TRAUMA INFORMED CARE & CULTURAL HUMILITY WITH NATIVE AMERICAN YOUTH

ND ECHO Seminar, April 20th 2022

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INTRODUCTION

- Emily Sargent, PhD, LP
- Clinical Psychologist , Sanford Traumatic Stress Treatment Center/TCTY- Fargo, ND
- Enrolled Tribal Member of the White Earth Band of Minnesota Chippewa Tribe
- Vicechair Woman, Fargo Native American Commission
- Doctorate in Clinical Psychology at University of North Dakota
- Specialty in research and treatment of Traumatic Stress, specifically in Native American population

TCTY NORTH DAKOTA

SANFORD HEALTH

OBJECTIVES

- **Objectives 1:** Trauma 101 in Native American population
- **Objective 2:** Knowledge of cultural practices and resiliency to help engage Native American Youth
- **Objective 3:** Cultural Sensitivity with evidence based screening tool for children with trauma

How many have treated Native American youth and/or provided care in an indigenous community?

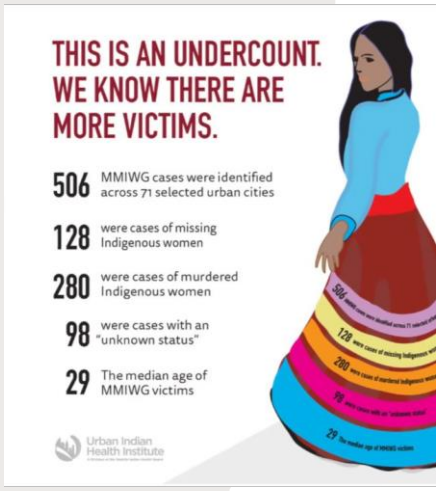
MENTAL HEALTH DISPARITIES IN TRIBAL COMMUNITIES

- Higher rates of exposure to trauma and PTSD
- Families highest rates for physical, sexual, abuse and neglect.
- Rates of substance abuse and mental health disorders more elevated compared to other ethnic groups.
- Impact of high suicide rates on siblings, peers, family members and community.
- High education drop out rates
- High Incarceration rates

(Smith, 2017)

TRAUMA IN INDIGENOUS COMMUNITIES

- Southwest tribal communities: ***82%*** have experienced at least 1 traumatic event and ***66%*** have experienced several
- Tribal communities across the nation: ***94% have experienced at least 1 traumatic event*** in their lifetime
- AI/AN women face murder rates ***10 times*** more than the national average
- Homicide is ***3rd*** leading cause of death of AI/AN women between 10-24 years of age
- In the lifetime of AI/AN women, ***56.1%*** experienced sexual violence, ***84%*** physical violence, and ***53.6%*** severe physical violence
- Of the women reporting experiencing violence in their lifetime:
  - ***97%*** reported at least one incident of violence perpetrated by a non-AI/AN
  - ***96%*** reported at least one incident of sexual violence perpetrated by a non-AI/AN



Danes (2017); Ehlers, Gizer, Gilder, & Yehuda (2013); Robin et al. (1997) In a 2016 Department of Justice report, Rosay (2016); UIHI (2016)

ACES AND PREVALENCE IN TRIBAL COMMUNITIES

- Among NA (reservation based) Youth 78% reported at least one ACE and 40% reported at least two ACEs
- Risk outcomes: 37% attempted suicide, 51% Multiple drug use, 55% PTSD symptoms, 57% Depression
- NA college students in ND average number of ACEs were 3

Number of Reported ACEs	UND Caucasians	UND American Indians
	YES (%)	YES(%)
0	51.60	14.50
1	16.50	20.30
2	5.50	13.00
3	8.80	13.00
4+	17.60	39.20

Sargent (2020); Whitebeck et al (2015)

HISTORICAL TRAUMA IN INDIGENOUS COMMUNITIES

Cultural Trauma

Attack on the cultural aspects of a specific community, affecting the well-being of community and it's members

Historical Trauma

Repeated exposure of traumatic events that affect an individual and continues to affect future generations (gene adaptation)

Intergenerational Trauma

Occurs when trauma is not resolved in individual or community→ internalized→ passed on to one generation to the next

All 3 play a role in an Native American child's current state of experiencing trauma and related symptoms.

BigFoot and Schmidt (2018)

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GREAT CONFUSION THROUGH GENOCIDE

- Loss of Land
- Loss of Culture
- Loss of Language
- Loss of Community Structure
- Loss of Family Structure
- Loss of Identity

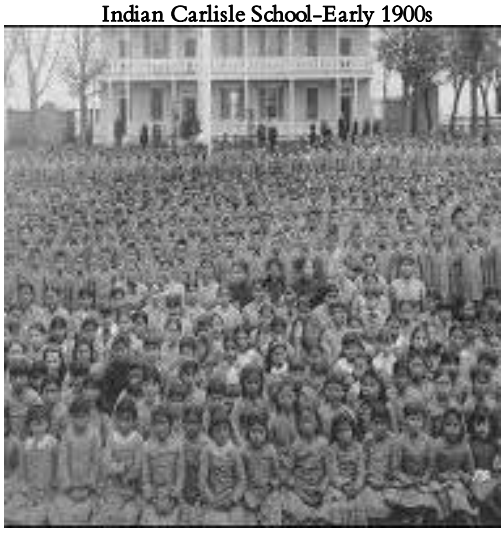
- 1830-Indian Removal Act
- 1883- Religious Crimes Code Act
- 1887- Dawes Act (Allotment Act)
- 1890- 1930's Indian Boarding School Era
- 1924- Native Citizenship
- 1950-70's Indian Relocation
- 1975- ICWA
- 1978- Freedom of Religion Act

(Smith, 2017)

CONSEQUENCES OF HISTORICAL TRAUMA

- Authoritarian and inconsistent or rejecting of child
- Insensitivity to child's needs
- Poor school and healthcare relations
- Distrust of systems
- Weak spiritual foundations
- Weak ethnic identity

Indian Carlisle School-Early 1900s



(Yellow Horse Brave Heart, 2003)

INDIGENOUS RESILIENCE

"Ability of American Indians to maintain optimism during adversity is related to spirituality, compassion, empathy, humor, friendships and familial and community strengths."

(Goodluck, 2002)

Protective and Resiliency Factors for NA youth:

- ❖Feeling connected to tribal community
- ❖Cultural Identity
- ❖Language
- ❖Ceremony
- ❖Spirituality

(Smith, 2017)

INDIGENOUS RESILIENCE RESEARCH

- **NA college students** expressed strong **importance of AI traditions** in order to develop resiliency traits (Montgomery et al., 2000)
- AI passing on ***resiliency narratives to one generation to the next*** may aid in the recognition of their past, therefore, providing them with strength to aid in overcoming future difficulties (Fast & Collin-Vézina, 2010).
- **NA college students had higher self-perceived resiliency compared to white peers**
  - ❖ AI students adjusting to new city/school/culture
  - ❖ Have lowest retention rates in universities (Brayboy, 2005)
  - ❖ Historical trauma and fostering resilience (Fast & Collin-Vézina, 2010).

So how do we continue to foster resilience for our Native American youth & families who have endured high rates of ACES and trauma?

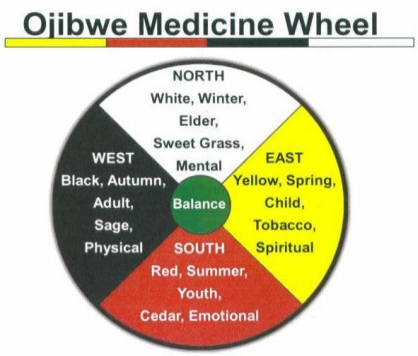
TREATMENTS FOR TRAUMATIZED NATIVE AMERICAN YOUTH

It is crucial to have treatments available for Native American communities that honor and utilize their culture into trauma healing. Indigenous communities have been healing trauma and emotional wounds for centuries through our traditions and "way of life".

Evidence based culturally enhanced treatments:

- **Honoring Children Mending The Circle Treatment (culturally enhanced TF-CBT)-** Indian Country Child Trauma Center
- **Culturally Enhanced Cognitive Behavioral Intervention for Trauma in Schools (CBITS)-** National Native Children's Trauma Center

Cognitive and Behavioral Coping Skills	Medicine Wheel
Relaxation	Physical
Emotional Regulation	Emotional
Cognitive Restructure	Mental
Mindfulness	Spiritual



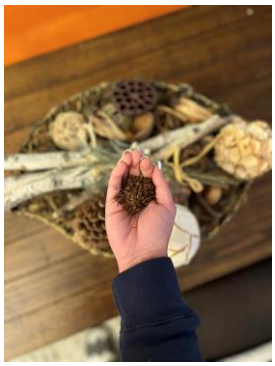
TRADITIONAL HEALING PRACTICES

RELAXATION

- Mindfulness: Outdoors, Prayer, Smudging (burning sage)
- Drumming, singing traditional songs
- Beadwork, crafting artwork, dancing
- Seasonal harvesting: wild rice, berries, syrup
- Smudging- purpose is to cleanse any negative energy in physical body, mind and spirt, to help relax and smooth individual

MINDFULNESS/SPIRITUALITY

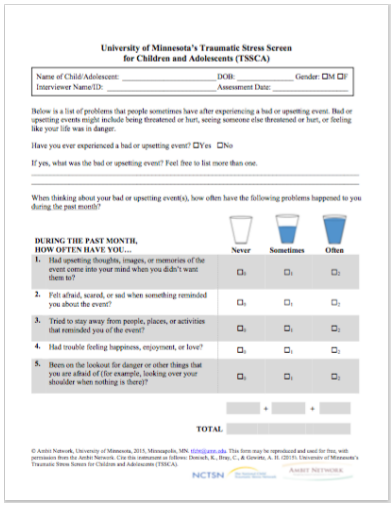
- Tobacco is sacred medicine used when asking higher power/Creator and spirits for something or giving them thanks
- Sign of respect, honor, and appreciation for all walks of life
- Prayers using traditional medicines, being outdoors, traditional ceremonies
- Traditional medicines help aid, soothe, and treatment physical, emotional, mental, spiritual illness



TRAUMA SCREENING TOOL: WHAT IS THE TSSCA?

- University of Minnesota's Traumatic Stress Screen for Children and Adolescents
- 5 question screen for PTSD symptomology
- For use by child welfare professionals, clinicians/providers, educators, juvenile probation officers and other trained staff
- For use with children 5-18
- Used to refer for additional assessment and services

(Donisch, Bray, & Gewirtz, 2015)



University of Minnesota's Traumatic Stress Screen for Children and Adolescents (TSSCA)

Name of Child/Adolescent: _____ DOB: _____ Gender: ☐M ☐F
Interviewer Name/ID: _____ Assessment Date: _____

Below is a list of problems that people sometimes have after experiencing a bad or upsetting event. Bad or upsetting events might include being threatened or hurt, seeing someone else threatened or hurt, or feeling like your life was in danger.

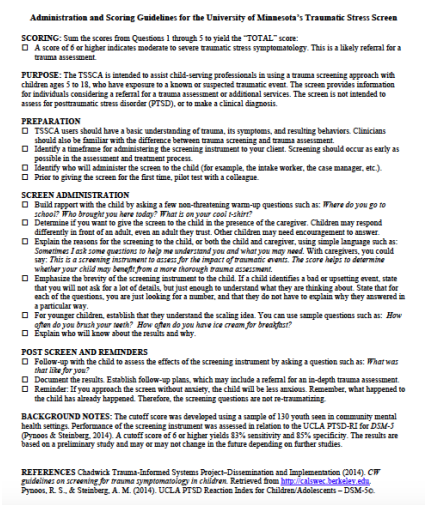
Have you ever experienced a bad or upsetting event? ☐Yes ☐No

If yes, what was the bad or upsetting event? Feel free to list more than one.

When thinking about your bad or upsetting event(s), how often have the following problems happened to you during the past month?

DURING THE PAST MONTH, HOW OFTEN HAVE YOU…	Never	Sometimes	Often
1. Had upsetting thoughts, images, or memories of the event come into your mind when you didn't want them to?	☐0	☐1	☐2
2. Felt afraid, scared, or sad when something reminded you about the event?	☐0	☐1	☐2
3. Tried to stay away from people, places, or activities that reminded you of the event?	☐0	☐1	☐2
4. Had trouble feeling happiness, enjoyment, or love?	☐0	☐1	☐2
5. Been on the lookout for danger or other things that you are afraid of (for example, looking over your shoulder when nothing is there)?	☐0	☐1	☐2
		+	+
TOTAL			

NCTSN AMBIT NETWORK



Administration and Scoring Guidelines for the University of Minnesota's Traumatic Stress Screen

SCORING: Sum the scores from Questions 1 through 5 to yield the "TOTAL" score:
☐ A score of 6 or higher indicates moderate to severe traumatic stress symptomatology. This is a likely referral for a trauma assessment.

PURPOSE: The TSSCA is intended to assist child-serving professionals in using a trauma screening approach with children ages 5 to 18, who have exposure to a known or suspected traumatic event. The screen provides information for individuals considering a referral for a trauma assessment or additional services. The screen is not intended to assess for posttraumatic stress disorder (PTSD), or to make a clinical diagnosis.

PREPARATION
☐ TSSCA users should have a basic understanding of trauma, its symptoms, and resulting behaviors. Clinicians should also be familiar with the difference between trauma screening and trauma assessment.
☐ Identify a timeframe for administering the screening instrument to your client. Screening should occur as early as possible in the assessment and treatment process.
☐ Identify who will administer the screen to the child (for example, the intake worker, the case manager, etc.).
☐ Prior to giving the screen for the first time, pilot test with a colleague.

SCREEN ADMINISTRATION
☐ Build rapport with the child by asking a few non-threatening warm-up questions such as: *Where do you go to school? Who brought you here today? What is on your cool t-shirt?*
☐ Determine if you want to give the screen to the child in the presence of the caregiver. Children may respond differently in front of an adult, even an adult they trust. Other children may need encouragement to answer.
☐ Explain the reasons for the screening to the child, or both the child and caregiver, using simple language such as: *Sometimes I ask some questions to help me understand you and what you may need.* With caregivers, you could say: *This is a screening instrument to assess for the impact of traumatic events. The score helps to determine whether your child may benefit from a more thorough trauma assessment.*
☐ Emphasize the brevity of the screening instrument to the child. If a child identifies a bad or upsetting event, state that you will not ask for a lot of details, but just enough to understand what they are thinking about. State that for each of the questions, you are just looking for a number, and that they do not have to explain why they answered in a particular way.
☐ For younger children, establish that they understand the scaling idea. You can use sample questions such as: *How often do you brush your teeth? How often do you have ice cream for breakfast?*
☐ Explain who will know about the results and why.

POST SCREEN AND REMINDERS
☐ Follow-up with the child to assess the effects of the screening instrument by asking a question such as: *What was that like for you?*
☐ Document the results. Establish follow-up plans, which may include a referral for an in-depth trauma assessment.
☐ Reminder: If you approach the screen without anxiety, the child will be less anxious. Remember, what happened to the child has already happened. Therefore, the screening questions are not re-traumatizing.

BACKGROUND NOTES: The cutoff score was developed using a sample of 130 youth seen in community mental health settings. Performance of the screening instrument was assessed in relation to the UCLA PTSD-RI for *DSM-5* (Pynoos & Steinberg, 2014). A cutoff score of 6 or higher yields 83% sensitivity and 85% specificity. The results are based on a preliminary study and may or may not change in the future depending on further studies.

REFERENCES Chadwick Trauma-Informed Systems Project-Dissemination and Implementation (2014). *CW guidelines on screening for trauma symptomatology in children.* Retrieved from http://calswec.berkeley.edu.
Pynoos, R. S., & Steinberg, A. M. (2014). UCLA PTSD Reaction Index for Children/Adolescents – DSM-5©.

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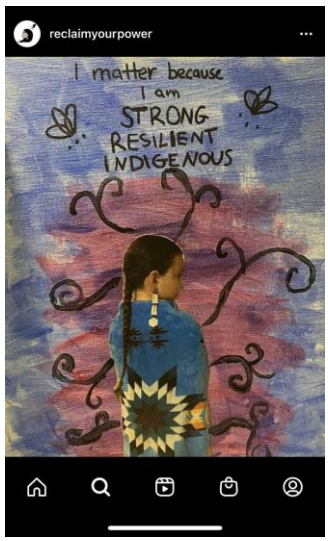
CULTURAL HUMILITY IN SCREENING TRAUMA

- Assessing traumatic event(s)- consider historical trauma and its impact on patient, their family, community
- Leaving the assessment with a positive (culture, resilience) memory or concept
- Its important for youth to know their identity is not just all trauma, trauma, trauma!.....and health disparities
- Engaging them in conversation about their strengths, culture, and resiliency will aid in building rapport and trust as a provider



Discussion Questions:

1. What are some ways your knowledge about Native American trauma/ACES, historical trauma, and resiliency can aid in treatment for indigenous populations?
2. What are ways you can integrate and/or be mindful of cultural considerations in your practice with Native American patients?
3. What are some challenges that may arise when trying to integrate culture humility into care?
4. Other comments/questions?

MIIGWECH (THANK YOU)!

Further Questions?

Email: Emily.sargent@sanfordhealth.org