



Backgrounder



Resilience & Trauma NCAI Policy Research Center October 2015

Purpose

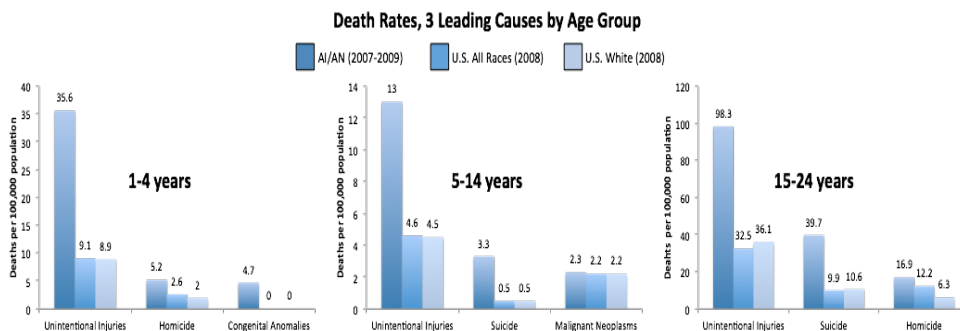
There is a growing recognition that for health and wellness efforts to have a meaningful impact in American Indian and Alaska Native (AI/AN) communities they must explicitly emphasize resilience and seek to address trauma. Historical experiences of colonization and trauma, as well as current rates of violence and abuse within tribal communities, vary throughout the United States. Similarly, there are a range of strengths and resiliencies present in our places, cultures, families, and governments that are a critical part of fostering Native health and wellness. Thus, facilitating positive change for American Indian and Alaska Native peoples, it is important to develop an understanding of common aspects of resilience and trauma-related experiences. This backgrounder provides an overview of key statistics and concepts relevant to understand trauma in Indian Country, a summary of available evidence on the health impacts of trauma, and examples of how tribal communities are engaging in efforts to heal and build resilience. In an effort to assist tribal leaders, researchers, practitioners, and those who work with tribal communities in making decisions around resilience and trauma, we provide suggestions to help guide research and policy development.

Critical Elements for Understanding Trauma: Data and Concepts

Available Data

It is difficult to accurately capture the diverse experiences of AI/AN populations using summary statistics; however, data that are available indicate that trauma is an important area of focus for some demographic groups and communities within Indian Country due to high levels of traumatic experiences and exposure to trauma.

Trauma-related events such as unintentional injuries (e.g., injuries due to motor vehicle accidents, suffocation, drowning, poisoning, fire/burns, falls), suicide, and homicide are among the leading causes of death for AI/AN children and youth, and these causes of death occur at higher rates compared to youth of all races and whites in the United States (Indian Health Service, 2014).



Additionally, in terms of the leading causes of hospitalization for Indian Health Service (IHS) users, injury and poisonings are within the top five for those between the ages of 1 and 64; and, mental disorders are within the top five for those between the ages of 5 and 44.

Regional data also point to high trauma exposure for some AI/AN communities. A study of reservation-based American Indian youth (n=288) ages 15-24 in the Northern Plains identified a high prevalence of self-reported experiences of abuse (physical 30%, emotional 48%, sexual 20%), neglect (emotional 42%, physical 42%), and witness of mother's abuse (40%) (Brockie et al., 2015).

The National Indian Child Welfare Association (NICWA) has noted that behavioral health and incarceration issues contribute to the trauma environment for AI/AN children, with alcohol abuse and violence being reported more often in AI/AN families and AI/AN men being incarcerated at high rates, which in turn increases the number of youth who live with the trauma of having an incarcerated parent (NICWA, 2014).

Concepts

Discussions of trauma in academic and program settings often use a variety of terms that reflect both negative experiences and positive responses to those experiences including: historical, cultural, spiritual, current/contemporary, and intergenerational trauma; soul wound; historical oppression; adverse childhood experiences (ACEs); resilience; and resistance. A baseline understanding of the most common and more encompassing terms can help further dialogue and action in Indian Country.

Historical Trauma. "Historical trauma," encompasses the extensive, cumulative, and intergenerational experiences of trauma AI/ANs have experienced, including land dispossession, widespread death through warfare and disease, famine, forced removal, assimilative boarding schools, prohibition of religious practices, forced sterilization, and the flooding and dumping of toxic materials onto AI/AN lands, amongst so many others (Brave Heart & DeBruyn, 1998; Duran, Duran, Brave Heart, & Yellow Horse-Davis, 1998; Evans-Campbell, 2008; Harper & Entekin, 2006). Although historical trauma is a collective experience, it is thought to have social and individual-level impacts (Brave Heart & DeBruyn, 1998; Duran et al., 1998). People who have endured historical trauma may exhibit the "historical trauma response," with symptoms such as unresolved emotional trauma, high mortality rates, depression, alcohol abuse, child abuse, and domestic violence (Brave Heart & DeBruyn, 1998; Duran et al., 1998). Although historical trauma has been a profoundly influential concept, scholars have noted that AI/ANs continue to experience chronic oppression, including disrupted cultural patterns, poverty, and clashes between traditional and mainstream life ways (Kirmayer, Gone, & Moses, 2014). Moreover, AI/ANs are vastly diverse peoples, with historically distinct experiences of colonization based in places and institutions. Thus, descriptions of historical trauma may or may not resonate with some tribal members and may not capture the more chronic forms of oppression (i.e., discrimination and poverty) that disproportionately affect AI/ANs. With these limitations, scholars have noted the need to grow and expand this concept (Gone, 2013; Walters et al., 2011).

Historical Oppression. In response to these critiques, the conceptualization of "historical oppression" is offered as a broader framework, inclusive of historical traumas, which explains how history may interact with the more contemporary and chronic forms oppression that AI/ANs continue to experience (Burnette, 2015). For instance, although not every AI/AN person may have a relative or an ancestor who attended a punitive boarding school, the majority, if not all AI/ANs, can readily locate experiences of

historical oppression in their own or their relatives or ancestors' lives. Burnette (2015) defined historical oppression as the chronic, insidious, and intergenerational experiences of subjugation that have been imposed, and may be normalized and internalized, into the daily lives of many AI/AN communities, families, and individuals. Historical oppression is inclusive of historical traumas, along with the more proximal factors of inequality that continue to perpetuate oppression, such as discrimination, "microaggressions" (i.e., daily experiences of injustice and demeaning messages inflicted on minority populations) (Walters & Simoni, 2009), poverty, and marginalization (Burnette, 2015). Forms of historical oppression are localized, varying by context and tribe, yet impacts likely transcend tribal boundaries affecting many Native people.

Historical oppression may be imposed and embodied through the internalization of the devaluing beliefs imposed by dominant populations onto communities, families, and individuals (Burnette, 2015). Because dominant populations hold disproportionately more power, instead of directly confronting the structural roots of oppression, those who have experienced oppression may instead strike out through "horizontal violence" or lateral violence at their fellow community members, family members, or engage in self-destructive actions (Burnette, 2015, Freire, 2000). One manifestation of this is the "crabs in the bucket" dynamic where we disregard another community member's success and try to hold them down. These effects are not characteristics of the community members themselves, but the result of historical oppression and the chronic and pervasive structural inequality they experience.

Adverse Childhood Experiences (ACEs). The Adverse Childhood Experiences (ACE) study, which surveyed approximately 10,000 adults participating in a large Health Maintenance Organization (HMO), demonstrated a strong cumulative relationship between self-reported exposure to adversity in the first 18 years of life and several leading causes of morbidity and mortality among adults including heart disease, cancer, chronic lung disease, fractures, and liver disease (Felitti et al., 1998). In other words, early exposure to trauma can have a major impact on a person's health later in life. Seven categories of adverse childhood experiences examined in the initial study were: psychological, physical, or sexual abuse; violence against one's mother; and living in a home with individuals who were substance abusers, mentally ill or suicidal, or ever incarcerated. From the initial phase of the ACE Study, the sample has grown to include approximately 17,000 individuals (CDC Injury Prevention & Control, 2014) and associations with additional adult outcomes such as risk for sexually transmitted diseases (Hillis et al., 2000), unintended pregnancy (Dietz et al., 1999), and mental health conditions (Anda et al., 2002) have been identified. The linkage between childhood experiences of trauma and a broad array of adult health outcomes has been ground-breaking, especially given the sample was predominantly white and educated (74.8% white, 92.8% high school or greater education) (CDC Injury Prevention & Control, 2014). Exposure to the seven categories of adverse childhood experiences, commonly referred to today as ACEs, can be assessed using a ten-item questionnaire that allows calculation of an ACE Score. Some state governments have efforts to gauge the level of ACEs in their citizens in order to coordinate health and wellness responses focused on trauma-informed care. While this measure provides a quick assessment of early trauma exposure for individuals, research on whether it is useful in relation to historical trauma and oppression has only recently begun.

Resilience and Resistance. Despite experiencing historical oppression, AI/AN peoples have always sought liberation and resisted subjugation and oppression, demonstrating resilience and "survivance" (i.e., the ingenuity, commitment to homeland, humor, strength, and resistance to colonial subjugation) (Vizenor, 2008). Cross (1998) recommends characterizing AI/AN resilience from a relational worldview, emphasizing the interrelatedness and harmony of the mind, body, context and spiritual aspects of all things. Individuals and communities draw strength from places, cultural ways of living, kinship and

other relationships, ceremony, humor, and collective successes. Resilience has always been present among AI/AN peoples, and a strong recognition and focus on this is recommended for practice, policy, and research endeavors.

Associations between Trauma and Health

There are multiple hypothesized pathways between historical trauma and contemporary AI/AN health outcomes. Walters and her colleagues (2011) described four such pathways to include: 1) historical trauma as a causal or etiological agent; 2) historical trauma as an effect or outcome (example: colonial trauma response, see above), 3) historical trauma as the root cause of poor health and social problems passed down across generations, and 4) stressors related to historical trauma (e.g., collective loss). Efforts to systematically investigate these potential pathways are relatively recent in the scientific research community and draw from experiences of Indigenous populations more broadly. For example, researchers have documented associations between historical trauma and health in terms of thoughts of historical cultural losses and psychological distress (Whitbeck, et al., 2009), boarding/residential school experiences and suicidality among First Nations populations in Canada (Elias, et al., 2012), and intergenerational impacts of relocation and residential school policies on depressive symptoms and delinquency in both Canada and the US (Bombay, Matheson & Anisman, 2011; Walls & Whitbeck, 2012). Researchers hypothesize that mechanisms for the impact of trauma on health across generations may be due to changes in social and parenting norms as a result or response to trauma, as well as epigenetic changes in DNA (Palacios & Portillo, 2009; Brockie et al., 2013). In addition, there is potential for historical trauma to have an interactive or cumulative impact on contemporary trauma experiences and exacerbate negative health outcomes. To that end, recent evidence documents dose-response relationships between commonly defined ACEs (e.g., neglect, abuse) with added culturally-specific factors (i.e., discrimination, historical loss associated symptoms) and outcomes like PTSD, poly-drug use, and depression (Brockie et al., 2015). Altogether, this research points to the importance of framing AI/AN health disparities in terms of collective and cumulative trauma exposure.

Organizational and Community Responses to Trauma

With growing evidence of the prevalence and impacts of trauma across the life-course, many organizations have begun to develop trauma-informed approaches and systems of care. These efforts aim to raise awareness of trauma among providers, staff, program participants/patients, and students while also adapting organizational culture, practice, and policies to better meet the needs of individuals and communities. The Substance Abuse and Mental Health Services Administration's (SAMHSA) National Center for Trauma-Informed Care (NCTIC) and the National Child Traumatic Stress Network (NCTSN) are two examples of organizations that have outlined critical elements and principles of trauma-informed approaches.

Efforts to define and understand concepts related to historical and contemporary trauma can be part of a healing process that allows tribal communities to identify and build upon cultural strengths and resilience. AI/AN researchers and communities have begun to address trauma through approaches grounded in locally and tribally relevant knowledge. At the Indian Country Child Trauma Center (ICCTC), Dr. Delores "Dee" Subia Bigfoot and colleagues have culturally adapted four evidence-based trauma-related treatments (Trauma-Focused Cognitive Behavior Therapy, Treatment for Children with Sexual Behavior Problems, Parent-Child Interaction Therapy, and the American Indian Life Skills Development Curriculum) to create the Honoring Children Series. Similarly, investigators at the

Southwest Tribal Native American Research Center for Health (NARCH) have embarked on an effort to identify needs, services, and interventions that will build resilience and promote well-being for tribal children in New Mexico through a pilot/feasibility study led by Dr. Tassy Parker. The study, titled *Tribal Solutions for Youth Affected by Adverse Childhood Experiences* (grant no. U261HS0075-03-00), grew from Behavioral Risk Factor Surveillance Study (BRFSS) data from tribal communities in the Southwest that indicated a high proportion of AI/AN adults experienced childhood adversity. The Menominee Nation of Wisconsin was also recently part of the two-year Fostering Futures Collaborative pilot project, which aimed to extend the science of ACEs, trauma-informed care, and resilience to the community-level. As part of the collaborative, the tribe worked with two non-Native pilot sites to engage in peer-learning opportunities and create public health awareness campaigns and resources related trauma-informed care, concepts, and policies.

Future Research and Policy Directions

Tribal Nations have initiated efforts centered around resilience, trauma-informed care, healing, and the reduction of systemic violence to provide supports to Native youth and peoples. As one tribal leader recently shared with us, "In Indian Country, we have answers for the world. Our strengths got us to this point, not our weaknesses." This message was imbued with a call to transform the ways in which we frame these issues of trauma, the outcomes we emphasize in research, policies, programs, and funding announcements. It is a call to promote positive, strengths-based messaging about Native cultures--knowing that this contributes the healthy development of youth and families.

In 2012, the US Department of Health and Human Services and National Institute on Minority Health and Health Disparities funded the Center for American Indian Resilience (CAIR) as an Exploratory Center of Excellence (P20). Coming from a strengths-based perspective, the Center asserts that "American Indians have succeeded in the face of adversity"; yet it acknowledges that these "successes and paths of resilience largely have been ignored by public health and health research communities" (NIH RePORT, 2015). To rectify this reality, the CAIR promotes the examination of community *assets* and "the role of traditional knowledge, collective memory, and cultural strategies in teaching health behaviors and supporting positive health outcomes" (Center for American Indian Resilience, 2015). This Center is exemplary in its approach--researching models of resilience, utilizing digital storytelling as a means of empowering participants, and producing tools for wellness mapping, to name a few.

At the national policy level, we have witnessed a surge of attention to and investment in Native youth through the Generation Indigenous Initiative, White House Tribal Youth Gathering, and the Alyce Spotted Bear and Walter Soboleff Commission on Native Children (S.1622). The latter, which began as a bipartisan bill introduced in 2013 by Senators Heitkamp (D-ND) and Murkowski (R-AK), is inherently concerned with enhancing the health and well-being of Native youth--drawing attention to the rising trends in child maltreatment, poverty, suicide, and substance use. Once the Commission is funded and appointed, their purpose will be to issue a report with recommendations on how to collect meaningful data on the status of Native youth, compile best practices with measurable outcomes to advance their well-being, enhance interagency coordination, and streamline federal investments to support tribal self-determination in program development and delivery. In the words of the First Lady Michelle Obama, "We are talking about a small group of young people, so while the investment needs to be deep, this challenge is not overwhelming, especially given everything we have to work with" (White House Convening on Creating Opportunity for Native Youth, 2015). As such, there are many opportunities to foster resilience through policy that include promoting new awareness and

understanding, funding initiatives that make a significant impact, equipping governments to address trauma, and developing a cohesive and comprehensive effort to promote the wellness of our nation's First Peoples.

ABOUT THIS PUBLICATION

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