The Historical Trauma Response Among Natives and Its Relationship with Substance Abuse: A Lakota Illustration

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Abstract—Historical trauma (HT) is cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma experiences; the historical trauma response (HTR) is the constellation of features in reaction to this trauma. The HTR often includes depression, self-destructive behavior, suicidal thoughts and gestures, anxiety, low self-esteem, anger, and difficulty recognizing and expressing emotions. It may include substance abuse, often an attempt to avoid painful feelings through self-medication. Historical unresolved grief is the associated affect that accompanies HTR; this grief may be considered fixated, impaired, delayed, and/or disenfranchised. This article will explain HT theory and the HTR, delineate the features of the HTR and its grounding in the literature, offer specific Native examples of HT and HTR, and will suggest ways to incorporate HT theory in treatment, research and evaluation. The article will conclude with implications for all massively traumatized populations.

Keywords—healing, historical trauma, intergenerational grief, Lakota, mental health, substance abuse

> I feel like I have been carrying a weight around that I've inherited. I have this theory that grief is passed on genetically because it's there and I never knew where it came from. I feel a sense of responsibility to undo the pain of the past. I can't separate myself from the past, the history and the trauma. It has been paralyzing to us as a group.
> —A Lakota/Dakota Woman (Brave Heart & DeBruyn 1998)

Historical trauma (HT) is cumulative emotional and psychological wounding, over the lifespan and across generations, emanating from massive group trauma experiences. The historical trauma response (HTR) is the constellation of features in reaction to this trauma. The HTR may include substance abuse, as a vehicle for attempting to numb the pain associated with trauma. The HTR often includes other types of self-destructive behavior, suicidal thoughts and gestures, depression, anxiety, low self-esteem, anger, and difficulty recognizing and expressing emotions. Associated with HTR is historical unresolved grief that accompanies the trauma; this grief may be considered impaired, delayed, fixated, and/or disenfranchised (Brave Heart 1999a, b, 1998, 1995).

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HISTORICAL TRAUMA THEORY DEVELOPMENT

Historical trauma theory emerged from more than 20 years of clinical practice and observations as well as preliminary qualitative and quantitative research. This theory describes massive cumulative trauma across generations rather than the more limited diagnosis of posttraumatic

stress disorder (PTSD), which is inadequate in capturing the influence and attributes of Native trauma (Brave Heart 1999a, b; Robin, Chester & Goldman 1996). General trauma literature (van der Kolk, McFarlane & Weisaeth 1996) and Jewish Holocaust literature (Yehuda 1999; Fogelman 1998, 1991) support the theoretical constructs underpinning the concept of HT, specifically the HTR features and their intergenerational transfer. Native-specific literature calls for the need to develop precise culturally-based trauma theory and interventions (Manson et al 1996; Robin, Chester & Goldman 1996). In addition to culturally congruent trauma theory and interventions, a consideration of Native history and the continuing transfer of trauma across generations are critical in developing prevention and intervention strategies that will be effective for Native Peoples.

This article will examine the relationship between HTR and substance abuse, and explain HT theory and the HTR, delineating its features. Implications for substance abuse prevention will be suggested, including interventions aimed at ameliorating the intergenerational transfer of HTR (which compounds the transfer of substance abuse across generations).

THE LAKOTA ILLUSTRATION OF HISTORICAL TRAUMA AND THE HTR

Although the Lakota traditionally had no mind- or mood-altering substances, alcohol was introduced and now the Lakota, like other Native communities, suffer from psychosocial problems such as extremely high levels of substance abuse, violence, and suicidal behavior. For Native females, the mortality rate is 24% and for Native males, 35%; both are significantly higher rates than that for all races in the United States at 10.3% (IHS 1997b). Alcoholism, suicide, and homicide death rates are higher for Native youth than youth in the population in general. Native premature death rates are higher than those for African Americans, with 31% of the deaths occurring before 45 years of age (AAIHS 1999; IHS 1997a). In the Indian Health Service Aberdeen Area (which includes mostly the Lakota and Dakota/Nakota reservations) the age-adjusted mortality rate is 1,426.2 deaths per 100,000, compared with a rate of 513.3 deaths per 100,000 for the United States in general—almost 3.6 times the national average (AAIHS 1999).

For the Lakota and Dakota/Nakota reservations, alcoholism mortality rates are almost 29 times higher than for the U.S. as a whole (AAIHS 1999). Suicide rates for the Aberdeen Area are the second highest in the Indian Health Service area, preceded only by Alaska. Further, homicide rates in the Aberdeen Area are 1.5 times greater than the all-Indian rate and 2.2 times higher than the U.S. rate for all races. Other mortality and morbidity rates are elevated among the Lakota. For example, the tuberculosis death rates, highest on the Lakota and Dakota/Nakota reservations, are more than six times the national average and almost three times the rate for all Indians (IHS 1997a, b).

High mortality rates from alcoholism, suicide, homicide, and poor health conditions suggest elevated substance abuse as well as mental health risks and needs. Further, the high incidence of death exposes surviving community members to frequent traumatic deaths and the accompanying grief. Oppression, racism, low socioeconomic status, in addition to the elevated mortality rates, place Native peoples at higher risk for traumatic loss and trauma exposure (Brave Heart 1999b; Manson et al 1996; Robin, Chester & Goldman 1996; Holm 1994). On some Lakota reservations, the age-adjusted mortality rate is almost 3.6 times the national average (AAIHS 1999). With unemployment soaring up to 73% on some Lakota reservations, nearly 50% of the reservation population lives below the poverty level (BIA 1998; IHS 1997a, b).

These modern psychosocial problems are superimposed upon a background of historically traumatic losses across generations. The historical losses of Native peoples meet the United Nations definition of genocide (Brave Heart & DeBruyn 1998). For example, Lakota (Teton Sioux) history includes massive traumatic group experiences (Brave Heart & DeBruyn In press; Brave Heart 1998) incorporating (a) the 1890 Wounded Knee Massacre; (b) war trauma, prisoner of war experiences, starvation, and displacement; (c) the separation of Lakota children from families and their placement in compulsory (and often abusive) boarding schools (Tanner 1982); and (d) the tuberculosis epidemic where more than one third of the Lakota population died between 1936-1941 (Hoxie 1989). Forced assimilation and cumulative losses across generations, including language, culture, and spirituality, contributed to the breakdown of family kinship networks and social structures. This historical legacy and the current psychosocial conditions contribute to ongoing intergenerational trauma.

Historical unresolved grief, a component of HTR, may be exacerbated by the quality of attachment traditional among the Lakota, as distinct from European American connections. The extent of emotional attachment to family is manifested in the traditional mourning practices among the Lakota (Brave Heart 1998). Bereaved close relatives would cut their hair and sometimes their bodies as external manifestations of their grief, suggesting a deep attachment to the lost relative. Some Lakota traditionally would "keep the spirit" of the deceased for one year before releasing the spirit, thereby permitting time to adjust to the loss. At the end of an appropriate mourning time, traditional grief resolution included a "wiping of the tears" ceremony. However, with the United States' 1881 policy outlawing the practice of Native ceremonies, many Natives were forced to either abandon ceremonies or practice indigenous spirituality in secret, thereby impairing

traditional mourning resolution. With the rapid succession of massive traumatic losses, Native grief became unresolved and impaired.

THE INTERGENERATIONAL TRANSFER OF THE HISTORICAL TRAUMA RESPONSE

> It is our way to mourn for one year when one of our relations enters the Spirit World. Tradition is to wear black while mourning our lost one, tradition is not to be happy, not to sing and dance and enjoy life's beauty during mourning time. Tradition is to suffer with the remembering of our lost one, and to give away much of what we own and to cut our hair short. Chief Sitting Bull was more than a relation. He represented an entire people: our freedom, our way of life—all that we were. And for one hundred years we as a people have mourned our great leader. We have followed tradition in our mourning. We have not been happy, have not enjoyed life's beauty, have not danced or sung as a proud nation. We have suffered remembering our great Chief and have given away much of what was ours. And tens of thousands of Lakota Sioux have worn their hair short for a hundred years, and blackness has been around us for a hundred years. During this time the heartbeat of our people has been weak, and our life style has deteriorated to a devastating degree. Our people now suffer from the highest rates of unemployment, poverty, alcoholism, and suicide in the country (Blackcloud, quoted in Brave Heart 1995).

This eloquent testimony to the existence of genocide across generations frames the question regarding the modes of transfer across generations. The trauma may manifest itself among Indian youth as alcohol use, which is more prevalent than in the general U.S. population at 96% for Indian males and 92% for females by the 12th grade for lifetime use (Oetting & Beauvais 1989). Not only is the frequency and intensity of drinking greater, and negative consequences are more prevalent and severe, but the age at first involvement with alcohol is younger for Indian youths (Beauvais et al.—see Brave Heart & DeBruyn In press; Moran 1999a, b). Alcohol remains the drug of choice, although inhalants and marijuana use are prevalent. Intergenerational transfer of the HTR, as well as the existence of other risk factors for substance abuse among Native youth, are suggested by these findings. Also, there may be a correlation of substance use with impaired Native parenting resulting from HT, specifically associated with boarding school trauma.

The legacy of traumatic history, specifically regarding boarding schools, has negatively impacted Lakota and other Native families. The HTR is complicated by socioeconomic conditions, racism and oppression. Risk factors for substance abuse, violence, mental illness, and other family problems among Native people may be exacerbated by HTR (Brave Heart 1999b; Robin, Chester & Goldman 1996; Holm 1994). Generations of untreated HT victims may pass on this trauma to subsequent generations (Brave Heart 1998). Having undermined the fabric of Native families, boarding schools have deprived these families of traditional Lakota parenting role models, impairing their capacity to parent within an indigenous healthy cultural milieu (Brave Heart 1999a).

Parental and other intergenerational boarding school experiences negatively impact protective factors against substance abuse, such as parental competence, parental emotional availability and support, and parental involvement with a child's schooling, Parents raised in boarding schools, who are most likely to have been victims of punitive or "boarding school style discipline," may be more likely to have experienced trauma as children—at a minimum, the separation from family. This legacy is perceived as negatively impacting parental interaction with children and contributing to risk factors for youth substance abuse (Brave Heart 1999a, 1998; Morrissette in Brave Heart 1999a). Boarding school survivor parents lack healthy traditional Native role models of parenting within a culturally indigenous normative environment. This places parents at risk for parental incompetence. Traumatic childhood experiences may result in emotional unavailability of parents for their own children. The legacy of a lack of control over choices about education, the school environment, and negative boarding school experiences across generations (Brave Heart 1995, 1999a) places Lakota and other Native parents at greater risk for insufficient involvement in the education of their offspring.

Intergenerational trauma is clearly illustrated in this testimony given by a 43 year-old Lakota male recovering alcoholic:

> I never bonded with any parental figures in my home. At seven years old, I could be gone for days at a time and no one would look for me . . . I've never been in a boarding school. I wished I was [had] because all of the abuse we've talked about happened in my home. If it had happened by strangers, it wouldn't have been so bad—the sexual abuse, the neglect. Then I could blame it all on another race. . . . And yes, they [my parents] went to boarding school (Brave Heart 1999a).

HTR AND RISK FACTORS FOR NATIVE YOUTH SUBSTANCE ABUSE

The degree of trauma exposure for children is impacted by the quality of parenting. Greater lifetime trauma exposure is increased by substance abuse (Segal In press). The risk for substance abuse, as well as trauma exposure, increases when children are subjected to: non-nurturing and ineffective parental disciplinary practices, absence of family rituals, alcohol-related violence, parental psychiatric problems such as depression, sibling alcohol use, and stressful life events such as verbal, physical, and sexual child abuse perpetrated by a family member (Brave Heart & DeBruyn In press; Brave Heart 1999a). A lack of effective Native parenting role models and the lack of nurturing as

well as abuse in boarding schools have resulted in uninvolved, non-nurturing, punitive, and authoritarian parents to varying degrees (Brave Heart 2000, 1999a, 1995; Morrisette in Brave Heart 1999a). Consequences of the boarding school legacy and spiritual oppression—poor spiritual foundations, weak Native identity, and poor family affiliation—are associated with Indian youth alcohol and other substance abuse (Brave Heart 1999a; Oetting & Beauvais 1989).

In contrast to the substance abuse risk factors, positive family relations with supervision, monitoring, and anti-drug family norms serve as protective factors against youth substance abuse (Nye, Zucker & Fitzgerald 1995). Protective family factors include high parental involvement, bonding with family and social groups that value nonuse of alcohol and other substances, external social support, positive discipline methods, and spiritual involvement (Brave Heart 1999a). Parental encouragement of children's dreaming and setting goals about their life's purpose, an important protective factor (Brave Heart & DeBruyn In press; Brave Heart 1999a), is a challenge for Native parents who carry a legacy of disempowerment and oppression. This legacy coupled with the prohibition against the open practice of Native spirituality historically has, to varying degrees, deteriorated the capacity of Native people to set life goals, dream about the future, and find one's spiritual purpose.

INTERGENERATIONAL TRANSFER OF TRAUMA RESEARCH

Childhood exposure to trauma, often associated with parental substance abuse, influences perceptual and emotional experiences of childhood events; these effects persist into adulthood. Substance abuse is implicated in parental neglect and abuse and is related to emotional problems and sexual victimization of offspring among Alaska Native females (Segal In press).

Risk factors for PTSD among descendants of Jewish Holocaust survivors have been studied. Yehuda (1999) identified well-designed studies demonstrating vulnerability among children of Holocaust survivors for the development of PTSD. Yehuda's research found that adult children of survivors had a greater degree of cumulative lifetime stress, despite a lack of statistically significant differences in the actual self-reported number of traumatic events or in the degree of trauma exposure (Brave Heart & DeBruyn In press). This implies that there is a propensity among offspring to perceive or experience events as more traumatic and stressful.; children of Holocaust survivors with a parent having chronic PTSD were more likely to develop PTSD in response to their own lifespan traumatic events. The trauma symptoms of the parents, rather than the trauma exposure per se, are the critical risk factors for offspring manifesting their own trauma responses.

A significant proportion of traumatic events reported by children of Holocaust survivors were related to being a descendant of survivors. On the Antonovsky Life Crisis Scale, the incidence of both lifetime and current PTSD was significantly higher among Holocaust descendants (31% and 15% respectively) than among the comparison groups (Yehuda 1999). PTSD prevalence among American Indians and Alaska Natives is 22%, which is substantially higher than the 8% prevalence rate for the general population; American Indian veterans also have significantly higher PTSD rates than both African Americans and the general population, attributed at least in part to higher rates of trauma exposure (DHHS 2001). These rates are considerable, even though PTSD nomenclature inadequately represents Native trauma (Robin, Chester & Goldman 1996), specifically historical trauma. Culture may impact symptom presentation and assessment, and may skew the number of American Indians meeting the PTSD criteria, despite the pervasiveness of trauma exposure (Manson et al 1996). In addition to the development of HT theory, the Takini Network (a Native nonprofit organization) promises to advance further understanding of the HTR, refine its assessment, and capture a more accurate picture of Native trauma across generations. The Takini Network is developing HTR assessment tools and evaluating the effectiveness of HT interventions.

INTERGENERATIONAL TRANSFER OF HTR: FURTHER REFLECTIONS

In addition to the Jewish Holocaust literature, the experiences of Japanese American descendants of World War II internment camp survivors also manifest intergenerational trauma response features (Nagata 1998, 1991). According to this literature, descendants carry internal intuitive representations of generational trauma, which become the organizing concepts in their lives and perpetuate trauma transfer to successive generations (Danieli 1998; Nagata 1991). Among African Americans, oppression and racism exacerbate PTSD (Allen 1996). Trauma exposure increases with lower socioeconomic status and shorter life expectancy, both factors for African Americans; darker skin color negatively impacts socioeconomic status (Hughes & Hertel—see Brave Heart 1999b). Native peoples have similar risk factors for trauma exposure. Native mortality and substance abuse rates, their high degree of trauma exposure (Manson et al. 1996), and the impairment of traditional grief resolution practices, may result in Native peoples becoming *wakiksuyapi* (memorial people), carrying internalized ancestral trauma and unintentionally passing this on to their children (Brave Heart & DeBruyn In press; Brave Heart 2000, 1998 ; Wardi in Brave Heart 2000).

HTR AND SUBSTANCE ABUSE

Substance abuse and dependence may co-occur with PTSD; the traumatized individual attempts to self-medicate to reduce the emotional pain (Segal In press). First-degree relatives of trauma survivors with PTSD manifest a higher prevalence of substance use disorders as well as mood and anxiety disorders (Yehuda 1999). Suicide attempts among children of substance abusers appear to be more prevalent (Segal In press). Another possible manifestation of intergenerational trauma transfer, childhood sexual abuse reported among boarding school survivors, is a significant risk factor for substance abuse as well as depression, and/or anxiety disorders (Brave Heart & DeBruyn In press; Brave Heart 1999a; Robin, Chester & Goldman 1996). Substance abuse and depression are both prevalent among Natives and are correlated with PTSD (Brave Heart & DeBruyn In press; Brave Heart1999b; Robin et al 1996); high trauma exposure is also significant among Natives (Manson et al 1996).

IMPLICATIONS FOR HT PREVENTION, TREATMENT, RESEARCH, AND EVALUATION

Both prevention and treatment need to focus on ameliorating the HTR and fostering a reattachment to traditional Native values, which may serve as protective factors to limit or prevent both substance abuse and further transmission of trauma across generations. For the Lakota, children are *wakanheja*—sacred (wakan) spirits returning to earth; parents are caretakers of these sacred beings, whichi is a sacred responsibility. Rekindling or imparting these values through intervention and prevention activities promises to promote improved parenting skills and parent-child relationships. Improved relationships across generations may serve as protection against both substance abuse and the transfer of the HTR. The focus on helping parents heal from HT and improving parenting skills is one type of HT intervention delivered to Lakota parents by the Takini Network (Brave Heart 1999a).

An emphasis on traditional culture may also mitigate substance abuse (Brave Heart & DeBruyn In press). The Lakota traditionally utilized no mood- or mind-altering substances. Even tobacco use and abuse was foreign to the Lakota who used *cansasa*—a healthy natural substance with no mood altering or physically damaging effects—rather than tobacco. Most Native groups who did use certain psychoactive substances limited that use to ceremonies or certain prescribed times. A Native culture that traditionally fosters extensive familial and social support networks also offers protection against substance abuse. Native ceremonies often require discipline and commitment, delay gratification, and provide Native children with healthy role models of skills needed in refusal behavior and healthy defenses against substance use.

One model useful in both prevention and intervention programs is the Historical Trauma and Unresolved Grief Intervention (HTUG). This model, developed by the Takini Network, has been recognized as an exemplary model by the Center for Mental Health Services. The model is validated through both preliminary quantitative and qualitative research and evaluation, documented in peer reviewed journals as well as other publications. Group trauma and psychoeducational interventions which seek to restore an attachment to traditional values manifest promising results for the Lakota (Brave Heart & DeBruyn In press). HTUG promises efficacy for addressing risk and protective factors for substance abuse for Lakota children and families as well as manifesting potential in halting the transfer of trauma across generations; HTUG is perceived by respondents as highly relevant for the Lakota population (Brave Heart & DeBruyn In press; Brave Heart 2001, 2000, 1999a, b, 1998).

HTUG focuses on ameliorating the cumulative trauma response through intensive psychoeducational group experiences. Intervention goals are congruent with PTSD treatment: a sense of mastery and control is transmitted (van der Kolk, McFarlane & Weisaeth 1996) within a traditional retreat-like setting (i.e., the Black Hills sacred to the Lakota), providing a safe, affectively containing milieu. Participants in the HTUG model are exposed to content, through audiovisual materials, that stimulates historically traumatic memories; this is done in order to provide opportunities for cognitive integration of the trauma as well as the affective cathartic working-through necessary for healing. Small and large group processing provides occasions for increasing capacity to tolerate and regulate emotions, trauma mastery, and at least short-term amelioration of HTR. Traditional prayer and ceremonies, incorporated throughout the intervention as feasible, afford emotional containment and increased connection to indigenous values and a pretraumatic Lakota past (Brave Heart 2001, 1998; Brave Heart-Jordan 1995). Purification ceremonies have been observed as having a curative effect in PTSD treatment (Silver & Wilson 1988).

Preliminary research on the HTUG model and on its integration into parenting sessions indicated that there was: (a) a beginning trauma and grief resolution, including a decrease in hopelessness as well as an increase in joy, (b) an increase in positive Lakota identity, (c) an increase in protective factors and a decrease in risk factors for substance abuse, (d) perceived improvement in parental relationships with children and family relationships across generations, and (e) perceived improvement in parenting skills, family connections and sensitivity to one's children. The Takini Network is developing research on longer-term benefits of the HTUG model and has expanded its

application to other tribes across the country in New Mexico, North Carolina, Idaho, Montana, Oklahoma, Alaska, Washington, and California. Additional research focuses on both the efficacy of HT interventions as well as the qualities and degree of HTR across tribes. Plans are currently underway to develop a HTR assessment instrument and further exploratory studies.

CONCLUSION

HT and HTR are critical concepts for Native Peoples. Increasing understanding of these phenomena, and their intergenerational transmission, should facilitate preventing or limiting their transfer to subsequent generations. Continued research must include not only evaluation of the effectiveness of HT interventions but also further study and assessment of the HTR and its relationship with substance abuse, and investigation of the method of its transfer to descendants. Sharing knowledge across massively traumatized groups can facilitate increased understanding of HTR and the implications for prevention and treatment. A beginning formal process of such sharing took place during the Takini Network-sponsored conference "Models of Healing Indigenous Survivors of Historical Trauma: A Multicultural Dialogue Among Allies" held in September 2001 (just prior to 9/11). During this four-day event, indigenous survivors from Native groups in Canada, Hawaii, Alaska, and the other parts of North, Central, and South America exchanged experiences and healing models with international trauma experts and clinicians from (a) the Jewish Holocaust community, (b) Japanese-American World War II internment camp descendants, (c) African-American descendants of slaves, and (d) Latino survivors of colonization. A follow-up conference will be held again in September 2003, to continue knowledge exchange, dialogue, and recognition of common features of all survivors of massive group trauma, in an effort to help each community heal from genocide. The hope is also that we can unite to prevent genocide in the future.

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