Proceedings of the Second Annual Symposium

Reclaiming Our Roots:

RISING FROM THE ASHES OF HISTORICAL TRAUMA

National American Indian & Alaska Native

ATTC Addiction Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

National American Indian and Alaska Native Addiction Technology Transfer Center · University of Iowa · 145 North Riverside Dr N410 · Iowa City, IA 52242
Phone: 319-335-9750 · Fax: 319-335-6068 · Email: americanindianalaskanative@attcnetwork.org · Website: attcnetwork.org

Proceedings of the Second Annual Symposium

RECLAIMING OUR ROOTS: RISING FROM THE ASHES OF HISTORICAL TRAUMA

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Wild Horse Pass Hotel and Casino, Chandler, AZ

EDITED BY:

Anne Helene Skinstad, PhD
Peter Nathan, PhD
Lena Thompson, MPH
Kate Thrams, BA
Roxanne Tang

In collaboration with the United States Department of Health and Human Services Region 9, Substance Abuse Mental Health Services Administration Office of Tribal Affairs and Policy, and the Pacific Southwest Addiction Technology Transfer Center

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CONTRIBUTORS:

Shirley Matt, LISAC, Confederated Salish/Kootenai Tribes of Montana

Ray Daw, MA, Navajo
Behavioral Health Administrator, Yukon-Kuskokwim Health Cooperation, AK

R. Dale Walker, MD, Cherokee
Director, One Sky Center; Emeritus Professor of Psychiatry, Oregon Health Sciences University

Ann Bullock, MD, Minnesota Chippewa
Acting Director and Clinical Consultant, Division of Diabetes Treatment and Prevention, Indian Health Services

Dennis Norman, Ed D, ABPP, descendant of the Southern Cheyenne and Cherokee Nations
Associate Professor & Faculty Chair, Native American Program, Harvard University; Chief of Psychology, Massachusetts General Hospital

Shane Eynon, PhD (LT, USPHS), descendant of the Seneca and Ojibwe
Special Advisor to the Secretary for Native American Veterans, US Department of Veterans Affairs

Elicia Goodsoldier, BA, Navajo, Spirit Lake Dakota Nation
Commissioner, Denver American Indian Commission

COLLABORATORS:

Captain Jon Perez, PhD
SAMHSA Region 9 Administrator

Mirtha Beadle, MHA
SAMHSA Director of Office of Tribal Affairs and Policy

Pacific Southwest ATTC

NATIONAL AMERICAN INDIAN & ALASKA NATIVE ADDICTION TECHNOLOGY TRANSFER CENTER STAFF

Anne Helene Skinstad, PhD
Project Director, National AI & AN ATTC
Associate Professor, Department of Community and Behavioral Health, University of Iowa

Lena Thompson, MPH
Research Associate

Kate Thrams, BA
Research Support Coordinator

Jacki Bock
Program Manager, Fiscal and Contractual Manager

Sean A. Bear 1st, BA, CADC, Meskwaki Tribal Nation
Senior Behavioral Health Consultant and Training Coordinator

Jenny Gringer Richards, MSW, LMSW
Evaluation and Curriculum Development Coordinator

Matt Ignacio, Tohono O'odham, MSSW
Senior Behavioral Health Consultant

INTRODUCTION TO THE PROCEEDINGS DOCUMENT

Anne Helene Skistad

Welcome to the second symposium organized by the National American Indian and Alaska Native Addiction Technology Transfer Center (ATTC); *Reclaiming our Roots: Rising from the Ashes of Historical Trauma*. My name is Anne Helene Skinstad, and I direct the National American Indian and Alaska Native ATTC. Our ATTC was awarded the first National Focus Area for American Indian and Alaska Native communities in 2012 from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), an agency within the US Department of Health and Human Services.

Immediately after we were awarded the grant, we started our "year of listening" by traveling to tribal and urban Indian communities across the country. Our goals for this listening tour were to get to know the Native communities and to better understand the training and technical assistance needs of the Native behavioral health workforce. We spent countless days and weeks zigzagging across the country to meet with tribal and urban Indian leaders and stakeholders. Our colleagues expressed a number of pressing needs for training and technical assistance, and we are currently working to respond to these expressed needs. However, the overriding theme was a need to better understand trauma-informed care, and how trauma has short and long-term impact and consequences for both the individual and the Native community.

Historic and generational trauma has affected American Indian and Alaska Native tribal members, their families, and their communities for centuries. We heard many stories of cultural devastation, suppression of cultural ways, and the trauma of being sent to boarding schools. From the time the settlers landed on the shores of New England to the present time, Native communities and people have experienced trauma. Broken promises and treaties from the federal government have also caused widespread trauma for Native people. These traumas and attacks on Native cultural ways of living have had devastating effects on the health and wellbeing of Native people of today.

Our ATTC decided to dedicate a symposium to introducing and discussing various issues of trauma in Indian Country, and the short and long-term consequences of living with traumas, both for the individual and the community. We wanted to make sure we understood how we could be of assistance to Native communities and their behavioral health workforce. In addition, we want to focus on prevention and treatment initiatives on an individual and community level to prevent and alleviate the effect of the trauma on the health and well-being of Native American community members.

However, before we start this very important symposium, I would like to have us begin the day in a good way. We have invited Ms. Shirley Matt to welcome us on behalf of the Gila River tribe and the Native community in the Phoenix area. She will start the day with a blessing.

Shirley Matt, is a member of the LISAC-Confederated Salish/Kootenai Tribes of Montana, and is a licensed substance abuse counselor at the Phoenix Indian Medical Center where she has worked for 40 years. What she wants us to know about her personally is that she loves meeting new friends, learning about other cultures and she enjoys "oldies" (people and music). Shirley is the mother of

two wonderful sons, grandmother of three beautiful granddaughters, and great-grandmother of one great-grandson. Shirley: thank you so much for providing the welcome to the community and the blessing of the day.

Ms. Shirley Matt offers the welcome and the blessing of the day.

Thank you very much, Shirley, for the very beautiful welcome and blessing of the day. Our center really appreciates this.

Before we start the rest of the day, I am delighted to acknowledge that we have about 100 participants in the audience today. I am also very pleased to let the audience here at the Wild Horse Resort and Casino know that we have close to 200 people calling in and listening to this symposium. We have had some technical difficulties streaming these presentations, but we are working on fixing it, so all of you online can hear the presentations.

We are very honored to have two representatives from our funder; The Substance Abuse and Mental Health Services Administration (SAMHSA) who will both offer opening remarks and welcome.

First of all, let me introduce you to Ms. Mirtha Beadle, MPA, who is the Director of the newly established Office of Tribal Affairs and Policy (OTAP) within SAMHSA. OTAP serves as SAMHSA's primary point of contact for tribal nations, tribal organizations, federal departments and agencies, and other governments and agencies on behavioral health issues facing American Indians and Alaska Natives.

Secondly, let me introduce to you Captain Jon Perez, PhD. He is very familiar with the Phoenix Area Indian Health Service, having worked here for many years. Currently, Dr. Perez is SAMHSA's Regional Administrator for Region 9, which serves Arizona, Nevada, California, Hawaii, and the Pacific Islands. It is a huge territory; he also works closely with the local ATTC: Pacific Southwest ATTC. The local ATTC is exhibiting out in the hallway, so please take the time to visit their booth today.

Dr. Perez developed various programs when he was working in IHS and is familiar with disaster response both nationally and internationally, through his diplomacy efforts. He began his disaster relief work in 1989 during the Loma Pietra earthquake in California and has been actively involved in developing and deploying disaster teams domestically and internationally since that time. He has served as a senior liaison officer between coalition forces and the Afghanistan Ministry of Public Health. His domestic deployments include leading health response teams on a range of missions from hurricane response to presidential inaugurations. He has received numerous awards and I just want to highlight one. He received White Eagle Feather in 1999 from the people of White Mountain Apache Tribe for his seven years work with them as a Behavioral Health Director. So please help me welcome Dr. Perez.

WELCOME STATEMENT

Captain Jon Perez, PhD

I hate that bio. I really do. Official biographies make you think, "who is that guy?" Luckily, I am home here and you do know me outside of the bio, so first off it is a pleasure and it is an honor to be home, to be here with all of you.

It is a honor to be back home, an honor to be here, with family. I've got two stories I would like to relay to you. They're both from here and translational, but I hope set a frame for what we are talking about today.

When I was with IHS, I was working in Behavioral Health for several years, and when we work in Indian Country we take the inter-generational issues for granted. By that, I mean it's an integrated part of what we do on a daily basis, the programs we put together, the way we intervene with our patients, with our community, with anyone. And the intergenerational issues are always there in the back of our minds. However, we do not specifically look and think about it in ways that people from outside the community, people that are researching or studying the issue for example, would know about intuitively the way we do. I didn't think about intergenerational issues that much until about ten to fifteen years ago. We were working on water pollution in an urban population and the issue kept coming back and coming back: we've been living with this for a long time. Generations, not a few years. It's like the temporal frames are different, how you frame the difficulties and be able bring people in the community and out of the community to understand what it basically means to have an intergenerational view of the world and your place in it. It became so important, and so important for others to understand if they were to better understand the community they were in.

Some of the suicide prevention programs that we had been doing at IHS all those years ago were designed specifically to bring the traditions and Western medicine together. Now here we are, fifteen years later and we do not talk about it as much directly anymore. However, let me tell you something. About ten days ago, I got an email. "Jon, I don't know if you remember this or not but my name is _____ and we worked together _____ (years ago)." And the work was in a program we put together in Central Eastern Arizona to get kids who were either at risk of harm, or could benefit from re-connection with some of their tribal traditions as part of their healthy development. It turns out that the person writing to me is one of those people in that program. She started as client in the program, and ended up being a guide for the program. We worked together for several years. She wrote me to say "I'm a doctor now." I am thinking, "No…no way. This is…she was only this old when she started. By the time I left she was this old. And now she is a doctor? Yeah. Yeah, she is a doctor." Think about that as we think about our communities. This is a young woman now who was a young girl at the time we began. And she could have developed in many different ways, some more positive - or dangerous - than others. Now, here we are, fifteen years later, and she is a doctor. And she is writing to ask me where she could go to look for employment with the Indian community.

The second story is really much more my own. Walking in here is like coming home. It is a family reunion. Reconnecting with the people that we started to work with twenty years ago on programs

that people outside the community could not then understand. There was very little concrete information to help guide us in the programs. Now here we are many, many years later and the programs have actually been happening. Take a look at the people on the panel. Twenty years ago, we would not see a Native face among the national experts represented. Now it is the norm. So as you listen to this, think about the hope that drives health and healing, think about what we do now that integrates culture and life-ways, where we draw strength from; and especially where we have come from and where we are now going. It is remarkable and very powerful.

It is my honor to introduce my colleague; Mirtha R. Beadle, Director of the newly opened Office of Tribal Affair and Policy (OTAP) within the Office of Policy, Planning and Innovations in SAMHSA. Ms. Beadle emigrated from Cuba at a young age and holds a Master of Public Administration from Western Michigan University and a Bachelor of Science in Management Systems from the College of Technology at Andrews University. The new OTAP serves as SAMHSA's primary point of contact for tribal nations, tribal organizations, federal departments and agencies, and other governments and agencies on behavioral health issues facing American Indians and Alaska Natives. This office was opened just months before this symposium and our center featured the office in our most recent newsletter. Opening this office shows a strong commitment from SAMHSA's side towards tribal prevention and treatment programs. Being able to coordinate the different programs within SAMHSA and staff working on AI & AN issues enhances our collaborative efforts and reduces duplication of efforts as well.

Please help me welcome Ms. Mirtha Beadle.

WELCOME STATEMENT

Mirtha Beadle, MHA

Good morning. It is such a pleasure to be here with you! Thank you, Jon, for a great introduction. I am honored to work with you and appreciate your making me feel welcomed to Region 10.

I bring all of you a welcome from SAMHSA Administrator Pamela Hyde. If she could have been here herself, she would have been. Pam is as committed and motivated to working on American Indian and Alaska Native issues as everyone in the audience. I am fortunate that she asked me to work on improving the behavioral health of Native communities and will always thank her for the opportunity. I would also like to thank Anne Helene. She has been remarkable in pulling together and hosting this important symposium, as she always does. I also want to thank her team for the depth and quality of work they do every day.

Jon introduced the Office of Tribal Affairs and Policy. I'm going to add a bit more and talk about why I am standing before you today. I think most of you know this, but last summer (2014) President Obama visited the Standing Rock Sioux Nation and had an opportunity to meet with young people. When he came back to the White House he talked to his staff and told them that he wanted to make a difference. Not a difference in two years or ten years, but during his administration.

That conversation trickled down to federal agencies and contributed in part to the creation of the Office of Tribal Affairs and Policy. Just like every federal agency we have an acronym — so if you hear OTAP, that's who we are, the Office of Tribal Affairs and Policy. There is a lot of activity at SAMHSA around tribal issues that will now benefit from greater coordination. It was difficult to assess the impact of individual activities and now there is a focal point for coordinating tribal behavioral health efforts. You now have a place to call. You now have an advocate who is going to work for you and your communities. Pam established, about a year and a half ago, a work group called the SAMHSA American Indian and Alaska Native Team — or SAIANT. Members of SAIANT are managers, government project officers, and others who work on Native American issues. Establishing SAIANT motivated us to talk and work together. I can tell you, one action has already resulted in improvements. I'll give you an example.

Since SAIANT has been established, SAMHSA funding to tribes has increased. Why? Because the voices of SAIANT are elevating the issues being faced by tribal communities, it is making clear that behavioral health issues for tribal communities are significant and ought to be supported, not just as a by-product, but clearly supported as an integral part of our work. We're trying to simplify the way that our grant programs are announced to minimize the burden. The point I'm trying to make is that there is a reason why OTAP is here and efforts to reach out to you is purposeful.

There is another reason why it was important to be here today. I'm reminded every day that working on tribal issues is "heart" work not "hard" work. At times, it's hard to assess the direct impact of policy work on the lives of people. But, working on tribal issues the connection is clear and it is

palpable. It makes the work that we do in Washington DC all the more important and the approach we take must be done in partnership with tribal communities. It's not just about what can be done quickly. It's about the significance of the work we're doing and how it may impact Indian children, youth, elders, families, and communities. So it is a pleasure to be a part of the heart work that is taking place at this symposium today.

I'd like to address three questions and then sit down so the real conversation can begin. My questions are, "what is a symposium, really?" The second question is, "how will the conversation today contribute to larger national policies on the various topics being covered?" And finally, "what do the first two questions mean to each of you?" Not one of you can escape the challenge. What does it mean to you?

Historical trauma is not new. There have been ever-growing conversations about the impact of historical trauma and the relationship to the behavioral health of Native American communities. There was a recent Senate Committee on Indian Affairs hearing and round table discussion of concerned citizens that addressed trauma in Native American communities. The conversations are growing and there are deeper discussions about how historical trauma should be addressed. I will take back what I hear today.

How many of you are familiar with the HHS Secretary's Tribal Advisory Committee? I saw a couple of hands, and I hope that more of you will start learning about what the HHS Secretary's Tribal Advisory Committee is doing on your behalf in Washington DC. Every quarter of the year, tribal leaders come to DC, meet with HHS executives, and have an opportunity to talk with the secretary about issues that are of import to them.

In December, tribal leaders spoke with the secretary about historical trauma in a different way. Tribal leader requests, and the secretary's responsiveness to their requests elevate issues for action. What tribal leaders said in December is that they are tired of addressing the symptoms of historical trauma and there is a need to focus on the root causes. The conversation that you are having here today will inform what we do over the coming year, two years, and over time.

A session for the SAMHSA Administrator and Principal Deputy Administrator on historical trauma is already planned for an upcoming meeting of the secretary's Tribal Advisory Committee. My point is that the pulse of the discussion on historical trauma is building. So what you do here today is going to inform what happens over the next many months. I'm here to listen, to hear your points of view, and take information back. This is not just a pleasant trip, but an opportunity to hear from all of you.

One final point and then I'll sit down. The conversation about historical trauma isn't an isolated discussion. We have talked with SAMHSA's Tribal Technical Advisory Committee, comprised of tribal leaders about developing what we are calling the National Tribal Behavioral Health Agenda (TBHA). I don't currently have a lot of the specifics about the TBHA. We are working in collaboration with tribes, tribal leaders, and IHS on what the TBHA will contain. The message is that tribal leaders want to elevate and change the discourse at a national level on tribal behavioral health. While every tribe has its creation story, culture, and teachings, there are enough commonalities among tribes and how Indian people view life, health, and well-being that this is

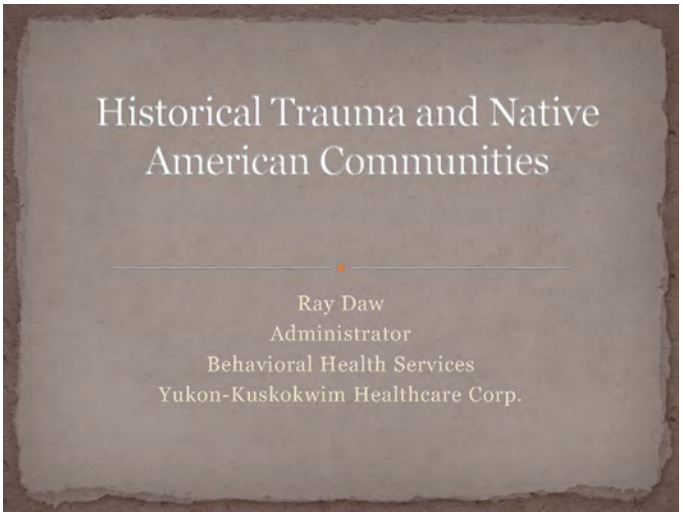
an opportunity to come together across commonalities. The TBHA is not about federal agencies working in isolation, but rather the federal government and federal partners, in concert with tribes, working together to make a more meaningful difference in the lives of tribal communities.

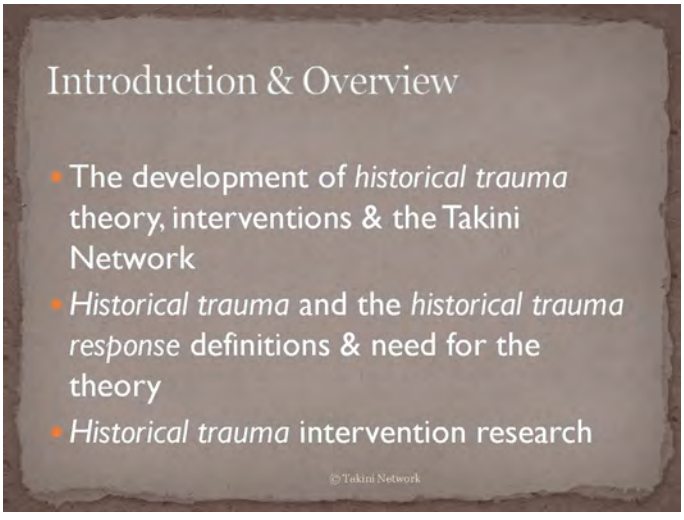
The challenge to each of you today is: when you go home, let your tribal leaders know that you were here. Let them know that the symposium focused on historical trauma. Let them know that there is a purposeful conversation between tribes and federal agencies about trauma. They need to be part of that conversation. You also need to let them know about SAMHSA and the Office of Tribal Affairs and Policy and the fact that we are here because of you. Help them become involved in the dialog about the Tribal Behavioral Health Agenda. Federal agencies want to build their trust relationship with Native communities. We want to be held accountable for working with tribes. So please go back home and have the conversations that are being furthered by your participation in this symposium.

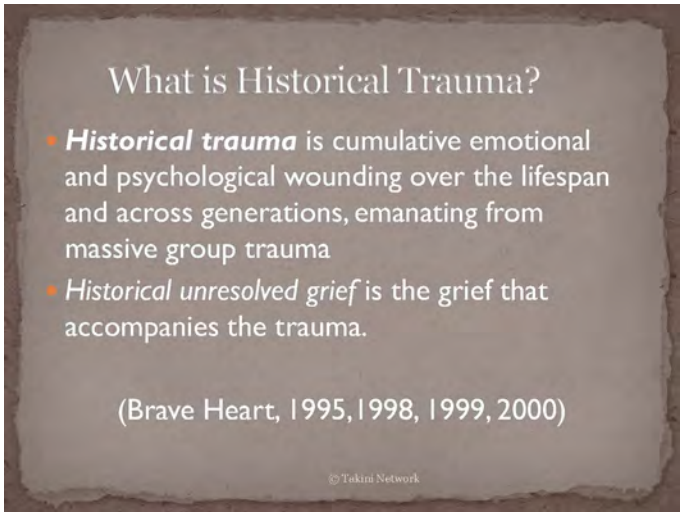
I am deeply honored to be here and look forward to hearing from you on these important issues. Thank you very much.

HISTORICAL TRAUMA and NATIVE AMERICAN COMMUNITIES

Ray Daw, MA, Navajo

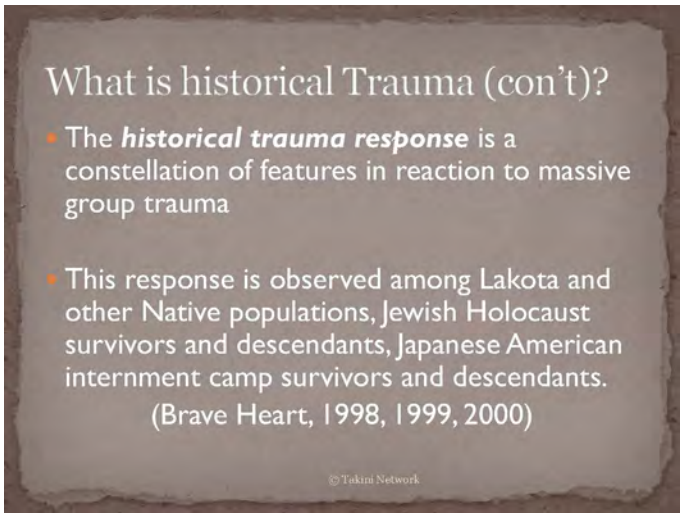






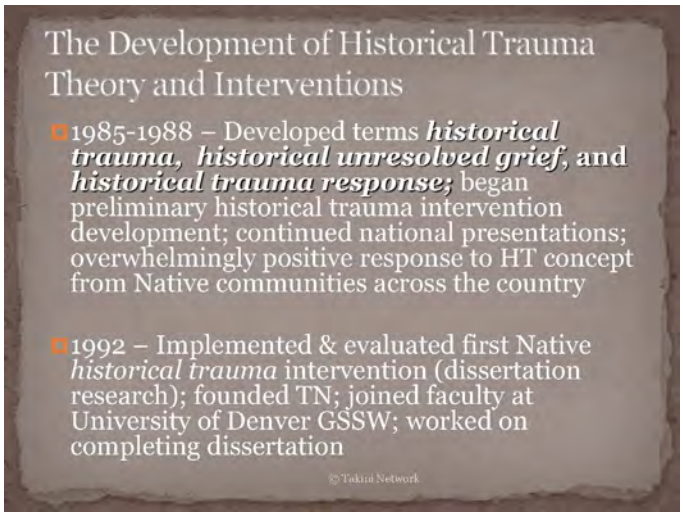
Historical trauma is what we accumulate in our lives individually, in the lives of our families, and in the lives of our communities. We accumulate emotional reactions to the things that have touched our hearts and psychological wounding: how we think over time, over the lifespan of other individuals, the lifespan of our families, and the lifespan of our communities. Think about that. In our communities, we tend to think of them really narrowly now, and that's a reflection of the impact of colonization. Often times we think of our communities in terms of our reservations' histories. That's not our history. Our history goes back thousands and thousands and thousands of years. That's our history. So when we look for solutions and ideas and an understanding of how our lives got this way, one of the important things to do, we believe, is to go back into our histories and our experiences with colonization. And more and more reading and research and thinking among indigenous people across the world are coming to the similar kind of conclusion I've given you today. These conclusions are the cumulative emotional and psychological wounding of colonization, and what this does is create massive trauma *(Brave Heart, 1998, 1999, 2003)*.

There is total unresolved grief or grief that accompanies the trauma *(Brave Heart, 1998, 1999, 2003)*. When we are hurt, our emotional and psychological reaction is to grieve that wound, that pain. Think about that: how the pain is going to change us or totally not change us. There's grief attached to wounds and pain. And many of our people, a large majority of our people, are able to manage to live through the wounding and resolve the grief. Many of our people are like that; many of you are like that. A segment of our population really struggles with understanding how their traumas are affecting their lives. Those of us who seek to understand and help look from a trauma perspective want to create potential changes. That results in a historical trauma response which is composed of reactions and features that show up sometimes really clearly and sometimes not too clearly. But we have reactions to this trauma. Individually, as a family, as a community.

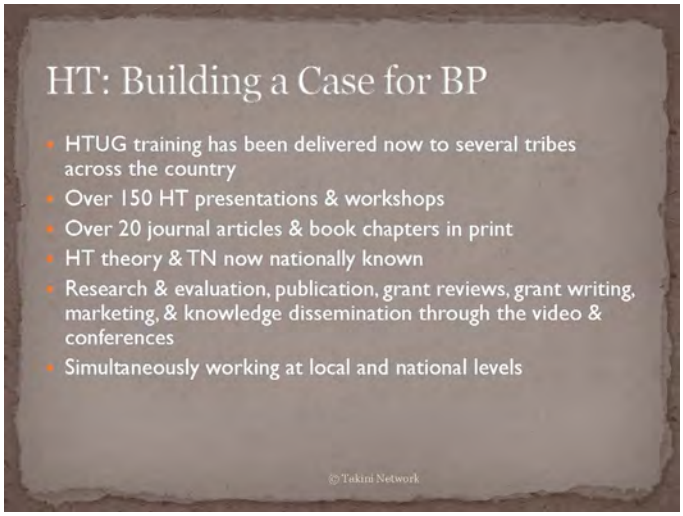


Dr. Brave Heart did early work on this sequence of events and noted the historical trauma response among her people, the Lakota people, among other Native populations; the Jewish Holocaust survivors; the descendants of Japanese American people. And that's when she began to figure a way to describe what she was noting in a clear concept. That's when the idea of historical trauma was proposed, that's when she came up the theory of historical trauma response.

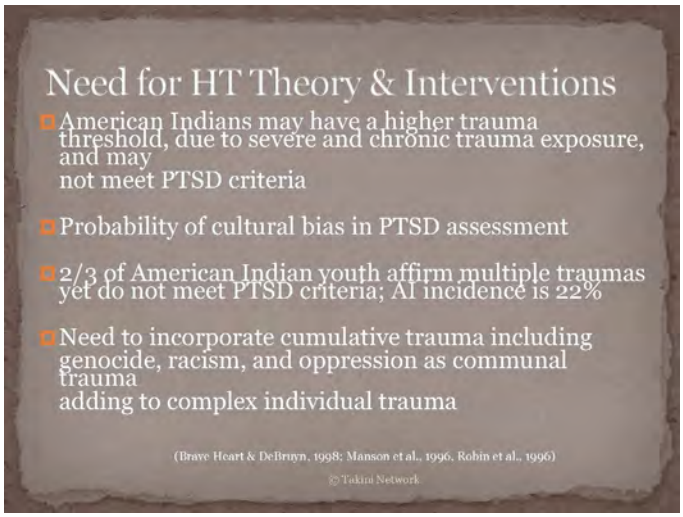
The concept of historical trauma developed from Dr. Brave Heart's research on the Lakota people's historical trauma response. In 1992, Dr. Braveheart implemented the Native American historical trauma intervention and formed a support group of allies and friends, advocates and learners, people she could talk with and called it the Tahini Network. In 23 years we've gone from an idea to what is now generally accepted as a valid concept: historical trauma. I want to mention that Dr. Brave Heart hoped to be here with you today, giving this talk that I'm giving, but her schedule and demands on her time kept her from joining us. That would have been a pleasure. So, twenty-three years ago Dr. Brave Heart began working on how to build a case for this idea that she had, that historical trauma exists among Native people. And what she began doing through the Tahini Network and other folks, she began doing what we're doing today; she began doing presentations and workshops.



And she began writing, rather prolifically, about trauma and her understanding about how it's appearing among our people. And what we have today is a historical trauma theory that is internationally known, even in Washington. I believe that these discussions are critical. And when I go into a Native community I look at it through a historical trauma lens. And that is how a behavioral health manager and administrator has gotten to work on facilitating more positive work on trauma in many communities.



It is well accepted that Native Americans have a higher trauma threshold than others. Because we are born into highly stressed communities and often highly stressed families, we end up becoming fairly responsive and able to cope pretty well with the trauma and stress that exists normally in many, many Native communities. Many of us are very adaptive. Some folks, including some of our relatives, have a harder time with the chronic trauma exposure that our people experience. And they're the ones that end up killing themselves, hurting or killing another, becoming drug or alcohol dependent,

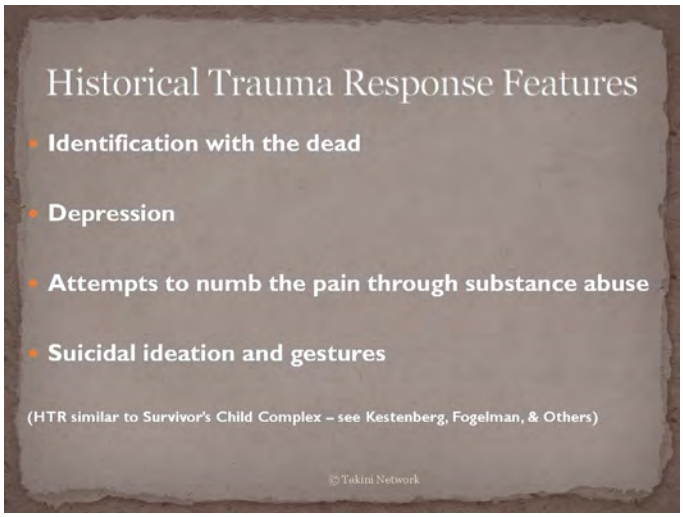


or having negative lifestyles that further impact their quality of life. We also understand that the approaches toward understanding PTSD are not effectively designed to meet the needs of indigenous communities, and so we have to work at understanding our traumas quite a bit differently. We also understand that two of every three Native Americans affirm that they have had multiple traumas in their lives. Who in this room has not had a trauma experience in the last five years, raise your hand? We all have these kinds of trauma.

Young people often suffer the most from stress and trauma because they don't have skills or abilities to resolve the trauma that they experience early in life, particularly in families that are further removed from culturally understanding the trauma in their lives. Compounding this are the problems related to genocide, racism, oppression, and communal trauma.

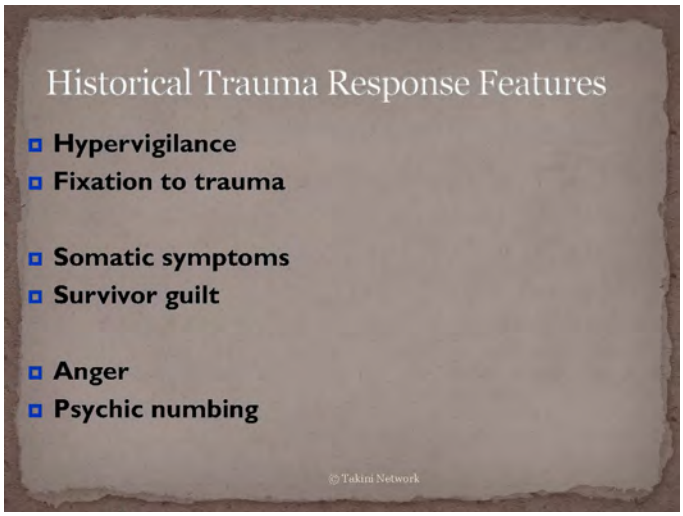
Unfortunately, this one Native community has experienced racism in a public setting. And that's not talked about. The impact of racism on young kids and how it can sometimes trigger the self-destructive behaviors that we are now seeing in some communities is hard to ignore. In response, we often look at what's wrong with the individual instead of what's wrong within the context of the community.

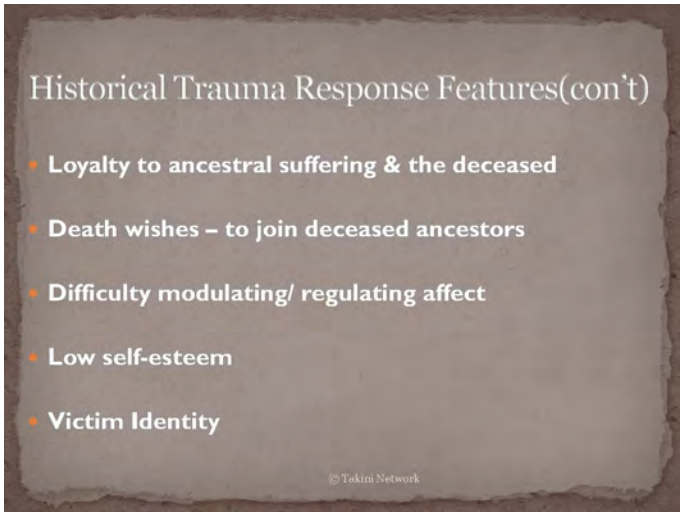
We hear this often in our work in preserving lives or keeping our people from killing themselves by what was earlier referred to as suicide. I'm one of those who doesn't enjoy using the word suicide. I believe that this behavior is what we're wanting to change, which is our people killing themselves. Our people should be protective of their bodies. One of the features of people who begin to think about taking their lives is identifying with others in their personal life or family life who have already passed on. We tend to think the major problem is about our feeling bad about ourselves; thinking bad about our lives. There's more research coming out that Dr. Walker and I and a number of others have pursued suggesting that nutrition is one of the major drivers in how depression is appearing in our tribal communities.



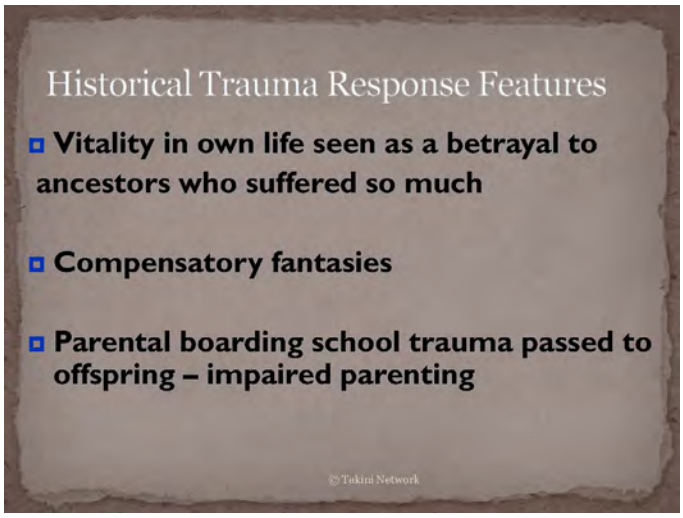
Depression is important. When we feel crappy, we're going to do something to not feel so crappy. One of those things is to start drinking coffee, right? Energy drinks. Or start taking alcohol or drugs. That's how we start to feel better physically, let alone emotionally and mentally. But we're feeling crappy because of what's going on around us, and we start doing it a lot more frequently, a lot more consistently. And we end up being dependent. That's how we tend to numb the pain. And as we begin to realize that how we're managing our pain isn't quite effective, we feel really bad about ourselves. And we begin to think, why am I living? And some of our young, some of our males, especially young teens, think about taking their lives and some do end up killing themselves.

Some other features of historical trauma: hyper-vigilance, maintaining extraordinary alertness. In our tribal histories many of our elders taught us always be alert to our environment, always be aware. Hyper-vigilance is a product of that teaching. It means being aware fearfully and being fixated on trauma. Now one of the features of the Euro/ American culture is the concept of visualization. I am a victim, and I have this trauma and I can't let it go. And I won't let it go. Our elders didn't live their lives that way. We also begin to experience physical problems when we have chronic, traumatic experiences with which we begin to associate trauma. We begin to get sick a lot more often, our bodies begin to wear down when we have these experiences, our tendency is to develop cancers, our brain begins to start slowing down. You know the problems are symptomatic, physical, we can begin to have guilt about being the ones that lived through the traumatic experience. That's very common among our veterans in the military: survivor guilt. Anger is a really bad problem associated with historical trauma. One of the things we do work on when we do this sort of trauma work is to work on letting go of the anger.





Other responses, including loyalty to death wishes, difficulty regulating our emotions or affect, and low self-esteem are major problems, as is identifying with other victims or over-identification.

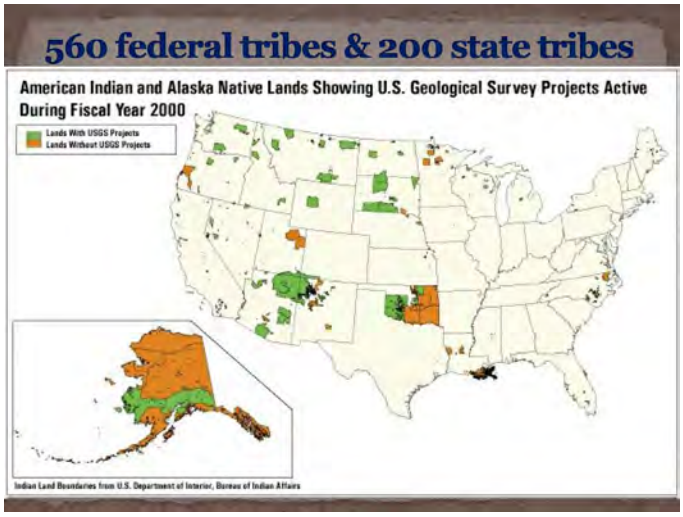


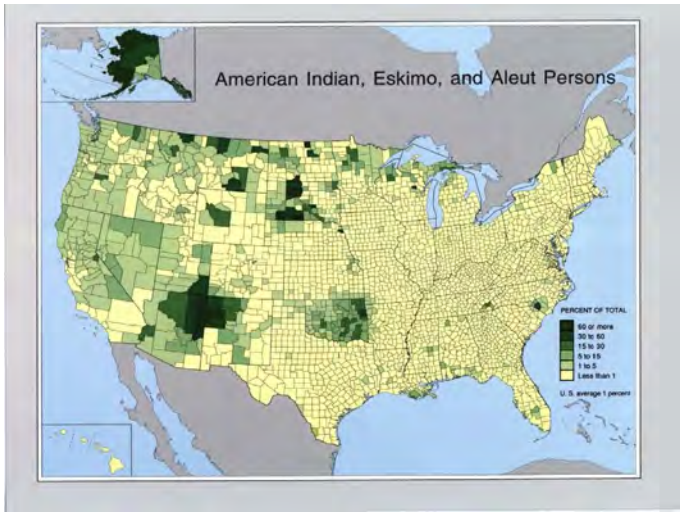
We've really become alert to other features of historical trauma and we have begun to look at our lives not following the ways of our ancestors. Our ancestors suffered a lot more than we ever did. And we tend to forget our reflections about that. None of us has been forced to live in internment, or experienced hunger for days and days, as our ancestors did. We have also begun to develop fantasies about how life should be, whether it be really good or really bad, these tend to be unrealistic fantasies. We also know that consequences of the trauma of boarding school permeated our land from the lower 48, to Canada, and up through Alaska. They, really affected us individually, as well as our families. As we begin to develop better understanding of those traumatic circumstances, we need stronger approaches to dealing with them.

So that is part of the historical trauma model. What I'm now going to do is describe the four parts of the historical trauma model that are often not talked about. We do have a process for intervention in historical trauma. A major feature of Dr. Brave Heart's work is this four-tier historical trauma intervention. One of my disappointments about discussions of historical trauma is too much discussion about confronting the trauma. But that's just part of the intervention. There are three other parts of the historical trauma model that are important to understand. What is that trauma doing to us? The third part of historical trauma intervention is beginning to release that pain, so it doesn't affect our lives physically, mentally, emotionally, and spiritually. And from that comes the last part of the intervention, transcending trauma. How do we know when we're transcending historical trauma? Being happy with ourselves, being happy with who we are, being happy with our families, and being happy with our communities; wanting to create changes within that context. These are the four parts of the historical trauma intervention and I'll go through them carefully with you *(Brave Heart, 1998, 1999, 2003)*.

We tend to think of Native Americans as living within these federal lands. Five-hundred and sixty tribes are all on reservations. And we tend to think that life is all reservation-centric. But actually it looks more like this. This is where we are. We're not reservation bound anymore like our ancestors were. One hundred years ago, it wouldn't have been possible for me to leave the reservation and work and live somewhere else. Today it's possible. And for many of us, that's possible. Right?

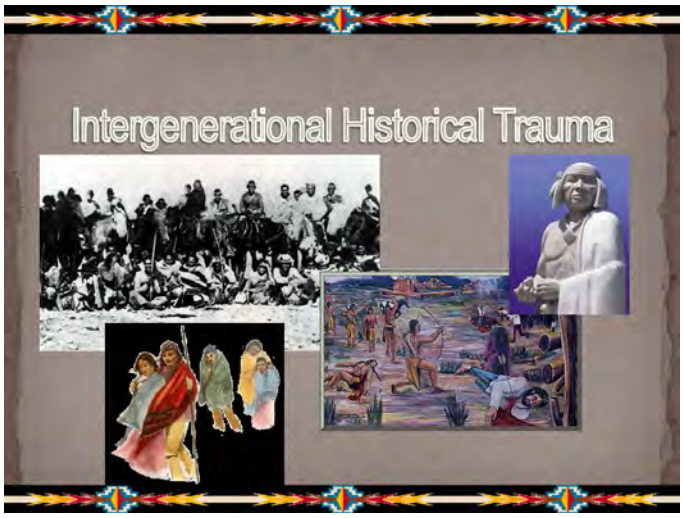
Over 70% of our people live off reservation. That has some compounding effects on how we work and understand historical trauma. And our understandings are modern reservation-centric.

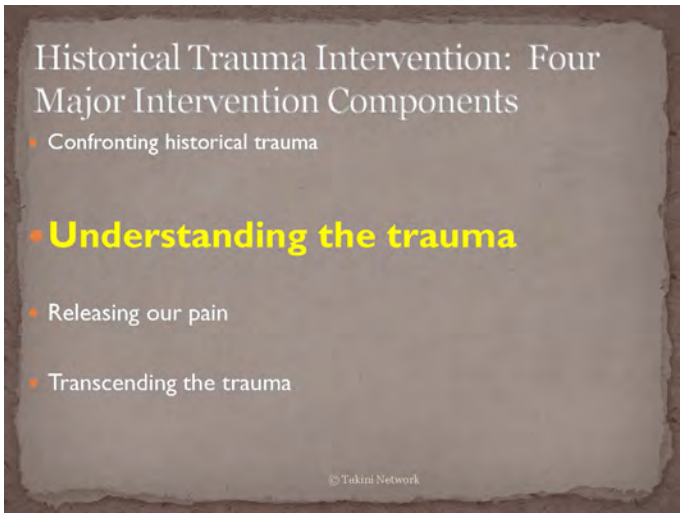


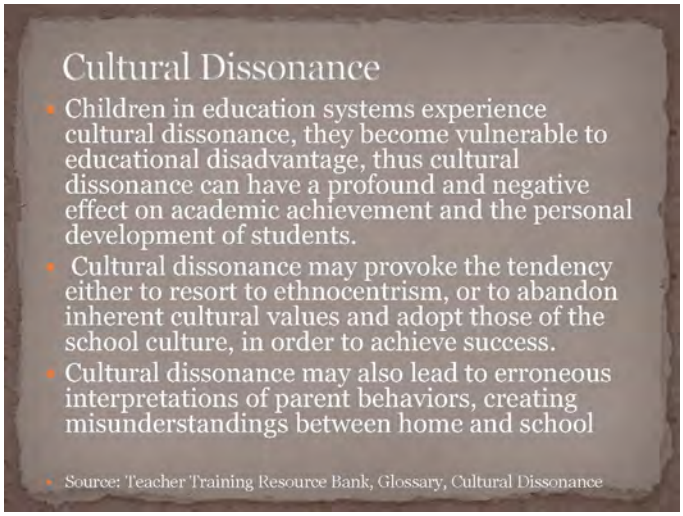


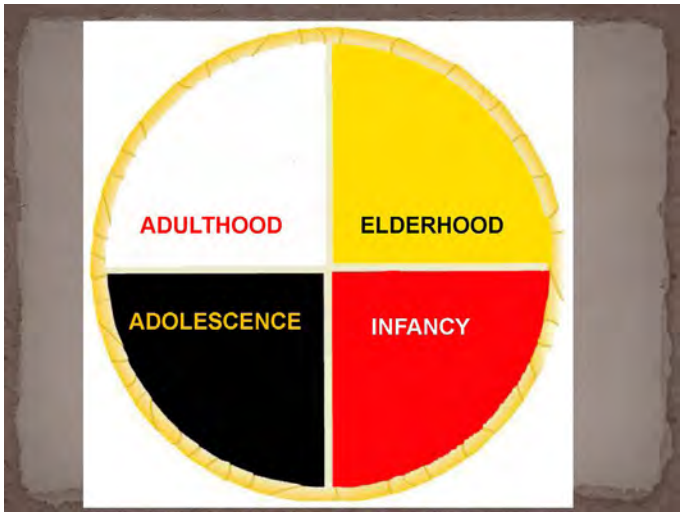
Some major traumatic events in our histories are really common. Colonization. It's not about people coming in and peacefully settling on Native land, nicely immigrating into our land, it's about colonization. It's about many of our tribes being forced out or killed to make room for colonization. It's about tribes being imprisoned, whole tribes being imprisoned, and that's what the reservations are: prisons. Our way of civilization, developed over 20, 30, 40 thousand years, being compressed. And our ways, the ways our ancestors practiced simple living. And what of our languages? We were stripped of our identities as Navajo, Yupik, Mohave. All of this was done for us so we would begin to look at ourselves as brown Europeans. That's hard to do. Governmental institutions told us, "We will do this, we will do that; we will educate your children, we will give you food so you won't starve." And they made our community leaders dependent on these systems. And today we are left with a lot of dependency that impacts our work in historical trauma. It occurs in many settings and all 560 tribes in the United States and First Nations people in Canada.

And that's the product of historical trauma, really taking a good look at our history. And saying yes, this is what occurred. Yes, this is how I understand my people, my family, and my community. It's how I understand how I am; how I am today. So confronting that trauma is really cheap. I am disappointed in how historical trauma is talked about these days; it is a fixation on these traumas. Historical trauma isn't about those bad things that happened: it's about understanding how they affect us today. How does it affect Ray Daw, how does it affect my children, my grandchildren? How does it affect my community? How does it affect my people? How does it affect people I love? And that's what we give them. They can take a good look at the big part of historical trauma intervention because they understand the impact.



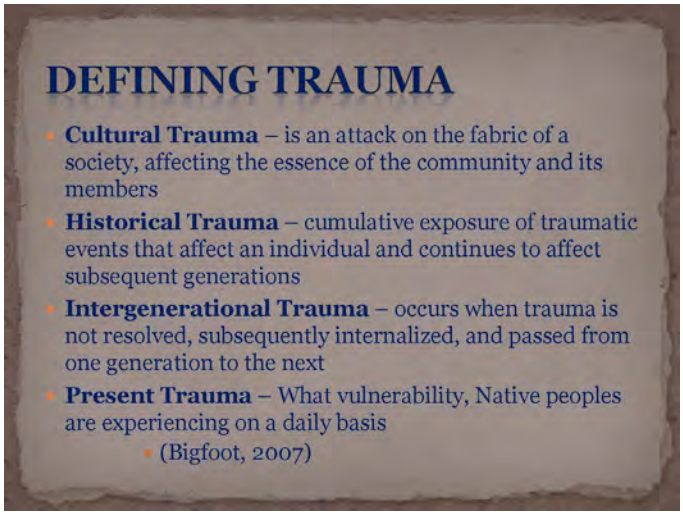




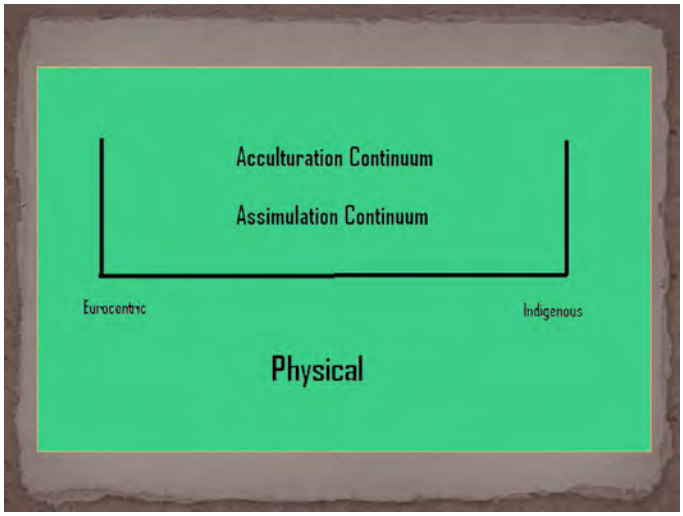


It's important to understand that there are different kinds of trauma.

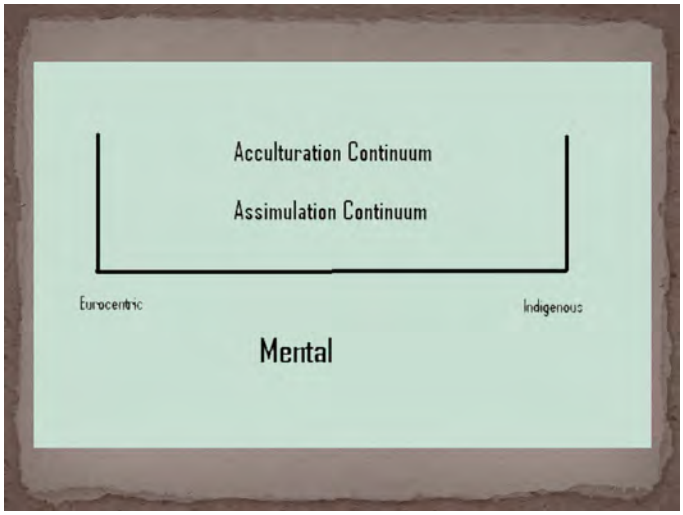
There's cultural trauma, historical trauma, intergenerational trauma, as well as trauma we're experiencing today. Dee BigFoot is a really good teacher and writer on this issue. How does that trauma affect us culturally?



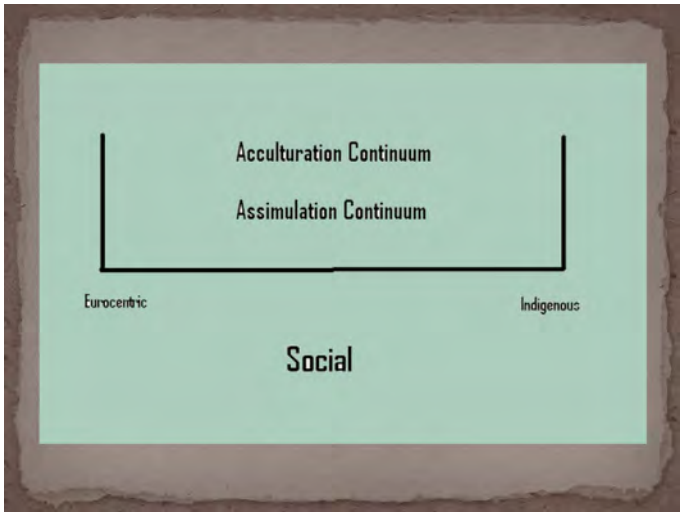
How did we assimilate to this life as it exists today? Because our people were forced to do so, they went from looking one way to looking another way.



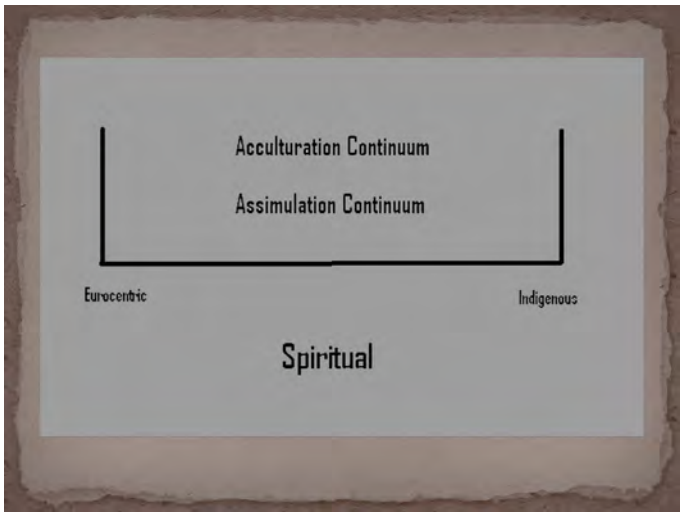
How did the acculturation and assimilation processes affect us mentally? Particularly, mentally, which has been taught to us for generations. I now accept that this belief isn't true. How did those acculturation and assimilation processes that we deal with as Native people affect us socially? This one question helps us get a stronger understanding.

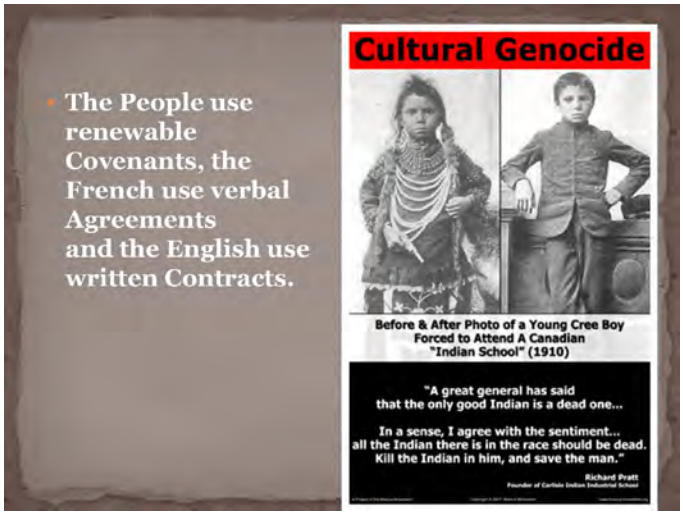


Because our social interactions are really limited nowadays, our social interactions are a lot more isolated than they were before colonization. Our people really interacted with each other then. Tribes did as well. There was a lot more sharing.

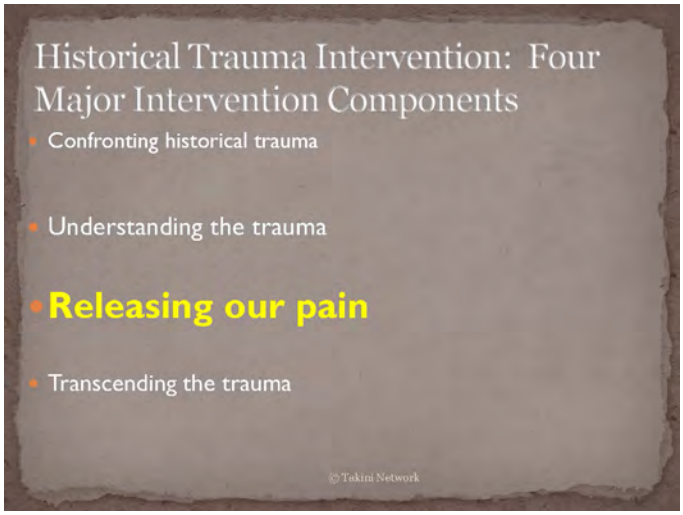


And how did that acculturation and assimilation affect us spiritually? We were once forced to be Christian, many of us are choosing to be Christian, and many of us are choosing to go back to our traditional ways. So a blessing, or prayer, honoring them.



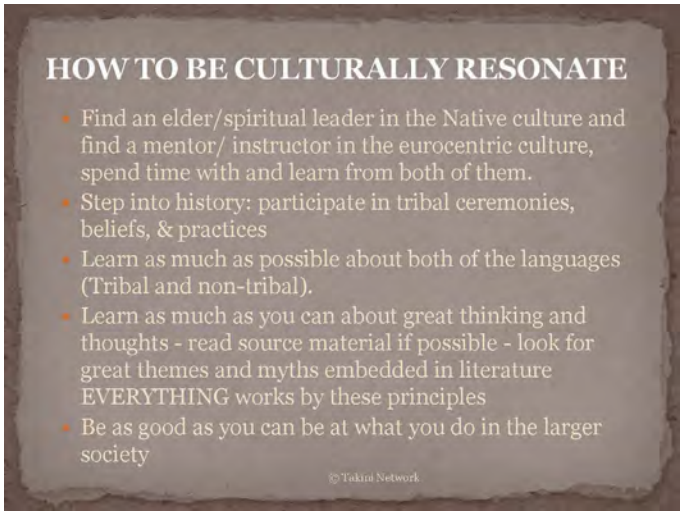


The third part of the historical trauma intervention is releasing that pain.



One of the things that happens when we see how colonization has affected us is that we begin to see how we relate to it, and look hard to understand our anger a lot more. And none of us wants to be angry still.

We have begun to work on ways to release that anger, And for years and years, what has happened as Dr. Perez mentioned: How have European ways been applied to our people – and failed? The consequence of our trying to take on Euro/American ways of behavioral health has been an increase in sickness, right? It's taken us quite a while to realize it wasn't a good path. As a result, we begin to understand the idea of being more culturally resonant. How do I talk to elders who only speak Navajo? How do I talk to a young person who has adopted ways of living that are different from mine? How do I go to Yupik country and understand their ways of living so I can be a more effective behavioral health manager? In those ways we become culturally aware and resonant.

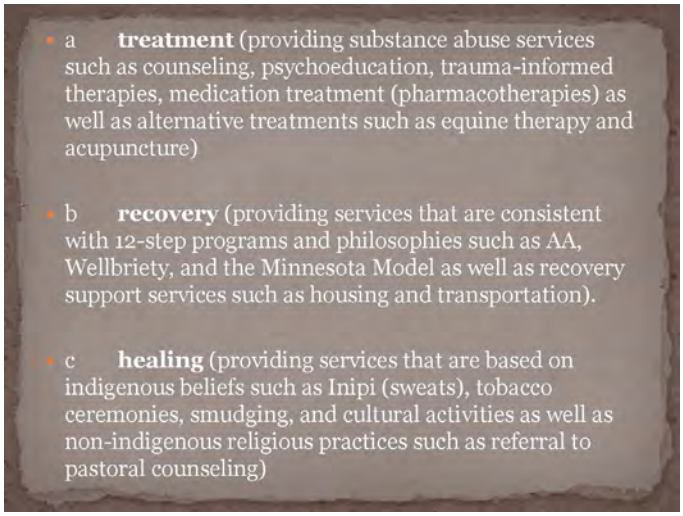


The American system of professions, you know that doesn't work.

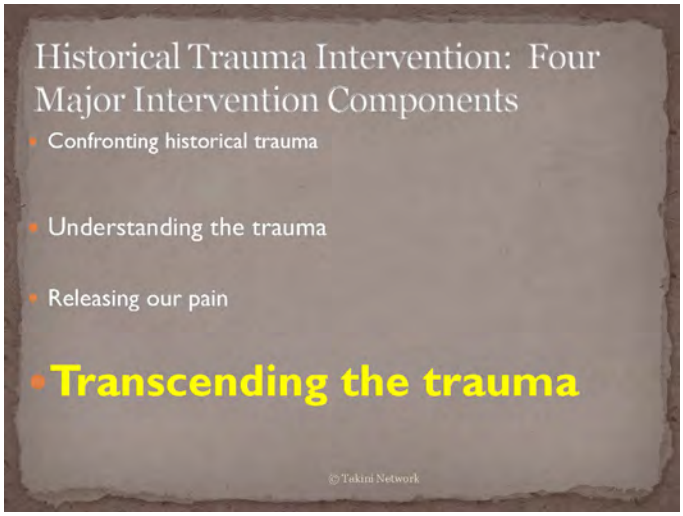
Many of our tribal communities sustain different types of healthy men or different types of healthy healing, and this is characteristic of Navajo country as well. These are things we need to understand.

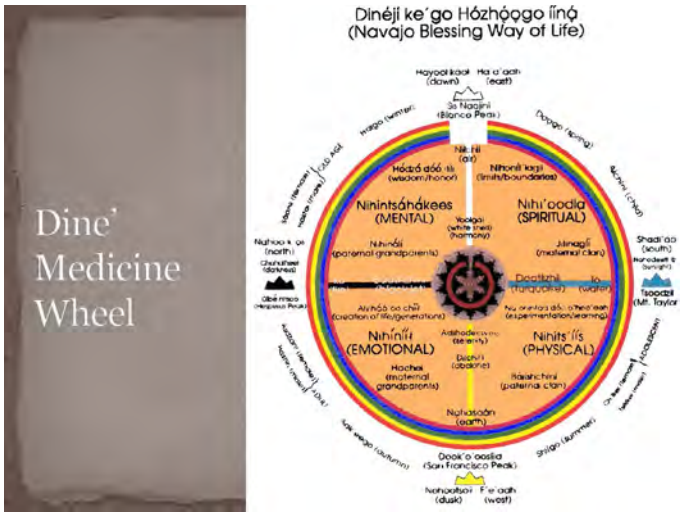
In the American system, there are a little over 300 different ways of therapy. As a physician I have a big bag that I can choose from, but a lot of them don't apply. The Native way is king of these ways of helping people.

The American system, particularly in ways of behavioral health, focuses on treatment, recovery, and healing. The three are not the same thing. Treatment ways are different from recovery ways are different from healing ways. They're not the same. There are some Native Americans who respond to treatment, but don't respond to healing ways. There are many Native Americans who are more responsive to healing ways than to treatment.

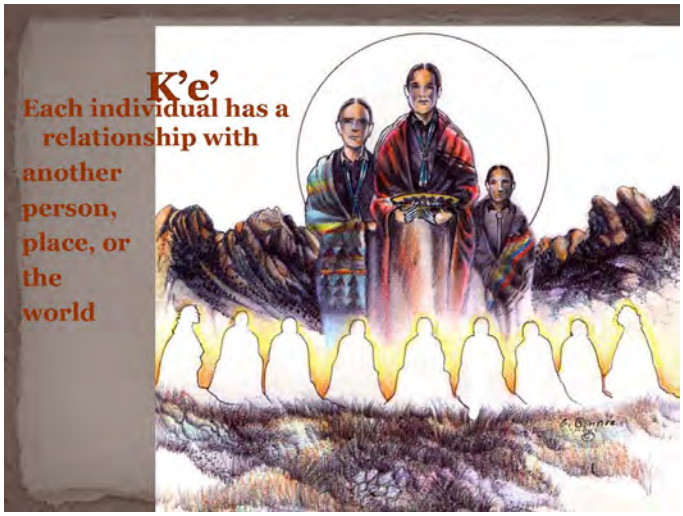


The final part of the intervention model for historical trauma is transcending the pain, feeling good about our families, our communities, and our lives, and keeping things that way. Among our people, my people, we have a world view that is really remarkable. I went over to the San Francisco peak in Flagstaff. It moved me to see our sacred mountain. I'm a child of the sacred mountain. I am the grandchild of the sacred mountain. That is who I am, that is what I am, and that is the traditional teaching for Navajo people. I am a child of water, I am a child of dawn, I am a child of darkness.

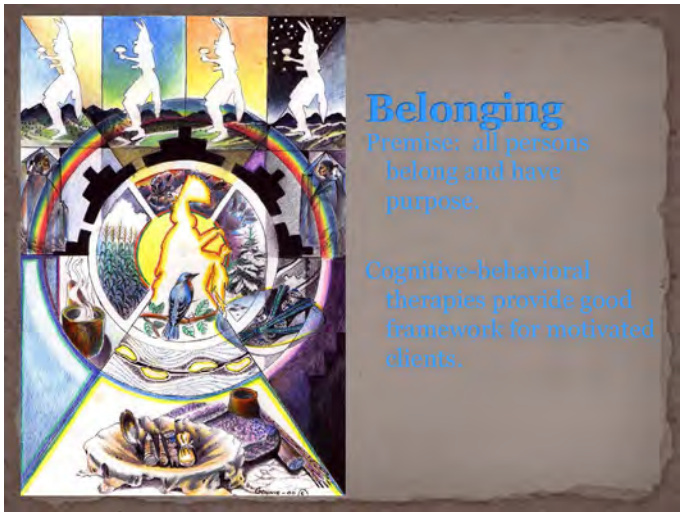




And I have relationships with each of those things, as well as relationships with family and relatives.

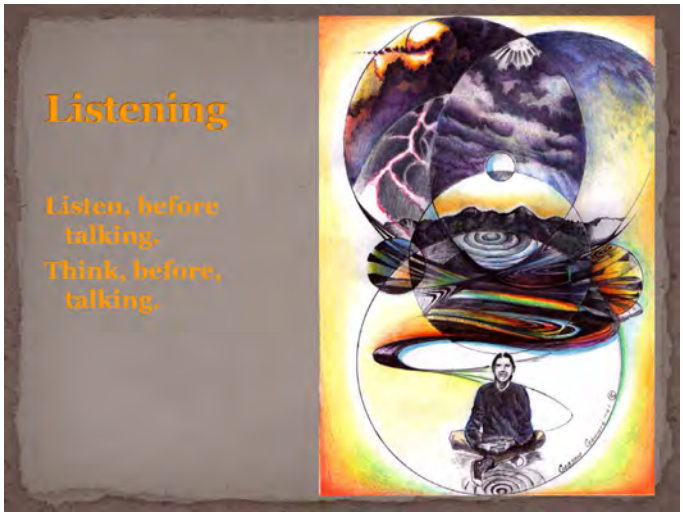


And I belong here, on this earth. I belong. Because I belong, and I care about my relationships, and I am a child of so many good things in life, I can take on these traumas that are affecting me.

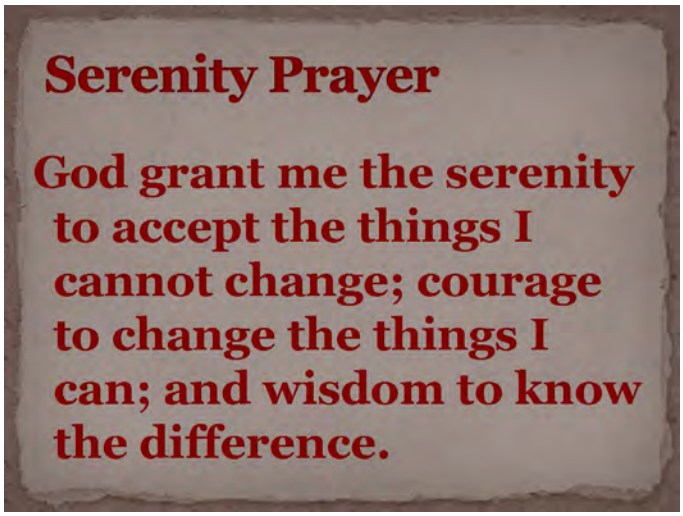


I do it fearlessly, like a grandmother here is doing.

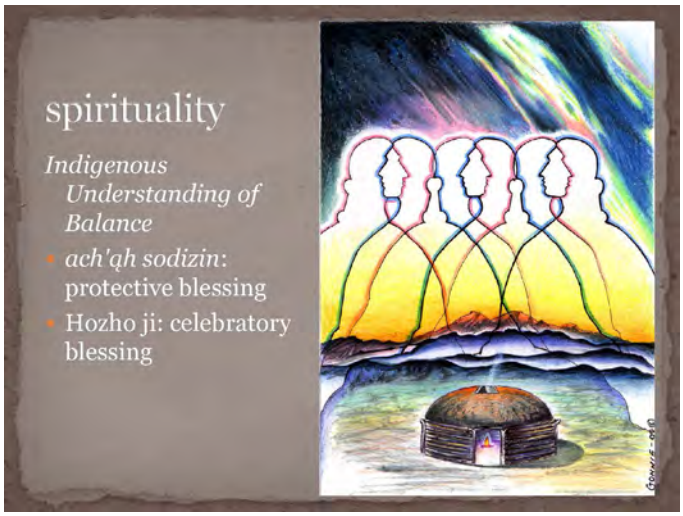
Because we learn, we become good listeners. Our elders taught us to always learn and listen.



Our healing perspective is centered in prayer; I'm not the recovery person. I am describing a very basic indigenous kind of way. With it comes spirituality. Our relationship to everything.



And coming at that with balance, no matter where we are.



But in the end, it's about our children and, for some of us, our grandchildren.

Thank you for your time. We have had some really good presenters, we have a Facebook page on historical trauma, we have a website on historical trauma where we try to work on teachings, and we ask you to keep them carefully. Thank you for joining us today and honoring us with your presence.

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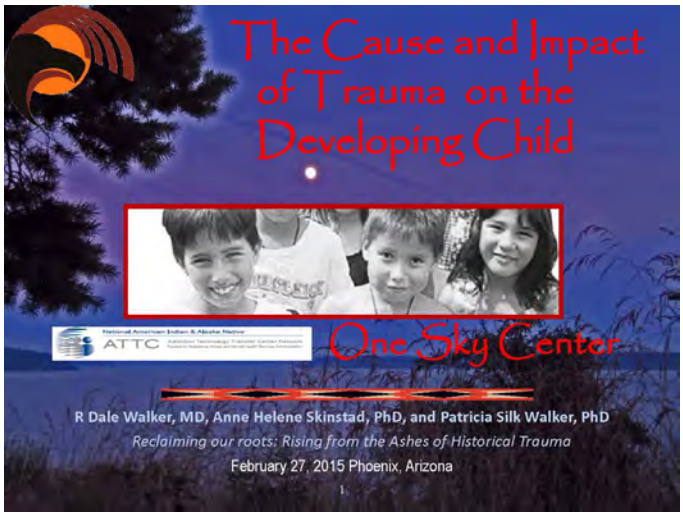
THE CAUSE and IMPACT of TRAUMA on the DEVELOPING CHILD

R· Dale Walker, MD, Cherokee



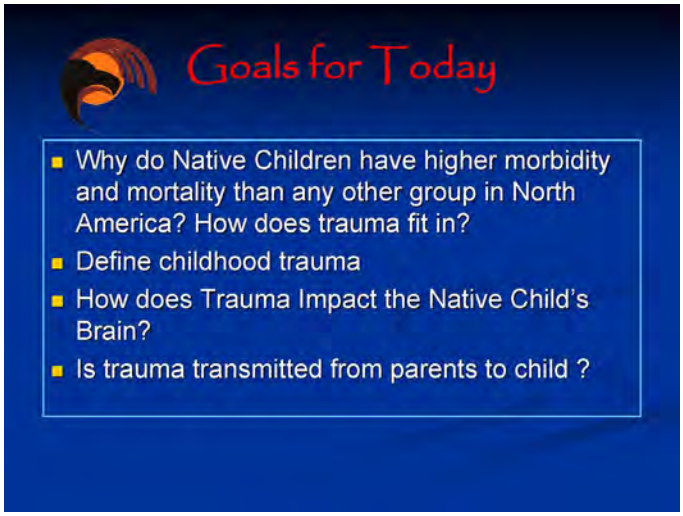
I will present today neuroscientific knowledge and information on the topic of historical trauma. First, I'd like to introduce myself. You've heard that I'm Cherokee and I've been doing work in Indian country now for about 40-45 years. It's interesting to try to think through, as a Cherokee person, what the medical aspects of trauma are and share those thoughts with you. I'm going to talk about the cause and impact of trauma on the developing child. I suppose I should first share a little information on it because, as you heard, there are different types of trauma and those differences are important. I'll try to examine differences between contemporary trauma and historical trauma.

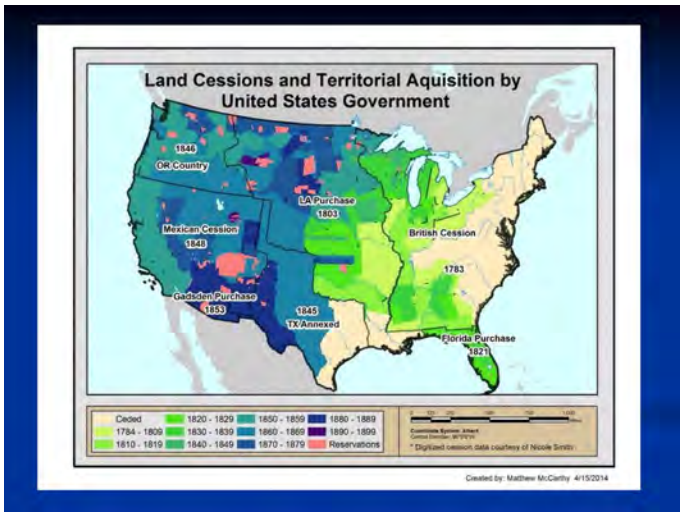
By the way, how many people here are Natives, raise your hand to help me. OK, thank you. You know, historical trauma isn't unique to American Indians. Historical trauma follows everybody in this room. We've all had in our genetics and in our history traumatic events, episodes, and parts of our lives that have been lasting. And we've learned to deal with that. I want to give that as an optimistic point. But while events happen and historical trauma occurs, people get better. There are ways and mechanisms we can use, biologically, and therapeutically, and culturally; and that's, in part, what my presentation will be discussing and reviewing today.

The goal I have today is to answer these questions: why do Native children have higher morbidity and mortality than any other group, and how does trauma fit into that problem? How do we define childhood trauma? How does trauma impact the Native child's brain? And is trauma transmitted from parent to child? There's evidence about that that I want to share with you that makes me think we have good ideas for the future about how to deal with this problem.

If we look at where Native people were in the United States in 1492 and where we are now, land acquisition was a big issue and land loss was a big problem. But it was more than just the land: it was the control and power in the lives of the people that were there. And the loss of that control and the difficulty and struggle of the interaction which made that happen.

This next slide *(bottom of this page)* is an interesting one that shows each of the treaties agreed to for the sections of land and how it affected individual tribes over time since 1784. And I thought it might be interesting for you to see the steps of how this happened by decades. You saw this slide a little bit from Ray Daw, who also began to talk about the fact that Indians don't live just on reservations; 70% live off them. Another point to make is that the geography for the population has changed; but so have the treaties. Treaties don't cover Indians who live off reservation. We have to form new relations with states, counties, and cities. That's why SAMHSA is very important, and that's why we needed to be included in block grants, in state grants, and state -incentive grants. That gives this relationship the chance to make the important statement that 70% of our people need more predictable, consistent, understandable relationships with their funding sources for education and healthcare.

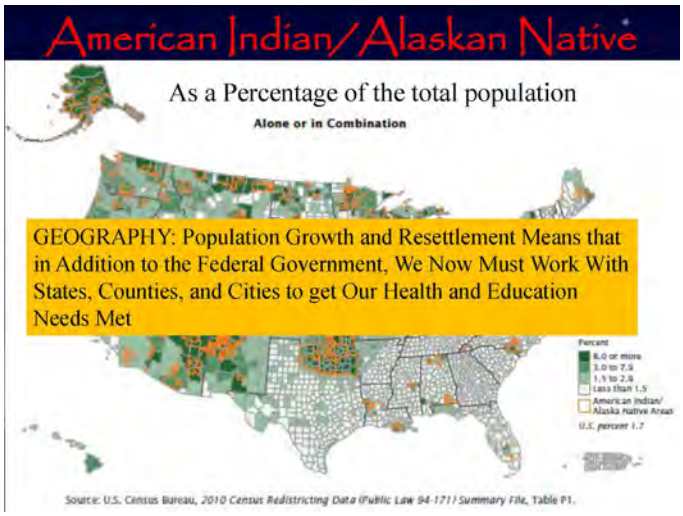


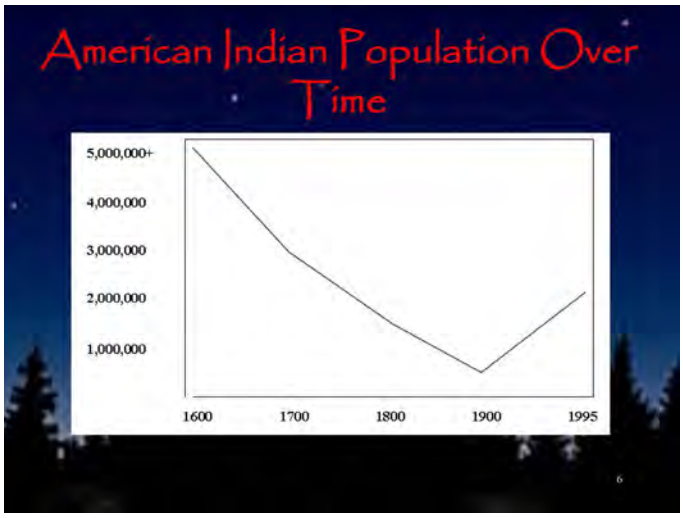


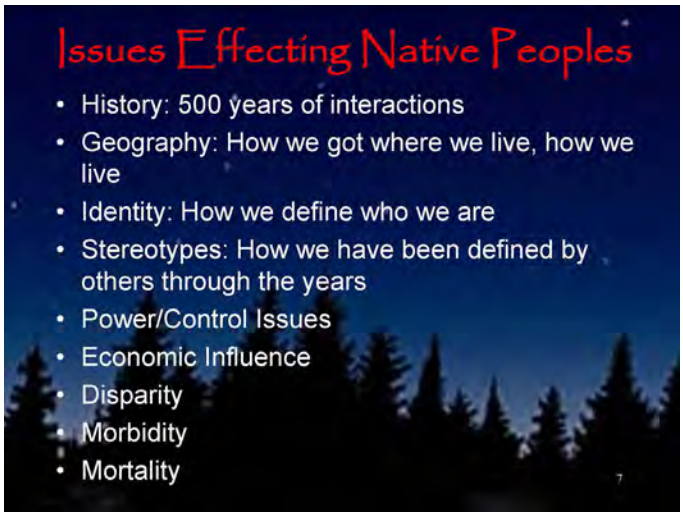
So we've got geography and we've got loss of land. Another issue for us is that we have population loss. We lost 90% of our population from 1492 until 1900.

The term "Vanishing American Indian" in the 1890s marked the birth of the social work movement in this country. How many people here are social workers? It derived from the substantial loss of Indian people at that time.

Collectively, if you want to look at the impact of events on people, it's necessary to look at the history of those events. We've had a 500-year interaction with visitors from Europe. And, you know, sometimes you want your neighbors to leave. Geography plays an important role in how we meet or get our needs met. As well, our identities as Natives are a political issue at every level. How we work and relate and inside the tribe; how our identity is challenged. Outside the tribe our identity is challenged even more. That pressure of who we are has a direct impact on young children. Ray Daw introduced the suicide issues that we talked about earlier, by observing that there are suicide concerns in many parts of Indian country that really have to do with who those children are and how they relate. The stereotypes of Indians are in our history books, in our movies. I am astounded when I go to Washington, DC and talk to people in Congress and talk like this to government workers who are out there working with Native people. When I ask how many people have talked to an Indian person for one hour in their lives, not even half the people raise their hands. That kind of minimal interaction creates stereotypes and misunderstandings that continue. Accordingly, I want to make the argument that historical trauma didn't happen in 1492. It has happened daily from 1492 to now. All of our generations, all of our people, all of our families, all of our children have had these things happen continuously, non-stop. It's here, it's now; and that's our problem. We have to deal with it. I want to add that so do other Americans. It's a critical element for all of us in this country. Wouldn't it be nice if





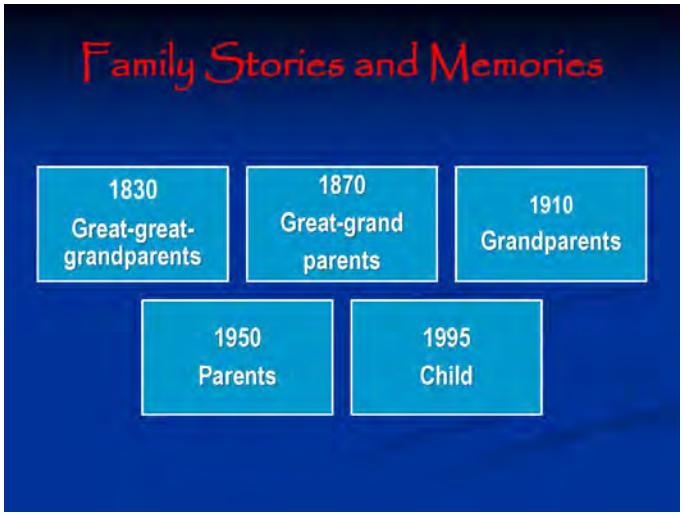


we could have common ground with all people; not just the ethnic people, but all people; to deal with this issue in a better way? Power, control, and empowerment are the biggest words and social determinants of health. And I think they're the biggest words in trauma.

As we look at family stories and histories, I try to take a look at this and who we are. You know, children who were born in 1995 have a 20-year history and knowledge. Parents have 40, grandparents have another 40, great-grandparents another 40, and great-great-grandparents another 40 years. That goes back to 1830. American Indian people have been very good at story-telling about who we are as people; all tribes look at that issue. And the knowledge we have about the losses, difficulties, and struggles is still with us today in our own history and understanding of who we are as people.

I want to share with you a little bit about contemporary trauma because, except for about four studies, that's where the science is. If you argue that every generation has experienced these trauma episodes, a look at contemporary trauma helps us begin to take a look at historical trauma as well.

Now, what is contemporary trauma? You all know these events. How many people here have children? A pretty good sized group. Now I'll ask the other tricky question. How many people here are children? How many people used to be children? Contemporary trauma is around us and its part of who we are. You heard Ray ask the same question. But witnessing or hearing or experiencing physical, sexual abuse, neglect, domestic violence, stalking, divorce, war, natural disasters, and severe motor vehicle accidents, all of those things can be a part of contemporary trauma.

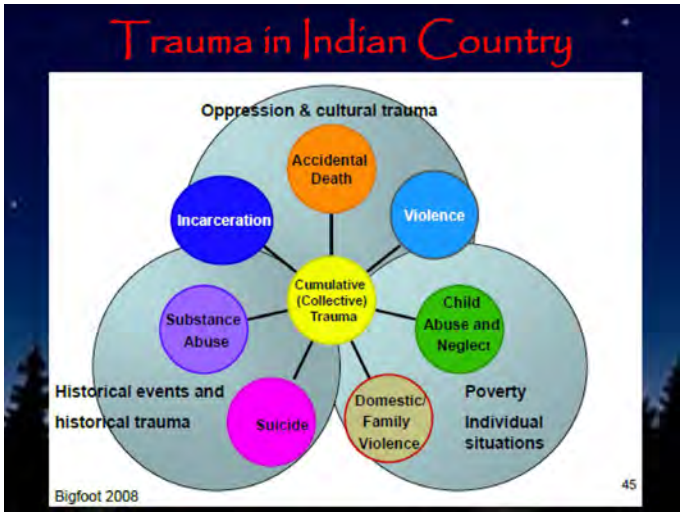


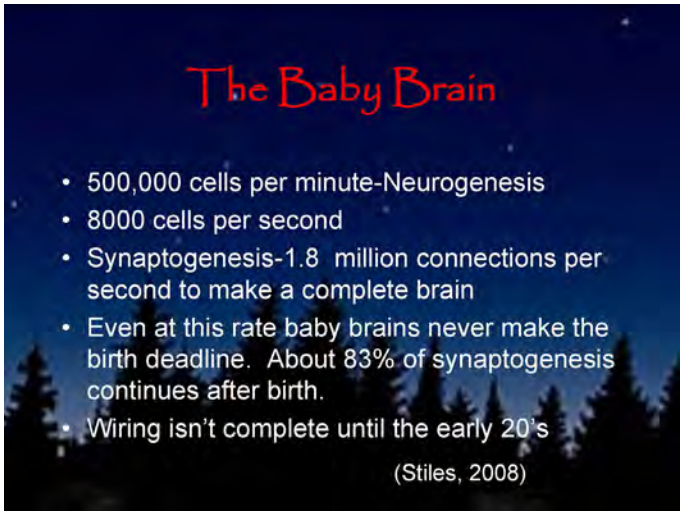
And Ray also pointed out clearly that culture and gender differences in perception and experience are in the expression of trauma. It's different across genders, isn't it? We really see a little bit of difference there. It's also different across tribes and across cultures.

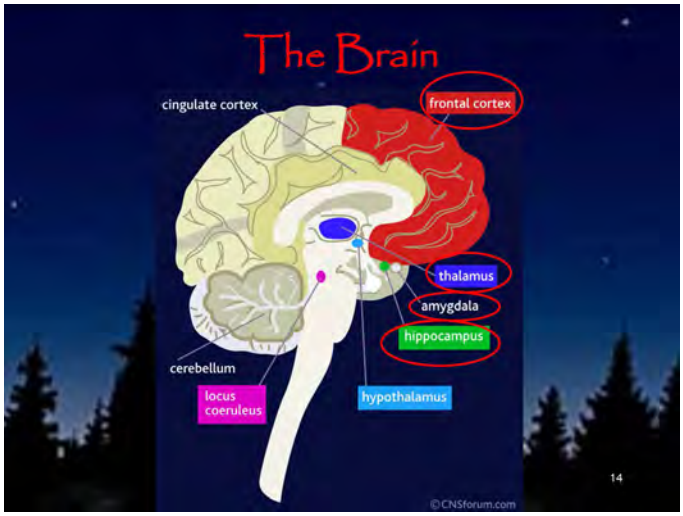
Now we're going to talk about historical trauma a lot more, but the forms of traumatic injuries are psychological, spiritual, and brain/body physical. So physical things happen in trauma.

Dee BigFoot's introduction to this theory stresses that trauma occurs in various areas. There are historical events that relate to trauma, there's depression and culture trauma, and there's also poverty and individual situations. Collecting those together describes all of the events that fit in a traumatic episode *(Bigfoot, 2010)*.

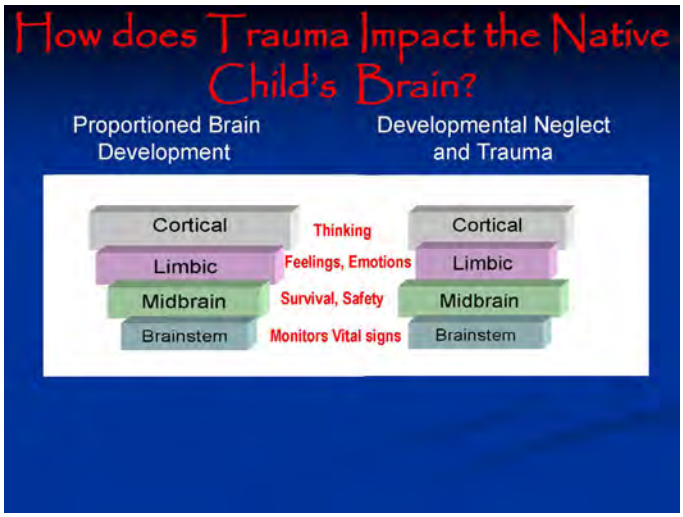
Now, before we talk about that child, we have to think about the brain for a minute. The baby's brain is a remarkable piece of equipment. Five hundred thousand cells per minute were developed between that baby's conception until delivery. Five hundred thousand cells per minute. We're talking about a pretty large function here and a remarkable chemistry as it develops. Eight thousand cells per second are added to the baby's emerging brain, and those cells have to connect. That's what synaptogenesis is. Cells connect at the rate of 1.8 million connections per second to complete the brain. Even at this rate the baby brain never makes the birth deadline. About eighty-three percent of nerve connections continue from birth until age 20 to 25. And so we have a child whose thinking engine, the brain, is rapidly growing, developing, and moving forward *(Stiles, 2010)*.





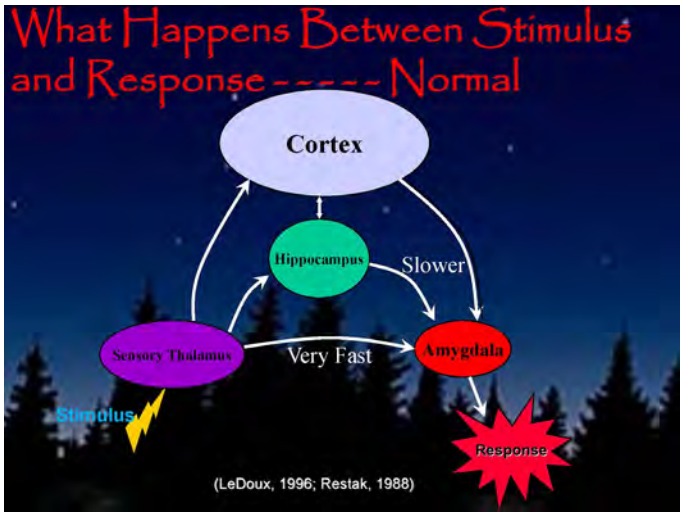


I think you're going to have a lot of fun talking about the brain, so we're going to jump into this. We're going to talk about the frontal cortex. That's where your thinking, judgment, your ability to make decisions about different things; that's where they all occur. The logic of your thinking is up there. The amygdala is a part of the brain that recognizes stress, the difficulties that occur in life; and it prepares the body to deal with emergency situations. The hippocampus is a part of the brain that deals with memory. And the thalamus receives messages from our senses. You remember those things in your classes about touch, seeing, hearing, smelling, temperature, pressure? The thalamus senses those events and says, *Something's going on. Something's a problem here, we'd better deal with it but we need to take it to different levels in the brain.* These are the four brain structures that we talk about with trauma.

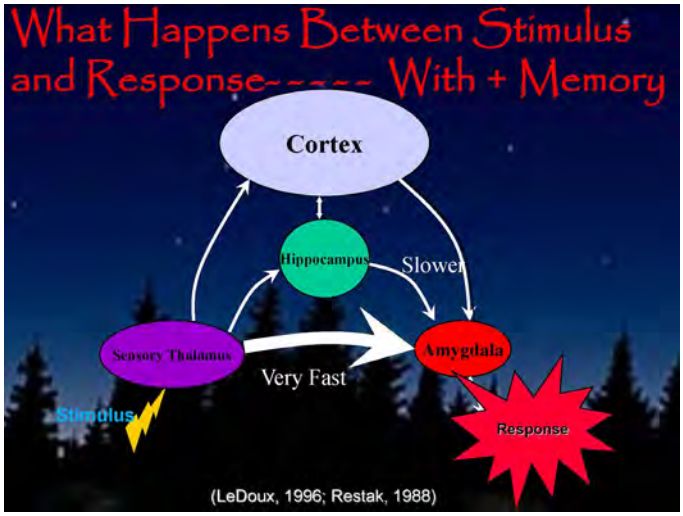


Another way to look at this is by understanding how trauma impacts the brain. On the left is the brain of a normal person. If you look at it from top down, it looks like an upside down pyramid. There's the cortical part of the brain up here and there's the limbic which is a little bit part of that memory. You can also see the mid-brain, which controls how you respond to stimuli; and the brain stem, which looks out for temperature, pressure, noises, and things like that. If you look at that upside down pyramid, the usual brain is about 2:1, so cortical and limbic systems are twice as large as the mid-brain and the brain stem. These proportions help explain how thinking is an important part of human existence, how thinking and emotions and memory are important, and survival and safety are important. Now you remember that we're talking about children. Guess which system develops last? The cortical. That's the part that continues developing until age 20 or so. Whenever you ask a child to think carefully before they make a decision - and your child never thinks carefully - they try it right out, don't they? Well, that's because their amygdala is telling them to go right ahead. Children don't need to worry about the, *Do you want me to,* type of thing. It's not going to happen that way. Now that's the normal brain, OK? The brain that has experienced neglect and trauma is different. Notice the size of that pyramid; it's not a pyramid anymore in the way that it's demonstrated. The cortical and the limbic systems are reduced in size. The mid-brain is a little bit larger. You will remember that the mid-brain controls how your body reacts to stress. In this instance, it's overworking. The chemicals in the brain are telling it to work harder to protect the body. This brain feels that it has to protect itself instead of learning.

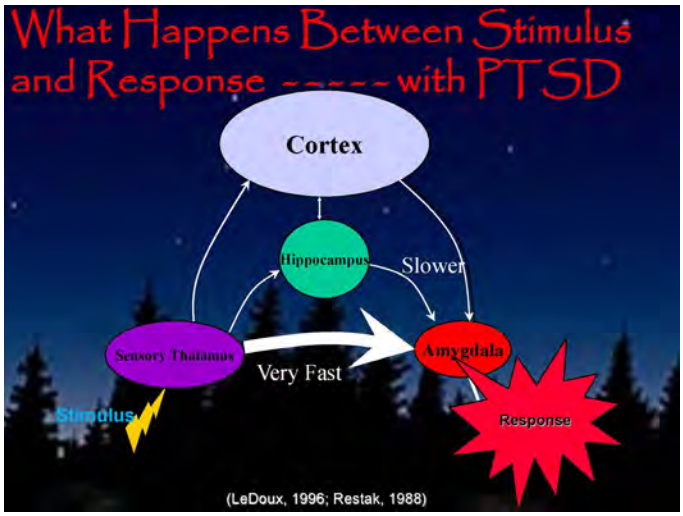
Now we're going to go through a little more of this. I'm a visual learner, and I hope you are, too. It helps me understand the brain a bit better to have pictures of brain structures. What happens between the stimulus and the response is the issue. The normal brain reacts just as this diagram shows. If a stimulus is experienced - and this is a normal brain we're talking about now - that stimulus affects the thalamus. And remember, I've told you that the thalamus receives external stimuli on the senses pressure, smell, sight, hearing. When it does, it sends the signal out to the cortex, the hippocampus, and the amygdala that there's something going on.



Respectively, those structures control the thinking part, the memory part, and the amygdala, which responds to stress. Now we're in this room, and there's a door there in the back, and you guys are concentrating totally on what I'm sharing with you. Nobody is asleep; everybody is looking face forward, and taking notes. Something happens in the back of the room and that door which is open absolutely slams with the loudest noise you can imagine, and what happens? You're startled. Your heart rate and respiration might even increase a bit. You'll turn your head and look. That's what happens when all these things happen because that's the emergency response. But the normal brain of an adult says, *You know, I have memories of doors closing like that and nothing really happens, so I think we're going to be OK.* So it's a startle but that's really it. Now let's take it to another level.



Let's say we're back to four days after 9/11. And let's say this lecture takes place on the 80th floor of the Empire State Building, and that same door slams. What would happen to the normal brain? It would be the same reaction, but it would be very fast and you would react more. You might get up and walk around the room and go over to the door and walk outside to make sure things are OK. You might even turn on your cell phone to see whether there is any news about the attacks four days ago. That's a somewhat bigger reaction to the door slam. But what happens to you if you have PTSD? The

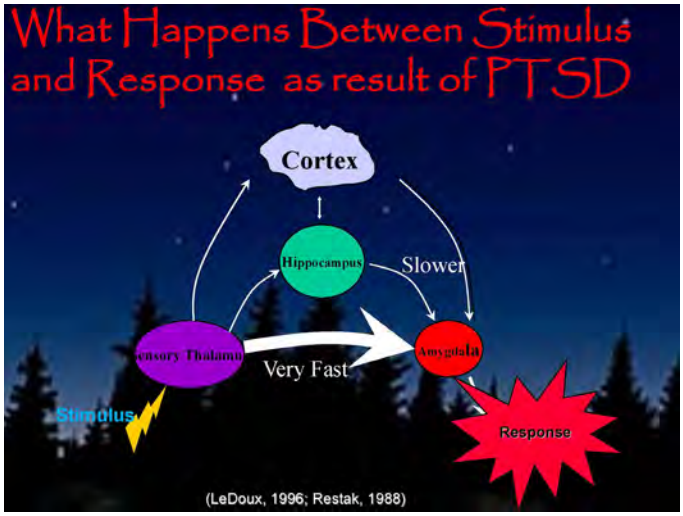


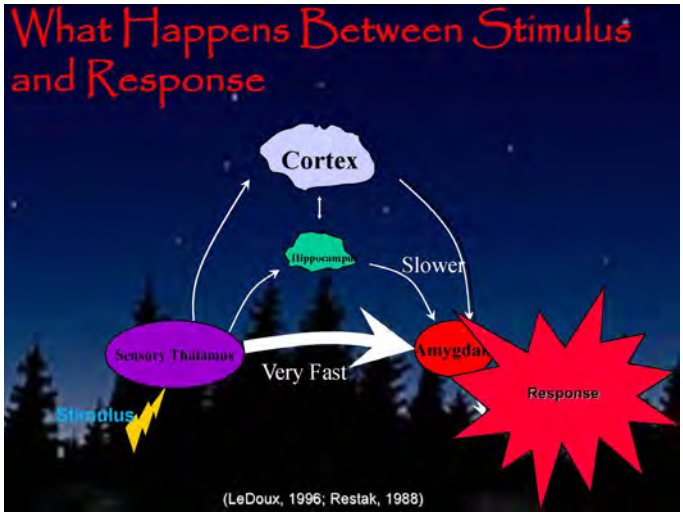
door slams, that person responds, the big part of the brain that works becomes not as operational. We don't think about it, we automatically respond, even if it was not an emergency but was just a door slamming. Or it could be an emergency vehicle with a siren going. How many people here work with PTSD patients? That's what happens with PTSD patients. They see those kinds of problems and respond with an emergency response even if it's not logical thinking.

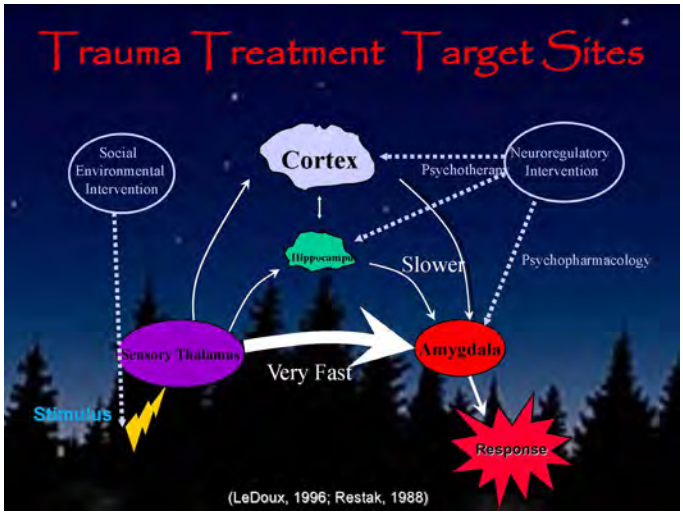
We can go further with this because a PTSD patient who continuously has this response problem experiences a reduction in size of the cortex, the thinking part of the brain. And a reduction in size of the hippocampus. And so, as a therapist, that very fast reaction by the amygdala is what you're dealing with when you provide the therapies that Ray Daw talked about earlier today.

As you continue to have problems with stress, and you're in situations like those in that room in the Empire State Building, and you suffer from PTSD and, as the slides indicates, your cortex and hippocampus are also affected, you experience a reaction of loss of control. That's what families notice first, friends notice second, and communities notice next. And it's of great concern for us. Now, there are treatment interventions for PTSD. One focuses on the stimulus. Ray discussed some ways to approach the stimulus. You know about cognitive behavioral therapy, you know about motivational enhancement therapy. Those two approaches address the PTSD stimulus. You want to train the person to deal with noises that are unsettling, so that if they hear that noise, the frontal lobe will give better information and say "Calm down. Yes, I know last time, you got up and ran out of the room, but it's just a door." That's what the therapy is all about, is to train them about how to work in that situation. You get a response that has a little bit better control.

In addition there's now neuroregulatory interventions, medicines that slow down chemicals. There are chemicals that go over to the amygdala,





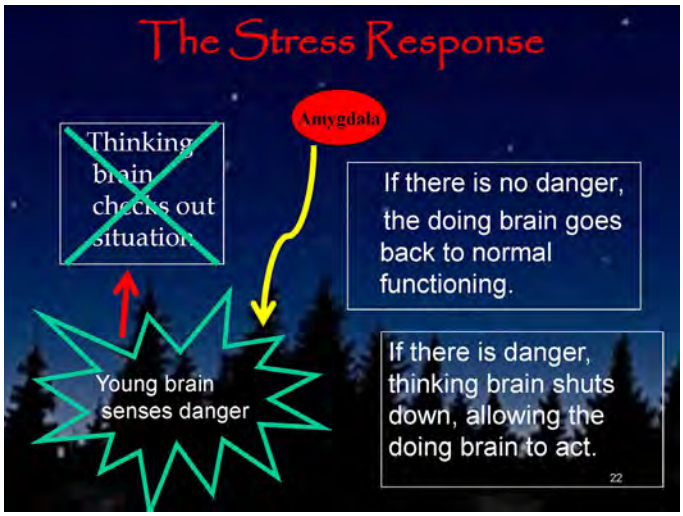


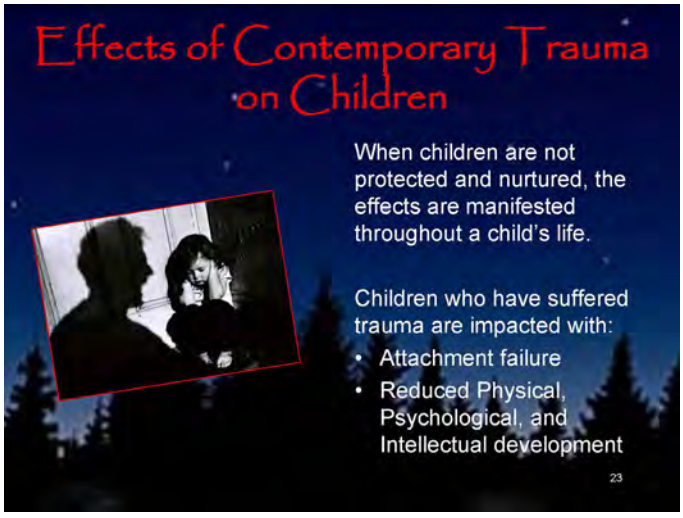
and you're trying to reduce the impact of those chemicals upon the amygdala so that your brain will have a chance to function *(LeDoux, 1996)*.

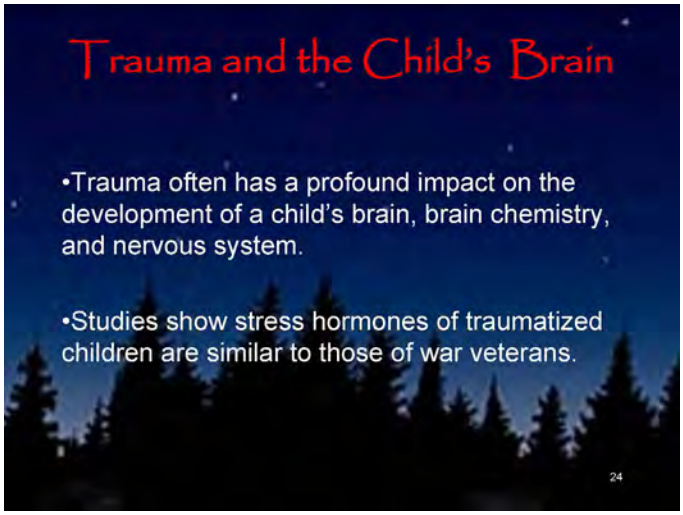
So if you are given cognitive behavioral therapy and are also given some medication to slow the stress reaction down, you really have the best of both worlds. Now quickly reviewing a stress response, let's review what happens when this young brain senses danger. The thinking brain checks out the situation. If there is no danger, the thinking, doing brain goes back to normal functioning. Everything's OK. If there is a stress response the amygdala is called into action. There's danger, the brain shuts down, and the amygdala rescues the body.

When children are not protected and not nurtured, the effects of contemporary trauma are manifested throughout the child's life. Children who have suffered trauma are impacted with attachment failure and by reduced physical, psychological, and intellectual development. So we have big, big problems if we don't pay attention to childhood development, including reactions to historical trauma.

Trauma often has a profound impact on the development of a child's brain, brain chemistry, and nervous system. So once again, thinking back, I told you that historical trauma is not just the first time: it's all of the time and through all those generations. That means that there are changes all along the path, so you need to be sensitive to them as you're helping the child in school and through development. By the way, the parent who has the same kind of stress responses to historical trauma going on affects the family and the community. So these interventions that Ray discussed, about which you will hear more today, are really directed at a much broader base. I think that's the catch with what we do in inner cities, what we do in high poverty areas, high immigrations areas, and those are the things we really need to be concerned about.



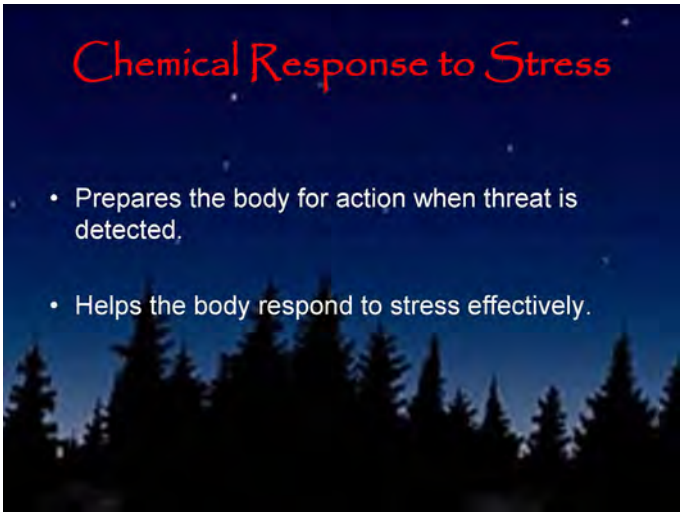


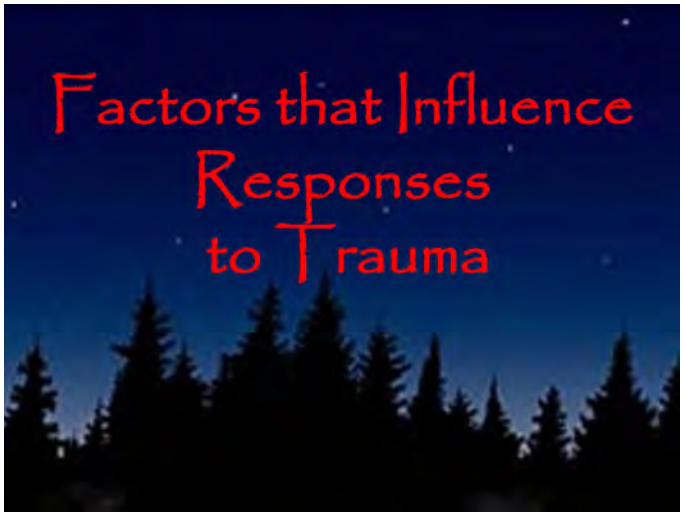


Chemical responses to stress are another issue but they prepare the body for action, they help the body respond. It's not a pathology to respond to stress: it's OK. We just don't want too much of it.

That stress response is flight, fight, or freeze. You probably have all heard that somewhere during your teaching and education. Those are normal and healthy responses to stress and it's important to have them, just not too much of them. What are the factors that influence the nature and extent of these three responses? If you look at history, prior exposure to trauma is a big issue and that's true in the cases of people we are talking about. The mental health concerns are there. And then there are concerns about current functioning. What are the strengths and coping skills of the individual? Have you noticed differences in response to stress? When people go through the same kind of stress, one person will do well and another not so well.

There's variability in the stress response; not everybody's the same.

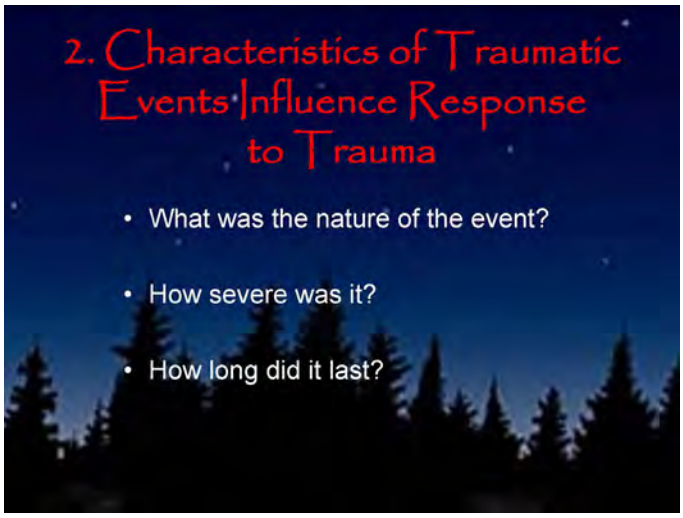


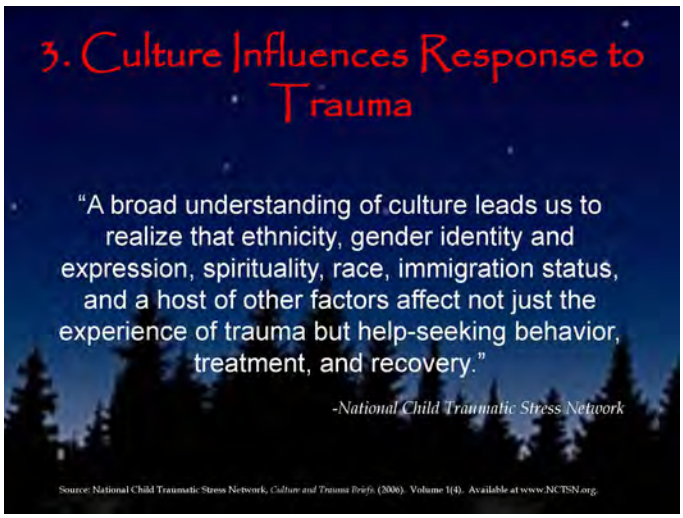


That's important for us to remember. Current living situation is paramount. In this context, the environment of the child matters a great deal: what's happening where that child is living, and how do they respond to it.

What about the characteristics of traumatic events? What was the trauma or nature of the event? How severe was or is it and how long did it last? A couple of years ago I worked in a reservation where there were seventeen suicides in four months. All of them were adolescents. An event like that is bigger than trauma: it's a disaster. By any definition that we use in this country, it's a disaster. But it doesn't get addressed that way often enough in Indian country. So how long did it last, how severe was it? What are the things that happen that become quite critical for us to know and understand?

The culture's response and influence is an important part of that. I brought a quote I want to read to you. "A broad understanding of culture leads us to realize that ethnicity, gender identity and expression, spirituality, race, immigration status, and a host of other factors affect not just the experience of trauma but help-seeking behavior, treatment, and recovery," *(NCTSN, 2006).*

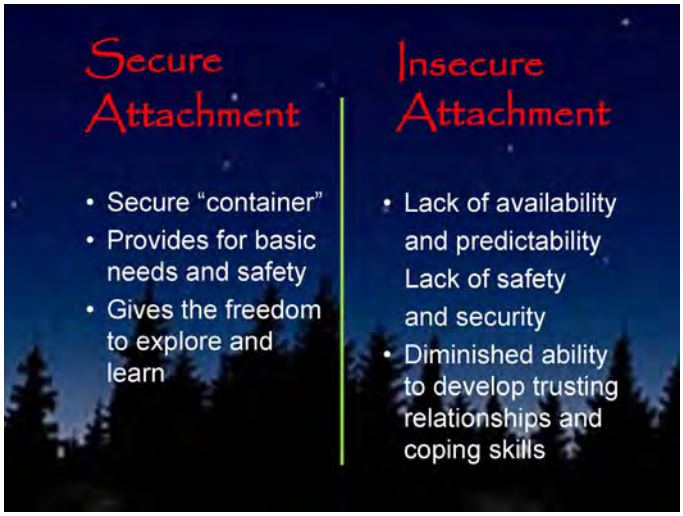




My final point here has to do with the eight stages of man. Most of you have heard of them. We talk about the stages of development; that's pretty well established. You might not know, however, that the eight stages were all written and developed in the Navajo nation. It's interesting that Erik Erikson's well-known work is Native work. The stages of development are critical in trying to understand trauma. As I told you before, the reason is that the brain is not developed in all of those stages up to adulthood, and so the ability of the brain to actually rationalize and think and manage is quite limited.

Child development and trauma skills specific to each developmental stage are built on learning from the previous stage. So if you don't get to that stage, you are in trouble. Psychological issues compound trauma. Children exposed to trauma invest energy in survival instead of into developmental mastery. You have undoubtedly noticed how some people have great difficulty and frustration with solving some problems, sometimes doing so in a very negative way, like throwing the telephone that they can't enter the numbers right? It's a significant thing to see in children.

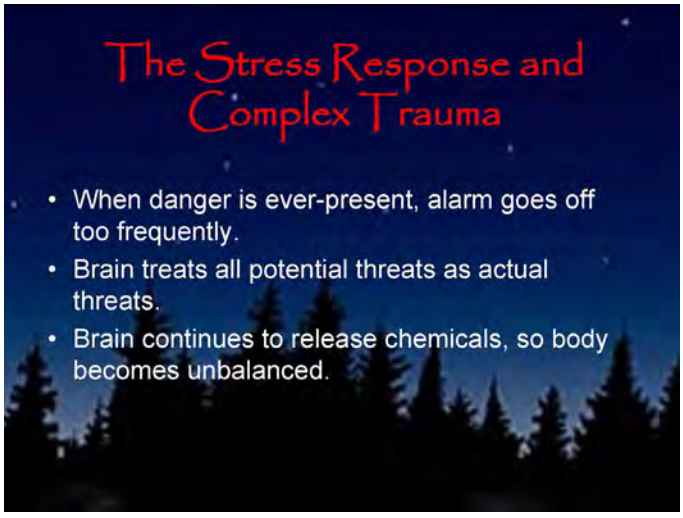
Attachments are equally important. You all know that you want a nest for children; you want them to be protected. You want a structure that allows them to grow and develop in a safe way that provides for basic needs and gives the freedom to explore. Insecure attachment is the reverse of that. It's the lack of availability and predictability. It's a lack of safety. There's diminished ability to develop trusting relationships. Unfortunately, we see that all too often in our communities. And it is related to social determinants of health. Poverty, homelessness, unemployment all compound these problems. So once again, a tribe which can develop effective, adequate support for its members can reduce complications of trauma.



The job that the federal government must take on to help these situations is much more complex than they ever thought it would be. The cost of taking all of the land is a lot more than reservation land; there's a lot that needs to be done. So the risk for more severe trauma responses remains and grows. The risk includes poor current functioning, whether a particular event is received appropriately or not, and trauma early in development.

When danger is ever present the alarm goes off too frequently. So you might want to focus on environment a bit, you might want to change the way things happen and make a safer place for a person to be. You might also want to talk with the person to find out what the things that are pushing their buttons. The brain treats all potential threats as actual threats. Everything's real. Don't ever think it isn't. People sometimes respond in very dangerous ways, believing that what's about to happen is going to destroy their life.

These triggers and reminders of past danger signal that the brain has become more sensitive to danger. That's when the thinking brain automatically shuts off.



What are these common triggers we are talking about? They include reminders of past traumatic events, lack of power and control, conflict in relationships, separation, or loss. Although these are just growing up things for most people, they are not to a person who has experienced trauma. Incidentally, the thing that we've been discussing, suicide in Indian country, is obviously a big issue and much of what we've been talking about leads to trauma and thoughts of suicide.

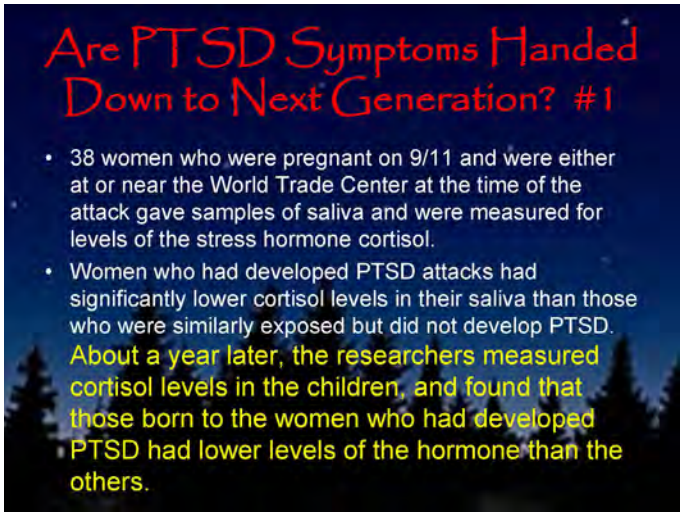
Pathways to healing will be discussed; safety and stabilization are primary. Our communities need trauma-informed services, services that are culturally competent and relevant. You'll hear more about such vital services.

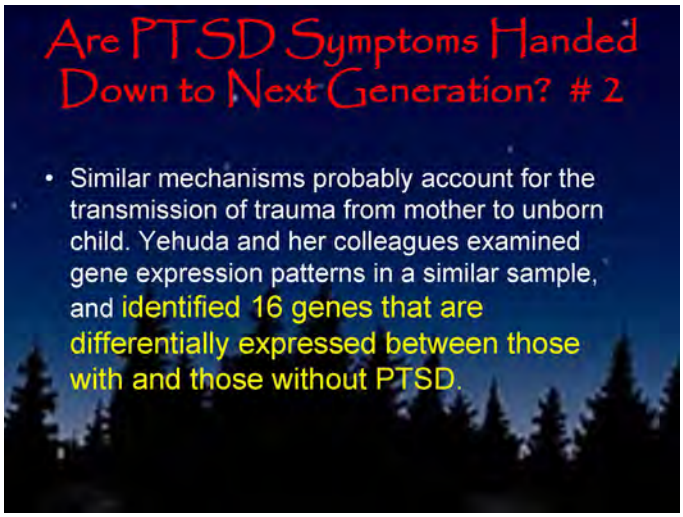
Now I want to make a final point in three slides. It's a long point but you're going to love it.

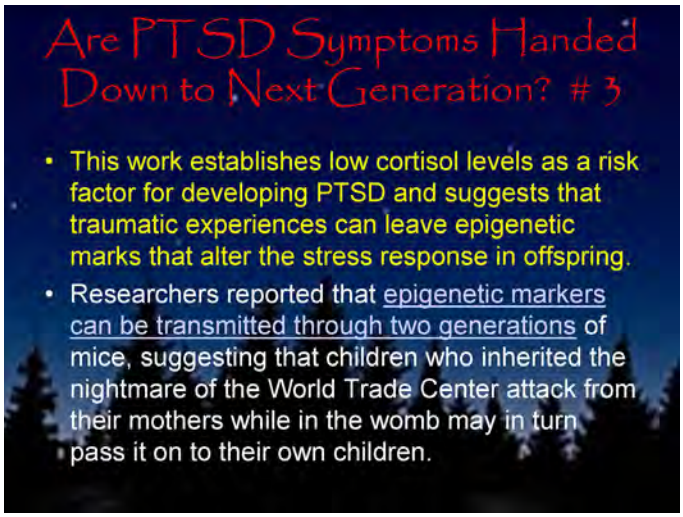
The question is: Are PTSD symptoms handed down to the next generation? That's the crux of validating historical trauma. And I can share with you some research that's been done that might imply that this is, indeed, the situation. Thirty-eight women who were pregnant on 9/11 and were either at or near the site of the attack in New York City gave samples of saliva and were measured for levels of the stress hormone, cortisol. A principal finding was that women who experienced PTSD from the attacks had significantly lower levels of cortisol in their saliva than those who were similarly exposed and did not develop PTSD. About a year later, the researchers measured cortisol levels in the offspring and found that those born to the women who had developed PTSD had lower levels of the hormone than the others. So, those are findings from one of the first studies that points out there's something passing on from one generation to the next.

By the way, Dr. Braveheart works with this group as well and is familiar with their work. It's really been a vital advance to the principles of historical trauma. Similar mechanisms probably account for transmission of trauma from mother to child. Rachel Yehuda, at the Veteran Affairs Medical Center in NYC, examined gene expression patterns in a similar sample. She identified sixteen genes that were differentially expressed in those with and without PTSD. So now we have genetic evidence to confirm that information about trauma may be passed from one generation to the next.

This work establishes low cortisol levels as a risk factor for the subsequent development of PTSD. You might want to remember that in some of your own work out in the community. It suggests that traumatic experiences can leave epigenetic marks that can alter response to stress in the responses of offspring. In a more recent study at the University of Pennsylvania, researchers reported that epigenetic markers can be transmitted through two generations of mice. The implication of this finding, if this finding can be replicated in humans, is the inheritance of the stress response to historical trauma will have been proven.

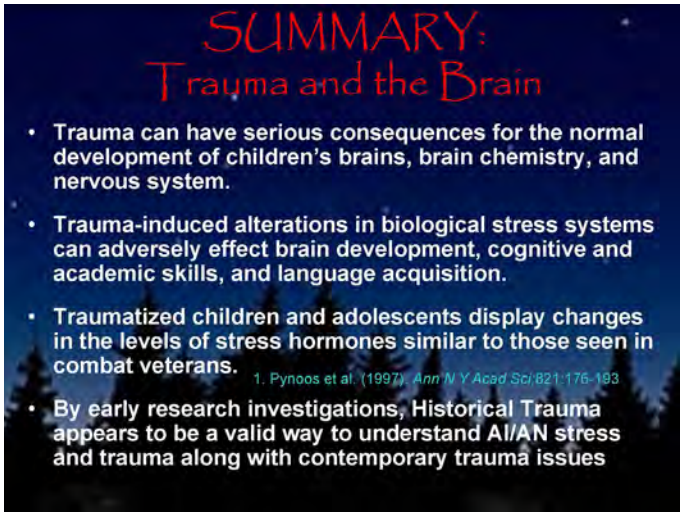






In other words, I think the evidence points to the conclusion that historical trauma is a true phenomenon that includes biological mechanisms and markers. Trauma can have serious consequences for the normal development of the child. Trauma-induced alterations in biological stress systems can adversely affect brain development. Traumatized children and adolescents display changes in the levels of stress hormones similar to those of combat veterans. Those findings are important for Native people to understand. Historical trauma appears to be a valid means to understand American Indian and Alaska Native responses to stress and trauma.

That completes my talk, I have this slide on as a phone number for contact and my email is down below. I would welcome anybody who wants to talk with me about this. I thank you all very much.



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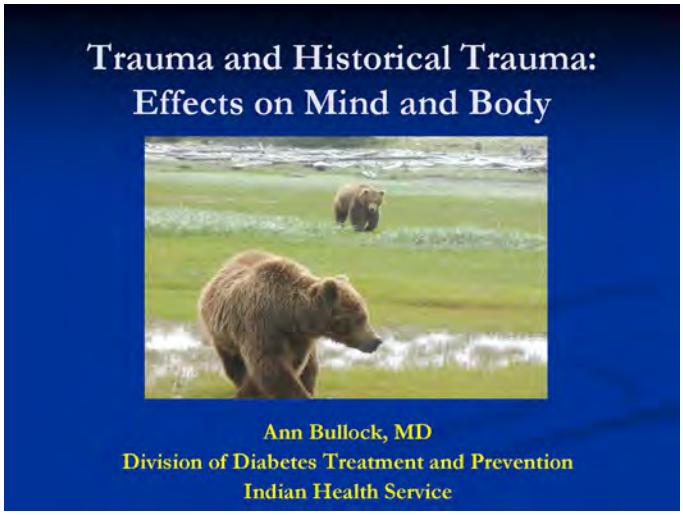
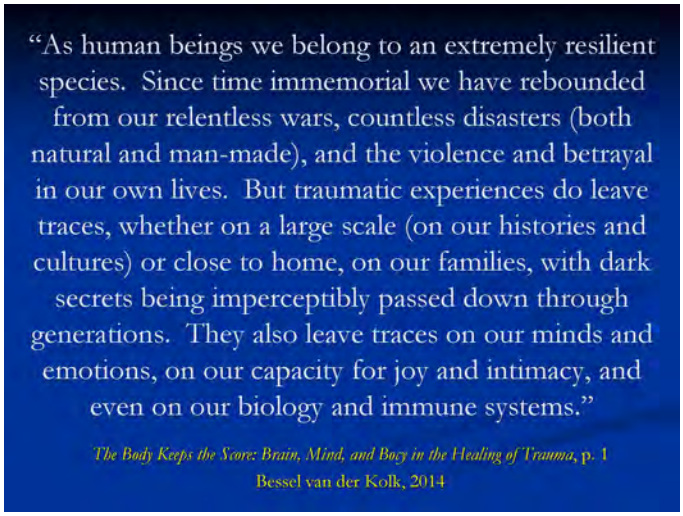
TRAUMA and HISTORICAL TRAUMA: EFFECTS on MIND and BODY

Ann Bullock, MD, Minnesota Chippewa



I am Ann Bullock with the Indian Health Services Division of Diabetes Treatment and Prevention. I myself am an enrolled member of the Minnesota Chippewa Tribe, so this topic is both of personal and professional interest. It's a delight to be with you today and I certainly appreciate the participation.

The point of view that I take on historical trauma, and will try to get across here in the next 45 minutes, is that historical trauma is a model which helps us understand the present. In a sense, historical trauma is not about the past, it's about the present. Historical trauma doesn't feel oppressive to us in spirit only, but also very much and very literally in mind and body - it's biology. Historical trauma is a variation on regular traumas of everyday life. I'm going to talk for the next little bit about how stress and trauma work in the brain and the body. I know many of you are familiar with some of the physiology of stress and trauma, but I want to give this introduction to frame our discussion of how historical trauma works.

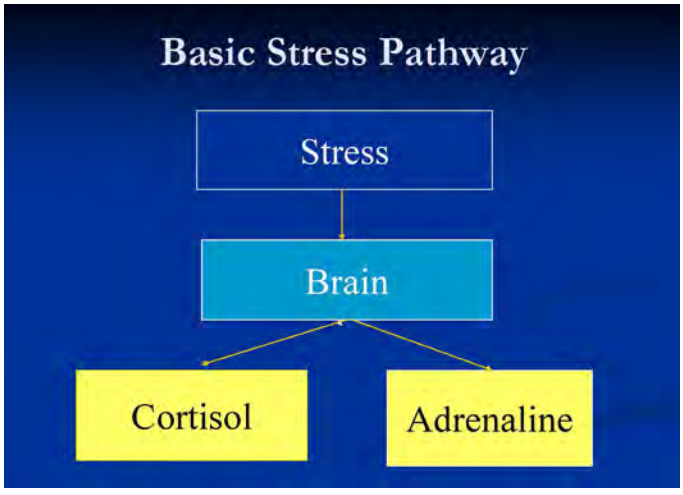


This is a quotation, even though it's a little bit long, I think it summarizes the situation well. Many of you are probably familiar with the work of Dr. Bessel van der Kolk, a psychiatrist at the Boston University School of Medicine. He also runs a trauma center in Boston and has written a number of books and articles about trauma. This particular book—The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma – was just published in September.

Although I recommend the entire book to you, I want to share with you here a quote from page 1. I think it is very germane to our discussions here today. It says:

> *"As human beings we belong to an extremely resilient species. Since time immemorial we have rebounded from our relentless wars, countless disasters (both natural and man-made), and the violence and betrayal in our own lives. But traumatic experiences do leave traces, whether on a large scale (on our histories and cultures) or close to home, on our families, with dark secrets being imperceptibly passed down through generations. They also leave traces on your minds and emotions, on our capacity for joy and intimacy, and even on our biology and immune systems," (van der Kolk, 2015).*

I don't know any better way of summing up what we term historical trauma than the way Dr. van der Kolk does here, especially including that the manner in which traumatic experiences pass through generations to become the historical part of trauma. They instill a wide range of effects, not only in our minds and emotions, but also in our capacity to experience joy and to form meaningful relationships with other people. Of course, as we'll talk soon here, we'll also talk about the biology of historical trauma.

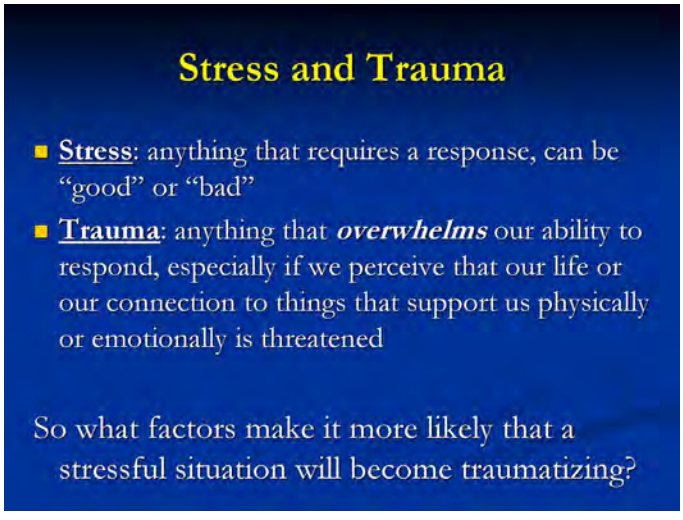


Let's start with how stress works. This slide is about as straightforward as I know how to describe the stress pathway. I'd like to share an example I've used for many years – but before doing so I want to apologize to anyone in the audience who may have heard me give it in another talk. I want to talk about a little gazelle. It's usually easier to talk about these matters in non-human animals at first. Doing so also shows us that the stress response has been used by many species on the planet, not just human beings. The Creator obviously thought this response to stress works very well so it gets used in many circumstances.

A stressful event occurs, and our brain correctly interprets the situation as stressful, perhaps even potentially dangerous, to us. Accordingly, two pathways in the brain are put into motion pretty quickly. One is the sympathetic nervous system, in which adrenaline, or epinephrine, is one of the principle hormones involved. The other is the HPA axis or stress hormone pathway, in which cortisol is one of

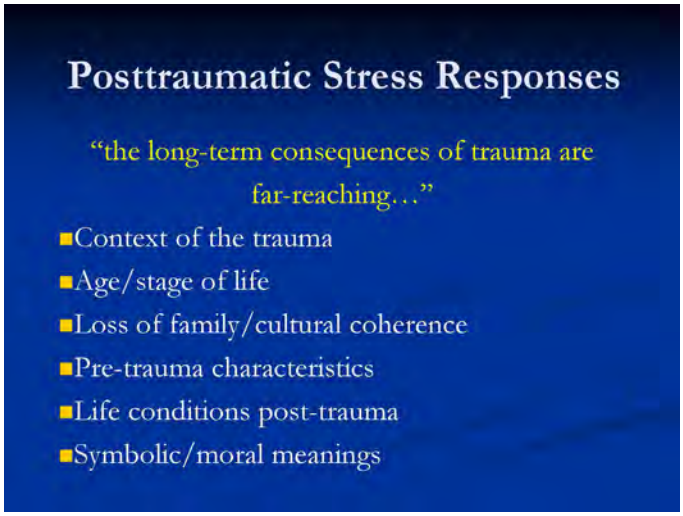
the primary hormones. Now let's return to our little gazelle, who is munching happily on the grasses of the savanna of Africa. She is calm and happy; every animal around her is doing fine, when out of the corner of her eye she sees a lion start to stalk her. This situation would be stressful for anyone, gazelle or human, and the gazelle's brain correctly responds by telling her this is something she needs to deal with. The brain responds with the "fight or flight" pathway with which many of you are familiar. The gazelle's brain quickly sets into motion those two pathways. Her sympathetic nervous system reacts to the threat and sends adrenaline - epinephrine - surging through her veins to increase her respiratory rate and get more oxygen into her body. In turn, her heart rate and blood pressure increase, which delivers that oxygen to the muscle cells that need it. Because if you're a gazelle looking at a lion, you're not going to be fighting. You're going to be running. The gazelle's muscles are going to need a lot of oxygen very quickly. Her muscles are also going to need energy or glucose - sugar. This is where the HPA axis hormones kick in. Cortisol increases the glucose or energy available for her to run, and it does so in one of three ways. First, it signals the liver, the store house for simple glucose, to pour that glucose into the system because it is needed immediately. The gazelle needs sugar because it needs energy immediately. Second, the HPA axis signals the pancreas to stop producing insulin now because insulin stores sugar in fat cells and the threatened gazelle doesn't need to be storing it. She wants to be using it. So, the pancreas pretty much shuts down its insulin secretion. Finally, the HPA signals fat cells that, although there's still some insulin floating around, the animal's system needs not listen to that insulin. The gazelle needs to be insulin resistant right now. With the oxygen now flowing to her veins, and sugar as well, our little gazelle is ready to flee. She takes off across the valley and gets away from the lion.

So what's the problem with this scenario? It's not a problem if all we're talking about is that little gazelle running away from an occasional lion. The problem comes if she has to run away from a lot of lions, or if you have to deal with an alcoholic spouse or kids who are always in trouble, the bills that aren't getting paid, and so on. The more of this kind of stress, the more times this pathway has to be activated and the more often released hormones are floating through your blood vessels. You can imagine that after months or years of repeated activation of this system, what might happen to your coronary arteries if epinephrine is pounding a heightened blood pressure against them repeatedly. And you can imagine what happens if cortisol is repeatedly floating through your system, pouring out sugar from your liver, decreasing the insulin from your pancreas and telling your fat cells to be insulin resistant. I've described two very likely ways to get type 2 diabetes; stress is an acknowledged cause of type 2 diabetes just as it is a known cause of cardiovascular disease. So, over time, this response to repeated stress has quite an impact.



Let's return to trauma and stress. We usually use the term "stress" negatively, to describe something we don't like. But a stressor is anything we have to respond to. It can be good or bad if we put a value judgment on it, but it's just something to which we have to respond. So, what then is trauma? This isn't my definition, but I think it is a fairly reasonable one. Trauma is anything that defeats our ability to respond. So if we're faced with a stressor that's so

challenging we despair of confronting it, or if our ability to deal with a stressor is clearly too modest to be successful, the stressor overwhelms us. This picture is especially true if we perceive the stressor to be something that threatens our life or we feel that our connection to things that support us physically or emotionally is threatened. In that situation, our ability to take care of ourselves is overwhelmed. That's when the stressor transforms from something stressful to something traumatizing.



What factors make it more likely that a stressful situation will become traumatizing? This slide is from an article in the Journal of the American Medical Association (JAMA) from a couple of years ago and its reference is on the next slide. It's an article by Jerome Kroll that says, "the long-term consequences of trauma are far-reaching…" He then lists several factors that he says make a difference in whether or not something will become traumatizing. The first is simply the context of the trauma. What is the trauma? Is it defined the way DSM-IV defines trauma, as experiences like combat or rape qualify as experiences that would be traumatizing? DSM-5 has broadened that definition because there are many, many other experiences besides combat and rape that have that potential as well. Trauma can be caused by many things, like an earthquake, for example. But the context of the trauma cannot be the whole explanation. Because if that were the case, then with any experience, either everyone who experienced what seemed to be a strong stressor would be traumatized, or no one would be. But that's not how it works. We know, for example, that about a third of soldiers who came back from Vietnam had developed post-traumatic stress disorder (PTSD). Although that's a huge number of people, it also means that two-thirds of these Vietnam veterans did not experience PTSD, even though they experienced traumatic experiences like those the victims of PTSD experienced. So it cannot be just the context of the trauma alone that dictates whether or not something will become traumatizing *(Kroll, 2003)*.

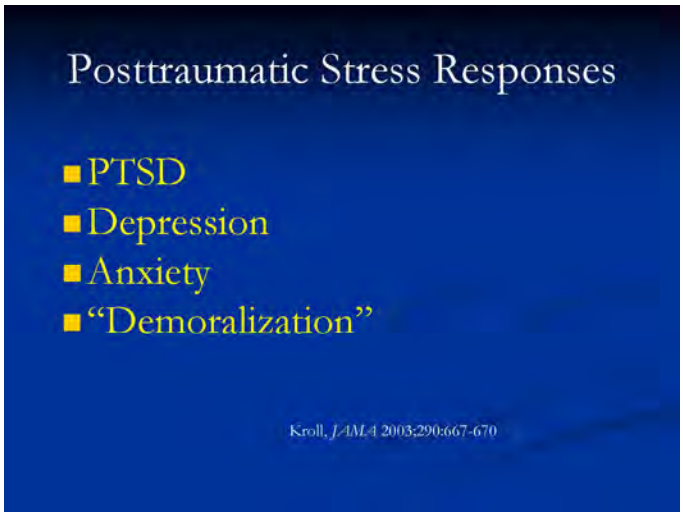
It also matters greatly what age and stage of life the person who is dealing with the stress is in. Let me give an example. If I fall down and get a big gash in my leg, I'm going to think that's really painful and it's a mess, but the most important thing I'm going to think about is that I'm probably going to be late to some work meeting. That's probably not going to be traumatizing. If your 8-year-old son or daughter falls down and suffers a big gash, there's going to be a lot of tears and upset, but if you can comfort them and talk with them and go through with them whatever they have to go through in the ER to get the injury taken care of – it's probably not going to be traumatizing. But if your 2-year-old falls down and gets the same gash, you've now got someone who is unable to understand what's happening. It's all blood and pain and fear. The people who should be supporting them are taking them to a place where they are held down and more painful things happen. Age and stage of life are huge in terms of determining whether something might be traumatizing. Something that's traumatizing for a 2-year-old may not be traumatizing for someone who is 8, 10, 12 years old, simply because of their different developmental stage. Both their ability to understand the trauma as well as their physical and psychological ability to deal with its consequences can change radically with age. If the event results in a loss of family or cultural coherence is another factor that might make it more

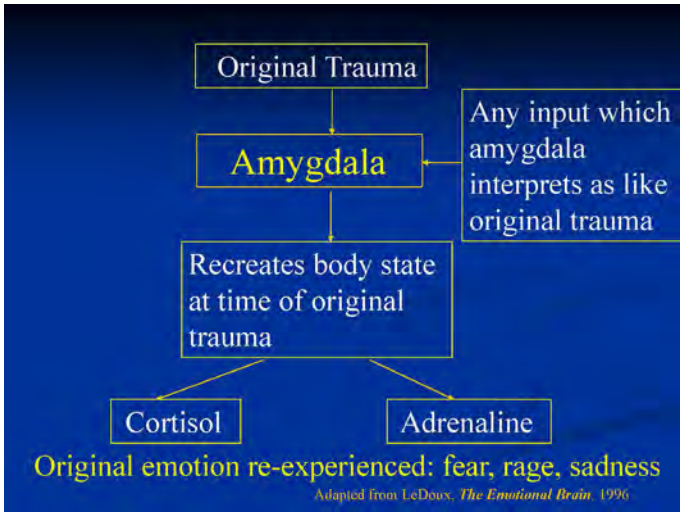
traumatizing. Think about what we know about Hurricane Katrina survivors. Not only did some of them actually die in the hurricane when it hit New Orleans, but when the city flooded, many had to be sent elsewhere just to have a place to live until things could be cleaned up. They were sent all over the country and separated from their connections to family and neighborhood. This consequence of Katrina's impact made it more likely that people who did not have similar experiences wouldn't be able to help the survivors make sense of what had happened and support them through their ordeal.

What happened to us before the trauma occurred also matters. I had a patient who had come back from the first Gulf War with really bad post-traumatic stress disorder, but he had also grown up in a family with a lot of physical abuse. Thus, he reported a significant amount of physical abuse during his childhood, and then he went to war and into combat. These experiences led to big trauma. Having suffered trauma during his childhood, he was much more likely to come back from a war situation with PTSD. What happens after the trauma also matters. Rape victims who are loved and cared for and supported - who get the right care and treatment - do much better overall than those who are shunned and not believed. And then, because we are creatures who think about things and have a soul, we attach symbolic or moral meanings to what has happened. So, if I get third degree burns over half my body because I ran in a burning house and saved a child, that act has a whole different meaning than if I get the same burns because an alcoholic spouse and I got into a knockdown, drag-out fight, one of us lit the house on fire, and two of our kids died. Same third degree burns—very different symbolic and moral meanings.

When you think about the things that effect whether a stressful situation becomes traumatizing, you realize that many people in our communities who went to boarding schools experienced all of those things. Kids, often as young as age five, were separated from their families. A lot of times things had been hard at home, with poverty and other kinds of traumas taking place. Once the children were at boarding school, they had little support except perhaps from each other. The impact and meaning of someone telling you your whole way of life, in fact, your whole people, are not good certainly would have a very decided negative symbolic or moral meaning.

As Kroll indicates, there are actually several post-traumatic stress responses. We're used to thinking about PTSD first, but good old-fashioned depression and anxiety are actually far more common consequences of stress. We're not used to thinking of those outcomes as trauma but they absolutely are for many, many people. Demoralization, as Kroll calls it, is a sense of hopelessness and purposefulness that can markedly impact someone's life *(Kroll, 2003)*. It's not depression and it's not even classic dysthymia, but we see the sense of demoralization a lot in our communities. When physicians and others ask the right question, a Native person may respond, "I get up, I go to work in the morning, I get the kids to soccer practice, but I just have this sense that life just doesn't feel right. I go home and turn on the TV and drink a beer and try not to think about it." I think we see this a lot. It's another outcome of trauma.





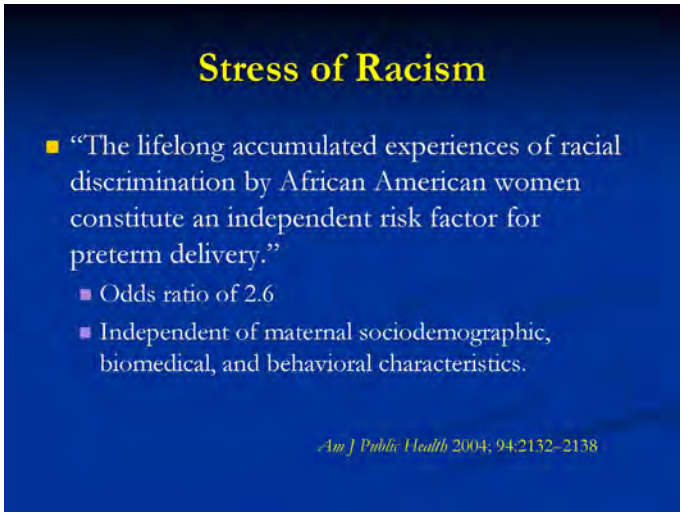
Back to our little gazelle for a minute. She did survive that original lion attack. And now, a week later, she's back with her herd munching on the grasses of the savanna when, out of the corner of her eye, she sees a shadow. Is it a lion or is it something else? The little gazelle does not wait around to find out. She takes off like a shot across the valley. Why would she do that? Well, at the time of the original encounter with the lion, the part of her brain called the amygdala said, "Oh my gosh, if we get out of here, we've got to make sure that we give ourselves the best chance the next time such a thing happens so I can get us out of here a little bit sooner." Her amygdala, so to speak, records all the sensory inputs associated with the original event, because all parts of the experience go through the amygdala. How does the amygdala know what it's looking for? Well, it's looking for something that could be dangerous. How would it know what's dangerous? Because it was once before. So at the time of the original lion attack, the amygdala recorded neurologically all of the things that were associated with the shadow coming out of her peripheral vision. The sound of the lion's paws on the grass; the smell when the wind shifted, and she could smell the lion. All those things got written down. The amygdala is always looking through current sensory inputs trying to find anything which is - or could be - dangerous because it was once before. And if it determines that something is reminiscent in any way of that original danger, it will set into motion very quickly the same bodily response that helped us successfully to run away or fight our way out of that situation. So, that same surge of adrenaline or epinephrine is released and so is that same surge of cortisol. And because we have the emotional part of this, in a sense this is a sensory part of what happens *(Ledoux, 1998)*.

Back to our little gazelle. When she saw the shadow in her peripheral vision, her amygdala responded with, "This is what it looked like last time. We've got to get out of here." The amygdala knows that a half a second can be the difference between living through something or being lunch for somebody else. So, the gazelle takes off and doesn't look back to see if it's a lion or not until she's halfway across the valley. The amygdala does not care if it's right; it only cares if it's not wrong. It does not want to miss an opportunity where it could have saved us. It would rather have us jump when we see a stick out of the corner of our eye instead of taking time to determine whether or not it is actually a snake. If we didn't have this capacity, our human species would not have lived to be the source of so much trauma for the planet. So what's the problem with this very adaptive mechanism? It seems like a good thing, right? The problem isn't the mechanism or the pathway. It's if you have to deal with a lot of trauma in your life, especially early in life, when you may have all those risk factors we just talked about stacking the deck, what you were experiencing during that time would be much more likely to be traumatizing. If you have a lot of trauma early in your life, you might have all kinds of things activating this pathway over and over again, sometimes in big ways sometimes in more subtle ways. But the stress pathway might be activated by a tone of voice or a facial expression or a body position or just the way someone says something. There are all kinds of things that the amygdala might associate with original events.

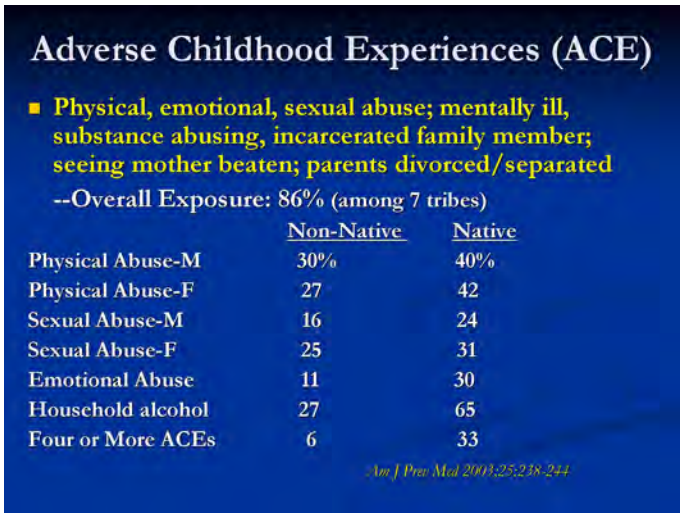
Do you ever feel afraid and not quite sure why? Maybe you occasionally feel angry or irritable and don't know why you feel that way. Some people feel sad or alone in the universe and again are not sure why. If we pay attention, these feelings happen a lot because emotions are being triggered and we can actually become aware of how that feels. Some years ago I heard Dr. van der Kolk, to whom I referred at the beginning of this talk, describe this pathway. Someone started coughing and he said, "Thanks, that was good timing because, until I brought it to everyone's conscious attention, probably none of you registered that someone was coughing - but if you had been raped by the man who was coughing, you would have been out the door and down the hall and your conscious brain might be going, '*What? What happened?'* The amygdala does not care whether or not the conscious brain is on track with this." It is irrelevant; this is a pathway which is stimulated to help protect us and if the conscious brain isn't on board it doesn't matter. What's surprising is that we may not realize what has triggered this pathway, or why it was triggered. So when we experience current stressors, even benign situations can trigger this response from things of which you don't even necessarily have a conscious memory or a conscious connection. So, if you've had a lot of trauma, this stress pathway gets triggered over and over and over again. And, again, what happens after months and years of cortisol and adrenaline pouring through your veins? Chronic disease, absolutely, along with mental health problems and other issues. It shouldn't surprise us that people try to find ways to avoid experiencing chronic stress, whether it's with drugs or alcohol or other agents, because omnipresent stress feels rotten.

We've talked a little bit about the physiology of stress and trauma, but the brain itself is also changed by stress and we should mention that. As neuroscientists say, "what fires together, wires together." So if you have a negative experience and experience all those stress hormones raging, perhaps because of abuse or neglect or someone who says they love you who then does mean things to you, all of those experiences may wire together to trigger those responses we just talked about. Until about a decade ago, we used to think that the brain was kind of fixed; now we know that this is not true at all. Actually, neuroscientists have discovered an ongoing complex process of sculpting the brain. Apparently, it is always adapting to convert experience into neuronal changes. That makes sense, because we have to be able to adapt to whichever situations are confronting us. We know the hormones that are involved in this process. One is called BDNF; the other is cortisol, which we were just talking about. Cortisol itself is involved in the process of sculpting the brain. So it makes sense that stressful or traumatic situations have an impact on the brain. It is not the occasional things that happen now and again that sculpt the brain. If you have frequent stressful experiences that take place often happening chronically, or if you're in a state of being chronically depressed, or both, in the part of the brain where sculpting takes place, the hippocampus and prefrontal cortex shrink. The hippocampus of course is highly involved with memory. We can't lay down any long-term memories without the hippocampus. The prefrontal cortex helps us with our executive functioning - our thinking and reasoning abilities. All of this means that chronic stress and depression actually shrink those parts of the brain that mediate our ability to

remember, to pay attention, and to make decisions in rational and logical ways. During this process, the amygdala has been shown to become larger, accompanied by an increase in our fear and hyper-vigilance, anxiety, and aggression. It makes sense. If many things are very stressful, we want to be a little twitchier - a little more able to jump into action should we be threatened in any way. The problem is that most of the situations we experience in life these days are not resolved by jumping up and running away *(McEwen, 2007)*.

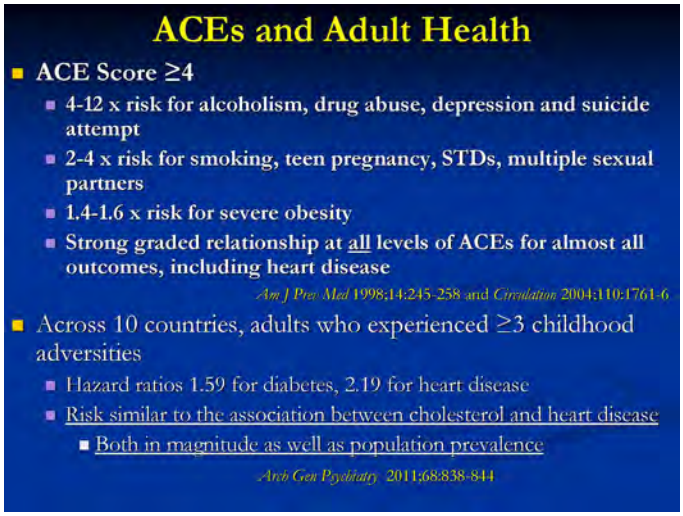


I want to mention now another type of stressor that we often don't talk about and that is the huge chronic stress of racism. Many, many Native American people deal with racism as just as many African Americans and others do in our society today. A study conducted by two neonatologists in Chicago reported on African American women and their newborn babies. The researchers, realizing quickly that the proportion of African American babies in their neonatal intensive care unit was way out of proportion to the percentage of the population of Chicago that was African American, then set out to determine why that was. At first, they thought it might be a function of socioeconomic status, but then they determined that the risk of pre-term or low birth-rate delivery was the same in a college-educated African American woman as it was in a Caucasian woman who had dropped out of high school. Clearly, more than just socioeconomic status was driving this finding. What the investigators finally realized was that when they asked whether a participant in the study agreed with a statement such as, "I deal with stress due to racism and discrimination on a daily basis," their odds ratio of delivering a pre-term baby was 2.6 - huge. The stress of racism on an ongoing basis hugely impacts pregnancy outcomes, and we know now that the earlier a baby is born and the smaller the baby, the greater the risk for later diabetes, heart disease, and other chronic diseases. Not surprisingly, then, a perfect storm has developed around many Native American people in terms of trauma and its long-term effects on health *(Collins et al, 2004)*.



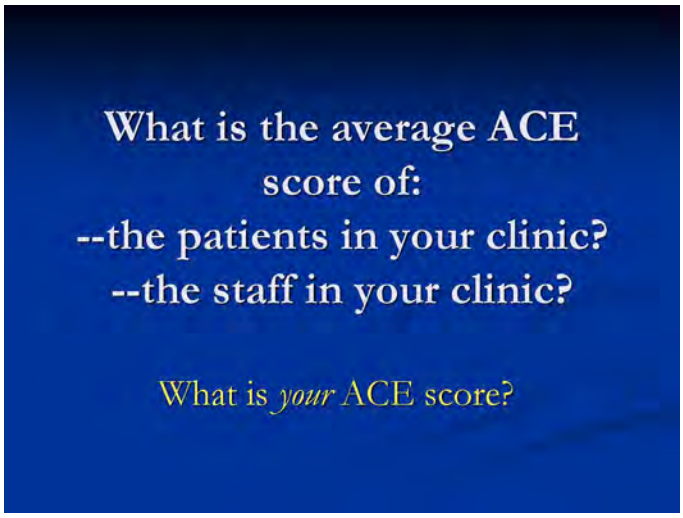
Many of you are familiar with the Adverse Childhood Experiences (ACE) study. It's the grandfather, if you will, of many studies that have been done since then. It was the ground-breaker that looked closely at whether what happens in childhood has an impact on us as adults. More than 7000 Health Management Organization (HMO) enrollees in the Kaiser HMO in California participated in the study. They were not asked whether they had experienced any current stress; they were asked which if any of these categories of stressful experiences they had experienced before the age of 18. The categories are listed in the slides: physical, emotional, or sexual abuse; growing up with a substance abusing,

mentally ill, or incarcerated family member; ever seeing your mother beaten; and parental separation or divorce. As you may know, the population of people who are enrolled in an HMO is not an average population because, in order to join an HMO, you or someone in your family has to be employed. For this reason, this population would probably have a lower risk of having experienced one or more of these stressors than those who are not in the HMO. What the investigators found, to their surprise, was that between half to two-thirds of these individuals said yes to at least one question. This was shocking back in the 1990s, when observers didn't expect that this group of subjects would report such high rates of dysfunction from childhood. As a consequence, someone got the good idea - in fact, it was Maria Yellow Horse Brave Heart and her colleagues who did so - to conduct a similar study in seven tribes in the Southwest. They posed most of the same questions, although they did not ask about parental separation or divorce. Eighty-six percent of the adults in this tribal population responded positively to at least one of the questions. When you look at the Native and non-native numbers in the slide (the non-natives were drawn from the Kaiser study in California and the Natives were members of one of the seven tribes in the Southwest), you can see that the numbers are high in both columns, but they are higher in the Native column. Take a look at household alcohol: two-thirds of the Native group said that they had grown up in a family where someone misused alcohol. There's also a question in the study which asks whether the subject reports four or more ACEs. Four or more ACEs means that the individual experienced four or more categories of stressors listed above at least once before the age of 18. *Six percent* of the Kaiser sample said yes to this question, while *one-third* of the Native sample did so *(Koss et al, 2003)*.

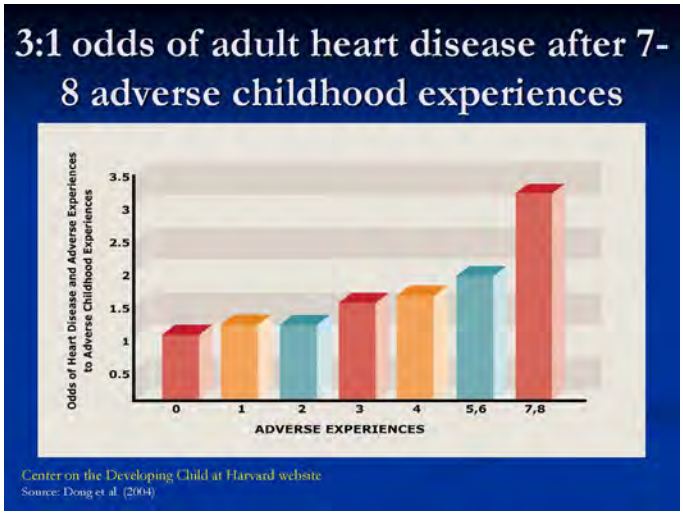


We know from the results of the Kaiser study that if your ACE score is four or more, you are 4-12 times more likely to be at risk for alcoholism, drug abuse, depression, and suicide attempts than if your ACE scores are lower. Again, when we think about how bad it feels to be dealing with all those stress hormones and those stressors triggered by all kinds of things in our daily lives, it shouldn't really surprise us that people use alcohol and drugs and other things to try to make those feelings less intense. Anything that we can do when we feel really bad, we'll do in order to feel a little bit better, at least for a time. If we're going to deal with depression and suicide attempts in our communities more effectively, we're certainly going to have to confront those ACE problems. If your ACE score is over four, you're 2-4 times more likely to smoke as an adult, to have a teenage pregnancy or sexually transmitted infection, or to report multiple sexual partners. You're also one and a half times more likely to be severely obese. In fact, there are strong graded relationships at all levels of ACEs for almost all outcomes, including heart disease. This means that people with an ACE score of 4 were at a higher risk than those with an ACE score of 3, and those with an ACE score of 3 were at higher risk than those who had an ACE score of 2 and even those who had an ACE score of 1 had a higher risk than those with an ACE score of zero. Clearly, what happens early in life has huge long term impact on our health and mental health as well as our health behaviors *(Scott et al, 2011)*.

Other studies have followed. The second one, summarized on this slide *(see slide on previous page)*, was done across 10 countries. Researchers looked at adults who had experienced at least three childhood adversities - a list similar to the one compiled in the ACE study. Risk for diabetes was almost two-thirds higher for those who had childhood adversities than for those who had not. The risk for heart disease in those who had an ACE score of 3 or more was almost twice as high as for those with an ACE of zero. In fact, having three childhood adversities puts the individual at just as much at risk for heart disease as high cholesterol does. Those of us who treat patients with high cholesterol by putting them on stints, we're not addressing the part that is just as likely to put people at risk for heart disease: chronic stress.



What is the average ACE score of patients in your clinic? What about clinic staff? When I ask this question of people in our Native American clinics, I'll often hear that the score is somewhere around 5 or 6. If I were to ask about the average ACE score for the staff in your clinic, I would probably hear a similar number: 4 or 5 or sometimes 6. Of course, it is also important to determine our own ACE score. As we learned from the Kaiser group's findings, the answer for half to two-thirds of us is not zero. In other words, as caregivers, we are dealing with traumatized populations and yet we may well have our own issues that can be inadvertently triggered by things our patients say or do. As a result, understanding our own issues, especially when they interact with those of our patients or clients, is especially important.



This is a graph showing the risk of heart disease. As the ACE score increases, so do your odds of having heart disease. Those with an ACE score of 7 or 8 are three-times more likely to have heart disease *(Center on the Developing Child, 2009)*.

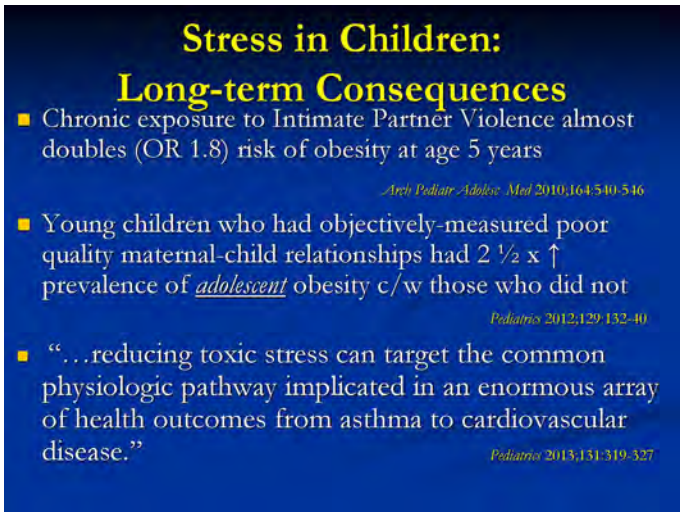
We don't have to wait for adulthood to be able to measure outcomes. Children experience physical outcomes from stress. This slide *(next page)* shows results from three of the many studies published on this topic. The first study examined the impact of chronic exposure to intimate partner violence. Children who responded to this study were not necessarily beaten themselves, but were exposed to their mothers being beaten. Seeing their mothers beaten almost doubled the risk of becoming obese by age 5 *(Boynton-Jarrett et al, 2010)*. In the second study, researchers followed moms and kids around at different points during the first few years of life to assess the quality of the maternal-child relationship. After following the children and waiting 10 years, researchers reported that the kids who did not have a

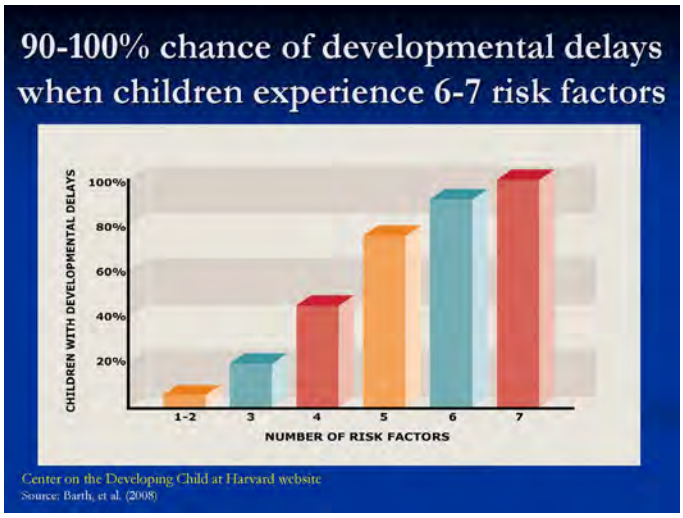
good relationship with their mothers were two-and-a-half times more likely to be obese as adolescents *(Anderson et al, 2012)*. Not having a secure maternal connection, and experiencing chronic stress while the immature brain was developing had real consequences. Pediatricians have noted that reducing toxic stress in childhood can target the common physiologic pathway implicated in an enormous array of health outcomes, from asthma to cardiovascular disease and including diabetes and other disorders *(Johnson et al, 2013)*. The bottom line: if we're going to reduce these chronic health problems, we're going to have to improve what happens to kids in childhood.

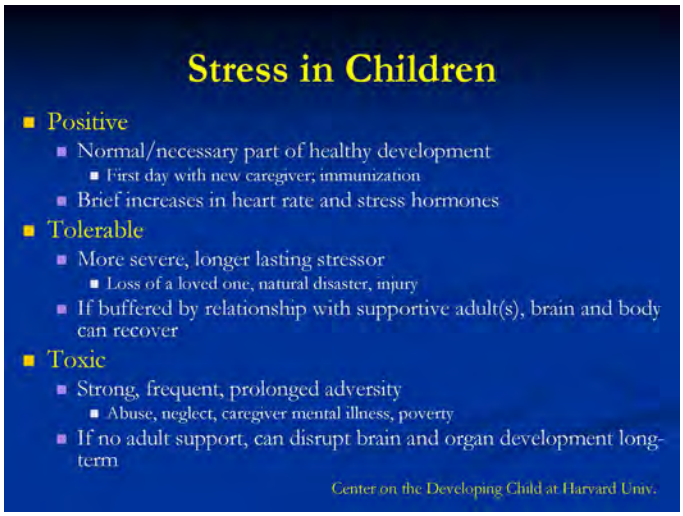
Children with high ACE scores also experience developmental delays. A kid who's had a 6 or higher ACE score has an almost 100% chance of having some form of developmental delay, often very serious *(Center on the Developing Child, 2009)*.

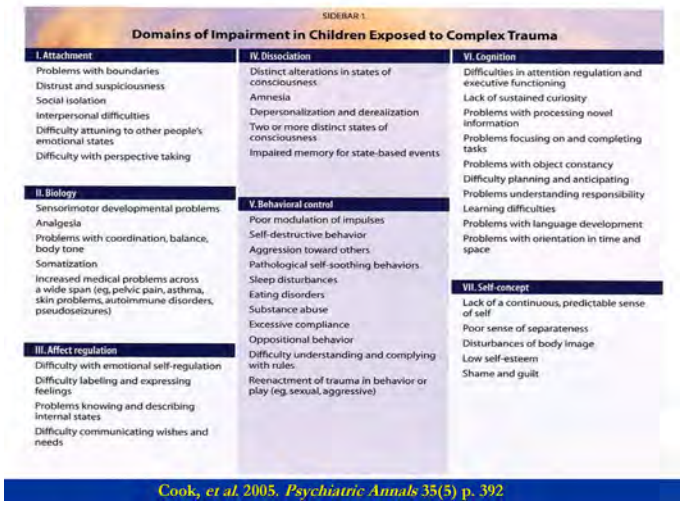
We know that in children as well as adults, not all stressors are negative. In fact, not only could we not avoid all stressors if we wanted to, we shouldn't even try to do so because this is the way the brain achieves a sense of mastery of skills at coping. Stressors in kids are a normal and necessary part of healthy development. The first day with a new baby sitter or a new teacher at day care, the child experiences brief increases in heart rate and stress hormones. This is okay as long as the kids have good support through these experiences. Both psychologically and neurologically, they can learn some mastery in these kinds of situations which will help them later in life. In terms of big stressors, like the loss of a parent, or going through a natural disaster, as long as these things are buffered by the support of adults, the brain and body can pretty much recover and feel some sense of accomplishment or mastery. With the right support, kids can learn that they can deal with these things so that when big things happen later in life, they're better able to handle them *(Center on the Developing Child, 2009)*.

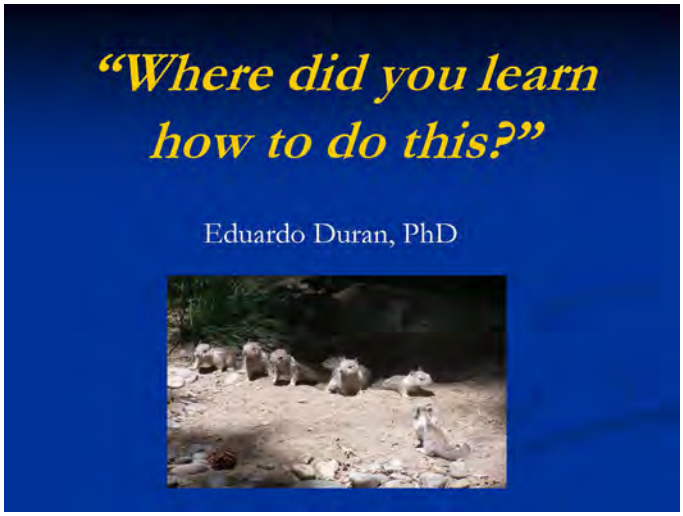
But problems arise when the stress is toxic. Toxic stress, also termed complex trauma, is strong,











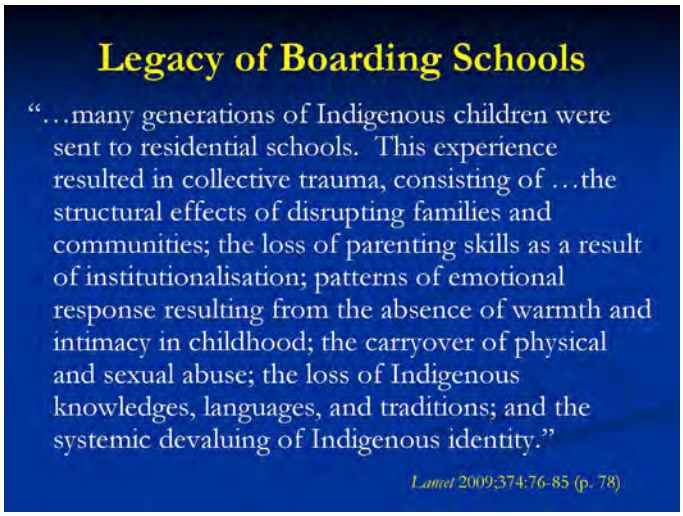
frequent and prolonged adversity such as abuse, neglect, or caregiver mental illness. Poverty itself is a toxic stressor. Without adult support, this kind of chronic stress can disrupt development long term. This slide shows results of a study by Dr. van der Kolk and colleagues that revealed that many different areas of development are impaired when children are exposed to toxic stress or complex trauma *(van der Kolk, 2015)*. We've already talked about the ability to bond and attach to other people and how doing so changes the ability to identify and control emotions. Dissociation is a completely appropriate response to a traumatic situation, but if we dissociate in response to many other things later in life, we will have a problem. Many of us work to help people control behaviors. Working in diabetes, I try to help people control their appetites, blood sugars, blood pressure. I have to remember that I may be talking to people who have dealt with trauma but have no sense of control over stressors in their lives. In fact, they feel controlled by these stressors. If you are told you are no good and never will be, and this is rooted in and connected to traumatic episodes, that sense of low self-esteem and guilt can be profound.

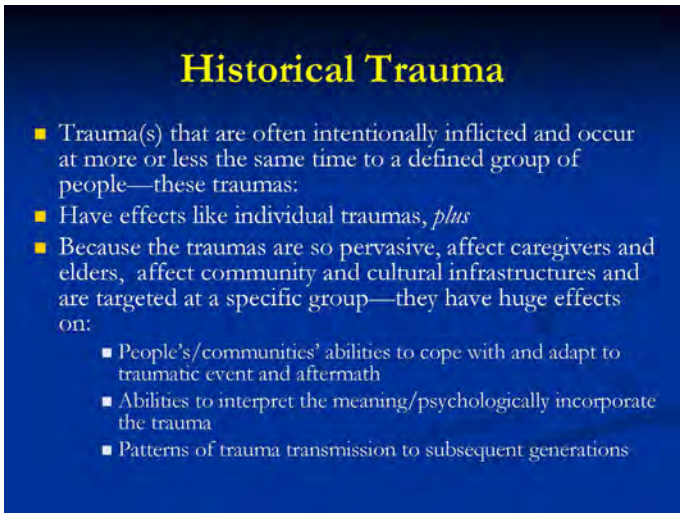
Why is this happening in our Native communities? As Dr. Eduardo Duran says, "where did we learn how to do it?" Dr. Duran, as many of you probably know, is a Native American psychologist who has written quite a bit on historical trauma. When young people who have been court-ordered to come to him, some of them slump in their chair and stare at him, as if to say, "You have nothing you can tell me." Instead of launching into a rebuttal, he says, "Let's see, you're here because you abused or neglected your kids, you've taken drugs, etc." He says, "Where did you learn how to do that?" And they go, "well, what?" Then he says, "You didn't make that up yourself, where did you learn how to do it?" And after some conversation and working with it a little, it comes out that there was a parent or grandparent in boarding school. We parent the way we were parented and that gets passed along. We often learn how to do these things when we are raised by people who were traumatized themselves. That keeps getting passed along.

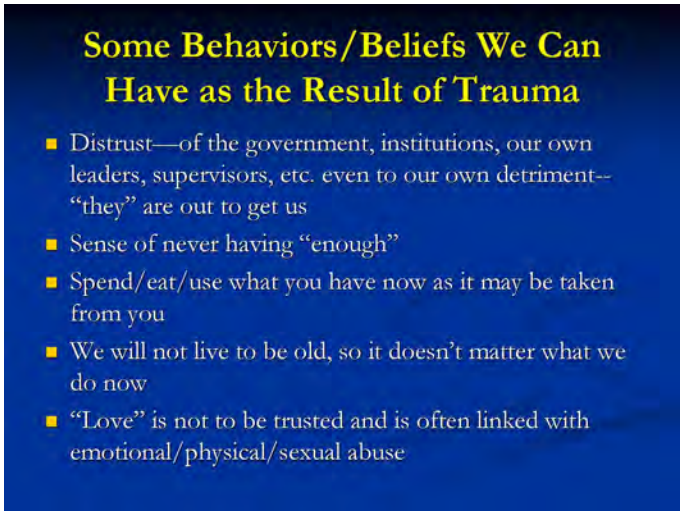
This article in the Lancet *(next page)* sums up the legacy of boarding school, not just boarding schools here in the United States, but many other places, because this sequence of events has taken place in many places around the world, including First Nations people in Canada, the Maoris in New Zealand, and the Aboriginal people in Australia. This Lancet article refers to "indigenous children in residential schools" because those are the terms used in some of those other countries, but it's the same idea. The quote says, "Many generations of indigenous children were sent to residential

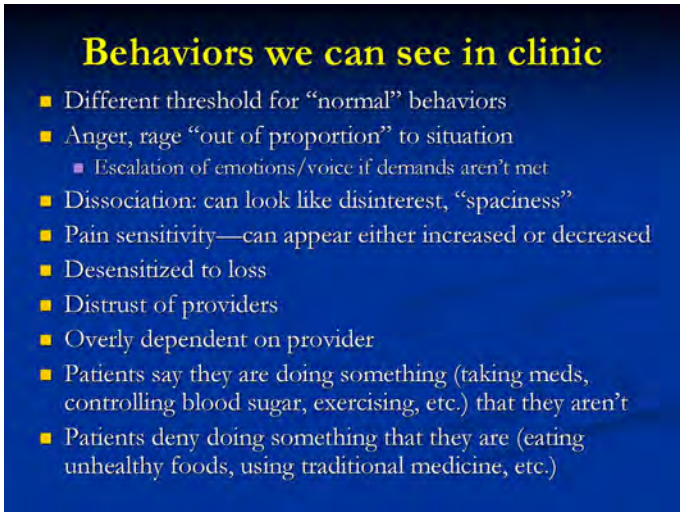
schools and the experience was a collective trauma consisting of the structural effects of disrupting families and communities and the loss of parenting skills as a result of institutionalization; patterns of emotional response resulting from the absence of warmth and intimacy in childhood; the carryover of physical and sexual abuse; the loss of Indigenous knowledges, languages, and traditions; and the systemic devaluing of indigenous identity" *(King et al 2009)*. I think that pretty well sums up the legacy for many people coming out of boarding school. Not all, of course. We never want to paint anything with a single brush.

In my mind, historical trauma is a model that helps explain the present. It's not just about the past. It's a model about the present, and it helps us understand the traumas that are often intentionally inflicted and occur at more or less the same time to a defined group of people. These traumas do have effects comparable to individual traumas - the things we've been talking about for the last half hour. But because the traumas are so pervasive, because they affect caregivers, elders, and parents, people cannot support children through these things. The elders who help us to understand our culture are also affected. Because our community and cultural infrastructures are affected and targeted, they have big effects on individual's and communities' abilities to adapt to traumatic events and aftermath. Often, it wasn't a single event, it was multiple events, and there was no chance to recover. These effects' impact on the abilities to interpret the meaning of and psychologically incorporate the trauma - how do you make sense of the world going forward after something hard and horrible has happened? And of course, there is also the transmission of traumatic behaviors to subsequent generations. If one person gets in a car accident it can be traumatizing to them, but what happens when a whole community gets in a car accident? Who's going to pick up the pieces? Who's there to help us move forward? It's a big issue.





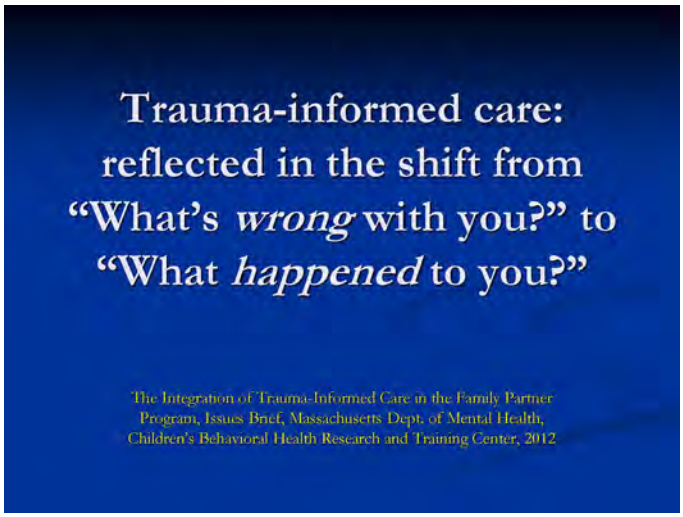


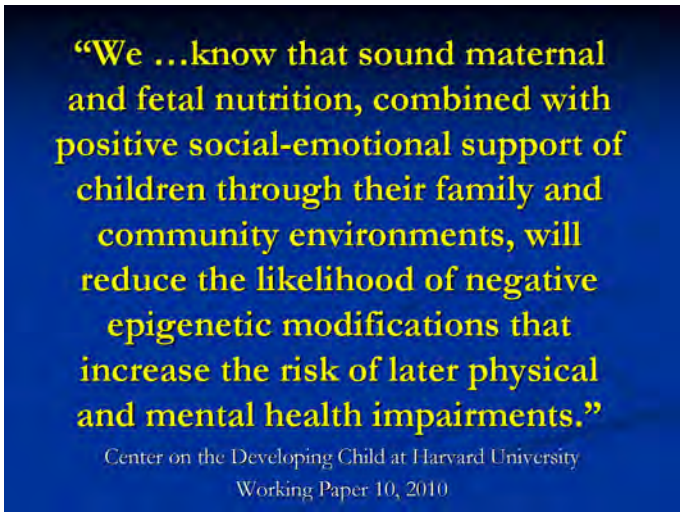


I know I'm getting a little short on time here. I've just listed on this slide some of the behaviors and beliefs. Do Indian people have reason to distrust institutions and governments? Of course, but sometimes that distrust is expressed in ways that are not helpful to us. We sometimes distrust our supervisors and leaders, sometimes to our own detriment. We think they are out to get us. That is not always true, but it's understandable that there might be that reaction. Many people have the sense of never having enough. That is understandable, but what they might do because of that is spend, eat, or use what they have now because it could be taken away, because indeed it has. These behaviors are not always helpful when we try to deal with our finances or deal with diabetes or many other things. That doesn't matter to some people because they believe that they are not going to live to be old. These beliefs are wired in, but they're not particularly helpful. And, of course, the concept of love itself can't always be trusted if it was wired together with some form of abuse.

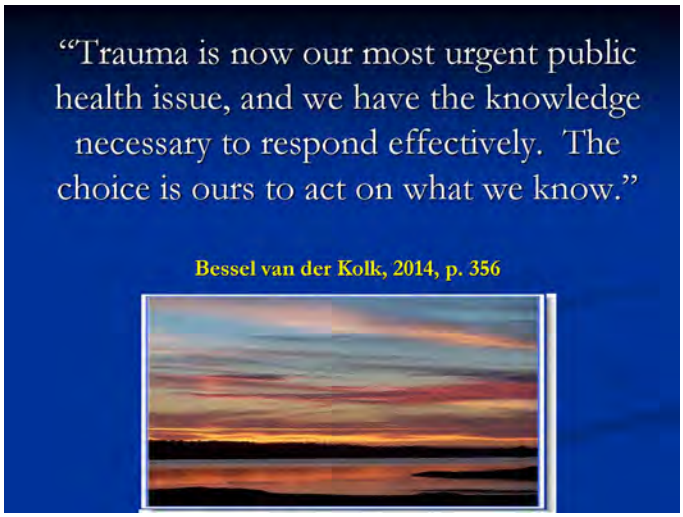
We see lots of different behaviors; I'm not going to spend much time working on this. You see it, you feel it, but these are all normal reactions for people working with authority figures, whether it was a parent, or a physician, or substance abuse counselor today. Whoever it is they're dealing with who is now an authority figure in their life, a lot of the same dynamics can make it difficult not only for the therapeutic encounter but for us. These folks are some of the hardest we have to work with, because these reactions to authority just keep coming up over and over again. But again, they're normal and it's important for us to maintain good boundaries - neither too rigid nor too closed, because those are things these folks will keep pushing against. They're not familiar with good healthy boundaries, and yet there's something inside them that knows these are good things, but they will still push them.

We don't have time to talk about a couple of big concepts that I wanted to end with. But I do want at least to refer to them. Many of you are familiar with the concept trauma-informed care. When people think about it, it helps them to realize that, instead of our judgmental medical care model, which assumes that most of what happens to people is because of diet or inactivity or bad genes, a shift has taken place so, instead of questions about what's wrong with you, the question is what's happened to you? That's a very different perspective. It has a whole different energy to it. I want us to stress the importance of not seeing people as victims but not blaming them for what is going on either. So, not so much what's wrong with you, rather, what's happened to you? The two are very different *(Massachusetts Dept. of Mental Health, 2012).*





I want to leave you with this one quote from the Center on the Developing Child at Harvard. "We know that things can help break this cycle of trauma and poverty; and we know that sound maternal and fetal nutrition, combined with positive social-emotional support of children through their family and community environments, will reduce the likelihood of negative epigenetic modifications that increase the risk of later physical and mental health impairments" *(Center on the Developing Child, 2010)*. So just as we understand the mechanisms by which the hard stuff gets in there, we're starting to understand the mechanisms to start to get at least some of the hard stuff out. And we're beginning to make sure that tribes take good care of young people before they even start having children - as well as pregnant women - so they get the best available food, and experience the least stress, and receive support as they take care of their children in their early years. Every tribe knows this. These are the kinds of things we know make a difference. It's easier to put trauma into people than it is to get it out, but there are ways to do it over time; over generations we can do it.



I opened this talk with a quotation from van der Kolk and I want to close with one as well: "Trauma is now our most urgent public health issue." This is a pretty profound statement, and given the huge consequences of trauma it makes sense. Van der Kolk goes on to say, "and we have the knowledge necessary to respond effectively. The choice is ours to act on what we know" *(van der Kolk, 2015)*. Native people see many reasons why there is so much trauma in our communities; as a result, we sometimes wonder if there's something wrong with us. We don't need to be an oppressor anymore; we're passing this along to the next generation and we wonder if there is something wrong with us. There isn't anything wrong with us. These are normal reactions to abnormal situations. As we understand how stress and trauma work and the intergenerational transmission of trauma takes place, we can realize that the medicine is already within that pain and suffering. Things have gone wrong in raising children without realizing that suppressing a long trauma without realizing the profound effects of poverty and poor nutrition on our kids is a big problem. Well, that's where the medicine is - that's what we need to do.

Thank you so much for your time. I hope that this talk was useful to all of you.

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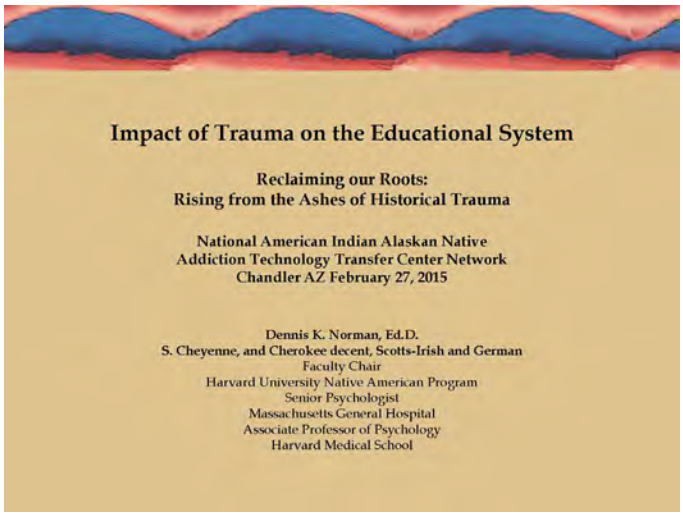
IMPACT of TRAUMA on the EDUCATIONAL SYSTEM

Dennis Norman, Ed D, ABPP, descendant of the Southern Cheyenne Nation

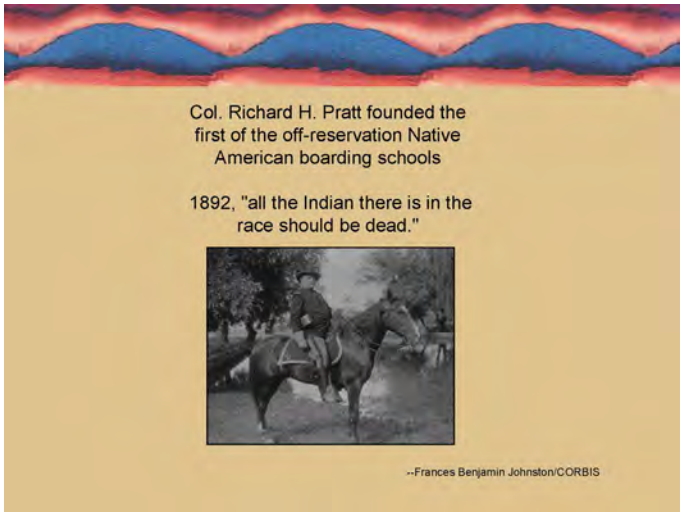


It is certainly interesting to discuss the impact of trauma on the educational system, especially when it has been the Euro-American educational system itself that historically and currently has been a significant source of trauma for American Indians and Alaska Natives. The imposition of the dominant culture's replication and alignment of values within the Euro-American world-view is the historical and current context of discussing the "educational system." Through colonization, subjugation, and a focused desire to annihilate or assimilate the cultures and world views of our indigenous peoples in North America, in addition to the other forces we have talked about today, we build a picture of sustained individual and collective trauma.

This must be contrasted with what existed in indigenous educational practices prior to colonization, what existed surreptitiously for decades, and what has been recently more openly sought in an effort to restore and maintain cultural ideals and norms, social values and survival skills. Prior to colonization, American Indian and Alaska Native peoples were highly aware of the need to educate their children for the lives they were going to lead and the roles they would play in their communities. The methods and approaches for achieving these ends were certainly in contrast to what was encountered post-contact with Euro-Americans. Besides being denigrated as uncivilized and primitive, American Indian

and Alaskan Natives were systematically deprived of every connection to their ways of life and methods of adaption to this life that had been integral to their indigenous practices and developed over centuries for the education of their young. Ironically, their denigration by Euro-Americans was matched by most Natives' views of the colonizers as unclean, greedy, ignorant about adaptive survival within nature, manipulative, and just plain uncivilized. As Ray Daw and his fellow authors point out in *Orenda Talking Medicine*, "Euro-American culture is starting to catch on to the fact that Indians actually may have been far more advanced in terms of social, psychological and ecological knowledge than any European culture," *(Daw et al, not found).*

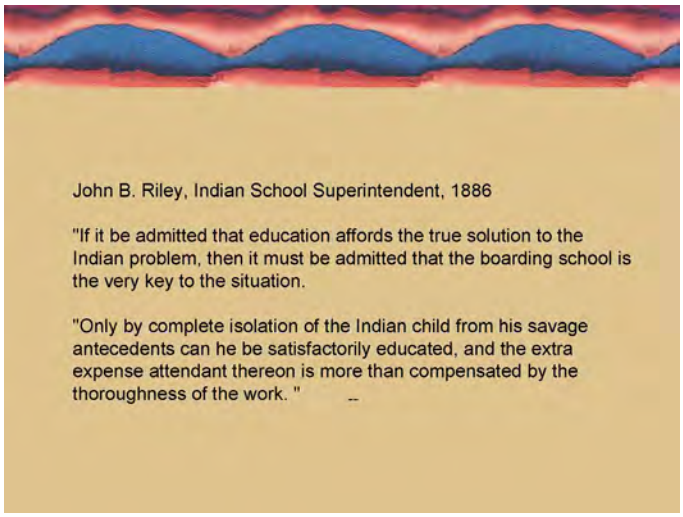
The history of the boarding schools was one of an all-out attempt to kill the Indian to save the child. As clearly stated by Colonel Richard Pratt, founder of the first off-reservation Native American boarding schools, "all the Indian there is in the race should be dead."



Although we know that often the environment also killed the child physically through communicable diseases, and mentally through identity-crushing tactics; it broke the traditional educational systems of tribal communities, disparaged their families and communities, their languages, rituals, values, and their identities. This was the opposite of what we would now call a culturally-sensitive, relevant educational system designed to foster the development of each child to maximize his or her potential, foster pride and competence, and help them take their places as contributing members of their communities and the larger society. The last part of that statement, *help them take their places as contributing members of their communities and the larger society,* unearths a contradiction: the ultimate goals and real practices of Euro-American education and where it places its values give little emphasis to the collective sense of responsibility that is such a major component of Indian values. Such was the encounter, and such has remained a historical difference in perceived values even to today.

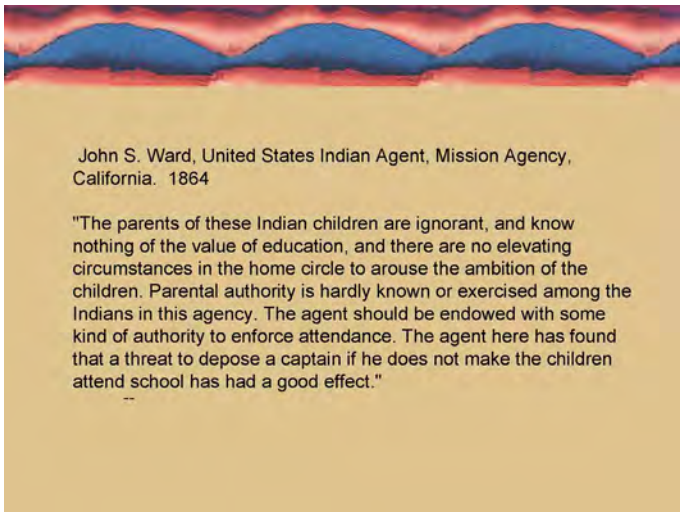
The following quote is from John B. Riley, an Indian School Superintendent in 1886:

> *"If it be admitted that education affords the true solution to the Indian problem, then it must be admitted that the boarding school is the very key to the situation. Only by complete isolation of the Indian child from his savage antecedents can he be satisfactorily educated, and the extra expense attendant thereon is more than compensated by the thoroughness of the work."*



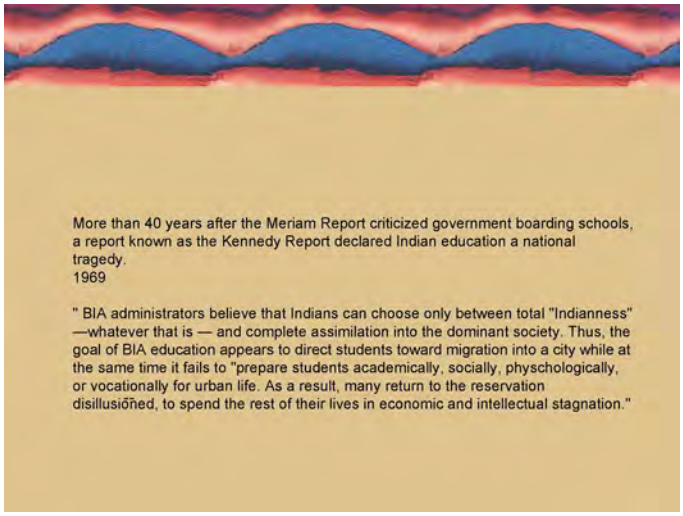
The following quote from John S. Ward, United States Indian Agent, Mission Agency, California in 1864, makes clear the predominant attitudes toward American Indian and Alaskan Natives and the role with which education was envisioned:

> *"The parents of these Indian children are ignorant, and know nothing of the value of education, and there are no elevating circumstances in the home circle to arouse the ambition of the children. Parental authority is hardly known or exercised among the Indians in this agency. The agent should be endowed with some kind of authority to enforce attendance. The agent here has found that a threat to depose a captain if he does not make the children attend school has had a good effect."*

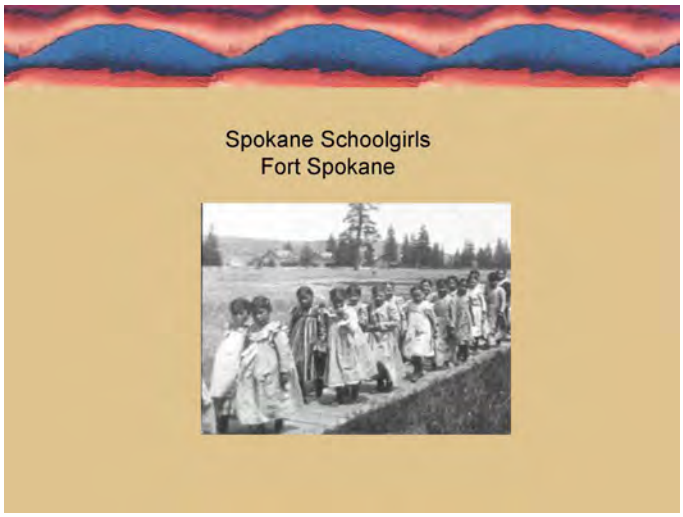


More than 40 years after the Meriam Report criticized government boarding schools, a 1969 report known as the Kennedy Report declared Indian education a national tragedy. Quoting from the Kennedy report:

> *"BIA (Bureau of Indian Affairs) administrators believe that Indians can choose only between total 'Indianness'"* - whatever that is - *"and complete assimilation into the dominant society. Thus, the goal of BIA education appears to direct students toward migration into a city while at the same time it fails to "prepare students academically, socially, psychologically, or vocationally for urban life. As a result, many return to the reservation disillusioned, to spend the rest of their lives in economic and intellectual stagnation."*

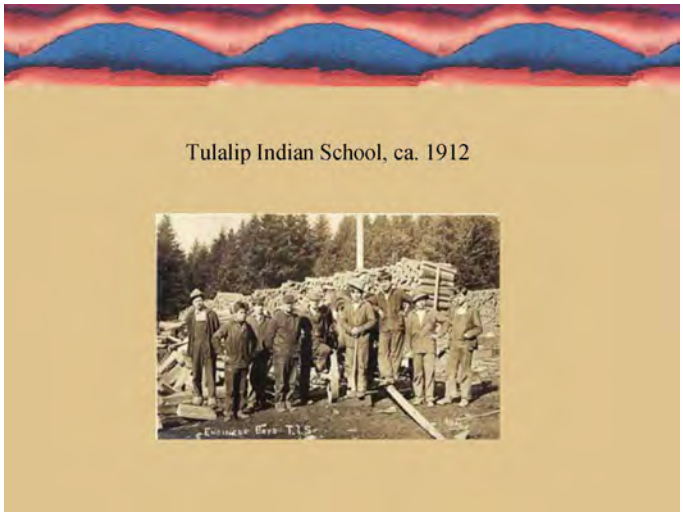


All of us know how important education is to the young as preparation for assuming a meaningful and responsible life. All of us also owe tremendous debt for the opportunities that education has given and continues to give to us and our children, but we also must remember and be aware of the current trade-offs and prices that are paid for succeeding in this system. What we are talking about is the price paid for forcing this system and it's values on American Indian and Alaska Natives, the traumatic impact it has had, and how it currently deals with people who have been individually and collectively traumatized. Successful achievement within the dominant culture can create gaps in an Indian's ability to connect with

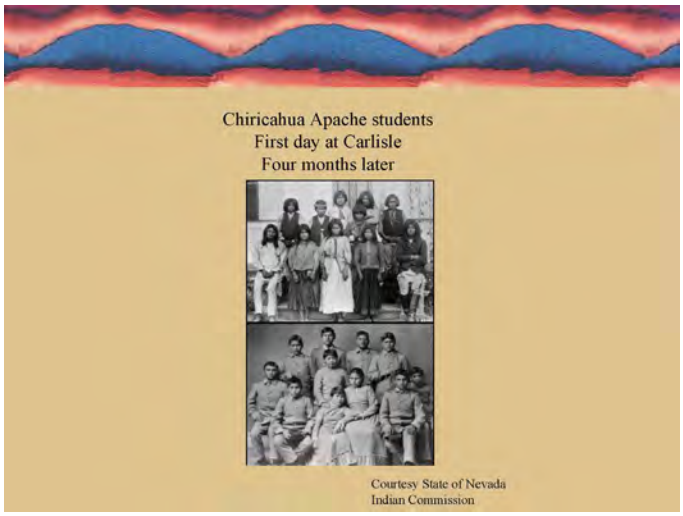


their families and communities, success can foster resentment and jealousy, success can mean learning skills that are not able to be practiced in one's community and require relocation, and success can make one suspect to some in their communities as having sold out or having been assimilated.

So briefly, when we speak of trauma and it's relation to the educational system, we are, in the case of American Indian and Alaska Natives, speaking about one of the main agents of trauma: the educational system itself. A system that removed children from their parents and communities to educate them not to be Indians, to assimilate them and prepare them for a life that was totally different from the communities that they were taken from and that lead to alienation and loss of heritage.



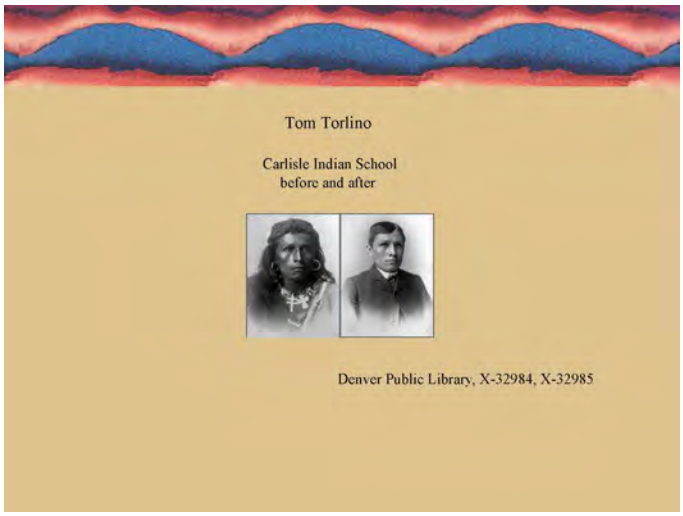
The most active years of the boarding and day schools were between 1860-1930 when tens of thousands of Indian children were forcibly enrolled in these institutions, many never to return home due to death by illness. Vestiges of these institutions and their dogma remained for years afterward and that legacy is still with us. The stated goals, besides total assimilation behaviorally and ideologically, were to Christianize the children, provide the rudiments of reading, writing and speaking English to the exclusion of their Native languages, and to be taught the importance of private property, material wealth and monogamous nuclear families. These are the socio-economic pillars of Euro-American society.



When you take someone's language, name, and dissolve their connection to their family, break their connection to culture and the ability to practice their religious and social rituals, you have deeply and often irreparably injured the person; what Duran refers to as the "Soul Wound," which is a much more apt term for the holistic view of these traumas *(Duran, 2003)*. In combination with disease, death by conflict, loss of homeland and all the other losses encountered with colonization, you get the picture of what we are talking about today: individual trauma often talked about as PTSD, collective traumas such as colonization and historical trauma, and the perpetuation of trauma through intergenerational trauma; secondary to the destruction of people's ability to care for their young appropriately and raise them with the skills to grow and endure the challenges of their life effectively. The response to these different forms of trauma are emotional, behavioral and cognitive difficulties which negatively impact all areas of life and, of course, a child's ability to thrive in the educational system where they spend so many hours of their developing years.

Again, I know many of us have benefited from and understand how education has enriched our lives and opportunities, but having spent my entire professional career as a child psychologist, I have acquired skepticism and dismay at the ability of society at large, and educational systems in particular, to commit to a sensible strategy for optimizing the growth and development of all children, much less those not fully reflecting the values of the dominant culture or those whose economic resources are limited.

The current educational environment is predominantly administered by non-natives often ignorant and therefore insensitive to both the history and the current atmosphere in Native communities. Because of this the children, their families, and communities become victims and are then blamed for lowered achievement, lack of family support, and behavioral and learning problems.



If we step back and look at the entire US educational system, it is impossible to get consensus on the broad range of goals, strategies and content of what is considered education. Whether it's "Core Curriculum," "No Child Left Behind," or investment in preschool environments, these are hotly debated topics with experts, teachers and parents which often leave them divided on the best solutions and the most important goals of education. What we do know is that the current system rewards affluent children with inordinately better chances of academic success, entrance into colleges, professional schools and life-long earnings.

I say this because for over 35 years I have evaluated, tested and advocated for children with learning and emotional needs, which were not being addressed in schools. I have also consulted extensively in Native communities as a point of comparison that I hope informs my perspective. Boston is a city with one of the highest number of learning and behavioral specialists per capita in the world, and it is still a major problem for thousands of children in the area to obtain adequate diagnosis and remediation for behavioral, mental health, and developmental and learning disabilities; and then translate these needs into appropriate educational plans which might address their needs. Boston families of modest or meager means face considerable barriers in terms financial strain and access to service. Only wealthier families have a likelihood of matching their child's needs within the various educational systems, public, private, or parochial. When this same scenario is moved to rural parts of the country, and most especially to reservations, it is not hard to imagine the incredible disparity of needs versus services, the difficulties recruiting and retaining teachers and professionals and the continuing struggles worsened by poverty.

Some of the American Indian Alaskan Native statistics speak for themselves.

Elevated high school drop out rate

- 76% American Indians 25 and older have a high school diploma vs. 84% general population
- 17% American Indian high school graduates pursue higher education vs. 62% general population
- 11% American Indians 25 or older have a bachelor's degree vs. 26.7% general population
- Only 50,500 American Indians and Alaska Natives hold advanced graduate degrees

So before getting specific about some of the challenges faced by Native communities and by schools, I feel it's important to review quickly a picture of differing values between American Indians and Alaska Natives and Euro-Americans that has a tremendous effect on how Native children and parents are seen within the majority of schools. These reflect differing cultural values that bias how children are viewed and often assessed. Ray Daw and his fellow authors point out, again, in *Orenda Talking Medicine,* these value conflicts that I would like to share.

American Indians and Alaska Natives

- Slower, softer speech
- Avoids speaker
- Little or no eye contact
- Interjects less
- Less "encouraging signs"
- Delayed response to auditory message
- Nonverbal communication valued
- Cooperation
- Importance of group needs
- Harmony with nature
- Control of self, not others
- Sharing
- Participating when certain of ability
- Physical punishment rare
- Patient
- Broken English accepted

Euro-Americans

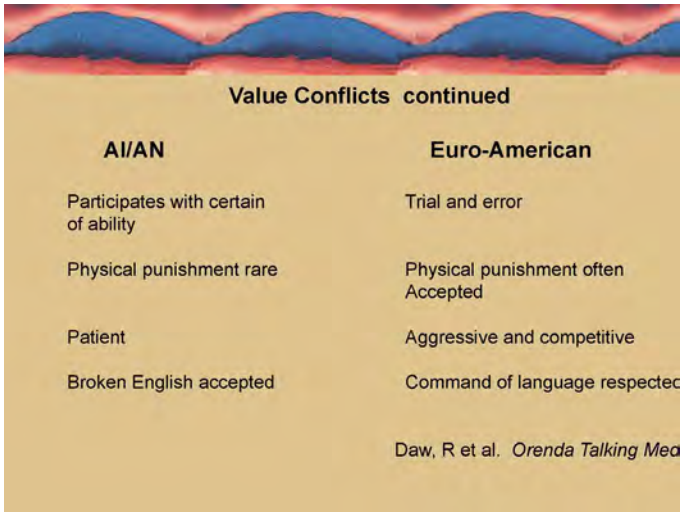
- Louder, faster speech
- Addresses listener by name
- Direct eye contact
- Interrupts frequently
- Much verbal encouragement
- Immediate response to auditory messages
- Verbal skills highly prized
- Competition
- Importance of personal goals
- Power and control over nature
- Control of self and others
- The collection of material things
- Trial and error
- Physical punishment often accepted
- Aggressive and competitive
- Command of language respected

(Daw et al, not found)

As one can see, adherence to one or the other set of views conflicts with cultural aspirations and norms for an individual, assessments of what is perceived to be "good" or normal behavior and even the process of communication.

So how are children evaluated when they are identified as having difficulties adjusting personally, behaviorally or academically in school? These practices are certainly in the domain of psychologists, school psychologists, psychiatrists, social workers and counselors, but the criteria for assessing emotional, behavioral and academic norms for functioning has been for most part developed by professionals totally unaware of the historical or cultural context that informs American Indians, Alaskan Natives, and their values.

Psychological symptoms are mainly viewed and judged within an individual and family context often focusing on intra-psychic conflict or family systems, but with little to no appreciation for differing cultural or collective values which we just reviewed, little to no awareness of the historical forces that might instill distrust in parents and children for professional attempts to influence, socialize or treat their children. How can you trust professionals or educators who label your child as odd or anti-social for not making eye contact, or being labeled as passive or dependent rather than an attempt to be respectful? How can you trust academic and intelligence tests that create a national normal range without regard for American Indian and Alaska Native norms, but that are used to judge their abilities, potential and progress in school? This is still the case even though most professionals know that there are racial, socio-economic-status, and cultural differences in performance on these measures always favoring the well-off and whites. Even the process of teaching is taken for granted and heavily biased in favor of the ability to sit for hours at a desk, to verbalize or read rather than "hands on" or to "see and do" which are indigenous methods of teaching that have endured and worked for eons. I would argue this bias in teaching methodology also misses many Euro-American children and is reflected in the paucity of knowledge about non-verbal learning disorders, in contrast to the plentiful research regarding reading and verbally expressive disorders.



Returning to trauma, we know that traumatic symptomatology, which is significantly higher in American Indians and Alaskan Natives than in the general population, has a deleterious effect on focused attention, regulation of emotion, executive functioning, and decision making. The National Institute of Mental Health estimates the prevalence rate in the general population as 3.6% and Brave Heart has estimated it as high as 22% in Native populations. It also impairs the critical process of the brain's ability to shift short-term learning into long-term memory. Problems associated with learning disabilities are most often blamed on individual biological and developmental deficits of a child rather than a history of individual and collective trauma in their communities that affects parents' and children's ability to perform in school and develop necessary life skills.

So does it make a difference as to which educational system you're in as to how a traumatic background is dealt with? Indeed, it does. We know public schools have to take all comers up to a certain age. Private and parochial schools can dismiss or expel children who are seen as outliers, and are relatively intolerant of children with behavioral or learning needs that don't conform to their specific standards. Many give philosophical lip-service to the needs of this population of children, but in practice implement a "gated community" practice in acceptance and retention.

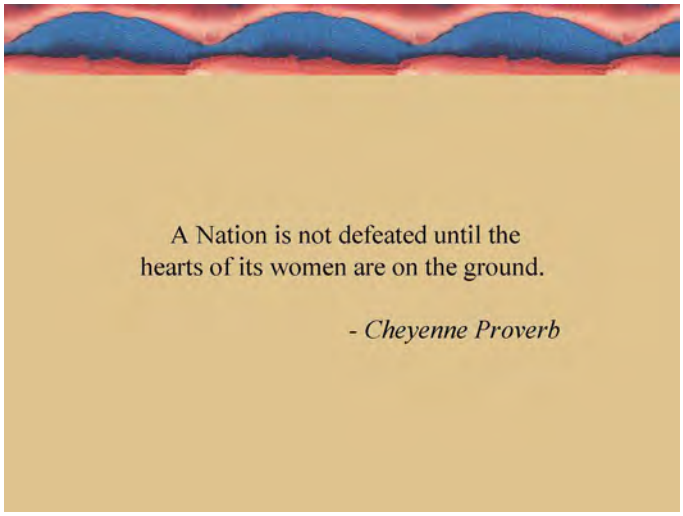
Public schools have their own methods of isolating and dealing with challenging children without addressing the underlying concerns. They are often underfunded for the special behavioral or emotional needs of children, and often do not have access to the appropriate professional expertise for accurate diagnosis and individualized education plans, and as a result, routinely practice an unspoken policy of benign neglect, empty assurances to parents or, if parents are vocal and persistent, fall into blame-game mode where parents, often besieged, overwhelmed, demoralized, and sometimes hopeless, are seen as the "real" source of the child's problems.

Schools are incentivized to label the subsequent behavioral difficulties the main problem rather than diagnosing learning difficulties secondary to trauma, social determinants and/or developmental disorders since they are inadequately trained and resourced to provide appropriate services. These children are disproportionately represented in the juvenile justice system secondary to the same history that made school so difficult to adapt to successfully.

Of course many of the things I have discussed represent a continuum of issues related to trauma and the educational experience. Not all communities have the same history or experience of trauma, not all have the same resources, and not all the same access to their traditional cultural foundations. Despite these differences, I posit that the overall tone is likely to resonate with many tribal communities, also reaching those who have been displaced or have moved into urban environments because of the shared history of historical trauma, whether this was many decades ago, or whether it is the continuing invisibility of their lives in the contemporary curricula of history, literature, religion, and culture in the vast majority of schools and universities. This invisibility represents a continuing assault and trauma to American Indian and Alaska Natives' lives, identities, and current or past contributions to life in North America.

In my own experiences in nation-building, where I work with tribal communities striving to build healthy institutions, one of the most pressing problems these communities want to address is the well-being of their children of which school is such a major component. The teachers and administrators, more often than not are non-native, often well-intentioned, but more often than not, burned-out and overwhelmed by the enormity of the challenges facing them and subsequently angry or resentful toward the children and their families. While this is understandable from a personal point of view, it

misses the gestalt and the possible remedies for traumatized communities. It takes more awareness of mental health and the underlying causes of traumatic responses and symptomatology. It requires sensitivity and knowledge of the community's history. It takes a collaborative effort by at least some community members to reconnect and support traditional values that are undermined, and as we have discussed, culturally adapted treatments for traumatic responses and symptomatology. Despite the damage done, trauma can healed but not forgotten.



I hope this overview has not seemed overly pessimistic, because I'm heartened by many activities I see in rebuilding Native communities. I am heartened by communities reclaiming aspects of their children's education and introducing their language and values into the curriculum. I am also heartened by the struggle to want better and more culturally-rich lives for their children. Thank you.

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NATIVE AMERICAN COMBAT VETERANS: INDIGENOUS PSYCHOTHERAPY for COMBAT PTSD

Shane Eynon, PhD (LT, USPHS), descendant of the Seneca and Ojibwe

I am going to try to make it a little more entertaining because I have found, over time, working with patients, that you remember more if I make it more entertaining. So I'm going to try to do that, although I am extremely nervous, and I tend to do bad things when I'm nervous. One of the things that I do is start talking like I'm actually in the military, and you're the military audience; which means that I will say things that are probably inappropriate, but I apologize ahead of time; I swear and I curse like a sailor.

Now I came here today with this suit that my wife picked out; I didn't pick it out because I am an Indian talking to you as an Indian, I'm not from the federal government. I don't want to talk to you that way today because what I'm going to talk about needs to be spoken in truth, and with the government, you can't always be exactly truthful. You get in trouble when you do that.

So I have to put up this disclaimer because I am an officer; what I'm about to say today doesn't express policy from the Department of Defense and the Department of Health and Human Services.

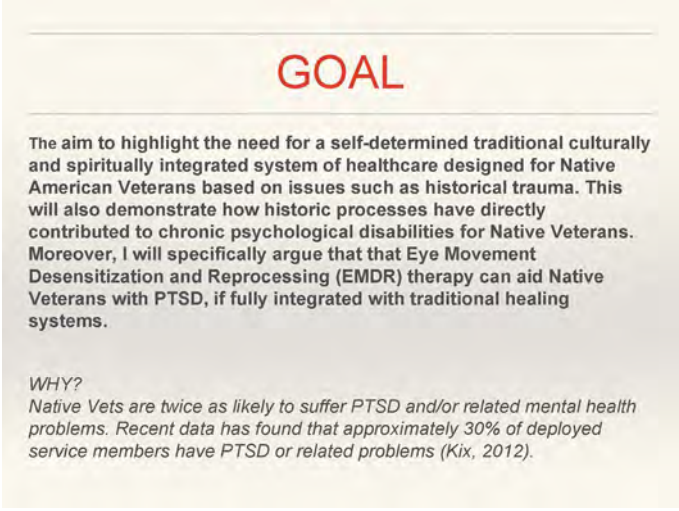
- The views and opinions expressed are the author's and no not necessarily reflect the policy or opinion of the DoD or DHHS.

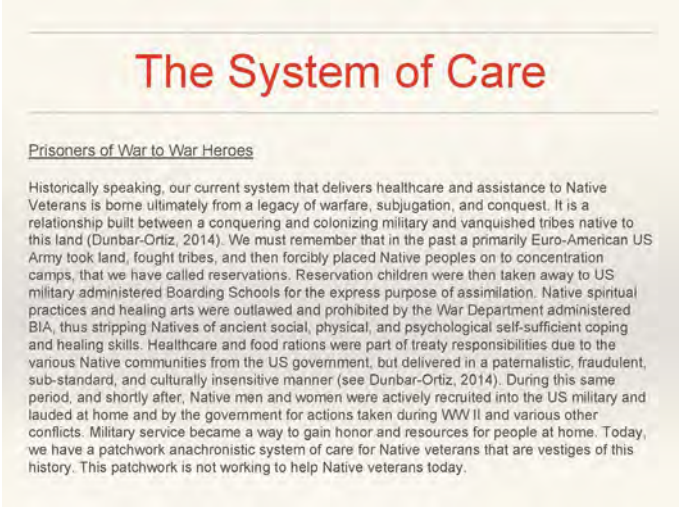
We're going to be talking today about Native American combat veterans. We're going to talk about the development of an indigenous psychotherapy specifically for their needs and I'm going to try to prove to you that we need to do so. To make things entertaining, I'm going to ask for a volunteer from the audience to help me show you what therapy really looks like.

My ultimate goal is to highlight the need for a self-determined, traditional, culturally and spiritually-integrated system of healthcare designed for Native American veterans based on issues including historical trauma. Doing so will illustrate how historic processes directly contributed to chronic psychological disabilities for Native veterans. I will argue that eye movement desensitization and reprocessing therapy can aid Native veterans with post-traumatic stress disorder (PTSD), if fully integrated with traditional healing systems. Native veterans are twice as likely to suffer PTSD and/or related mental health problems like depression as non-Natives. Recent data indicate that approximately 30% of deployed service members develop PTSD or related problems *(Kix, 2012)*. I'm going to go into why PTSD isn't just this thing that happens to your brain; instead, it's a soul disease as well and I'm going to highlight that. Okay, so how did we get here? For a social summary, we need to understand how we got to this point. We have Native veterans suffering at a greater rate than anyone else.

Historically speaking, our current system for delivering healthcare and assistance to Native veterans has arisen from a legacy of warfare, subjugation, and conquest. It is a relationship between a conquering and colonizing military and vanquished tribes native to this land. I'm taking much of this from an author whose excellent book on this subject thoroughly reviews an indigenous perspective on what happened in America and how things got from point A to point B going back tens of thousands of years *(Dunbar-Ortiz, 2014)*.

We must remember that, in the past, a largely Euro-





American US army took land, fought tribes, and forcibly placed Native peoples in concentration camps that have been called reservations. Reservation children were then taken away to US Military-administered boarding schools for the express purpose of assimilating them into the non-native culture. Now I'll take a little side-step here for a second. There's a spirit involved here because Dr. Norman's talk and the reasons why I'm here today are very emotional for me for a lot of reasons. My great grandmother was the valedictorian of the Carlisle Indian School in 1887. She gave a speech to the graduating class that asked the question, "Are we better for the coming of the white man?" By the way she lived her life, I can only assume that she answered that question in the affirmative. She tried to be white; it didn't work out for her, for my family, or for how I grew up.

So, on top of this, the children were taken away and assimilated. It wasn't a voluntary thing. It was just these kids taken away. Imagine that these 5 year old and 6 year old kids were taken on this train ride thousands and thousands of miles from home. Everything about you is dirty and nasty and heathen. You're going to be Christian and American. You're going to be made white. All of this was sanctioned and run by the military. Native spiritual practices and healing arts were outlawed and prohibited by the War Department-administered Bureau of Indian Affairs, thus depriving Natives of ancient social, physical, and psychological self-sufficient coping and healing skills.

Healthcare and food rations were part of treaty responsibilities due to the various Native communities from the US government, but delivered in a paternalistic, fraudulent, sub-standard and culturally insensitive manner. During this same period, and shortly thereafter, Native men and women were actively recruited into the US military and lauded at home and by the government for actions taken during WWII and various other conflicts. Now I find this ironic because, if you ask any military person, we would've lost WWII without Navajo help. Think about that for a second: after all this, they saved this country. Military service became a way to gain honor and resources for people at home. Today, we have a patchwork anachronistic system of care for Native veterans that are vestiges of history. This patchwork is not working to help Native veterans today.

Why do we need a new path? Twenty-two veterans commit suicide every day. That's massive. Native Americans proportionally make up the largest ethnic group in the military, with some communities with rates as high as 1 in 200 in uniform. Currently, 24,000 American Indians and Alaska Natives serve in active duty. The average Native veteran household lives on less than $10,000 yearly and experiences multiple barriers to care. Many veterans centers and health care services are not accessible to Native vets due to distance. Sixty percent of Native American vets are unemployed. Native Vets are twice as likely to suffer PTSD and/or related mental health problems compared with white veterans. Recent data has shown that approximately 30% of deployed service members suffer from PTSD or related problems. I consider this a low estimate. On top of all this, survey data indicate that Native vets prefer traditional ceremonies and medicine to standardized VA care for PTSD.

We all love stories, right? Culturally confident stories.

I'm going to tell you about Staff Sergeant Iron. He's not a real guy. For confidentiality I can't talk about a real person. But he is pretty similar to the people that I have treated over the years. SSG Iron is a 28-year-old married Diné man who came to see me for problems with insomnia, nightmares, and frightening visions. You're not going to hear about frightening visions a lot, but everyone with PTSD has them. You're not going to hear about them from a lot of academics but when you do psychotherapy and consequently develop a deep relationship with Native, white, and African American veterans, there is a spiritual force involved in what is going on: pain, suicidal thoughts, anger and anxiety. In this instance, the SSG experienced flashbacks of a boy he treated as a medic who died in his hands after suffering severe burns and shrapnel wounds. Children's cries and the smell from cooking over a grill set off rages and panic attacks. SSG Iron also had multiple problems with pain associated with serious wear and tear on his back and knees. Insomnia was noted on his last visit to a primary care provider as well as chronic migraine headaches. Another provider noted some concerns about drinking. He had been deployed four times. Once to Afghanistan and three times to Iraq. He had also experienced an IED blast. Most military forces across the world can't take us, the US, head on because of the technology we have and the way we fight so, like every culture, they adapt. One of these adaptations is creation of mines and bombs that go off in vehicles and buildings. In the old days they were called booby traps and that's what they are. SSG Iron suffered a concussion and some minor shrapnel wounds to the right arm and was observed for a few days.

Case Example

A Warrior's Story

Staff Sergeant Iron was a 28 year-old married Dine' man who came to see me for problems with insomnia, nightmares, frightening visions, pain, suicidal thoughts, anger, and anxiety. Flashbacks were frequently of a boy he treated as a medic and died in his hands after suffering severe burns and shrapnel wounds. Children's cries and the smell from cooking over a grill set him off into rages and panic attacks. Iron had multiple problems with pain associated with serious wear and tear on his back and knees.

He had insomnia noted on his last visit with a primary care provider and he had chronic migraine headaches. Another provider noted some concerns about drinking. He had been deployed 4 times: once to Afghanistan and three times to Iraq. Rattle had been in an IED blast and he was observed for a few days after having a concussion and some minor shrapnel wounds to the right arm.

When I began working with him SSG Iron was being threatened with loss of all benefits, and lifelong shame for a DUI he received last month. He was suicidal because he wanted to stop the pain and to stop hurting those around him whom he loved. His wife wanted a divorce. Prior treatment with prolonged exposure therapy, which is the number one standard VA therapy for PTSD. It was designed for college students and has a dropout rate of 50%. Anti-depressants brought SSG Iron only minor and short-lived relief. He felt he was always going to be broken and had no way out. Shame was eating him alive and spiritual pain was killing his spirit.

He was successfully treated with EMDR therapy that was significantly modified to meet his needs in a collaborative way with the guidance of his traditional healer. What I do in such cases is contact the traditional healer from the reservation and work with that person. That is a hard thing to do because I have to work hard to convince that person that I'm worthy of collaborating, but it's doable. SSG Iron returned and we finished the EMDR therapy

Case Example, continued

Currently, he was being threatened with loss of all benefits, and lifelong shame, for a DUI he received last month. He was suicidal because he wanted to stop the pain and to stop hurting those around him whom he loved. His wife wanted a divorce. Prior treatment with Prolonged Exposure and anti-depressants brought only minor and short-lived relief. He felt he was always going to be broken and had no way out. Shame was eating him alive and spiritual pain was killing his spirit.

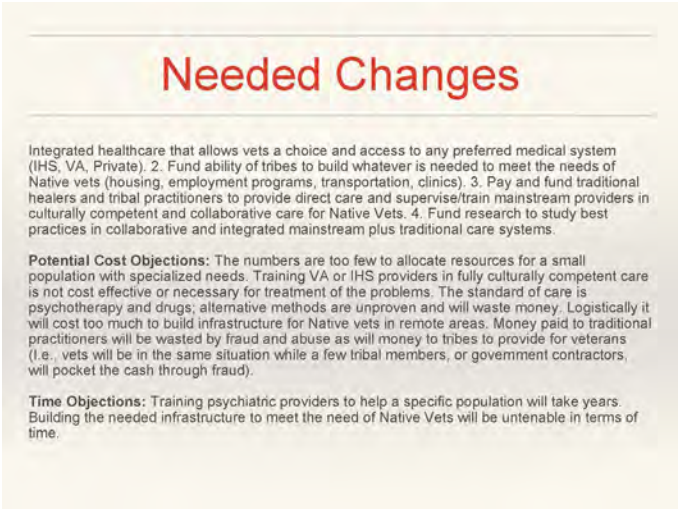
He was successfully treated with EMDR therapy that was significantly modified to meet his needs in a collaborative way with the guidance of his traditional healer. SSG Iron was sent home on convalesce leave to 20 days to be under the care of his healer. He returned and we finished his EMDR therapy with another 6 sessions. His symptoms were no longer causing him problems. As his provider, I went to his hearing for a dishonorable discharge and explained the treatment, diagnosis, and resulting wellness in a way that the military could understand. Charges for DUI were dismissed and SSG Iron was medically retired with full benefits. On our last phone call, he was still symptom free and attended ceremony frequently. He also began helping other veterans in his home community with outreach and advocacy.

*NB - De-identified: this is not a real person

sessions. I sent him away to undergo treatment at home. Now there's a way to do this called convalescent leave, because this guy's got to go home and see his healer and then we're going to bring him back so he can continue his therapy. So SSG Iron went home, is treated, and then I continue with him. When he returned, we finished his EMDR therapy in 6 more sessions. His symptoms were no longer causing him problems. As his provider, I went to his dishonorable discharge hearing and explained the treatment, diagnosis, and resulting wellness in a way that the military judges could understand. Charges for DUI were dismissed and SSG Iron was medically retired with full benefits and honors. On our last phone call, he was still symptom-free and attending ceremonies frequently. He also began helping other veterans in his home community with outreach and advocacy as a part of the healing process.

I'm going to try to go through the rest of this material pretty quickly because I want to show you what some of the therapy looks like.

Integrated healthcare allows vets a choice and access to any preferred medical system. Funding permits tribes to build whatever is needed to meet the needs of Native vets (housing, employment programs, transportation, and clinics). Traditional healers and tribal practitioners are funded to provide direct care and supervise/train mainstream providers in culturally competent and collaborative care for Native veterans. Research is funded to study best practices in collaborative and integrated mainstream therapy plus traditional care systems.



There's going to be a bunch of objections to what I represent here. The main things you're going to hear about when you try to present something like this is that all this money is going to be fraudulently taken away.

Now I want you to visualize what tribal warrior welfare would look like if we make it function the way we all want it to. Staff Sergeant Iron would be allowed to receive an honorable discharge with full medical retirement from the US Army. This is a tough period for him, but a happy transition when SSG Iron and his wife are called by a tribal member assigned to help them with his homecoming. The family will make a first stop at a lodge designed for families in transition when they return home. They will stay in the lodge to await a new home to be built using VA funds and home loans, which have rarely been used on homes for veterans returning to a reservation. The lodge is administered and run by tribal elders. Traditional healers and VA and

IHS medical providers and staff provide treatment under Elder supervision and direction. Traditional healers direct the plan of care and supervise the doctors who provide the physical and psychological support needed.

Ceremonies are performed regularly. Children whose parents are in the military are all over the place in all of these different bases. One of the things considered most helpful is to take the whole family and reintroduce them to their cultural heritage and language when they come back home after retirement for medical discharges. So the goal of fully integrated care with Euro-American medicine allows for an easier transition that honors culture and hands back respect and sovereignty to allow Native people to care for wounded warriors in their own way, as they have for millennia. It also allows a re-integration of Native vets and their families to a welcoming community full of hope and a good future.

I want to talk briefly about the symbol of wounding now. This is the traditional Lakota practice: When wounded in battle, you mark the place where the wound was received. So I use this ritual to help patients understand that PTSD is an actual wound that needs to be marked. One of the symbols for doing so is a red hand.

One of the things I urge you need to do whenever you're trying to do therapy with a Native American veteran is look at the degree of assimilation and decolonization of the patient. What you are trying to figure out is how much traditional emphasis should be put into the psychotherapy and how much you need to back it off depending on how they view their degree of assimilation into the culture. There are no formal methods to measure degree of assimilation and decolonization. It is something you have to figure out on a Likert-type scale.

Visualizing

The welcome home Lodge is designed for families to live together for a period of up to a year while children are culturally immersed in language and customs from Elders and teachers as veterans heal and find a place in the community. Ceremonies are performed regularly, or as needed with traditional customs. The building and grounds are beautiful, comfortable, and welcoming. Unlike many past austere government buildings, these buildings are designed and built by tribal members to reflect cultural ascetics and needs. Control and administration of the VA transition system is under tribal control and supported by the VA. Clinics and medical facilities for veterans are under the supervision of tribal healers who have final say in treatment in collaboration with VA physicians.

The goal is a completely integrated system of care without Euro-american medicine dictating treatment plans. This allows for an easier transition that honors culture and hands-back respect and sovereignty to allow Native people to care for wounded warriors in their own way, as they have for millennia. It also allows for Native Vets and their families a re-integration back to a welcoming community full of hope and a good future that gives to his whole people after honorable service.

The symbol of wounding: a lesson from the Lakota

Mark of the Spirit Wound

Symbol for showing a psychological or physical wound.

Oredna Medicine

Assimilation and decolonization assessment

Each person of native decent or mixed ethnicity who is treated in formal psychotherapy requires an assessment of the degree of assimilation toward mainstream EuroAmerican culture.

There are no formal methods to assess this combat veterans. Use of a Likert scale helps.

I want to talk briefly now about historical trauma and epigenetics. A lot of the problems that Native American veterans experience come from the fact that they are working for a military that once killed their ancestors. Now there is a lot of honor being a warrior; it's an honorable thing to do because you are protecting, serving, and taking care of your family. But doing so also creates a psychological bind that has to be talked about in therapy. When talking about this, we have to understand how people perceive their roles and how they play out each individual's psychology.

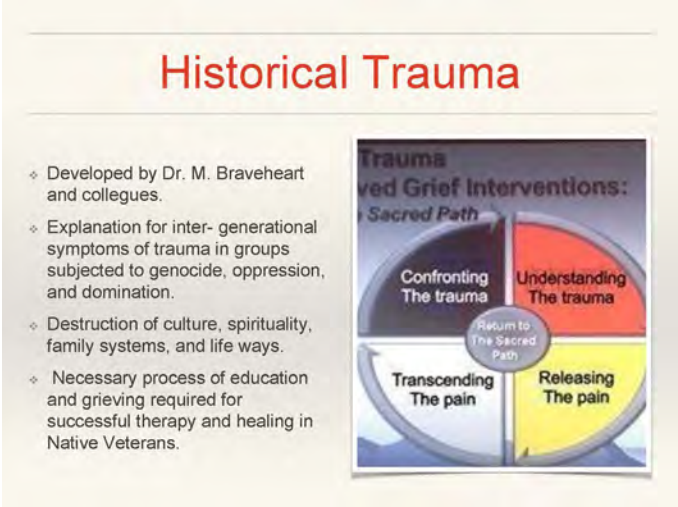
I am going to give a demonstration of EMDR modified for Native veterans. We are going to suppose the Native veteran is a very traditional person. So, I modify this for the assimilation level of the person. I do a consultation with healers, and use a lot of stories. I treat the therapy as a ceremony; that is the way I explain it. I am going to use the concept with PTSD of spirit retrieval.

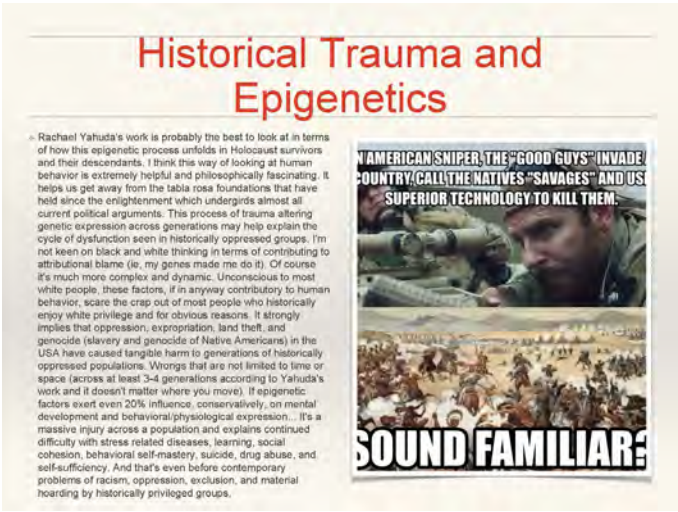
Now, when you look at the practice of EMDR, what you are doing, the back and forth; the theory that I agree with is that you are creating a sort of dream-like state. And through that, what we want to do is a soul retrieval; meaning the very Native American concept that your split-off soul has been stuck somewhere where the trauma occurred. And what you are doing is circling back to grab the soul and pull it back, and then close off the window.

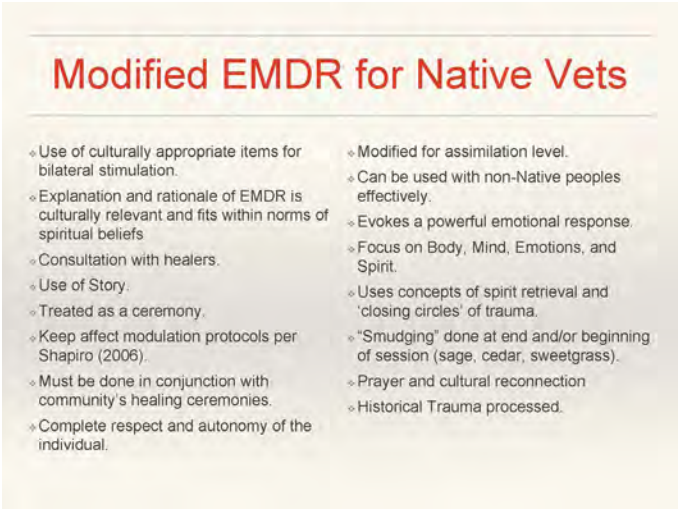
I have a technique for doing this, and what we have to start with is a good memory, a good place. And you prep that with sweet grass, so the person knows that the good place exists, which they might have forgotten. Then you go into the bad; you go into the trauma. You bring it forward, and you have them visualize bringing their soul back, and then you shut the door. I use sage to shut that off, and all the bad and negative spirits are shut off. If they are still very upset after that, I bring back the good memory.

I am going to show you how this is done. May I have a volunteer?

EMDR demonstration modified for Native veterans given at this time.



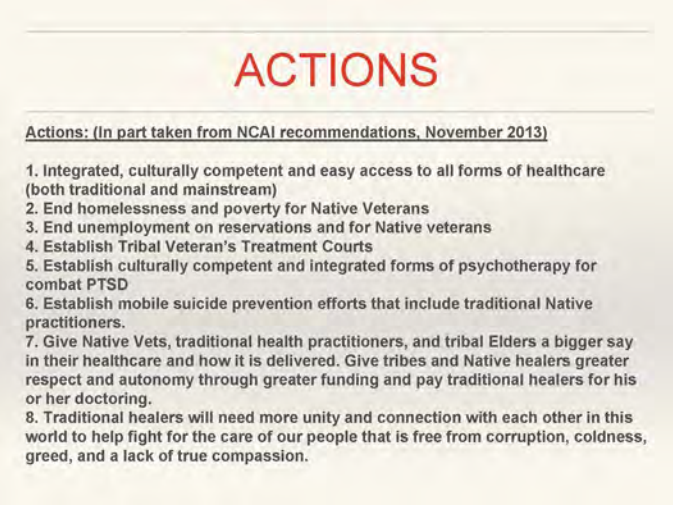




What I am trying to do is to make it so the Native person who goes to therapy will feel like they are being heard; their needs are being met. I am not approaching it as an expert who knows the therapy, and who sends the message, *If you do it the way I tell you to do it you'll be fine*. Because you know what? That doesn't work.

This modified EMDR works. I am amazed at what happens. People ask me to do this and they say they find relief.

And this is all to honor you.



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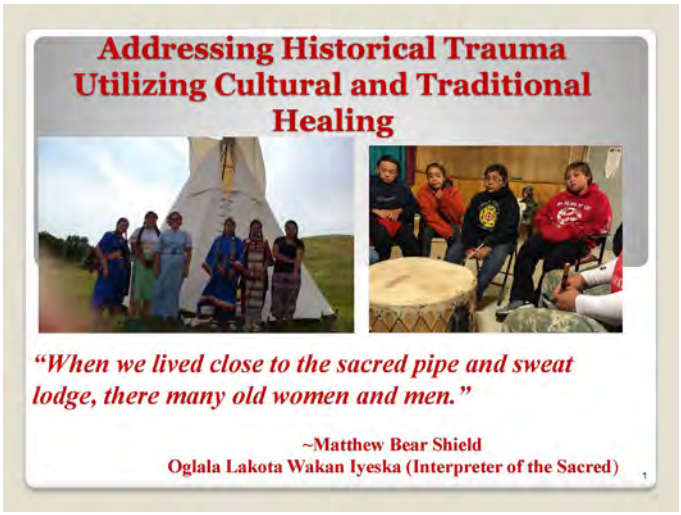
ADDRESSING HISTORICAL TRAUMA UTILIZING CULTURAL and TRADITIONAL HEALING

Elicia Goodsoldier, BA, Navajo, Spirit Lake Dakota



Thank you very much for allowing me to be here to speak to you. I also want to say thank you to my awesome elders and relatives for allowing us to be here, now, on your land. I'm going to talk today about addressing historical and intergenerational trauma utilizing cultural and traditional healing. It's very hard to talk about traditional healing in a general sense because we're also talking about the traditions, cultures, and languages of 566 very distinct tribal nations. For that reason I'm going to focus on the Lakota people and the work that they're doing in their community on the Pine Ridge Reservation to address historical and intergenerational trauma.

I spent the last fifteen years or so living and working on that reservation. I now live in Colorado but I go back quite often to help the community there. It's also the community where my children belong, it's their community as well. But I want to introduce myself first. My mother is Navajo, and we grew up in a community in Arizona. My maternal clan are most important. That's how I identify. I also come from the Spirit Lake. That's where my grandfather is from: North Dakota. I have had a really great opportunity to learn from traditional healers and Elders of the community of Pine Ridge, and they're a Lakota speaking people. My Lakota name is Itokagatahan Win which means "Woman that Comes from the South."

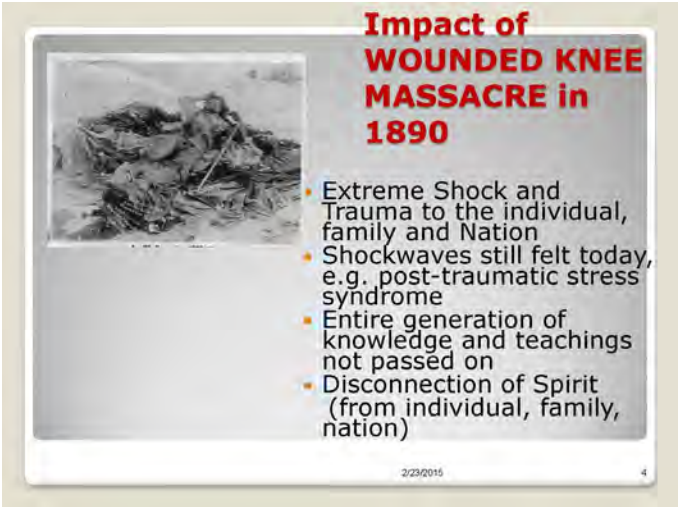
Matthew Bear Shield, whose quote I love, was what we would consider a *Wakan Iyeska,* which means "interpreter of the sacred." And what he said was, "When we lived close to the sacred pipe and the sweat lodge, there were many old women and men." The Pine Ridge Indian Reservation is located in the southwest of South Dakota, close to the border of South Dakota and Nebraska. I chose this quote

because of the life expectancy on the Pine Ridge Reservation. For a male, it is 42 years; for a female, 47 years old. That's why this topic is so incredibly important. Because it means that if we're able to return and have a reconnection to our traditional ways, we can live to be 100-years-old again. And I want to make that point.

I would not be in this room, in fact, I probably would not be living, if it weren't for two people. This is my aunt and her Native name is *Sina Ikikcu Win,* (Takes the Robe Woman). Her English name is Ethleen Iron Cloud-Two Dogs. And her husband, whom I consider a father, is named *Hmuya Mani,* (Walks with a Roaring). His English name is Richard Two Dogs. But I always recognize them because, when I talk about what I'm going to present, I realize this is all their knowledge. This is knowledge that was given to them by their families, so many of years of knowledge. Everything that I have learned from them over the last fifteen years means that I always recognize them.

As a Native person, I'm going to focus on this point of one tribe, one organization. They were a childhood trauma therapy agency that utilized both traditional healing and also Western methods. They based all of their teachings and therapy delivery on input from traditional healers, elders, the community, and the children. And so their mission states that when the people follow the Lakota life, ways and laws, the people flourish. Right now, the organization has gone through many changes. Because this organization is directed by our ancestors, by our grandfathers, they take direction from them. So they say, "This is going to be your direction now, because this is what happened to the community, we have to follow that." But that was what came out of it.

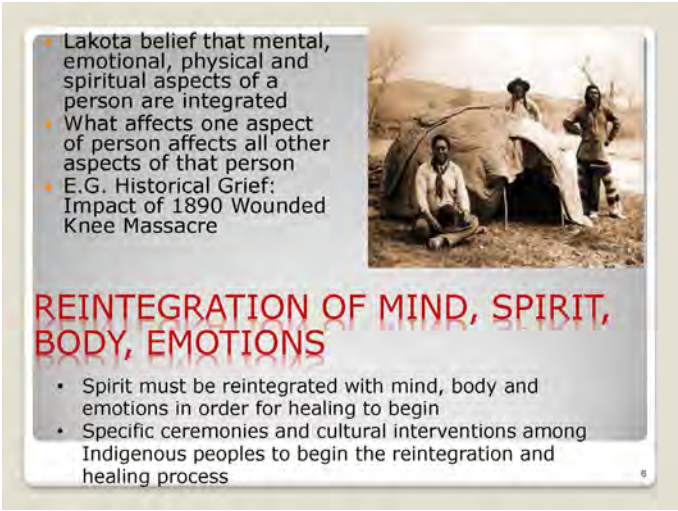
So, when we talk about historical trauma, one of the greatest memories of trauma in Lakota history is the Wounded Knee Massacre in 1890. In this infamous event, 200 men, women, and mostly children were gunned down in the early morning of December 29th, 1890. At the end of the day, Natives' remains



were just thrown into a huge pit and buried. Understandably, there was extreme shock and trauma to the individuals who were there, to the families and to our Nation; to the Lakota people. And those shock waves from that event are still felt today. An entire generation of knowledge and teachings was buried there. We can never measure what was lost, and that's one of the things that we have to remember when we're talking about that trauma: that an entire generation of teaching and culture and language is gone forever. And then we also have a disconnection of our spirit: a disconnection from ourselves, a disconnection from our families, and a disconnection from our people.

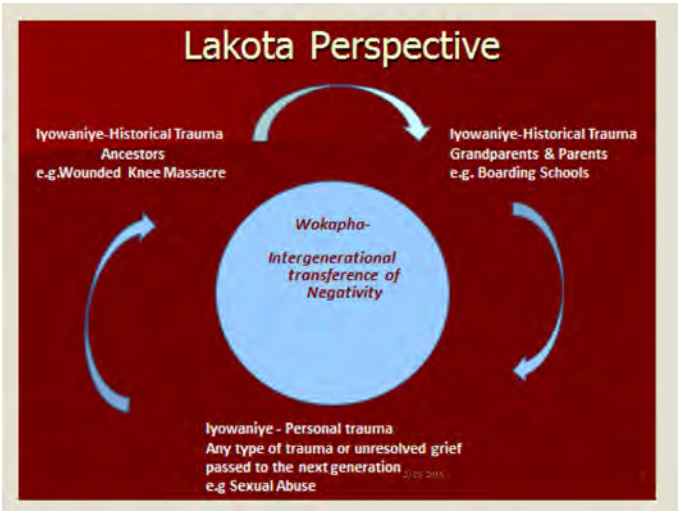
So we have a disconnection from our spirit. Traumatization can result from physical, sexual, or emotional abuse or having witnessed a traumatic event. Trauma culturally and spiritually results in the loss of our spirit. Often, when we experience trauma, our spirit can physically leave us. That's why a lot of times we detect in our children a flat affect, they're walking around like they don't really know what's going on. That's because they're walking around without spirit. Some symptoms are patterns of wandering, searching, inability to sustain relationships, alcoholism, nightmares, depression, wanting and waiting to die, whether that's through suicide or drinking oneself to death, you're wanting and waiting to die; and the hopelessness.

Lakota people believe that the mental, emotional, physical, and spiritual aspects of a person are integrated. And I kind of laugh sometimes; in the last couple of years, I've worked in my community mental health center and all of a sudden these mental health guys are saying, "Oh, there are all these things; it's no longer the mind, we can't look at the mind, we have to look at the spirit of a person, we have to look at the emotional aspects and the physical aspects of their lives." I laugh because that's something we've known for thousands of years. And now, in Western society, the light is going on, finally. And I'm thinking, hello! But what effect, what aspect of a person, effects all other aspects of that person? If I am unbalanced physically, I'm going to have issues emotionally, spiritually, etc. So we have to figure out how to reintegrate. What do we do to reintegrate our minds, our spirit, our body, and our emotions, since we cannot begin to heal until those elements are reintegrated? When we undertake interventions among indigenous people, we should begin with integration and the healing process.



I like to talk about myself in my presentations because I come from five generations of sexual abuse in my family. And we can trace that abuse all the way back to the boarding schools. My great-grandfather went to boarding school in Arizona. My grandmother went to Near Mountain Boarding School in Utah. And my mother went to school in Gallup, New Mexico. My great-grandfather was sexually abused when he was in the boarding school in Arizona and when he came home, he sexually abused my grandmother, then my mother, and then me. So, that's why this is so important to me. When people say you need to get over it, that it's in the past, we can't get over it because I feel I was betrayed. I have a dark stain in my past.

So, when I was 27 years old and in the midst of learning and talking to Elders about healing and historical trauma, I went through a period of paranoid thinking. Six months previous to the onset of this paranoia, I had lost my adopted father. His loss had a great impact on me. It was very hard because I had grown up without a father. I went into the ceremony, and he came to me and said, daughter, you're going to be given a gift but in order to receive this gift, you have to find a way to heal first. I had no idea what he was talking about. I had no clue. I sat there thinking to myself, *I have no idea what he's talking about, what do I have to do?* I was 24 years old at the time. I'm 34 now, and right after that, I went to sleep and during my sleep all these memories of the sexual abuse came flooding out. I had repressed those memories my whole life, from the age of nine years; I had repressed all that. It had been talked about in my family, and people would say, "No, no, that never happened to [you]." And I truly believed that it never happened to me. But after that, after the ceremony, after all the flooding of that came back, I was angry for a long time because I couldn't understand for a long time whether that was the gift that my father was giving me. But I also realized that my path was to do this work, to help people with this work. And so my father saw that I needed to recognize my own trauma; that I needed to heal myself in order to start this work. And doing this work is that gift. So, that experience in itself was the start of my healing.



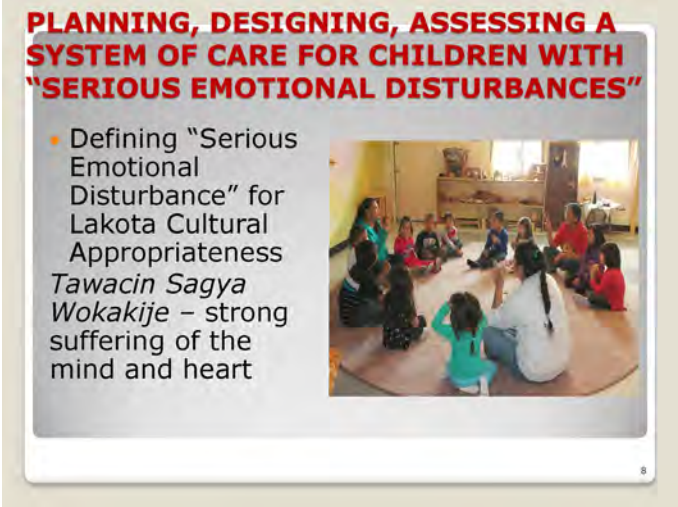
Here's the Lakota perspective on this intergenerational trauma, this historical trauma. It's the term in the center, *Wokapha,* the intergenerational transference of negativity. That's a Lakota term we'll talk about. So we look at this never ending cycle that, if there's no Spiritual intervention, this cycle will continue, and that's what we're seeing in our communities today. So if you look at the one, if we start here at *Iyowaniye,* that's the historical trauma of our ancestors. So that would be the Wounded Knee Massacre. Then you come over here to *Iyowaniye* the historical trauma of our grandparents and parents and that's boarding school. And then you come over here and here is our own personal trauma that we've buried, including sexual abuse, domestic violence, alcoholism. This is our own personal trauma; and when I think about this, I think about our children. Our people who are not only experiencing their own trauma but carrying all of this additional trauma. They're carrying all this trauma and it's heavy. It's a really heavy thing to carry. A study was done once on the Pine Ridge Reservation which claimed that at least 8 in 10 children on the Pine Ridge Reservation had been sexually abused at

some point in their lifetime. Eighty-percent of our children. Eighty-percent. They're dealing with their own trauma, but they're also carrying this, and there's no intervention. The Lakota children are killing themselves, they're killing themselves with alcoholism and meth.

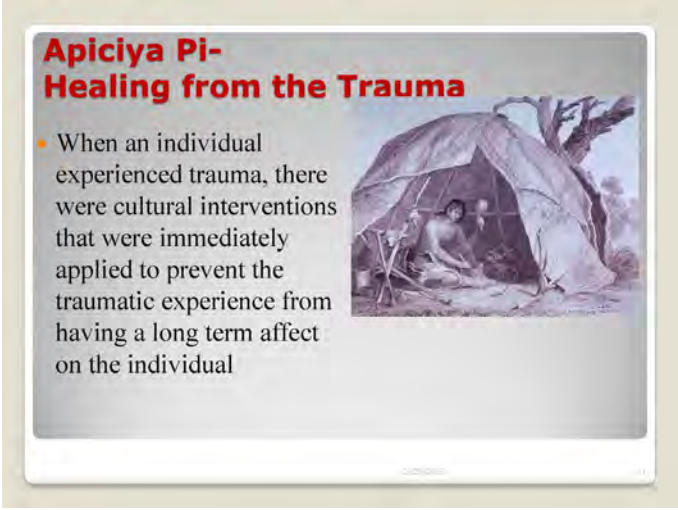
When talk about how we're going to help our children, how we're going to plan, design, and assess a system of care for our children, one of the things that we need to start doing is, to stop looking at them as clients, as patients; we have to start acknowledging our children as our relatives. Even if we don't know them, even if we've never met them before, they are our relatives and we have a responsibility to take care of them. So changing our terminology is incredibly important. Instead of labeling our children with serious emotional disturbances, we would say that our children are from the *Tawacin Sagya Wokakije* - a strong suffering of the mind and the heart. That's what our children are suffering from. It's important to recognize that.

Even our assumptions about our children and our youth need to be changed. One assumption is that medication is the answer. Research shows, though, that medication is most effective when combined with counseling, and behavior and family intervention. Another assumption is that children and youths don't know what they need. People talk to the adults without getting input from the child/youth. We also make the assumption of pathology as a foundation for care planning; we are dealing with a strength-based model versus a deficit-based model. When we're talking with families, the first thing we always try to do is to assess their strengths. What can we use? Even if it's only one or two things, we can offload the strength for them because we use it as a support system. Another assumption is that diagnosing Native youth according to Western-based models is the way to do it. It is not. I hope I'm not offending any of you because I am talking about spiritual healing.

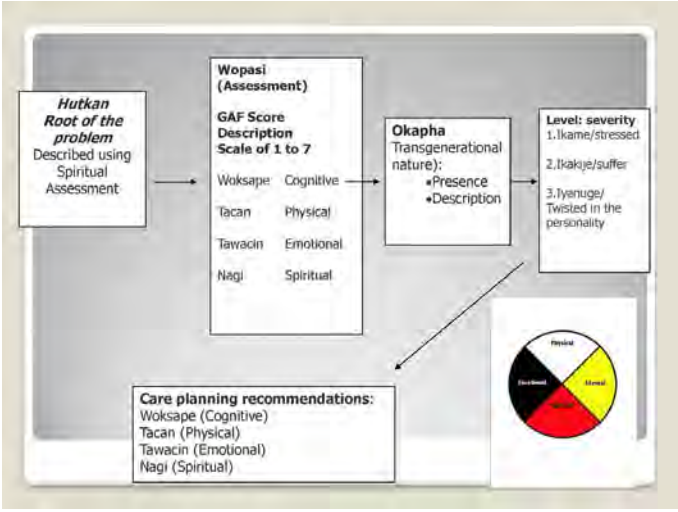
So we have mentioned some of the strengths of our people. All tribes can do this. They can look at



their communities and figure out what their strengths are and how they can build upon them. Our organization looks at what the strengths of our Lakota community are. *Wakanyeja* refers to sacred beings or children. That is how they were viewed. Traditionally and historically, they were thought of and treated as sacred. Just that term, *wakanyeja,* is sacred. If you know anything about elders, you know they are wisdom seekers, teachers, and advisors. And then there is the *Tiospaye,* which refers to the extended family. Your *tiospaye* is your husband, your children, your mother, your father. Your *tiospaye* is your aunts and uncles and your grandparents. Your *tiospaye* is the clan system, that's your extended family. So that translates into collaborating with everybody, everybody helping each other. Everybody should help each other. A long time ago, you know, the reason why we have *tiospaye* ceremonies is the making of relatives. If a parent dies or something happens to a parent, we know that this relationship still exists. So we know that if something happens to us, my sister is going to take care of my children. I know that my children are going to be taken care of by her. I would never ask any of you to use English names and I would never use the English names of the children. That's a sign of respect, that's showing respect. Even Lakota people say that there's power in the words, there's power in the language. I remember that, when saying the word in Lakota which is grandchild, my grandmother expressed love just in the way that she said it, just in saying, "*Wakanyeja,"* I could feel that love. Going back to that, having a more spiritual connection, having those sacred rights and ceremonies shows love and respect.



Apiciya Pi: Healing from the trauma. How do you heal from the trauma? When an individual has experienced trauma, there are always cultural interventions that are immediately applied to prevent the traumatic experience from having a long term effect on the individual. One of the interventions, for example, after the Wounded Knee Massacre, could not take care of us immediately after that because we were always running; they were trying to survive. So there was no safe place to put in place those traditional interventions. As well, using traditional ceremonies was outlawed. And a lot of the survivors ended up going underground, and that's why a lot of them feel like this today. They and their children were not given back their religious rights until the 1970s. That's also one of the issues. That was a reason a lot of these ceremonies were not passed down, because we were trying to survive.



And these traditional interventions work. They work very well. And you know, we have long term goals to implement these interventions again. We have several grants from SAMHSA that allow us to

do this work. But of course, with SAMHSA, there's guidelines and rules, so it has been very hard. I really wish SAMHSA would take cultural factors. Eating is a very big part of our culture. We have to feed everybody, so food is always a part of whatever we do. But SAMHSA will come back and say, "Hey, you can't submit for a payment for food." Or, "Why are you paying your spiritual healers?" What they don't understand is that for many of these spiritual leaders, that's their work. That's their livelihood, so you have to pay them. A lot of times they don't have any other choice because that was the spiritual path that they fell on and they have to follow that path.

Here are some examples of Lakota Cultural Diagnoses. In Lakota society, there are cultural taboos: things that you should do, things that you shouldn't do, things that you need to do. But again, a lot of these teachings are not passed on, they're not taught, and so often times we don't even know what they are. We have no idea that we're breaking a spiritual law. One example of a Lakota spiritual diagnosis is *Sica Teya.* If you have a baby or a child and they smell everything, they refuse to eat, they become depressed and experience failure to thrive. And if we want to initiate this ceremony, and they said, "Yes, this child is having all of these symptoms, but the problem is this child's mother or sister was experiencing the time of their monthly purification when they stepped over their belongings. They stepped over or they took them at dinner time and it made the baby sick." So, the spiritual aspects or spiritual laws need to be adhered to because they turn into physical issues. This other one here, *Sil Okihanpi,* represents an extreme violation of the spirit of that person that results from sexual abuse or physical abuse.

Sometimes, when we consider traditional interventions, I look at what we have and I think, who wouldn't do this? To give *Wokinga,* to give comfort to somebody, could help somebody incredibly. Just giving somebody a hug is healing in itself. One of the few things my grandmother taught me was that a long time ago, when we would embrace each other and give each other hugs, we would cry because we were so happy to see each other. Even if we saw them yesterday, we would still cry because we were so happy to see them. That's *wokinga;* that's comfort. So many of our children live without that today. And that comes from the boarding school: we don't know how to parent. We know how to love but our ancestors were put into a corner and told to cry by themselves. They weren't given that nurturing. So that's important. Then there's *Wopakinte* which is the spiritual cleansing of the four parts of the *Nagi,* or "spirit." Oftentimes

they'll pick a bunch of sage and they would wipe down, they're wiping out the four parts of their spirit. And then they would have a *Nagi Kicopi,* calling their spirit back. So we know that trauma happens, their spirit leaves them, it's wandering all those years, and they are able to reconnect and bring them back together. And they do that by calling your spiritual name, that's why it's incredibly important to have a spiritual name, because that keeps you here. You have that ability to call yourself back. So a wiping of the tears, addressing and releasing grief, is so important. A lot of times the confidence returns after one year of acknowledging that pain. Or having *Woapiye,* a doctoring, which usually means having a more severe issue. More severe trauma. So again, healing all four parts of the self: the mental, physical, emotional, and spiritual, is the key.

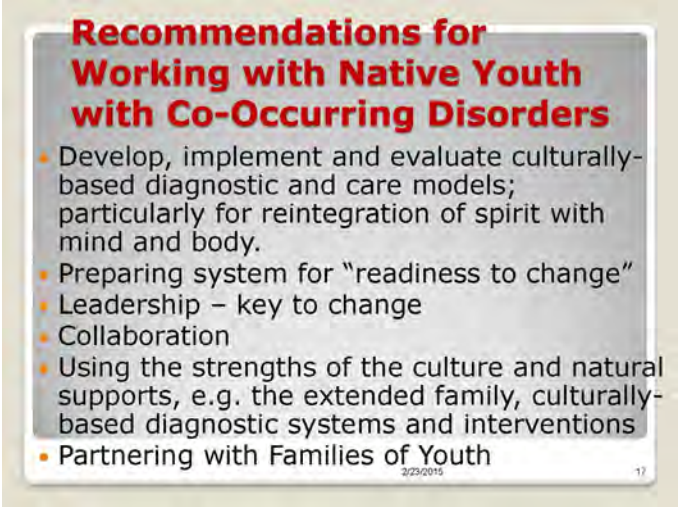
What are some things that we can do to provide support? This is my niece here. We have a girls' camp or healing camp for young girls and they came and they went through their womanhood ceremony if they were of age. They were taught to gather herbs and know what the herbs are and what to use them for. They were taught how to say a prayer, to write a prayer, and now they remember that when they're having a hard time. Combining cultural teachings, that's incredibly important, combining that spiritual foundation, even if it's just finding a spiritual name because you're already providing that spiritual foundation. Promoting the language is incredibly important. Finding the support of family, just the importance of being a family, and the support of sobriety is important. It's incredibly important to support our relatives who are having alcoholism issues or drug addiction issues. Supporting them in their sobriety, listening and caring, that's also incredibly important. Not trying to solve everything, not trying to say, "This is what I think you need to do," but just listening to them and acting like you care.

The huge one is elders. That's just incredibly important. And it's really hard nowadays too, because so many of our people die at an early age, very few elders are left. In Lakota society, once you reach 50 you're considered an elder. And then also the use of *Waziliya,* or the burning of the sage and the sweetgrass. Every day we come in contact with negativity. Every day. So being able at the beginning or the end of the day to burn that sage and that sweetgrass or whatever it is that your nation, your tribe, your tradition whatever it is that you use, to get rid of that negative energy, is incredibly important. We had mentioned earlier that one of the issues we're facing right now at Pine Ridge is mass suicide. We've had five suicides in the last two and a half to three weeks and seven in the last two months. One of the things contributing to this is *Waziliya.* So it is important to burn that sage and that sweetgrass. They act as a barrier to negative energy out there. And that includes the things the community is doing in the schools. And the teachers who are born into the schools and are doing it in their class every day. And then combining the *Wokpan* with the spiritual tradition. The spiritual tradition consists of shells, sage, sweetgrass, and more. And you should always have that on you because whatever or whenever that negativity comes around, you can get rid of it like that. So one of our goals is to be able to supply that to our schools, to our family and child service agencies, to our families; even if that means going from door to door. That's what we want to do; that's what we need to do.

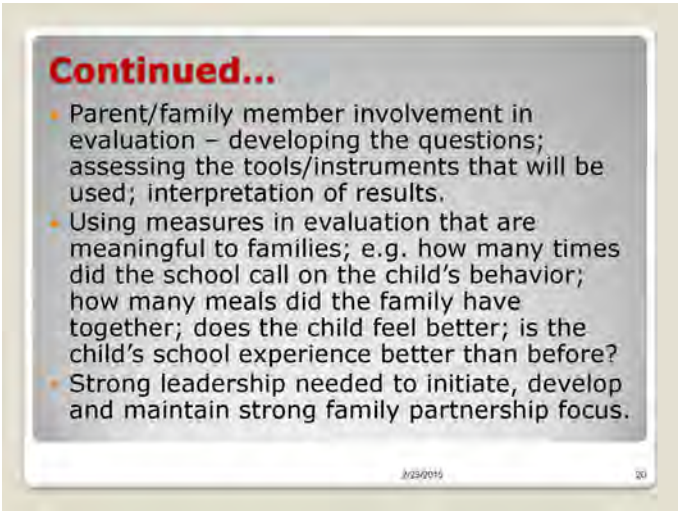
I don't like the word "sweat lodge." It takes away the real meaning behind it. In Lakota belief, sweat lodge represents the womb of our mother. But every time we go into the sweat lodge, we're being reborn because we're getting rid of all that negativity. So every time we come out of there we're reborn. Utilizing prayer, *Wocekiye*. What *wocekiye* means is being able to cry or appeal to the creator. Whether you stay in your tribal ways or whether you're Christian or Catholic, prayer needs to be the foundation, something that we can always fall back to.

I don't know if any of you have ever watched a herd of Buffalo. It's kind of an amazing thing to see. If one of the Buffalo in the herd is hurt or is dying, you watch the other members of the herd come around the sick one to see if they can help. That's one of the things that our organization and other community members should value. They will understand our reconnection to the buffalo and the horse because there are a lot of lessons in them. So they use this here as an example of what we should do for our community's members. So just like the buffalo surrounding their injured or dead or if any of them are hurt, we should also do that for our families and our children and all of us. That's how we're going to be able to get through this to work together for the betterment of our children and our families.

So these are just some of the things that this organization talks about: finding, designing, and developing more supportive environments for younger members of our tribal communities. Finding, developing, implementing and evaluating culturally-based diagnostic and care models, particularly for the reintegration of the Spirit with the mind and the body, is an important feature of our work. Preparing the system for readiness to change is another. Leadership is the key to change as well. Being able to collaborate with each other, using the strength of the culture and natural supports so the extended family, culturally-based diagnostic systems, and interventions are successful. And then partnering with the families of youth.



What are some of the barriers to these family partnerships? We often see that they are not included in the planning from the very beginning; negative staff attitudes, looking down at the families, labeling them as dysfunctional, and blaming the parent for the health issues that the children are having are all barriers to the family partnerships. Policies and rules that restrict parent participation; acting as if the child's problems exist in isolation are also big problems. Logistics, that's one of the biggest issues. So many of our families don't have transportation because they're spread out across the reservation. We only had, at one point, two behavioral health providers on Pine Ridge to serve 40,000 people. There's that issue - the lack or services, but there's also that the services are based in Pine Ridge, and a family who lives out in the community 20 miles away are not going to be able to connect. Work schedules interfere. The problem that we run into quite often is our staff hours are 9-5 because people don't want to work at night, they want to go home, but a lot of families need help in the evening. So being able to deal with that is one of the issues. And this is also an issue for the children.



Increasing the success of partnership with families prominently involves building on the strengths of the child and the family instead of focusing on their deficits, refraining from labeling them, including parents in training sessions and program meetings, including family members in decision-making. All of these steps increase the chances partnership success. Oftentimes what we see is one of the grandparents ending up caring for their grandchildren. And so if there's no legal agreement between the parents and the grandparents oftentimes the child will end up thinking he or she doesn't have to obey a grandparent directive "because you're not a legal caregiver." We see that a lot. There are a lot of grandparents who are raising their grandchildren today. Offering childcare, transportation, gas money, and reimbursement for taking time off of work to be able to provide childcare are essential. Training staff to be respectful of parents and caregivers - talking with them instead of at them and to them is also important. So the Lakota example of treating children and their parents as relatives rather than as clients or cases is well-founded. All of these here will increase the success in partnering with these families.

But in the end, collaboration is the key. We can't do it by ourselves, there are just too many factors. So we have to make sure that we're collaborating with each other. And I have a quote by Black Elk: "So I know it is a good thing I am going to do; and because no good thing can be done by any man alone, I will first make an offering and send a voice to the Spirit of the World, that it will help me to be true."

So what do we want? What is our hope for the future? My hope is that my daughter and my niece are going to grow up to be like those old women there. That's my grandmother on the left and Marie Randol on the right. That's my hope. That's what I want to see. Thank you.

Q&A: PANEL DISCUSSION

Ray Daw, Dale Walker, Dennis Norman, Shane Eynon, Elicia Goodsoldier, Anne Helene Skinstad, Melissa Campbell, Sean Bear, Mirtha Beadle

Q: A few of the presenters have mentioned how trauma leads to an increase in suicidal ideation, especially in youth. Have there been any studies or focus on suicide prevention and social media outreach to help youth reconnect with their culture?

A: Ray Daw: One of the really key things, a movement that has occurred in social media in the last year is an increase in youth-oriented wellness teaching on Facebook and Twitter. I saw, for example, one of the Midwest tribes doing a page on suicide prevention geared toward kids. I am seeing more of that occurring across Native country not only in the lower United States but also in Canada. Not only that, but there are pages and groups in social media that are taking on decolonization as a topic that is oriented towards young people. And not only dealing with trauma and emotional wellness, but indigenous nutrition, for example.

Dennis Norman: We are currently working on exactly that kind of thing for a tribe in Montana where we are working on a pamphlet for suicidality and stress reduction response that is going to be able to be sent through text message, email, and spread around through social media to kids.

Q: Dr. Norman, what are your thoughts on trauma and ADHD?

A: Dennis Norman: It is a complicated question in many ways, because all of those things we learned about the brain and trauma, the things that affect the brain affect the neocortex first, which is where your attention and concentration are, but there are a lot of other causes and influences that negatively affect it. We are looking at fetal alcohol spectrum disorders (FASD) in Indian country, too, which really attack that part of the brain as well, so it is multi-determined, and a problem.

Q: The Johns Hopkins study of an increase in income of $6,000/year reduced the incidents of mental illness in children of 13 years of age and younger. If over 14 years old, the income increase did not help. These were Native American children. Why the impact?

A: Dale Walker: I'll have a go at it. I think when we talk about resources for health care for children... and I would never have thought to do an age division in impact, which is an interesting approach... because I think the variability of illnesses in the young and in the older is quite different. If you can provide money and resources for the young, the usual focus is education and training, and cognitive behavioral training and programs like childhood self-control. Older kids don't have the same kinds of opportunities, there are not the same kinds of programs. And frankly, they have passed the time where those early programs would work well. That would be my explanation. If you look at older children, they have already aged into problems of greater severity, and I think that is a major concern. It is a difficult analysis to make that argument, because older kids have more problems, and they have also learned a particular way to control their lives in a way that is a little out-of-control. Young kids have much more control surrounding their environment. Remember the cradle talk? It's a good cradle.

Q: Dr. Eynon, can a non-native Euro/white counselor practice traditional EMDR? Will it be effective? Any limitations by not being Native American?

A: Shane Eynon: Let's see. It's a complicated question. Any of the elders I have spoken to, there is nothing that says that a Euro-American cannot practice this way, but the caveat to that is that you have to understand the culture. You have to immerse yourself in it, you have to understand it, and know the issues and what's going on for that individual community or that individual person. If you're interested in doing that work, and doing EMDR that is Native focus-adapted, I think you should get with an elder or a healer that could help you walk through the issues you would need to know.

Dale Walker: I just wanted to magnify that comment of getting with an elder, because that is a permission comment, not a learning comment. I think that you need to be evaluated by someone who does this kind of work to make sure that it is OK; that there is a step of approval. We have seen some neo-learning experiences of a sweat lodge, and such that haven't turned out well. Just as we believe that there are training steps in health care education, there are training steps in traditional care as well. *(To Dr. Eynon):* You would agree with that?

Shane Eynon: Oh, yes.

Elicia Goodsoldier: And I would add on top of that, it is also important to recognize the community that you are doing this work in. So, if I am an EMDR practitioner and I am in the community of the Meskwaki people, for example, I would want to go and learn from Ray Slick over here, for example, how Meskwaki people would use "smudging," or what other kind of ritual like burning sage and cedar they might use. What I don't want to see happen is creating this "one-size-fits-all" concept; to assume that smudging is for all tribes. Maybe they don't even do that; maybe they do something else. So be aware of that; be aware of what community you are in and ask permission from the elders from within that community.

Q: Where can we find research and studies linking nutrition and depression, and how is it applicable to prevention of substance abuse?

A: Ray Daw: There are some really great sources of information on this topic; one of the first places to look at is the National Council on Vitamin D *(https://www.vitamindcouncil.org/)*. There is an organization

that works on gathering information on vitamin D nutrition and other kinds of malnutrition as they are related to physical health and mental health and emotional care. They not only keep a surveillance view of what is going on with this in the United States, but also get information that is gathered across the world. It is becoming more and more apparent that malnutrition is a worldwide public health concern, and variety appears to be driving what we are labeling as emotional illnesses are really related to malnutrition. In fact, many of the features of psychotic disorders such as schizophrenia are reported to be driven by malnutrition as well, in terms of early-onset and the severity of symptoms that occur.

Dennis Norman: May I just add one thing? The human brain uses 25% of the calories that we intake in a day, so if you are malnourished, the brain is the organ that suffers the most.

Anne Helene Skinstad: I also would like to hear what Dr. Campbell has to say from a medical perspective.

Melissa Campbell: My main thought is about folate. I am always worried that my patients might not have adequate folate; particularly women of child-bearing age, and particularly if they are taking other medications in addition to my own. Reduced folate during pregnancy increases the risk of birth defect, and supplementation vastly reduces that risk. It is extremely important nutrient, among many others.

Q: Ray Daw, How does Dr. Braveheart understand historical trauma as it relates to leadership and decision-making?

A: Ray Daw: I think we understand leadership and decision making as being affected by the impact of colonization. I think it is fair to say that it is the imposition of federally-driven systems of government in the 1930's that were the major creators of social change on tribal lands, which lead to problems that are not well taken care of by traditional forms of government. The business councils that were developed in the 1930's to thoroughly oppose tribal councils clearly contribute to many of the problems today we have with tribal council: being imported, misuse of funds, excluding voters, excluding from policy-making decisions. Unfortunately, we have trouble with some tribal councils that are comprised of folks who are not accepted or knowledgeable or experienced in working in systems of government; and that has been one of the contributors to the kind of disparities that we see between the quality of life on the reservation, and the quality of life off-reservation. Time and again, we see around reservations that non-native communities economically benefit from poorer quality of life that exists on the reservation. You can see that even excluding problems like alcoholism and homelessness, which occur more frequently in border town communities.

Q: In some Native American teachings, if someone cannot overcome fear, it can lead to sickness; which may affect the mind, such as mental illness and PTSD. In regards to fear, what ways would you suggest in resolving fear in veterans as well as others?

A: Shane Eynon: Complicated question. Fear is a natural response to any type of stressful situation. If you are talking about veterans, in a combat scenario, they are trained how to not have fear in a situation. My thinking is that each individual is different in how they handle their fear. It can become like a cancer that is inside you, and spreads out into everything. An example would be, if a bird attacks you when you are six years old, you have a fear of that bird, and then phobias can grow and grow and grow, so that anything with a feather is going to create a phobia. So handling fear and getting a hold of it, my universal way of looking at it is that you have to have people that will help you. Any kind of fear you have, an inoculation comes from family and love from others. In the military, one way to overcome fear is love of your comrades in arms, who will help you get through that period, so it doesn't grow, and it doesn't disable you.

Dennis Norman: I totally agree with the notion of mastery of fear, where the lack of fear I think is actually associated with a certain kind of sickness. It is missing something tremendously in life if one does not have a sense of fear; but the people who work best around fear have learned to master it.

Dale Walker: It has been said that fear equals trauma, so one has to pay special attention to the process, and it is interesting because it is also perfectly natural. There is a kind of tipping point where the fear is out of control, which is what has been said. There are other ways to deal with fear and other kinds of aversions that I think could be mentioned in the therapeutic context. You can look at the trigger responses that cause fear, and you can practice scenarios and examples with the individual to identify triggers and have a planned resolution of the process. That is the way that you would resolve or reduce or alter the fear response.

Q: What are some suggestions you would give to non-native providers working with Natives using cognitive behavioral therapy (CBT)?

A: Shane Eynon: Don't do it. *(Laughter.)* I have been trained in almost any major form of therapy you can think of, and cognitive behavioral therapy is wonderful, but it is an extremely Euro-centric model. Bottom line: it is based on the belief that the way you think is abhorrent; and therefore, if you change your thinking, everything else will fall into place. Culturally, I would say that CBT is almost impossible to apply outside of a Euro-centric world view. It can be done, but it is going to take a lot of work and a lot of modification. You're going to have to use a different kind of language, and a different kind of understanding of what is normal thought and what is abnormal thought. You have to understand, CBT was developed through college students. White, middle-class college students. I've been to that part of the country. I love those people; they are very nice people. They do great work; but that is not a cure-all for all cultures. If you're from a Euro-centric world view, it's great. If you're not, it's going to be a problem. You're not going to adapt to it. You're going to hear what they're saying, and you're going to think, *What are you talking about, meta-cognition? What does that mean?* That would be my bottom line. Anyone else can pitch in on that. It's not that I don't like it, it's just for one population.

Dale Walker: I must use a different kind of CBT. *(Laughter.)* I think that there is a different point of view. I would agree that you have to have your language clear in therapy with any person. I don't think that ethnicity or even historical understanding should determine what kinds of therapies we use. I really don't feel that strongly about being against it. I have used CBT with Native people. Let me say it this way. CBT isn't my therapy, it's the patient's therapy, and the patient has control. I don't want the fear to go away, the patient wants to make the fear go away. I'm trying to say that I think the architecture of the methodology is sound, and if there is cognitive thinking with the patient, they can tell me what they want to do to change, and I think that works very well with the process.

Q: Being mindful of evidence-based practices, and overseers of behavioral health programs and their western expectations, how do you include traditional or holistic practices to meet the cultural needs of our clients and community, but which may not be backed by research, and may not find support financially through western systems of funding?

A: Shane Eynon: This kind of brings things back full circle to the discussion we were having. The people that are paying and deciding what is worthwhile therapy are using a Euro-American model. They control the dollars. They are saying that your therapy has to be proven right by getting the research grant from NIH to prove that it will work in this population. Not many people in here could do that. My solution to this problem is that we have to go back and modify what is already evidence-based to suit our needs and what is culturally relevant to us. That way, the overseers are satisfied, and the need

gets met at the same time. But there is a whole research background going on; and the way we do social science research in this country is coming under very heavy criticism. The DSM is practically thrown out at this point, and has almost no validity. You have to understand a lot of this imposition of a world view of how disease works and how it is cured. And that is what we are grappling with here. That whole system is built around those concepts. So, if you have science that is not really great, saying this is evidence-based, what do you really have? Other than an agency saying, "Well, we are only going to pay for this because we think that works."

Ray Daw: Your question touches on a topic that is really deeply discussed on several levels, and there is a lot of consensus that evidence-based practices and the way they are designed off-reservation with non-native populations are really inapplicable with Native populations. The consensus seems to be more that we look at promising practices and best practices which are locally driven, and work on understanding them a lot clearer so we can see how they are effective in the population they are working with. Like educational practices of the Navajo, or the spiritual practices of the Lakota. They are very specific to those groups. Another thing, really, is that we, as a people, do not have social scientists. The few that we have are really busy understanding their parts of the world. So, from a manpower perspective we are behind around having the ability to generate evidence-based practices; which is really a misnomer for us because to have an evidence-based practice, you have to show replication. You have to have a manual that can be replicated across different populations; you can't do that with 500 different populations. Even if you take that to an urban setting, you still have sub-populations that are not able to do that kind of evidence-based practice research. I don't think we will come to a time in Native history where we will look at traditional practices at the level of evidence that meets the rigor of scientific inquiry. It is faulty, like you said. I don't think it is realistic to expect that. I think what we do is continue to learn and appreciate the best practices that we do have and then broaden them for our population.

Q: How can we describe or address spiritual sickness to non-native clinicians who are working with Native clients who suffer from this type of sickness?

A: Dennis Norman: I just don't see much hope. *(Laughter.)* If you don't believe in that, I just don't know how you can make someone aware of that dimension if they don't believe in it. I don't know that they can do any work; they will just limit the work and they will only see a two-dimensional person rather than a three-dimensional person.

Ray Daw: That is a really interesting question because I think non-native practitioners coming into any Native setting, if they are not sensitive to being appropriate, or sensitive to being relevant, it would be a real deficit to any need that a person or Native family would present. Whenever we have a non-native coming into a Native setting, and coming in with a very rigid approach, they will often understand in a very short period of time that they don't necessarily belong there. They will run into a lot of barriers towards their being effective. When non-native therapists do feel that they are not effective, then they will leave. And if they do try to stay, we have a growing group of Native health professionals who work hard to teach understanding, and getting non-natives to understand the need to be sensitive, and the need to be appropriate. I think that occurs in Indian country a lot more these days than it did 15 or 20 years ago. Then we are also beginning to understand our own reasons to be appreciative of the approaches that our elders have. I think one of the features across Indian country that is really good is that we do strongly understand the value of spirituality. The value of spirituality in terms of how it affects our mental being, our emotional being, and our physical being. I think some parts of the

Euro-American systems are really beginning to appreciate it. During the Bush administration there was a big push around faith initiatives. This continues on today under the Obama administration. So spirituality in and of itself, under the faith umbrella has been really appreciated in non-native settings in the last 10 years.

Dennis Norman: Just a very concrete observation: psychiatry does understand that you can't diagnose someone as depressed if they are grieving. That is a very concrete example of how looking at the symptomatology doesn't match what is going on in the person. I think there are many, many other things in Native communities that stand in like that; whether you are being anxious, depressed or anything, those symptoms stand for many breakdowns of social structures and support in the community, that you just miss that dimension if you think of it just as symptoms.

Shane Eynon: What I want to do is give a little history lesson. What does psychology mean? Now, it's not "study of the mind." Psyche: the Greek word for "soul." Psychology started as "the study of the human soul." Psychiatry is "the medicine of the soul." That is the root. Now, we had great thinkers at one time who actually delved into these topics, like Carl Jung, and really explored these issues. Then Americans got a hold of it, and they said, "Dang it, we're going to make it real good." And this guy named B.F. Skinner came along, and said, "I'm going to make it like physics. Stimulus, response. All that other stuff is hokey-pokey. It's not real, hard science." Well, where are we at now? The point I am trying to make is that spirituality is part of humanity. It is part of what makes us human. Everybody who is not a psychiatrist realizes this. *(Laughter.)* Alright, alright, I apologize. I want to make the point that spirituality has always been a part of psychology; it is part of the domain. It's just that as things went on, and as things changed, it kind of got twisted and put into very scientific language, as close to medicine as possible, and as close to physics as possible. As a psychologist, I am calling for that to change.

Anne Helene Skinstad: I am not from the panel, but I just want to add that our Center believes that the issue of spirituality is very important, and we are embarking on a series of round-table discussions across the country, and we are going to focus on the importance of spirituality in treatment.

Elicia Goodsoldier: This reminds me of something that my father told me once; that there is a lot of fear of the other; fear of the spirituality of the other. That's why the United States government banished ceremonies. You can say that that is happening again today, that there is fear of the other. Fear of something that is not seen, I guess. So many of our children who experience trauma on a day-to-day basis often get sent to institutions, and a lot of them end up being drugged, basically, and left in institutions just to sit there. That's what happens in the state of South Dakota. I have seen that in places such as the Black Hills Children's Home, where 80% of children in their care come from Native communities; whereas the overall Native population is very small. This fear of the other still exists today; it is not anything different from what existed 100 years ago. That is why we are fighting so hard to get traditional healing recognized; we see it in our communities, and we know that it works, but it is very hard for those from the outside to understand because of that fear.

Sean Bear: I would like to also add on to that a little bit. There is big talk about spirituality pretty much around the world now. There are also those that are considered new-age, given their practices and beliefs from the old age. There is also, in my teaching, a higher level than living a spiritual life; and that is the reason why those who believe in spirituality go to these medicine men and women who are living a *medicine way of life*. They understand that they are a link to the spiritual world, into abstract things that

need to be taken out to be healed in those ways. It is often difficult for Native people to see the medical field and medications as belonging to the *Medicines* they know from the traditional ways.

Dennis Norman: I just want to bring up something related to what we talked about before; one of the more encouraging things I have seen in Western and in Native communities is a movement toward mindfulness. I really think that it transcends the therapies with cultural issues around them, and it overcomes some of the problems of CBT, and some of the other therapies. I have seen it around the world, and there is something to the process of mindfulness that can help heal a lot of different people from a lot of different backgrounds. And it can probably get at something different for different cultural groups.

Q: In understanding that the education system today is an important aspect of life, what harm do you see that has been created by the education system in the past, and what do you believe should be changed in regards to traditional Native American values and beliefs?

*A: Ray Daw: I*t is accepted in the United States that the American education system is fail-proof. Efforts to standardize have not been effective. I don't see any Native school district where they are exceeding educational standards. Across the board, they are saying our students are testing at lower levels than non-native students. So our students are being introduced to a structure and system where they are further stigmatized as failures. That's a consequence of trying to creating a rigid system, just like evidence-based practices, to measure what is good and what is bad. It becomes a question of what is best. Another point I do need to make is that the American society is geared towards a kind of economy that doesn't exist on many Native lands; it's about making money. Its about going to college, getting an education and making money. It's about taking what you learn, and taking what you believe you are worth as a wage-earner, and being able to shop around for a job that you can fit into anywhere in the world; where many of us have really big struggles with that. Many of our kids don't necessarily want to be big wage earners. So there are two sets of values in conflict that really affect our young people. I think we get caught up in believing that making money is the only paradigm from which we measure quality of life. More of our tribal governments begin to develop standards based around poverty, which is waste-driven measurement, and we end up looking at ourselves as less-than. This all comes from education systems that leave us at a deficit, which we intentionally buy into. So, I think that is a big, core issue for many of our young people.

Dennis Norman: Ray did a better job than I did taking about education. But I do want to underline more strongly: the current system creates winners and losers; and more losers than winners. That is inherent in the system. I just don't believe that's true of children; all children can win with the right standards and the right educational system in place.

Q: The title, Reclaiming our Roots: Rising from the Ashes of Historical Trauma; thinking about that, many refers to what is lost, and what still remains in traditional Native American spirituality and healing; but what would you suggest for all Natives who practice and believe in reclaiming of those, when that knowledge is no longer available to others?

A: Ray Daw: I think the first thing is to reclaim and accept our identity as Native people. If there is any teaching that we can offer our children and grandchildren; as grandfathers and grandparents, it is to be able to have our children understand, and appreciate, and accept, and to grow from having that identity. How they choose to lead their lives as Native people is up to them. We have Native kids who are English-speaking only, and are living good, productive lives from a Euro-American perspective. They have assimilated and acculturated to the Euro-American society, and are highly effective and

successful from that standpoint. We also have Native American kids who don't speak the indigenous language, but are as good a hunter, and as good a gatherer and as good a fisherman as a Native speaking fisherman, or hunter, or gatherer. Because they know where they are, and they have adapted to that lifestyle and culture, and understand how to survive in that culture. So, from my point of view, it's about how we look at ourselves; to be able to survive in whatever context. I think the beginning of it is to be able to say, "This is who I am." As a man, as a woman, as a boy, or as a girl. To be able to say, "This is how I will be." Whether we become Judeo-Christian, or traditional practicing, or Native American Church practicing, it is understanding who we are first.

Dale Walker: If I could control the world, I would want all Native people to be able to accentuate the positive. I would like to see all of our people optimistic and hopeful, and prayerful, and reflective. I would like to see our people encouraging our young people for school and education, however that is defined. The problem is, I don't control the world. But I think that attitude is something here, and I think we need to get a grip on some of the issues, and look at reflecting positive things that Indians bring to North America and the rest of the world. A lot of things that came from here, including the medications that many of us use came from North and South American Native cultures. 75% of pharmacological knowledge came from Native use of medications. That's very important, but how many Native people know it? How many Native people are able to be engaged? I think it reflects on power and control, and the lack of empowerment. We don't have a good relationship with the government; even when a president absolutely supports us without hesitation, we still don't have a good government relationship. Even when the Indian Health Service had seven years of increased funding, more than we have ever had before in the IHS, for Indian people, it's still been difficult and painful and quite awkward in Indian country. Somehow we need to understand that our assertion into action can make a difference, and that is going to be where the change happens. For me, that's the hope that Ray's view of the opportunity for our children will be in place. And we'll be able to have a change in attitude, and once again reflect upon the successes of our people. The song, the art, the music, the medicine; the fact that how we look at the earth and the elements, how we see ourselves and the environment, are things that everybody across the world actually admires when they stop to think about it. But do we have a chance to feel good about those things? I think it is about empowerment and making a decision to change.

Anne Helene Skinstad: I am going to ask each of the panelists to share their final thoughts at this time before we end the day in a good way.

Elicia Goodsoldier: If I ruled the world...one of the things that I would love to see within our communities is the ability to treat each other as relatives; because we are our own worst enemies sometimes. We are like, I call them, "crabs in a bucket." Sometimes we tell our children, "Go out and get that education and come back and help your people." When that happens, they come back and try to help and they are belittled, and talked down to. What I would love to see is for our people to support each other and treat each other as relatives. No more of this, "full-blood vs. half-breed," and that kind of thing, because, as I said, we are our own worst enemies sometimes, so we have to be mindful of that.

Mirtha Beadle: I just want to reflect a little bit. I fully understand why there is distrust in the government. Frankly, there are parts that I distrust, myself. But I tend to be an optimist, and I tend to look for opportunities. I love the way some of the presenters this morning talked about historical trauma, and not necessarily looking at the past, but looking at the future. One of the things that I would hope each

one of use would walk away with is knowing that the future is brighter than the past, and that we have such a great opportunity today. One of the things that makes me want to do this work every single day is that everyone that I work with has their hearts, and their minds, and their spirits in the right place. I want to make sure that, as there are discussions about the issues that have been very traumatizing for people, that we don't forget to look forward, to walk forward, to know that there are people really trying to help American Indian communities move beyond what has happened. So, don't lose that opportunity. There are really good people - not everyone is good (my sister is also a psychologist and she says that there is a little good and a little bad in everybody) - but I want to make sure that opportunities to really do some phenomenal and exciting things for people aren't lost because it's hard to trust the intention of people in these positions. We need to be sure that we are creating a relationship where we are not telling Indian people what to do, but to support what Indian people want to do. Hang on to those good people; find those good people. Go through those open doors that are currently there. I personally have only been involved in American Indian issues since 1998, and I have never seen a better time, a better future to do the things that I have heard here today. There are some beautiful opportunities for traditional practices and gaining support for that. I could go on and on about that, but the message is that there is a good opportunity to really make a difference, and people are here to work with you.

Melissa Campbell: I just want to expand a little bit on two themes we have talked about today: fear, and what providers need to know and do. I don't know how many people here today are providers, but providers, also, can become afraid. Afraid that they might make a mistake, that they don't understand, that they can't help, and that they don't have all of the information; and all those things are true. Speaking to the mindfulness part of that, there is a movement called "Patient-Centered Therapy," which reminds providers to take some time and make some space in the way that you feel the safest before you see your patients, after you see your patients, when you go home; take the opportunity of your phone ringing, the door knocking, the beeper going off; whatever interruption or thing that you normally don't like, to pause for yourself and think about what you're trying to bring. You're not trying to bring cures; you're trying to bring healing, you're trying to bring presence. You can only heal when you are present, and you can't be present if you are afraid. So, work on those things.

Dale Walker: Mirtha reminds me of a quote, when she talked about the good and the bad: "There is so much good in the worst of us, and so much bad in the best of us, that it ill behooves any of us to [find fault] with the rest of us."[1] In a way maybe it does reflect a little bit on who we are, what we think about, how we work as a family; I love your comment about how we are really family. We are family across tribes; we are also family across ethnicities. With that being true, if we can solve those interactions that are negative, if we can deal with that, it would be a better world. I think that it really is important for us to reach out and partner, and find resources and support where they are, and begin to solve and build internally. And as we grow, our power and empowerment will grow. It's practical; it's a way that does work. It's a way that has worked with many tribes that I've seen when they have problems that seem like they will just never, never go away. Last comment that I have: students, it is so critical that we have people in the health care business for Indian people. It is also critical that we have health care professionals who are Native in all of our training schools and institutions. It is hard to believe how few there are out there. It's hard to have role models. We need all of you to work as

1. 'Sometimes quoted "To talk about the rest of us." Author not found. Attributed to R. L. Stevenson, not found. Lloyd Osborne, his literary executor, states he did not write it. Claimed for Governor Hoch of Kansas, in The Reader, Sept. 7, 1907, but authorship denied by him. Accredited to Ellen Thorneycroft Fowler, who denies writing it. Claimed also for Elbert Hubbard.' Reference: Hoyt & Roberts, comps. *Hoyt's New Cyclopedia of Practical Quotations.* 1922. Found on Bartleby.com: *http://www.bartleby.com/78/134.html.* Accessed 4/19/2017.

much as you can in bringing up our standards to a way that we can feel very proud of the students and the young people working with us.

Dennis Norman: It's really hard to take everything that we have talked about today and say something simple about it. One thing that comes up over and over in my work in communities, in my own family, and in my friends is the old values - that are just as pertinent to modernity - that is: being responsible to yourself, your family, and your community. I think everything else follows from that if we can do it. I know those were values that cut across most tribal nations; that is what kept them alive for a really long time. It's been hurt and broken by a lot of people as we talked about today, but it hasn't disappeared; there is still the memory of it. I think that humanness is something that the rest of the world even looks at Indian communities and has some sort of interest in. It's just that we need to reclaim it. How better to make ourselves responsible for ourselves, and our families, and our communities? A cohesion and connectedness can overcome all kinds of stresses and historical issues.

Ray Daw: First of all, I want to give my deep thanks and appreciation to Dr. Braveheart for designing this model and making possible a tool that we can use to understand and apply to our struggles with acculturation and assimilation in a colonized society. How we can create for our children and our grandchildren a way of life that resonates with them; being healthy, well adults down the line. I think that is paramount. It is why we are all here today; to learn from each other ways to have healthier communities, healthier families, healthier individuals. That comes from understanding as much of our lives as Native people as possible - whether it be politics, education, health, behavioral health, whether it be spirituality; understanding the strengths and weaknesses we have in our communities - what I call a "historical trauma lens." The key question that I have when I go to any community, is "How did life get this way?" Well, the actual question is, "How the hell did life get this way?" Then the second question I ask myself is, "What good is happening in this community? What are the strengths?" What I usually see is that the majority of families in any Native community are really doing very well. Our challenge, then, is to reach out to the families in our communities who are doing well and engaging them to be participants; to be involved in changing the quality of life of our people. That is about engaging our community members who are not as healthy, and nurturing that and growing that. Whether it be elders, or spiritual leaders, or churches, or doctors and nurses, or social workers. That's our challenge. Otherwise, we are faced with 20 or 30% of our population dying too young. And that is what's happening among our people. Thank you for joining us.

Shane Eynon: I would like to echo what everyone is saying; thank you very much for being here and listening to us. I am here today because this guy right here, Brett Sheldon, reached out to me. Remember that, Brett? He said, "We need you to help out with some of this historical trauma stuff." And I was like, "I don't know; I'm an Indian, but we don't talk about that in my family." And it kind of brings me back to the whole point of this, and the whole point of how to go forward. And I can only share with you what I have had to do. I was this guy who knew I was an Indian, but was in the white world, fully accepted as white. I could act white, talk white, do all those things. How could go about finding all of this stuff and get to where I am, here, today? Well, there is a prophecy that the Anishinaabe have. They said that there would be seven fires lit; one after another over time. The seventh fire would be lit when the people, the children would go back and find their elders and retrace the past. And out of that, the eighth fire will be lit, which is a new society that has harmony and love. And I have done that. I have searched out the elders, I have asked them questions I have been respectful and I have learned. And that is the answer to the questions of, "How do we go from here? How do we get over

this historical trauma? Do we bury our heads in the sand and say that 'stuff happens?'" I think the answer is that we reach out to one another and start loving one another and finding that connection. This is my uncle, and that's my brother. And from that simple love and connection we can rebuild what's been lost. Thanks.

Anne Helene Skinstad: Thank you to the panelists for all the gifts that we have received today. And thank you to the audience for all the questions and the gifts you have given us. I would like call Shirley Matt up, and we will end the day in a good way to wherever we go.

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National American Indian and Alaska Native Addiction Technology Transfer Center · University of Iowa · 145 North Riverside Dr N410 · Iowa City, IA 52242
Phone: 319-335-9750 · Fax: 319-335-6068 · Email: americanindianalaskanative@attcnetwork.org · Website: attcnetwork.org