

HISTORICAL TRAUMA AND THE HEALTH AND WELLBEING OF COMMUNITIES OF COLOR

By: Dr. Michele Andrasik, HVTN Core, Seattle, WA, USA

Historical Trauma

Historical trauma is an event, or a set of events, that happen to a group of people who share a specific identity. That identity could be based in nationality, tribal affiliation, ethnicity, race and/or religious affiliation. The events are often done with genocidal or ethnocidal intent, and result in annihilation or disruption of traditional ways of life, culture and/or identity. Each individual event is profoundly traumatic and when you look at events as a whole, they represent a history of sustained cultural disruption and community destruction.



Picking cotton on Alexander plantation. Pulaski County, ArkansasLibrary of Congress, Prints & Photographs Division, FSA/OWI Collection, LC-DIG-fsa-8a17057

Slavery in the US spanned from 1619-1865. It is estimated that 6 to 7 millions of Africans were imported to the US during the 18th century alone. The status of slave became a caste associated with African ancestry. The rapid expansion of the cotton industry in the late 1700s and early 1800s made Southern Sates dependent on slavery for their economy. Slaves were

generally denied the opportunity to learn to read or write and were prohibited from associating in groups (with the exception (in some cases) of religious meetings). Murder of slaves was allowable if the slave was “resisting” or if done “under moderate correction”. Rape and sexual abuse of enslaved women were common. (<https://www.history.com/topics/black-history/slavery>).

In the United States, African Americans, Native Americans, and Alaska Natives have endured a history of multiple traumas. From the time the first colonists came to shore on what would come to be known as the United States, Native Americans and Alaska Natives have been subjected to:

- colonization;
- epidemic diseases brought from Europe;
- the tradition of extermination and mass homicide;
- forced marches and displacement from their lands;
- peace treaties often signed under coercion and later broken;
- Indian Boarding schools in response to the “Kill the Indian, Save the Man” policy;
- widespread sexual and physical abuse of children; and
- rates of violence and victimization higher than any other racial group.

African Americans have endured the legacy of:

- being stolen from their native lands;
- enslaved from 1619-1865;
- systematically abused and denied education;
- forced “breeding”;
- widespread sexual assault and rape of Black women;
- the abolition of slavery gave way to indentured servitude;
- Jim Crow laws;
- mass lynching;
- mass incarceration; and
- homicide rates higher than any other racial group.

The Tulalip Indian School opening on Jan. 23, 1905, and during the next two years it held enrollment of 200 students. From 1879 through around 1935 Native American families were forced to send their children to boarding schools under the “Kill the Indian, Save the Man” policy. Attendance was mandatory or parents were imprisoned. More than 100,000 Native children were forced to attend the schools, which were modeled on a school developed in prison. Sexual, physical and emotional abuse was rampant in boarding schools. The FBI found one teacher (John Boone) had sexually abused at least 142 boys in a school where the principal never investigated the allegations (American Indian Boarding Schools: An Exploration of Global Ethnic & Cultural Cleansing, accessed at <http://www.sagchip.org/ziibiwing/planyourvisit/pdf/aibscurrguide.pdf>).



Children in front of girls' dormitory building, Tulalip Indian School, ca. 1912 28.MOHA1, Ferdinand Brady Photographic Postcards, 1988.11.13

Research exploring historical trauma looks at how the trauma of these events is “embodied” or held personally and passed down over generations, such that even family members who have not directly experienced the trauma can feel the effects of the events generations later [Walters et al., 2011]. Individual trauma then becomes collective, as it affects a significant

portion of the community and becomes compounded. Multiple historically traumatic events occur over generations and join an overarching legacy of assaults. The impact of these ongoing traumas has effects on a person’s brain and body, increasing their vulnerability to Post-Traumatic Stress Disorder (PTSD) and other mental health disorders [Walters et al, 2011; Yehuda et al, 1998]. This higher stress vulnerability may impair a person’s ability to cope effectively with current stressors as they arise.

From 1941-1945, Jewish people were systematically murdered in a genocide in Europe by the Nazi regime. Approximately 6 million Jewish people were killed during WWII (and an additional 5-million non-Jewish victims). Initially the German government passed laws to exclude Jewish people from civil society. Beginning in 1939, Jewish people were required to wear a distinctive sign to “mark them as Jews”, either a badge (yellow star of David) or armband (white with blue star of David). By the end of 1942, victims were regularly transported by freight train to extermination camps (United States Holocaust Museum, Learn about the Holocaust, <https://www.ushmm.org/learn>).



Child survivors of Auschwitz, wearing adult-size prisoner jackets, stand behind a barbed wire fence. United States Holocaust Memorial Museum, courtesy of Belarusian State Archive of Documentary Film and Photography

Transmission of trauma across generations was first seen in 1966 by clinicians who were alarmed by the number of children of people who had survived the Nazi Holocaust who were seeking mental health treatment [Trossman, 1968]. The trauma experienced by the Jewish people in the Holocaust was being seen in poor mental and physical health outcomes in their descendant generations. The children of Holocaust survivors were presenting with symptoms of PTSD, survivor guilt, anxiety, anger, grief, symptoms of depression, impaired self-esteem, a preoccupation with death, impaired communication, substance abuse, and exaggerated personal attachments or interdependence [Kellerman, 1999; Yehuda et al, 1998]. Not only does historical trauma influence psychological functioning at the individual level, it also affects family level communication and can appear in stress around parenting [Kellerman, 2001; Last & Klein, 1984]. An important point is that the children of Holocaust survivors were NOT more likely than others to have poor mental health. They may have been vulnerable to higher stress, so that when they experienced high levels of stress in their lives, they were more likely to exhibit PTSD or related symptoms than others [Kellerman, 2000].

1942 – President Roosevelt issues an executive order allowing the military to remove Japanese Americans from the entire U.S. West Coast (California, Oregon, Washington and Arizona). 110,000 – 120,000 Japanese Americans were forcibly relocated and incarcerated in eight U.S. Department of Justice Camps (in Texas, Idaho, North Dakota, New Mexico, and Montana). Living conditions were crowded and often did not include plumbing or cooking facilities. December 1944 Supreme Court rules that “while removal of Japanese Americans from the West Coast was constitutional loyal citizens of the US, regardless of cultural descent, could not be detained without cause.” The order was not rescinded until January 2, 1945 (postponed until after the 1944 presidential election to avoid any negative impact on Roosevelt’s reelection campaign) (Virtual Museum of the city of San Francisco, Internment of San Francisco Japanese, <http://www.sfmuseum.net/war/evactxt.html>).



Los Angeles, California. The evacuation of the Japanese-Americans from West Coast areas under U.S. Army war emergency order. Japanese-Americans waiting for a train to take them and their parents to Owens Valley. Library of Congress, Prints & Photographs Division, FSA/OWI Collection, LC-DIG-fsa-8a31160

Since these early studies with the children of Holocaust survivors, scientists have also been gathering evidence showing that historical trauma has an impact at the cellular level. This body of evidence shows the neurological toll of stress on the health of descendant generations. Powerful stressful environmental conditions can leave an imprint or “mark” on the epigenome (cellular material) that can be carried into future generations with devastating consequences [Serpeloni et al, 2017, Ryan et al, 2017]. In studies of pregnant women, we see that psychological and nutritional stress in the mother during pregnancy can lead to

biological changes that predispose their children to diabetes, heart disease, high blood pressure, and PTSD as adults. In a study of pregnant women who experienced the stress of the World Trade Center attacks on September 11, 2001, data suggest that effects of maternal PTSD on cortisol (a hormone released in response to stress) can be observed very early in the life of their children. This highlights the importance of effects during pregnancy as factors that contribute to biological risk for PTSD [Yehuda et al, 2005]. In these mothers, the correlation between maternal PTSD and cortisol levels in their infants was remarkably similar to that reported between parental PTSD and cortisol levels in adult children of Holocaust survivors [Yehuda et al, 2002]. Knowing how the human body holds onto this stress reminds us that we cannot ignore the social, historical or cumulative experiences of stress and their impact on wellness. There is growing evidence that biological and psychological expressions of historical trauma may be partly responsible for producing health disparities in a wide spectrum of health outcomes from diabetes to PTSD.

Microaggressions

Stress vulnerability may be especially challenging for racial and ethnic groups who deal with stress daily. Non-White people in the United States often deal with the continuous threat of discrimination and distress due to continuous microaggressions. Microaggressions are the chronic and commonplace verbal, behavioral or environmental indignities and injustices, intentional and unintentional, that communicate hostile, derogatory, demeaning, invalidating, and/or negative (racial, ethnic, homophobic, etc.) slights and insults toward people (of color, homosexual individuals, etc.) [Sue, 2007]. These verbal and non-verbal encounters most often place the burden of addressing them on the recipient of the encounter, creating stress! There are three types of microaggressions – microassaults, microinsults and microinvalidations. Microassaults are characterized by explicit racial derogatory verbal or nonverbal attacks or purposeful discriminatory action. With microassaults the intention is clear and they are most likely to be deliberate (for example, deliberately serving a White patron before a Black patron, displaying a swastika, saying that being gay is a sin, making fun of people with disabilities). Microinsults are behaviors that convey rudeness, insensitivity, reflect unfair treatment, or demean identity or heritage. These are often subtle snubs that the perpetrator may not realize they are doing (for example, when a White teacher fails to call on students of color in the classroom). Microinvalidations are communications that nullify, exclude, or negate the experiences, identity, thoughts and feelings of a person (for example, when Blacks are told that “I don’t see color” or “We are all human beings,” or when gay adolescents are told, “You are just going through a phase.”)

Microaggressions are the chronic and commonplace verbal, behavioral or environmental indignities and injustices, intentional and unintentional, that communicate hostile, derogatory, demeaning, invalidating, and/or negative (racial, ethnic, homophobic, etc.) slights and insults toward people (of color, homosexual individuals, etc.) [Sue, 2007].

There is a great deal of power in microaggressions. Most people see themselves as good, moral and decent, and find it difficult to believe that they have biased attitudes, and that they might engage in discriminatory behaviors. As a result, microaggressions are usually ignored, denied or explained away by seemingly unbiased and valid reasons. Indeed, when other explanations seem reasonable, microaggressions are very difficult to name and identify. This lack of awareness and sensitivity leads to an inability to accept responsibility for behaviors and for changing them. In contrast, 96% of African Americans reported experiencing racial discrimination in a one-year period, including being mistaken for a service worker, being ignored, receiving poor service, being treated rudely, or experiencing strangers who act fearful or intimidated when around them [Sellars & Shelton, 2003]. Experiences of microaggressions have been associated with anger, mistrust, loss of self-esteem, the triggering of old wounds, thinking about and replaying the event (“Did that really happen?”),

and triggering feelings of internalized colonization, racism and homophobia, stress, self-doubt, frustration, isolation and shame [Solorzano et al, 2000].

Individually, each encounter creates a great deal of stress. Collectively they result in a tremendous amount of trauma for the individual and the community. Again, this may have a greater impact on racial minorities who have a high stress vulnerability resulting from the historical trauma experienced by their communities.

Trauma and Trauma-Informed Care

“Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being” [U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), 2013]. Trauma occurs throughout a person’s lifetime and is often experienced first in early childhood (or even before birth, during pregnancy, as described above) and there may be subsequent re-traumatizing experiences. Each person experiences trauma differently. Some may have few or no lingering symptoms. People who experience repeated, chronic or multiple traumas, including historical trauma, are more likely to have more pronounced symptoms and consequences including:

- substance abuse and dependence;
- depression symptoms and disorders;
- anxiety symptoms and disorders;
- impairment in relational/social and other major life areas (including treatment);
- increased risk for mental illness and increases in symptom severity;
- sleep disorders; and
- many health problems, physical disorders and conditions.

In our work, we frequently encounter individuals from marginalized communities, and it is important that we recognize and respond to the effects of historical trauma. They may not even be aware of how this history impacts them! Not only is historical trauma associated with increased stress vulnerability and trauma symptoms, the experience of trauma is a significant risk factor for sexually transmitted infections, depression, alcohol abuse, intravenous drug use, intimate partner violence and attempted suicide [CDC, 2014]. It is crucial that we practice trauma-informed care. SAMHSA (2012) states that, “A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for healing; recognizes the signs and symptoms of trauma in staff, clients, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, practices, and settings.”

It is really important that we assess how our existing spaces, such as our clinical trial sites, may cause distress [Kamen et al, 2012]. This requires examining the power dynamics of relationships, the impact of a loss or lack of privacy during questioning and/or procedures, and the potential experience of loss when there are changes in staff with little or no notice. Invasive procedures, the removal of clothing, vulnerable physical positions, the gender of a provider, and being asked personal questions by someone who is a stranger may be experienced as traumatizing or re-traumatizing. To reduce the potential negative impact of these factors, we can improve and enhance the things we do to ensure a favorable participant experience by infusing trauma-informed care into our efforts.

A trauma-informed approach builds on understanding the effects of violence and abuse on a person's life and development [Machtinger et al, 2015; SAMHSA]. It is rooted in a strength-based empowerment model, which fosters growth, and recognizes and promotes strength and resiliency. It is important to be aware of the fact that behaviors have traditionally been viewed through a pathological lens. This means thinking a person is at fault for their reactions or that there is something wrong with them, leading to labelling people as problematic or difficult. In reality, they may just be unsuccessful at coping with a situation that may (or may not) have the outcome that an individual wanted.

To get started on a path toward trauma-informed care, it is important that every member of the clinic team participate in training to learn about the impact of trauma on the health and wellbeing of providers, staff and participants. Training will help clinic staff develop skills to communicate more effectively with participants and with each other. As the clinic team continues down its path to trauma-informed care it will be important to identify clinic champions who will sustain trauma-informed care approaches over time. These individuals would identify and develop partnerships with local trauma and service organizations, and work collaboratively to develop procedures for providing referrals and responding to a participant's needs [Elliot et al, 2005].

The key steps to a trauma-informed approach are:

1. Create a safe environment.
2. Prevent practices that re-traumatize people who have histories of trauma and are engaging in clinical trial research.
3. Build on the strengths and resilience of the individual in the context of their environments and communities.
4. Endorse trauma-informed principles in the clinic through support, consultation and supervision of staff.
5. Recognize that trauma-related symptoms and behaviors originate from adapting to traumatic experiences.
6. Create collaborative relationships and participation opportunities.
7. Use a strengths-focused perspective: promote resilience.

In our communities, there are many people who not only carry the burden of historical trauma, but must also navigate a disproportionate amount of daily stressors. To improve the health of our collective community, we must strive to make every effort to understand how human beings take in and hold onto trauma and stress so that we can avoid traumatizing and re-traumatizing one another.

References

1. Trossman B. Adolescent children of concentration camp survivors. *Can Psychiatr Assoc J.* 13:121-123. 1968.
2. Blair IV, Judd CM, Chapleau KM. The influence of Afrocentric facial features in criminal sentencing. *Psychol Sci.* 15(10):674-679. 2004
3. Brand SR, Brennan PA, Newport DJ, Smith AK, Weiss T, & Stowe ZN. The Impact of Maternal Childhood Abuse on Maternal and Infant HPA Axis Function in the Postpartum Period. *Psychoneuroendocrinology.* 35(5): 686-693. 2010
4. Evans-Campbell T. Historical Trauma in American Indian/Native Alaska Communities: A Multilevel Framework for Exploring Impacts on Individuals, Families, and Communities. *Journal of Interpersonal Violence.* 23(3): 316-338. 2008
5. Kaati G., Bygren LO, and Edvinsson S. Cardiovascular and Diabetes Mortality Determined by Nutrition During Parents' and Grandparents' Slow Growth Period. *European Journal of Human Genetics.* 10(11): 682-688. 2002
6. Kellermann NPF. Bibliography: Children of Holocaust survivors. AMCHA, the National Israeli Centre for Psychosocial Support of Holocaust Survivors and the Second Generation, Jerusalem. 1999
7. Yehuda R, Schmeidler J, Wainberg M. Binder-Brynes K, Duvdevani T. Vulnerability to Posttraumatic Stress Disorder in Adult Offspring of Holocaust Survivors. *Am J Psychiatry.* 155:1163-1171. 1998
8. Kellermann NPF. Perceived parental rearing behavior in children of Holocaust survivors. *Isr J Psychiatry relat Sci.* 38(1):58-68. 2001

9. Kellermann NPF. Transmission of Holocaust Trauma. National Israeli Center for Psychosocial Support of Survivors of the Holocaust & the Second Generations. Accessed 3/2/18 at <http://www.yadvashem.org/yv/en/education/languages/dutch/pdf/kellermann.pdf>
10. Last U & Klein H. Impact of parental holocaust traumatization on offsprings' reports of parental child-rearing practices. *J Youth Adolesc.* 13(4):267-83. 1984
11. Kuzawa CW & Sweet E. Epigenetics and the Embodiment of Race: Developmental Origins of US Racial Disparities In Cardiovascular Health. *American Journal of Human Biology.* 21(1): 2–15. 2009
12. Plant EA, Peruche BM. The consequences of race for police officers' responses to criminal suspects. *Psychol Sci.* 16(3):180-3. 2005
13. Sellers RM, Shelton JN. The role of racial identity in perceived racial discrimination. *J. Pers Soc Psychol.* 84(5):1079-92. 2003
14. Solorzano, D., Ceja, M., & Yosso, T. Critical Race Theory, Racial Microaggressions, and Campus Racial Climate: The Experiences of African American College Students. *Journal of Negro Education.* 69(1/2), 60. 2000
15. Substance Abuse and Mental Health Services Administration. Trauma-informed care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57. HHS Publication NO. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857
16. Sue DW, Capodilupo CM, Torino GC, Bucceri JM, Holder AMB, Nadal KL, Esquilin M. Racial Microaggressions in Everyday Life: Implications for Clinical Practice. *American Psychologist.* 62(4):271-286. 2007.
17. Sue DW. Whiteness and ethnocentric monoculturalism: making the "invisible" visible. *American Psychologist.* 59(8):761-769. 2004
18. Walters KL, Mohammed SA, Evans-Campbell T. Beltran RE, Chae DH, & Duran B. Bodies don't just tell stories, they tell histories. *Du Bois Review.* 8(1): 179-189. 2011
19. Whitbeck LB, Adams GW, Hoyt DR, & Chen X. Conceptualizing and Measuring Historical Trauma among American Indian People. *American Journal of Community Psychology.* 33(3-4): 119–130. 2004
20. Serpeloni F, Radtke K, de Assis SG, Henning F, Natt D, Elbert T. Grandmaternal stress during pregnancy and DNA methylation of the third generation: an epigenome-wide association study. *Transl Psychiatry.* 7(8):e1202. 2017.
21. Ryan J, Mansell T, Fransquet P, Saffery R. Does maternal mental well-being in pregnancy impact the early human epigenome? *Epigenomics.* 9(3):313-332. 2017
22. Yehuda R, Engel SM, Brand SR, Seckl J, Marcus SM, & Berkowitz GS. Transgenerational Effects of Posttraumatic Stress Disorder in Babies of Mothers Exposed to the World Trade Center Attacks during Pregnancy. *Journal of Clinical Endocrinology & Metabolism.* 90(7): 4115–4118. 2005
23. Yehuda R, Halligan SL, Bierer LM. Cortisol levels in adult offspring of Holocaust survivors: relation to PTSD symptom severity in the parent and child. *Psychoneuroendocrinology.* 27:171–180. 2002
24. Machtinger EL, Cuca YP, Khanna N, Rose CD, Kimberg LS. From Treatment to Healing: The Promise of Trauma-Informed Primary Care. *Women's Health Issues.* 25(3):193-197 2015
25. Elliot DE, Bjelajac P, Fallot RD, Markoff LS, Reed BG. Trauma-Informed or Trauma-Denied: Principles and Implementation of Trauma-Informed Services for Women. *J Comm Psychol.* 33(4):461-477. 2005
26. Centers for Disease Control and Prevention Division of Violence Prevention. Adverse Childhood Experiences Study. 2014. Accessed 3/15/18 at: <https://www.cdc.gov/violenceprevention/acesstudy/>
27. Library of Congress, Prints & Photographs Division, FSA/OWI Collection, LC-DIG-fsa-8a17057
28. MOHAI, Ferdinand Brady Photographic Postcards, 1988.11.13."
29. United States Holocaust Memorial Museum, courtesy of Belarusian State Archive of Documentary Film and Photography
30. Library of Congress, Prints & Photographs Division, FSA/OWI Collection, LC-DIG-fsa-8a31160

* Dr. Michele Andrasik is the Director of Social and Behavioral Science and Community Engagement for the HVTN.