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 [the history] has been paralyzing to us as a group [American Indian people].

A Lakota/Dakota woman
(Brave Heart & DeBruyn, 1998, p. 68)

**Historical trauma** describes the cumulative emotional and psychological wounding across generations, resulting from a people’s collective traumatic experiences (Brave Heart, 1998, 1999). Unresolved grief in light of native (American Indian/Alaska Native) history, oppression, and intergenerational transfer are also key components of the **historical trauma response**. Similar intergenerational trauma response features are also illustrated in the literature from the Holocaust and the experiences of Japanese-American descendants of WWII internment camp survivors (Nagata, 1991, 1998).

The symptomology associated with historical trauma response surpasses the intensity of those symptoms identified in posttraumatic stress disorder. The features most frequently associated with historical trauma response include substance abuse, suicidal behavior, depression, anxiety, low self-esteem, anger, and difficulty recognizing and expressing emotions (Brave Heart, 2003). This author suggests that historical trauma response is prevalent in the American Indian/Alaska Native (AI/AN) population. This article addresses some of the issues related to historical trauma response and substance abuse among some AI/AN people.

Native history is rife with trauma, and includes, broadly speaking, the decimation of the cultural underpinnings of a way of life. The buffalo were killed; natives were displaced or killed during western expansion, or were victims of massacre (including the Wounded Knee Massacre in 1890); and alcohol was introduced into native society, where it was previously unknown. Specifically, native history includes the interruption of the life cycle with boarding school placement, beginning as a federal policy for natives in 1879 with the opening of the Carlisle (Pennsylvania) Indian School.
AMERICAN INDIANS/ALASKA NATIVES—SUBSTANCE ABUSE FACTS

It is no secret that disparities exist within the U.S. health care system. Studies have shown, repeatedly, that ethnic and minority groups (such as African Americans and Latinos) have higher rates of preventable diseases and less access to quality health care than the “mainstream” population. Among these groups, American Indians and Alaska Natives have higher percentages of such problems as substance abuse and psychological disorders (Barnes, Adams, & Powell-Griner, 2005).

For example:

• American Indian or Alaska Native adults (33.5 percent) were more likely to be current smokers than white adults (23.2 percent), black adults (22.4 percent), and Asian adults (12.7 percent).

• American Indian or Alaska Native men (27.8 percent) were as likely as white men (29.3 percent) and more likely than black men (20.5 percent) and Asian men (14.9 percent) to be current moderate or heavier drinkers.

• About one-fourth of American Indian or Alaska Native adults (24.6 percent) were former drinkers compared with black adults, white adults, and Asian adults (18.4 percent, 14.6 percent, and 9.3 percent, respectively).

• Overall, American Indian or Alaska Native adults (8.2 percent) were about twice as likely as black adults (3.2 percent), three times as likely as white adults (2.8 percent), and five times as likely as Asian adults (1.7 percent) to have experienced serious psychological distress within the past 30 days.

• American Indian or Alaska Native women (11.8 percent) were about three times as likely as black women (4.0 percent), three and a half times as likely as white women (3.4 percent), and five times as likely as Asian women (2.4 percent) to have experienced serious psychological distress within the past 30 days.

• American Indian or Alaska Native adults (5.9 percent) were more than twice as likely as black adults (2.1 percent), about three times as likely as white adults (1.9 percent), and four times as likely as Asian adults (1.5 percent) to have felt hopeless most or all of the time within the past 30 days.

• American Indian or Alaska Native adults (5.8 percent) were about three times as likely as black adults (1.9 percent), about three times as likely as white adults (1.7 percent), and five times as likely as Asian adults (1.2 percent) to have felt worthless most or all of the time within the past 30 days.

(National Center for Health Statistics, 2005)

REFERENCE

The Boarding School Legacy
The legacy of boarding schools included prolonged and forced separation of children from tribal communities, parents, and families—often for several years. As what would become known as the United States’ Peace Policy, more than 500 military-style boarding schools were established in the 1860s to assimilate the American Indian children into Euro-American culture (Smith, 2006). In most cases, this forced separation occurred as youth were going through critical developmental stages. In addition to being kept from their families, communities, and their native culture and ceremonies, many children were beaten for speaking their native languages, and were subjected to other forms of physical and sexual abuse (Smith).

The lack of parental role models in boarding schools, harsh corporal punishment instead of cultural teaching, and a devaluation of native languages and cultural practices undermined the development of children’s cultural identities. In addition, the 1881 and 1883 federal prohibition of religious practices on reservations and in boarding schools led to an inability to find one’s spiritual purpose, to dream, and to set goals (Brave Heart, 2003). The availability of alcohol in the peer-centered society of the boarding school made for a volatile situation.

The Impact of Historical Trauma
Positive family relations, high parental involvement, and constructive disciplinary methods are among protective factors for substance abuse. On the other hand, weak cultural identity and weak family affiliation are associated with youth substance abuse (Oetting & Beauvais, 1989). Unfortunately, the lack of emotional availability and disempowerment seen among native people raised in boarding schools weakened their parental involvement with their own families.

In general, childhood exposure to parental substance abuse and trauma—including sexual abuse—exacerbates trauma symptoms. Parents who are boarding school survivors often are coping with their own boarding school trauma, which decreases their capacity to be emotionally available to their children. Additionally, their trauma may also result in impaired parenting skill competence, as boarding school survivors were deprived of growing up in a normal native home with positive and culturally congruent parental role modeling.

Based on this information, prevention and treatment of substance abuse and other issues in native people must focus on ameliorating historical trauma response and fostering a re-attachment to traditional native values. These values may serve as protective factors to limit or prevent substance abuse and further transmission of trauma across generations.

A Promising Intervention
The historical trauma and unresolved grief (HTUG) intervention was first developed in 1992 as a psycho-educational intervention for groups. It is a promising approach for addressing historical trauma response in native people (Brave Heart, 2003). The HTUG intervention is consistent with interventions for PTSD and aims to provide a sense of trauma mastery and control in clients.

The intervention takes place in a retreat setting that is meaningful to the specific native community to whom it is delivered. Audio-visual materials help stimulate historically traumatic memories. Working through memories and emotions in small and large groups helps to integrate the trauma. Using a combination of these techniques—together with traditional native prayer and ceremonies—participants are able to connect with their native values (Brave Heart, 2003).

In 2001, under a special minority community action grant, the Center for Mental Health Services recognized HTUG as an exemplary model. HTUG has been validated through both preliminary quantitative and qualitative research.
(Brave Heart, 2003) and has been documented in peer-reviewed journals and other publications.

This author has delivered HTUG to a number of tribal communities across the United States. Preliminary research on this model and its integration into parenting sessions indicated that participants perceived the following:

- Beginnings of trauma and grief resolution, including a decrease in hopelessness and an increase in joy;
- Improved positive Lakota identity;
- Increased protective factors and a decrease in risk factors for substance abuse;
- Enhanced parental relationships with children and family relationships across generations; and
- Improved parenting skills, family connections, and sensitivity to one’s children.

(Brave Heart, 1998, 1999a, 1999b, 2000; Brave Heart & DeBruyn, in press)

The work on historical trauma promises to increase our understanding of the intergenerational transfer of trauma, its root causes, and will hopefully lead to preventing or limiting the negative effects for the next generations.

The Takini Network, a native non-profit organization formed in 1992 to address historical trauma healing among native peoples, is developing research on longer-term benefits of the HTUG model. Additionally, the Network is conducting research on the efficacy of historical trauma interventions and the qualities and degree of historical trauma response across AI/AN tribes. Plans are currently underway to develop an instrument that would accurately measure and assess historical trauma.

**Continued Research Shows Promise**

Historical trauma and the historical trauma response are critical and meaningful concepts for native peoples. The response to historical trauma theory across native communities has been a positive, empowering experience. In fact, many native communities are asking for additional training and research on historical trauma, and native social workers are currently involved in historical trauma research.

Continued research is needed, however, to: (a) increase the effectiveness of HTUG; and (b) assess the historical trauma response, its relationship with substance abuse, and how trauma is transferred to descendants. In 2001, a historic conference titled “Models of Healing Indigenous Survivors of Historical Trauma: A Multicultural Dialogue Among Allies Conference,” took place.

The four day event included indigenous survivors from native groups in the mainland United States, Hawaii, and Alaska, as well as natives from Canada and other parts of North, Central, and South America. Participants came together to exchange experiences and healing models with international trauma experts and clinicians from other massively traumatized groups, including: Jewish Holocaust survivors and descendants; Japanese American World War II internment camp descendants; African American descendants of slaves; and Latino survivors of colonization.

Follow up conferences were held in September 2003, and December 2004. These conferences continued knowledge exchange, dialogue, and building coalitions across diverse traumatized populations—recognizing common features of all survivors of massive group trauma—in an effort to help each community heal. The unity at the Models of Healing conferences and the historical trauma group interventions gives hope that trauma survivors can heal, and that we can prevent massive group trauma for future generations.

Maria Yellow Horse Brave Heart, PhD, MSW, LCSW, is an associate research professor, and also coordinator and developer/associate professor of the Native Peoples Curriculum Project at University of Denver Graduate School of Social Work. A Lakota, Dr. Brave Heart is also president of The Takini Network. In January 2007, Dr. Brave Heart will join the faculty at Columbia University School of Social Work as associate professor. She may be contacted at takininet@aol.com
EXPLORING SUBSTANCE ABUSE IN AMERICAN INDIANS/ALASKA NATIVES

Throughout history, people have used—and misused—alcohol. In fact, it is the oldest known, most abused drug, with a broad range of use and consequences among various populations (Frisbee, 2005). Every community, it seems, has its own particular relationship with one of the nation’s most widely accepted and readily available social drugs.

Among American Indian and Alaska Native (AI/AN) communities, alcohol misuse is the single most significant substance abuse problem, though methamphetamine is a growing threat on reservations across the United States (Gerard, 2005). In 2003, there were 49.3 alcohol-related deaths for every 100,000 natives. This number was significantly higher than deaths due to drug use or firearms within the same community (Gerard).

Because prevention and treatment of substance abuse is most effective when cultural context is taken into consideration, it is important to explore the environment in which abuse of alcohol and other drugs occurs. In a 2005 article for Indian Times, author Shirley Frisbee wrote:
The American Indian experience with chemical dependency is unique. While there are hundreds of American Indian tribes, each with their own culture and subgroups, each tribe and subgroup has its own drinking patterns. However, they have one factor in common: post-traumatic stress caused by discrimination and racism resulting from colonization. Social injustice, ethnocentrism and economic instability contribute to alcohol consumption by Native Americans.

A sign of deeper problems, she added, is that substance abuse among American Indians has become a means of coping with low self-esteem, hopelessness, and despair that arise from oppression. Understanding this social context is essential when addressing substance abuse in the AI/AN population.

In the front page article of this Section Connection, Maria Yellow Horse Brave Heart examined the phenomenon of historical trauma, which she defines as: “…the cumulative emotional and psychological wounding across generations, resulting from a people’s collective traumatic experiences.”

The resulting historical trauma response, she writes, can result in a broad array of problems including substance abuse, depression, and suicide. Brave Heart offers a group intervention model—a promising approach for addressing trauma in native people.

In the second article of this newsletter, Suzanne L. Cross, discusses the reasons why many native parents are not raising their own children—a troubling trend in AI/AN communities.

Feelings of hopelessness in the AI/AN community extend across all age categories, sparing not even the young. In fact, the 2002 National Drug Use Survey shows that AI/AN youth are more likely than any other ethnic or minority group to have used illegal drugs, smoked cigarettes, and participated in binge drinking (five or more drinks at one time) during the past 30 days (Gerard, 2005).

What does it take to raise healthy AI/AN children when faced by these figures? In 2004, Priscilla A. Day, and two colleagues at the University of Minnesota-Duluth Department of Social Work, received a grant to explore this question. Day shares what she learned.

Each of these articles offers a different perspective on substance abuse problems in AI/ANs. A common thread, however, runs through them: the concept of cultural context in addressing misuse of alcohol and other drugs in these communities.

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Many American Indian grandparents provide sole care for their grandchildren. In fact, approximately 53,000 American Indian and Alaskan Native grandparents, age 45 and older, fulfill this role in kinship-care relationships, according to the U.S. Census Bureau (2004). While American Indian grandparents have always played an important part in their grandchildren’s lives, the reasons behind this current trend are troubling.

Historically, among diverse tribal nations, grandparents were (and are) a valuable resource for teaching children traditional cultural values. Elders serve as keepers of the culture, kinship keepers, mediators, unifiers, counselors, healers, and caregivers (Ryan, 1981; Emick & Hayslip, 1996; Erera, 2002; Herring, 1992). Taking into consideration the cultural value of informal care, the number of grandparents caring for their grandchildren—without legal adoption, foster parenting, or legal guardianship—is probably greater than that shown in official reports.

Among the non-American Indian population, reasons why grandparents parent their grandchildren include parental substance abuse and addictions; incarceration of a parent; divorce; parental unemployment; lack of childcare; and parents’ mental disorders, serious illness, or death (Bell & Garner, 1996; Brownell & Berman, 2000; Franklin, 1999; Mills, 2001). While the same reasons are also prevalent in the American Indian population, alcohol abuse is the main reason why American Indian grandparents provide sole care for their grandchildren. This article takes a closer look at research performed by this author examining this unfortunate phenomenon.

Examsining Kinship Care

A two-part qualitative study conducted by this author from 2003–2005 examined several aspects of the American Indian grandparent-grandchild kinship care relationship in Michigan. Part One of the study included 31 individual grandparent interviews in 12 counties. Part Two included 27 nine-person focus groups in six counties. These interviews examined reasons for care, background information, the influence of the Indian Child Welfare Act (ICWA) of 1978 on the kinship relationship, the grandparents’ major health issues, and services the grandparents accessed.

The average age of the grandparents in the study was 59.7 years, and 23 of 31 individuals had major and multiple health issues. The average age of the participants’ grandchildren (26 males and 19 females) was nine years. One became a foster child with his grandmother, three were under formal guardianship, seven were adopted by their grandparents, and 34 had no legal relationship with their grandparents.

Reasons for Caregiving

When asked why they were serving as caregivers to their grandchildren, the interviewees listed various reasons. Twenty-six participants reported that parental substance abuse—primarily alcohol abuse—was the primary reason their grandchildren lived with them.

Other reasons interviewees provided were: abandonment (8); unemployment (5); lack of day care (5); teen pregnancy (4); separation/divorce (4); death, including one alcohol-related car accident (2); mother in school (2); parental mental disorder (1); serious illness of parent (1); child’s health problems (1); parental learning disability (1); cultural tradition (1); and, “To keep them out of foster care” (1).

These reasons are similar to those listed by non-American Indian grandparents who care for their grandchildren. However, an important cultural value emerged: Allowing grandparents to raise their grandchildren on reservation land or in an established American Indian Indian community off
reservation land ensures that the children will grow up in the culture. In fact, seven grandparents participating in the study noted that the Indian Child Welfare Act (ICWA), a policy designed to keep American Indian children with American Indian families, was helpful in their cases.

**Frustrations about Parents**
Except for the seven grandparents who had adopted their grandchildren, most saw their own parenting roles as temporary, and were waiting for their adult children to provide full care of their children. Some grandparents reported frustration with what they saw as disruptive behavior on the part of their adult children. Some parents, they said, return home, live with them, and then leave again without the children. Other parents, interviewees said, find new jobs, take their children, and then return them a short time later. “In a month or so,” one grandparent said, “when the jobs don’t work out, the children are brought back and left.” The grandparents must then resume parenting, re-enroll the children in their schools, and help them cope with yet another failed attempt by their parents.

**Role of Cultural Values**
In these situations, the adult children may be exploiting the traditional cultural value of respect for elders, sharing, and intergenerational involvement that sustained American Indian families throughout history. They take advantage of their children’s grandparents by redefining and manipulating traditional values—pressing for money to purchase alcohol or other drugs, and charging elders with not adhering to the cultural value of sharing if they deny these requests.

Adult children also show disrespect by expecting their parents to act as sole providers of care for their grandchildren, thus rewriting the traditional role of grandparents as part of a caring, extended family network. Instead, they tell the grandparents that they should be willing to provide sole care for their grandchildren because it is a traditional value. “Sharing was [traditionally] seen as something positive, more respected,” one grandparent said.

The traditional, culturally grounded values of respect for elders, sharing, and intergenerational involvement are still intact for many grandparents, who practice their roles effectively in their communities. Unfortunately, for others, their adult children’s problems have strongly affected their lives: Because their own children have substance abuse problems, these grandparents must become sole providers of care for their grandchildren.

**Helping Grandparent Caregivers**
By offering educational programs on the effects of substance abuse and the impact of policies such as the ICWA, social workers can assist American Indian grandparents. Additionally, familiarizing grandparents—and all family members—with tribal and non-tribal services available to address their needs within the context of their culture is also essential. And, most importantly, social workers can support grandparents’ traditional roles in the lives of their families, extended families, clans, and tribal nations.

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PREVENTING ALCOHOL ABUSE: IDENTIFYING DEVELOPMENTAL ASSETS IN HEALTHY ANISHINAABE CHILDREN
Priscilla A. Day, EdD, MSW

What does it take to raise healthy American Indian children? Researchers at the University of Minnesota-Duluth Department of Social Work have been asking this question of northern Minnesota tribal members as part of a Bremer Foundation-funded study of Anishinaabe tribal communities.

In 2004, the Bremer Foundation provided me, and two other faculty members, with a three-year grant. Our research attempts to apply a strengths-based approach to child welfare by identifying the specific assets used in childrearing and by documenting the Anishinaabe (part of the Ojibwe tribe) community’s childrearing successes.

The outcome of this study may help create a healthier community in the future. Promoting a healthy cultural identity provides a protective factor from behavior such as alcohol abuse. Additionally, it can be used to intervene in high-risk behavior by providing a basis for recovery.

Identifying Assets
We performed our research in collaboration with the Search Institute, a Minneapolis-based agency known around the world for its work with children, family, and communities. The Search Institute identified a series of 20 internal and 20 external developmental assets that help children grow up strong, capable, and caring. These assets provide children with powerful influences that protect them from negative pressures, while encouraging them to adopt more positive behaviors (Search Institute, 2005).

In 2003, the Search Institute conducted a study in more than 200 communities across the United States with approximately 150,000 adolescents in grades six through 12. The study revealed that the more assets adolescents had, the less likely they were to engage in high-risk behaviors like alcohol abuse, illicit drug use, violence, and sexual activity. For example, the Institute found that 45 percent of adolescents with 10 or fewer...
assets were likely to engage in problem drinking, while only three percent of adolescents with 31 to 40 assets exhibited the same behavior.

This protective influence is also seen in other high-risk behaviors affecting many tribal communities. Our goal was to examine whether these same developmental assets could be identified in tribal communities and to determine whether there were cultural differences in assets.

Exploring Anishinaabe Assets
Our research primarily explored the developmental assets of healthy Anishinaabe children, including internal assets (values, behaviors, and skills that children develop to assist them in making life choices) and external assets (environmental factors that help children feel positive about themselves).

When working with tribal communities, it is important to understand and respect the tribal sovereignty of reservations. Accordingly, we began by making a formal request to the tribal council of the reservation asking if we could interview their elders. Once we received official permission, we used the existing elderly nutrition program to conduct a series of 12 to 15-person focus groups with elders over age 55. We used the Search Institute’s developmental assets as a guiding framework.

After receiving additional input and feedback from our tribal advisory group—six women and two men, ages 30 to 75 of American Indian elders and human service professionals from northern Minnesota reservations—we developed interview questions and presented them to a convenience sample of 10 Anishinaabe elders and key informants aged 45 to 72. Elders were interviewed on two separate occasions.

Preliminary Findings
We found that, while the basic tenets of what it takes to raise a healthy child are the same across cultures (food, shelter, and security), the order of importance is different for native children. For example, culture, spirituality, extended family, and tribal connections play a more central role for American Indian families than for families in other cultures. Respect for the earth and all its creatures, staying close to home, helping extended family, and practicing other traditional tribal ways were identified as: “Living a good Anishinaabe life.”

Emphasizing Cultural Identity
Involving children in daily activities like housekeeping, hunting, fishing, and picking berries were among the elders’ suggestions for helping them become healthier adults. Many also expressed the importance of involving children in cultural events like pow-wows and “arts and crafts.” These, they said, help native children “develop a sense of cultural pride” that “reinforces identity.” Elders also commented on the importance of receiving spiritual guidance and participating in traditional ceremonies.

Praising Properly
The elders stressed the importance of praising children, not just for a positive outcome, but also for making a good effort. This, they explained, helps children feel rewarded for trying. Also, they said, experiencing “trial and error” is part of a healthy childhood: “Let them make mistakes,” one elder said. “Don’t be critical—let them figure things out for themselves.” Over time, the elders said, this will give children a sense of competence and mastery they would not have achieved had they simply given up because they were told they were not doing something well enough.

Some participants also suggested that in today’s busy society, parents tend to get frustrated and just tell their children what to do to make things go quicker. The elders we interviewed said this robs children of the chance to think about and solve problems for themselves. When parents do this repeatedly, they explained, children never have to think about how to do things for themselves.
Parents’ Roles
Good parenting behaviors extend beyond cultural lines, including being a good role model and providing a secure home. Caring about children and spending time engaging them in activities like reading and playing were also seen as important by interviewees. Additionally, most elders discussed the significance of teaching children including the traditional native values of treating elders with respect, behaving at ceremonies, and assuming proper gender roles.

One elder talked about planting a garden when his children were small and how they kept walking over the newly planted seeds. “We decided to give them a corner of the garden that was theirs,” he said. “They learned on their own not to walk on their plants, and took pride in keeping [their corner] weeded. They felt good when it grew up and they could harvest it.” Allowing children to explore nature and to learn how plants and animals are crucial to their survival is also essential, according to this elder. “Our children need to know how we are all connected,” he said, “in order to respect the world around them.”

The elders also noted that parents should make sure their children complete any homework assigned to them. Research shows that children whose parents care about, and are involved in, their education do better in school (Strand & Peacock, 2002; Blum & Rinehart, 1997).

The Role of the Tribe and Community
When asked what the tribe or community could do to help support raising healthy children, the elders suggested the following:
• Offer parenting classes,
• Provide day care,
• Create opportunities for family and community healing
• Promote traditional ceremonies, traditional songs, and other traditional activities
• Plan community development activities, led by elders invested in retaining traditional values and practices that promote family

Implications for Providers
While many of the findings show that tribal people utilize developmental assets in raising their children, the ways in which assets are developed and used may be culturally unique. Knowing this enables social workers, parent-educators, teachers, and others to use tribal activities and teachings in prevention or intervention of high-risk behaviors with native children.

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