

FASD and Historical Trauma Considerations to Improve Care for Native People:

Focus on Child Welfare and Domestic Violence

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DISCLOSURE

- The presenters have no financial relationship to this program.

objectives

- 1) Describe the contexts of FASD, historical trauma and grief and how they relate to maternal and child health.
- 2) Identify specific influences of FASD, historical trauma and grief in child welfare and domestic violence.
- 3) Apply learning to improve care and treatment for Native people.

roadmap

- 1) Prenatal Alcohol Exposure (PAE) and Fetal Alcohol Spectrum Disorders (FASD) effects on brain and behavior
- 2) Historical trauma, child welfare, and domestic violence
- 3) Community perspectives
- 4) Recommendations
- 5) Discussion / questions

A nation is not conquered until the hearts of its women are on the ground. Then it is done, no matter how brave its warriors nor how strong their weapons.

--Cheyenne Proverb

PAE/FASD EFFECTS ON BRAIN AND BEHAVIOR

Scope of fasd among AI/ANs

- Some tribes: rates as high as 1.5-2.5 per 1,000 live births; others: rates comparable to the general population, 0.2-1.0 (CDC, 2002)
- Alcohol use and related challenges one of the most significant public health problems for AI/ANs
- Tribes/communities vary greatly, some with higher abstinence rates than the general population
- May effect multiple generations
- Tribes lead the way with prevention, education, training, other interventions

How does prenatal alcohol exposure (pae) affect the brain?

PAE can cause

Cognitive and neuropsychological problems in memory, attention, intellectual functioning, information processing.

In particular, problems with

Executive Function

Sensory Integration

Executive function is impaired by pae

Executive function is a higher order neurological process that includes the ability to

- Organize stored information and integrate it with new incoming information
- Plan, weigh options, reason, anticipate consequences, and sequence behavior
- Solve problems and shift gears (cognitive flexibility)

Sensory integration is impaired by pae

A person with sensory integration problems may

- Become overstimulated in social situations (crowded rooms, many people, strangers)
- Overreact to unexpected (and often, insignificant) events with surprisingly strong emotions; no modulation
- Have a poor ability to focus attention, stay on task

Brain damage

problem behaviors



- Poor judgment.....easily victimized
- Attention deficits.....unfocused/distractible
- Arithmetic disability.....difficulty w/money
- Memory problems.....doesn't learn from experience
- Difficulty abstracting.....doesn't understand consequences
- Disoriented in time and space.....misses social cues
- Poor frustration tolerance.....quick to anger

Problem behaviors associated with fasd adverse life consequences



Deficits in social behavior are becoming a widespread mark in FASD individuals (*Spohr et al, 2007; Kelly et al, 2009*)

Examples include:

- School failure (about 60%)
- Trouble with the law (about 60%)
- Substance abuse (about 40%)
- Mental health problems (about 90%)

(Streissguth, 1996)

HISTORICAL TRAUMA, CHILD WELFARE, AND DOMESTIC VIOLENCE

Historical Context of work with indigenous women

- Context is essential when interpreting epidemiological data and disseminating it.
- Failure to account for the socio-environmental context can lead to pathologized perceptions of Natives and reinforce power inequities.

Historical Trauma

- Collective and cumulative emotional wounding across generations that results from massive cataclysmic events – Historically Traumatic Events (HTE)*
- The trauma is held personally and collectively and is transmitted over generations.
- Intergenerational transmission of trauma is a relatively recent focus of mental health. First observed in 1966 by clinicians alarmed by the number of children of survivors of the Holocaust seeking treatment.

Resilience and Strength

- While the history of traumatic events is important to know, it does not define who we are.
- That people experiencing historical traumas, have survived, learned to live with, and even thrived under such oppression truly underscores how amazingly resilient and strong they are.



history

Historical Origins

Prior to European Contact

- 20-45 million Native individuals
- 1000s of sovereign Nations each with own culture

Early Contact

- By 1900, only 250k survived starvation, disease, murder, wars.
- Women & children were considered sacred, held esteemed positions in the nation
- Matrilineal/matriarchal tribal nations
- Women were not seen as property of men
- Swift and severe tribal justice in response to violence
- DV rare until after colonization

Erosion of Tribal Societies and Traditional Ways

- European contact began in large part in 1492, and led to an historic and tragic change in the lives of indigenous people: the beginning of the loss of culture and the change in the status of Native women.



Boarding School Period

- 1880s – 1930s: During this time, thousands of Native children were forcefully removed from their families and placed in Indian boarding schools.
- The overt mission of the boarding schools was to assimilate Native children into mainstream culture. Tribes were effectively stripped of their right to raise their children.
- The children were forced to learn English, cut their hair, and were not allowed to practice traditional ways. Many children were abused and neglected in these settings.

Boarding school stats

- Expansion of Native-targeted education began in 1819 with the passage of the Indian Civilization Act.
- By 1900, 153 Indian Boarding schools were operating in the US (Adams, 1995).
- By 1930, close to half of all Native children were enrolled in a boarding or industrial school (USDHHS, 2001).



BRADY PHOTO



Indian Child Welfare

- In the 1930s, the government began to shift its focus from education to alternative policies aimed at Native children. Public child welfare agencies began actively advocating for the placement of AIAN children in non-Native homes (eg. Indian Adoption Act).
- Federally-funded studies conducted in the early 1970s found that in the five states with the largest Native populations, between 25% and 35% of all Native children were in out-of-home placement or adoptive homes (Byler, 1977).
- These studies also found that over 99% of these cases were initially opened based upon neglect (Byler, 1977). In virtually all of these cases, the neglect was determined by a non-Native child welfare worker.

All of this has contributed to both how non-Native people view and relate to indigenous people, and in some ways how they view and relate to themselves.

Disregarded, not valued.

The Indian Child Welfare Act

- After many years of activism and advocacy the ICWA became law on November 8th, 1978 and was implemented in May of 1979 (U.S. Senate Select committee on Indian Affairs, 2001). The Act required strict requirements in Indian child welfare cases and deferred authority for Native children to the tribes.
- The Act is premised on the belief that protecting the cultural identity of Native children is fundamental to their well being and to the cultural integrity of their communities (Weaver and White, 1999). Towards these ends, the Act outlines major provisions regarding Native children involved in the child welfare system.

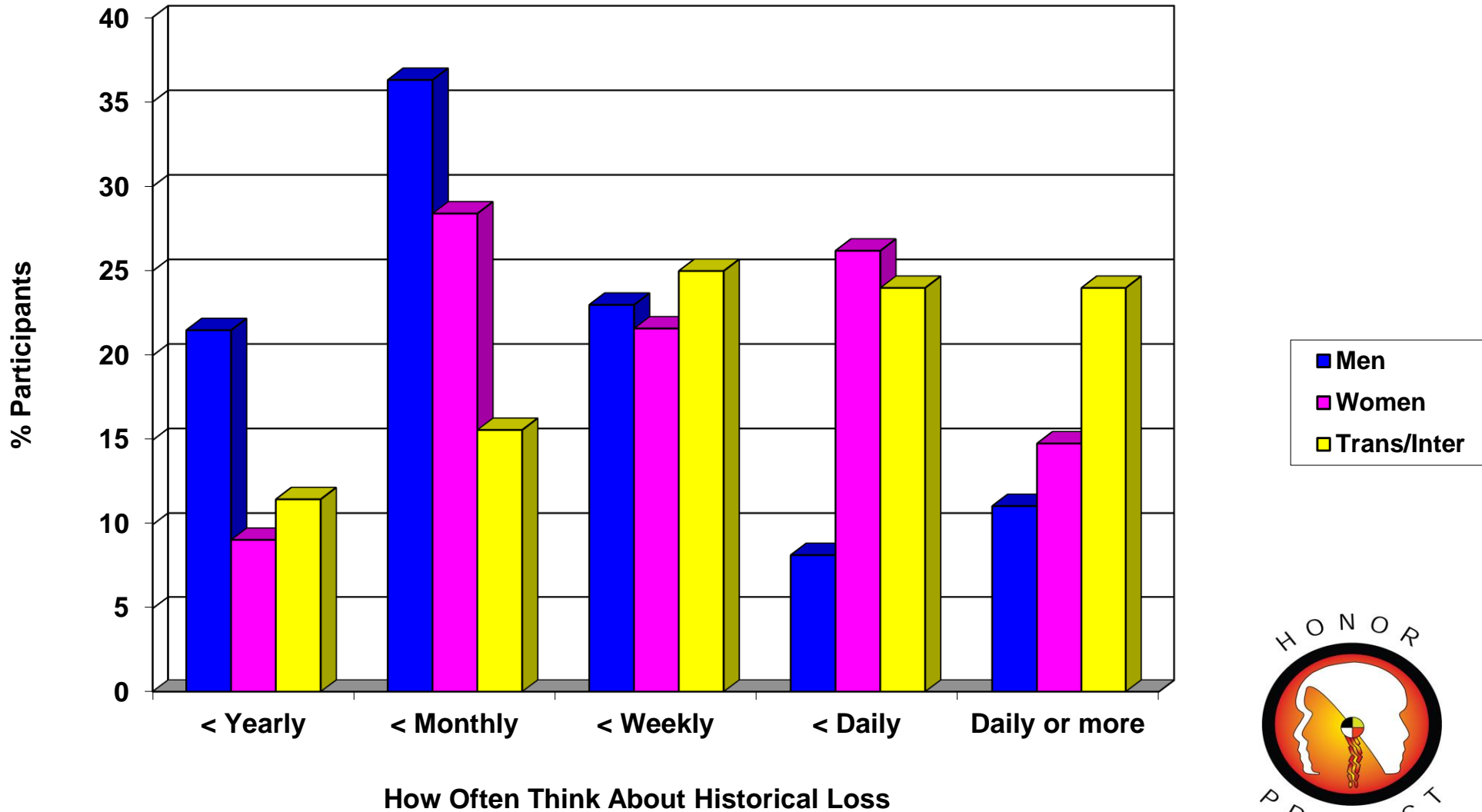
SOCIETAL REACTIONS AND THEIR IMPACT

- The reactions of society at large to survivors of massive trauma have a significant impact on their health and their ability to integrate their traumatic experiences.
- Many indigenous people today encounter a pervasive societal reaction that includes: indifference, disbelief, avoidance, repression, and denial of their community's historical experiences.
- What are the implications for practice?

Historical Trauma Events by Generation - Honor Project 5-year multi-site national study 2002-2007 (5 R01 MH065871)

	Current	Parents	Grandparents	G-grandparents	G-G-grandparents
1. Boarding school	13%	28%	32%	37%	6%
2. Adoption/foster care	19%	13%	11%	57%	6%
3. Prevention of cultural expression	14%	26%	37%	39%	6%
4. Exploitation of homeland	13%	16%	26%	59%	6%
5. BIA relocation program	10%	17%	22%	56%	6%
6. Community massacre	3%	3%	25%	64%	6%
7. Land allotments stolen	9%	14%	38%	50%	5%
8. Medical procedures no consent	6%	6%	14%	73%	6%
9. Forcible Relocation	6%	4%	32%	55%	7%
10. Held hostage or experienced combat	5%	5%	17%	70%	7%
11. Prevention of traditional healing	8%	15%	39%	49%	6%
12. Relative's artifacts/remains stolen	7%	6%	21%	67%	8%
13. Relative's artifacts/remains desecrated	6%	5%	21%	66%	9%
<i>Average sources of trauma: Mean (SD)</i>	1.2 (2.3)	1.6 (2.2)	3.4 (3.6)	7.4 (4.2)	0.8 (2.5)

Historical Trauma Loss



MULTI-LEVEL IMPACTS (Evans-Campbell, 2008)

- Not surprisingly, impacts of these events are quite diverse, depending on individual mental health, differences in family and social structures.
- Although the long-term social manifestations are profound and pervasive, research focuses mainly on individual effects with only limited work on familial and communal effects.

Stress Vulnerability

- The majority of studies involving non-clinical samples show that rates of mental health disorder are not usually higher than those found in the general population (eg. van Ijzendoorn et al., 2003).
- Researchers have found that children of HT events survivors are more likely to have a stress vulnerability – more likely to develop PTSD symptoms when exposed to stressful events (eg. Nagata et al., 1991; Yehuda, 1999).
- For indigenous people, events that act as reminders of their colonized status may predispose AIANs to trauma responses and corresponding symptoms (Evans-Campbell & Walters, 2006).

Mental Health and Substance Use Indicators among Boarding School Attendees

(Evans-Campbell, 2008)

Variable	Boarding (n=21)	None (n=176)	Adj. Odds Ratio
	%	%	
Ever Depressed	84	58	15.01 (1.89, 118.76)**
Ever Dyphoria	69	49	4.07 (1.23, 13.53)*
Inpatient Mental Health Treatment	42	20	3.26 (1.18, 9.01)*
Traditional Sub Use Treatment	46	23	6.23 (1.92, 20.22)**
Current Drinking – Moderate to Heavy	23	17	1.76 (.41, 7.46)
Used Marijuana in the past year	48	24	4.34 (1.53, 12.34)**
Used other illicit drugs in past year	50	30	3.17 (1.09, 9.25)*

FAMILIAL level RESPONSES

- Among historically oppressed peoples, HT can become an organizing concept for family systems (eg. Danieli, 1998; Nagata, 1991; Wardi, 1992).
- For example, children report feeling that they were expected to serve certain familial roles (e.g., consoling parents) (Felsen, 1998).
- Descendants of survivors may feel that they cannot talk about the past without traumatizing their parents, grandparents, etc.

COMMUNITY LEVEL RESPONSES

- Perhaps the **least understood area** of trauma effects
- Boarding school example – scholars suggest that the boarding school movement contributed significantly to the loss of language and other traditional practices in communities (eg. Duran and Duran).
- Individuals living within such communities may experience secondary effects (people more susceptible to drug use; higher levels of parental stress).

Reframing HT Responses

- While much of the research focuses on dysfunction related to HT, more research is looking at the strengths and resiliencies resulting from survival and adaptation.
- As Danieli (1998) points out, we need to reframe the roles of guilt, denial, and mourning in the context of massive trauma. The dynamics in survivors and their descendants are different than western notions of “functional” mourning. **But we’re not talking about typical mourning.**
- In fact, some denial and a prolonged period of mourning may be very normal when dealing with massive trauma and, in fact, may be beneficial.

Moderating Role of Cultural Factors – Results from Focus groups (Evans-Campbell, 2009)

Positive Identity

Enculturation

Cultural Resilience

Spirituality

Mentors

Engagement in Traditional Practices

Intergenerational Contact



Domestic Violence and native women

Domestic violence

“We define domestic violence as a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner. Domestic violence can be physical, sexual, emotional, economic, or psychological actions or threats of actions that influence another person. This includes any behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame, hurt, injure, or wound someone” (USDOJ: Domestic Violence, 2013).

Focus population

- 40% of Domestic Violence victims are men
- Our focus is on the 60% of women
- “The United States Department of Justice estimates that 4.5 million women are violently victimized in the United States every year”
(Santana, 2004).



National Institute of Justice
Violence Against American Indian and
Alaska Native Women and Men

**2010 Findings From the
National Intimate Partner and
Sexual Violence Survey**

By André B. Rosay, Ph.D.



Lifetime Violence Against AI/AN Women

More than 4 in 5 American Indian and Alaska Native women (84.3%) have experienced violence in their lifetime. This includes —

- ■ 56.1% who have experienced sexual violence.
- ■ 55.5% who have experienced physical violence by an intimate partner.
- ■ 48.8% who have experienced stalking.
- ■ 66.4% who have experienced psychological aggression by an intimate partner.



Past Year Violence Against AI/AN Women

More than 1 in 3 American Indian and Alaska Native women (39.8%) have experienced violence in the past year.

This includes —

- ■ 14.4% who have experienced sexual violence.
- ■ 8.6% who have experienced physical violence by an intimate partner.
- ■ 11.6% who have experienced stalking.
- ■ 25.5% who have experienced psychological aggression by an intimate partner.



Relative to non-Hispanic White-only:

- AI/AN women are 1.2 times as likely to have experienced violence in their lifetime and are 1.7 times as likely to have experienced violence in the past year ($p < .05$).
- Primarily by interracial perpetrators.



Very similar graphs for sexual assault.

Figure 3.1 Interracial Physical Violence by Intimate Partners: Weighted Estimates for Lifetime Victims

Percentage of victims experiencing physical violence by an interracial intimate partner

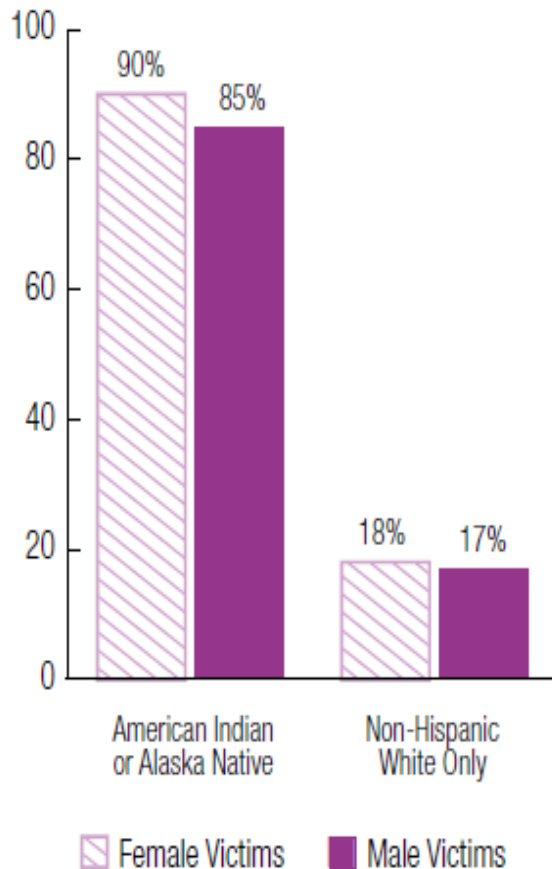
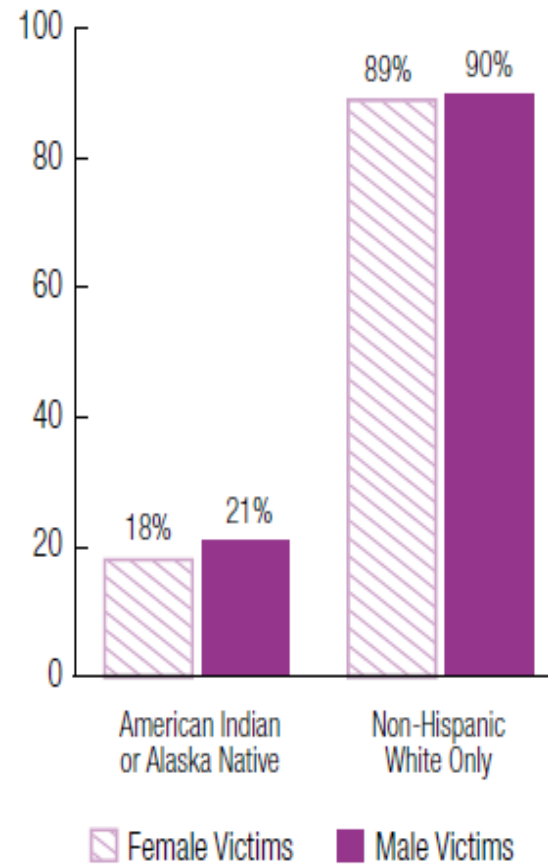


Figure 3.2 Intraracial Physical Violence by Intimate Partners: Weighted Estimates for Lifetime Victims

Percentage of victims experiencing physical violence by an intraracial intimate partner



Services Needed

- Most common service needed by AI/AN victims of lifetime physical violence by intimate partners, stalking, and sexual violence was medical care (38% women, 9% men).
- Among victims who needed services, 38% of AI/AN women and 17% men were unable to get the services they needed.



Health concerns (Lancet, 2002)

- Physical: Chronic pain, gastrointestinal disorders, psychosomatic symptoms, eating problems
- Mental/emotional: (anxiety, post-traumatic stress disorder, depression)
- **Reproductive: Increased risk of unplanned or early pregnancies and sexually transmitted disease**
- **Behavioral: Increased risk of substance abuse**

Psychosocial concerns

- Low self esteem
 - Emotional and economic dependency
- Continued faith and hope abuser will "stop"
- Depression, stress, psychosomatic complaints
 - Accepts blame and guilt for violence
 - Social isolation
- Believes battering myths, stereotypical sex roles
 - Poor self-image
 - Contemplates suicide or self-harms
 - Nervous or anxious
 - May defend criticism of abuser

ADDRESSING DOMESTIC VIOLENCE
IN NATIVE COMMUNITIES



INTRODUCTORY MANUAL

MENDING THE SACRED HOOP
TECHNICAL ASSISTANCE PROJECT



*“You must be able to see where you have been,
before you can possibly know where you want to go.”*

~ Muscogee Creek

Barriers to Reporting DV and Accessing Treatment

- Small communities – even in urban settings people know each other
- Confidentiality
- Limited services offered
- Mistrust of services/legal system
- Worry about reporting perpetrator due to institutional racism

Progress: 1970's to Today

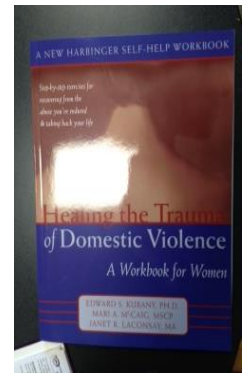
- Anti-rape movement
- 1978: Indian Child Welfare Act helped AIAN children to stay in AIAN homes; Indian Religious Freedom Act legalized Native spiritual practices
- DV shelters and programs
- National advocacy organizations/coalitions focused on addressing AI/AN DV
- Violence Against Women Act 1994; 2013 Title IX: Safety for Indian Women

- **Primary** (prevent from initially occurring) – educational outreach to community groups, churches, schools.
- **Secondary** (targeted to at risk) – routine assessments for domestic violence at standard medical visits (in pregnancy, especially).
- **Tertiary** (minimize the problem) – increase levels of services required by battered women (shelters, legal protection, emergency hotlines, etc.)



Potential Interventions

- Healing the Trauma of Domestic Violence: A Workbook for Women (Edward S. Kubany and Mari McCraig, 2004).
- Addressing Domestic Violence in Native Communities: Introductory Manual (Mending the Sacred Hoop Technical Assistance Project, 2003).



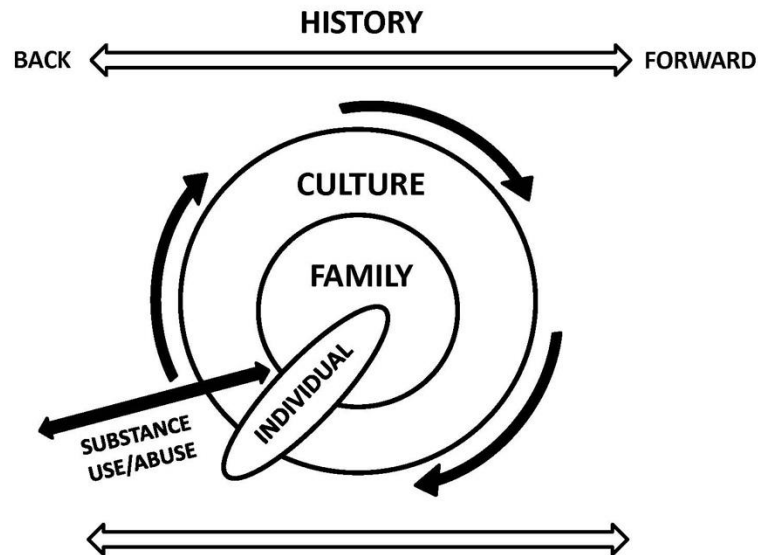
COMMUNITY PERSPECTIVES

(with sincere thanks to the tribal communities)

Two pacific northwest tribal community studies

- CBPR/TPR
- 4 communities, 153 participant study focused on substance use, needs, and resources (Radin et al, 2015)
- 1 community, 68 participant study focused on relationship health and domestic violence
- Interviews, focus groups, existing community data, survey, advisors' knowledge/input

Relationships between family, culture, and individual embedded within an ongoing historical context



Sociocultural/historical nature of DV: impacts on individuals and communities

- The nature of DV is intimately tied to the tribe's and community's history and culture, including devastating hardships and cultural losses that have negatively impacted some families' and individuals' ability to nurture each other and build healthy relationships. Some experiences (e.g., boarding schools) have contributed to maladaptive coping/behaviors, including substance abuse and domestic violence.
- Tapping into traditional culture to strengthen the community and people is of vital importance, especially as it builds self-worth and understanding of roles, responsibilities, and "how to walk in this world."

healthy relationships

- Healthy relationships: “**Good things**”: love, honesty, respect, mutual support and goals, togetherness, peace, loyalty, trust, communication, forgiveness, sharing; **communication**; life and self **balance**
- Ability to engage in healthy relationships: culture and teachings from elders/family, especially roles responsibilities, boundaries

unhealthy relationships

- Unhealthy relationships: abuse and harm, control, substance use/abuse and mental health
- Contributors to engaging in unhealthy relationship/s:
 - Substance use, abuse, and dependence (SUAD) changes behavior and personality
 - SUAD in the family environment causes chaos/destruction, abuse and neglect, and alters the learning environment
 - SUAD affects the abuser and the victim (she might not leave)
- History, “lack something,” stolen culture
- Intergenerational – patterns of learned behavior
- Self limitations, depression, feeling “stuck”

women's and children's safety addressed in the past

- **Social practices in the past, less in the present**
 - Community intervention and separating couples; children taught in public by elders and extended family members; accountability and community monitoring
- **“Individuals don’t learn how to be” with loss of rites of passage and other traditional protocols and ceremonies**
- **“It was a man’s world” circa 1950s; gender inequality**
 - Women seen as responsible: “You made your bed, now you lay in it.”
- DV less “hush hush” or “swept under the rug”
- Teachings about “being a good mate,” uphold the family name
- Fewer helpful MH/behavioral services and pgms in the past

DV consequences and harm

- **Everybody: “primarily the victim but also the entire family and community”**
- Children: confusing, scary, chaotic, impairs healthy relationship ability
- Pain and dysfunction, lower level functioning overall
- Lack of community involvement/contribution
- If DV is considered “normal,” the perpetrator may not experience consequences. Same if there is denial by partners and family members.

barriers and needs

- Privacy, confidentiality, social processes, intimidation and denial
- Stigma, shame
- Everyone knows everyone's business
- "attitude to not get involved"
- Collective, widespread low self-esteem, self-efficacy

(ADDITIONAL)

RECOMMENDATIONS

Multilevel prevention/intervention

- Community
- Family
- Individual

multilevel

- Improve the social environment together, focusing on education and traditional culture and teachings. (community)
- Strengthen individuals and address substance use and MH. (individual/family)
- Support and recognize healthy relationships and skills. (all levels)
- Improve visibility of DV and services and reduce stigma/shame. (mainly community)
- Assess relationship health, violence (individual and family, but could be community level, too)

Pae/fasd interventions

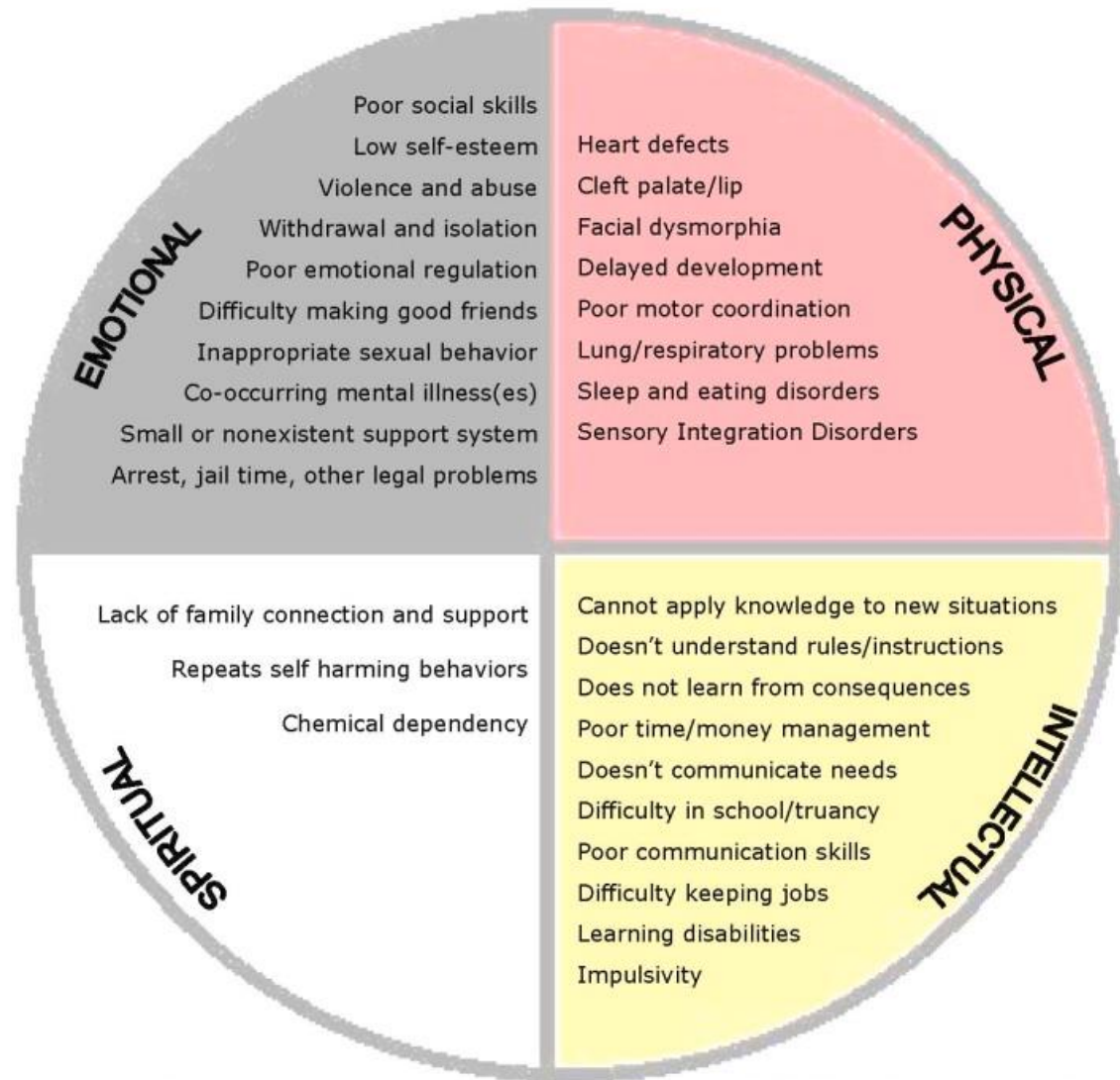
- Increase awareness and education
- Incorporate tribal practices (talking circles, ceremonies), combining with evidence-based strategies
- Address individual alcohol use and within families
- Assess for PAE/FASD
- Training, such as effective parenting, at home and school

(DHHS, 2007)

Blending culture with intervention

- Tribe or tribal community
- What is meaningful and effective?
- What are the local considerations, such as strengths, barriers, resources?

Signs of FASD



PROVIDERS' GUIDANCE

(if we have time; if not, another time)

- June LaMarr, Ph.D., Paiute and Pit River
- April James, B.A., Swinomish and Samish
- Kimberly Brown, CDPT, Coeur d'Alene
- Karen Lizzy, LMHC-A, CDP, Chippewa from Bay Mills Indian Community



Awareness of:

- Trauma
- Racism
- Habits – “It’s what we do.”
- Grief
- Assumptions
- Underestimations of trauma, PAE

- Help them to know themselves
- Medicine Wheel
- Spirituality
- Communication
- Focus on strengths
- What’s their motivation

How to help:

- Tribal Tx
- Get to know them

Connect to Tribal Treatment

- What is the client's Native identity or identification?
- Native vs. non-Native counselor
- 1) Referral to tribal treatment (incorporates culture and EBPs with excellence!)
- 2) Collaboration with Native program
- 3) Supplemental treatment or some other connection to culture

Get to know them

- Get to know who they are and help them to know who they are.
- Know who you are.
- Explore what identity means to them, how they feel about it.
- What is it to be a Native American?
- Natives and non-Natives need to know hx
- Focus on and really develop strengths
- Build self-esteem, self-worth, strong and positive identity

Reconnect to Culture, spirituality, identity

- Different for all. What are their beliefs? What will keep them grounded?
- May need to be a first step, otherwise, they won't care about recovery, wellness.
- Use nature and stories as learning tools
- Experiences like being in the forest, clamming
- In-house activities also helpful – beading, weaving, drumming
- Medicine wheel
- Community and tribal events and experiences



“By bringing culture back I feel that we learn who we are a little better and find out that we don’t have to cover up who we really are, and we can have feelings and they’re valid, and we’re OK being who we are.”

Self-esteem, identity building blocks:

- Some feel ashamed not to know hx and culture
- Help to understand that they are a part of something much bigger than themselves.
- Learn wisdom of the elders – study concepts and teachings
- Need to know that we/they cannot compare themselves to the mainstream.
- Life philosophy: indigenous teachings from the Earth

Counselor-Client Communication

- Clients need to feel good in a care setting, accepted, welcomed, respected.
- Stories; story is the 1st language
- Time; silence
 - English style/speed is not 1st language of Native people
- Space, body language
- Your understanding of Native history and culture translates into how you connect and communicate with clients.
- Let them know that they are heard.

What is their motivation?

- Typical: “Don’t you want a job, money, to stay out of trouble?”
- “Lots of lost souls who don’t have the connection that others have in the communities.”
- People want to feel safe and good about themselves. They want to feel accepted.

DISCUSSION / QUESTIONS

Multiple choice question

A person with sensory integration problems may

- a) Become overstimulated in social situations (crowded rooms, many people, strangers)
- b) Overreact to unexpected (and often, insignificant) events with surprisingly strong emotions; no modulation
- c) Have a poor ability to focus attention, stay on task
- d) All of the above

Multiple choice question

Which of the following statements is false?

- a) The majority of studies with non-clinical samples show that rates of mental health disorder are not usually higher than those in the general population.
- b) Researchers have found that children of HT events survivors are more likely to have a stress vulnerability – more likely to develop PTSD symptoms when exposed to stressful events.
- c) For indigenous people, events that act as reminders of their colonized status may predispose AIANs to trauma responses and corresponding symptoms.
- d) None of the above.

Multiple choice question

Which of the following recommendations may be least helpful?

- a) Interventions can blend evidence-based practices with meaningful cultural practices.
- b) Interventions should focus on the individual alone.
- c) Assessment of an individual's trauma and grief experiences can aid helpful intervention.
- d) Counselors and other health care providers should be aware of their own assumptions.

Thank You

- To the amazing communities we work with - who pave the way for a new generation and have shared their stories with us
- To our incredible colleagues at the UW and IWRI
- To the IHS and FADU for this opportunity to share our thoughts and ideas