



Title: Transition Management in an era where many individuals are living with the impact of Social Determinants of Health, Historical Trauma and Unresolved Grief.

ADDENDUM for the Care Coordination and Transition Management (CCTM) Core Curriculum text 2nd edition to update content on Transition Management with consideration of Historical Trauma and Unresolved Grief.

Sheila A. Haas, PhD, RN, FAAN, Ann Solari-Twadell, RN, PhD, MPA, FAAN, Loyola University Chicago Niehoff School of Nursing

Janel Barajas, RN, BSN, faculty at Oglala Lakota Community College Nursing Program, Pine Ridge, South Dakota.

When we were doing research and developing the dimensions of care coordination and transition management for the Care Coordination and Transition Management Core Curriculum text, transition management was defined and limited to assisting patients and families to navigate within health care organizations and settings to consult with physicians, nurse practitioners, physical therapists, and other professionals such as dietitians and, mental health specialists.

Transition Management has become a major component of nursing care, knowledge, and skills. Transition Management is also far more complex than projected as we are coming to understand the impact of Social Determinants of health (SDH) historical trauma, intergenerational, transgenerational trauma, and unresolved grief on individuals, families, communities. SDH are defined as “the non-medical factors that influence health outcomes. They are conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life. These forces include economic policies and systems, development agendas, social norms, social policies and political systems (WHO, 2022). Historical trauma can be a byproduct of SDOH. Dr. Maria Yellow Horse Braveheart, PhD, conceptualized historical trauma in the 1980's and describes historical trauma as “the cumulative emotional and psychological wounding over one’s lifetime and from generation to generation following loss of lives, land and vital aspects of culture.” (Brave Heart & DeBruyn, 1998). Other definitions for Historical Trauma include “Cumulative emotional and psychological wounding that is

transmitted from one generation to the next” (Dass-Brailsford, 2007, Rakoff et al., 1966). Sangalang and Vang, (2017), as well as Bombay and his colleagues (2009) define Intergenerational or transgenerational trauma as “trauma experienced in one generation that affects the health and wellbeing in subsequent generations.” Over time their have been several cultural groups including American Indians, African American and Hispanic people to name a few that have been affected by this phenomena.

Brave Heart and DeBruyn (1998) in the text *The American Indian Holocaust: Healing Historical Unresolved Grief* describe the concept of historical unresolved grief and historical trauma among Indigenous people outlining the historical as well as present social and political forces which exacerbate this unresolved grief. Today, however, historical trauma is experienced by not only Jewish Holocaust survivors and their children, but by many immigrant populations such as African Americans, Hispanics, Ukrainians to name a few.

Some affected populations have experienced massive losses of lives, land, and culture from European contact and colonization resulting in a long legacy of chronic trauma and unresolved grief across generations. This phenomenon, labeled historical unresolved grief, contributes to poor SDH and pathologies including high rates of suicide, homicide, domestic violence, child abuse, alcoholism, and other social problems among Indigenous people (Brave Heart& DeBruyn, 1998).

Through a HRSA (Health Resources and Services Administration) funded Primary Care Workforce Grant, (Solari-Twadell, P.A. July 1, 2018 – June 30, 2022), Asynchronous E Learning educational modules were developed on primary care nursing of underserved populations. One module in this series is focused on historical trauma focused particularly on Indigenous People. (Barajas, J., Zurek, S., & Solari-Twadell, P.A. 2020). The link to this module is: (<https://loyolanpath.com/historical-trauma-in-the-native-indian-population/>).

Nurses as health professionals need to assess patients SDH and identify the impact of historical trauma on health, including mental health, level of wellness, family relationships and lifestyles including problems such as substance abuse. There also must be an understanding on the part of the provider that historical trauma will, in most cases, interfere with the trust between the patient and provider. This lack of trust will require consistency in provider and patience in achieving a level of trust with the patient where the patient will feel comfortable being truthful regarding their health issues and behaviors.

The incidence and impact of SDH and historical trauma impacts large numbers of individuals today. We have persons and families from Mexico, Central America, Ukraine, Afghanistan, Haiti, and other countries where people have been and continue to be victims of persecution, violence, starvation, and other trauma. The issues of SDH and loss of homeland, home, family members, community, and separation of children from parents for extended periods as well as challenges and failures with reuniting children with their parents as parents seek asylum in countries such as the USA will have profound effects on many over time. These traumatic events remain within all who have had such experiences and are shared from generation to generation. Children whose parents are victims of Historical Trauma are subsequently traumatized also.

Consequently, nurses especially those providing Primary Care for patients and families need to understand SDH along with historical trauma and its impact on health and wellbeing as well as methods to support to persons who are suffering and turning to addictive and self-destructive behaviors as part of their coping.

Brave Heart, (1998, 1999, 2000) defines historical trauma response (HTR) as a constellation of features in reaction to massive group trauma. This response is observed among Lakota and other Native populations, Jewish Holocaust survivors as well as Japanese American internment camp survivors, African Americans, Hispanics and their descendants.

Brave Heart goes on to list historical trauma Response Features: “Survivor guilt, depression, sometimes PTSD symptoms, psychic numbing, fixation to trauma, somatic symptoms, low self-esteem, victim Identity, anger, self-destructive behavior including substance abuse, suicidal ideation, hypervigilance, intense fear, dissociation, compensatory fantasies, poor affect (emotion) tolerance, death identity – fantasies of reunification with the deceased, loyalty to ancestral suffering and the deceased, preoccupation with trauma, with death, dreams of massacres” (American Indian and Alaska Native Mental Health Research, 1998).

Dr. Brave Heart’s work was focused on finding ways to help persons heal from the historical unresolved grief that many indigenous individuals and communities are struggling with. Understanding the experiences of a community is important towards beginning the healing process. Genocide, imprisonment, forced assimilation, and misguided governance has resulted in loss of culture and identity, alcoholism, poverty, and despair. Dr. Brave Heart offered the historical trauma intervention model, which includes four major community intervention components: “First is confronting the

historical trauma, second is understanding the trauma, third is releasing the pain of historical trauma, and fourth is transcending the trauma.” (Brave Heart, 1998).

Assessment for SDH along with Historical Trauma and its resulting impact on individuals is an important consideration in completing a comprehensive plan of care for individuals. Key to identification of the effects of SDH along with historical trauma and the provision of historical informed trauma care is listening to the person’s individual story. This may be time consuming and require a trusted relationship with the client being served. A tool that may be helpful with some populations and individuals in identification of historical trauma is the 14 item *Trauma History Screen* (THS) (Carlson et al., 2011). Time to listen to a client’s individual experience will be key to identification of the full ramification of a patients generational and life experience.

Dr. Brave Heart offers three major hypotheses for the intervention model:

1. Education increases awareness of trauma.
2. Sharing effects of trauma provides relief.
3. Grief resolution through collective mourning/healing creates positive group identity and commitment to community.

Dr. Brave Heart specifies Six Phases of Historical Unresolved Grief:

1. 1st Contact; life shock, genocide, no time for grief, Colonization Period: Introduction of disease and alcohol, traumatic events such as Wounded Knee Massacre.
2. Economic competition, sustenance loss (physical/spiritual).
3. Invasion/War Period: extermination, refugee symptoms.
4. Subjugation/reservation Period: confined/translocated, forced dependency on oppressor, lack of security.
5. Boarding School Period: destroyed family system, beatings, rape, prohibition of Native language and religion; Lasting Effect: ill-prepared for parenting, identity confusion.
6. Forced Relocation and Termination period: transfer to urban areas, prohibition of religious freedom, racism and being viewed as second class; loss of governmental system and community.” (American Indian and Alaska Native Mental Health Research: *Journal of the National Center*, 01 Jan 1998, 8(2):56-78). PMID: 9842066).

When we read the hypotheses and phrases above, it is obvious that we are seeing these experiences play out today and will be working with persons and families who are migrants from many countries who are victims of historical trauma and unresolved grief.

Please note that Dr. Brave Heart often published articles on her findings and recommendations in journals rather than books, so locating some of her publications can be challenging. Also note that there are several YouTube videos where Indigenous persons and other populations that describe their SDH experiences and responses to Trauma and Grief.

The phenomena of Historical Trauma, Intergenerational, Transgenerational Trauma, and Unresolved Grief must be considered in preparing nurses in ambulatory care operationalizing Transition Management in their day-to-day work with patients and families.

References

American Indian and Alaska Native Mental Health Research: *Journal of the National Center* 01 Jan 1998, 8(2), 56-78 PMID: 9842066.

Barajas, J., Zurek, S., & Solari-Twadell, P.A. (2020). Historical Trauma. In Solari-Twadell, P.A. Nurses - Providing Access to Community-based Healthcare
<https://loyolanpath.com/historical-trauma-in-the-native-indian-population/>

Beals, J., Manson, S., Whitesell, N., Spicer, P., Novins, D., & Mitchell, C. (2005). Prevalence of DSM-IV disorders and attendant help seeking in 2 American Indian Reservation populations. *Archives of General Psychiatry*, 162, 99-108.

Beristain, C., Paez, D. & Gonzalez, J. (2000). Rituals, social sharing, silence, emotions, and collective memory claims in the case of Guatemalan genocide. *Psicothema*, 12 (Supl.), 117-130.

Bombay, A., Matheson, K., & Anisman, H. (2009). Intergenerational trauma: Convergence of multiple processes among First Nations peoples in Canada. *Journal of Aboriginal Health*, 5(30), 6–47. <https://doi.org/10.3138/ijih.v5i3.28987>.

Bombay, A., Matheson, K., & Anisman, H. (2014). The intergenerational effect of Indian residential schools: Implications for the concept of historical trauma. *Transcultural Psychiatry*, 5(3), 329–338. <https://doi.org/10.1177/1363461513503380>.

Brave Heart, M.Y.H. (1999) Oyate Ptayela: Rebuilding the Lakota Nation through addressing historical trauma among Lakota parents. *Journal of Human Behavior and Social environment*, 2(1/2), 109-126.

Brave Heart, M.Y.H. (2000) Wakiksuyapi: Carrying the historical trauma of the Lakota. *Tulane Studies in Social Welfare*, 21-22, 245-266.

Brave Heart, M.Y.H. (2001) Clinical assessment with American Indians in R. Fong & S. Furuto (Eds), *Culturally competent social work practice: Practice skills, interventions, and evaluation* 163-177 and 285-298. Reading MA: Longman Publishers.

Brave Heart, M.Y.H., DeBruyn, L.M., Crazy Thunder, D., Rodriguez, B., & Grube, K. (2005). This is hallowed ground: Native Voices from Ground Zero, in Danieli, Y. & Dingman, R. (Eds) *On the Ground After September 11: Mental Health Responses and Practical Knowledge Gained*. New York: Haworth Press.

Brave Heart, M.Y.H (2003) The Historical Trauma Response Among Natives and Its Relationship with Substance Abuse: A Lakota Illustration, *Journal of Psychoactive Drugs*, 35(1), 7-13.

Brave Heart, M.Y.H. (1998). The return to the sacred path: Healing the historical trauma response among the Lakota. *Smith College Studies in Social Work*, 68(3), 287-305.

Carlson, E.B, Smith, S.R., Palmieri, P.A. Dalenberg, C.J. Ruzek, J.I., Kimerling, R. Burling, T.A. & Spain, D.A. (2011). Development and validation of a brief self-report measure of trauma exposure: The Trauma History Screen (PDF). *Psychological Assessment*, 23, 463-477. Doi:10.1037/a0022294.

(Dass-Brailsford, 2007; Rakoff et al, 1966). A Practical Approach to Trauma: Empowering Interventions by Priscilla Dass-Brailsford (2007-02-14)

M Y Brave Heart, L M DeBruyn (1998) (*The American Indian holocaust: Healing historical unresolved grief*).

Solari-Twadell, P.A. "Nurses - Providing Access to Community-based Healthcare" (N-PATH). Nurse Education, Practice, Quality and Retention (NEPQR- Registered Nurses in Primary Care (RNPC). Award Number 5UKIHP31718-04-00. Unique Federal Award Identification Number (FAIN) UK131718. July 1, 2018 – June 30, 2022).

World Health Organization (WHO). Social determinants of health. Retrieve on October 17, 2022 from https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1