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Ground-Up Approach to Understanding the Impacts of Historical Trauma in One Reserve-Dwelling First Nations Community

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Objective: First Nations peoples experience disproportionate health inequities compared to most non-Indigenous populations. Historical trauma is one factor that has received growing attention in relation to health inequities among First Nations populations. The goal of the present study was to improve understanding of the specific forms, impacts, and mechanisms of transmission of events that lead to historical trauma and the historical trauma response in First Nations peoples. ***Method:*** Five focus groups were conducted among adult members of one First Nations community in Canada ($N = 34$; 70.4% female). ***Results:*** Conventional content analysis revealed the numerous forms that historical trauma take in this First Nations community; individual-, familial-, community-, and societal-level impacts of historical trauma; and ways in which historical trauma has been transmitted in this community. Loss of culture, alcohol use, and parenting were major themes identified across these domains. ***Conclusions:*** Findings provide important information on the experience of historical trauma in one First Nations community, highlighting the roles of loss of culture; alcohol use; and parenting in the forms, impacts, and transmission of historical trauma.

What is the public health significance of this article?
This study provides important information on the experience of historical trauma in one reserve-dwelling First Nations community. Results highlight the roles of loss of culture, alcohol use, and parenting in historical trauma. An important next step is to use this Indigenous knowledge to guide the development and rigorous evaluation of a culturally grounded, trauma-informed intervention that addresses historical trauma among First Nations peoples.

Keywords: historical trauma, First Nations, Indigenous, alcohol use

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In concert with public health priorities and initiatives aimed at addressing health care inequities, there has been increasing research attention to North American Indigenous peoples of the United States and Canada, including American Indian, Alaska Native, Native Hawaiian, and other Native Pacific Islander peoples in the United States and First Nations, Métis, Inuit, and other Aboriginal peoples in Canada, among others. First Nations communities in Canada are widespread, with more than 1.67 million Canadian people—or approximately 5% of the population—identifying as First Nations (Statistics Canada, 2021).[1] First Nations peoples experience a disproportionate burden of disease, injury, and violence as well as fewer opportunities to achieve optimal health compared to the non-Indigenous Canadian population (Adelson, 2005; Frohlich et al., 2006). Life expectancies for First Nations men and women are 72.5 and 77.7 years, respectively, compared to 81.4 and 87.3 years for non-Indigenous Canadian men and women (Park, 2021). Infant mortality deaths are more than twice as high for the First Nations (vs. non-Indigenous) population in Canada (Sheppard et al., 2017). First Nations peoples experience elevated rates of chronic and infectious diseases such as diabetes and lung disease (Tjepkema, 2002), greater behavioral health concerns (e.g., harmful alcohol use; Spillane et al., 2015), and higher rates of suicide (Kumar & Tjepkema, 2019) compared to non-Indigenous people in Canada. These concerning statistics have led to numerous and ongoing calls from scholars and community members alike to better understand the contributions to health inequities among First Nations communities (Adelson, 2005; Frohlich et al., 2006).

One overarching factor that has received growing attention in the literature in relation to health disparities among North American Indigenous populations is historical trauma (Gone et al., 2019). Historical trauma describes emotional and psychological wounding over the life span and across generations stemming from the massive cumulative trauma associated with the historical loss of culture, land, and relatives, among other effects of colonization (Brave Heart, 1998). The distinguishing characteristics of historical trauma—its widespread impact among Indigenous populations, perpetration by outsiders with purposeful and destructive intent, and resultant collective distress in contemporary communities—make this form of trauma particularly devastating for Indigenous individuals, families, and communities (Evans-Campbell, 2008). The historical trauma response (Brave Heart et al., 2011) is a constellation of physical, psychological, and social problems related to this accumulated historical trauma (Walters et al., 2011) and includes responses at the individual (e.g., mental health), familial (e.g., parental stress), and community (e.g., breakdown of traditional culture) levels (Evans-Campbell, 2008). These consequences of historical trauma are transmitted intergenerationally as descendants continue to identify emotionally with ancestral and present suffering (Sotero, 2006).

First Nations communities have faced histories of genocide, colonization, forced assimilation, and exclusion that have caused harm to health and well-being. The mass traumas to which Indigenous peoples have been subjected have resulted in the disruption and devastation of economic systems, sustenance practices, spiritual customs, kinship networks, and family ties, causing historical losses of people, land, family, and culture (Brave Heart, 1998; Brave Heart & DeBruyn, 1998; Heart et al., 2011). A prominent institutional example experienced by First Nations peoples of Canada is the residential school system. The purpose of the residential school system was to force Indigenous peoples to assimilate to European cultural standards, accomplished through banning Indigenous language; adoption of a foreign religion; forced haircuts/shaved heads; lack of nutritious diet and insufficient quantities of food; and vilification of local cultural traditions (Bombay et al., 2014). Strict rules were developed, and harsh enforcement by staff occurred, including starvation and physical and sexual abuse (Bombay et al., 2014), which, for many, resulted in death (Coletta, 2021). The last of Canada's 139 residential schools only closed in 1998 (Chrétien, 2013), highlighting the fact that many First Nations peoples are still recovering from the direct effects of historical trauma. Further, as evidence of mass graves of First Nations children continues to be uncovered (Coletta, 2021), First Nations peoples are exposed to ongoing reminders of trauma experienced in their communities.

Although the events that lead to historical trauma have been well documented in First Nations communities (Crawford, 2014; Gone, 2009, 2013), research on the historical trauma response has been far more limited in this North American Indigenous population (Bernards et al., 2019; Bombay et al., 2009, 2014). Indeed, empirical investigations of the historical trauma response have almost exclusively focused on Indigenous communities within the United States—predominantly among the Lakota (Brave Heart, 1999, 2003; Brave Heart & DeBruyn, 1998). While this formative work has been instrumental to understanding the widespread and long-lasting consequences of historical trauma—and has encouraged scholarly exploration within this field (e.g., Whitbeck et al., 2004, for measures applicable across tribes)—further inquiry regarding the generalizability of these findings to other Indigenous groups is imperative. Indeed, while there are important distinctions and cultural diversity across North American Indigenous bands (Voyageur & Calliou, 2000), significant similarities may exist with regard to events that lead to historical trauma and the ways in which the historical trauma response manifests.

Consistent with this assertion, work on historical trauma among First Nations persons in Canada highlights impacts to individuals (e.g., elevated rates of depression, anxiety, posttraumatic stress, and substance use), families (e.g., greater parental disengagement, neglect, and abuse; fewer positive parent–child interactions), and communities (e.g., erosion of trust; silence; deterioration of social norms, morals, and values; Bombay et al., 2009) that are similar to what has been described in other North American Indigenous peoples (Whitbeck et al., 2004). As one example, Bombay et al.'s (2014) review of the intergenerational effects of residential schools provides evidence for the enduring links between Indian residential school attendance and psychological distress among the descendants of those who attended. Another study showed that a greater number of

[1] While it is important to acknowledge the substantial diversity both within and between North American Indigenous groups, it is also important to highlight the fact that colonialization led to the development of "arbitrary, foreign impos(ed)" borders (DePasquale et al., 2009), resulting in North American Indigenous groups with communities in both the United States and Canada often not being seen as a united people (DePasquale et al., 2009). Indeed, precolonization, tribal sovereignty was identified through tribal land that separated the continent based on its inhabitants. With colonization, arbitrary borders separated the United States and Canada to define and uphold European colonization of tribal lands and enforce new European autonomous governments. Consequently, North American Indigenous peoples and tribal lands were separated based on which side of the border they fell and were differentially categorized as American Indian tribes and First Nations bands.

historical losses among individuals from First Nations communities increased the likelihood of depression and anxiety (Bernards et al., 2019). These early works underscore the need for additional research on the impacts of historical trauma among First Nations peoples.

It is critically important to acknowledge the immense strength and survivance (Vizenor, 2008) that Indigenous communities showcase despite historically traumatic events and lasting impacts. Research on the health of Indigenous persons has centered on narratives of deficits and pathology, positioning Indigenous peoples' health as a problem to be solved (Fogarty et al., 2018). Such deficit-based narratives have promoted pathologizing views of Indigenous peoples as being prone to negative health outcomes and in need of intervention. These perspectives not only uphold settler-colonial ideals regarding health (Todd, 2016) but also conceal the resources and capacities of Indigenous peoples that have maintained health and well-being that have overcome multiple centuries of attempts to eradicate Indigenous peoples through genocide, colonization, forced assimilation, and exclusion (Bryant et al., 2021). In contrast, the Indigenous intellectual Vizenor (2008) introduced the term survivance, which is a portmanteau of survival and resistance. This concept emphasizes the legacy of survival that is instilled in Indigenous peoples and acknowledges and leverages the aspects of Indigenous peoples' identities that have resulted in resistance, continuing presence, and triumph in the face of historical events of oppression (Vizenor, 2008). In conjunction with investigating the lasting impacts of historical trauma, research that includes methods to elicit strengths and survivance is essential to the development of interventions that are relevant to and valued by Indigenous peoples (Kirmayer et al., 2011; Wilbur & Gone, 2023).

Thus, the goal of the present study was to better understand historical trauma in First Nations peoples, including the specific forms, impacts, and mechanisms of transmission of events that lead to historical trauma and the historical trauma response. We also explored the specific relation of historical trauma to lived trauma and alcohol use. The aims of this study were part of a larger study to develop a culturally grounded, trauma-informed alcohol intervention for one reserve-dwelling First Nations group. Consistent with growing calls to reframe health interventions with an emphasis on community strengths and survivance, this intervention will draw from Indigenous history, language, values, and healing traditions to aid Indigenous peoples in reclaiming cultural beliefs, practices, and aspirations that promote health and well-being and restore order to daily living in accordance with ancient and enduring cultural values. In line with recommendations both set forth in the literature and advocated for by Indigenous communities (Bassett et al., 2012), this work was carried out through a close collaborative partnership between one reserve-dwelling First Nations group and researchers with expertise in trauma and alcohol use among North American Indigenous (e.g., First Nations) populations. Consistent with the goals of the larger study, focus groups were conducted to gather Indigenous knowledge, protocols, and practices related to events that led to historical trauma and the historical trauma response from the "ground up." The present study presents qualitative findings on historical trauma events and the historical trauma response in this community.

Method

All procedures were reviewed and approved by the University of Rhode Island's institutional review board. This study was conducted following Consolidated Criteria for Reporting Qualitative Studies guidelines (Tong et al., 2007). We report how we determined our sample size and all data exclusions, manipulations, and measures. Our community partner has expressed the desire to not publicly share their data because of the potential for misuse and stigmatization, as well as possible identification (see Norton & Manson, 1996, for research considerations when working with Indigenous communities). This practice aligns with Indigenous data sovereignty or the right for Indigenous peoples to determine the means of collection, access, analysis, interpretation, management, dissemination, and reuse of data pertaining to the Indigenous peoples from whom it has been derived or to whom it relates (Walter et al., 2021). This study's design and its analysis were not preregistered.

A community-based participatory research approach was used at every stage of the research process—from developing and refining study questions to planning the study protocol, to conducting the study, to disseminating study results—to facilitate an authentic, collaborative, and equitable relationship with community partners. Community-based participatory research is guided by a set of core principles, including colearning, community capacity building, equal benefits, and a long-term commitment to reduce health disparities (Wallerstein & Duran, 2006). Such engagement facilitates the inclusion of unique experiential understanding and underlying values of community partners (Gone, in press) and ensures that research priorities reflect their concerns and preferences (Kapiriri & Norheim, 2002). Collaboration with key stakeholders also provides opportunities for improved research outcomes, including validity and relevance (Bate & Robert, 2006). For instance, collaborative partnerships ensure that research is relevant within the context of a community's resource constraints and preferences (DiStefano et al., 2013); elicits a community's strengths, autonomy, and capacity to solve problems; and emphasizes exchange of knowledge and critical dialogue (Israel et al., 2017; Collins et al., 2018).

Participants

Participants ($N = 34$) were recruited in 2021 from one First Nations community in Canada using mailed flyers and letters sent to each household in the community and distributed within community buildings and through an advertisement in the community newsletter. To increase recruitment, we also used snowball sampling (i.e., participants were asked to send information about the study to people who may be interested and eligible to participate). To recruit elders, the principal investigators collaborated with members of the band and the health center to obtain recommendations for whom to invite to participate. Participants were stratified into the following focus groups: elders, individuals currently using alcohol, individuals abstinent from alcohol (in recovery), and health care workers. Each group had six to eight community members of mixed sexes. Information was not collected on the number of people who refused to participate.

Eligibility criteria for individuals who were currently using alcohol included (a) alcohol use within the previous week. Eligibility criteria for individuals in recovery from alcohol use included (a) being abstinent from alcohol for at least 1 year. Eligibility criteria for elders included (a) no current use of alcohol and (b) being defined as an elder in the community. Eligibility criteria for health care workers included (a) community health workers who worked with the First Nations group, including

individuals working in the alcohol and drug program, the director of the health center, and other community mental health workers. Exclusion criteria for all participants included (a) being under the age of 18 and (b) any current psychotic symptoms.

Measures

Participants provided demographic information on age, sex, race, ethnicity, education level, and household income, as well as their band name, community, and role in the community (e.g., community member, community health care worker, and/or community elder). Participants were primarily American Indian ($n = 32$; 94.1%), with one participant each identifying as White (2.9%) and multiracial (2.9%). Most participants were female ($n = 24$; 70.4%); 10 identified as male (29.4%). Nearly half ($n = 18$; 52.9%) of the participants were between the ages of 36 and 64; six participants each were between the ages of 18 and 35 (17.6%) and over the age of 65 (17.6%). Data on age were missing for four participants. Semistructured interview guides utilizing open-ended questions were created by the principal investigators and focused on understanding historical trauma (e.g., "What historical traumas have been experienced by your community?") and its interconnection with alcohol use (e.g., "What is the relationship between historical trauma and alcohol use?") in this community. Interview guides were developed alongside members of our community advisory board (CAB) who identified questions relevant to the assessment of historical trauma and the historical trauma response as well as provided feedback on questions in these areas that were developed by members of the research team.

Procedure

Community Advisory Board

We utilized a 15-member CAB, composed of influential community members (i.e., elected Band council members) and community members who know the community well, to ensure cultural validity of research findings and to prevent further perpetration of harm caused by researchers within Indigenous communities. The CAB comprised a traditional healer, tribal council members, tribal health care workers, and other community members. The CAB was consulted throughout the entire research process—from planning the study to implementing the project, to finalizing the results and preparing them for publication. A meeting with the CAB prior to proposal development identified the need to heal from historical trauma as a means to reduce alcohol use within the community. Researchers met with the CAB two additional times regarding the focus groups: once prior to focus group data collection (e.g., to inform the study procedures and questions) and once after focus group data collection (i.e., to present the study findings and plan for dissemination). CAB members were compensated $50 for each meeting.

Focus Groups

Focus groups were used to gather knowledge on historical trauma in this community. All focus groups were audio recorded and occurred in a private conference room in the community's centrally located health center, where members of the community receive medical and mental health services. Only the principal investigators and the participants were present for the focus groups. Both principal investigators are licensed psychologists who have PhDs in clinical psychology. Principal investigator Nichea S. Spillane is an associate professor of psychology at the University of Rhode Island and identifies as female and Maliseet. Principal investigator Nicole H. Weiss is an associate professor of psychology at the University of Rhode Island and identifies as female and White. Principal investigator Nichea S. Spillane has a long-standing research partnership with this First Nations community dating back to 2004. Focus groups were moderated by the principal investigators and each lasted approximately 2 hr in duration. At the start of each focus group, information about the researchers (e.g., reasons for conducting this research; bias/assumptions) was shared with the participants. Field notes were taken during the focus groups. Participants were compensated $50 for completing the focus group. Following completion of the five focus groups, the principal investigators assessed saturation and agreed that an adequate sample size had been reached. Recordings were then transcribed by a professional service and subsequently underwent the redaction of all identifying information by the research team. Transcripts were reviewed by the principal investigators for accuracy; they were not returned to the community for comment or correction.

Analytic Strategy

Conventional content analysis was used to interpret the transcripts through systematic coding and thematic classification (Hsieh & Shannon, 2005) to enhance a naturalistic understanding of the transcripts rather than utilizing predetermined codes. Data analysis was an iterative process that began during focus groups and continued throughout data collection. The principal investigators discussed emerging topics and themes as they arose during focus groups; themes/subthemes that formed the coding tree were derived from the data. Following completion of focus groups, the principal investigators, with the support of two advanced graduate students (Silvi C. Goldstein and Tessa Nalven), developed a codebook through immersive reading and reviewing focus group recordings. Silvi C. Goldstein is a doctoral student in clinical psychology at the University of Rhode Island and identifies as a multiethnic White woman. Tessa Nalven is a doctoral student in clinical psychology at the University of Rhode Island and identifies as a Multiracial woman. This codebook was further refined through consensus meetings, pooling codes, and the elimination of redundant or idiosyncratic codes. Using the codebook and ATLAS.ti, a qualitative software program, four graduate students (Reina Kiefer, Alexa M. Raudales, Alana Egan, and Catherine D. Trinh) conducted independent double coding and reliability checks. Reina Kiefer is a doctoral student in clinical psychology at the University of Rhode Island and identifies as non-Hispanic White woman. Alexa M. Raudales is a doctoral student in clinical psychology at the University of Rhode Island and identifies as a Hispanic and Arab woman. Alana Egan is a doctoral student in clinical psychology at the University of Rhode Island and identifies as a mixed-race Native Hawaiian/Pacific Islander woman. Catherine D. Trinh is a doctoral student in clinical psychology at the University of Rhode Island and identifies as a Southeast Asian/Vietnamese woman. For this article, we selected sections of the transcripts that were relevant to the discussion of the impact of historical trauma. Double coding was repeated until consistency (>80%) was reached across reviewers (Miles & Huberman, 1994);

for the present analyses, we achieved an average agreement of above 80% after aggregating the scores from all five focus groups.

Results

Five focus groups were conducted among adult community members of one First Nations group in Canada. Participants responded to a series of questions related to the experience and impact of historical traumas in their community. The principal investigators identified themes for each question based on common responses from participants. While some themes were discussed in-depth, with detailed context, other themes were merely listed by participants as though the themes spoke for themselves. Therefore, we decided to include themes based on the frequency and endorsement of themes mentioned, rather than the depth of context provided. Table 1 shows the themes within each of the overall categories. Prior to submission of this article, the CAB provided feedback on the study findings (e.g., themes). Study findings are being disseminated to the broader community via a community newsletter. Findings are being used to inform the development of a culturally grounded, trauma-informed alcohol intervention for this First Nations group that will undergo a randomized controlled trial during the second phase of this larger study.

Table 1
Themes From Content Analysis of Focus Group Data

Themes and Subthemes
Historical traumas experienced by First Nations peoples
Colonialism, genocide, and racism
Suicide
Loss of culture
Alcohol use
Physical abuse
Impact of historical trauma on parenting, family, relationships, and community
Loss of culture
Broad impact
Family life
Alcohol use
Education and occupation
Psychological
Historical trauma passed through generations
Abuse
Loss of culture
Psychological/emotional
Storytelling
Colonization
Alcohol use
Historical trauma linked to living trauma
Lack of belonging/displacement
Desensitization to/normalization of trauma
Generational
Access to resources
Fear responses
Relationship between historical trauma and alcohol use
Alcohol as a coping mechanism
Breaking the cycle
Normalization of alcohol via peer/parent use
Availability of alcohol
Colonizers bringing alcohol to the community

Forms of Historical Trauma

Colonialism, Genocide, and Racism

When asked to share what historical traumas had been experienced by their community, participants noted examples of colonialism that included residential and day schools, broken families, broken treaties, and government interference with Indigenous life. Specifically, participants noted laws such as "the Indian Act," which enforced strict colonialized government rules and standards on Indigenous peoples, and "the Pass Act," which prevented Indigenous peoples from leaving a community without permission from an Indian agent (Canadian government representatives on First Nations reserves, Leslie, 2002). One participant explained government interference as: "waltzing in whenever they feel like it and telling you what to do instead of asking you what to do." Further, participants noted the impact of colonization/government impositions on their identities and Band status: "the assumption if there's no father on the birth certificate, the child automatically loses their status." Another participant elaborated: "they become a six-two[2] automatically … My dad's not on my birth certificate, so I'm automatically a six-two. Therefore, my oldest child has no status." Another participant explained: "women … would lose their status by marrying a non-Indigenous person or getting a post-secondary education." Participants experience colonialism as dehumanizing and "complete indoctrination":

> We had to conform to settlers' society … everything about us was made to feel wrong … even now, as somebody who's visibly Indigenous, occupying space in these realms, you can feel your beliefs, your ways, your medicines—like, traditional medicines, traditional practices—are so demonized or dehumanized, not seen as valid.

Experiences with discrimination and racism were noted as how participants experienced historical traumas: "the way you're treated in the healthcare system … how you're treated at the hospital … how you're treated at a drugstore, with your healthcare professional, how kids are treated at school." One participant shared about their children and grandchildren's experiences with racism:

> lots of us in here have little kids, and grandkids, and young kids, and they still experience racism and abuse … it's not always straight out, but you feel it when you feel it. So, sometimes it's more of a feeling than a straight out slight.

Regarding institutional racism, one participant remarked on the specific experience of racist stereotypes within health care settings: "the language they use when somebody goes to the hospital [is] drug-seeking. Or if it's an Indigenous patient, their pain is not valid, and they don't believe them. And if it's an Indigenous baby … it's addicted." Further, another participant spoke about "the over-incarceration of [Indigenous] people" as a by-product of racist policing and law enforcement noting, "we make up five percent of

[2] Six-two refers to a circumstance known as "the second generation cut-off," regarding Indian registration authorized by the federal government. The federal government has the sole authority, using the Indian Registrar, to decide who has the right to be registered as having Indian status. If a person, who is registered under Section 6(1) (one may be registered under Section 6[1] if both of their parents are, or were, registered, or entitled to be registered), has a child with someone without Indian status, their children will have a right to register under Section 6(2). If a person, who is registered under Section 6(2), has a child with a non-Indian person, then their children will not have a right Indian registration (Assembly of First Nations, n.d.).

the national population, but we're 25 to 50 percent represented in institutions across this nation." Furthermore, "genocide" was also mentioned as an example of historical trauma when asked about historical trauma experienced by First Nations peoples.

Suicide

Several participants shared about the high rate of deaths-by-suicide within their community as experiences of historical trauma within the community. Specific examples of suicides mentioned included intentional car accidents and drownings. One participant noted the impact: "We had suicides. That was very traumatic for our community just 'cause we're so tight-knit … it affects everybody."

Loss of Culture

Another common theme in response to historical trauma experienced by participants included loss of culture, such as loss of language and loss of ceremonies. One participant shared how school rules prohibited Indigenous cultural practices:

> [In] the high school, I know we've had quite a few students that complained because … there's some that use smudging to calm themselves down, and they're not allowed to do that inside the high school. And, you know, they just take any chance they can to stop our ways of healing ourselves.

Another participant explained how certain government policies banned cultural practices, such as the Pass Act, which prohibited the "harvest[ing … of] traditional foods."

Alcohol Use

Alcohol use was another example of what historical traumas had been experienced by their community.

Physical Abuse

Participants mentioned specific punishment tactics used by teachers in the residential and day schools (e.g., "strapping").

Impact of Historical Trauma

Loss of Culture

One of the most frequent topics that arose from discussions about the impact of historical trauma was the loss of culture. Specifically, participants discussed the loss of culture through the loss of their Native language: "back in the day, if they talked the language, they would be punished … that's why … most have never talked … that's why we never learned. Because our parents were punished for talking." The loss of Native language was often discussed in the context of fearing punishment. For instance, one participant noted: "[My father] didn't speak the language to us because he didn't want us to be abused." This participant also explained that their father "didn't teach us a lot of what he knew" regarding his work as a medicine man. Participants also shared about the "loss of ceremony" and the "loss of stories," given that elders are the only remaining keepers of such info: "we're losing a lot of our stories from our elders because a lot of our elders are passing on. So, we didn't have much time with them."

Family Life

Participants spoke about the impact of historical trauma on family life, including the "division of families" or separation from family members. Historical traumatic events, like forced attendance at residential schools, directly impacted the separation of children from parents and created a ripple effect of traumatic loss of family systems, loss of culture, and thereafter loss of traditional healing methods and coping skills. For example, one participant discussed living with their grandmother because their mother and father were "alcoholics, abusive … emotional, [and] manipulative." Another participant described the impact of trauma from surviving residential schools on their marriage: "It definitely had an effect on my marriage … my ex-husband is a residential school survivor, so it affected him, and his behaviors, and his choices, which affected me and our children."

Alcohol Use

Alcohol use, including drinking alcohol because of parents' drinking habits, was also mentioned as an impact of historical trauma. For example, one participant recalled consuming alcohol for the first time at the age of 5, stating, "It was given to me by an adult." They elaborated, stating that the next time they consumed alcohol, they did so "willingly" at the age of 12, "and then … it just escalated from there." Another participant noted the link between physical abuse and parents' drinking: "Most of the ones that endured abuse were the ones that their parents might have drank." Others discussed how their parent's alcohol use resulted in living with other family members (e.g., "I lived with my grandmother for most of my life … because my mother and my father were both alcoholics").

Traumatic Stress

The pervasive psychological impact of historical trauma was referenced by numerous participants as well. Multiple participants remarked that historical trauma "affected everything." One participant stated, "It affects everything. But that was the intent, right? Genocide was the intent. We were never meant to be here. All of us. We're miracles." Participants specifically described the "normalization of trauma" as well, stating that they were simply "around trauma all the time." Participants explained becoming "desensitized" to emotion, avoiding historical trauma-related memories and conversations: "most of these people … probably got strapped and they probably don't even want to admit it." Other examples included fear or hypervigilance about having their children taken away:

> if you didn't have both parents, it made it easier for them [government workers] to waltz in anytime they felt like [it], to look in your cupboards, and look in your fridge … I can't imagine … their stress … back then.

Education and Occupation

Participants also shared about the impact of historical trauma on their education (e.g., "how far you go in school") and occupation (e.g., "career choices"). Government interference on education was mentioned as an impact of historical trauma. For example, one participant recalled their experience of receiving threats from the

government if their children did not attend school: "Whenever you didn't go to school for a couple [of] days, the government worker would come in and say, you know, you don't get your kids to school, they're going to be taken away."

Intergenerational Transmission of Historical Trauma

Abuse

When sharing about how historical trauma has been passed through generations, physical abuse emerged as a frequent topic. Some participants spoke about the impact of the abuse that took place within the residential schools (e.g., "the abuse from the residential schools was so integrated into them"), and many shared about the cycle of abuse within families (e.g., "you live what you learn"; "they only did what they were taught, and they passed it on to us, and we continued it"). One participant shared about witnessing arguments between their parents and experiencing physical abuse themselves, highlighting the way in which abuse was normalized: "you witness abuse. Seeing your … parents fighting … We think that's a norm. So, we start doing that. Or even spanking our children. I know for a fact … that I got spanked by my mom." Regarding the experience of abuse, participants spoke about being spanked and hit with objects (e.g., a fly swatter, a switch). Others elaborated on how the prevalence of abuse led to its normalization and that a lack of examples of other forms of punishment may lead to using physical punishments with their own children:

> I'm going to be truthful about it … she wouldn't keep quiet … So you know, I stopped the van, pulled over and ch-ch-ch,.But it was anger, right … It wasn't, you know, because I hate her. It was because of that spur of the moment … That was the last time I ever, you know.

Loss of Culture

Numerous participants noted the loss of Indigenous culture as an example of historical trauma passed through generations. Loss of Native language was the most common example shared by participants. One participant noted, "I'm 45 years old and I wish I would have known my Native tongue. I don't know how to speak it. I don't know how to understand it." Participants expressed sadness when recounting the reasons for loss of language:

> Parents that could speak the language fully stopped teaching their children because they didn't want their children to get beat the way they got beat. And it's really sad … so many people have lost it. That's going to take a long time to come back.

Sharing about the traumatic impact of residential schools on the loss of culture, one participant said:

> The abuse from the residential schools was so integrated into [my parents] that even when it was long past those times, they would still hide and gather in secret just so they could speak their language. And they wouldn't do it outside. It would just always be in the safety of their own homes.

Parenting

Independent of corporal punishment, participants also spoke about how historical trauma passed through generations has changed parenting practices. For example, one participant explained:

> Like, sometimes it's the silent treatment or ignoring your child. When traditionally, our parents were very attentive. It's like, even in our parentings systems like, co-sleeping, that was just sleeping. But colonial forms of parenting mean you put your baby in the crib and don't attend to it when it's crying where our parents were very attentive and picked their baby up when they were crying.

Also mentioned was how the separation of families (e.g., residential schools, adoptions) impacted parents' expression of love toward their children, as well as their ability to support their children with guidance in school and life:

> People were taken away and they had no love. So, a lot of people don't know how to show love. They also don't know how to accept it because they were stuck in residential schools or even in the day schools and experienced so much abuse that they don't know how to parent their children. They don't know how to help them with school. They don't know how to guide them in good directions.

Psychological/Emotional

Parents' low self-esteem, confidence, and self-worth were also listed as examples of historical trauma passed through generations. One participant spoke about "unhealthy coping mechanisms" (e.g., "not talking about things, keeping things buried"), which they posited were developed in response to the "shame of residential school or Indian day school." Another participant noted how the communal experience of historical trauma has led to the tendency to connect over tragic rather than joyous events:

> So, you will bond with the people you're close to over a traumatic event, right? You'll always bitch and complain about the neighbor, the kid, your job versus seeing the good things that you can bond about, right? So, I really notice that in smaller communities. And it happens everywhere, but that we'll bond over a crisis, we'll bond over a tragedy, but people won't bond in celebration.

Storytelling

When asked about how historical trauma is passed through generations, participants remarked about their experience of hearing stories of abuse from older relatives (e.g., "For me, it's hearing stories, like, from older—my aunts or uncles talking about it").

Colonization

The impact of colonialization was another theme noted as an example of historical trauma passed through generations. One participant explained: "the government taught us to fight amongst each other. You know, and now to this day, we compete to this day for supremacy, so we don't have to be poor."

Alcohol Use

The use of alcohol in the community was mentioned as an example of historical trauma passed through generations.

Historical Trauma Linked to Living Trauma

Lack of Belonging/Displacement

Displacement emerged as a frequent theme in discussions about living trauma. Experiences of displacement were referenced in the context of emotional/psychological belonging as well as physical (i.e., land) belonging:

> Not being in a community for a long time and coming back … makes a big difference regardless if it was residential school that displaced you from your community or you moved out of your community to have a job, or go get an education, or you met somebody … so, when you leave and come back, you feel displaced.

Elaborating on this lack of belonging, one participant shared about knowing a person that calls themselves a "displaced Indian" because:

> they were adopted by a non-Native family and then realized they were Indigenous … if you're not born and raised in a community, sometimes you're made to feel that you don't belong no matter how much you try … that's what Indian Affairs created by making people have [blood] status.

On the topic of blood quantum status,[3] another participant noted:

> Blood quantum's colonial, and I think even the creation of reservations is colonial. You were put on this piece of land, made to feel uncomfortable and to sever your relationship with the land. And then, this is the place where we all feel comfortable now. It's like, we don't feel comfortable on the rest of our territory because we've been displaced from that, and that connection has been lost.

Desensitization to/Normalization of Trauma

When asked how historical trauma is linked to living trauma, numerous participants spoke about the communal desensitization to trauma: "A lot of desensitization of our people going down to living traumas. It doesn't affect a lot of people the way it should." Others shared how historical trauma has been "normalized" as an example of living trauma.

Generational

Relatedly, participants noted how the normalization of trauma has contributed to the challenge of disrupting generational cycles (e.g., "how do you stop a cycle if you don't know you're in it?"). The insidiousness of historical trauma was referenced as well: "you don't really recognize that you're retraumatizing your children when you think that you're not, right?" Another participant spoke about the role of shame (e.g., due to experiencing abuse) in driving avoidance of conversations about historical trauma:

> A lot of our parents back then were ashamed for certain things. So, they didn't talk about it, right? It was just kind of, like, you didn't mention it to nobody and that's how it was passed on down … [they] didn't talk to you about it because they didn't know how to. They weren't taught how to handle certain situations. So, it was just kind of like, tucked under the rug … you didn't say nothing because you didn't know who believed you.

When sharing about the impact of the domestic violence they witnessed as a child, one participant spoke about their efforts to disrupt the cycle of abuse:

> I grew up with two parents and I've seen a lot … my dad would drink, you know? I've seen him, you know [implying domestic violence] to my mother … when I had my family, I had kind of—that's not going to be in my family, so I was trying to stop it. But some of my kids in relationships are hitting their partners and I'm like, where did that come from? How did it skip from me but you're doing it?

Access to Resources

Limited access to mental health resources was also mentioned as an example of living trauma. For instance, one participant explained the impact of limited resources: "not having direct resources … you don't know how to channel it and you never dealt with it in the right way … you just take it out on your spouse, children, whoever it may be." Another participant elaborated, stating that "nobody really developed any coping mechanisms" or "had anybody to confide in."

Fear Responses

Relatedly, mental health symptoms that align with fear responses were listed as examples of living trauma (e.g., hypervigilance). One participant shared:

> I think fear had a lot to do with it. Like, if you get a classmate who did something wrong in the teacher's eyes, and you're saying, well, I grew up with this guy and then, all of the sudden, you see him get strapped, or hit with a cane, or a yardstick, and you know you helped that guy out with his homework, then all of the sudden you say, am I next?

Alcohol Use and Historical Trauma

Alcohol as a Coping Mechanism

The frequent common theme that emerged from participants' responses about the relationship between historical trauma and alcohol use was the use of alcohol as a coping mechanism in response to historical trauma. Some spoke about using alcohol to "numb the pain," "escape," or suppress trauma-related emotions and thoughts:

> Most of the time, they were trying to repress their memories, so they could sleep through the night; we have so many people who are … functioning alcoholics. They work, they raise families, but every night they drink themselves to sleep … just having … a mechanism to cope with the trauma they've been through.

Speaking on the link between historical trauma and alcohol use, one participant reasoned, "it was probably a way of … not thinking about it." Another noted, "they don't cope through processing their

[3] Blood quantum status refers to the federal governments' classification of "Indian status," defined by the fraction of relationship to one's Native American ancestors who are documented as full-blood Native Americans (Schmidt, 2011). The terms identity, ethnicity, and heritage in the North Americas are all entangled with the English conception of race, born out of the English colonization biophysically defining and manufacturing Indigenous groups into a synthetic process that formalized and institutionalized differences among early Indigenous populations (Schimidt, 2011). Beginning in the early 1800s, blood quantum status became an identifier for the federal government to grant various benefits, usually land and money, to mixed individuals with Native American descent (Schimidt, 2011).

emotions or their feelings. It's 'cause they don't know how or were never taught. So, it's like they've seen people numb with substances and that comes to fruition in their adulthood." Participants also discussed the use of alcohol to manage anxiety. For example, some spoke about relief from social anxiety: "you don't worry about what someone else is going to think of you." Another noted,

> You can stand there and dance, or sing, or do whatever you want to do without worrying, "oh my God, they're going to see me and they're going to think I'm a total dork." Because you just don't care what they think.

Other participants talked about drinking as an activity to cope with boredom: "I don't have nothing to do, you know what I mean? And I think, go over to the liquor store … I've got nothing to do. It's a boring day." Last, participants discussed using alcohol to upregulate positive emotions, such as feelings of self-confidence, particularly with one's appearance: "sometimes you feel seen when you drink, or you feel beautiful when you never felt beautiful as a child."

Breaking the Cycle

Another theme that emerged from discussions about the relationship between historical trauma and alcohol use included disrupting the cycle of generational alcohol use. For example, one participant—who shared that their father was a "recovering alcoholic" (e.g., "I don't remember my father drinking, ever. But … my mom said that he was an alcoholic") and that their mother "hated" alcohol because her "parents were alcoholics"—spoke about avoiding alcohol out of respect for their mother:

> I think out of ten of us [siblings] I'm the only [one] that didn't indulge in that kind of stuff and I think it was because I had that much respect for my mom … she was like shattered because my older siblings were having fun [i.e., drinking] and it was her anniversary or her birthday … she was so broken-hearted … she was bawling.

Further, this participant also spoke about the impact of witnessing their peers drink: "Hanging out with my peers and seeing the way they would act when they … had a few too many … I didn't want that for me. I don't know. Thank God." Others reported avoiding alcohol for other reasons (e.g., "I never drank and I didn't care what people think"; "I wouldn't drink it because I didn't like the taste of it"). One participant shared about attempts to "stop the cycle" by moderating the alcohol they drank in front of their children: "I don't drink in front of my children. Not the way … they [participant's parents] drank in front of me … So, I tried to stop the cycle in that way."

Normalization and Availability of Alcohol

Normalization of alcohol use (via parental or peer use) was raised when discussing its link to historical trauma. For example, one participant stated, "We have to have the liquor there, right. And some of the children … snuck some liquor away … when we had a chance." Another participant shared, "if your life hasn't been going good or you're hanging around with people that like to drink, of course you're going to drink." Another participant shared about their mother providing them with alcohol to help with menstrual cramps when they were a teenager: "rather than give us a pill or something, she bought a pint. And she said for us to drink that, said that would kill your cramps." Relatedly, several participants spoke about the widespread availability of alcohol: "you go to almost every house there's … going to [be] liquor. So, of course, everyone's going to try it."

Colonizers Bringing Alcohol to the Community

Another theme that emerged from discussions about the link between historical trauma and alcohol use is the role of colonizers: "Alcohol was used as a tool to destroy us, you know. And then it created addictions for our people." Others shared about how colonizers provided alcohol as a form of voting coercion: "they brought alcohol to us and even passed it out as a way to get [us] to vote for [them] in the provincial and federal elections … Turned our people into alcoholics."

Discussion

The present study is the result of a collaborative partnership between one reserve-dwelling First Nations group and researchers with expertise in trauma and alcohol use among North American Indigenous (e.g., First Nations) populations. A community-based participatory research approach using qualitative methods was used to gain a deeper understanding of historical trauma in one First Nations community to ultimately inform a culturally grounded and trauma-informed alcohol treatment. Specifically, focus groups were conducted with community elders, individuals who reported current alcohol use, individuals who were abstinent from alcohol (in recovery), and health care workers to gather Indigenous knowledge related to events that lead to historical trauma and the historical trauma response. Findings highlighted the specific forms, impacts, and mechanisms of transmission of events that lead to historical trauma and the historical trauma response in one First Nations community, as well as the relation of historical trauma to lived trauma and alcohol use. Cross-cutting themes that emerged from our analyses are further described below, and implications for future research and clinical practice are discussed.

One theme that emerged across all questions was the prominent role that loss of culture plays in historical trauma. Specifically, many participants highlighted the loss of culture as a historical trauma event experienced by their community, a way in which the historical trauma response manifested and was passed along to subsequent generations in their community, and a mechanism through which historical trauma increased the risk for lived trauma (e.g., sexual violence) and alcohol use. This finding underscores the potential utility of fostering reattachment to cultural values and practices in interventions aiming to address historical trauma with First Nations persons, consistent with evidence-based recommendations for Indigenous populations (Gone, 2009). Reattachment to cultural values may be achieved through engagement in traditional cultural practices, such as prayer and ceremonies (e.g., smudging, sweats, focus groups), language learning, and storytelling (e.g., telling of legends specific to the culture).

Engagement in such practices may aid in reversing the damage that has been done by historical trauma on cultural identity, belonging, and purpose, such as by connecting Indigenous peoples to their pretraumatic past and limiting transmission of historical trauma across generations (Brave Heart, 1998, 1999; Brave Heart & DeBruyn, 1998; Gone, 2009, 2013, 2023; Grayshield et al., 2015;

Heart et al., 2011; Nutton & Fast, 2015). This approach aligns with best practices for culturally grounded interventions, whereby Indigenous worldviews and protocols are central to the design and implementation of treatments (Dickerson et al., 2020; Gone, 2021b; Walters et al., 2020). Culturally grounded interventions draw from cultural strengths, using Indigenous history, language, values, and healing traditions as a way for Indigenous populations to reclaim their cultural beliefs, practices, and aspirations that promote health and well-being (Belone et al., 2017; Dutta, 2007).

At their core, they focus on restoring order to daily living in accordance with ancient and enduring cultural values (Castellano, 2014; Gone & Calf Looking, 2011, 2015). Further, culturally grounded interventions center on Indigenous knowledges and ways of being that underlie health and well-being among Indigenous peoples, which differ from Western worldviews, to increase the salience and utility of these interventions for Indigenous communities (Smith, 1999; Wilson, 2001). For instance, as described by Walters et al. (2020), culturally grounded interventions move beyond adapting interventions drawn from Western-based theories by rooting intervention processes in Indigenous knowing, doing, and being in the world (Martin & Mirraboopa, 2003). Such commitments can reflect and represent the decolonization of the therapeutic endeavor (Gone, 2021a).

However, despite calls by Indigenous populations, a dearth of interventions have been developed from the ground up and empirically tested through randomized controlled trials. Early studies highlight the potential utility of targeting collective mourning, facilitation of communal connection based on Indigenous ways of being, awareness of the intergenerational transmission of trauma, and re(connection) to cultural values in the treatment of historical trauma among Indigenous persons. As one example, Historical Trauma and Unresolved Grief (HTUG) is one treatment that targets the historical trauma response through the stimulation of generational traumatic memories (Brave Heart, 1998, 1999, 2003). Improvements have been shown following HTUG, including increases in positive Lakota identity and family connectedness, and decreases in negative emotions (Brave Heart, 1998); yet, evaluations of HTUG have been limited to the Lakota and have not occurred through randomized clinical trials. Research that applies a culturally grounded framework to address historical trauma is a crucial step to improving the health and well-being of First Nations persons (Gone, 2009).

Another common theme was that of alcohol use in relation to historical trauma. Alcohol was identified as a specific type of historical trauma in this community, as well as part of the historical trauma response and transmission processes. Prior to colonial contact—except for specific ceremonies—alcohol was not part of Indigenous culture (Brave Heart, 2003). Historical trauma experienced by Indigenous populations resulted in cultural shifts in alcohol use. Acts of oppression stemming from colonization, such as the banning of traditional ways of healing, left Indigenous populations without mechanisms for coping with emotional distress (Brave Heart, 1998) or alternative sources of reinforcement (Spillane & Smith, 2007). Subsequently, the effects of weaponized alcohol, coupled with the emotional aftereffects of other mass cumulative trauma, left Indigenous peoples without adaptive ways of coping. In turn, Indigenous peoples began using alcohol as a way of self-medicating to cope with emotional pain (Brave Heart, 2003), although it is notable that Indigenous peoples have reported lower rates of current alcohol use compared to other racial/ethnic groups (Substance Abuse and Mental Health Services Administration, 2011).

These observations are consistent with empirical findings, with one recent scoping review finding that 86.4% of studies found evidence for a positive link between alcohol and other drug use and historical trauma (Spillane et al., 2022). For instance, the findings of Whitbeck et al. (2004) showed that higher levels of historical loss predicted an increased likelihood of alcohol use disorder among American Indians. Similarly, Wiechelt et al. (2012) found that historical trauma symptoms were significantly positively associated with past-month alcohol use in an urban American Indian sample. A consistent pattern of findings has been detected among qualitative studies, with Indigenous peoples identifying historical trauma as contributing to alcohol use in their communities (Brown et al., 2016; Goldstein et al., 2022; Gonzales et al., 2018; Trinidad et al., 2020). Notably, fostering reattachment to cultural values may also be one mechanism through which to address alcohol use resultant from historical trauma. Specifically, consistent with the principles of behavioral choice theory and behavioral economics (Khoddam & Leventhal, 2016; Spillane & Smith, 2007), engagement in cultural practices may serve as an alternative reinforcer for alcohol use among First Nations persons (Spillane et al., 2013, 2020, 2021).

Engagement in cultural practices also plays a key role in mitigating and preventing alcohol use because abstaining from alcohol use is often a prerequisite to engaging in cultural practices (Goldstein et al., 2021; Spillane et al., 2013, 2020). However, it is important to acknowledge the challenges to (re)connecting to Indigenous epistemologies and their corresponding core values and actions that have resulted from centuries of colonization. For instance, language conveys worldviews, and thus there is an inherent link between language loss resultant from forced assimilation and Indigenous peoples' ability to understand relationality and one's place in relation to everything else in the world (King, 2009). Addressing alcohol use resultant from historical trauma in First Nations groups is relevant to public health as it may increase the risk for lived trauma, consistent with findings here, theoretical explanations (high-risk hypothesis; Windle, 1994), and empirical findings among North American Indigenous persons (Spillane, Nalven, et al., 2022).

Parenting was a third theme that emerged across most of the questions. Participants described how historical traumas disrupted their family structures, took away their ability to engage in traditional parenting, and increased physical abuse within families. Further, they described how the consequences of historical trauma were maintained and exacerbated through intergenerational cycles that undermined healthy family functioning and child development. This is consistent with the larger literature, which indicates that experiences of childhood trauma may impede adults' abilities to provide consistent and responsive caregiving to their children. Specifically, parents can rely on excessively punitive or emotionally detached caregiving when they lack models in their own lives of parents and other trusted adults providing love and protection (Cicchetti et al., 2006). Literature in this area underscores how intergenerational cycles of trauma manifest within families (Chamberlain et al., 2019); this extends to communities in the context of historical trauma.

For instance, the results of Walls and Whitbeck (2012) revealed that grandparent-generation participation in government relocation programs negatively affected not only grandparent-generation well-

being (i.e., depression symptoms, alcohol and drug problems) and parenting (i.e., caretaker warmth and support) but also subsequent generations' well-being (i.e., depression symptoms, delinquency) among families who lived on or proximate to four American Indian reservations in the Northern Midwest and four Canadian First Nation reserves. Evidence here for the important role of family systems in the intergenerational transmission of historical trauma highlights the need for interventions that target caregiver–child relations in healing from historical trauma in First Nations communities. Notably, however, a recent review of trauma intervention adaptations for Indigenous caregivers and children found a limited number of examples of such interventions ($n = 13$); only four of these were developed in partnership with the community the program was meant to serve and only one was developed among First Nations peoples (Richardson et al., 2022). This represents an important avenue for future work on historical trauma in First Nations communities.

Finally, participants raised concerns about access to mental health resources, which is an important consideration for intervention development with Indigenous communities. A recent review of the literature identified several barriers to mental health help seeking in Indigenous populations, including a preference for informal (vs. formal) mental health supports, structural obstacles to accessing mental health services (e.g., limited availability of mental health services and inaccessibility to services), stigma against help seeking for mental health conditions, self-reliance and uncertainty about whether mental health services would be helpful, mistrust and fear of formal mental health services, and the need for outreach and information regarding mental health and services (Goetz et al., 2023). Treatment development efforts with Indigenous populations should consider these barriers, such as reducing structural obstacles and supports by bringing mental health services into the community and providing transportation, stigma by integrating mental health services into general medical health care, and mistrust by having Indigenous facilitators and embedding services into existing services (see Goetz et al., 2023, for additional examples of facilitators to mental health help seeking for Indigenous populations).

Although the present study adds to the growing body of literature on historical trauma in North American Indigenous communities, several limitations must be considered. First, while our results reveal similarities in the historical trauma response across populations that have been impacted by historical trauma, our findings only reflect the perspectives of 34 reserve-dwelling individuals from one First Nations community. Thus, while this sample size was adequate to achieve saturation (Guest et al., 2017), findings may not represent the experiences of other individuals in this community (e.g., those living off reserves), other First Nations groups in Canada, and North American Indigenous communities broadly. Future research should explore this question by using larger samples and expanding recruitment to other First Nations and North American Indigenous reserve communities, as well as to urban-dwelling First Nations and North American Indigenous peoples. Second, our utilization of snowball sampling recruitment has limitations, most notably the potential that we recruited a nonrepresentative sample of this reserve-dwelling First Nations community.

Third, consistent with traditional cultural practice in this First Nations group, we utilized focus groups. While focus groups were the preference of the community—and research suggests a number of strengths of focus groups compared to individual interviews (e.g., interpersonal nature produces information that may not be gathered from a single respondent; generation of a wider range of views and ideas than could be captured through individual methods, Kidd & Parshall, 2000; valuable for studying systemically excluded and marginalized populations, Peek & Fothergill, 2009)—focus groups require more time and effort to generate the data (Guest et al., 2017). Further, it is possible that participants were more likely to provide socially desirable and stereotypical answers in this group setting (Acocella, 2012), and thus focus groups may have been a less effective method of generating a broad range of responses (Guest et al., 2017). Indeed, elders were not excluded from participating in the alcohol use, alcohol recovery, or health care worker group, and their presence could have influenced what information was shared by other members. Finally, the requirement for elders to have no current alcohol use is an important limitation that curtails the range of perspectives available, given that alcohol use is a downstream effect of historical trauma.

Conclusion

The results of the present study provide important insight into the experience of historical trauma in one reserve-dwelling First Nations group. Specifically, our results characterize events that lead to historical trauma and the historical trauma response itself in one First Nations group, highlighting the roles of loss of culture, alcohol use, and parenting in the specific forms, impacts, and mechanisms of transmission of historical trauma. Notably, while many of the events that have led to historical trauma in First Nations peoples are distinct from those events experienced by other populations impacted by historical trauma (e.g., slavery among African Americans, Henderson et al., 2021; the Holocaust among Jews, Felsen, 1998), our results reveal common threads in the historical trauma response across these populations—specifically, loss of culture, self-medication (e.g., alcohol use), and disruption to family systems. Accordingly, our findings on historical trauma may be generalized to and integrated within the extant literature on related, but distinct, occurrences of historical trauma in non-Indigenous populations for the purpose of advancing understanding of the historical trauma response. Further, our results indicate that interventions designed to address the historical trauma response may benefit from incorporating common themes across populations impacted by historical trauma, including both Indigenous and non-Indigenous groups. In particular, the present study underscores the utility of fostering reattachment to cultural values and family relations in interventions aimed at addressing historical trauma and alcohol use among First Nations persons. An important next step in this area is to leverage this Indigenous knowledge of historical trauma to guide the development and rigorous evaluation of a culturally grounded, trauma-informed intervention that addresses historical trauma among First Nations persons. Further, knowledge gained from this study may be used to inform local actions aimed at historical trauma in this community.

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