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Historical Trauma, Ethnic Experience, and Mental Health in a Sample of Urban American Indians

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Abstract

BACKGROUND: Historical trauma (HT) among American Indians (AIs) has been linked with poor mental health but has been inadequately studied among urban populations. **OBJECTIVES:** The purpose of this study was to describe historical trauma, historical loss associated thoughts, ethnic experience, and psychological symptoms among a population of urban AIs. **METHOD:** This was a mixed methods study. In addition to focus groups, survey participants were administered the Historical Losses Scale, the Historical Losses Associated Symptoms Scale, the Scale of Ethnic Experience, and the Achenbach System of Empirically Based Assessment Adult Self-Report. Rates of psychological symptoms were compared with matched controls from a normative data set. **RESULTS:** Participants reported a strong sense of ethnic identity, a moderate desire to associate with other AIs, moderate comfort within mainstream society, and moderately high perceived discrimination. The most common HT themes were loss of culture, respect by children of traditional ways, and language. Compared with controls, participants had higher rates of aggressive behavior, substance use, thought problems, and obsessive symptoms, but some of these issues are likely explained by cultural factors. A greater number of participants met the clinical threshold for multiple problems compared with controls. **CONCLUSIONS:** This sample of AIs reported frequent experiences of discrimination. HT is a significant factor in the lives of many urban AIs who also have significantly higher rates of a number of mental health problems. Providers must be aware of these issues to provide the most effective care to AIs.

Keywords

minority populations, transcultural psychiatry, trauma-informed care

Introduction

The number and magnitude of mental health problems among American Indians (AI) has reached crisis proportions and threatens the sustainability of entire communities across the country. AIs are almost twice as likely to have substance abuse/dependence when compared with whites (Substance Abuse and Mental Health Services Administration, 2014). In some AI communities, as many as 25% of individuals suffer from posttraumatic stress disorder (PTSD; Bassett, Buchwald, & Manson, 2014). One study reported a 13.8% lifetime prevalence of generalized anxiety disorder in AI women (Duran et al., 2004). The suicide rate in the AI population is 1.5 times higher than the national average among young adults (Centers for Disease Control and Prevention, 2013).

Higher rates of interpersonal violence, poverty, and other life stressors have been found to account for some of the elevated rates of mental illness among AIs (Kong, Roh, Easton, Lee, & Lawler, 2016). However, researchers also have hypothesized that historical trauma (HT) may account for a significant portion of the excess psychiatric morbidity (Brave Heart, Chase, Elkins, & Altschul, 2011). Various definitions of HT have been proposed but the one most often applied to AIs is "cumulative and collective emotional and psychological injury both over the life span and across generations, resulting from a cataclysmic history of genocide" (Brave Heart, 1999, p. 2). In this population, HT is the result of a combination of a number of

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horrific experiences including displacement, confinement, massacres, boarding schools, suppression of cultural and religious practices, and the removal of children from their families (Heckert & Eisenhauer, 2014).

A number of studies have examined the phenomenon and impact of HT among AIs. However, despite the fact that only 22% of AIs live on reservations, only one study was found that examined HT in a general urban AI population (Norris, Vines, & Hoeffel, 2012; Wiechelt, Gryczynski, Johnson, & Caldwell, 2012).

Researchers who study HT among reservation-dwelling AIs have acknowledged that their findings may not apply to urban-dwelling AIs even if they come from the same tribe (Whitbeck, Walls, Johnson, & Morrisseau, 2009). Urban AIs are removed from their ancestral homeland, community, and many cultural practices. In fact, the only study conducted in this population found that HT was higher in AIs living in urban areas compared with those living on reservations (Wiechelt et al., 2012). Factors such as cultural identity and social-kinship connection were suggested to reduce HT among AIs on reservations relative to their urban counterparts.

If HT is a significant factor contributing to mental health symptoms among AIs, psychiatric treatment will be of limited effectiveness if it does not address these issues (Urban Indian Health Institute, Seattle Indian Health Board, 2012). The link between HT and mental health among urban AIs must be understood so that we can incorporate traditional healing methods into treatment plans to help end this transgenerational handicap. In addition, the ethnic experience of urban AIs is not well understood.

Mental health nurses are well suited to help reduce HT among AIs. Nurses treat individuals and communities from a holistic perspective. It is clear that the reduction of HT will require interventions that extend well beyond traditional medical models of health and illness.

Review of Literature

HT is a concept that has been used since the 1960s to describe the transgenerational psychological effects of a number of historical events including the Great Depression, the Holocaust, and famines (Mohatt, Thompson, Thai, & Tebes, 2014). Brave Heart and DeBruyn (1998) were among the first to apply this concept to AIs. Although HT can help explore the effects of natural phenomena that affect all members of a society (i.e., a famine), the concept likely has a greater and more enduring impact when examining persecuted minorities (i.e., AIs, African Americans) who continue to face discrimination and disparities in almost every aspect of life.

The largest body of research on HT has been conducted among Holocaust survivor offspring. In a meta-analysis, Van Ijzendoorn, Bakermans-Kranenburg, and Sagi-Schwartz (2003) found that HT has the greatest ongoing mental health effects on individuals who also require physical or mental health treatment. This finding has important implications for AIs because they face rates of both physical and psychiatric comorbidities that are often several times higher than that found in the general population (Gone & Trimble, 2012; Hutchinson & Shin, 2014).

Research on HT and mental health among AIs has been limited. The majority of articles published on this topic have been conceptual with a limited number of qualitative analyses and even fewer quantitative studies. HT among AIs has been linked to drug use (Lemstra, Rogers, Thompson, Moraros, & Buckingham, 2012; Pokhrel & Herzog, 2014), depressive symptoms (Bombay, Matheson, & Anisman, 2011; Evans-Campbell, 2008; Whitbeck, Walls, Johnson, Morrisseau, & McDougall, 2009), and anxiety (Evans-Campbell, 2008). Ehlers, Gizer, Gilder, Ellingson, and Yehuda (2013) reported that AI survivors of assaultive trauma or those who had a lifetime diagnosis of an affective disorder, anxiety, or PTSD had higher historical loss symptoms. To our knowledge, this study is only the second to examine HT among AIs in urban areas and the first to measure mental health symptoms beyond substance abuse. The purpose of this study was to describe historical trauma, historical loss associated thoughts, ethnic experience, and psychological symptoms among a population of urban AIs.

Method

Research Approach

A community-based participatory research approach was used for the design and implementation of this study (Wallerstein & Duran, 2006). HT is founded in psychosocial, political/economic, and social/ecological systems theories (Mohatt et al., 2014). Although HT affects individuals, it is rooted in community-based experiences and requires community-focused interventions to help members overcome its effects. This study was born out of the interests of the local AI community. The Southeast Nebraska Native American Coalition maintains understanding and addressing historical trauma as one of its core priorities. The focus group questions were developed by the principal investigator (PI) and then reviewed by multiple community members. Community members also reviewed the instruments used in the study. The community members involved with this study do not have the tools or background to conduct either qualitative or quantitative analyses. As a result, these were conducted by the PI. However, the results were reviewed with community members who provided feedback and insights both individually and at a community dinner held for that purpose. In addition, the de-identified

Table 1. Instruments Administered to American Indian Sample, $n = 139$.

Instrument	Concept		
	Quantitative		Qualitative
	Subscales	Number of Items	
Historical trauma			
Historical Loss Scale		12	Focus group discussion
Historical Loss Associated Symptoms Scale		12	Focus group discussion
Ethnic experience			
Scale of Ethnic Experience	Ethnic identity	12	Focus group discussion
	Social affiliation	5	Focus group discussion
	Mainstream comfort	6	Focus group discussion
	Perceived discrimination	9	Focus group discussion
Mental health			
ASEBA Adult Self-Report	Adaptive functioning scales	126	Focus group discussion
	DSM-oriented scales		
	Substance use scales		
	Syndrome scales		

Note. ASEBA = Achenbach System of Empirically Based Assessment; *DSM* = *Diagnostic and Statistical Manual of Mental Disorders*.

quantitative data sets and the original focus group transcripts were provided to community members on request. Lastly, multiple members of the community reviewed this manuscript before its submission. This study was approved by the University of Nebraska Medical Center Institutional Review Board (470-16-EX and 217-16-EX).

Design

This mixed methods study used a concurrent triangulation design to describe historical trauma, historical loss associated thoughts, ethnic experience, and psychological symptoms among a population of urban AIs (see Table 1; Creswell & Plano Clark, 2007). The qualitative data were collected through focus groups and the quantitative data were collected through surveys of a convenience sample (see focus group questions in the appendix).

Sample and Setting. In both phases, a convenience sample of individuals were recruited who were 19 years of age or older, able to communicate in English, lived within 50 miles of two Midwestern cities, and self-identified as AI. Focus group participants were recruited through announcements at community events and contacts of research assistants who were also community members. Survey participants signed up for the study at local powwows and through contacts of the research assistants. A total of 139 community members were surveyed. Three focus groups comprised six to eight members each (Ritchie, Lewis, Nicholls, & Ormston, 2013). Based on the fact that more women participate in AI community events in this region, we decided to conduct one focus group with younger women, one with older women, and one with men.

Qualitative Data Collection

Community members were involved as advisors in designing and completing the study. In addition, three community members were recruited to work as research assistants. They completed ethics training, focus group training, and survey administration training. The study was explained by the PI or a research assistant in person or over the phone in a private space. Potential participants were given the opportunity to ask any questions before being asked if they agreed to participate in the study. Interested persons signed the informed consent in person, or a consent was mailed to the person in cases of discussion over the phone, signed, and returned by the U.S. Postal Service mail in a postage-paid envelope.

The focus groups were completed in person at the AI cultural center by AI research assistants. A structured guide with questions for the focus groups was established by the PI in collaboration with consulting community members and research assistants. Only AI individuals were present during the focus groups to allow group members to speak as freely as possible.

Instruments

Survey participants were contacted to respond to the questions over the phone. The survey portion consisted of demographics (age, sex, marital status, tribe, percentage AI), the Historical Loss Scale, the Historical Loss Associated Symptoms Scale, the Scale of Ethnic Experience (SEE), and the Achenbach System of Empirically Based Assessment Adult Self-Report (ASEBA ASR). Survey responses were entered into a REDCap database, and

responses for the ASR were entered into the ASEBA Web-Link (Achenbach, 2009).

Whitbeck, Adams, Hoyt, and Chen (2004) developed two scales with input from AIs to measure HT. The Historical Loss Scale is a unidimensional instrument consisting of 12 questions asking how often individuals think about specific losses such as land, language, and respect for elders. Possible responses include "Never," "Yearly or at special times," Monthly," "Weekly," "Daily," and "Several times a day." In a previous study, it had a Cronbach's α coefficient of .92 in a sample of AI adults in the Midwest (Whitbeck, Adams, Hoyt, & Chen, 2004). The Cronbach's α in this study was .93.

The Historical Loss Associated Symptoms Scale consists of 12 questions asking respondents to report how often they have particular symptoms (i.e., anger, anxiety, insomnia) when thinking about the historical losses. Responses included "Always," "Often," "Sometimes," "Seldom," and "Never." In previous research, the Historical Loss Associated Symptoms Scale had a Cronbach's α coefficient of .89 in a sample of AI adults in the Midwest (Whitbeck, Chen, Hoyt, & Adams, 2004)). The Cronbach's α in this study was .84.

The SEE consists of 32 questions with responses 1 to 5 indicating *Strongly agree, Agree, Neither, Disagree*, and *Strongly disagree* (Malcarne, Chavira, Fernandez, & Liu, 2006). The responses to questions produce four subscales of ethnic identity (i.e., "Being a member of my ethnic group is an important part of who I am"), social affiliation (i.e., "I feel most comfortable talking about personal things with people from my own ethnic group"), mainstream comfort (i.e., "I think of myself as a typical American"), and perceived discrimination (i.e., In my life, I have experienced prejudice because of my ethnicity"). The SEE was developed, in part, based on a focus group with AIs and has been used in one study with AIs, but the reliability of this tool has not been evaluated specifically with AIs (Tucker, Wingate, & O'Keefe, 2016). During the development of the tool with a culturally diverse undergraduate sample, the SEE was shown to have Cronbach's α of .80 to .86 on the various subscales (Malcarne et al., 2006). The subscale Cronbach's α in this study ranged from .68 to .75. The lower reliability in the current study may be a result of a more heterogeneous community sample when compared with college students.

The ASR is a psychological symptom inventory that assesses competencies, adaptive functioning, and behavioral, emotional, and social problems for individuals aged 19 to 59 years. The questionnaire consists of 123 close-ended questions, three open-ended questions, and a set of questions regarding living status and demographics. The scale scores range from 0 (*not true*) to 2 (*very/often true*). The items are distributed between adaptive functioning scales, *Diagnostic and Statistical Manual of Mental Disorders*–orientated scales, substance use scales, and syndrome scales. Using the ASEBA Web-Link (Achenbach, 2009), *t* scores are calculated and results are rated normal, borderline, or clinical. The reliability of these scales range from .51 to .97, with most $>.80$ (Achenbach & Rescorla, 2003). The subscale Cronbach's α in this study ranged from .66 to .92, with most $>.80$.

Data Analysis

The focus group recordings were transcribed by One Transcription Services in Omaha, Nebraska. They were analyzed with the use of the MAXQDA 12 software package. The transcript analyses consisted of close reading and line-by-line coding of all three transcripts. The process of open and focused coding guided by grounded theory produced a set of codes used to provide context for the questionnaire responses (Glaser, 2002). The statistical results from the quantitative data and codes from the qualitative data sets were merged through a process of transforming the qualitative data into quantitative data. Based on methods described by Creswell and Plano Clark (2007), the codes were counted and placed into matrices to compare them with the quantitative results on the various measures (i.e., the constructs of ethnic identity, rates, mental health symptoms, etc.). The authors then extracted representative statements from participants to highlight comparisons. Descriptive statistics for the HT scales and the SEE subscales were generated using SPSS 25 (IBM, 2017). These results were used along with previous means and standard deviation to determine if the current sample of AIs differed on the subscales from earlier studies conducted with African, Caucasian, Filipino, and Mexican Americans using the Graph Pad Quick Calcs Website: http://graphpad.com/quickcalcs/ttest1.cfm.

An ASEBA data set of normative individuals from a national sample was purchased. Participants aged 19 to 59 years in the current study were matched with individuals in the normative data set based on sex and age who then became controls. This process was completed with SPSS case–control matching with zero tolerance for sex (i.e., each case female was matched with a control female). Due to a lack of younger individuals in the normative data, the process required a "fuzzy matching" of up to 11 years on age to match each case to a control. Chi-square analyses were used to compare the proportion of individuals from the AI sample who met the ASEBA clinical threshold for each problem with those who met the threshold among the control group.

Table 2. Demographics.

	AI participants, $n = 139$		
	HT and SEE	ASEBA	Controls, $n = 95$
Age	41.1 years ($SD = 15.8$)	36.7 ($SD = 12.2$)	38.9 years ($SD = 9.9$)*
Female	87 (69.8%)	78 (66.7%)	78 (66.7%)*
Male	42 (30.2%)	39 (33.3%)	39 (33.3%)*
Enrolled tribal member	122 (87.8%)	102 (87.2%)	
Descended from multiple tribes	56 (40.3%)	45 (38.5%)	
Proportion of life on a reservation	None: 51 (37%)	None: 17 (14.5%)	
	1%-50%: 69 (50%)	1%-50%: 54 (46.2%)	
	>50%: 18 (13%)	>50%: 46 (39.3%)	
Mean AI blood quantity	60.4% ($SD = 25.7\%$)	56.8% ($SD = 24.9\%$)	

Note. AI = American Indian; HT = historical trauma; SEE = Scale of Ethnic Experience; ASEBA = Achenbach System of Empirically Based Assessment; *SD* = standard deviation.
*No statistical significance between the ASEBA and Control groups.

Results

Sample Characteristics

The demographics of focus group participants were not collected. The mean age of survey participants was 41.1 years with a standard deviation (*SD*) of 15.9 years (see Table 2). The majority of participants were female (69.8%). Most participants (87.8%) were enrolled in a tribe and 40% identified themselves as descendants from multiple tribes. Participants reported living an average of 17.5% of their lives on a reservation, but there was a significant degree of variation with an *SD* of 23.3 years. More than one third (36.7%) of participants reported that they had never lived on a reservation and another half (49.6%) reported living on a reservation for less than half of their lives. Participants reported a mean AI blood quantity of 60% with an *SD* of 26%.

Qualitative Data Results

Themes that emerged from the qualitative analysis were as follows: historical loss, cultural loss, race consciousness, stereotypes and discrimination, and positive practices.

Historical Loss. Participants sometimes referred to the impact of historical events such as times when it was legal to kill an AI off a reservation. One individual stated, "What we inherited is an adaptation to survive in this community, and we struggle with it." Other individuals discussed somewhat more recent events, such as a participant whose grandmother was sent to a boarding school. The individual reported that she developed mistrust for law enforcement and white people, which was then transmitted to her children and grandchildren. They also noted that long hair was cut from individuals forced into boarding schools and that some families have had difficulty returning to this tradition since then. The focus groups did not discuss historical loss associated symptoms in depth. Some stated they become upset or angry when thinking about the losses. Others returned to defining the concept in their own terms and resigned themselves to accepting HT stating, "They call that generational grief because that bleeds all the way down" and "That grief is never gonna leave us. It's always gonna be there."

Cultural Loss. Many participants lamented the loss of respect for the elderly. They stated that AIs within the city are often less patient with them. This change was tied to a loss of guidance from nonparent authority figures. Participants stated that on reservations, extended relatives or other members of the tribe would often reprimand or provide other guidance to children. However, they lamented that this practice is uncommon in the city. The most significant loss identified by many focus group participants was that of traditional languages.

Participants expressed frustration with the fact that they believe AI history and heritage are not celebrated or taught accurately within the educational system. They also expressed dismay that many AI children are embarrassed of their identity and do not claim their Native heritage. Focus group participants also expressed a number of more complex sentiments of ethnic identity that could not be expressed in survey responses. For example, a number of survey participants conveyed the identity difficulties experienced by mixed-race individuals. One individual stated, "I'm too white to be red, and too red to be white" and indicated challenges in his identity that resulted from not being fully accepted by either ethnic group. Other participants expressed identity challenges stemming from being Native while living in a city. One stated, "Basically,

I am [an] urban Indian that lived in the city his whole life. I try to keep to my roots, but at the same time got to maneuver to the white man's world." Another expressed the difficulty in relating to AIs on reservations, stating that he sometimes received comments from them such as "it is just another Native from the urban area."

Individuals made comments such as "I just think it's easier to associate with Natives than people of other races because we know what we're talking about." Other participants agreed, stating "You don't have to explain stuff" and "We get our own jokes." Interestingly, some participants expressed that they interacted with people from diverse backgrounds when they were children, but as they have grown older, they have started to spend time primarily with family members or other Natives.

Race Consciousness. Many participants stated that they were always "consciously aware" of being Native when they were out in public. Some expressed difficulty blending in and stated they had "that feeling that people are watching me for whatever reasons." Participants stated that they sometimes received stares while in public and many participants expressed discomfort at being the only AI. Some stated they always look for other Natives and may even leave if they find they are the only AI. One stated, "My guard, I'll admit it, goes up when I'm surrounded, outnumbered . . . It's just the way I was treated growing up made me feel uncomfortable with them."

Stereotypes and Discrimination. Focus group participants stated that they had encountered stereotypes, including being "another drunk Indian," being a "wild Indian," living "in a teepee . . . without electricity," being expected to be either in prison, homeless, or poor. Participants attributed some of the stereotypes to a difference in visibility. For example, one participant stated that other ethnic groups have high rates of alcoholism but that it is often more hidden compared with AIs. Some participants reported experiencing stereotypes that an individual's appearance (i.e., dark features) would confirm their Native heritage. Participants also reported experiencing discrimination of various types. In particular, participants reported being profiled by law enforcement, with one stating, "When the cops are around now, I don't feel safe." They also reported being followed in stores, experiencing housing discrimination, and having access to only "the lowest job." One individual also expressed a feeling that Child Protective Services remove Native children from the home more quickly than nonminority children. Lastly, some of the women reported intersectional discrimination resulting from being Native and being a woman. It is clear that stereotypes and discrimination had a significant and negative impact on participants. One stated, "I think it is more the lack of respect they have towards us, and you lose your own self-respect sometimes in that crowd because you feel like you are being beaten down."

Specifically, methamphetamines and marijuana were identified as the most commonly used substances. Addiction was identified as a common source of strife within families, sometimes leading children to be placed in foster care. They also mentioned additional problems associated with addiction, including physical health issues, legal problems, and car collisions. Participants also noted the prevalence of drug and alcohol use across generations. For example, some noted seeing individuals using drugs and/or alcohol with their children and grandchildren.

Participants identified a number of differences in drug and alcohol use patterns between urban areas and reservations. First, participants stated that urban AIs have easier access to a wider variety of drugs than those on reservations. Second, participants stated that it is often easier for AIs to access alcohol in the city than in the reservation (likely contrasting the city to "dry" reservations in the region). Third, participants reported that it is easier for individuals to leave a group of people using drugs in the city than it is on the reservations. Fourth, it was noted that the city has a greater number of options for help recovering from addiction than the reservations.

Other mental health problems were discussed more briefly during the focus groups. Participants stated that disorders such as depression, anxiety, and posttraumatic stress disorder are very common among urban AIs. In particular, some members stated that urban Native women suffer from high rates of domestic violence, sexual assault, and suicide. However, some participants noted that many individuals are afraid to ask for help because they fear Child Protective Services involvement if their mental health problems are exposed. Others noted that many people are uncomfortable going to a therapist because they feel they are being judged.

Positive Practices. Focus group participants identified a number of ways positive cultural practices can improve the mental health of community members. For example, one participant reported that engaging in cultural practices helps individuals stay sober because it is against tradition to participate in them while under the influence of drugs or alcohol. Many participants also reported they believe that learning their native languages was critical; one individual said, "It influences how you think of yourself." Individuals discussed feelings of being upset about the history of boarding schools in which their ancestors were forbidden from speaking their languages. Others expressed concern that many Native languages are being lost. Some participants discussed the importance of seeking traditional knowledge such as learning one's "name, clanship,

Table 3. Percentage Frequency of Historical Loss Thoughts in American Indian Sample $N = 139$ (Percentage[a]).

Items	Several times a day	Daily	Weekly	Monthly	Yearly or only at special times	Never	Don't know
Loss of our land	11 (8)	50 (38)	29 (22)	27 (20)	14 (11)	2 (2)	6 (5)
Loss of our language	16 (12)	65 (48)	30 (22)	17 (13)	7 (5)	1 (1)	3 (2)
Losing our traditional spiritual ways	16 (12)	59 (43)	38 (28)	15 (11)	4 (3)	5 (4)	2 (1)
The loss of our family ties because of boarding schools	10 (8)	37 (29)	26 (20)	24 (19)	19 (15)	13 (10)	10 (8)
The loss of families from the reservation to government relocation	8 (6)	33 (25)	18 (14)	32 (24)	29 (22)	13 (10)	6 (5)
The loss of self-respect from poor treatment by government officials	9 (7)	58 (44)	30 (23)	14 (11)	15 (11)	6 (5)	7 (5)
The loss of trust in whites from broken treaties	15 (11)	54 (39)	27 (20)	22 (16)	15 (11)	4 (3)	2 (1)
Losing our culture	13 (9)	73 (53)	26 (19)	18 (13)	3 (2)	5 (4)	1 (1)
The losses from the effects of alcoholism on our people	17 (12)	64 (47)	36 (26)	15 (11)	4 (3)	1 (1)	2 (1)
Loss of respect by our children and grandchildren for elders	11 (8)	64 (46)	33 (24)	19 (14)	6 (4)	5 (4)	1 (1)
Loss of our people through early death	9 (7)	61 (45)	26 (19)	25 (18)	11 (8)	5 (4)	2 (1)
Loss of respect by our children for traditional ways	8 (6)	68 (49)	23 (17)	30 (22)	6 (4)	3 (2)	1 (1)

[a]Percentages total greater than 100 due to rounding in each cell.

their lineage, where [they] come from . . . and following the taboos within their clanship." They also reported the benefits of dancing stating, "There's a point where they're dancing when they're just one with that whole process. It's like a spiritual act, too, in a sense. That is good for mental health." Other positive cultural practices included sweat lodges, cooking, making bread, storytelling, and singing. Participants stated that practicing their traditions, embracing cultural practices, and identifying as Native were positive: "It changes how we feel about ourselves."

Quantitative Data Results

Historical Loss. Participants reported thinking most frequently about the loss of culture, respect by children of traditional ways, and language (see Table 3). These were followed closely by thoughts of losses from the effects of alcoholism, respect by children and grandchildren for elders, and loss of people through early death.

Historical Loss Associated Symptoms. The most commonly reported reactions to thoughts of historical losses were sadness or depression, anger, and feeling like it is happening again (see Table 4). The next two most commonly reported reactions included being fearful or distrusting the intentions of white people and feeling uncomfortable around white people.

Ethnic Experience. Participants' response on questions of ethnic identity had a mean of 4.02 ($SD = 0.43$) corresponding most closely with a response of "Agree" to most questions of ethnic identity. Mean responses to questions of ethnic identity were significantly higher among the current sample when compared with African Americans, Caucasian Americans, Filipino Americans, and Mexican Americans (Malcarne et al., 2006).

The responses to questions of social affiliation had a mean score of 3.36 ($SD = 0.65$). This mean is closest to the response of "Neither agree nor disagree" on questions relating to social affiliation. The current sample rated social affiliation higher than Caucasian Americans and Mexican Americans but was not significantly different from African Americans and Filipino Americans (Malcarne et al., 2006).

Questions of mainstream comfort had a mean value of 3.0 ($SD = 0.70$). This mean reflects an average response of "Neither agree nor disagree" on questions relating to feeling comfortable within the mainstream society. AIs in this sample reported that they were more comfortable in the mainstream society than African, Filipino, and Mexican Americans but showed no difference from Caucasian Americans (Malcarne et al., 2006).

The perceived discrimination had a mean score of 4.13 ($SD = 0.49$). This mean corresponds most closely with a response of "Agree" on questions of perceived discrimination. AI participants reported significantly greater perceived discrimination than Caucasian and Filipino Americans but significantly less perceived discrimination than African and Mexican Americans (Malcarne et al., 2006).

Table 4. Percentage Frequency of Historical Loss Associated Symptoms in American Indian Sample, $N = 139$ (Percentage[a]).

Items	Always	Often	Sometimes	Seldom	Never	Don't know
Sadness or depression	25 (18)	49 (36)	42 (30)	20 (14)	2 (1)	1 (1)
Anger	22 (16)	36 (26)	38 (28)	33 (24)	9 (7)	1 (1)
Anxiety or nervousness	15 (11)	23 (17)	39 (28)	30 (22)	30 (22)	2 (1)
Uncomfortable around white people	27 (20)	27 (20)	38 (28)	21 (15)	25 (18)	1 (1)
Shame	5 (4)	19 (14)	24 (18)	26 (19)	62 (46)	3 (2)
Loss of concentration	4 (3)	18 (13)	36 (26)	30 (22)	49 (36)	2 (1)
Isolated or distant from other people	9 (7)	19 (14)	33 (24)	36 (26)	40 (29)	2 (1)
A loss of sleep	2 (1)	8 (6)	26 (19)	33 (24)	68 (50)	2 (1)
Rage	10 (7)	19 (14)	35 (25)	38 (28)	36 (26)	1 (1)
Fearful or distrust the intentions of white people	34 (25)	27 (20)	38 (28)	14 (10)	24 (18)	2 (1)
Feel like it is happening again	54 (39)	34 (25)	32 (23)	10 (7)	8 (6)	1 (1)
Feel like avoiding places or people that remind you of these losses	11 (8)	22 (16)	31 (22)	28 (20)	46 (33)	1 (1)

[a]Percentages total greater than 100 due to rounding in each cell.

Table 5. Percentage of Participants ($n = 234$) Meeting the Clinical Threshold for Each Symptom Type.

		AI, $n = 139$	Normative, $n = 95$	
Externalizing	Externalizing problems	31 (26.5%)	22 (18.8%)	$\chi^2(1) = 1.976$, $p = .16$
	Aggressive behavior	16 (13.7%)	3 (2.6%)	$\chi^2(1) = 9.681$, $p = .002$*
	Intrusive	11 (9.4%)	6 (5.1%)	$\chi^2(1) = 1.586$, $p = .208$
	Rule-breaking behavior	17 (14.5%)	9 (7.7%)	$\chi^2(1) = 2.769$, $p = .096$
Internalizing	Internalizing problems	18 (15.4%)	19 (16.2%)	$\chi^2(1) = 0.032$, $p = .858$
	Depressive problems	7 (6%)	6 (5.1%)	$\chi^2(1) = 0.081$, $p = .775$
	Anxiety problems	10 (8.5%)	4 (3.4%)	$\chi^2(1) = 2.735$, $p = .098$
	Somatic problems	7 (6%)	8 (6.8%)	$\chi^2(1) = 0.071$, $p = .79$
	Withdrawn	8 (6.8%)	9 (7.7%)	$\chi^2(1) = 0.063$, $p = .801$
Personality	Avoidant personality problems	4 (3.4%)	6 (5.1%)	$\chi^2(1) = 0.418$, $p = .518$
	Antisocial personality problems	17 (14.5%)	8 (6.8%)	$\chi^2(1) = 3.628$, $p = .057$
Substance	Alcohol drunk days	15 (12.8%)	0 (0%)	$\chi^2(1) = 16.027$, $p < .001$*
	Drugs used days	8 (6.8%)	0 (0%)	$\chi^2(1) = 8.283$, $p = .004$*
Other	Thought problems	34 (29.1%)	4 (3.4%)	$\chi^2(1) = 28.276$, $p < .001$*
	Obsessive-compulsive problems	22 (18.8%)	2 (1.7%)	$\chi^2(1) = 18.571$, $p < .001$*
	ADH problems	8 (6.8%)	8 (6.8%)	$\chi^2(1) = 0$, $p = 1$

Note. AI = American Indian; χ^2 = chi-square distribution; ADH = Attention deficit/hyperactivity.
*$p < .05$.

There were no significant differences found between males and females in any of the instruments. In addition, Pearson correlations showed no association between ethnic experience responses and age.

Psychological Symptoms. Participants aged 19 to 59 years ($n = 117$) were included in the analysis of psychological symptoms. Study participants had a mean age of 36.7 years ($SD = 12.2$), whereas matched controls from the normative data set had a mean age of 41.5 years ($SD = 8.6$). This difference was statistically significant ($t = 25.637$, $p = .001$).

The results of the proportion of individuals in each group who met the ASEBA clinical threshold are presented in Table 5. AI participants had higher rates of symptoms in only five of the 16 areas. These included aggressive behavior, alcohol drunk days, drugs used days, thought problems, and obsessive-compulsive problems. The rate of clinically significant aggressive behavior problems was 5.3 times higher among participants compared with controls. Rates of thought problems and obsessive-compulsive problems were 5.6 and 11 times higher, respectively, among AI participants.

Although the rates of most psychological problems were similar between the two groups, a greater proportion of participants had clinically significant symptoms according to ASEBA compared with matched controls. In

Table 6. Percentage of Participants Meeting the Clinical Threshold for Each Number of Problems ($N = 234$).

Number of clinical problems	AI participants, $n = 139$	Controls, $n = 95$	χ^2	p
0	55 (47%)	82 (70.1%)	12.837	<.001*
1	18 (15.4%)	11 (9.4%)	1.929	.165
2	10 (8.5%)	8 (6.8%)	0.241	.624
≥3	34 (29.1%)	16 (13.7%)	8.241	.004*

Note. χ^2 = chi-square distribution.
*$p < .05$.

addition to the four groups of symptoms with levels that were statistically higher than controls, participants had rates in seven other symptom groups that were higher than controls, but the difference was not statistically significant.

Participants had higher rates of multiple morbidity (see Table 6), with 11% having two problems versus 8.5% of controls; this difference was not statistically significant. However, 29.9% of participants had three or more problems versus 12.9% of controls ($p = .001$).

Discussion

To our knowledge, this is the first study describing historical trauma, historical loss associated thoughts, ethnic experience, and psychological symptoms among a population of urban AIs. The demographics of this sample were notable in their diversity. Almost one-half (40%) of survey respondents self-identified as descendants from multiple tribes. Identifying with multiple tribes could increase an individual's experience of HT as they carry the weight of the negative historical and contemporary experiences of two or more tribes rather than just one. This sample also differed from most previous studies in that about half of participants reported spending less than half of their lives on a reservation and over a third reported they had never lived on a reservation, which likely had an impact on HT (Wiechelt et al., 2012). Previous studies have found that individuals on reservations often draw on traditional practices for strength (Whitbeck, Adams, Hoyt, & Chen, 2004)). It is unclear how this dynamic may work in an urban environment with individuals from many different tribal backgrounds. Participants reported an average AI blood quantity of approximately 60%. This fact likely has a significant impact the way individuals identify themselves and how they are identified by others. As noted in the focus group responses, some individuals of mixed heritage feel they are not accepted in either the AI or the white communities.

The most common *historical loss thoughts* reported were of culture, respect by children of traditional ways, and language. It is likely that the urban environment had a significant impact on these findings (Wiechelt et al., 2012). For example, loss of culture and language would likely be reported less often on reservations where the majority of the individuals engage in cultural practices and speak traditional languages to some degree (Whitbeck, Adams, Hoyt, & Chen, 2004)). The most common loss associated symptoms were sadness/depression, anger, and feeling like it is happening again. Two historical events that occurred in the region may have had an impact on these results. First, the Standing Rock protests against the Dakota Access Pipeline were a frequent topic of discussion in the community. Multiple community members made repeated trips to Oceti Sakowin and other camps in the area. Second, in 2017, AI and other groups increased pressure to close alcohol retail locations in White Clay, Nebraska, which primarily served to sell alcohol to Oglala Lakota from the Pine Ridge Reservation where the sale of alcohol is prohibited. Both of these events were discussed during the focus groups.

Survey respondents expressed strong *ethnic identity*. This was also reflected in the responses of focus group participants. Some individuals voiced some of the challenges with being an urban AI. Survey responses on questions of social affiliation were fairly neutral in that they did not express a strong preference for or against association primarily with other AIs. As noted above, this was in clear contrast to most focus group responses, where individuals discussed a desire to spend most of their time with other AIs. The reason for this discrepancy is unclear, especially given that many of the examples discussed in the focus groups matched closely with the survey questions. No comparison studies were found for SEE results.

A similar discrepancy between survey and focus group responses was found with regard to *mainstream comfort*. In the surveys, averages indicated that individuals were neither comfortable nor uncomfortable within the mainstream society. However, in the focus groups, most individuals expressed being uncomfortable when they were out in public around mostly non-Native individuals. Survey responses were in closer agreement with focus group discussions regarding perceived discrimination. Many focus group participants readily gave examples of stereotypes and discrimination they experienced from

non-Natives. In particular, many individuals reported they were disturbed by frequent profiling by police. It is interesting to consider how such interactions may represent a new face of HT as the scale asks how often respondents think about "the loss of self-respect from poor treatment by government officials."

According to ASR results of mental health symptoms, AI participants had significantly higher rates of thought problems than matched controls. However, after conducting specific item analyses, it has become clear that many of these responses likely reflect cultural practices and values. For example, visual or auditory experiences unique to an individual are often thought to be hallucinations in the mainstream society, whereas these are often interpreted as visions in many AI communities. Some focus group participants cited the rejection of supernatural experiences by non-Natives as one reason they prefer to associate primarily with other AIs.

Participants also had higher rates of aggressive behavior and antisocial personality symptoms than matched controls. While this may be surprising for individuals of more privileged backgrounds, confrontations can be an unfortunate reality for many individuals of all ethnicities living in more challenging conditions (Chong, Lee, & Victorino, 2015).

Although the sample had relatively low rates of drug and alcohol use, these problems were frequently reported in the focus groups. In part, this may reflect sample selection bias. Individuals struggling with drug and alcohol problems may have been less likely to participate in the study. The common experiences of depression and anxiety discussed in the focus groups were not found in the ASEBA results, possibly also due to selection bias.

Participants had rates of most *mental health problems* that were no higher than matched controls, but rates of multiple morbidity were significantly higher in participants. Almost 30% of AIs in the sample met the clinical threshold for three or more problem areas. These results indicate that while the majority of individuals may have few psychological symptoms, the individuals who do have symptoms suffer more significantly from multiple conditions.

As with all research, this study had a number of strengths and limitations. The community-based participatory approach was essential to the success of this study. The study addressed HT and mental health, which have been long-standing priorities of the community. The PI was able to recruit a significant number of individuals at community events. However, all data collection was completed by the research assistants who were well-known community members. Lastly, we helped ensure accurate interpretation of the results by holding a community dinner where we reviewed the findings of the study and elicited feedback, which has been included in the discussion.

One strength of this study is that community members recruited participants and collected the data. This allowed for the participation of individuals who may not have trusted outside individuals. However, in contrast to reservation settings, urban AIs have no registries. The convenience sample may have biased the results toward the null hypothesis as individuals suffering from more severe mental health problems may have been less likely to enroll in the study. We did not track refusal rates from individuals approached by research assistants. Our recruitment strategies did not allow for estimating refusal rates. For example, announcements were made at events such as powwows, and people who were interested came to sign up. The lack of younger individuals in the normative data set resulted in a significant age difference between the AI group and controls. However, it is unlikely that a mean age difference of less than 5 years had a significant impact on the rates of mental health symptoms in the respective groups. The survey participants and the focus group participants were recruited from the same population, but we did not collect demographics from the focus group participants. As a result, it is impossible to know if demographic differences accounted for some of the differences in findings between the survey responses and the focus group discussions.

Lastly, the relatively lower number of male participants did not result in a level of power likely sufficient to detect a significant difference between the sexes. However, the lack of even a trending difference makes it very unlikely that a difference existed regarding ethnic experience. The average difference between the sexes on these four subscales was less than 0.08 units on a 5-point scale. In addition, the percentage of participants reporting each frequency of historical loss thoughts and associated symptoms differed between males and females by only 5%.

Conclusion

We conclude that our findings increase the understanding of HT, ethnic experience, and mental health symptoms in an urban population of adult AIs. The importance of involving urban AIs in research is growing because the majority of AIs are now living off of reservations. Between 2000 and 2010, the proportion of AIs living outside tribal areas increased from 61.4% to 78% (U.S. Census Bureau, 2006, 2012). Our findings support those of Wiechelt et al. (2012) that HT may be greater in urban AI populations compared with those living on reservations.

Our native population suffers from many of the greatest psychiatric disparities. We cannot rightfully believe that we are succeeding in improving the mental health of this country if we do not work with AI communities to understand their unique mental health needs and assist in their recovery from the centuries of horrific events they have experienced.

Appendix

Focus Group Questions

1. Historical trauma: How do you see historical trauma affecting individuals in this city?
2. What specific cultural losses have the greatest impact? How?
3. Ethnic identity: Describe the ways in which AIs identify themselves in this city.
4. Discrimination: What forms of discrimination have you experienced or heard of other AIs experiencing here in this city? Is this a common experience?
5. Mainstream comfort: How comfortable the AIs of this city feel within the mainstream culture of the area?
6. Social affiliation: Do people here associate more with AIs or non-Indians?
7. PTSD: Do you see PTSD as being a significant problems in the community?
8. Anxiety: Do many members of the community suffer from anxiety?
9. Depression: How much does depression affect community members?
10. Alcohol abuse: Can you describe the impact of alcohol abuse on the community?
11. Drug abuse: How does drug abuse affect community members?
12. Closing: How might traditional practices support the mental health of community members?

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Author Roles

Nicholas Guenzel—secured funding, designed study, obtained IRB approval, directed study, major responsibility for writing and revising the manuscript.
Leeza Struwe—designed, created, and completed the statistical analysis; provided initial data interpretation and assisted with writing the quantitative results portion. Both authors read and approved the final version of the manuscript.

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References

Achenbach, T. M. (2009). *Achenbach system of empirically based assessment (ASEBA): Development, findings, theory, and applications*. Burlington: University of Vermont, Research Center of Children, Youth & Families.

Achenbach, T. M., & Rescorla, L. A. (2003). *Manual for the ASEBA adult forms & profiles*. Burlington: University of Vermont, Research Center for Children, Youth, & Families.

Bassett, D., Buchwald, D., & Manson, S. (2014). Posttraumatic stress disorder and symptoms among American Indians and Alaska natives: A review of the literature. *Social Psychiatry and Psychiatric Epidemiology*, *49*, 417-433.

Bombay, A., Matheson, K., & Anisman, H. (2011). The impact of stressors on second generation Indian residential school survivors. *Transcultural Psychiatry*, *48*, 367-391.

Brave Heart, M. (1999). Gender differences in the historical trauma response among the Lakota. *Journal of Health & Social Policy*, *10*(4), 1-21.

Brave Heart, M., Chase, J., Elkins, J., & Altschul, D. B. (2011). Historical trauma among indigenous peoples of the Americas: Concepts, research, and clinical considerations. *Journal of Psychoactive Drugs*, *43*, 282-290.

Brave Heart, M., & DeBruyn, L. M. (1998). The American Indian holocaust: Healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research*, *8*(2), 60-82.

Centers for Disease Control and Prevention. (2013). *Web-based injury statistics query and reporting system (WISQARS)*. Retrieved from http://www.cdc.gov/injury/wisqars/index.html

Chong, V. E., Lee, W. S., & Victorino, G. P. (2015). Neighborhood socioeconomic status is associated with violent reinjury. *Journal of Surgical Research*, *199*, 177-182.

Creswell, J. W., & Plano Clark, V. L. (2007). *Designing and conducting mixed methods research*. Thousand Oaks, CA: Sage.

Duran, B., Sanders, M., Skipper, B., Waitzkin, H., Malcoe, L. H., Paine, S., & Yager, J. (2004). Prevalence and correlates of mental disorders among American Indian women in primary care. *American Journal of Public Health*, *94*, 71-77.

Ehlers, C. L., Gizer, I. R., Gilder, D. A., Ellingson, J. M., & Yehuda, R. (2013). Measuring historical trauma in an American Indian community sample: Contributions of substance dependence, affective disorder, conduct disorder and PTSD. *Drug and Alcohol Dependence*, *133*, 180-187.

Evans-Campbell, T. (2008). Historical trauma in American Indian/Native Alaska communities: A multilevel framework for exploring impacts on individuals, families, and communities. *Journal of Interpersonal Violence*, *23*, 316-338.

Glaser, B. (2002). Conceptualization: On theory and theorizing using grounded theory. *International Journal of Qualitative Methods*, *1*(2), 23-38.

Gone, J. P., & Trimble, J. E. (2012). American Indian and Alaska Native mental health: Diverse perspectives on enduring disparities. *Annual Review of Clinical Psychology*, *8*, 131-160.

Heckert, W., & Eisenhauer, C. (2014). A case report of historical trauma among American Indians on a rural northern plains reservation. *Journal of Forensic Nursing*, *10*, 106-109.

Hutchinson, R. N., & Shin, S. (2014). Systematic review of health disparities for cardiovascular diseases and associated factors among American Indian and Alaska Native populations. *PLoS One*, *9*(1), 1-9.

IBM. (2017). IBM SPSS statistics for Windows (Version 25.0) [Computer software]. Armonk, NY: Author.

Kong, J., Roh, S., Easton, S. D., Lee, Y. S., & Lawler, M. J. (2016). A history of childhood maltreatment and intimate partner violence victimization among Native American adults. *Journal of Interpersonal Violence*, *2*, 1-23.

Lemstra, M., Rogers, M., Thompson, A., Moraros, J., & Buckingham, R. (2012). Risk indicators associated with injection drug use in the aboriginal population. *AIDS Care*, *24*, 1416-1424.

Malcarne, V. L., Chavira, D. A., Fernandez, S., & Liu, P. J. (2006). The scale of ethnic experience: Development and psychometric properties. *Journal of Personality Assessment*, *86*, 150-161.

Mohatt, N. V., Thompson, A. B., Thai, N. D., & Tebes, J. K. (2014). Historical trauma as public narrative: A conceptual review of how history impacts present-day health. *Social Science & Medicine*, *106*, 128-136.

Norris, T., Vines, P. L., & Hoeffel, E. M. (2012). *The American Indian and Alaska Native population: 2010*. Washington, DC: U.S. Census Bureau.

Pokhrel, P., & Herzog, T. A. (2014). Historical trauma and substance use among Native Hawaiian college students. *American Journal of Health Behavior*, *38*, 420-429.

Ritchie, J., Lewis, J., Nicholls, C. M., & Ormston, R. (Eds.). (2013). *Qualitative research practice: A guide for social science students and researchers*. London, England: Sage.

Substance Abuse and Mental Health Services Administration. (2014). *Results from the 2013 National Survey on Drug Use and Health: Summary of national findings* (NSDUH Series H-48, HHS Publication No. (SMA) 14-48). Rockville, MD: Author.

Tucker, R. P., Wingate, L. R., & O'Keefe, V. M. (2016). Historical loss thinking and symptoms of depression are influenced by ethnic experience in American Indian college students. *Cultural Diversity and Ethnic Minority Psychology*, *22*(3), 350.

U.S. Census Bureau. (2006). *The American Indian and Alaska Native Population: 2010*. Retrieved from https://census.gov/history/pdf/c2010br-10.pdf

U.S. Census Bureau. (2012). *We the people: American Indians and Alaska Natives in the United States*. Retrieved from https://census.gov/prod/2006pubs/censr-28.pdf

Urban Indian Health Institute, Seattle Indian Health Board. (2012). *Addressing depression among American Indians and Alaska Natives: A literature review*. Seattle, WA: Author.

Van Ijzendoorn, M. H., Bakermans-Kranenburg, M. J., & Sagi-Schwartz, A. (2003). Are children of holocaust survivors less well-adapted? A meta-analytic investigation of secondary traumatization. *Journal of Traumatic Stress*, *16*, 459-469.

Wallerstein, N. B., & Duran, B. (2006). Using community-based participatory research to address health disparities. *Health Promotion Practice*, *7*, 312-323.

Whitbeck, L. B., Adams, G. W., Hoyt, D. R., & Chen, X. (2004). Conceptualizing and measuring historical trauma among American Indian people. *American Journal of Community Psychology*, *33*, 119-130.

Whitbeck, L. B., Chen, X., Hoyt, D. R., & Adams, G. W. (2004). Discrimination, historical loss and enculturation: Culturally specific risk and resiliency factors for alcohol abuse among American Indians. *Journal of Studies on Alcohol*, *65*, 409-418.

Whitbeck, L. B., Walls, M. L., Johnson, K. D., Morrisseau, A. D., & McDougall, C. M. (2009). Depressed affect and historical loss among North American indigenous adolescents. *American Indian and Alaska Native Mental Health Research*, *16*(3), 16-41.

Wiechelt, S. A., Gryczynski, J., Johnson, J. L., & Caldwell, D. (2012). Historical trauma among urban American Indians: Impact on substance abuse and family cohesion. *Journal of Loss and Trauma*, *17*, 319-336.

Continuing Education

Disclosures: The authors and planners have no conflict of interest to disclose. Off-label medication use will not be discussed.

Target Audience: Registered nurses and advance practice registered nurses

Learning Outcomes:
Upon completion of this article, the participant will be able to:
1. Identify the most common historical loss thoughts among urban American Indians.
2. Describe the most common historical loss associated symptoms among urban American Indians.
3. Explain the four aspects of ethnic experience among urban American Indians discussed in this article.

Cost: There is no fee for continuing education credit.

Contact Hours: 1 CE The ability to earn contact hours for this article expires April 30, 2022.

Continuing Education Information: *In order to receive contact hours, you must* read the entire article, complete an evaluation, and earn a passing score on the post-test. You will have 5 tries to correctly answer the questions on the post-test and a score of 80% is required to pass. You will be able to print or email a CE certificate once all steps are completed. Go to www.apna.org/JAPNACEApril2020 to access the post-test, evaluation and certificate.

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