>
<td>6%</td>
</tr>
<tr>
<td>12. Relative’s artifacts/remains stolen</td>
<td>7%</td>
<td>6%</td>
<td>21%</td>
<td>67%</td>
<td>8%</td>
</tr>
<tr>
<td>13. Relative’s artifacts/remains desecrated</td>
<td>6%</td>
<td>5%</td>
<td>21%</td>
<td>66%</td>
<td>9%</td>
</tr>
</tbody>
</table>

*Average sources of trauma: Mean (SD)*

<table>
<thead>
<tr>
<th></th>
<th>Current Mean (SD)</th>
<th>Parents Mean (SD)</th>
<th>Grandparents Mean (SD)</th>
<th>G-grandparents Mean (SD)</th>
<th>G-G-grandparents Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>1.2 (2.3)</td>
<td>1.6 (2.2)</td>
<td>3.4 (3.6)</td>
<td>7.4 (4.2)</td>
<td>0.8 (2.5)</td>
</tr>
</tbody>
</table>

### Historical Trauma Analyses controlling for lifetime physical and sexual violence (Longitudinal regressions)

<table>
<thead>
<tr>
<th>Event</th>
<th>PTSD Anxiety (RE)</th>
<th>PTSD Avoidance (AV)</th>
<th>PTSD Arousal (AR)</th>
<th>CESD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Boarding school</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Adoption/foster care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Prevention of cultural expression</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Exploitation of traditional homeland</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. BIA relocation program</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Community massacre</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>7. Land allotments stolen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Medical procedures w/o consent</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Forcible Relocation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Held hostage or experienced combat</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Prevention of traditional healing</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>12. Relative’s artifacts/remains stolen</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Relative’s artifacts/remains desecrated</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Across all types of trauma (average total)</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

PTSD (1) = Re-experiencing symptoms PTSD (2) = Avoidance symptoms PTSD (3) = Arousal symptoms
All significant results follow this general pattern where flatter profiles (associated with chronic trauma through the generations) is associated with poorer mental health in the present generation.

The Relationship Between HT and Discrimination with Smoking, and Physical Pain

- What are implications of historical loss and discrimination for smoking and physical pain?
- AIAN shown to have higher prevalence of smoking
- Greater risk of smoking as a means of coping with stress associated with historical loss and discrimination.
- Pain as embodiment of historical trauma loss and discrimination distress

Historical Trauma Loss

How Often Think About Historical Loss

Microaggression Distress

How Bothered by Discrimination
Current Smoking: Risk Behavior

Physical Pain: Embodiment of Trauma
**Microinvalidations**
Communications that nullify the experiential reality or identity of Native persons

<table>
<thead>
<tr>
<th>How much distressed or bothered by…</th>
</tr>
</thead>
<tbody>
<tr>
<td>being told by non-Natives how they wished they were Indian too</td>
</tr>
<tr>
<td>told by on-Natives that they felt a spiritual connection to Indian people</td>
</tr>
<tr>
<td>Hearing racist statements such as “Indian giver”</td>
</tr>
<tr>
<td>being mistaken by non-Natives as a racial group other than Native</td>
</tr>
<tr>
<td>Being told by non-Natives how “lucky” you are to be Indian</td>
</tr>
<tr>
<td>Being told by non-Native person that he or she was an Indian in a past life or that their grandmother was a Cherokee princess</td>
</tr>
<tr>
<td>Being asked if you are a “real Indian” by a non-Native person</td>
</tr>
<tr>
<td>Being told you are “paranoid” by others</td>
</tr>
<tr>
<td>Being told that Indians are conquered and should stop trying to live in the past</td>
</tr>
<tr>
<td>being told to lighten-up or get a sense of humor about Indian mascots or logos</td>
</tr>
<tr>
<td>By having non-Native strangers speak a foreign language to you such as Spanish or Chinese</td>
</tr>
<tr>
<td>By anti-Indian statements made to you</td>
</tr>
</tbody>
</table>

**Microinsults**
Behaviors that convey rudeness, insensitivity, or reflect unfair treatment or demean identity

<table>
<thead>
<tr>
<th>How much distressed or bothered by…</th>
</tr>
</thead>
<tbody>
<tr>
<td>By unfair treatment from people in helping or social service jobs such as therapist or social worker</td>
</tr>
<tr>
<td>By unfair treatment by institutions such as schools, police, social services, or immigration because you are Native</td>
</tr>
<tr>
<td>By wanting to verbally respond to someone for being anti-Indian, but didn’t</td>
</tr>
<tr>
<td>By being accused of not doing your share of the work because you are Native</td>
</tr>
<tr>
<td>By unfair treatment by your bosses or supervisors because you are Native</td>
</tr>
<tr>
<td>By having to take drastic steps such as quitting job or moving away to deal with some racist thing that was done to you</td>
</tr>
<tr>
<td>Bothered by getting into an argument with non-Natives about something they said that was racist towards Native Americans</td>
</tr>
</tbody>
</table>
**Microassaults**

Characterized by explicit racial derogatory attacks or purposeful discriminatory actions

<table>
<thead>
<tr>
<th>How much distressed or bothered by...</th>
</tr>
</thead>
<tbody>
<tr>
<td>By being called a racist name like Chief, Wahoo, Squaw or Pocohontas</td>
</tr>
<tr>
<td>By being hit, kicked or physically attacked because you are Native</td>
</tr>
<tr>
<td>By being trailed or followed in a store because you are Native</td>
</tr>
</tbody>
</table>

**Microinvalidation- Colonial Erasure**

Characterized by invalidating experiences that erase indianness or indigeneity

<table>
<thead>
<tr>
<th>How much distressed or bothered by...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling stereotyped or boxed-in to a certain way of being &quot;Native by non-Native persons</td>
</tr>
<tr>
<td>Hearing discussion by instructors or persons in authority about Indians is if they no longer exist</td>
</tr>
<tr>
<td>Hearing from non-Natives how surprisingly articulate, well read or good your language skills are</td>
</tr>
<tr>
<td>Teaching &quot;Indian 101&quot; to non-Natives to make your point or be heard</td>
</tr>
<tr>
<td>Non-Natives stating to you that you &quot;don't look or act Indian&quot;</td>
</tr>
<tr>
<td>Being asked to change your Native appearance or apparel by your employer or agency (e.g., being asked to cut your hair)</td>
</tr>
</tbody>
</table>
**Microinsult—Colonial Authority**

Characterized by experiences where non-Natives assert colonial authority to control images, to invade physical space or assert their own authority over all things Native

<table>
<thead>
<tr>
<th>How much distressed or bothered by...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling &quot;invisible to non-Natives&quot;</td>
</tr>
<tr>
<td>Being made fun of or picked on because you are Native</td>
</tr>
<tr>
<td>Being asked by a stranger if he or she could touch you because you are Native</td>
</tr>
<tr>
<td>Being asked to prove your Indianness or authenticity by a non-Native person</td>
</tr>
<tr>
<td>Being asked by a non-Native stranger if you could perform a ceremony or contact a medicine person for him or her</td>
</tr>
</tbody>
</table>

**Historical Loss and Current Smoking**

<table>
<thead>
<tr>
<th>Smoking Frequency</th>
<th>OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; Yearly</td>
<td>(ref)</td>
</tr>
<tr>
<td>Yearly to &lt; Monthly</td>
<td>1.7 (0.8-3.8)</td>
</tr>
<tr>
<td>Monthly to &lt; Weekly</td>
<td>1.7 (0.8-3.9)</td>
</tr>
<tr>
<td>Weekly to &lt; Daily</td>
<td>2.1 (0.8-5.3)</td>
</tr>
<tr>
<td>Daily or More</td>
<td>3.5 (1.4-8.9)*</td>
</tr>
</tbody>
</table>

Note: Controlling for gender, age, % Indian blood, sexual orientation, HIV status, current partner status, household income, and education; we found a significant association between historical loss and current smoking, with...
Discrimination and Current Smoking

<table>
<thead>
<tr>
<th>Categorization</th>
<th>OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; A Little</td>
<td>(ref)</td>
</tr>
<tr>
<td>A Little to &lt; Moderately</td>
<td>1.1 (0.7-1.9)</td>
</tr>
<tr>
<td>Moderately to &lt; Quite a Bit</td>
<td>1.6 (0.9-3.0)</td>
</tr>
<tr>
<td>Quite a Bit or More</td>
<td>2.2 (1.1-4.7)</td>
</tr>
</tbody>
</table>

Note: Controlling for gender, age, % Indian blood, sexual orientation, HIV status, current partner status, household income, and education; we found a significant association between discrimination distress and current smoking, with each unit increase in discrimination distress being associated with 2.2 times the odds of current smoking.

Historical Loss and Physical Pain

<table>
<thead>
<tr>
<th>Categorization</th>
<th>b (SE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; Yearly</td>
<td>(ref)</td>
</tr>
<tr>
<td>Yearly to &lt; Monthly</td>
<td>-0.07 (0.25)</td>
</tr>
<tr>
<td>Monthly to &lt; Weekly</td>
<td>0.32 (0.26)</td>
</tr>
<tr>
<td>Weekly to &lt; Daily</td>
<td>0.40 (0.28)</td>
</tr>
<tr>
<td>Daily or More</td>
<td>0.74 (0.29)*</td>
</tr>
</tbody>
</table>

Note: Controlling for gender, age, % Indian blood, sexual orientation, HIV status, current partner status, household income, and education; 22% of variance.
Discrimination and Physical Pain

<table>
<thead>
<tr>
<th>Category</th>
<th>b (SE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; A Little</td>
<td>(ref)</td>
</tr>
<tr>
<td>A Little to &lt; Moderately</td>
<td>0.41 (0.16)*</td>
</tr>
<tr>
<td>Moderately to &lt; Quite a Bit</td>
<td>0.47 (0.19)*</td>
</tr>
<tr>
<td>Quite a Bit or More</td>
<td>0.48 (0.23)*</td>
</tr>
</tbody>
</table>

Note: Controlling for gender, age, % Indian blood, sexual orientation, HIV status, current partner status, household income, and education; each unit increase in discrimination was associated with 1.31 times the odds of reporting physical pain/impairment (95% CI = 1.09, 1.56)

Trauma and Health

- The pathways and temporal relationships between different types of traumatic experience and mental health outcomes are complex and multidimensional.
- Many stress-coping theories of health risk behaviors or mental health outcomes do not take into account the nuances of cumulative and ongoing discrimination as stressors.
- Clearly, not everyone who experiences high levels of traumatic stress develop poor health or health risk behaviors.
- What factors might buffer the impact of these traumatic stressors on health status?
Self-reported fair/poor general health status by interaction between discrimination and identity among two-spirits.

The association between discrimination and self-rated health was lower among participants with higher levels of actualization identity attitudes compared to those with lower levels of actualization identity attitudes.

Limitations

- Cross-sectional nature of our data, limiting our ability to make causal inferences.
- Limited generalizability of our findings-- may not be relevant to other ethnic or sexual minority populations, or to two-spirit American Indians in rural geographical areas.
- Although participants were recruited from six cities, we were unable to perform stratified analyses due to the small number of participants recruited from some areas.
- Despite the existence of these alternative interpretations, our findings are consistent with the existing literature on the negative influence of discrimination on health outcomes, and are concordant with our theoretical framework.
Studies have increasingly shown that stressors may directly impact physical health through biological mechanisms. Our finding suggest that self-reported body pain and impairment may reflect the embodiment of stressful events, particularly historical trauma related losses and microaggression distress.

Our findings suggest that more subtle forms of racial discrimination in the form of microaggressions have negative health effects and should also be addressed.

Our results also indicate that community-level efforts to improve levels of identity among Natives may be effective in promoting health or mitigating the consequences of racial discrimination or internalized colonization.

Historical or intergenerational trauma may have long term effects across generations on mental health, in particular, PTSD and depressive symptoms.
Clinical Implications

- HT linked to mental health symptom expression—in particular, PTSD, depression, alcohol dependence
- Variance in PTSD symptoms are accounted for, in part, by Native-specific symptom expression (CTR)
- Historical loss and microaggressions embodied in physical (self-reported pain) and risk taking behaviors (smoking)
- A positive identity buffers impact of discrimination distress on self-reported health and pain

Decolonizing Practice Strategies

- Decolonizing strategies to address intergenerational trauma (e.g., soul wound timelines with focus on OI)
- Develop communal, familial, and individual interventions that promote positive identity attitudes and decolonizing approaches to practice
- Decolonizing approaches = creating new narratives from which to deeply contextualize mental health and substance use issues (e.g., naming, reframing) and focus on cultural protective factors for program development and innovation
Practice-Based Strategies

- Community memorialization processes sites of resistance and healing
- Tribal justice and healing systems working together (Hollow Water example)
- Decolonizing narratives and learned violence across generations (genograms/timeline)
- Distinguish between CTR and OI-based cultural practices (Leary and field example)
- Incorporate ancestral and spatial understanding to healing (e.g., power now)
- [Re]naming ceremonies (e.g., depression, entities, and relations)
- Returning secrets to the sacred and returning silence to the sacred and safe
- Relational restoration and healing of disruptions (e.g., wiping the tears)
- Secondary traumatization (exercise with rocks and flowers)

DECOLONIZING PRACTICE STRATEGIES I

- Recognizing Violence as a Historical Inheritance (Eduardo Duran)
  - Explore genesis of violence & AOD use within HT context
  - Where did you learn to be so violent? If not part of tribal OI, then where did it start?—shifting from “defective Indian” to historical perspective
  - Use medicines that make sense to client (to set safety and boundaries)

- Learning About Pre-Colonial History
  - Explore cultural narratives and history with focus on identifying traditional ways of addressing trauma and re-connect to historic ways of healing

- Reinterpreting Mistrust as a Healthy Reaction To Historical Trauma
  - Practitioners should anticipate it, understand it, and reframe it

- Documenting Historically Traumatic Events and Colonial Trauma
  - Family members may not be aware of events that contextualize family functioning. Use genograms, culturagrams, and soul wounding timelines. Document births, deaths, cultural events, HT events and family reactions.
  - Violence and AOD has an energy to it—place to place and across generations
DECOLONIZING PRACTICE STRATEGIES II

Communicating About Historical Trauma

- Communication is an integral force in healing. Denial and anger may be functional and protective responses to trauma when surviving major catastrophic traumas; yet, the maintenance of such responses can undermine family health, promote silence over time, and constrain critical relationships.

- Assist family members in exploring losses and making links to current family functioning.

- How a family makes meaning out of colonial trauma is critical in healing and identifying tribal resilience.

- Identify intergenerational anniversary patterns—preoccupations with mortality may happen around the anniversary of a community massacre.

- **Powerful place**—you can heal your great grandparents and future generations; this is the place and time to heal soul wound—you can bring a lot of medicine to family and tribe; who is present today?

Decolonizing Strategies

- **Reframing Relationships with “sickness” and medicines to treat (Duran, 2006)**
  
  - Example of depression and spirit of sadness (I’m depressed example)—naming ceremony
  
  - Idea of suffering—is sacred and should not be wasted—offer up suffering as a sacrifice for the well-being of the people vs. punishment approach.

- **Re-Establishing Protocols and Offerings (Duran, 2006)**
  
  - Example—Use of tobacco offerings to spirit of alcohol (e.g. store aisle)
  
  - Establishing protocol to spirit of wellness—recognizing dual nature of wellness and dis-ease (dis-harmony).

- **Creating new narratives to build relationship to dis-ease**
  
  - Psychiatric labeling ceremonies

Decolonizing Practice Strategies III

**Highlighting Intergenerational Resiliencies and Strengths**
Help families document their histories of power, resilience and resistance—recognition of survival strategies in family stories can illuminate new strategies.

**Creating New Narratives**
Identify how and when behaviors were learned—when did family members become “infected” with the soul would-- and vampire syndrome.
Dreams are where intergenerational processing can happen—place in which ancestors bring “gifts”—increases interest in own healing.

**Renaming and Reframing**: Identifying Colonial Trauma Response vs. “Cultural” Practices (Evans-Campbell & Walters, 2006)
Sometimes we call experiences “cultural” when in fact they are colonial trauma responses (e.g., women’s moon time and ceremonies) or survival strategies used by our ancestors to protect used that may or may not be optimal in the here and now.

**Supporting Community Healing Ceremonies**
Community memorialization examples forthcoming.

Bigfoot Memorial Ride
Long Walk Commemoration
Choctaws

Humane Immigrant rights 3
East LA
Heal for the children
Northern Ireland

When one sits in the Hoop Of The People,
one must be responsible because
All of Creation is related.
And the hurt of one is the hurt of all.
And the honor of one is the honor of all.
And whatever we do effects everything in the universe.

If you do it that way - that is,
if you truly join your heart and mind
as One - whatever you ask for,
that's the Way It's Going To Be.

Passed down from White Buffalo Calf Woman
Thank You

To the Two-Spirit women who have risked their lives to help pave the way for a new generation and have shared their stories with us
To Dr. Bea Medicine who helped to create decolonizing academic space for us
To Honor Project Partners:
- Northwest Two Spirit Society, WA
- American Indian Community House and Northeast Two Spirit Society, NYC
- Indigenous Peoples Task Force, MN
- Urban American Indian Involvement, LA/ APLA Red Circle Project
- National Native American AIDS Prevention Center, San Fran./Oakland
- BAITS, San Francisco
- Site coordinators: Sharon Day, John Cocke’ (qualitative), Don Little, Gloria Bellymule, Rose Weaheke, Elton Naswood, Raven Heavy Runner, Alison Whitmore, Dennis Manuelito, Laura Oropeza, and special thank you to Randy Burns for his tireless efforts
- All the interviewers on the project!!
- And many others too numerous to list here for their support, guidance, and stories