Historical Trauma Informed Clinical Intervention Research and Practice

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&

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Traditional Protective Factors: Woope Sakowin
(7 Laws of the Lakota)*

• Wacante Ognake - Generosity
• Wowaunsila – Compassion
• Wowayuonihan – Respect
• Wowacin Tanka - To Have a Great Mind
• Wowahwala – Humility, State of Silence, To be humble
• Woohitike – Courage, Bravery, Principal, Discipline
• Woksape – Wisdom, Understanding
• *Tiblo B. Kills Straight (some versions differ slightly but core values similar)
Ground Rules based upon the 
Woope Sakowin
(7 Laws of the Lakota)

• Wacante Ognake - Generosity
  – To share time with others, to share opinions, thoughts and feelings in a good way
  – To remain silent at times to allow others to share
  – To share, help, give

• Wowaunsila – Compassion, Pity
  – Compassion for other participants
Ground Rules
(Con’t.)

• Wowayuoniyan – Respect, Honor
  – To have respect and honor for others
  – Each opinion is valued

• Wowacin Tanka - To Have a Great Mind
  – To be patient and silent, and to observe
  – No need to repeat what has already been said
  – Patience, tolerance
Ground Rules
(Con’t.)

• Wowahwala – Humility, State of Silence, To be humble
  – To put the good of the group first
  – No one is above another

• Woohitike – Courage, Bravery, Principal, Discipline
  – To be honest
Ground Rules
(Con’t.)

• Woksape – Wisdom, Understanding
  – Wisdom which is sought through respectful listening and observing
  – Use wisdom in the group process
  – Self-discipline; focus on the task at hand
Commitment to the Process

• *Sitanka Wokiksuye Rider – I sacrificed to wipe the tears of the people but until today, no one had wiped my tears*

• This historical trauma work requires commitment

• For this workshop, we are asking that you commit to full attendance and participation and follow the *Woope Sakowin* (particularly respect and generosity by staying in the workshop, sharing with others, and having courage)

• We recommend abstinence and self-care over these two days
Self-Care Suggestions & What to Expect

• Everyone’s process is unique – don’t compare yourself to others.

• However, some common feelings:
  1. overwhelmed, like you’re losing control
  2. scared of the thoughts and feeling like something is wrong with you
  3. anger
  4. loneliness
**Self-Care Suggestions & What to Expect**

- Sometimes others are uncomfortable talking about grief or losses so they may not be very supportive and may avoid the person who has lost someone; talking with others who have lost loved ones can help.

- Healthy ways to cope with anger and sadness: exercise, talking about the feelings with other workshop members, spirituality, praying about the feelings, for help to deal with the feelings.
Self-Care Suggestions & What to Expect

• Self-care and nurturing
• Trust the process – we’re being supported and guided spiritually
• Feelings are just feelings—feelings aren’t good or bad, they just are. We can learn to live with them and to cope
• You can’t grieve alone; you have to share your grief with others.
Self-Care Suggestions & What to Expect

• **Some stages of grieving may be:** 1) denial, 2) numbness, 3) anger, 4) sadness, and 5) resolution – working through the grief process, making peace with it; acceptance

• **Grieving is normal and is a part of life.** Our relatives in the animal nations also grieve and mourn.
Self-Care Suggestions & What to Expect

• Healing from trauma and grief is like healing a deep cut, it stops bleeding and there’s less pain but sometimes a scar remains. It can still hurt but it hurts less and less often over time. The scar is a reminder of the injury but you are able to function.

• We all have the strength, power, and ability to heal within ourselves and others can help us to do that.
Introductory Exercise

• Who Am I?
(in one word)
Introductory Exercise

• What is my ethnicity (can be cultural, racial, religious group/s, etc - as many or as few words as you choose)
Introductory Exercise

Name 3 instances where you have felt discriminated against or oppressed
Awareness of Research Roles and Responsibilities: The Takini Network/Institute

Founded in 1992 in the sacred Paha Sapa

Tunkasila Tatanka Iyotake, Mother Her
Holy Door, Daughter, and Grandchild
We all practice our traditional spirituality; we periodically have ceremonies to pray that our work continues to help Native Peoples. We are grounded in our traditions. We embrace and try to live our lives according to the *Woope Sakowin*: Seven Laws and integrate that in our work, as our foundation and guide for our work and our lives. We are all survivors and no one is above another. We are all teachers and learners. * now called Takini Institute
Awareness of Research Roles and Responsibilities: The Takini Network/Institute

• Our work emerged from a desire to reduce the suffering of Native Peoples
• Began as clinicians and community leaders
• Historical Trauma & Unresolved Grief (HTUG) concept and intervention perceived as helpful & people “felt better”
• Began to want to know more about the effect of HTUG and documenting that through research
• Interest in trauma research deepened – wanted to make sure we are doing utmost best to help Native Peoples
Roles & Responsibilities as Researchers

• True community engaged, tribally driven research is NOT for the “faint of heart” of for those who do NOT have a commitment to the people with whom you are working

• Challenges navigating community obstacles, changes in leadership, limited resources, and the funding agency’s system which often requires things that are culturally inappropriate
Role & Responsibilities as Researchers

- Know your biases
- Addressing one’s own HT Response (to be covered, survivor guilt, compensatory fantasies)
- Transference, Countertransference
- When conducting Behavioral Health Research hearing about someone else’s experience may trigger your memories and grief - trauma response
- You have to be prepared to manage your own emotions, reactions & to protect your participants (Therapeutic Neutrality)
Development of Evidence Based Behavioral Health Research

- Start with theoretical and practice wisdom, your own cultural experience and grounding, and your clinical experience
- Listen, listen, listen and listen some more with the 3rd ear (hearing what is not overt)
- Observe, maintain humility, be respectful
- Immersion in the community and be open to experiencing and to diversity within and across tribal groups
Development of Evidence Based Behavioral Health Research

• Talk with others, elicit feedback, and share your observations – check for accuracy (reflective listening and clarification)

• Connect with tribal elders, grassroots folks, traditional leaders, ask for help and blessings

• Come with a good heart, be genuine, and committed, and patient, and a desire to be of service and not be looking to just further your career
Overview of Historical Trauma Theory and Intervention

• What is Historical Trauma and Historical Unresolved Grief?
• Healing Historical Trauma and Unresolved Grief: The HTUG Intervention: A Tribal Best Practice
• Incorporating historical trauma with the clinical assessment: DSM IV Cultural Formulation and its application to research
• Celebration of Survival: The Takini Network
It is our way to mourn for one year when one of our relations enters the Spirit World. Tradition is to wear black while mourning our lost one, tradition is not to be happy, not to sing and dance and enjoy life’s beauty during mourning time. Tradition is to suffer with the remembering of our lost one, and to give away much of what we own and to cut our hair short....Chief Sitting Bull was more than a relation....He represented an entire people: our freedom, our way of life -- all that we were. And for one hundred years we as a people have mourned our great leader.
Omniciye Woiyaksape

We have followed tradition in our mourning. We have not been happy, have not enjoyed life’s beauty, have not danced or sung as a proud nation. We have suffered remembering our great Chief and have given away much of what was ours…. blackness has been around us for a hundred years. During this time the heartbeat of our people has been weak, and our life style has deteriorated to a devastating degree. Our people now suffer from the highest rates of unemployment, poverty, alcoholism, and suicide in the country.

Traditional Hunkpapa Lakota Elders Council (Blackcloud, 1990)
I never bonded with any parental figures in my home. At seven years old, I could be gone for days at a time and no one would look for me....I’ve never been to a boarding school....all of the abuse we’ve talked about happened in my home. If it had happened by strangers, it wouldn’t have been so bad- the sexual abuse, the neglect. Then, I could blame it all on another race....And, yes, they [my parents] went to boarding school.

A Lakota Parent in Recovery
(Brave Heart, 2000, pp. 254-255)
Multiple Losses and Trauma Exposure

- Death of five family members killed in a collision by a drunk driver on a reservation road
- One month earlier, death of a diabetic relative
- Following month, adolescent cousin’s suicide and the death of another relative from a heart attack
- Surviving family members include individuals who are descendants of massacre survivors & abuse in boarding schools
- Many community members comment that they feel they are always in a state of mourning and constantly attending funerals.
Historical Trauma Theory and Practice

• Distortions in presentations about historical trauma - it is not about staying stuck in the past

• Original intent – to begin a healing process, to move forward; to reclaim traditional cultural protective factors; to stop identifying ourselves as victims; to move from identifying as survivors to transcending and thriving
Historical Trauma Theory and Practice

• Recognizes tribal and regional differences
• Original HT Intervention developed among the Lakota but we humbly respect all tribal communities, cultures, and histories
• Work with different tribes across the US and Canada to tailor work for their tribal groups
• Approximately 300 workshops/training, presentations across the US and Canada
Historical Trauma and Unresolved Grief

• *Historical trauma* is cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma (1985-88)

• *Historical unresolved grief* accompanies that trauma

Historical Trauma Response

• The *historical trauma response* (HTR) is a constellation of features in reaction to massive group trauma.

• This response is observed among Lakota and other Native populations, Jewish Holocaust survivors and descendants, Japanese American internment camp survivors and descendants.

Historical Trauma & Unresolved Grief Interventions: Return to the Sacred Path

- Confronting Historical Trauma & Embracing Our History
- Understanding the Trauma
- Transcending the Trauma
- Releasing Our Pain
Confronting the Cumulative, Massive Group Trauma

- Origins of trauma are in genocide
- Boarding schools compounded trauma
- Trauma is transferred across generations through impairment of traditional parenting skills, identification, and other complex processes; epigenetics research relevant (Yehuda)
- Children of genocide survivors, children of boarding school survivors may pass on the trauma to their descendents
Background: Genocide

- Native history meets UN 1948 Geneva Convention definition of genocide
- Congressional genocidal policy: *no further recognition of their rights to the land over which they roam; go upon said reservations…chose between this policy of the government and extermination; wards of the government, controlled and managed at its discretion*
- BIA Education Division called “Civilization Division”
- Congressional policy of forced separation of children from family and tribe; militaristic
- Gender roles and relationships impaired by boarding schools
HT, Gender, Parenting Issues

- Traditional gender roles and relationships impaired – women & children were never the property of men, sacredness of children lost, & men lost traditional parenting roles as well as roles of warriors and protectors
- Many Native men internalized white male values, including the view of women & children as property due to forced socialization in boarding schools
- Parents received messages that our culture was inferior and we could not raise our own children
Trauma Exposure and Prolonged Grief

- American Indians had an adult trauma exposure rate of 62.4% to 69.8% to at least one traumatic event; a substantial proportion of these entail death of a loved one (Manson, Beals, Klein, Croy, & AI-SUPERPFP Team, 2005).

- CG/PG: sadness, separation distress including strong yearnings, longing for and preoccupation with thoughts of the deceased, and intrusive images, psychic numbness, guilt, extreme difficulty moving on with life, and a sense of the part of the self having died (Boelen & Prigerson, 2007; Shear et al., 2005). CG may also co-occur with PTSD (20-50%); prevalence unclear for American Indians/Alaska Natives.

- Historical unresolved grief includes these but also yearning, pining, preoccupation with thoughts of ancestors lost in massacres, loyalty to ancestors with a focus on their suffering, as if to not suffer is to not honor them, to forget them.
Prolonged or Complicated Grief

- Tribes may also be at high risk for CG/PG related to the impact of genocide across generations and frequent deaths of attachment figures, due to high morbidity and mortality rates, & generational boarding school trauma.
- Rather than ambivalent relationships, some CG researchers think that close attachments may predispose CG development; AI/AN attachment styles may be closer and more intense as a cultural norm.
Intergenerational Traumatic Grief

• Federal prohibition against practice of traditional Native spirituality limited bereavement resulting in unresolved grief across generations

• Dominant societal view of Natives as “savage” and unfeeling – dehumanizing, invalidating grief

• Acute grief which persists becomes unresolved, prolonged, complicated

• Modern multiple losses & cumulative traumatic losses superimposed upon collective generational trauma
HT Theory & Symptoms of Depression, PTSD, Prolonged Grief

• Native mourning resolution is distinct from European American grief
• Loss of close relative experienced as loss of part of self, exhibited by cutting the hair
• Natives maintain active relationship with ancestor spirits
• Massive group trauma (genocide) impairs normative grief; extent & quality of losses (trauma exposure) limit time for culturally congruent mourning resolution; history of prohibition of bereavement ceremonies
Historical Trauma Response Features

- Survivor guilt
- Depression
- Sometimes PTSD symptoms
- Psychic numbing
- Fixation to trauma
- Somatic (physical) symptoms
- Low self-esteem
- Victim Identity
- Anger

- Self-destructive behavior including substance abuse
- Suicidal ideation
- Hypervigilance
- Intense fear
- Dissociation
- Compensatory fantasies
- Poor affect (emotion) tolerance
Historical Trauma Response Features

- Death identity – fantasies of reunification with the deceased; cheated death
- Preoccupation with trauma, with death
- Dreams of massacres, historical trauma content

- Loyalty to ancestral suffering & the deceased
- Internalization of ancestral suffering
- Vitality in own life seen as a betrayal to ancestors who suffered so much
Identification & Self-Hatred

- Identification with the aggressor (A. Freud) & internalized oppression (Freire)
- Identification with the oppressor’s view of Natives, resulting in self-hatred
- Self-destructive behavior (i.e. SA) to avoid pain and to act out the self-hatred
- Identifying with parents’ trauma response patterns
Perceived Discrimination and Microaggressions

- Perceived discrimination - relationship with increased depression (see Whitbeck)
- Microaggressions (term coined by Chester Pierce, MD; further development by D. Wing Sue, PhD) can include instances of being racially profiled, experiences of discrimination, being stereotyped, being intentionally or unintentionally excluded, hearing racist comments, etc.
- Associated with historical trauma response, PTSD symptoms, and depression (preliminary research of Dr. Karina Walters (Choctaw) U of WA)
Yehuda (1999)

- Vulnerability among children of Holocaust survivors for the development of PTSD
- COS had greater degree of cumulative lifetime stress yet no differences in degree of trauma exposure (self-report)
- Offspring perceive or experience events as more traumatic and stressful
- COS with chronic PTSD parent more likely to develop PTSD
- **Parental trauma symptoms are the critical risk factors for COS trauma responses**
- Lifetime and current PTSD was significantly higher among Holocaust descendants
Epigenetics, Transgenerational Effects, and PTSD

- Walters et al., (2011) *Du Bois Review: Social Science Research on Race, 8*(1)
- Transgenerational, higher stress vulnerability (doesn’t mean poor mental health necessarily but greater risk for traumatic responses to stress and more likely to have PTSD-like symptoms)
- Stressful environmental conditions *can* leave a genetic imprint, changes in neurobiology
- Testimonies of “inherited” grief in qualitative research
HTUG Tribal Best Practice

- Traditional culture & ceremonies throughout facilitated release of emotions
- Psychoeducation; narratives & trauma testimony
- Delivered over 4 days; small process groups with the trained Native facilitators
- Focus on *returning to the sacred path* – the strengths in our traditional culture
- Ceremonies may help in the healing process, changing brain chemistry, calming traumatic brain
HT and Native Veterans

• Insert slides from vet presentation – PTSD and TBI
American Indian Veterans

Approximately 177,000 American Indians and Alaska Natives are veterans. Source: U.S. Census Bureau, 2006.

World War I

- About 12,000 American Indians served during WW I

World War II

- More than 44,000 American Indians served in the military from 1941 to 1945, including 800 women.
- An estimated 99 percent of healthy male American Indians ages 21 to 44 were registered for the draft.
American Indian Veterans

Korean War
• More than 10,000 American Indians served during the Korean War.

Vietnam War
• More than 42,000 American Indians served in the Armed Forces between 1965 and 1975.
American Indian Veterans

Post-Vietnam Era
• During the Gulf War, more than 3,000 American Indians served in the Gulf region.
• Includes Desert Storm/Shield and Operations Enduring Freedom and Iraqi Freedom.

American Indians in Current Active Duty Military
• More than 24,000 active duty military are American Indians.

Source: Department of Defense 2005

The DOD number is somewhat understated in that American Indians of mixed ancestry (that is, those who are of another race or races as well as American Indian) are not included.
American Indian Veterans

- Both Native male and female veterans have frequent signs of PTSD, PTS, TBI; although Native men have greater combat exposure, Native women have higher rates of victimization and sexual trauma in military; sexual trauma in the military exists among both genders.

- Both Native men and women need outreach and support; victims of such trauma tend to blame themselves and feel shame often keeping them from seeking help.

- Substances abuse can cause changes in brain and body, making it difficult to stay clean and sober.

- Research that shows people participating in traditional ceremonies are more likely to stay drug and alcohol free.

- Reduction in sense of feeling responsible to undo painful historical past
- Less shame, stigma, anger, sadness
- Decrease in guilt
- Increase in joy
- Improved valuation of true self and of tribe
- Increased sense of personal power
### Changes on the Lakota GEQ

[Statistical significance achieved for 7 items including these (Brave Heart, 1995, 1998)]

<table>
<thead>
<tr>
<th>Concept</th>
<th>M (T1)</th>
<th>M (T2)</th>
<th>P</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shame</td>
<td>3.21</td>
<td>2.67</td>
<td>.004</td>
<td>p&lt;.01</td>
</tr>
<tr>
<td>Stigma</td>
<td>2.92</td>
<td>2.31</td>
<td>.001</td>
<td>p&lt;.01</td>
</tr>
<tr>
<td>Anger</td>
<td>3.15</td>
<td>2.87</td>
<td>.012</td>
<td>p&lt;.05</td>
</tr>
<tr>
<td>Obsessive thoughts</td>
<td>3.38</td>
<td>2.79</td>
<td>.007</td>
<td>p&lt;.01</td>
</tr>
<tr>
<td>Feeling responsible for undoing the pain of the past</td>
<td>3.04</td>
<td>2.46</td>
<td>.023</td>
<td>p&lt;.05</td>
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</tbody>
</table>
Semantic Differential Results: Changes Over Time

- Evaluation Scale
  - My True Self ($P=0.004$, $p<.01$)
  - Anger ($P=0.032$, $p<.05$)
  - The Past ($P=0.004$, $p<.01$)
  - Wasicu ($P=0.001$, $p<.01$)
Semantic Differential Results: Changes Over Time

- Potency Scale
  - My True Self (P=.035, p<.05)
  - Wasicu (P=.002, p<.01)
  - The American Indian Holocaust (P=.000, p<.0001)
Semantic Differential Results: Changes Over Time

• Activity Scale
  - The American Indian Holocaust (P=.012, p<.05)
  - The Past (P=.001, p<.01)
  - My People (P=.006, p<.01)
### Gender Differences: Boarding School Experiences

<table>
<thead>
<tr>
<th>Experiences</th>
<th>%Men</th>
<th>%Women</th>
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</thead>
<tbody>
<tr>
<td>Attended boarding school</td>
<td>82.4%</td>
<td>65.4%</td>
</tr>
<tr>
<td>Hit at boarding school</td>
<td>85.7%</td>
<td>35.3%</td>
</tr>
<tr>
<td>Punished for speaking</td>
<td>57.1%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Racism in boarding school</td>
<td>85.7%</td>
<td>58.8%</td>
</tr>
<tr>
<td>Sexually abused at school</td>
<td>28.6%</td>
<td>17.7%</td>
</tr>
</tbody>
</table>

Table 11: Gender Differences for Affects Experienced Often Before, During and After the Intervention

<table>
<thead>
<tr>
<th></th>
<th>Before Female/Male</th>
<th>During Female/Male</th>
<th>After Female/Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anger</td>
<td>70.6%  73.3%</td>
<td>41.2%  66.7%</td>
<td>11.8%  26.7%</td>
</tr>
<tr>
<td>Sadness</td>
<td>70.6%  66.7%</td>
<td>100.0%  80.0%</td>
<td>5.9%  33.3%</td>
</tr>
<tr>
<td>Guilt</td>
<td>70.6%  53.3%</td>
<td>29.4%  33.3%</td>
<td>0.0%  13.3%</td>
</tr>
<tr>
<td>Shame</td>
<td>64.7%  60.0%</td>
<td>5.9%  40.0%</td>
<td>0.0%  13.3%</td>
</tr>
<tr>
<td>Joy</td>
<td>58.8%  33.3%</td>
<td>64.7%  66.7%</td>
<td>70.6%  86.7%</td>
</tr>
</tbody>
</table>
HT Qualitative Research: Superordinate Themes (2000)

Wakiksuyapi – Carrying the Trauma & Grief

- Trauma Testimony
  1. Wounded Knee
  2. Boarding School
  3. Day School
  4. Boarding School Descendant

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HT Qualitative Research: Superordinate Themes (2000)

**Trauma Responses**

- Trauma Identity
- Carrying Trauma
- Anger
- Impaired Bonding
- Transposition
- Somatic Symptoms
- Survivor Guilt
- Suicidal Ideation
- Multiple Traumas

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HT Qualitative Research: Superordinate Themes (2000)

Transcending Trauma

- Coping Strategies
- Ideas about Healing
- Transforming Past

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Themes from Qualitative Evaluation of Parental Responses (1996-2004)

• Increased sense of parental competence
• Increase in use of traditional language
• Increased communication with own parents and grandparents about HT
• Improved relationships with children, parents, grandparents, and extended kinship network
• Increased pride in being Lakota and valuing own culture, i.e. Seven Laws
Iwankapiya – Healing: Historical Trauma Practice and Group IPT for American Indians
NIMH R34 Pilot Study/Clinical Trial Planning Grant 1R34MH097834-01A1 (Brave Heart, PI)

- **Lack of Empirically Supported Treatment (EST) models** or research for American Indian depression and related disorders; virtually no American Indians included in clinical trials for psychotherapy

- **High risk factors** for depression, PTSD, prolonged grief due to traumatic losses (high accidental & violent death rates, alcohol related death rates, suicides; cultural attachment styles may increase risk for prolonged grief)

- **American Indian PTSD rates & degree of trauma exposure** exceed national averages

- **Psychosocial risk factors** include poverty, limited resources, high unemployment
Iwankapiya (Healing) Study

**Purpose** – to reduce emotional suffering among American Indians by developing an intervention model that improves treatment for depression, unresolved grief, and co-occurring PTSD

**Overall Design** – Randomized assignment to Group Interpersonal Psychotherapy (IPT) combined with the *Historical Trauma and Unresolved Grief Intervention* (HTUG) vs IPT Only in outpatient behavioral health clinics for adults at two tribal sites – one reservation and one urban
Iwankapiya (Healing) Study

• Builds upon more than 20 years of work with tribal communities (primarily reservations) through HT presentations and workshops, modified versions of HTUG and Training of Trainers and pilot evaluation of response to HTUG and HTUG-informed parenting work

• Incorporates clinical behavioral health practice and experience

• Integrates traditional cultural healing experiences and traditionally grounded coping strategies (e.g. self-soothing and affect [emotions] tolerance)
Iwankapiya (Healing) Study

- Measures include standard mental health screening and assessment instruments for depression, grief, and trauma (PHQ-9, Hamilton Depression Scale, PTSD screening, complicated/prolonged grief, interpersonal/social functioning) and Indigenous Peoples Survey (clinician administered – debriefing provided as needed)

- Study Monitoring Team includes clinical intervention research experts who are also clinicians
Indigenous Peoples of the Americas Survey (IPS)

- Inventory of Complicated Grief
- Trauma History Inventory/HTQ
- PTSD Checklist-Civilian Version (supplement with Military Version as indicated)
- Historical Loss Scale and HLAS (Whitbeck)
- Center for Epidemiologic Studies Depression Scale
- Duke-UNC Functional Social Support Questionnaire
- Items from the Lakota Grief Experience Questionnaire (Experimental) and the Return to the Sacred Path Study (PI-constructed)
- Experiences of racism and discrimination
- Identity
Indigenous Peoples Survey

• Provides preliminary data on the psychometric properties
• Finalize for research use by tribal communities who have identified a need for such an instrument
• Preliminary data on the nature and prevalence of the emotional challenges (depression, collective trauma exposure, interpersonal losses, and unresolved grief)
IPS Cultural Content Issues

• Inventory of Complicated Grief – need supplemental information that can come from the interview – what is culturally appropriate to determine CG or Prolonged Grief? 1 year? 2 years? 5 years?

• Native forms of grieving, Native time frames – although the year of mourning common is some tribes, other factors also come in – degree of trauma exposure, how many losses – grief overload
IPS Cultural Content Issues

• Distortions in traditional grieving practices due to prohibition of open practice of ceremonies dating back to 1883 and we still cannot bury our dead as our ancestors did due to laws, health codes, etc.

• Misinformation among our tribal communities about the “right way to grieve” and confusion about releasing the spirit vs mourning process for the surviving relatives (the bereaved)
IPS Cultural Content Issues

• Magnitude of contemporary losses, frequency, building upon the collective generational trauma AND the past prohibition of ceremonies AND the disenfranchised grief (K. Doka) – that we have been seen as savages without feelings – invalidating our grief

• Internalization of the oppressors’ view of us and displacing that on one another – all of this impairs grief resolution
IPS Content

• Probes: who they lost – uncles, aunties not specifically mentioned
• Questions about trouble accepting the death; Natives may more easily accept death, feel less resentment BUT may have intense searching, pining, longing so ICG may not fully capture Native prolonged grief – OR is our searching
• What is Native “normal” grieving? Native attachment styles traditionally differ from what Freud described – we have deep abiding attachments to not only the living and recently deceased but to our ancestors
IPT vs HTGU/IPT Pilot WAVE 2 Timepoints

**Screening Interview**
- Brief Clinical interview
- Inclusion Criteria
- Exclusion Criteria

**Client Screening Measures**
- HAMD-24
- AUDIT
- PHQ-9
- IPS

**Baseline Assessment**
- Week 1: T1

**Engagement Measures**
- TARQ (T2)

**Outcome Measures**
- ICG
- IIP-32
- Duke UNC FSQ
- PCL
- HLS
- HLAS
- HAM-D24 (T2, T3)

**Other services use**
- Questionnaire of use of other treatment

**Screening Interview**
- Week 20: T2, T3

**End of Treatment**
- Post Treatment

**HAM-D24 Questionnaire of use of other treatment**
- Week 20

**Week 20**
- Two Waves, Two Sites

**Timepoints**
- Week 1
- Week 2
- Week 3
- Week 4
- Week 5
- Week 6
- Week 7
- Week 8
- Week 9
- Week 10
- Week 11
- Week 12
IPS Content

• 63. Do you ever drink alcohol (including beer or wine)? YES or NO

• 64. Did you ever use drugs for reasons that are not medical or misuse drugs that were prescribed for a medical reason? YES or NO

• Better questions: Tell me about your alcohol use. Tell me about your alcohol use. Assume use – easier for person to be honest – de-stigmatizes response

• 79. Needs formatting – unclear where to check yes or no – This IS a clinician administered instrument.
Other Considerations for Clinical Intervention Research

• Assessment of drinking patterns (DSM V – moderate to severe excluded)
• Medication such as antidepressants compliance and monitoring
• Other medications for related issues such as sleep disturbance caused by depression
• Other psychiatric medications for co-occurring conditions
• Medication for non-psychiatric issues and examining impact of those on treatment
• Substance use vs abuse – use and/or abuse of prescription meds, social drinking, “street” drugs
Other Considerations for Clinical Intervention Research: Fidelity to Model

- Clinician tracking and reflection reports – clinician fidelity checklist
- Intermittent independent observations
- Session by session content format for clinician guidance
- Importance of participant engagement measures
- Values and attitudes regarding treatment and medication
Other Considerations for Clinical Intervention Research: Real World vs Ideal Research

• Issue of modifying measures for cultural appropriateness
• Resources and infrastructure
• Tapering off antidepressants example
• Purist, clinical “laboratory” for experimental studies in resource
• Multiple IRB and RRBs with tribal research sites
• Consent process – go through informed consent with the research candidate – don’t just hand them a form to read and sign! Use simple, clear language
Other Considerations for Clinical Intervention Research: Crisis Protocols and Clinical Coverage

• Identify potential risk factors so crises can be averted
• Screening and baseline assessment of research candidates for behavioral health interventions including identification of any suicidal ideation and risks, and referral resources
• Evaluate trauma exposure, depressive symptoms, complicated or prolonged grief
• Debriefing for clinicians and evaluators through ongoing training and supervision
Other Considerations for Clinical Intervention Research: Crisis Protocols and Clinical Coverage

• Traditional practices such as prayer and smudging provide comfort and emotional containment

• Psychoeducation in HTUG includes sharing knowledge physical and psychological effects of trauma and grief on the body and brain, and coping strategies

• Clinically trained providers should be available to research team for quick intervention, debriefing, individual time with the participant as needed
Other Considerations for Clinical Intervention Research: Crisis Protocols and Clinical Coverage

• Participants who manifested any difficulties during the research interview or therapy session receive a 24 hour follow up outreach contact by a clinician or provider

• Participant expresses thoughts of self-harm or harming others – contact tribal law enforcement, IHS on-call mental health provider or other tribal licensed mental health professional

• Immediate follow up with mental health services for anyone with suicidal thoughts (ideation) to prevent an escalation and crisis
Culturally Sensitive Diagnosis: the DSM IV Cultural Formulation (Day 2)

Cultural Identity
- Ethnic or cultural reference group(s)
- Degree of involvement w/culture of origin & host culture
- Language abilities, use, & preference

Cultural Explanations of Illness
- Meaning & perceived severity of symptoms in relation to reference group/s norms
- Perceived causes & explanatory models that the pt. & reference group(s) use to explain the illness
- Preferences for sources of care
Culturally Sensitive Diagnosis: the DSM IV Cultural Formulation

Cultural factors related to psychosocial environment & levels of functioning
- Culturally relevant interpretations of social stressors, available supports, levels of functioning & disability
- Stresses in the local social environment
- Role of religion & kin networks in providing emotional, instrumental, & informational support

Cultural elements of the relationship between the individual and the clinician
- Individual differences in culture & social status between the individual & clinician
- Problems these differences may cause
Culturally Sensitive Diagnosis: the DSM IV Cultural Formulation

Overall cultural assessment for diagnosis and care
• Discussion of how cultural considerations specifically influence comprehensive diagnosis and care

Reference:

Examples for Native clients: skin color issues, risk for trauma exposure, traditional mourning practices, racism, unemployment rates, housing availability
Cultural Formulation (con’t)

• Indirect styles of communication, values of non-interference and non-intrusiveness, & polite reserve may delay help-seeking and true presenting problem

• Variation in eye contact; cultural differences in personal space & cross-gender interaction

• Listening for the meaning in the metaphor

• Client use of narratives, stories; talking in the displacement

• Beginning phase may be longer
Culturally & Historically Responsive Assessment

• Explore generational boarding school history, tribal traumatic events, and investigate how these were/are processed in the family.

• Explore degree of involvement in traditional Indigenous culture; complexity of cultural responsiveness is examined in literature on assessment and intervention with Indigenous populations (e.g. Brave Heart, 2001 a, b).

• Use adaptation of the DSM IV Cultural Formulation (Lewis-Fernandez & Diaz, 2002), expanded to include exploration of boarding school trauma, tribal relocations, migration, trauma in tribal community of origin, language...
Celebration of Survival

Video Presentation:

*A Celebration of Survival: The Takini Network* (supported by CSAT)

- includes historic boarding school slides
- summarizes historical trauma intervention theory and approach
- describes historic 2001 *Models for Healing Indigenous Survivors Conference*

Follow up conferences held in 2003 and 2004 (CMHS and CSAT funded)
Development of Evidence Based Behavioral Health Research

- Qualitative research, publish and honor the community in what you write – always “carrying the People in your heart” and making sure that what you are doing is helpful

- Conduct small pilot outcome studies of your intervention – be creative about funding sources; share results

- Find mentors (challenging for Native researchers due to institutional racism)
Development of Evidence Based Behavioral Health Research

• Collaborate and mentor others; develop a team – everyone needs mentoring at all levels including peer mentoring

• Participate in webinars, attend conferences, stimulate your thinking and deepen your understanding

• Find opportunities to present your ideas and your work at all stages - helps you to obtain feedback and deepen your development of your theoretical framework
Secondary Trauma

• Also called vicarious trauma; “Compassion Fatigue” (Figley, 1995)

• Frequent, intimate contact with traumatized individuals can result in similar symptoms in friends, relatives, therapists, and even neighbors

• Special challenges for Native counselors and counselors from other traumatized groups
Why We Develop Secondary Trauma

- Intensity of trauma exposure – our clients are suffering a great deal and we are constantly surrounded by that trauma.
- We may have our own similar trauma experiences as our clients.
- We may have unresolved trauma issues that get triggered by our clients.
Secondary Trauma

• Trauma can be triggered
• May include physical symptoms
• Irritability
• Work-related symptoms and burnout, i.e. poor job performance, missing work, etc.
• Overworking, working at home consistently
Self-test (Figley, 1995)

- I am losing sleep over a client’s traumatic experience
- I am experiencing troubling dreams similar to those of a client of mine
- I feel a sense of helplessness while working with clients
- I feel “on edge” working with clients
Self-test con’t.

• I feel depressed, run down working as a therapist or counselor
• I have trouble separating my work from my personal life
• I feel like a failure in my work as a therapist or counselor
Special Challenges for Natives

• Our work with traumatized clients may be a spiritual as well as personal and professional commitment
• Our view of commitment is different from the dominant culture
• We may not separate our professional lives from our personal in the same way as the dominant society
Self Care

• Write Down One Thing That You Can Do For Yourself
• Share with a partner
• Come up with a plan for how you will keep this commitment to yourself and have a tangible reminder – share ideas and examples (pictures, post-it note reminders, telling your family and friends so they can support you, regular reminders, etc)
Relevant Recent HT Publications


References


References


References


References


References


• US Senate Miscellaneous Document, #1, 40th Congress, 2nd Session, 1868, [1319]
References


Additonal References

• Boelen & Prigerson, 2007 on Prolonged Grief
• Duran, B. (2004) CA/N article
• Manson, Beals, Klein, Croy 2005