Integrating Trauma Informed and Historical Trauma Informed Care in Behavioral Health Interventions with American Indians and Alaska Natives: Part 3

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Brief Summary of Learning Objectives and Content from Part 2

a. Formulated and described key elements in the use of historical and cultural trauma informed practice;

b. Described three implementation strategies to use evidence based practices with American Indians and Alaska Natives; and

c. Described implementation of the DSM IV (5) Cultural Formulation in treatment in your practice setting.

Overview:

- Brief review of development of historical trauma work (1978 to present) and research, definitions of historical trauma response features, compounding factors for specific trauma exposed groups: American Indian veterans and descendants
- Continued awareness of transference, countertransference, therapeutic alliance (introduced in Part 1) and concepts of ambivalence, holding or nurturing treatment environment with traumatized tribal communities

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Learning Objectives and Overview Part 3

a. Recognize and briefly describe the value of self-knowledge and how it enters into the treatment relationship

b. List key characteristics that distinguish between objective countertransference and induced countertransference

c. Identify and briefly describe two techniques to develop self-awareness and integrate it into trauma informed treatment

Overview:

- Brief review of historical trauma response features and compounding factors for specific trauma exposed groups: American Indian veterans and descendants continued
- Introduction of the concept of the Wounded Healer and its role in transference, countertransference, therapeutic alliance (introduced in Part 1), ambivalence, holding or nurturing treatment environment in therapy and in trauma informed settings

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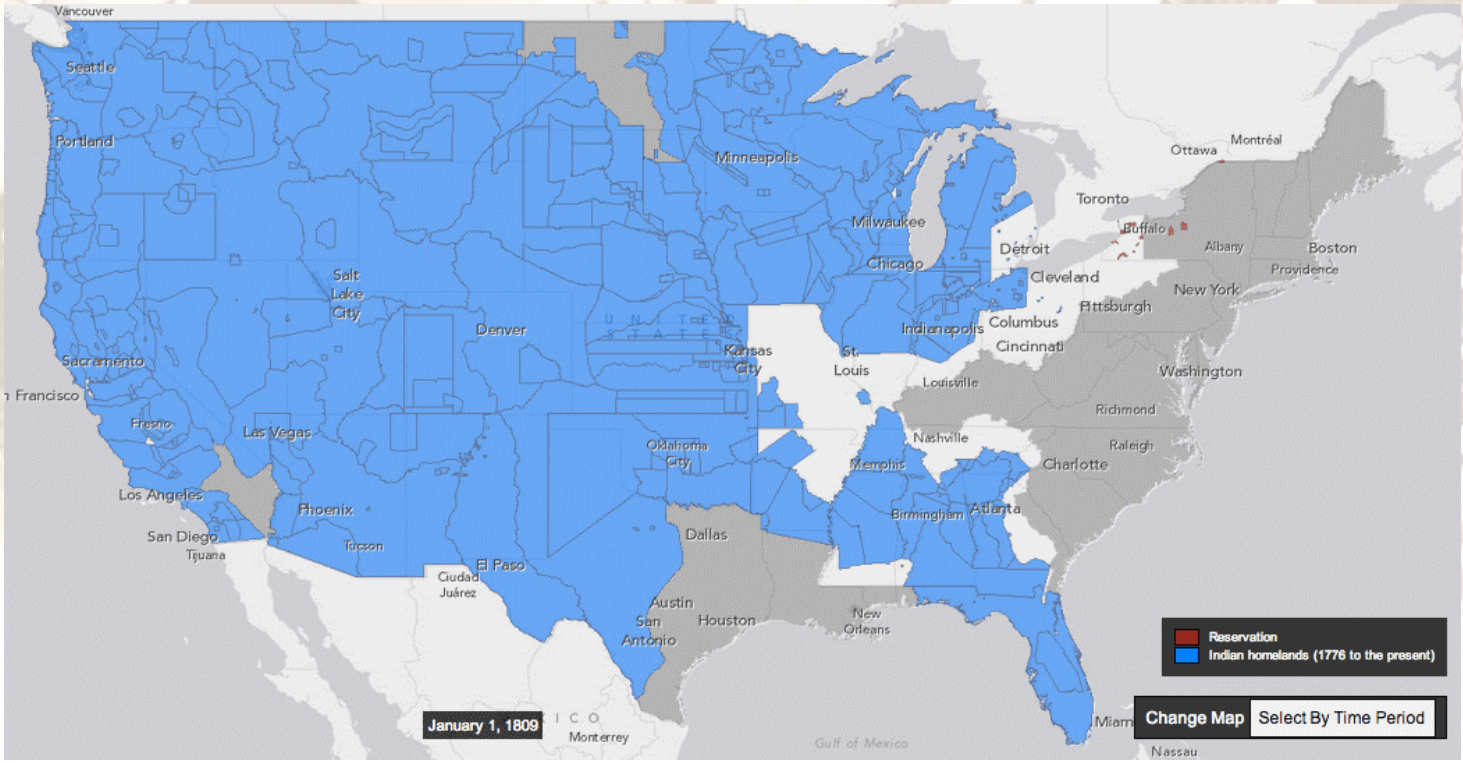


http://www.slate.com/blogs/the_vault/2014/06/17/interactive_map_loss_of_indian_land.html

Review: Historical Trauma and Unresolved Grief Intervention (HTUG) - Example of Historically and Culturally Trauma Informed Practice

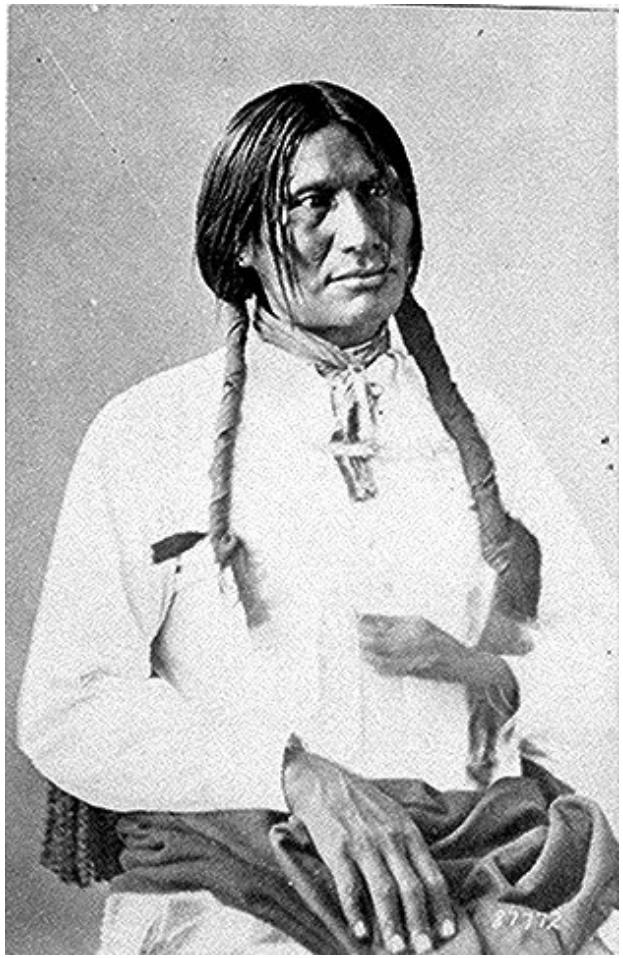
Tunkasila Tatanka Iyotake, Mother Her Holy Door, Daughter, and Grandchild

Review HT Theory & Intervention Development

- 1976 – began clinical practice & *psychoanalytic training*
- 1981 - *ceremony* to ask for help for our people to heal from the historical trauma
- 1992 – First version of HTUG (doctoral dissertation)
- 1996 – 2004 - Designed Lakota parenting curriculum incorporating HTUG components; SAMHSA grants including CMHS-funded Lakota Regional Community Action Grant on Historical Trauma
- 2009 – HTUG selected as Tribal Best Practice by First Nations Behavioral Health Association, Pacific Substance Abuse & Mental Health Collaborating Council, and SAMHSA
- University of Denver GSSW faculty 1992 through 2006; operated Takini Network in Rapid City, SD from 1998 through 2003
- Joined faculty as Associate Professor at Columbia January 2007 through September, 2010 and UNM October 2010 to present
- NIMH funded HTUG study just ended June 30, 2017

Tatanka Iyotake & Sitanka Wokiksuye
Sitting Bull Memorial & Bigfoot Memorial Ride

1990 – 100 years later



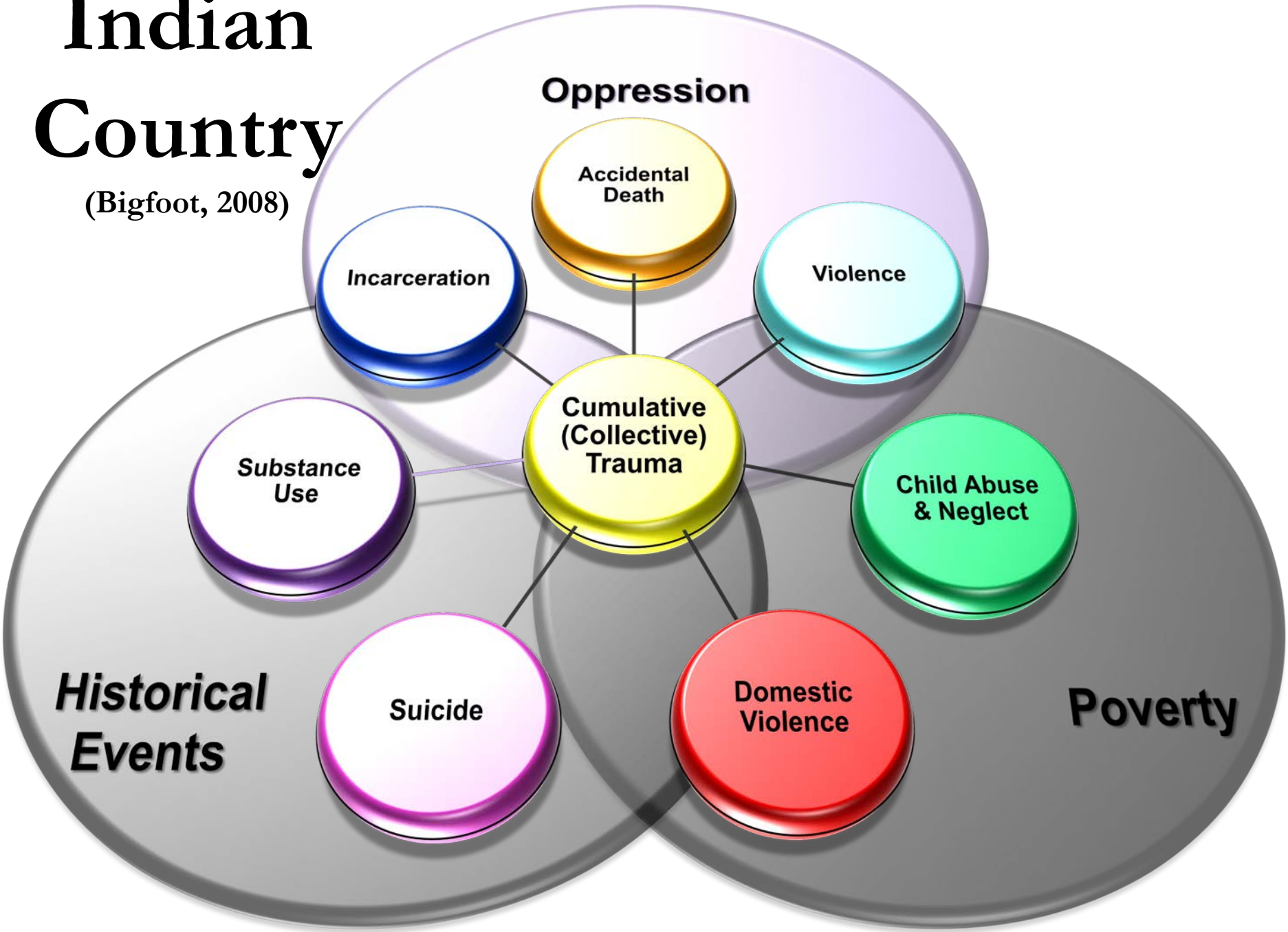
Sitanka (Bigfoot)

Takini

Wounded Knee Massacre Survivors:
Tunkasila Wapaha Ska (White Lance),
Joseph Horn Cloud, & Dewey Beard

Indian Country

(Bigfoot, 2008)



Spontaneous Testimonies at the End of the Four Days of the first HTUG in 1992

- Sitanka Wokiksuye Rider – *I sacrificed to wipe the tears of the people but until today, no one had wiped my tears*
- Expressions of transformative experience
- We formed a kinship network
- Own experience – further solidified my commitment to this sacred path; asked by Lakota elder to lead the people in this historical trauma healing work and have maintained this commitment
- **As therapists, providers, healers, we need to help to wipe our tears**

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Objective a. Recognize & briefly describe the value of self-knowledge and how it enters into the treatment relationship

- Identify ones own HT Response Features (HTR) and tribal as well as family and individual trauma history, vulnerabilities, potential trauma triggers
- This can be done through ones own HT work, therapy, and supervision with a supportive supervisor and through peer supervision, and through ceremonies
- Psychoanalytic principle – *one cannot take someone further in treatment than one has gone themselves* – so you must go through your own healing process in order to truly be helpful to your patients/clients, work through your own resistance (which is a normal part of therapy as well as being on a spiritual path or any path of growth and development)

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Objective b. List key characteristics that distinguish between objective countertransference and induced countertransference

- Important to attend to ones own thoughts, associations, feelings, where ones mind goes during sessions – clues to what is going on in treatment, how the patient/client might be feeling or something they may not be conscious of but that is important for the treatment
- *Unconscious communication* – recall example from first presentation about the microwave pizza – pay attention to where your mind may wander
- *Transference* is the patient's displacement or reenactment of feelings and dynamics with significant relationships, usually childhood relationships, particularly parents or caretakers.
- *Countertransference* is the reaction of the therapist to the patient's transference.

b. List key characteristics that distinguish between objective countertransference and induced countertransference

- Transference and countertransference could be either positive or negative; often both appear.
- *Objective countertransference* – anyone would react similarly to the patient – feelings in the therapist are being induced. Feelings do not last long after the session. Staff at your clinic may also experience similar feelings towards the patient – this may be a clue.
- *Subjective countertransference* - specific to therapist's own reaction to patient's behavior, communications, etc. Requires therapist's deeper exploration in supervision and own therapy about what is getting triggered.
- There could be an objective countertransference but may possibly also trigger subjective countertransference reactions based on therapist's past relationships and issues.
- Clues are thinking about patient a lot outside of sessions, more than other patients, feeling irritated or angry, etc.

Historical Trauma Response Features – may come up in countertransference reactions towards patient

- ***Survivor guilt***
- ***Depression***
- **Sometimes *PTSD* symptoms**
- ***Psychic numbing***
- ***Fixation to trauma***
- **Somatic (physical) symptoms**
- **Low self-esteem**
- **Victim Identity**
- **Anger**
- **Self-destructive behavior including substance abuse**
- **Suicidal ideation**
- ***Hypervigilance***
- **Intense fear**
- **Dissociation**
- ***Compensatory fantasies***
- **Poor affect (emotion) tolerance**

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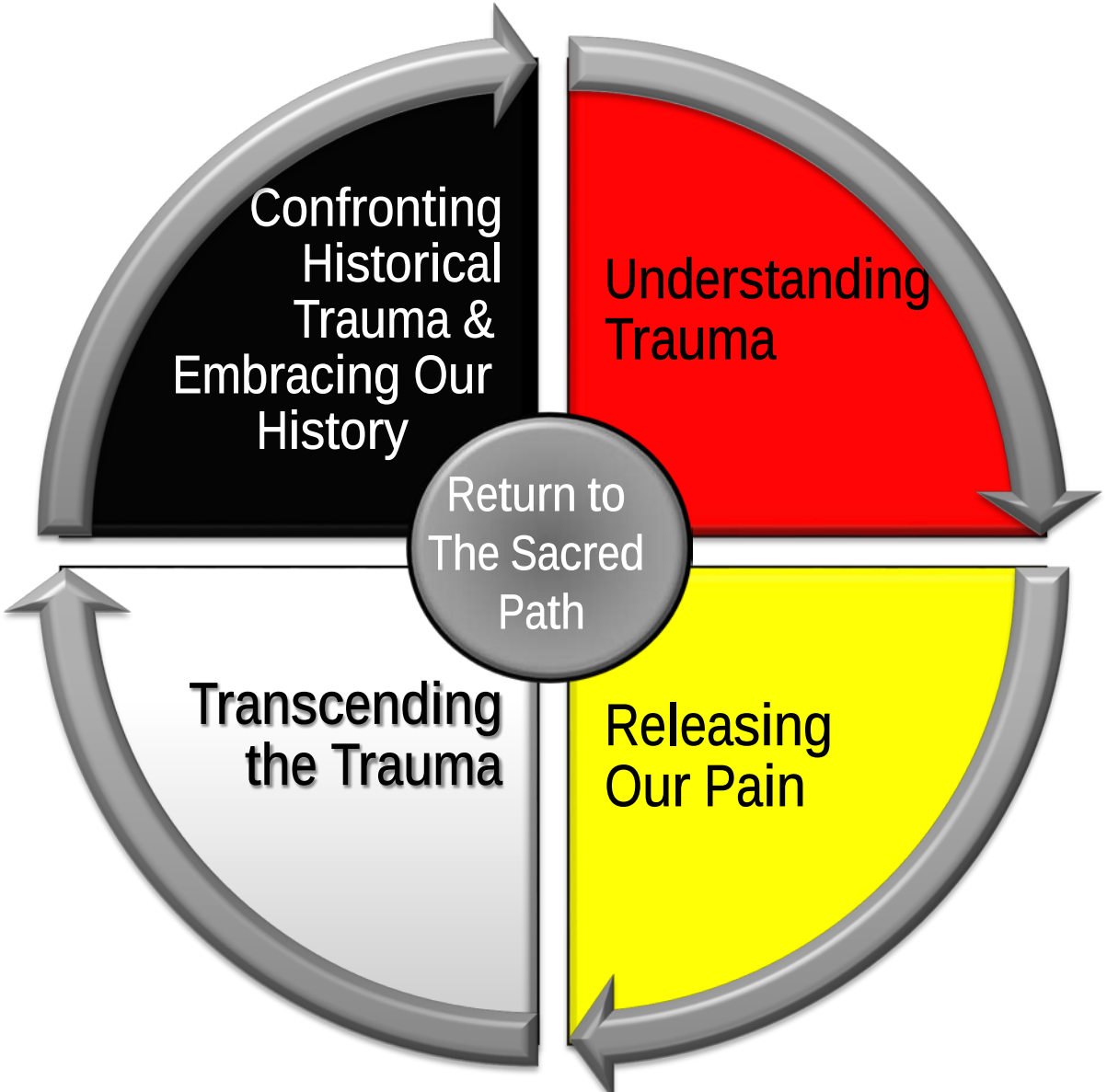
Historical Trauma & Unresolved Grief Tribal Best Practice Example as a Strategy for Self-Awareness to Enhance Treatment



Learning Objective c. Identify and briefly describe two techniques to develop self-awareness and integrate it into trauma informed treatment

Suggested Techniques:

- Journaling
- Peer supervision groups
- Request regular individual supervision and try using a psychodynamic supervision approach of focusing on two cases in depth – goal is to generalize learning to all cases
- Advocate for supervisory safety – trauma informed – and perhaps arrange for a separate clinical supervisor from administrative supervisor
- Private supervision arrangements
- Advanced training programs, post-graduate institutes, peer support group, and some online therapists collectives
- Literature on the wounded healer – good resources
- Change the culture of your site – talk more openly about “wounded healers” and that we are all survivors of wounding
- Clinical consultation groups – one starting now supported by IHS

Wakiksuyapi (Memorial People)

- Takini Network/Institute as *Wakiksuyapi*, carrying the historical trauma but working on healing
- For the Lakota, specific *tiospaye* (extended kinship network) or bands may carry the trauma for the Nation, i.e. those most impacted by Wounded Knee Massacre
- We are descendants of traditional warriors and survivors, including 1890 Wounded Knee Massacre descendants; we are children of World War II Marine, Army, and Navy veterans; Takini includes Vietnam veterans and involving Korean War, OEF/OIF veterans
- Our awareness of being *Wakiksuyapi* in process of healing is important for effectiveness as therapists and healers

Wakiksuyapi
(Memorial People)

- Being family members of veterans and active duty military can affect our work with veterans and families if we don't address our own unresolved issues – could get triggered and then not provide the best treatment for patients
- We are wounded warriors and wounded healers transcending the trauma
- DVD Presentation: *Oyate Wiconi Kte Cha Lechel Echu Kun Pi : We Do This So That the People May Live.* Great Plains IHS Division of Behavioral Health – Part 2

DSM Cultural Formulation: *Some Content Specific to Countertransference*

Cultural elements of the relationship between the individual and the clinician

- Individual differences in culture & social status between the individual & clinician
- Problems these differences may cause
- ***Similarities may also be challenging – example working with a male Marine veteran and my own relationship with my deceased Marine father – and a Marine relative killed in Iraq - need for heightened awareness of countertransference issues***

Cultural Identity

- Ethnic or cultural reference group(s)
- Degree of involvement w/culture of origin & host culture
- Language abilities, use, & preference
- ***Adding tribal military culture in this consideration***

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Culturally Sensitive Diagnosis: the DSM Cultural Formulation

Overall cultural assessment for diagnosis and care

- Discussion of how cultural considerations specifically influence comprehensive diagnosis and care

Reference:

Lewis-Fernandez, R. and Diaz, N. The Cultural Formulation: A method for assessing cultural factors affecting the clinical encounter. Psychiatric Quarterly, 2002, 73(4): 271-295. (Table 1, p. 275)

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Examples for Native clients: skin color issues, risk for trauma exposure, traditional mourning practices, racism, unemployment rates, housing availability

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Example of Traditional Native Values:
Woope Sakowin (7 Laws of the Lakota)*

- Wacante Ognake - Generosity
- Wowaunsila – Compassion
- Wowayuonihan – Respect
- Wowacin Tanka - To Have a Great Mind
- Wowahwala – Humility, State of Silence, To be humble
- Woohitike – Courage, Bravery, Principal, Discipline
- Woksape – Wisdom, Understanding
- **Tiblo* B. Kills Straight (some versions differ slightly but core values similar)

Trauma Informed Supervision – Awareness is Key!

- **We bring our past into the workplace – not conscious**
- **We often reenact our family dynamics and traumatic histories in work and personal relationships [unconscious attempt to recreate and master trauma]**
- **We get triggered may have compassion fatigue**
- ***Supervision as a parallel process* – for behavioral health providers, as we present a case we unconsciously bring in dynamics with the patient into the supervision– *this is normal! Understanding this and using this in supervision help in comprehending the dynamics of a case and the therapeutic relationship***
- **Importance of self-care and attending to ones own trauma history and work those through – owe it to our patients and ourselves!**

Perceived Discrimination

- Perceived discrimination has been studied re: impact on both mental and physical health through psychological and physiological stress responses and health behaviors
- Perceived discrimination produces significantly heightened stress responses and is related to unhealthy behaviors
- (Citation: Perceived discrimination and health: A meta-analytic review. Pascoe, Elizabeth A.; Smart Richman, Laura; Psychological Bulletin, Vol 135(4), Jul 2009, 531-554)
- Note: Others by Les Whitbeck who discusses perceived discrimination and depression

Perceived Discrimination and Microagressions

- Perceived discrimination - relationship with increased depression (see Whitbeck)
- Microagressions (term coined by Chester Pierce, MD; further development by D. Wing Sue, PhD) can include instances of being racially profiled, experiences of discrimination, being stereotyped, being intentionally or unintentionally excluded, hearing racist comments, etc.
- Associated with historical trauma response, PTSD symptoms, and depression (preliminary research of Dr. Karina Walters (Choctaw) U of WA

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- Associated with historical trauma response, PTSD symptoms, and depression (preliminary research of Dr. Karina Walters (Choctaw) U of WA; associated with lowered self-esteem

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Complex Trauma

- Not a DSM 5 diagnosis but planned for inclusion in ICD-11
- DSM IV field trial showed that 92% of people with complex PTSD/Complex Trauma also met diagnostic criteria for PTSD
- **PTSD doesn't cover the intricacy of complex trauma nor historical trauma**
- Found in people who have experienced multiple, chronic or prolonged traumas
- Complex trauma congruent with Historical Trauma Response but HTR includes generational prolonged and repeated trauma exposure
- Symptoms may include dissociation, anger, depression, change in self concept, change in response to stressful events, irritability, frozen/restricted, flashbacks, altered perceptions/beliefs – similar to features of HTR

Complex Trauma and Historical Trauma

- Complex trauma - prolonged, repeated trauma in which the person was “in a state of captivity” physically or emotionally (Herman, 1997).
- Early reservation days and POW designation for some tribal groups, massacres, colonization, forced separation of children from families and tribe, may be emotionally experienced as a legacy of living in a state of captivity.
- Treatment involves need for person to regain sense of control and power, and work in interpersonal relationships – many AIAN face repeated disruption in sense of agency and experiences collectively of powerlessness related to past and ongoing oppression, e.g. DAPL which has been triggering for AIAN

Trauma informed supervision

- **Bringing ones past into the workplace**
- **Getting triggered, compassion fatigue, addressing self-care**
- **Supervision as a parallel process – when presenting a case, supervisor may start experiencing similar feelings that supervisee had in the clinical session or feelings that the patient may have had. Good to examine these – helpful to understanding the case**
- **Importance of self-care**

Culturally & Historically Responsive Assessment

- Explore instances of perceived discrimination and microaggressions
- “War stories” and testimonies – traumatic!
- Some Examples:
- Being stopped for drinking water
- Having security called at hotel gift shop – assumed I was not a hotel guest and that I was loitering and planning to steal something
- Being mistaken for the help numerous times while dressed in a business suit on professional travel
- Being told I was standing in the wrong line to board a flight – I had a free first class upgrade due to frequent travel miles and frequent flyer status

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Trauma Informed Use of Self, Transference and Countertransference

- Trauma narratives of patients will be triggering particularly if therapist has own trauma history.
- Developing comfort with one's own reactions and working on healing from one's own trauma is essential.
- **Awareness of trauma is helpful rather than harmful** (avoidance is worse as one can "act out" by not listening to the patient, shutting down emotionally, becoming judgmental, and interfering with the patient's healing)
- Trauma informed care includes addressing providers own needs and healing. Review information on Secondary, Vicarious Trauma, Compassion Fatigue, and Burnout from previous sessions and kickoff slides. **As you watch/listen to the DVD clip attend to your own reactions as well as what you are observing or hearing and how you are experiencing this; think about HT, HTR, and the Cultural Formulation.**

Let a hundred drums gather. It must be a time of celebration, of living, of rebuilding, and of moving on. Our warriors will sing a new song, a song of a new beginning, a song of victory.

Let our warriors sing clear and loud so the heartbeat of our people will be heard by Sitting Bull and all our ancestors in the Spirit World....Let us send to our great chief a new song to sing when he rides around the people in the Spirit World:

Look at our children, They're going to live again, They're going to live again. Sitting Bull says this as he rides.

Traditional Hunkpapa Lakota Elders Council (Blackcloud, 1990)

TAKINI-REBIRTH: HOPE THROUGH HTUG

Celebration of Survival

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Celebration of Survival

Celebration of Survival

Websites

- ACES Connection

http://www.acesconnection.com/

- ACES Too High

www.acestoohigh.com

- International Society for Traumatic Stress Studies (ISTSS)

www.istss.org

- The National Council for Behavioral Health

https://www.thenationalcouncil.org/topics/trauma-informed-care/

- National Child Traumatic Stress Network (NCTSN)

http://www.nctsn.org/

Websites-continued

- PTSD: National Center for PTSD (US Department of Veterans Affairs)

https://www.ptsd.va.gov/

- SAMHSA National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint (NCTIC)

https://www.samhsa.gov/nctic

- SAMHSA National Child Traumatic Stress Initiative (NCTSI)

https://www.samhsa.gov/child-trauma

Acknowledgement: Video clips contributed by Rashmi Sabu, MD, UNM Department of Psychiatry and Behavioral Sciences

Relevant Recent HT Publications

- Brave Heart, M.Y.H., Elkins, J., Tafoya, G., Bird, D., & Salvador (2012). *Wicasa Was'aka*: Restoring the traditional strength of American Indian males. *American Journal of Public Health*, *102* (S2), 177-183.
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HT, Depression, PTSD, Prolonged Grief

- Native mourning resolution is distinct from European American grief
- Loss of close relative experienced as loss of part of self, may be exhibited by cutting the hair
- Natives maintain active relationship with ancestor spirits
- Massive group trauma (genocide) impairs normative grief; extent & quality of losses (trauma exposure) limit time for culturally congruent mourning resolution; history of prohibition of bereavement ceremonies
- Close attachments may predispose PG

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