



Fact Sheet: Trauma Among American Indians and Alaska Natives

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Introduction: The ACE Study

Thanks to the landmark Adverse Childhood Experiences (ACEs) study conducted by the CDC and Kaiser Permanente (2016), which has generated numerous papers and been validated by many subsequent studies, we know that the long-term consequences of exposure to ACEs (or traumatic experiences in childhood) such as abuse, neglect, and household volatility include increased risk for a wide range of negative health and wellness outcomes. These negative outcomes include alcoholism, drug use, smoking, depression, suicide attempts, risky sexual behaviors, teen pregnancy, fetal death, poor academic and work performance, sexual violence risk, risk for intimate partner violence, heart and pulmonary disease, and liver disease, among others. As the number of traumas experienced by the individual increases, the risk for each of these negative outcomes also increases. For example, the lifetime risk of suicide attempt rises by a factor ranging from two to five for people with ACE scores greater than zero (Dube et al., 2001). Among those with 7 or more ACEs, suicide attempt risk rises by a factor of more than 30.

The original ACE study sample consisted of 17,337 members of the Kaiser Permanente Health Maintenance Organization (HMO) in California. The sample was more educated than the general population, and demographically it was 74.8% white, 11.2% Hispanic/Latino, 7.2% Asian/Pacific Islander, and 4.5% African-American. The high exposure rates among this relatively privileged sample of people, along with the direct linkage of these exposures to negative health and wellness outcomes, has had a dramatic impact on mental health practice and policy.

Studies Focusing on American Indian/Alaska Native Populations

Soon after data collection for the original ACE Study ended (1995-1997), a study focusing on ACE exposure exclusively among AI/AN populations (Koss et al., 2003) surveyed 1,660 enrolled tribal members in seven tribes. The exposure rates among the

AI/AN population studied by Koss and colleagues were much higher than those found in the original ACE Study:

	ACE Study Sample	AI/AN Population Sample
Reported at least 1 ACE	63.9%	86%
Reported 4 or more ACEs	12.5%	33%

Other studies have also found elevated rates of trauma exposure among AI/AN populations. These studies differ in their sampling approaches, as noted below. Three of the studies assessed exposure to trauma across the lifespan, including both ACEs and events that occurred in adulthood, while two assessed childhood trauma using the ACE Study approach. All suggest that AI/AN populations experience trauma at rates that exceed those of the general U.S. population:

Study	Population sample	Trauma category	Trauma exposures	
			1+	Multiple / severe
Robin et al. (1997)	247 adult members of one Southwest tribe	Lifetime	81.4%	<ul style="list-style-type: none"> • 66% • Median # of exposures=6.47
Manson et al. (2005)	3,084 tribal members aged 15-57 on one Southwest and two Northern Plains reservations	Lifetime	62.4%-69.8%	Not reported
De Ravello, Abeita, & Brown (2008)	36 incarcerated AI/AN women in New Mexico	Childhood (ACEs)	97.2% (35 of 36)	<ul style="list-style-type: none"> • 81% • 53% reported childhood sexual abuse
Ehlers, Gizer, Gilder, & Yehuda (2013)	309 AI adults from 8 geographically contiguous reservations	Lifetime	94%	Not reported
Brockie et al. (2015)	288 tribal youth aged 15-24 from one Northern Plains reservation	Childhood (ACEs)	78%	<ul style="list-style-type: none"> • 40% • 37% reported 3-6 exposures

Historical Trauma

The ACE study, along with the other studies cited above, attempt to capture the extent and the effects of individual experiences of trauma. Individual experiences of trauma tell only part of the story of trauma in Indian Country, however.

Indigenous people in North America have experienced tremendous losses over the course of more than 400 years. These include genocide, forced relocation, the introduction of diseases, forced assimilation policies such as those that removed children from their

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homes to be Westernized in Indian boarding schools, policies that prohibited tribal spiritual and cultural practices, and persistent racism and stereotyping. These and other experiences have resulted in what the Lakota researcher Maria Yellow Horse Brave Heart (1998, 2003) calls “historical trauma,” a concept derived from studies of Jewish Holocaust descendants (Fogelman, 1988; Kestenberg, 1990) and defined as “the cumulative psychological wounding across generations, including the lifespan, which emanates from massive group trauma.” This wounding began in the past, during the period of first contact with Europeans and Euro-Americans, but the attempted destruction of tribal cultures, languages, spirituality, and community cohesiveness has continued in many modern forms, and the traumatic responses to these losses has been transmitted from generation to generation.

Some studies have identified linkage between historical events and subsequent collective suffering, including substance use disorders and high rates of PTSD (Beals et al., 2005; Manson et al., 2005; Whitbeck, Adams, Hoyt, & Chen, 2004). The attempt to verify and quantify the linkage between historical and current symptoms is complicated by numerous conceptual issues, such as the difficulty of separating historical trauma from individual traumas like those assessed by the ACE study and the difficulty of translating multigenerational, collective phenomena into Western clinical terminology that focuses on the individual. Despite these difficulties, many of today’s most pressing social and public-health problems in Indian Country would appear to have historical roots.

It is likely that the levels of trauma exposure captured by the studies of individual trauma underestimate the full extent of trauma in American Indian and Alaska Native communities. Experiences related to disenrollment, present-day racism, community-level losses, and fears for the future of one’s tribe are not, for example, generally included in surveys of trauma prevalence. The trauma responses related to such experiences do not fit neatly into existing psychological assessment tools and diagnoses, so they are not included as part of an individual’s trauma history. This prevents us not only from quantifying an AI/AN individual’s cumulative trauma symptoms but also from determining how historical and individual traumas interact. For example, consider the case of a teenager who abuses alcohol and has attempted suicide. If we determine that this teenager has a history of being physically abused by her caregiver and that she additionally feels despairing grief about the destiny of her people related to widespread poverty and the loss of cultural traditions, how do we determine the degree to which her negative health outcomes are influenced by individual traumas versus historical traumas? Do the historical trauma responses intensify or complicate individual trauma responses? Might the two types of traumas interact in other ways?

These and other questions related to historical trauma highlight the ways in which trauma in Indian Country may differ from trauma among other U.S. populations. Further research is needed to determine the degrees and types of difference from other populations and to determine culturally appropriate treatments and public health approaches for American Indian and Alaska Native populations.

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