

The eReview summarizes children's mental health research and implications for practice and policy

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Historical Trauma and Microaggressions: A Framework for Culturally-Based Practice

This is the second issue in a series focusing on trauma and child welfare systems. This issue captures the presentation of Dr. Karina Walters on December 4, 2009 titled "Historical Trauma, Microaggressions, and Identity: A Framework for Culturally-Based Practice", which was part of the Center for Excellence in Children's Mental Health (CECMH) Lessons from the Field seminar series.

Research Summary

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Introduction

An estimated 4.9 million individuals in the United States are classified as American Indian and Alaska Native (AIAN) alone or AIAN in combination with one or more other races.¹ About thirty percent of AIANs are children, a higher percentage than other ethnic groups. Similar to many states, AIAN children in Minnesota are over-represented in the child welfare system, comprising 1.8% of the child population and 13% of children in foster care.² In 2008, 1,798 American Indian children were in out-of-home care in Minnesota (unduplicated count).³ During this time American Indian children were twelve times more likely than a White child to be placed out of home. To understand the health and experiences of AIAN people in general, and AIAN children within the child welfare system in particular, it is critical to understand historical trauma and its effect on populations of people over generations of time. "Historic and current traumatic assaults have enduring consequences – environmentally, socially, culturally, emotionally, biologically, psychologically and, above all, spiritually for both indigenous peoples and their perpetrators"⁴.

Historical Trauma and Microaggression

Historical trauma is defined by Brave Heart as "a constellation of characteristics associated with massive cumulative group trauma across generations".⁵ Historical trauma differs from other types of trauma in that the traumatic event is shared by a collective group of people who experience the consequences of the event, as well as the fact that the impact of the trauma is held personally and can be transmitted over generations. Children of survivors can experience symptoms similar to their parents despite the fact that they were not directly exposed to the trauma. Examples of historical trauma include planned violence or segregation (genocide, massacres, imprisonment), prevention of cultural or spiritual practices (forced conversion designed to deculturate and assimilate an entire group of people), and environmental decisions (radioactive dumping in specific geographic areas that affect specific groups of people).

There have been numerous studies of the intergenerational transmission of trauma. The phenomenon was first observed in 1966 by clinicians "who were alarmed by and concerned about the number of children of survivors of the Nazi Holocaust seeking treatment in Canada".^{6,26} Some research has shown that children of Holocaust survivors may experience a stress vulnerability that is greater than their peers.^{7,8,9} Children of survivors may not exhibit clinical symptoms as a result of their parent's trauma, but they may experience greater trauma when



faced with a new stressor. Nagata^{10,11,12} has extensively explored the experiences of the descendents of Japanese Americans interned in camps during World War II. Findings suggest that historical trauma associated with internment may account for differences in confidence, self-esteem, assertiveness, shame, and family communication. Nagata explains how those interned at very young ages, though too young to remember many of the camp events, “nevertheless carry the burden of this past and may explore its psychological significance only after entering therapy in adult life”¹². Studies of events that lead to historical trauma among AIAN communities have revealed three distinguishing characteristics —

- The *traumatic events are widespread* and many people either experienced or were affected by the events;
- The events generate *high levels of collective distress and mourning* in contemporary communities;
- The events are usually *perpetrated by outsiders* with purposeful and often destructive intent.¹³

In addition to historical trauma, AIAN children are also exposed to overt and covert *contemporary violence* in their everyday lives. The increased risk of overt contemporary violence for AIAN women is reflected in national sexual assault data. AIAN women experience much higher levels of sexual violence than other women in the United States.¹⁴ A Department of Justice report estimates that one in three AIAN women will be raped during their lifetime¹⁵, a statistic that does not account for the fact that many women never report rape and are not represented in national data. Sexual violence against AIAN women also tends to be more physically brutal than sexual violence in other cultural groups.¹⁶ In approximately 86% of cases of reported rape or sexual assault against Native women, victims report that the perpetrators are non-Native men.¹⁴ This is in sharp contrast to other ethnic groups, where sexual assault is usually committed within an individual's own cultural group.

Another form of contemporary violence experienced by AIANs is *microaggression*. Unlike historical trauma, microaggressions are current events, and are often covert in nature. They are defined as “events involving discrimination, racism, and daily hassles that are targeted at individuals from diverse racial and ethnic groups”.¹³ Microaggressions are chronic and can occur on a daily basis. A group of people (AIANs, for example) may be susceptible to both historical trauma and microaggressions, and the microaggressive acts can perpetuate the trauma.

Wing Sue and his colleagues identify three types of microaggressions¹⁷ —

1. A *microinsult* is characterized by communications that convey rudeness and insensitivity and demean a person's racial heritage or identity (for example, eye rolling during a discussion about an individual's racial identity).
2. *Microinvalidations* are communications that exclude, negate or nullify the psychological thoughts, feelings, or experiential reality of a person of color. An example is a white person stating to a person of color that they “don't see color”, which denies that person's racial and ethnic experiences. Another example is a non-Native person asking someone of AIAN culture whether or not he or she is a “real Indian”. This demands an explanation that few others are required to deliver.
3. A *microassault* is an explicit racial derogation characterized primarily by a verbal or nonverbal attack meant to hurt the intended victim. This can happen through name-calling, avoidant behavior, or purposeful discriminatory actions. Microassaults against AIAN people also appear in the form of advertisements that depict white models in Native clothing, associations between AIAN people and aggressive sports teams, and messages that connect AIAN people with alcohol use. Microassaults are typically more conscious and deliberate than other forms of microaggression.

Microaggressive acts may be clear and recognizable, but they are more often subtle and hard to define, articulate, and address. In fact, “the power of racial microaggressions lies in their invisibility to the perpetrator and, oftentimes, the recipient”.¹⁷ The burden of interpreting and responding to a microaggressive act falls on the individual. The victim must determine whether the incident was intentional or perhaps reflects misunderstanding or ignorance, and then make a decision about whether or not to address it. Bringing attention to the incident may promote a further negative response, such as anger, denial, and accusations. Microaggressive acts need not be specific or verbal but can refer to environments that are either intentionally or unintentionally unsupportive to a person because of his or her racial identity. Wing Sue gives the example of a college or university with buildings that are all named after white heterosexual upper class males. The message is “You don't belong here, you won't succeed here, there is only so far you can go”. Microaggressions affect the psyche of the individual victim and the group

to which he or she belongs. They also deliver persistent, inaccurate messages about a group of people and, as a result, obscure the true cultural nature of the group and replace it with a stereotype. "While each event might be tolerated in isolation, the overall cumulative effect of microaggressions can be devastating..."¹⁸ Microaggressions are significant because research suggests that daily discrimination can result in more distress and stronger negative health outcomes than time-limited episodic discrimination.¹⁹

Historical Trauma Response

American Indians have unique experiences directly related to surviving colonization within the boundaries of the United States. The federal government has attempted to acculturate and deculturate American Indians on their own lands through government sponsored policies of tribal/tribal genocide and ethnocide (i.e. destroying their ethnic, cultural, tribal being). Examples of institutionalized acculturative practices include forcing Native children into boarding schools and forbidding them to speak their Native languages; outlawing Native religious practices; forcibly removing and relocating Indians away from traditional lands; and disproportionately removing Indian children and placing them into non-Indian homes.

*From a Native Son: Selected Essays on Indigenism, 1985-1995*²⁰ as cited in Walters²¹

The term *historical trauma response* has been defined as "the cumulative effect of historical trauma brought on by centuries of colonialism, genocide, and oppression".⁴ In their study of AIANs, Evans-Campbell and Walters have also defined the term *colonial trauma response (CTR)*. This term incorporates the historical group trauma response but also includes contemporary and individual responses to injustice, trauma or microaggression. The defining feature of CTR is its connection to colonialism.¹³ Colonialism is defined generally as "a relationship of domination between an indigenous majority and a minority of foreign invaders"²². A definition of colonial trauma specific to AIANs is "historical and contemporary traumatic events that reflect colonial practices to colonize, subjugate, and perpetuate ethnocide and genocide against contemporary AIAN peoples".⁴ Many AIANs who experienced historical trauma as part of their community are also subject to microaggressions as individuals. These everyday injustices "serve to connect [the individual] with a collective and often historical sense of injustice and trauma".¹³ The individual can feel more closely connected with ancestors who have experienced historical trauma and sometimes feel a particularly strong reaction to the microaggression.

Brave Heart⁵ summarizes the characteristics of Lakota service providers and community leaders as a result of historical trauma, and notes their similarity in response to those identified in the Holocaust literature²³ —

- Anxiety
- Intrusive trauma imagery
- Depression
- Survivor guilt
- Elevated mortality rates from cardiovascular diseases as well as suicide and other forms of violent death
- Identification with ancestral pain and deceased ancestors
- Psychic numbing and poor affect tolerance
- Unresolved grief

Several factors can influence the degree to which an individual experiences historical trauma. Having two traumatized parents increases the risk of a historical trauma response in children.²⁴ The loss of a spouse or child is a particular risk in producing a response of historical trauma in offspring.²⁵ This finding is particularly important for AIANs who have experienced the loss of children due to the creation of boarding schools and

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forced removal of children from their families. Researchers have examined the effects of boarding schools on these children, but few have considered the effect on their parents. Some research describes how AIAN women tend to carry more of the grief and trauma for others and feel a stronger burden to carry the pain of their tribal members.⁵ How parents communicate about the traumatic event is a significant factor influencing the historical trauma response in their offspring. Silence can create a sense of dread and secrecy about events.²⁶ Among those close to survivors, the absence of information can result in heightened curiosity, increased sense of dread, and misinformation that is sometimes worse than what was experienced. More profound silence can also lead to a greater inner impact on the individual who experienced the trauma.²⁷ Danieli²⁸ describes Holocaust survivors who meet denial and avoidance when sharing their stories with others. This denial affects the survivor's experience "by intensifying their already profound sense of isolation, loneliness, and mistrust of society". In response, they choose to remain quiet about their experiences, and the resulting "conspiracy of silence" intensifies isolation and prevents healing.

In 1980, descriptions of "survivor syndrome" were included in the DSM-III definition of Post-traumatic Stress Disorder (PTSD).²⁹ While standardized definitions such as PTSD reflect some of the symptoms resulting from historical trauma, researchers have noted that they are "limited in their ability to explore the additive effects of multiple traumatic events occurring over generations".¹³ Simpson has noted that definitions of PTSD overlook the variety of types of posttraumatic syndromes and neglect communal responses to trauma.³⁰ Evans-Campbell identifies how definitions could be expanded to better reflect the historical trauma experience by (1) capturing the compounding nature of responses to multiple stressors, (2) addressing familial and social impacts of trauma reactions (not just individual), (3) exploring how historical and contemporary traumas interact, and (4) including factors that buffer the impact of trauma.¹³

Indigenist Stress-Coping Model

Walters and colleagues^{31,32} present an indigenist stress-coping model that identifies how "cultural buffers" moderate the effects of historical trauma and microaggressions on the health of AIAN women. These buffers, or coping strategies, delineate the pathway between historical trauma (and other traumatic experiences) and health outcomes, including physical health, mental health, and alcohol and drug use. The model highlights protective factors rather than pathology, and emphasizes resilience within AIAN communities. The four cultural buffers identified in this model are identity attitudes, enculturation, spiritual methods of coping, and traditional healing practices.

Identity attitudes refer to the extent to which one internalizes or externalizes attitudes toward oneself and one's group. Positive identity attitudes have been connected with enhanced self esteem, ability to cope with psychological distress, and avoidance of depression.²¹ Research examining the specific method by which AIANs may move through identity development describes several steps, including internalizing and/or overvaluing the majority culture, becoming aware of differences between the majority culture and one's own culture, shedding stereotypes about one's own culture, and integrating identity attitudes and cultural buffers.²¹ *Enculturation* is the process by which individuals learn about and identify with their minority culture. This is distinguished from acculturation, which is the process by which people from a minority culture adopt and assimilate into the majority culture. It is important for AIANs in particular to distinguish between what is part of their original culture and what has been forced upon them due to historically traumatic events and/or discrimination. *Spiritual methods of coping* for AIANs are associated with both adjustment to stressful life events and physical and mental health.³³ "Spirituality permeates all



aspects of Native life and lifeways” and is an important protective factor against historical and contemporary trauma.³¹ The use of *traditional healing practices* has also been shown to relate to positive health outcomes for AIANs. One study showed that seventy percent of AIAN patients in an urban primary care setting often used traditional health practices.³⁴ Health practices such as the use of herbal medicines or sweat lodge ceremonies were often chosen to heal the underlying causes of physical and mental illness or trauma, rather than acute symptoms. Overall, these cultural buffers identify why some AIANs have better health outcomes than others in the midst of stress and historical or contemporary trauma.

Decolonizing Strategies

In their article “Catching our Breath: A Decolonizing Framework for Healing Indigenous Families”, Evans-Campbell and Walters outline how some child welfare systems have been involved in decolonizing attempts, and present specific *decolonizing practice competencies* to help guide providers working with children and families.⁴ These include —

1. *Enacting a culturally relevant framework for practice* that includes training related to historical trauma and AIAN-specific child rearing practices;
2. *Learning about precolonial history* such as helping families identify traditional ways of identifying and healing from trauma;
3. *Dealing with mistrust*, which includes reinterpreting mistrust as a healthy reaction to historical trauma;
4. *Documenting historically traumatic events and colonial trauma* that give meaning to an individual's current experiences;
5. *Communicating about historical trauma* in a way that recognizes that initial denial may serve as functional and protective at the time of the trauma, but can be detrimental to healing later on;
6. *Highlighting resilience* within AIAN cultures and individuals;
7. *Creating new narratives* that recognize negative influences on Native culture and identify how and why behaviors were learned;
8. *Supporting community grief ceremonies* that include cultural rituals and support healing.

More research is needed to explore the effectiveness of these strategies and the cultural resilience of AIANs in order to heal the effects of historical trauma.

Implications for Practice and Policy

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It should not be presumed that mental health professionals inclusive of those from cultural communities are aware of or clear on the historical trauma and microaggression constructs embedded in this eReview. Therefore, I urge that this content be imported into provider training and education, and used to inform program development and service design. Specifically, this needs to be a part of graduate education and professional development as part of sensitization training. The content should also be used “on the ground” by providers to affect the client's service experience. There are many constructs that require thorough examination for full understanding – historical trauma and microaggressions need to be personally understood in order to apply them professionally. This study cannot be simply an intellectual exercise. It is critical to incorporate the concepts of historical trauma and microaggressions – as well as the personal stories of those who have experienced them – into our everyday communications and work.

The research summarized in this eReview should prompt concern, pause, and reflection about our system of care and its pre-assumptions of service design and implementation. One of the core issues related to historical trauma is the fact that there is a timeline associated with it. The stories we grow up hearing from our elders leave us with the sense that the systems haven't changed. People coming into systems of care are affected by this history – they may believe that the systems don't support them and are not likely to in the future. Even today, people of color may enter systems of care looking to corroborate what they have heard from members of their communities. Policies need to support the families we serve everyday, and need to be informed by our ancestral wisdom as well as current research and experience.

I have always been drawn to research such as this that brings forward personal, familial and cultural dynamics that may not be obvious to all. This is powerful and provocative material. I am immediately moved to consider the value of this research for cross-cultural engagement. The article's content deepens one sense of the insidiousness of racism and oppression and its transgenerational transmission. These constructs can

apply in varying degrees to all who have experienced denigration. But user beware and be aware – the farther we move from the relevant cultural community's validation of this article's constructs - their meaning, value and utility - the more we are likely to be engaged in potential colonialization practices. It's important that we avoid *applying* this research to specific communities – we need to *engage* communities to share this dialogue. As an African American born fifty-nine years ago, I am able to appreciate the lessons and stories shared by my elders related to firsthand experiences and related consequences, yet I struggle in ways I hardly share to this very day. The dynamics of historical trauma and microaggressions teach people to go underground. Those of us who suffer do so quietly, and we are taught to do this because of what happened to our elders.

The constructs described here are rich and complex, and worthy of more study. The best way to respond is to honor this for what it is and recognize its power. The next steps in research should engage the communities that experience historical trauma and microaggression firsthand. I believe that not paying attention to this is a danger. The more we bring this to light, the less power it has. The more people understand the dynamics of historical trauma, the deeper and freer the conversation.

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Historical trauma plays a significant role in the lives of many immigrants and refugees. Within the population where I work, many come from war torn countries where they have experienced or witnessed traumatic experiences and loss or were separated from loved ones. Historical trauma is something we often miss out on when we think of trauma, and yet there is significant trauma history reflected in the Hmong culture, often through regular re-telling of stories. Immigrant populations love story telling about their history and culture. It is a means to preserve family history and help the children understand the journey of their family and relatives. The events told were traumatic to the individual, and can also be traumatic in the re-telling. There is little research about historical trauma and refugee populations, and more is needed. The historical trauma research summarized in this eReview should be incorporated into training for mental health providers, teachers and school staff, and others who work with children

on a daily basis. Hmong families often seek help from medical providers, so these professionals also need to know what historical trauma is and how it affects their clients.

This eReview's section on microaggression is particularly pertinent because the acculturation process itself is a means of microaggression. As refugees land on the United States soil, they are categorized as aliens. They need to obtain their citizenship to have a voice in the democratic system. Due to fear of the legal system and deportation, many refugees do not speak up about microaggression. Instead they keep everything to themselves. Initially, they work hard to learn the English language and learn job skills to support their family. They understand that education is the best way for their child to be successful in the United States. However, there is fear of their children losing their native language and culture as the children become more acculturated. The children quickly learn English and it often becomes the main language spoken at home amongst the children. If people feel they are being discriminated against, they may feel they don't have a right to speak up. It becomes important to fit in with the larger culture, and it becomes a melting pot rather than a multi-cultural community. Training about microaggressions needs to go beyond, for example, facts about the cultural practices of Hmong culture. This is a sensitive topic, and providers need to know not only how to be cultural sensitive but also how to take active steps to advocate on their clients' behalf.



It is important to look at how the rules and regulations of state and health care organizations are preventing individuals from accessing medical or behavioral health services. We want individuals to fit into a box, but their symptoms or cultural practices may not fit the systems' definition. Trauma as it relates to PTSD is significantly under-diagnosed. Children who have experienced historical trauma often don't meet the PTSD diagnosis, and may be given another diagnosis (and treatment) such as anxiety. Providers can identify the presence of acculturation issues for a client, but this is not a condition they are paid to treat in a therapeutic manner. They may give a diagnosis of adjustment disorder instead. Also, many of our diagnoses do not translate verbatim into other languages. For example, our Hmong clients often report their symptoms as depression or *nyuaj siab*. Therefore, clinicians resort to treating the diagnosed label and not the trauma. Refugees have their own cultural practices and healing practices. Our medical model approach does not encompass alternative holistic healing practices. Alternative healing is not covered through health care coverage. Instead the family pays out of pocket for their own cultural healing. In addition, it takes time to engage people who have experienced historical trauma, and providers often don't have the time to build rapport before starting billable service. Children and families tend to return for service when they have developed a relationship with the provider. It is also important to engage community members and partner organizations in this work, which also takes time.

We need research about evidence-based practice versus practiced-based evidence models. Many of these models have not been normed to be used through an interpreter or adjusted for use in a different language. In many languages, there is no exact language translation. Sometimes, the interpreter is not knowledgeable about the mental health terminology. Sometimes a term does not mean the same thing in a different language. Interpretation could impact the effectiveness of services.

Don Eubanks
Commissioner of Health and Human Services
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The research in this eReview is critical for training because it explains current and past definitions of historical trauma, and it introduces the idea of microaggressions. Training that incorporates these concepts is particularly important for tribes. Many tribes lack educated band members with the skills to work directly

with clients, or have professional staff who are non-Indian. The framework presented in this issue can help structure training within tribes related to child welfare, family services, and particularly behavioral health.

As an Indian and a person of color, it is clear to me that the specific types of microaggressions described in this eReview happen on a regular basis. However, the concept of microaggressions may be difficult for non-Indians to understand and incorporate into their work. Many people have the desire to work with tribes and have genuine heart, but may lack understanding of the bigger picture of their clients' experience. A service provider working with American Indians needs to be able to explain these definitions because it validates what their clients experience everyday. So this research summary serves as an excellent guide for non-Indians as well.

e Review

Editorial Information

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There has been published research related to historical trauma for many years. It's important to understand that related research about discrimination, anger, grief, etc. is sometimes really about historical trauma and microaggressions. Our pool of research may be larger than we realize. This is important as we prepare to incorporate this research into training and policy. While some will wait for more quantitative data to reinforce people's stories and experiences, the data we already have is rich and broad.

This research provides a framework for understanding and educating others. As a social worker by profession, I recommend that this research be incorporated into social work curricula. Many social work students are white, and many of their clients are not. Educational leaders within social work schools are beginning to understand that, even though their teachings may not be discriminatory, the institutions in which they sit can be. My enthusiasm about a paper like this is that it presents data that formalizes the experiences many people face everyday. The concepts presented here related to microaggressions fit many people of color, not just AIANs. This research can be used as a tool to help those creating policy at the state level or within our higher education institutions. It can be a difficult battle to educate policy-makers about the potential impact of their decisions, but without knowledge of microaggressions, the policies we're making can have a negative impact on communities of color. Next steps should include broader education, particularly for behavioral health staff and family services staff, and more research that further explores and validates the microaggression concepts presented here.

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